

EFFECTS AND MEDIATION OF CHILD-CENTERED PLAY THERAPY ON
YOUNG CHILDREN WHO ARE ANXIOUS

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Anxiety is one of the most pervasive childhood disorders, with a poor prognosis if left untreated. Traditional methods of treating anxiety have been less effective with young children. Based on theoretical assumptions regarding the potential effectiveness of child-centered play therapy (CCPT) as a treatment approach, I sought to explore the effects and mediating factors of CCPT on young children with symptoms of anxiety. Fifty-three participants between the ages of 6 to 8 years old were recruited from four elementary schools, including 36 males and 17 females. Of participants, 11 were African American, 24 were Caucasian, 10 were Hispanic/Latino, one was Asian, and seven were biracial. Twenty-five participants were randomly assigned to an experimental group receiving a mean of 15 sessions of individual CCPT, and 28 participants were assigned to an 8-session active control group. Five factorial analyses of variance (ANOVA) were conducted applying an alpha level of .05 for interpretation of statistical significance and Cohen's *d* to assess practical significance. ANOVA results indicated a statistically significant interaction with a large effect size on Total Anxiety score of the Revised Children's Manifest Anxiety Scale-2nd edition ($p = .013$, $d = .715$). Subscale ANOVA results indicated a statistically significant interaction effect with large effect size on the Worry subscale ($p = .006$, $d = .795$), no statistically significant interaction on the Defensiveness subscale ($p = .710$, $d = .110$), no statistically significant interaction but moderate effect size on the Physiological subscale ($p = .076$, $d = .506$), and no statistically significant interaction but moderate effect size on the Social Anxiety subscale ($p = .162$, $d = .398$). Statistically significant differences with large practical effects were found in total anxiety and worry, suggesting that children who received CCPT

decreased their overall levels of anxiety and worry whereas children who were in the active control group increased their levels of anxiety and worry. When examining differences in relationships between groups, the CCPT group relationship scores were significantly higher than the control group relationship scores, as reported by counselors. Although the groups were different in their relationships, the relationship was not considered a statistical mediator of anxiety due to the lack of correlation between relationship scores and outcome. Overall, children seemed to benefit from CCPT, and it may be considered a viable treatment for children who are anxious. Due to the lack of mediation of relationship found in this study, further research is encouraged to consider other mediating and/or moderating effects when attempting to investigate the therapeutic relationship as a mediator.

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Happy is the heart that still feels pain. Darkness drains and light will come again. Swing open up your chest and let it in. Just let the love, love, love begin...

The song lyrics capture my experiences throughout the doctoral program while also expressing the meaning and depth of my relationships throughout this time. The following relationships have all provided something unique for me to develop into who I am today. I cannot even begin to express the amount of gratitude I feel for having each of you in my life. To Dee- For seeing me and providing acceptance and empathic understanding always. To Sue- For providing warmth, acceptance, and light. To Casey- For providing encouragement, space, and opportunities. To my cohort- For allowing my own exploration while always being a constant group of support, encouraging learning and growth, and for accepting me as me. To past mentors- For laying the foundation for me to begin this journey. To my clients, supervisees, and students- For teaching me more than I thought was possible. To my family (grandparents, parents, Jeffrey, aunts, uncles, and cousins)- For being there from the beginning, always ready to cheer, comfort, or celebrate in whatever shape that would take, and for not taking life too seriously. To Danny- For loving me unconditionally.

...Everybody heals with love.

Ingrid Michaelson

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EFFECTS OF CHILD-CENTERED PLAY THERAPY ON YOUNG CHILDREN WHO ARE ANXIOUS

Between 10 and 20% of children experience heightened levels of anxiety, resulting in anxiety as the most prevalent childhood disorder (Costello, Egger, & Angold, 2004; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Ezpeleta, Keeler, Erkanli, Costello, & Angold, 2001; Kendall, Furr, & Podell, 2010). The National Institute of Mental Health (NIMH, 2013) estimated that 25% of 13 to 18 year olds experience an anxiety disorder, with 5.9% experiencing “severe” anxiety disorders. Unfortunately, prevalence of anxiety for young children is not specifically available.

Children experience anxiety and fear as a normal part of development. When anxiety outgrows developmental appropriateness or is intense for children, anxiety may have surpassed the normal threshold (Lyness-Richard, 1997; Muris, 2001; Ollendick, Grills, & Alexander, 2001). Anxiety becomes an issue of concern when the level of severity begins to impact the child or the family system (Kendall, Chansky, Kane, Kim, Kortlander, Ronan, Sessa, & Siqueland, 1992). Clinical levels of anxiety that are intensely experienced impair a child’s ability to master developmentally appropriate tasks, and prevent the ability to self-regulate when the anxiety provoking event is not occurring (Knell & Dasari, 2006).

Children’s anxiety symptoms mirror those of adults, encompassing physiological, behavioral, and cognitive components. The anxiety experienced by children is multifaceted and can be a result of a combination of stimuli (Kendall et al., 1992). The duration of fears may result from a lack of support or coping skills to overcome fears (Lyness-Richard, 1997). If left untreated, children with anxiety disorders are at high risk for developmental delays because of the high level of comorbidity and low levels of remission (Kendall et al., 2010; Paul, & Barrett,

2010; Pollock, Rosenbaum, Marrs, Miller, & Biederman, 1996, McLoone, Hudson, & Rapee, 2006; Seligman & Ollendick, 1998; Silverman & Kurtines, 1996). Children who have anxiety disorders struggle with academic achievement, family cohesion, general happiness, self-esteem, and social and peer relationships (Kendall et al., 2010; Rapee, Wignall, Psych, Hudson, & Schniering, 2000). They tend to experience a great deal of personal distress based on their levels of anxiety (Rapee et al., 2000).

Currently, cognitive-behavioral therapy (CBT) is the best-supported intervention for childhood anxiety disorders based on its research foundation (Compton, March, Brent, Albano, Weersing, & Curry, 2004; McClellan & Werry, 2003; Silverman, Pina, & Viswesvaran, 2008; Weisz, Jensen, & McLeod, 2005). Several meta-analyses and systematic reviews have been conducted with studies utilizing CBT as an intervention for childhood anxiety (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Compton et al., 2004; In-Albon & Schneider, 2007; Silverman et al., 2008). These meta-analyses have concluded that CBT is effective and an evidence-based treatment for children with anxiety.

However, many gaps in the literature still exist, specifically with young children. Most CBT studies conducted with children have an average age ranging from 8 to 13. Studies with children younger than 8 lack information to calculate effect sizes (Compton et al., 2004; McKay & Storch, 2009; Silverman et al., 2008). CBT is not effective in reducing anxiety diagnoses for 20 to 40% of children who successfully complete treatment (Silverman et al., 2008). In addition, characteristics such as symptom severity, negative self-statements, comorbidity, and family patterns contraindicate the use of CBT (McKay & Storch, 2009; Rey, Marin, & Silverman, 2011). Although Anticich, Barrett, Gillies, and Silverman (2012) reviewed successful early CBT interventions for children with anxiety, there were few that explored the use of CBT treatment

directly with young children. Primarily, the focus of treatment has been with parents for children of that age group, despite the internalizing nature of anxiety. Grave and Blissett (2004) proposed that young children's thinking is based solely on their experiences and perceptions of those experiences. They have egocentric views of the world, lacking the ability to take another's perspective or view themselves as separate from their environment. Additionally, young children have all-or-nothing thinking and struggle to distinguish how something that was bad could potentially be good. Cartwright-Hatton et al. (2004) noted that "for some groups, particularly very young children, it is likely that traditional CBT will never be appropriate" (p. 430). Therefore, it is important to consider other approaches to working with young children who are anxious.

Person-Centered Approach to Anxiety

Person-centered theorists believe that anxiety is a result of incongruence between experience and self-structure that ultimately forces a change in the self-structure (Bryant-Jefferies, 2012; Wilkins, 2010). More specifically, anxiety occurs as the person's self-structure feels threatened. Threat occurs "when an experience is perceived or anticipated (subceived) as incongruent with the structure of the self" (Rogers, 1959, p. 204). People develop a self-concept in childhood and can become rigid in their self-structure through interactions with their environments that lack empathy, acceptance, and genuineness. If a person is operating out of a rigid self-structure, personal experiences may not match a personal sense of self; hence the person will feel threatened, creating anxiety or incongruence. The level of anxiety is dependent upon the level of threat experienced to the self-structure (Rogers, 1959).

Person-centered theory proposes the therapeutic relationship as the curative factor in counseling. Within the therapeutic relationship are the environmental conditions necessary for change including empathic understanding, unconditional positive regard, and genuineness (Rogers, 1957). Child-centered play therapy (CCPT) was created as a developmentally appropriate application of person-centered theory to working with children (Axline, 1947). For children who exhibit symptoms of anxiety, CCPT is a proposed intervention based on the theoretical assumption that the relationship between counselor and child is the change factor that helps reduce anxiety, specifically when the intervention is delivered to children in their developmentally appropriate language of play.

Theoretically, CCPT is an effective modality in helping lessen anxiety as it allows children to be self-directed, with the understanding that children know what they need (Landreth, 2012; Ray, 2011). CCPT does not force children to face what they are not yet ready to face. Additionally, CCPT helps foster a greater sense of self with a more integrated self-structure. The diminished incongruence resulting from a more integrated sense of self is inherently a lessened state of anxiety and discomfort. Furthermore, children who are in a secure relationship with the play therapist, characterized by congruence, empathy, and unconditional positive regard, will be able to accept parts of themselves and their experiences that they have denied, including fears and anxiety. This greater self-acceptance will lead to self-understanding, self-integration, and congruence within the child.

CCPT is identified as the most popular theoretical approach to play therapy (Lambert, Leblanc, Mullen, Ray, Baggerly, White, & Kaplan, 2005). Between 1947 and 2010, 62 studies on play therapy effectiveness have been conducted (Ray, 2011), with more continuing to be published every year. Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analysis on the

effectiveness of play therapy as a treatment intervention. They included 93 studies in their analysis and calculated a large overall effect of 0.80, demonstrating effectiveness of play therapy across theoretical orientations, presenting problems, and outcomes measured. When specifically viewing nondirective or humanistic types of play therapy, 73 studies were included with an overall mean effect size of 0.92. The meta-analysis included 24 studies conducted on internalizing problem behaviors, such as anxiety and depressed mood, with an effect size of 0.81. Seven studies measured anxiety as an outcome with an effect size of 0.69.

Individual CCPT studies have examined anxiety as an outcome in relationship to main presenting issues. In exploring the impact of play therapy with 168 at-risk fourth, fifth, and sixth graders, Post (1999) used measures for self-esteem, locus of control, and anxiety in a pre-posttest design while studying the impact of CCPT with school children identified as at-risk. Regarding anxiety, neither children in the experimental group nor control group decreased anxiety at a statistically significant level. Shen (2002) investigated the effects of short-term group play therapy on anxiety, depression, and adjustment with 30 Chinese earthquake victims in grades 3 through 6. Physiological anxiety and Worry/Oversensitivity [HS1] were statistically and practically reduced in children who participated in play therapy. Rae, Worchel, Upchurch, Sanner, and Daniel (1989) determined that hospitalized children who had two 30 minute sessions of CCPT were less fearful of the hospital compared to children who did not receive CCPT. Baggerly (2004) studied the effects of child-centered group play therapy on self-concept, depression, and anxiety on 42 children, ages 5 to 11, who were homeless. After receiving between 9 to 12 sessions of group play therapy, statistically significant decreases in total and physiological anxiety were noted. Although CCPT seems to be promising in the reduction of anxiety symptoms associated

with other presenting issues, there appears to be a void in the literature regarding the impact of play therapy with children who are seeking treatment specifically for anxiety.

Purpose

The purpose of the present study was to explore the effects of CCPT with young children experiencing anxiety. Due to high prevalence rates of anxiety in the child population and the lack of developmentally appropriate interventions for young children, there is a need to explore effective interventions that best meet the needs of young anxious children. This study sought to determine if participation in CCPT resulted in substantial positive outcomes for children demonstrating anxiety symptoms. The examined research question was: What impact does CCPT have on young children with reported elevated levels of anxiety symptoms?

Method

Participants

Participants were recruited from four Title 1 elementary schools in the southwest United States. Criteria for inclusion in this study included the following: 1) Children were between 6 and 8 years old; 2) Children's scores on any subscale of the Revised Children's Manifest Anxiety Scale fell in elevated range with a *t*-score above 50 or fell in the Clinical or Borderline range on the Anxious/Depressed subscale on the Teacher Report Form with *t*-scores above 65; 3) Children understood and spoke English; 4) Parents were willing to give consent; 5) Teachers of children were willing to complete instruments. Fifty-five participants were recruited who met criteria for anxiety threshold. Two were dropped from the study due to inconsistencies with play therapy delivery.

Of the 53 participants, 5 were in kindergarten, 22 were in first grade, and 26 were in second grade. The age range of participants was from 6 to 8 years old with 26 6-year-olds, 24 7-year-olds, and 3 8-year-olds. There were 36 males and 17 females who participated. Of participants, 11 were African American, 24 were Caucasian, 11 were Hispanic/Latino, 1 was Asian, and 6 were biracial. Twenty-five participants were in the play therapy group and 28 participants were in the active control group.

Instruments

Revised Children's Manifest Anxiety Scale. The Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2; Reynolds & Richmond, 2008) is a 49-item self-report measure of anxiety for children 6 to 19 years old. Each question is answered by circling either "yes" or "no" in response to a statement. The RCMAS-2 consists of six scales, two validity scales and four anxiety scales. The validity scales are Inconsistent Responding Index and Defensiveness. The anxiety scales are Total Anxiety, Physiological Anxiety, Worry, and Social Anxiety. The Total Anxiety score encompasses all questions related to physiological anxiety, worry, and social anxiety. Physiological Anxiety assesses physiological responses that often accompany anxiety. The Worry scale assesses children's level of fear, nervousness, or oversensitivity to environmental pressures. The Social Anxiety scale measures concern about self in relation to others. All of the scales were used as qualifying criteria for this research study, including defensiveness as children who are responding defensively may be more anxious than they are reporting (Reynolds & Richmond, 2008).

When scoring the RCMAS-2, raw scores are calculated then translated into T scores. T scores above 60 fall in the significant range, suggesting that the respondent has difficulties with

anxiety. T scores that are 71 or higher are categorized as extremely problematic while T scores from 61 to 70 are considered moderately problematic. T scores above 50 indicate elevated levels of anxiety. T scores below 40 indicate that respondents are unusually anxiety free.

Reliability estimates for the RCMAS-2 are considered strong. Reynolds and Richmond (2008) reported a Cronbach's alpha of .92 for Total score of the RCMAS-2, with subscale scores ranging from .75 to .86. When examining test-retest reliability, they reported Total score at .75, with ranges from .64 to .73 for the subscale scores. Reynolds and Richmond reported that validity of the RCMAS-2 has been thoroughly examined through theoretical considerations in creation and careful construction of items.

Teacher Report Form. The Teacher Report Form (TRF; Achenbach & Rescorla, 2001) assesses children's level of functioning as reported by teachers. The TRF can be used with children ages 6 to 18 years old. For the purpose of this research, the Anxious/Depressed subscale was used as a screening for inclusion criteria. The Anxious/Depressed subscale measures children's behaviors that may be indicative of anxiety or depression if displayed in excess of that observed with other children. For the Anxiety/Depressed subscale, T scores below 64 are considered normal. T scores between 65 and 69 are in the borderline range. T scores 70 and above are considered to fall in the clinical range.

The TRF reports strong psychometric properties. The TRF has internal consistency ratings from .54 to .96 on subscales and test retest reliability ranging from .86 to .89. Achenbach and Rescorla (2001) reported test-retest reliability estimate for the Anxious/Depressed subscale at $r = .68$.

Procedures

Human subjects approval was obtained prior to the recruitment of participants for this study. School personnel were asked to identify children who seemed anxious and exhibited problems in school such as picking their skin, having frequent headaches, or crying, items under the Anxious/Depressed subscale of the TRF. Following informed consent and assent, teacher and child measures were completed to determine eligibility for the study. The RCMAS-2 was administered individually and directly to the children and the TRF was administered to teachers of identified children.

In accordance with randomized controlled trial procedures, children who met criteria were randomly assigned into a treatment or active control group by school. Children in the experimental group received two 30 minute individual CCPT sessions per week for the period of 8 weeks. Participants in the active control group participated in 30 minutes of weekly small activity groups over 8 weeks.

The study was designed to provide 16 CCPT sessions for the experimental group and 8 activity sessions for the active control group over 8 weeks. Due to student and counselor absences and inclement weather, children in CCPT received between 12 and 16 sessions of play therapy with a mean of 15.32 sessions. To control for attention, children in the active control group participated in an activity group once a week over the 8-week period. Due to student and counselor absences and inclement weather, children in the control group received between 6 and 8 groups with a mean of 7.32.

At the completion of the 8-week period, the RCMAS-2 was administered as a post-test measure. Additionally, children in the active control group were provided play therapy services at the conclusion of the 8 weeks.

Experimental group procedures. Children assigned to the treatment group participated in 12 to 16 30-minute sessions of individual CCPT over 8 weeks. CCPT uses children's natural language of play to provide a therapeutic environment that is developmentally appropriate for young children. Treatment was provided according to the protocol as outlined in CCPT treatment manual (Ray, 2011). Counselors responded with verbal and nonverbal communication to develop the therapeutic relationship including empathic responses, limit setting, returning responsibility, and facilitating emotional expression. Counselors used these skills to facilitate a warm, empathic, and non-judgmental environment.

Playrooms were assembled and materials chosen based on recommendations by Landreth (2012) and Ray (2011). The toys in the playrooms were selected to match the developmental age of children and to allow for maximum communication potential. Toys were representative of many categories, such as nurturing, mastery, aggression, imaginary, and creative expression in order to facilitate a wide range of emotional expression. Protocol adherence was assessed through fidelity checks of video-recorded sessions utilizing the Play Therapy Skills Checklist (PTSC; Ray, 2011). One session per counselor was randomly selected and reviewed in its entirety by the researcher. Sessions adhered to CCPT protocol over 90% of the time with an average of 96.64% adherence to protocol per session.

The counselors were doctoral level counseling students and one faculty member trained and experienced in play therapy procedures. All participating counselors had a minimum of a master's degree in counseling and had conducted play therapy for at least one year prior to participating in the study. Each counselor completed at least two play therapy courses and a counseling practicum with an emphasis on play therapy. Counselors included 9 females who identified as Caucasian ($n = 7$), Asian ($n = 2$), and African American ($n = 1$). Counselors

participated in a two hour training prior to delivering play therapy services to explain the protocol for conducting play therapy in the schools and emphasizing the use of CCPT skills and attitudes. Additionally, counselors received weekly supervision by advanced CCPT trained play therapists.

Active control group procedures. Children assigned to the active control group received a coloring based weekly activity group facilitated by doctoral level counselors. Students participated in groups of 2 to 4 students with one counselor. The purpose of the active control group was to address the internal validity threat of attention provided to children in the experimental group. Hence, the active control group participated in a task-oriented relationship with the counselor. Groups were designed to simulate typically activities conducted in schools.

The counselors for the small activity groups were doctoral level counselors with training and experience in school guidance. Guidance training consisted of a university course on school counseling, including guidance delivery. Further, group counselors were required to attend training conducted by the investigator on coloring activity protocol.

Results

In order to address the research question of determining play therapy's effectiveness on children's anxiety, the Total Anxiety score on the RCMAS-2 was utilized as the dependent variable and treatment group as the independent variable. Following the initial analysis, a series of repeated measures analysis of variances were conducted as post hoc analyses with treatment group as the independent variable and the remaining RCMAS-2 scales as the dependent variables to gather more information regarding the change in anxiety scores. Statistically significant differences between the means across time were tested at the .05 alpha level for Total Anxiety on

the RCMAS-2 and Anxious/Depressed subscale on TRF. The alpha level for the post hoc RCMAS-2 subscale analyses was lowered to .025 to control for Type 1 error. Mean scores for pre and post RCMAS-2 total and subscale scores for experimental groups are provided in Table 1. ANOVA results are provided in Table 2.

Total Anxiety on the RCMAS-2

The first ANOVA assessed the impact of play therapy and an active control group on participants' total scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. When examining the means of the groups over time, observation indicates a trend in which scores of the play therapy experimental group decreased (marking improvement) and scores of the active control group increased (marking deterioration).

There was a statistically significant interaction between treatment group and time, $F(1, 51) = 6.569, p = .013$, with a large effect size of Cohen's $d = .715$ and power of .71. There was no significant effect for time, $F(1, 51) = .749, p = .391$, with a small effect of Cohen's $d = .230$. The main effect comparing the two groups was not significant, $F(1, 51) = 2.265, p = .139$, with a moderate effect size of Cohen's $d = .424$.

Defensiveness Scores on RCMAS-2

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' defensiveness scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of

observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met.

There was no significant interaction between treatment group and time, $F(1, 51) = .140$, $p = .710$, with a small effect size of Cohen's $d = .110$. There was no significant effect for time, $F(1, 51) = .001$, $p = .974$, with a small effect of Cohen's $d = .009$. The main effect comparing the two groups was not significant, $F(1, 51) = .068$, $p = .795$, with a small effect size of Cohen's $d = .063$.

Physiological Anxiety Scores on RCMAS-2

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' physiological anxiety scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. When examining the means of the groups over time, there is a noticeable trend of the play therapy group scores decreasing in Physiological Anxiety and the control group scores increasing.

There was no significant interaction between treatment group and time, $F(1, 51) = 3.276$, $p = .076$, with a moderate effect size of Cohen's $d = .506$. There was no significant effect for time, $F(1, 51) = .292$, $p = .592$, with a small effect of Cohen's $d = .146$. The main effect comparing the two groups was not significant, $F(1, 51) = 2.505$, $p = .120$, with a moderate effect size of Cohen's $d = .445$.

Worry Scores on the RCMAS-2

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' worry scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. When examining the means of the groups over time, there is a noticeable trend of the play therapy group scores decreasing in Worry and the control group scores increasing.

There was a statistically significant interaction between treatment group and time, $F(1, 51) = 8.318, p = .006$, with a large effect size of Cohen's $d = .795$ and power of .81. There was no significant effect for time, $F(1, 51) = 1.708, p = .197$, with a small effect of Cohen's $d = .340$. The main effect comparing the two groups was not significant, $F(1, 51) = 2.527, p = .118$, with a moderate effect size of Cohen's $d = .445$.

Social Anxiety Scores on RCMAS-2

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' social anxiety scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. When examining the means of the groups over time, there is a noticeable trend of the play therapy group scores decreasing in Social Anxiety and the control group scores increasing.

There was no significant interaction between treatment group and time, $F(1, 51) = 2.018, p = .162$, with a small to medium effect size of Cohen's $d = .398$. There was no significant effect

for time, $F(1, 51) = .027, p = .870$, with a small effect of Cohen's $d = .045$. The main effect comparing the two groups was not significant, $F(1, 51) = 1.014, p = .319$, with a small effect size of Cohen's $d = .279$.

Discussion

The current study sought to determine the efficacy of CCPT with young children who are anxious. To date, there has been no play therapy study found in review specifically designed to identify and treat children with clinical levels of anxiety. Results of the current study indicated that play therapy was an effective intervention in reducing self-reported anxiety symptoms for young children. This finding provides evidentiary support for the use of CCPT with clinically anxious children. CCPT appears to be an appropriate intervention for both anxiety and worry in children in addition to offering prevention for the worsening of anxiety in children.

Effectiveness of CCPT with Children who are Anxious

Over the course of the present study, children who participated in play therapy demonstrated statistically significant improvement over children who participated in the active control group on Total Anxiety and the Worry subscale of the self-reported RCMAS-2. Statistical, practical, and clinical significance found for total anxiety speaks to the level of effectiveness of CCPT for young children who were identified as clinically anxious. Mean differences on all subscales of the RCMAS-2 indicated that children who participated in play therapy demonstrated a trend of improvement while children in the active control group demonstrated deterioration of symptoms. Although no previous studies concentrated solely on anxiety and play therapy, these results are consistent with group play therapy studies with young

children who were homeless (Baggerly, 2004) and children who experienced trauma (Shen, 2002) that showed statistically significant reductions in anxiety after participating in child-centered group play therapy.

Richmond and Reynolds (2008) described the Worry subscale of the RCMAS-2 in the following way: “A high WOR score suggests the respondent is afraid, nervous, or in some manner oversensitive to environmental pressures. A high score on this scale may indicate a child or adolescent who internalizes much of the anxiety he or she experiences and who may thus get overburdened with trying to relieve this anxiety” (p. 18). Richmond and Reynold’s conceptualization of the worry scale as an indicator of oversensitivity to environmental pressures supports the person-centered conceptualization of anxiety as an outcome of incongruence between person and environment. Hence, CCPT offers an intervention that provides an environment that supports the child’s ability to explore, change, or strengthen the self in connection to the perceived environment. Theoretically, as children are in a warm, understanding, and accepting environment, their developmental capabilities are released, allowing for greater self-exploration and expression (Landreth, 2012). Prior to play therapy, children’s behavior may be rigid in an attempt to defend the self-concept. Rigidity through worry and general anxiety may be one defense to protect the self-concept. Through the process of play therapy, and specifically in the presence of the attitudes provided by the play therapist, children are able to experience a reduced level of threat and begin to assimilate experiences into the self-concept (Landreth, 2012; Ray, 2011). Children begin to try out new behaviors and express new feelings, including taking risks, within the safety of the therapeutic relationship. Children may experience their own strengths and mistakes and accept themselves more fully in the presence of a play therapist who is providing this acceptance as well for them. The acceptance provided from

a play therapist may allow a child to develop greater inner strength and security within the self. Children develop a greater valuing of themselves as they reduce their fears and negative sense of self-worth. They begin to live more in the present, reducing levels of worry and anxiety for the future. Additionally, they begin to experience more of a feeling of control through experiencing the attitudinal conditions from their play therapists. Through the therapeutic relationship, children become more integrated in their self-structures and develop skills to function effectively within their environments, freeing children of the burden of internalization of anxiety (Landreth, 2012; Ray, 2011).

Additionally, worry has been conceptualized as an intrusive cognitive component of anxiety, which shuts down emotional processing of the fear or anxiety that is present for children (Silverman, La Greca, Wasserstein, 1995). Children are unable to integrate emotions effectively when under threat, increasing the need for an environment that facilitates emotional growth and integration for children, such as CCPT (Ray, 2011). Through the therapeutic relationship, characterized by Rogers' six conditions, children and play therapists are able to connect on an emotional level. Rogers' conditions are discussed as more than skills, but attitudes that are deeply felt in the inner person of the play therapist while being emotionally sensed by the child (Landreth, 2012). CCPT seeks to help a child feel understood and accepted at a holistic level. The person of the child is understood and valued, including her or his feelings of anxiety. Children are able to fully experience their anxiety within the presence of a congruent, empathic, and unconditionally accepting person, allowing them to integrate this experience on an emotional level. Child-centered play therapists seek to facilitate emotional growth through their therapeutic responses and attitudes.

Consistent with the anxiety literature (Albano et al., 2003; Kendall, et al., 2010; Paul, & Barrett, 2010; Pollock et al., 2006; Rapee et al., 2000; Seligman & Ollendick, 1998; Silverman & Kurtines, 1996), children in the current study who did not receive mental health intervention began to show trends of further decline through reported levels of increased anxiety. Previous researchers have found that anxiety symptoms that begin in childhood and are left untreated are more likely to continue and be exacerbated in adulthood, culminating in other psychopathology and comorbidity (Albano et al., 2003; Kendall et al., 2010; Rapee et al., 2000). Due to the early onset of anxiety and the high risks associated with untreated anxiety, early-intervention programs are crucial to change the trajectory for anxious children (Pollock et al., 1995).

Prior to this study, CBT had been deemed the only appropriate intervention for children with anxiety (Compton et al., 2004; McClellan & Werry, 2003; Silverman et al., 2008), despite the reported inherent flaws and developmental inappropriateness for young children in addition to the high percentages of children who do not improve as a result of successfully completing treatment (Cartwright-Hatton et al., 2004; McKay & Storch, 2009; Rey et al., 2011; Silverman et al., 2008). The prevalence rates of anxiety in children and the adverse effects of not intervening early further increases the importance of utilizing an intervention that meets the developmental needs of young children and can effectively improve symptoms of anxiety. CCPT intervention is substantially different from CBT, the traditional method of treating childhood anxiety. CBT may be contraindicated for young children with anxiety due to the coexistence of worry, which tends to consume children's thinking and thwart further emotional processing. The cognitive ability to simultaneously hold negative emotions and examine problematic thoughts is a higher order ability and may be limited in young children. Typically, in CBT, children are exposed to an anxiety-provoking stimulus and taught to cognitively work through their anxious thoughts;

however, this approach may be difficult with young children (Silverman et al., 1995). CCPT provides an intervention directed toward a child's developmental level, providing an emotional process outlet through the use of play and relationship, as opposed to cognitively working through thoughts.

Limitations

Although participants were selected for the study based on teacher and self-reports of elevated anxiety, inclusion criteria did not require that each child met diagnostic criteria as an anxiety disorder. Thus, generalizability of results was limited due to utilizing a screening measure as opposed to a diagnostic interview. Although play therapy was targeted as an intervention, the participants may not have met criteria for a generalized anxiety disorder.

A further limitation is lack of similarity across treatment groups. The control group met once a week for 8 weeks, while the play therapy group met twice a week for 8 weeks. Participants who were in the play therapy group received twice as much time with counselors, weakening the comparability of the two groups as equal treatments. However, the active control group was implemented to account for the validity threat, attention, not to serve as a comparable treatment.

Implications for Practice

CCPT is a developmentally appropriate intervention for young children, and results from the current study support its effectiveness with children who are anxious. Historically, person-centered counseling for anxious clients has not been supported by the research when compared to other interventions. In Elliott's (2013) meta-analysis of 19 studies examining the effects of

person-centered counseling with mostly adult clients who were anxious, person-centered counseling was deemed effective when compared to no treatment or pre-post testing; however, person-centered counseling was seen as less effective for treating this population when compared to other methods, primarily CBT, even when accounting for researcher alliance. The current study brings hope and promise for the application of person-centered counseling to the treatment of anxiety, specifically with children. CCPT may serve as a preventative measure for further emotional and behavioral decline in children who are exhibiting symptoms of anxiety. Additionally, CCPT may help improve or relieve anxiety symptoms, specifically overall levels of anxiety and worry.

Additionally, CCPT appears to be a viable and practical option for mental health intervention with children who are anxious. In the current study, all participants who began treatment also completed treatment. No students withdrew from the study for any reason, promoting the viability of treatment. CCPT for children who are anxious seems to be a treatment that children are responsive to and continue to participate in throughout the course of the treatment phase. In addition to demonstrable effectiveness of CCPT in reducing anxiety symptoms, CCPT appears to be accessible and non-threatening to participants, as evidenced by the completion rate of participants. Typically in intervention research in the schools, children are sent to alternative schools or move throughout the duration of the study. The total participant completion rate speaks to the viability of CCPT as a treatment option for children with anxiety.

Implications for Research

As this was the first study designed to specifically examine CCPT with children who are anxious, further studies with this population are needed to demonstrate that results can be

replicated. Additionally, due to previous inconsistent research results regarding person-centered approach and anxiety, it is especially important to seek consistent similar results. Furthermore, effectiveness research with children who are anxious should be extended into long-term research, examining the lasting effects of CCPT on anxiety. Determining the effectiveness of CCPT immediately after treatment is a positive finding; however, demonstrating long-term maintenance of the effects would strengthen the supporting evidence for CCPT as an effective intervention.

To further expand on the knowledge of CCPT effectiveness with children who are anxious, it would be important to examine other mediating and moderating effects of CCPT. The research base and therefore knowledge of educators, supervisors, and practitioners could be enhanced by truly understanding the mechanisms of change that are operating in CCPT. Additionally, moderators, or inherent characteristics that affect responsiveness to interventions, could be investigated to determine if CCPT is more effective with certain types of children or other therapeutic conditions.

Conclusion

This study sought to explore the effects of child-centered play therapy (CCPT) on young children with symptoms of anxiety. Theoretically, CCPT could be an intervention to intervene effectively with young children who are anxious. Anxiety is considered one of the most current and pervasive childhood disorders, with a poor prognosis if left untreated. Furthermore, traditional methods of treating anxiety have been less effective with young children. This study examined the effect of CCPT on 53 children who were anxious compared to children participating in an active control group. Statistically significant differences were found in total anxiety and worry, suggesting that children who received play therapy decreased their overall

levels of anxiety and worry while children who were in the active control group increased their levels of anxiety and worry. Overall, children seemed to benefit from CCPT and it may be considered a viable treatment for children who are anxious. Further research is encouraged to consider mediating and/or moderating effects of CCPT with children who are anxious.

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Table 1

Mean Scores on Dependent Variables for Each Group

RCMAS-2 Total Subscale*	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	53.40	9.77	54.54	11.79
Post-Test	49.36	10.52	56.54	11.29
RCMAS-2 Defensiveness	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	53.00	9.52	52.79	9.00
Post-Test	53.36	10.09	52.36	8.62
RCMAS-2 Physiological	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	53.28	9.72	54.57	10.59
Post-Test	50.24	9.71	56.21	8.13
RCMAS-2 Worry*	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	52.52	9.40	53.68	11.64
Post-Test	47.68	10.24	55.50	12.53
RCMAS-2 Social Anxiety	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	53.00	10.26	53.61	11.73
Post-Test	51.16	10.01	55.93	11.93

* Statistically significant at $p < .025$.

Table 2

ANOVAs for RMCAS-2 Total, RCMAS-2 Defensiveness, RCMAS-2 Physiological, RCMAS-2 Worry, and RCMAS-2 Social Anxiety as a Function of Group and Time

Source	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Cohen's <i>d</i>
RCMAS-2 Total Anxiety					
Group	1	456.118	2.265	.139	.424
Time	1	27.482	.749	.391	.230
Group*Time	1	240.916	6.569	.013*	.715
Error	51	36.676			
RCMAS-2 Defensiveness					
Group	1	9.783	.068	.795	.063
Time	1	.031	.001	.974	.009
Group*Time	1	4.107	.140	.710	.110
Error	51	29.300			
RCMAS-2 Physiological Anxiety					
Group	1	348.617	2.505	.120	.445
Time	1	12.891	.292	.592	.146
Group*Time	1	144.815	3.276	.076	.506
Error	51	36.676			
RCMAS-2 Worry					
Group	1	532.362	2.527	.118	.445
Time	1	60.172	1.708	.197	.340
Group*Time	1	293.040	8.318	.006*	.795
Error	51	35.230			
RCMAS-2 Social Anxiety					
Group	1	190.838	1.014	.319	.279
Time	1	1.531	.027	.870	.045
Group*Time	1	114.361	2.018	.162	.398
Error	51	56.681			

* Statistically significant at $p < .025$.

APPENDIX A
EXTENDED LITERATURE REVIEW

Person-centered theory posits the therapeutic relationship as the curative factor in counseling. Rogers (1951, 1957, 1959) outlined a theory of personality that lends itself to describing change through relationships created through a safe and accepting environment. Child-centered play therapy (CCPT) was created as a developmentally appropriate application of person-centered theory to working with children (Axline, 1947). CCPT has an underlying foundation of person-centered principles, but the delivery and creation of a safe environment is facilitated through children's natural language, play.

Rogers (1957) suggested that the presence of incongruences, or anxiety, within clients, is one of the six necessary and sufficient conditions for change in person-centered theory; therefore, anxiety can be conceptualized as an underlying cause of all presenting problems. Anxiety in children, although one of many presenting problems, will be the focus of this study due to the pervasive nature of anxiety from a theoretical standpoint. Currently, cognitive behavioral therapy (CBT) is the most widely accepted treatment for anxiety in children despite the percentage of children who do not improve after receiving treatment (Compton et al., 2004; McClellan & Werry, 2003; Silverman, Pina, & Viswesvaran, 2008; Weisz, Jensen, & McLeod, 2005). Person-centered theory provides an alternate conceptualization focused on changing the self-structure of young children, and therefore, supports an alternate treatment for children struggling with anxiety that can be integrated into common practices. Having a thorough understanding of the processes by which change occurs is important in producing high quality treatments. The identification of variables that affect outcome is especially relevant when applying theoretical conceptualizations to the application of counseling interventions. For children who exhibit symptoms of anxiety, CCPT is a proposed intervention based on the theoretical assumption that the relationship between counselor and child will be the mediating

change factor that helps reduce anxiety, specifically when the intervention is delivered to children in their developmentally appropriate language of play.

Person-Centered Theory

Carl Rogers (1951, 1957) developed a theory of human development and constructive personality change. Rogers (1951) explained his theory of personality development, psychological maladjustment, and personality change process in his 19 propositions (Ray, 2011; Wilkins, 2010):

1. Every individual exists in a continually changing world of experience of which he or she is the center.
2. The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality."
3. The organism reacts as an organized whole to this phenomenal field.
4. The organism has one basic tendency and striving-to actualize, maintain, and enhance the experiencing organism.
5. Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.
6. Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.
7. The best vantage point for understanding behavior is from the internal frame of reference of the individual.
8. A portion of the total perceptual field gradually becomes differentiated as the self.
9. As a result of the interaction with the environment, and particularly as a result of the evaluational interaction with others, the structure of the self is formed – an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the "I" or the "me," together with the values attached to these concepts.
10. The values are attached to experiences, and the values are part of the self-structure, in some instances are values experienced directly by the organism, and in some

instances are values introjected or taken over from others, but perceived in distorted fashion, as though they had been experienced directly.

11. As experiences occur in the life of the individual, they are (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, or (c) denied symbolization because the experience is inconsistent with the structure of the self.
12. Most of the ways of behaving that are adopted by the organism are those that are consistent with the concept of the self.
13. Behavior may, in some instances, be brought about by organismic experiences and needs that have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not “owned” by the individual.
14. Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basis for potential psychological tension.
15. Psychological adjustment exists when the concept of the self is such that all sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of the self.
16. Any experience that is inconsistent with the organization or structure of the self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself.
17. Under certain conditions, involving primarily complete absence of any threat to the self-structure, experiences that are inconsistent with it may be perceived and examined, the structure of the self-revised to assimilate and include such experiences.
18. When the individual perceives all his sensory and visceral experiences and accepts them into one consistent and integrated system, then he is necessarily more understanding and accepting of others as separate individuals.
19. As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system-based so largely on introjections that have been distortedly symbolized with a continuing organismic valuing process. (Rogers, 1951, p. 481-533)

Rogers (1959) believed that the goal of counseling was to become more in touch with the self, allowing the self to move towards self-actualization. He believed that the “change in the self is one of the most marked and significant changes occurring in therapy” (Rogers, 1959, p. 202).

This change of self can only occur within the context of a relationship and the core conditions. He deepened his explanation of contact to include at a minimum that each person “makes a perceived or subceived difference in the experiential field of another” (Rogers, 1959, p. 207). Once two people are in contact and other conditions are present, a therapeutic relationship characterized by growth and healing will be formed and the person can begin moving closer towards self-actualization.

Rogers outlined six necessary and sufficient conditions for change to occur: 1) the therapist and the client are in psychological contact, 2) the client experiences incongruence or anxiety, 3) the therapist is congruent within the therapeutic relationship, 4) the therapist experiences unconditional positive regard towards the client, 5) the therapist experiences and communicates empathic understanding towards the client, and 6) the client perceives the therapists’ unconditional positive regard and empathic understanding. The foundation of person-centered theory rests on these conditions in order for personality change to occur.

Barrett-Lennard studied under Rogers and continued to enhance person-centered theory through further publication and research. Barrett-Lennard (2007) believed that empathy, level of regard, unconditionality of regard, and congruence, referred to as the therapist attitudinal conditions (Bozarth, Zimring, & Tausch, 2002), are the cornerstones of the therapeutic relationship. Barrett-Lennard believed that “effective person-centred therapy is a process of developmental healing through relationship” (2007, p. 136). The counselor views the client as capable of self-direction and responsibility (Barrett-Lennard, 1965). The counselor needs to be congruent within the relationship with the client to allow for openness to experiencing. Counselors are transparent in their ways of expressing and relating to clients. When counselors demonstrate unconditional positive regard, they are valuing clients without any sense of

judgment either positively or negatively. As clients experience unconditional and holistic acceptance from counselors, they increase their openness to experiences and acceptance of those experiences. Additionally, counselors who possess unconditional positive regard for clients will be able to identify with clients' feelings without judgment, increasing levels of empathy for clients. Empathy continues as a deep resonance with another, allowing someone to feel accepted and heard once the empathy is expressed.

The sixth condition, that the client perceives all of the therapist attitudinal conditions is seldom discussed in great length throughout the literature. A relatively new term in person-centered counseling, relational depth, begins to place more of an emphasis on both the counselor and client meeting the conditions, implying the presence and perception of all conditions within the relationship; however, it also encompasses a deeper experience of the conditions and still is primarily focused on the attitudinal conditions (Mearns, 2003; Mearns & Cooper, 2005; Mearns & Thorne, 2000). Tudor (2000) argues that the lack of emphasis in the literature on all six of the conditions weakens the true understanding of Rogers' theory of change, and instead, places emphasis on a skill based or counselor based approach. Rogers specifically did not favor any one condition above the other (Wilkins, 2010).

With the therapist displaying empathy, unconditional positive regard, and congruence and the client experiencing these conditions, the two are in a therapeutic relationship that will produce change, developing clients' self-concept, tapping into their self-actualizing tendency, and allowing them to live more fulfilling and accepting lives characterized by openness to experience and fluidity in responding. True self-healing occurs through health in relationships (Barrett-Lennard, 2007).

Barrett-Lennard (1962) developed an instrument, Barrett-Lennard Relationship Inventory (BLRI), to quantitatively measure the therapeutic conditions between client and counselor in person-centered therapy. In creating his instrument, he operationalized the therapist attitudinal conditions, expanding on Rogers' (1957, 1959) definitions. He created this instrument from the foundational beliefs that these conditions are effective in bringing about constructive personality change. Although Rogers (1957) originally defined unconditional positive regard (UPR) as the combination of a high level of regard and low level of conditionality, he presented these concepts together as UPR. UPR is a true valuing of the person, regardless of actions or behaviors. It is the prizing of individuals as human. Barrett-Lennard separated this construct into two during the creation of his instrument as he believed they could be measured independently of one another (Barret-Lennard, 1962). Hence, Barrett-Lennard conceptualized the attitudinal conditions as empathic understanding, level of regard, unconditionality of regard, and genuineness.

Empathic Understanding

Empathic understanding is defined as “the extent to which one person is conscious of the immediate awareness of another” (Barrett-Lennard, 1962, p. 3). Further, it is the general experiencing of another, to understand another's experience and make meaning of the experiences as they are presented in awareness. Empathy is being in the client's experience while maintaining the therapist's experience as separate (Rogers, 1957). It involves moving with the client without judgment and constantly giving feedback in order to check for true understanding and shared experiencing (Rogers, 1975). Empathic understanding encompasses a sensing of affective experience with level of intensity and context in which it is occurring.

Empathy occurs through contact between two people, characterized by accurately communicating the meaning and experiencing of the other person (Rogers, 1957). This contact can become an actual experiencing of the others' internal process with awareness of this experience originating from the other person (Barrett-Lennard, 1986). This type of openness involves receptivity to all of another's experiences and truly understanding what the world is like for the other at that moment, including a permissiveness of allowing others to be heard as they wish from their internal frame of reference (Barrett-Lennard, 1988).

Empathic understanding is composed of empathic recognition and empathic inference. Empathic recognition is the identification of the explicitly communicated messages, and empathic inference is the sensing of the subtleties or covertly expressed content. Each of these processes is present within relationships to varying degrees across relationships and within relationships (Barrett-Lennard, 1962). More recently, the process of empathy within therapeutic relationships has been conceptualized by empathic resonance by the therapist, expression of this resonance, and the client's perception of the therapist as being accurate and understanding (Barrett-Lennard, 1986).

In order for empathic understanding to occur, the listener needs to be open to experiencing the other person's experience. In doing so, the listener sheds defenses and reduces feelings of threat that may occur within the experience. When listeners begin to confuse their own experiences with that of the other person, they begin to lower their levels of empathic understanding as they are more involved in their own levels of experiencing (Barrett-Lennard, 1962). Empathic understanding tends to be highly regarded as a primary force of change because with higher levels of empathy, levels of regard, congruence, and conditionality tend to improve (Barrett-Lennard, 1986; Barrett-Lennard, 1988, Raskin, 2001; Wilkins, 2010).

Level of Regard

Regard is described as the affect response to another person. Regard can vary from positive to negative experiences, including respect, enjoyment, like, dislike, frustration, and hatred. Therapists' level of regard is "the general tendency (at a given time) of the various affective reactions of one person in relation to another" (Barrett-Lennard, 1962, p. 4).

The level of regard is the summation of all current affective experiences of another, both good and bad. The spectrum of level of regard goes from liking to disdain (Barrett-Lennard, 1962). Level of regard is concerned with engaging relationships but does not involve extreme feelings such as love or rage. It is not based on others' behaviors, but an inherent feeling towards another (Barrett-Lennard, 1986).

It is possible for level of regard to shift throughout interactions with others and fluctuate during experiences. Level of regard is not a broad categorization meant to capture all feelings within a relationship or a measure of a specific moment in time, but it is a combination of experienced responses within a specific relationship along a continuum (Barrett-Lennard, 1986).

Unconditionality of Regard

Unconditionality of regard pertains to the lack of variability in levels of regard. The level of regard is constant, meaning the feelings towards another person are experienced similarly, whether positive or negative in nature. In relationships where there is little contact, the unconditionality of regard has little meaning because of the lack of intimacy between two people. Therefore, the feelings of one towards another are not likely to impact them (Barrett-Lennard, 1962). Unconditionality of regard is determined by the listener's level of affective consistency towards another person regardless of the experiences of the other person. The

listener continues to have similar experiences and attitudes of the other regardless of differences in the other person or types of conditions that the other person expresses (Barrett-Lennard, 1962; Barrett-Lennard, 1986).

Barrett-Lennard (1978) began the process of revising the BLRI to adapt his definitions of these terms as he began to view them differently. He expanded on his previous definition of unconditionality as:

The variation in regard toward another is conditional to the extent that A) it is contingent on varying or alternative behaviors, attitudes, feelings or ways of being of the other and B) it is experienced in the form of a response to the person or self of the other. (Barrett-Lennard, 1978, p. 6)

This definition of unconditionality allows for freedom in regards to the listener being open to experience and responding differently without affecting conditionality. Instead, conditionality refers to the listener's response changing in regards to the other person's experiencing.

Therefore, high unconditionality with high level of regard equals a cherishing of the other person.

Congruence

Congruence is defined as “the degree to which one person is functionally integrated in the context of his relationship with another, such that there is absence of conflict or inconsistency between his total experience, his awareness, and his overt communication” (Barrett-Lennard, 1962, p.4). Congruence accounts for the integration of experience and awareness that facilitates communication. It is a matching of true experience with what is in the therapist's awareness and what is expressed to the client (Rogers, 1980).

Experience in regards to congruence “includes all ways in which the person is aroused and active at a given moment which could, in the nature of the human organism, register and be

integrated in conscious awareness” (Barrett-Lennard, 1962, p. 444). Another person may be able to acknowledge incongruence or denied experiences within someone based on their expressions; however, it is impossible to identify incongruence within oneself during the experience of the incongruence. Instead, incongruence can only be self-identified after the experience or during the moment of change.

Congruence in and of itself is not explicitly expressed. People can experience a high level of congruence and may appear neutral based on this lack of expression. People who are operating from a congruent place are genuine in their expressions, lacking a need to constantly communicate all of their perceptions or hold them within themselves for protection. Examples of a lack of congruence include inconsistency between content and delivery of expression or feelings of discomfort. People who are incongruent are not fully integrating their experiences into their awareness and self-structure (Barrett-Lennard, 1962).

People who are congruent are able to wholly integrate their experiences utilizing their organismic process to convert experiences into conscious representations. They are not experiencing internal threats and are able to be open to their experiences and awareness that come from experiences, specifically in relation to others. They are able to distinguish their own experiences from those of others when in a state of congruence (Barrett-Lennard, 1962; Rogers, 1951, 1957).

Congruence is a construct that seems to be intertwined within the other stated conditions. People’s increased experience of congruence helps them separate their experiences from those of another, facilitating a deeper level of empathic understanding. However, congruence will not automatically increase the level of empathic understanding. The ability to respond unconditionally is also seen to be a product of level of integration within the self or congruence.

Although a person with a high level of inner consistency theoretically will respond in a consistent way, the actual state of being congruent allows for an openness and fluidity that may change the perceived level of unconditionality within a relationship. Additionally, level of regard for another tends to increase as congruence increases due to the lack of perceived threat and defensiveness that accompanies congruence, opening up the individual to more fully accept another (Barrett-Lennard, 1962; Rogers, 1951, 1957).

Super-Condition

It has also been argued that the therapist attitudinal conditions are all actually one super or meta-condition (Bozarth, 1998; Freire, 2001; Mearns & Thorne, 2007; Wilkins, 2010). Wilkins (2010) cautioned against ranking the conditions, prioritizing one over another or implying that one is more curative than the others. The conditions are all interrelated and can be conceptualized as facets of one greater relational experience. Mearns and Thorne (2007) viewed the combination of these three conditions as something more powerful than each condition individually. Together, these conditions are an overlapping experience within the therapeutic relationship (Freire, 2001).

Although Barrett-Lennard (1962) attempted to differentiate the conditions as he created his assessment, further analysis on the BLRI has indicated that the constructs are closely related and therefore may be one super-condition. Gurman (1977) reviewed 16 studies that investigated intercorrelations among the BLRI subscales and determined that empathy, level of regard, and congruence were moderately positively correlated with each other and moderately or highly correlated with the total score. This research supports the presence of a super-condition, with the therapist provided conditions working together to characterize a therapeutic relationship.

Therapeutic Process Outcomes with Conditions

Since the inception of person-centered therapy, many researchers have attempted to determine the efficacy of the therapeutic conditions on therapeutic outcome. Many have reviewed the outcome research related to the major tenets of person-centered therapy, concluding that the conditions seem to be effective in producing change.

Lambert and Barley (2002) consolidated previous research on therapeutic relationship and outcome and concluded that 40% of change in therapy can be attributed to extratherapeutic factors, 30% by common factors, 15% by expectancy, and 15% by techniques. Common factors were defined by relationship factors, therapeutic attributes and conditions including empathy, warmth, and acceptance, and the therapeutic alliance. They determined that the therapeutic relationship was most closely associated with positive therapeutic outcome regardless of theoretical orientation. Orlinsky, Ronnestad, and Willutski (2003) reviewed process-outcome research spanning the past 50 years. They also discovered that the therapeutic alliance was positively correlated with positive therapeutic outcomes. They noted that empathy, collaboration, and congruent engagement contributed most to enhanced therapeutic outcome. Additionally, Bohart, Elliott, Greenberg, and Watson (2002) included 47 studies in their meta-analysis on empathy and therapy success, and found a medium effect size, which can be interpreted as a meaningful correlation between empathy and positive outcomes in therapy. None of these studies were particularly concerned with a person-centered therapeutic relationship; however, their results are indicative of the importance of the presence of the conditions for therapeutic change to occur.

Barrett-Lennard (1962) conducted a study surrounding the creation of the BLRI, an assessment to measure the core conditions being expressed within therapeutic relationships. He

investigated the relationship between personality change and relationship constructs including, empathic understanding, level of regard, unconditionality, congruence, and willingness to be known from both therapist and client report. He determined that the five relationship variables were related to personality change; however, it is difficult to draw the conclusion that the perceived relationship was responsible for therapeutic change based on the results. He was able to conclude that higher levels of relational qualities from therapists were related to greater therapeutic change in clients. Client report of the relationship was more strongly associated with outcome; expert therapists tended to report similar levels of relationships as their clients.

Truax and Mitchell (1971) examined 14 studies that examined therapist attitudinal conditions, measured through instruments such as BLRI (Barrett-Lennard, 1962); they found 66 statistically significant correlations between positive outcome in therapy and attitudinal conditions, demonstrating compelling evidence for the efficacy of the attitudinal conditions as influences of therapeutic change. From previous research, it appears as if the therapeutic relationship characterized by Rogers' therapist attitudinal conditions is effective in producing change in therapy with adults. Although not all of the studies were conducted by therapists working within a person-centered framework, the relationship and relational factors characteristic of person-centered counseling were predictive of change and accounted for large percentages of change throughout the literature. Person-centered theory has been adapted to work with children, emphasizing the therapeutic relationship as the agent of change between therapist and child.

Therapeutic Relationship with Children

Emphasis on the child therapist relationship was first addressed with Sigmund Freud and

his ideas regarding transference. He recognized that children could use transference between themselves and the therapist in psychotherapy similarly to how adults utilize transference (Freud, 1940). Other psychoanalysts began integrating this concept into their work with children.

Anna Freud (1946) spoke specifically to the attachment formed between child and therapist as a precursor to any further work in therapy. She delineated developmental levels of therapeutic relationships in children. The least mature level was categorized by the child wanting to form a relationship with the therapist in order to gain gratification from the therapist and therefore from the relationship. Children will try to form relationships in order to gain a positive relationship from adults, especially if they are lacking these relationships in other areas of their lives. They may feel more fulfilled from having these positive interactions or simply just having interactions at all with adults. These relationships can be reparative of faulty relationships outside of the therapeutic environment.

More mature therapeutic alliances are characterized by children accepting positive feelings toward and from therapists and allowing therapists to aid in their healing. Children utilize the relationship to help work through their problems. The relationship is not the problem to be resolved, as seen in less mature therapeutic relationships; however, it is seen as an avenue to get other needs met. Instead of turning to the therapist to meet the children's needs, children are able to turn to the therapist to help facilitate changes within themselves (Freud, 1946).

As Axline (1947) developed nondirective play therapy based on person-centered theory, she introduced a shift in attitude regarding child-therapist relationship. Instead of the relationship being a means to an end, the relationship became an opportunity for children to change. Therapy was no longer a treatment, but an environment for children to be exposed to warmth, nonjudgmental acceptance, and understanding from another person. Through the relationship,

children grow towards their natural developmental tendency. The relationship was seen as the vehicle for change, not as a representation of collaboration or receptivity to therapeutic tasks by the child. The relationship began to be characterized by levels of the necessary and sufficient conditions present within the therapeutic relationship. Since Axline, many theorists have continued to develop the child-centered way of working with children, continuing to place emphasis on the relationship as the facilitator of change.

Child-Centered Play Therapy

Child-centered play therapy (CCPT) is a developmentally appropriate mental health intervention for children, created as an adaptation of Carl Rogers' theoretical approach to counseling, person-centered counseling (Landreth, 2012; Ray, 2011). Virginia Axline (1947) was the first person to utilize Rogers' concepts and apply them to children. She developed nondirective play therapy, now referred to as CCPT, with similar emphases as Rogers in regards to theoretical underpinnings and beliefs about people and therapeutic change. Axline developed eight basic principles for applying person-centered theory to children:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflect those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given the opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (Axline, 1947, pp. 73-74)

Within the development of these principles, Axline created a new way of working with children and defined the attitudes, beliefs, environment, and relationship that need to be enacted to produce therapeutic change. Many child-centered authors since Axline have continued to develop CCPT, expanding on her constructs and choosing to focus on specific aspects of person-centered theory in relation to children.

Guernsey (2001) emphasized children's innate motivation toward growth and self-directed behavior as major underpinnings of CCPT and highlighted the role of CCPT in facilitating this motivation. Children are detracted from their positive development of self when they are deprived of love, support, and belonging. Therefore, the therapist's goal is to be truly empathic by unquestionably accepting the client's reality. This empathic understanding will change clients' self-perceptions and will promote growth within clients. Guernsey noted five tenets of CCPT:

1. Child directs the content of therapy,
 2. The approach is not system specific or problem oriented,
 3. The internal frame of reference, or perceptions of reality of the child, is accepted by the therapist without challenge,
 4. CCPT is a system that must be followed in its totality,
 5. Those using CCPT must believe in the power of this therapeutic system.
- (Guernsey, 2001, pp. 17-19)

Through these tenets and underlying beliefs about children, it is evident that a belief in the relationship characterized by empathy and acceptance as the agent of change in therapy is crucial and necessary.

Landreth (2012) noted additional tenets for relating to children:

1. Children are not miniature adults
2. Children are people
3. Children are unique and worthy of respect
4. Children are resilient
5. Children have an inherent tendency toward growth and maturity
6. Children are capable of positive self-direction
7. Children's natural language is play
8. Children have a right to remain silent
9. Children will take the

therapeutic experience to where they need to be 10. Children's growth cannot be speeded up. (p. 46)

These tenets capture his beliefs about children, including the prizing and valuing of children as people. Landreth emphasized three components of understanding children: the person, the phenomenal field, and the self. The person encompasses the child's thoughts, behaviors, feelings, and physical being. The phenomenal field is the child's experiencing both internally and externally. The self is the complete experience of the child as differentiated from experiences. With these components, Landreth emphasized viewing the world from the child's internal frame of reference in therapy. He believed that children possess an inherent striving towards growth that is thwarted when children experience incongruence between their experiences and concepts of self. His interpretation of CCPT is based on having trust in the child.

Landreth (2012) listed three therapeutic conditions for growth in play therapy that align with Rogers' core conditions: being real; warm caring and accepting; and sensitive. These qualities of the therapist toward the child are characteristic of the therapeutic relationship in CCPT. Landreth believed "the relationship is therapy; it is not preparation for therapy or behavioral change" (p. 82). He elaborated, "the relationship provides consistent acceptance of the child, which is necessary for the development of enough inner freedom and security in the child for her to express herself in self-enhancing ways" (p. 83). Landreth further delineated therapeutic dimensions in the play therapy relationship that deepen the relationship and underlie all therapeutic responses and decisions in therapy. He developed facilitative responses such as tracking, returning responsibility, and esteem building to help therapists embody therapeutic attitudes through skills.

Cochran, Nordling, and Cochran (2010) built on Axline's principles, applying them to specific behaviors and skills. They believed that play therapists "create an atmosphere wherein the

child has an authentic relationship with his therapist, one where he is deeply understood and valued, and free to express all feelings without judgment or reproach” (p. 58). Further,

It is the therapeutic relationship with her that matters more than any toy or technique, and that if she is broken and unable to relate with the core conditions of deep empathy, genuineness, and unconditional positive regard, then therapy will not happen. (pp. xvi)

They believed that in play therapy children re-connect with their actualizing tendencies. Children are motivated to form relationships, to be known, and to share experiences, making the relationship in CCPT the healing factor.

Wilson and Ryan (2005) emphasized genuineness and authenticity, non-possessive warmth, and accurate empathy as primary elements of the therapeutic relationship in play therapy. However, they placed importance on reflections made by therapists to express these attitudes as opposed to experiencing these conditions. Wilson and Ryan operated out of the assumption that all therapeutic relationships contain the conditions and that CCPT is different in its non-directivity and freedom given to the child. Similarly, VanFleet, Sywulak, and Sniscak (2010) connected the relationship characterized by empathy and attunement to the child with the belief that children have an inherent ability to solve their own problems. They described acceptance, permissiveness, empathic recognitions, interest in the child, and non-directivity as important components of CCPT that facilitate change. Although these qualities are primarily descriptive of the therapeutic relationship, the authors focused more on the context of doing as opposed to feeling attitudes.

Ray (2011) explicitly focused on Rogers’ 19 propositions and the core conditions in order to successfully facilitate CCPT. Ray’s emphasis on play therapists’ deep understanding of theory and attitudinal conditions is unique from previous works on play therapy. Ray also developed the first CCPT treatment manual, allowing for more stringent research protocols. In her manual, she

continued to emphasize the theoretical underpinnings of CCPT and allowed for flexibility within using skills.

Although these descriptions of CCPT address Axline's eight principles stemming from Rogers' theory or other connections to person-centered theory, there seems to be a gap between the rationale and theory behind the skills and the use of skills. Many authors place emphasis on the attitudinal conditions, but lack description of how that occurs on an interpersonal level other than an outward expression of responses. The link between theory and practice is not explicitly stated and therefore, most research on the conditions in child therapy has focused on verbal responses instead of the attitudes and experiences felt within the child and therapist. In order to gain a deeper sense of CCPT, specifically the inner workings of the success of therapy, the consideration of therapists and children's processes and felt experiences enhances the examination of the effectiveness of CCPT.

CCPT Research Outcomes

CCPT has been researched extensively and has been shown to be an effective treatment for children with many different struggles (Bratton, Ray, Rhine, & Jones, 2005). Bratton et al. (2005) conducted a meta-analysis on the effectiveness of play therapy as a treatment intervention. They included 93 studies in their analysis and calculated a large overall effect of 0.80, demonstrating effectiveness of play therapy across theoretical orientations, presenting problems, and outcomes measured. When specifically viewing nondirective or humanistic types of play therapy, 73 studies were included with an overall mean effect size of 0.92.

Lin and Bratton (under review) conducted a more recent meta-analysis of 52 CCPT studies between 1995 and 2010. The overall treatment effect size was moderate ($d = 0.47$). The

average age of child participants included in the meta-analysis was 6.7 years old, indicating success of play therapy with young children. Specifically, CCPT with children 7 years old and younger produced an effect size of 0.53, compared to children 8 years old and over, 0.21.

Research CCPT literature continues to support the use of CCPT with young children.

CCPT has been identified as the most popular theoretical approach to play therapy (Lambert et al., 2005). Between 1947 and 2010, 62 studies on play therapy effectiveness have been conducted (Ray, 2011), with more continuing to be published every year. However, many of the studies lack replication and are not geared toward investigating mechanisms of change although many have expressed a need for play therapy research to move in that direction (Baggerly & Bratton, 2010; Phillips, 2010). Because of the theoretical assumption of the relationship as the primary facilitator of change, it seems important to begin understanding the mechanisms of play therapy through examining the therapeutic relationship.

Therapeutic Process Outcomes in Children

It is believed that a therapeutic relationship characterized by warmth and engagement with the child is a facilitative factor in the change process that occurs in therapy (McLeod & Weisz, 2005; Shirk & Saiz, 1992). Very few researchers have examined the impact of the therapist-child relationship on therapeutic outcome (Chiu, McLeod, Har, & Wood, 2009; Karver, Handelsmen, Filds, & Bickman, 2006). Unfortunately, many studies have focused on techniques in regards to efficacy rather than interpersonal characteristics that facilitate change in the therapeutic process. The behavioral therapy movement placed emphasis on techniques that can produce change and produce easily measured outcomes as opposed to the therapeutic relationship (Shirk & Saiz, 1992).

Shirk and Karver (2003) conducted a meta-analysis of the literature of therapeutic relationship variables in outcomes for children and adolescents. They examined 23 studies that investigated a relationship measure on therapeutic outcome. They included studies with family therapy and parent management, in addition to behavioral oriented therapies and non-behavioral oriented therapies such as psychodynamic, client-centered, and eclectic orientations. They found a small effect size between alliance and outcome (.22); however, the variance among effect sizes throughout the studies was statistically significant, leading to an investigation of moderators. They concluded that age (child or adolescent), manualized or nonmanualized treatments, and type of treatment (behavioral or non-behavioral) were not moderators of the association between relationship and outcome. Externalizing behavior was a moderator of relationship and outcome scores, with more externalizing behaviors, as opposed to internalizing behaviors, strengthening the association. Additionally, relationship scores measured at the end of treatment and reports of scores from a caregiver moderated effects. Therefore, children who presented to counseling for externalizing behaviors, were evaluated based on a parent or caregiver report, and measured relationship toward the end of therapy had stronger associations between therapeutic alliance and outcome measures. Although theoretical approach did not affect the relationship between relationship and outcome significantly, the non-behavioral category of therapeutic approach was comprised of various approaches, including eclectic approaches. Thus, there is a need to re-examine the effects of relationally based theoretical approaches as moderators of the association between relationship and outcome.

Karver, Handelsman, Fields, and Bickman (2005) conducted a meta-analysis of 49 studies to determine the magnitude of the correlations of outcome and therapeutic relationship variables in child therapy. They found that therapist direct influencing skills, such as active

structuring and providing a rationale for treatment approach, and affective bond with the client were related to outcome in moderate to large effects ($ES = 0.40$). Additionally, counselor interpersonal skills categorized by empathy, warmth, and genuineness were moderately correlated to treatment outcome ($ES = 0.35$). Therapeutic alliance with the youth client characterized by a cognitive connection and willingness to participate in treatment had a small to moderate relationship with treatment outcome ($ES = 0.21$). In each case, relational qualities appeared to influence therapeutic outcomes.

In order to better define the strength of this association, McLeod (2011) conducted a meta-analysis of regarding therapeutic alliance and outcomes in youth psychotherapy. He determined that 38 studies between 1992 and 2009 were eligible for inclusion in the meta-analysis. He found a small effect size ($ES = .14$) for overall alliance-outcomes; however, this estimate is likely to be conservative because some studies reported non-significant effect sizes. When effect sizes were split by ages, studies with children with a mean age of 13 or lower had a weighted mean effect size of .20, which was significantly higher than the effect size for adolescents ($ES = .10$). Therefore, therapeutic relationship is more strongly related to therapeutic outcome for younger children, further supporting a relationally based intervention for younger children.

Chiu, McLeod, Har, and Wood (2009) examined therapist-child alliance at the beginning of treatment, in the middle of treatment, and at the end of treatment in addition to anxiety scores at all three points. They determined that a strong child-therapist alliance at the beginning of treatment was significantly correlated with lessened symptomology in the middle of treatment and an increase in treatment satisfaction at post-treatment. There was no association between child-therapist alliance at the end of treatment and changes in parent report. Therefore, it seems

as if the therapeutic relationship at the beginning of treatment is crucial in facilitating changes throughout treatment.

Kendall (1994) examined the child's perception of the therapeutic relationship in cognitive behavioral therapy. Many of the children's relationship scores were high; however, relationship scores were not correlated with outcome scores. In a follow up study by Kendall et al. (1997), children's perception of the therapeutic relationship was not a predictor of change; however, many of the children rated the therapeutic relationship highly. This lack of correlation might be due to a lack in variability in relationship scores across therapists and children, which would not mathematically allow for statistical significance but does not confirm that the relationship is not a mediating factor of change.

Throughout the literature, therapeutic relationship in child therapy has been measured within CBT therapy. The results seem to be varied; however, the emphasis of CBT is not on the relationship, and the relationship is defined and measured differently within these studies (Shirk & Karver, 2003; Shirk & Saiz, 1992). Many of the assessments used to measure relationship in these studies were focused on the child and therapist liking each other, which can only be compared slightly to level of regard within the therapeutic relationship from a CCPT standpoint (Karver et al., 2005; McLeod, 2011). Many studies used observational assessments where a third party observer rated the strength of the relationship. Although the studies appear to be stringently conducted, the construct of relationship has been defined differently than within a child-centered framework. Therefore, it is necessary to investigate the relationship characterized by congruence, empathy, and unconditional positive regard within a therapeutic context.

The aforementioned studies measured therapeutic relationship as it is correlated to outcome, either through prediction or correlation. They did not view the relationship as a

statistical mediating factor, and therefore, did not measure it as such. The significant correlations between relationship and outcome are a basis for continued research, specifically examining the relationship as a mediator of change. It is important to focus researching the therapeutic relationship as a facilitator of change, especially within CCPT, a modality that conceptualizes change through the therapeutic relationship.

Conditions in Child Therapy Outcomes

Exploring the counseling relationship from a person-centered perspective requires an examination of the therapist attitudinal conditions and clients' experiences of those conditions. Stoffer (1968) explored the relationship between positive behavioral change in children and genuineness, nonpossessive warmth, and empathic understanding of the helping person. Children in grades 1 through 6 who demonstrated behavioral and academic problems were recruited to participate in the study. These children were paired with a community helper, whose goal was to establish a good relationship with each child through individual meetings. The relationship was measured through listening to tape-recorded segments of the helper-child interviews and rated on Truax scales and self-report from the children on an adapted Barrett-Lennard Relationship Inventory and helpers on the BLRI. Stoffer was not able to draw conclusions regarding genuineness in relation to outcome due to failure to produce acceptable inter-rater reliability. Nonpossessive warmth was statistically significantly related to a decrease in behavior problems and change in academic achievement; however, empathic understanding was only significantly correlated to academic achievement.

Siegel (1972) investigated changes in play therapy behaviors over time as a result of differing levels of therapist-offered conditions. Sixteen children with learning disabilities were

selected to participate in play therapy for 16 sessions. The 4 children with the highest relational scores and the 4 children with the lowest relational scores were compared for the study. The therapeutic relationship encompassed accurate empathy, unconditional positive regard, and therapist congruence and was measured by observers of segments of audiotapes. No significant differences existed between the two groups until after 8 therapy sessions. As sessions progressed, children with higher-rated relational sessions made statistically significantly more positive and insightful comments in their play sessions compared to children in the lower-rated relational sessions.

Truax, Altmann, Wright, and Mitchell (1973) explored the effects of accurate empathy, nonpossessive warmth, and genuineness on child therapy to determine if the therapeutic process, although primarily a nonverbal process, was similar to adult therapy. Therapists who participated in the study were associated with various theoretical orientations, including psychoanalytic and child-centered approaches. Children's sessions rated highly on the conditions had improved parental report scores at the conclusion of therapy; whereas, children's sessions rated on the lower end of the conditions had parental reports that indicated the children decreased in their level of functioning. Although the study had a small sample size, the results are indicative of the importance of the conditions in child therapy regardless of theoretical orientation.

Harnish (1983) examined the effects of children's perceptions of empathy, unconditional positive regard, and genuineness from the therapist on the process and outcome of non-directive play therapy. Children who were maladaptive were recruited for the study and their levels of anxiety, behaviors, and self-concept were measured at pre and post test. Results indicated that greater levels of the specific conditions as perceived by the child were related to improvements in outcome. Child-perceived empathy from the therapist was related to decreases in anxiety,

among many other specific relationships between conditions and outcome measures. Harnish used a revised version of the BLRI; however, no measures of validation were conducted prior to using the assessment. Therefore, the results should be interpreted with caution, as the validity of what was actually measured with the conditions cannot be determined.

Darr (1994) studied the development of the therapeutic relationship in CCPT and how the core conditions are manifested in play therapy. After analyzing transcripts, Darr determined that the therapist's sensitivity to the messages the child is sending and ability to move the process in the direction that those messages are signaling is important in the development of the relationship. Additionally, if counselors respond to content, feelings, relationship, underlying meaning, and generalization, the relationship will be more therapeutic. Darr concluded that the awareness of mutual influence of child and therapist is facilitative in the process of counseling. This study was conducted and analyzed by examining therapists' responses to children by a third party observer. It seems necessary that when investigating the conditions within therapy to involve the participants in the relationship due to the internal nature of many of the conditions. It is difficult to draw conclusions regarding presence of the conditions when listening to the process through recordings and without hearing about the internal process from one or both parties.

From these studies of the conditions within child therapy, it appears as if the conditions are present and impact change (Darr, 1994; Harnish, 1983; Siegel, 1972; Truax, Altmann, Wright, & Mitchell, 1973). However, many of the studies were conducted with small samples, inexperienced therapists, or therapists with varying theoretical orientations. The studies lay the foundation for continued exploration of the conditions within child counseling, specifically, the experiences of both child and counselor through self-report. Additionally, statistical techniques

may be employed to investigate the therapeutic relationship between therapist and child as a mediator of change, resulting in further generalization and confirmation of the therapeutic relationship as the primary facilitator of change. In an attempt to specify the mechanisms of change in CCPT, it is helpful to narrow in on one aspect of change that can occur through utilizing PCT.

Anxiety

Between 10 and 20% of children experience heightened levels of anxiety, resulting in anxiety as the most prevalent childhood disorder (Costello, Egger, & Angold, 2004; Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Ezpeleta et al., 2001; Kendall, Furr, & Podell, 2010). The National Institute of Mental Health (NIMH, 2013), estimated that 25.1% of 13 to 18 year olds experience an anxiety disorder, with 5.9% experiencing “severe” anxiety disorders. Unfortunately, prevalence of anxiety for young children is not specifically available.

Clinical levels of anxiety that are intensely experienced, impair children’s ability to master developmentally appropriate tasks, and prevent the ability to self-regulate when the anxiety provoking event is not occurring (Knell & Dasari, 2006). Children experience anxiety and fear as a normal part of development. However, when anxiety outgrows developmental appropriateness or is intense for children, anxiety may have surpassed the normal threshold (Lyness-Richard, 1997; Muris, 2001; Ollendick, Grills, & Alexander, 2001). Anxiety becomes an issue of concern when the level of severity begins to impact the child or the family system (Kendall et al., 1992).

Children’s anxiety symptoms mirror those of adults, encompassing physiological, behavioral, and cognitive components. The anxiety experienced by children is multifaceted and

can be a result of a combination of stimuli (Kendall et al., 1992). The duration of fears may result from a lack of support or coping skills to overcome fears (Lyness-Richard, 1997). If left untreated, children with anxiety disorders are at high risk for developmental delays because of the high level of comorbidity and low levels of remission (Kendall, et al., 2010; Paul, & Barrett, 2010; Pollock et al., 1996; McLoone, Hudson, & Rapee, 2006; Seligman & Ollendick, 1998; Silverman & Kurtines, 1996). Children who have anxiety disorders struggle with academic achievement, family cohesion, general happiness, self-esteem, and social and peer relationships (Kendall, Furr, & Podell, 2010; Rapee, Wignall, Psych, Hudson, & Schniering, 2000). They tend to experience a great deal of personal distress based on their levels of anxiety (Rapee et al., 2000).

The definition of anxiety throughout the literature is diverse, yet focused around key components; behavioral, physiological, and cognitive (Lang, 1977; Marks, 1969; Rachman & Hodgson, 1977; Silverman, La Greca, & Wasserstein, 1995). These concepts describe different aspects of anxiety that, taken together, describe a holistic view of anxiety. Children typically experience these components of anxiety, and therefore, are affected on many levels. Children's experience of anxiety is characterized by all three components and manifests similarly to adults (Kendall et al., 1992). Many theorists have developed their own ways of conceptualizing anxiety in order to most effectively treat clients. With an understanding of the different components of anxiety, the manifestation of anxiety in children, and the theoretical ways of viewing anxiety, the treatment of anxiety in children can be better understood.

Anxiety Components

Anxiety encompasses three main components; behavioral, physiological, and cognitive,

similarly in adults and children. Each of these components is an important part of the experience of anxiety. These concepts are interrelated and present as anxiety is being experienced. Each of them can be discussed separately, while also having an understanding of how they fit within a larger umbrella of anxiety. In order to identify anxiety in young children, it is important to understand the components of how anxiety manifests.

Behavioral

As people experience anxiety, they demonstrate behaviors as a result of their inner experience. Behavioral manifestations of anxiety are more outwardly visible and observable (Kendall et al., 2001). When experiencing fear, people begin to demonstrate avoidance behavior (Rachman & Hodgson, 1974). In the moment, behavioral responses include attempts to avoid or escape the threatening stimulus. They tend to avoid situations that would produce more fear and selectively decide the quantities of fear that are acceptable to them.

In children, the behavioral component of anxiety is the easiest to observe and is often the first indication of anxiety (Beidel & Turner, 2005). Children may cry, become physically attached to a parent or caregiver, or have tantrums as a result of their anxiety. Other less frequent behavioral manifestations include disobedience or opposition such as refusing to follow directions or go to school. Occasionally, children's behavioral expressions may come in the form of repetitive behaviors to ensure a feeling of safety. The behavioral component of anxiety in children is an external process, increasing visibility and focus on outward behaviors in traditional treatment as opposed to the internal process of anxiety for children.

Physiological

Physiological anxiety is sometimes conceptualized as fear (Knell & Dasari, 2006; Silverman, La Greca, & Wasserstein, 1995). Fear is a biological response that prepares an individual for escape. Physiological symptoms are produced by the autonomic nervous system (ANS), which is responsible for internal body regulation (Kendall et al., 2001). The ANS produces physical symptoms that accompany anxiety in an attempt to help the body physically regulate under the stress. Physiological anxiety, as seen as fear, typically occurs within the presence of real danger; however, physical symptoms are also noted when people experience anxiety.

Children's ANS produce physiological symptoms to regulate the experiences of anxiety. Children may experience shaking, nausea, stomachaches, headaches, muscle tension, heart palpitations, sweating, hot or cold flashes, or difficulty breathing as a result of their anxiety (Beidel & Turner, 2005; Kendall et al., 2001; Knell & Dasari, 2006). These involuntary responses to anxiety vary and may be proportionate to the internal experience of anxiety. Additionally, the involuntary nature of physiological symptoms may be more troubling to young children who may not understand their bodily processes.

Cognitive

Cognitive anxiety accompanies the above-mentioned components as the thought process of anxiety. Matthews (1990) viewed this process as worry, preparing people to anticipate possible future danger. Worrying encompasses rehearsing potential threats and outcomes while creating solutions to combat the experience or avoid it all together. This problem-solving process can be helpful; however, worry or cognitive anxiety is viewed as a form of anxiety when threats

are rehearsed and no solutions are discovered. This form of worrying is characterized as unstoppable negative thoughts about the future (Ollendick, Grills, & Alexander, 2001).

The cognitive component of anxiety in children is their mental experience, including worrying and other negative thoughts (Kendall et al., 2001). This may include thoughts about what is happening and how they think about and report feeling as a part of their anxiety. Children have a tendency to distort information, creating more worrying from a cognitive standpoint. Silverman, La Greca, and Wasserstein (1995) identified that children between the ages of 7 and 12 tend to worry most about school, health, and personal anxiety. Although children's anxiety contains a cognitive component, children are not able to manipulate their cognitions until approximately age 8, potentially increasing the level of worry in young children (Piaget, 1965).

Person-Centered Approach to Anxiety

As identified in Rogers' necessary and sufficient conditions for change, condition two states that "the client is in a state of incongruence, being vulnerable or anxious" (Rogers, 1957, p. 96). Therefore, it can be conceptualized that incongruence is synonymous to anxiety or is a direct cause of anxiety (Elliott, 2013). For the purposes of investigating the mechanisms of change in CCPT, anxiety is a logical outcome variable for exploration as it is an underlying condition of psychological distress in person-centered theory.

Carl Rogers (1959) defines anxiety as:

Phenomenologically a state of uneasiness or tension whose cause is unknown. From an external frame of reference, anxiety is a state in which the incongruence between the concept of self and the total experience of the individual is approaching symbolization in awareness. When experience is obviously discrepant from the self-concept, a defensive response to threat becomes increasingly difficult. Anxiety is the response of the organism to the "subception" that such discrepancy may enter awareness, thus forcing a change in the self-concept. (p. 204)

Person-centered theorists believe that anxiety is a result of experiencing incongruence between experience and self-structure that ultimately forces a change in the self-structure (Bryant-Jefferies, 2012; Wilkins, 2010). More specifically, anxiety occurs as the person's self-structure feels threatened. Threat occurs "when an experience is perceived or anticipated (subceived) as incongruent with the structure of the self. It may be regarded as an external view of the same phenomenon which, from an internal frame of reference, is anxiety" (Rogers, 1959, p. 204).

People develop a self-concept in childhood and can become rigid in their self-structure through interactions with their environments that lack empathy, acceptance, and genuineness. If a person is operating out of a rigid self-structure, personal experiences may not match a personal sense of self; hence the person will feel threatened, creating anxiety or incongruence. The level of anxiety is dependent upon the level of threat experienced to the self-structure (Rogers, 1959). However, a person who is unaware of incongruence is only subject to the possibility of anxiety. The actualizing tendency needs to be activated to prompt feelings of anxiety based on the discrepancies between experience and self-concept (Wilkins, 2010). The awareness of incongruence is not necessarily an awareness of the rationale of the incongruence but an awareness of the feeling (Bryant-Jefferies, 2012).

Person-centered theorists believe that anxiety is the manifestation of deeper psychological processes. Anxiety represents an inner struggle or conflict within people. Anxiety can be a signal that something is not matching a person's internal experience or that a threat is present (Bryant-Jefferies, 2012).

Another view of anxiety within a person-centered framework is that of experience beginning to approach the edge of awareness. Through this perspective, experiences are denied

into awareness and are stored within the person. At some point, this experience will threaten to come into conscious awareness, causing an anxious response (Bryant-Jefferies, 2012).

Few research studies have been conducted utilizing person-centered theory with anxious clients. Elliott and colleagues (2013) conducted a meta-analysis of almost 200 studies, up to 2008, that examined the efficacy of person-centered theory. Nineteen studies investigated anxiety with 305 clients included across studies. Pre-post test ($ES = .88$), controlled studies (utilizing a control group, $ES = .50$), and comparative studies ($ES = -.39$) were examined. Person-centered theory appears to be effective in producing change when compared to no treatment; however, other theories appear to be cited in the literature as successful in treating this population. The authors urged person-centered theorists to have a deeper understanding of this population in order to work more effectively. The limited literature on person-centered counseling and anxiety may be a result of person-centered counselors typically avoiding assigning diagnostic labels to their clients; however, it is encouraged for person-centered counselors to research anxiety due to the theoretical underpinnings of person-centered theory (Elliott, 2013).

The theoretical underpinnings of person-centered theory that encompass anxiety, describe anxiety differently than traditional pathological anxiety is described. Rogers uses anxiety as an all-encompassing experience that is the basis for unhealthy functioning. Pathological anxiety, instead, is described by symptoms and levels of impairment. However, pathological anxiety can be viewed as a behavioral manifestation of the concept of anxiety in person-centered theory. When people experience a difference between their experience and the way they view themselves, they experience anxiety or incongruence in person-centered terms. For example, people become overwhelmed from the amount of work they have and are starting to not perform

as well as they used to. They begin to see themselves as incompetent, whereas prior to this experience, they had always viewed themselves as being very capable. Instead of integrating this experience as a unique situation, the incongruence may begin to manifest in an extreme identification with or expectation of failure. Individuals start experiencing cognitions, such as “I won’t ever be good enough,” behaviors, such as avoiding more responsibilities when they used to take on plenty, and physiological reactions, such as racing heartbeat when attempting to get work accomplished. All of these symptoms can be described as anxiety or fear of failure. Through a person-centered framework, the intervention would be geared towards developing the self-concept instead of working with any piece of the symptoms that have resulted from the incongruence.

Current Interventions for Childhood Anxiety

Treatment of childhood anxiety has been focused on the use of cognitive behavioral therapy. CBT uses self-instruction to help mitigate the effects of anxiety disorders (McClellan & Werry, 2003). CBT uses self-control strategies that are centered around self-observation, self-modification, self-evaluation, and self-reward. Compton et al. (2004) identified five qualities of CBT interventions: 1) adherence to the scientist-clinical model, choosing treatments that have been deemed effective for specific problems; 2) a thorough assessment of target behaviors and the situational, cognitive, and behavioral factors that have been developed or are blocking progress; 3) an emphasis on psychoeducation; 4) problem-specific treatment interventions; and 5) relapse prevention training at the end of treatment.

Through the process of CBT, children identify when they are scared, identify their anxious or scared thoughts, learn to adapt their thinking and adopt alternative thoughts and

behaviors, and then praise themselves for standing up to their fears. Children modify their thought processes after being taught how to look for evidence for their anxious thoughts and restructuring their thinking based on more realistic views from the evidence or lack of evidence. Because of this manipulation of thought, CBT is hypothesized to be more effective for children who have more advanced levels of cognitive development (Rey, Marin, & Silverman, 2011).

Currently, cognitive-behavioral therapy (CBT) is the best-supported intervention for childhood anxiety disorders based on its research foundation (Compton et al., 2004; McClellan & Werry, 2003; Silverman, Pina, & Viswesvaran, 2008; Weisz, Jensen, & McLeod, 2005). Many meta-analyses and systematic reviews have been conducted with studies utilizing CBT as an intervention for childhood anxiety (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Compton et al., 2004; In-Albon & Schneider, 2007; Silverman et al., 2008). These meta-analyses have concluded that CBT is effective and an evidence based treatment for children with anxiety. However, many gaps in the literature still exist, specifically with young children. Most CBT studies conducted with children have an average age ranging from 8 to 13, with not enough information to calculate effect sizes when used with younger children (Compton et al., 2004; McKay & Storch, 2009; Silverman et al., 2008). CBT is not effective in reducing anxiety diagnoses for 20 to 40% of children who successfully complete treatment in addition to other child characteristics that are contraindicated for use of CBT (McKay & Storch, 2009; Silverman et al., 2008; Rey et al., 2011).

Silverman, Pina, and Viswesvaran (2008) reviewed 32 studies of psychosocial treatments for childhood anxiety and phobic disorders. They focused on studies that used methodologies to qualify as evidence based or efficacious treatments and then categorized treatments into a hierarchy based on previously established guidelines for quality research. They determined that

no psychosocial treatments for childhood anxiety and phobic disorders met criteria for the well-established treatment category. They decided that individual CBT, group CBT, social effectiveness training for children, and group CBT for social phobia were all treatments that are probably efficacious. According to the authors' evaluations, the possibly efficacious and experimental treatments are individual CBT with parents, emotive imagery for darkness phobia, individual CBT for school phobia or school refusal behavior, group CBT with parental anxiety management for anxious parents, graded in vivo behavioral exposures, graded exposures plus either contingency management or self-control for phobic disorders, FRIENDS, one-session behavioral exposure treatment for phobic disorders, skills for academic and social success, school-based group CBT, individual CBT with cognitive parent training, school-based modified CBT group therapy for adolescents for children with social phobia, parent group CBT, family CBT, and bibliotherapy.

After categorizing treatments, Silverman, Pina, and Viswesvaran (2008) conducted an overall meta-analysis to determine effectiveness of these treatments. After accounting for sampling error, the treatment effects ranged between 46 to 79%, meaning that approximately 46 to 79% of children in the studies reduced their anxiety diagnosis following treatment. These effects were found in both individual and group treatments. When examining symptom reduction, children who received CBT improved slightly less than half a standard deviation in anxiety symptoms compared to children who did not receive CBT ($d = .44$). Additionally, children who did not receive CBT improved one fourth of a standard deviation during the treatment phase ($d = .25$), indicating a more substantial effect with treatment. After treatment follow-up demonstrated a decrease in approximately 10% of the effect size, meaning that treatment gains began to decline with the passage of time (Silverman et al., 2008).

Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, and Harrington (2004) conducted a systematic review of randomized controlled trials of CBT for childhood or adolescent anxiety disorders. After assessing for study criteria, they included 10 studies in their analysis. All but one of the included studies found statistical significance over the no treatment control group. The one study that did not produce statistical significance was conducted in an early intervention setting, while all other studies were with older children. The authors determined that “for some groups, particularly very young children, it is likely that traditional CBT will never be appropriate” (p. 430). The authors noted the lack of follow-up with both the experimental and control group in studies in order to truly determine long term effectiveness of CBT. Additionally, they determined that the studies all had weaknesses in at least one methodological area.

In-Albon and Schneider (2007) conducted a meta-analysis of anxiety treatments with children. They used stringent inclusion criteria to assess for high quality studies including requirements that studies investigated efficacy of treatment for children on anxiety, participants met diagnostic criteria, researchers used treatment protocol, and means and standard deviations were reported. The researchers determined that 24 studies met criteria for the meta-analysis; all studies utilized CBT as their treatment. The overall pre and post test effect size for treatment was $d = .86$ and $d = .13$ for control groups. When viewing effect sizes for follow-up post testing, effect sizes decreased from 1.36 after 10 months of treatment to .82 after a 6-year follow up across multiple studies. CBT seems to be effective in reducing anxiety symptoms in the short term over a control group with effects being maintained after the completion of treatment.

Anticich, Barrett, Gillies, and Silverman (2012) conducted a review of the literature for interventions for early childhood anxiety. Nineteen studies were included in the review with children age 2 to 7. Nine of the 19 studies included tested interventions with parents only and

only one study included intervention with child only. Of the 19 studies with children between the ages of 2 and 8, only one intervened solely with the child. They preliminarily concluded that early intervention/prevention programs for child only, parent only, and child and parent programs of different theoretical orientations were effective in reducing anxiety symptoms. However, they encouraged more research in this area to attempt to mitigate the long-lasting effects of untreated anxiety. Results of this review also highlight the need for direct interventions for young children with anxiety.

In another review of the literature conducted by Compton et al. (2004), 21 randomized controlled trials were examined utilizing CBT with children ranging from 5 to 15 years of age. Most studies included children on average between 8 to 11 years old. Only one study included children 5 years old with insufficient data to calculate an effect size. They concluded that CBT is an effective treatment for children who are experiencing anxiety; however, the majority of participants were older children or adolescents.

Silverman, La Greca, and Wasserstein (1995) found that worry seems to occur in the earlier elementary grades, urging researchers to find treatments that can effectively target younger children. It seems imperative to continue to conduct other stringent research studies with interventions that can lessen anxiety in young children and diverse populations.

Critiques of CBT

Grave and Blissett (2004) presented a thorough argument against using CBT with children under 8 years old. Young children's thinking is based solely on their experiences and perception of those experiences. They have egocentric views of the world, lacking the ability to take another's perspective or view themselves as separate from their environment. Additionally,

young children have all-or-nothing thinking and struggle to distinguish how something that was bad could potentially be good. The foundation of CBT is that irrational beliefs, thoughts, and attitudes are the driving force behind problematic behavior, which requires a level of self-reflection, perspective taking, understanding causality, and reasoning. Children need to think rationally and logically in order to engage in CBT; however, young children are not capable of performing these tasks in the ways that older children can.

Throughout the literature, few studies examined CBT with young children (Compton et al., 2004; Silverman et al., 2008). Most participants fall between the ages of 8 to 11, leaving out a large age range of children, specifically young children. Although Anticich, Barrett, Gillies, and Silverman (2012) reviewed successful early CBT interventions for children with anxiety, there were few that explored the use of CBT treatment directly with young children. Primarily the focus of treatment has been with parents for children of that age group, despite the internalizing nature of anxiety. Because of the early onset of anxiety in children and the lack of research with a young population of anxious children, it is important to examine the effectiveness of established methods with young children or determine other treatments that may be geared more towards young children's developmental levels.

Rey, Marin, and Silverman (2011) compiled a list of failures of CBT. They defined failures as a lack of decrease in anxiety symptoms and continued presence of symptoms to warrant a diagnosis after successfully completing treatment. After examining the literature, they concluded that certain factors contribute to failures in CBT. The following circumstances were hypothesized to contribute to treatment failure: high symptom severity, more negative self-statements, comorbidity, presence of mother's fear or father's rejection, client's unwillingness to participate in treatment, and a weak therapist-child alliance. Through their conclusions, it

appears as if CBT is more likely to be successful when children exhibit few symptoms, have a generally more positive mindset, are only struggling with anxiety, have supportive environments, are willing to engage in treatment, and have strong connections with their therapists.

Shift in Perspective

The behavioral therapy movement lessened the value placed on the therapeutic relationship that existed in prior theories. Behaviorists criticized previous modalities of working with children for their lack of specific and measurable treatment goals and treatments to enhance them (Ross, 1978). Learning theories began to influence therapists, and they turned more toward working with parents and training them to conduct behavioral strategies with their child. The relationship between child and therapist became less significant. As the focus has been returned to working with children in therapy over parents, behaviorist clinicians have begun to place more of an emphasis on the therapeutic relationship (Kendall & Morris, 1991). Behaviorists value the therapeutic relationship; however, techniques and reinforcements within the relationship are considered the real producers of change.

Rey, Marin, and Silverman (2011) attempted to explain failures in CBT with children who are anxious, noting that a therapeutic alliance with strong client and counselor engagement is critical in the success of therapy. CBT therapists need the alliance to form in order for extra techniques to be employed. Grave and Blissett (2009) conducted a review of CBT literature with young children and concluded that CBT without adaptations is not developmentally appropriate for young children, under 11, and that other approaches such as psychodynamic or child-centered play therapy should be utilized with younger children.

Child centered play therapy may be an alternative treatment for young children as it was created specifically to meet the developmental needs of young children. CCPT utilizes the therapeutic relationship characterized by unconditional positive regard, empathy, and genuineness to help children develop sense of self. CCPT works with the internal process of the child as opposed to specific behavioral concerns, potentially addressing the physiological and cognitive components of anxiety that occur in young children.

CCPT and Anxiety

Play therapy has been shown to be effective with many populations and disorders (Bratton et al., 2005). Theoretically, CCPT is an effective modality in helping lessen anxiety as it allows children to be self-directed, with the understanding that children know what they need, not forcing children to face what they are not yet ready to face (Landreth, 2012; Ray, 2011). Additionally, CCPT helps foster a greater sense of self with a more integrated self-structure. The diminished incongruence resulting from a more integrated sense of self is inherently a lessened state of anxiety and discomfort. The relationship is conceptualized as the key facilitator of change. The uniqueness of this approach is demonstrated through Rogers (1939), “in no other type of treatment effort does the emotional situation between therapist and child occupy such a place of prominence (p. 343).” Furthermore, children who are in a secure relationship with the play therapist, characterized by congruence, empathy, and unconditional positive regard, will be able to accept parts of themselves and their experiences that they have denied, including fears and anxiety. This greater self-acceptance will lead to self-understanding, self-integration, and congruence within the child.

As a result of play therapy, children reported being able to better verbalize difficult emotions and find solutions to their concerns because of their counselors' empathy and acceptance, resulting in experiencing decreased levels of anxiety after participating in play therapy (Green & Christensen, 2006). Therefore, "play therapy is particularly well suited to the treatment of the fearful child" (Lyness-Richard, 1997, p. 40).

Many investigators have examined anxiety outcomes within play therapy studies; however, their focus has not been solely on anxiety or any other specific disorders. Instead, they have focused primarily on play therapy working to decrease many symptoms in children with diverse presenting problems or presenting problems that are not directly related to a diagnosis or assessment measure. Many studies measuring levels of anxiety seem to be targeting play therapy as effective in reducing many symptoms, but they lack a specific focus by not utilizing inclusion criteria to study children who are specifically referred for anxiety.

In exploring the impact of play therapy with 168 at-risk fourth, fifth, and sixth graders, Post (1999) used measures for self-esteem, locus of control, and anxiety in a pre-posttest design. Children who participated in a mean of 4 CCPT sessions demonstrated statistically significant differences in self-esteem and locus of control over children who did not participate in play therapy. Children in play therapy maintained stable self-esteem and locus of control scores over the course of the intervention while scores declined for children in the control group. Regarding anxiety, neither children in the experimental group nor control group decreased anxiety at a statistically significant level as measured by the State Trait Anxiety Scale. Although Post did not offer discussion regarding the lack of improvement on anxiety, she cited a lack of randomization as one limitation to the study. Additionally, the mean of 4 CCPT sessions may have limited the potential benefits of intervention for anxiety outcome.

Shen (2002) investigated the effects of short-term group play therapy on anxiety, depression, and adjustment with 30 Chinese earthquake victims in grades 3 through 6. In a pre-posttest design, she compared children's anxiety, depression, and adjustment between the two groups over time. Children who received play therapy were in groups of 3 for 10 40-minute sessions over 4 weeks and had statistically significant differences in overall anxiety as measured by the Revised Children's Manifest Anxiety Scale with a large effect (partial eta squared = .274). Physiological anxiety and Worry/Oversensitivity were significantly lower in children who participated in play therapy with large effects (.189, .135, respectively). There was no statistically significant difference in Social Anxiety between groups. Children who received play therapy had statistically significantly lower suicide risk levels. Although the results are encouraging, Shen utilized group play therapy in China, making the results difficult to generalize to individual CCPT in the United States.

Multiple studies have been conducted within hospital settings for children receiving a play intervention to lessen their anxiety. Lerwick (2011) examined the effects of play therapy on pre-neurosurgical pediatric patients and concluded that when children received play therapy, their levels of anxiety decreased. Clatworthy (1981) discovered that children who were hospitalized for longer amounts of time and received a therapeutic play intervention had significantly lower levels of anxiety than children who were in the hospital for comparable amounts of time without a therapeutic play intervention. Additionally, Rae, Worchel, Upchurch, Sanner, and Daniel (1989) determined that children who had two 30 minute sessions of CCPT, they were less fearful of the hospital compared to children who did not receive CCPT.

The effects of child-centered group play therapy on self-concept, depression, and anxiety on 42 children, ages 5 to 11, who were homeless was examined in a pre-posttest design by

Baggerly (2004). After receiving between 9 to 12 sessions of group play therapy with two children per group, only 25 children remained in the study. Children's Total Anxiety and Physiological Anxiety on the Revised Children's Manifest Anxiety Scale decreased significantly with moderate to large effect sizes (.43, .68, respectively) after participating in play therapy. Children's scores on Worry and Social did not significantly differ from children who did not receive play therapy. When examining anxiety through the Child Anxiety Scale, Baggerly concluded that Sten score of the Child Anxiety Scale was statistically significant at $p = .05$. The Percentile score on Child Anxiety Scale was not significantly different between groups. Self-concept and depression scores were also statistically different for children who received play therapy. Baggerly mentioned the 48% drop out rate; however, she did not address it as a limitation or conceptualize it in her results. The children who completed treatment may have been different from the children who were not able to complete treatment, and therefore, the results may be skewed. Additionally, it is unclear if children had to change groups throughout treatment, which could possibly be a barrier to further progress.

When examining trauma symptoms in sexually abused children, Reyes and Asbrand (2005) began their pre-posttest design with 43 children, ages 7 to 16, and ended with 18 after 9 months of treatment. Children's anxiety symptoms as measured by the Trauma Symptom Checklist for Children significantly decreased after 9 months of play therapy with an effect of partial eta squared = .33. Burroughs, Wagner, and Johnson (1997) compared 21 children whose parents were getting divorced in a board game intervention and a play therapy intervention for 5 sessions each. Children who received the play therapy intervention had statistically significantly lower levels of anxiety as measured by the State Trait Anxiety Scale than children who received the board game intervention.

Naderi, Heidarie, Bouron, and Asgari (2010) conducted a randomized control trial study comparing 80 children, ages 8 to 12, with a diagnosis of anxiety and ADHD who received play therapy and children who did not receive play therapy. At the conclusion of 10 play therapy sessions, there was a significant difference on anxiety scores, as measured by the Ahwaz Children Anxiety Test, between the experimental and control groups. Children who received play therapy were less anxious than children who did not receive play therapy, but the play therapy intervention was directive and activity-based. Similarly, Schmidtchen and Hobrucker (1978) concluded that after 50 children ages 9 to 13, received CCPT, they experienced decreases in anxiety compared to two untreated control groups.

Although none of the previous studies investigated play therapy with children who were referred specifically for anxiety, the literature is encouraging in the effectiveness of play therapy with this population. The Bratton et al. (2005) meta-analysis included 24 studies conducted on internalizing problem behaviors, such as anxiety and depressed mood, with an effect size of 0.81. Seven studies measured anxiety as an outcome with an effect size of 0.69. Yet, there appears to be a void in the literature with play therapy and children who are seeking treatment specifically for anxiety.

Furthermore, none of the studies have investigated the mechanisms of change that underlie the theoretical rationale of play therapy with children who are anxious. Because of the lack of targeting children who are anxious as a presenting problem, CCPT literature that includes children who are anxious is not focused on the process of change for children who are anxious. Theoretically, through CCPT, children will develop their self-concepts and will reduce their levels of incongruence or anxiety (Landreth, 2012; Nuding, 2013; Ray, 2011). They will experience fewer threats to their self-structure, allowing them to be flexible and open to new

experiences. These changes are hypothesized to occur through the context of the therapeutic relationship; however, the process of CCPT as it is hypothesized with children who are anxious has not been examined.

Mediators

Investigation of mediators is a recommended practice that is rarely enacted in child counseling research (Baggerly & Bratton, 2010; Kazdin & Nock, 2003; La Greca, Silverman, & Lochman, 2009; Phillips, 2010). Mediators are the cause or process of change that occurs in a phenomenon (Baron & Kenny, 1986; Holmbeck, 1997; Kazdin & Nock, 2003). In counseling outcome research, mediators are the reason why change occurs. For example, in play therapy intervention research, play therapy lessens children's scores on externalizing behavior. Although knowing that the intervention was able to decrease scores is important, deeper understanding of the change in scores can be found by examining the mediator of the change in the play therapy intervention.

Investigating mediators of change can enhance research and practice. Mediators help in ranking best treatment practices. If a component of therapy is a mediating factor of change, therapies that contain that factor should be utilized more than therapies that do not. Mediators can optimize therapeutic change by focusing practice and training on the mediating variables. Understanding variables that mediate change can help narrow moderators of change, or characteristics that inherently are more suited towards change. Target populations can be identified, and treatment can be matched more easily to these populations. Additionally, understanding how therapy works can be generalized to improving life in many areas (Kazdin & Nock, 2003).

Mediation can be viewed theoretically, as many outcome studies have investigated, correlating therapeutic relationship with outcome; however, statistical mediation involves a more complex process. The following are the steps needed for statistically examining mediation:

1. Efficacy test: The treatment or intervention (A) must be related to therapeutic change or treatment outcome (C).
2. Intervention test: The treatment has the specific effect intended; it must be related to the proposed mediator (B)
3. Mediator and change test: As a test that the proposed mediator is related to change in symptoms (or outcome domains), the mediator (B) must be related to therapeutic change (C)
4. Mediation, intervention, and change test: The relation between the intervention (A) and therapeutic change (C) must be reduced after statistically controlling for the proposed mediator (B) (Kazdin & Nock, 2003; p. 1122)

After these tests have been completed, a variable can be deemed a mediator if it meets these conditions:

a) variations in levels of the independent variable significantly account for variations in the presumed mediator, b) variations in the mediator significantly account for variations in the dependent variable, and c) when a and b are controlled, a previously significant relation between the independent and dependent variables is not longer significant. (Baron & Kenny, 1986, p. 1176)

Play therapy has many components; toys, verbal responses, non-verbal responses, therapeutic relationship, etc., making it difficult to pinpoint the most influential change aspects. Understanding mediators of change can help promote training and improve therapeutic contact. If children improve in play therapy because they are allowed to play with toys, trained play therapists are no longer necessary. However, if the relationship is the primary mediating factor of change, more emphasis needs to be placed on developing the relationship instead of learning skills or techniques in a traditional sense. CCPT therapists hypothesize that the relationship is the curative factor; however, no outcomes studies exist that examine the therapeutic relationship as a statistical mediator of change in therapy.

Summary

Person-centered theory is focused on reducing incongruence through the development of a relationship characterized by the six necessary and sufficient conditions for change. Without intervention, researchers conclude that children who are anxious progress through a trajectory of increased problematic symptoms and comorbidity of additional diagnoses (Kendall, et al., 2010; Paul, & Barrett, 2010; Pollock et al., 2006; Seligman & Ollendick, 1998; Silverman & Kurtines, 1996). Children who are anxious may benefit from CCPT through the use of the conditions in order to restructure the self and therefore, reduce anxiety. Young children who are anxious need interventions geared towards their developmental age and in their developmentally appropriate language of play (Landreth, 2012, Ray, 2011). Currently, CBT is widely utilized in treating children; however, many children who successfully complete CBT treatment continue to meet criteria for anxiety disorders. Additionally, CBT is less focused on matching the developmental needs of young children. Due to the early onset of anxiety, it is important to intervene early with this population. CCPT has been found to be effective with young children, specifically with reducing anxiety symptoms. However, no studies have specifically examined CCPT with children meeting clinical thresholds for anxiety symptoms, leaving a lack of true understanding as to the effectiveness with this population. Further, the underlying foundation of the relationship as the facilitative factor is an integral underpinning of CCPT, which has never been tested through statistical means.

APPENDIX B
COMPLETE METHODOLOGY

This appendix presents methods and procedures utilized for this study. Included are research assumptions, participant selection, discussion of instrument descriptions, approach to data collection, description of the treatment, approach to statistical analysis, and review of limitations of the study.

Hypotheses

The purpose of the study was to explore the effects and mediating factors of child-centered play therapy (CCPT) on young children with symptoms of anxiety. The current study was based on the following research questions:

Research Question 1: What impact does CCPT have on young children with reported elevated levels of anxiety symptoms?

Research Question 2: Is there a difference in therapeutic relationships between children who participate in play therapy and those in an active control group?

Research Question 3: Can therapeutic relationship be considered a statistical mediator of anxiety outcomes, and if so, to what degree does the therapeutic relationship mediate anxiety symptoms of young children?

Definitions

For the purpose of this study, anxiety, therapeutic relationship, and child-centered play therapy were defined as follows:

Anxiety: Anxiety was conceptualized as a threat to the self-structure manifested through physical symptoms such as nail biting, worrying, and nervousness. For the purposes of the current study, anxiety was operationally defined as the combination of scores on the TRF and RCMAS.

Therapeutic relationship: Therapeutic relationship was conceptually defined as the experience of two people being within each other's experiential field, characterized by empathy,

genuineness, level of regard, and conditionality of regard, also referred to as conditions for change (Barrett-Lennard, 1986; Rogers, 1959). For the purposes of the current study, therapeutic relationship was operationally defined as the total score on the Barrett-Lennard Relationship Inventory- Myself-to-Other (BLRI-MO).

Child-centered play therapy: CCPT is a developmentally appropriate, non-directive, mental health intervention. CCPT uses children's natural language, play, to provide a therapeutic relationship characterized by empathy, congruence, and unconditional positive regard. Through the relationship, children develop a greater sense of self-concept, leading to appropriate emotional expression and adaptive behavior (Landreth, 2012; Ray, 2011). For the purposes of the current study, CCPT was operationally defined by procedures in the CCPT manual (Ray, 2011).

Participants

Participants were recruited from four Title 1 local elementary schools in the southwest United States. Demographic information from the Academic Excellence Indicator report from 2012 regarding each school is listed in Table B.1. The researcher asked school personnel to refer children who displayed symptoms of anxiety including constant fidgeting, picking at nails/skin, and limited ability to articulate. The researcher obtained informed consent from parents, teachers, and play therapists and assent from children before screening of participants began. Participants were notified of the possibility of not qualifying for services and the possibility of delayed services. Participants were informed of the voluntary nature of participation including withdrawal at any time. Fifty-five participants were recruited who met criteria for anxiety threshold. Two children were dropped from the play therapy treatment group due to inconsistencies with play therapy delivery. The remaining 53 who began the study completed the

study protocol. Criteria for inclusion in this study included the following: 1) Children were between 6 and 8 years old; 2) Children’s scores on any subscale of the RCMAS-2 fell in elevated range with a T-score above 50 or fell in the Clinical or Borderline range on the Anxious/Depressed subscale on the TRF with T-scores above 65; 3) Children understood and spoke English; 4) Parents were willing to give consent; 5) Teachers of children were willing to complete instruments.

Table B.1

Demographics of Schools

	School 1	School 2	School 3	School 4
<i>Ethnicity</i>				
African American	8.4%	20.5%	17.7%	10.9%
Hispanic	52.4%	54.1%	23.8%	65.4%
White	36.5%	21.2%	53.1%	20.9%
American Indian	1.2%	0.6%	0.7%	0.8%
Asian	1.1%	1.2%	2.3%	0.2%
Pacific Islander	0.0%	0.0%	0.0%	0.0%
Two or More Races	0.5%	2.3%	2.3%	1.9%
<i>Educational/Social</i>				
Economically Disadvantaged	75.7%	89.6%	46.9%	78.8%
At-Risk	54.5%	64.9%	17.5%	64.9%
Number of participants	<i>n</i> = 17	<i>n</i> = 22	<i>n</i> = 8	<i>n</i> = 6

Of the 53 participants, 5 were in kindergarten, 22 were in first grade, and 26 were in second grade. The age range of participants was from 6 to 8 years old with 26 6-year-olds, 24 7-

year-olds, and 3 8-year-olds. There were 36 males and 17 females who participated. Of participants, 11 were African American, 24 were Caucasian, 11 were Hispanic/Latino, 1 was Asian, and 6 were Biracial. Twenty-five participants were in the play therapy group and 28 participants were in the active control group. The distribution of age, grade, gender, and ethnicity across the two groups is displayed in Table B.2.

Table B.2

Demographics of Child Participants

	Play Therapy Group (<i>n</i> = 25)	Control Group (<i>n</i> = 28)
Grade		
Kindergarten	2	3
First	8	14
Second	15	11
Age		
Six	10	16
Seven	10	12
Eight	3	0
Gender		
Male	16	18
	Play Therapy Group (<i>n</i> = 25)	Control Group (<i>n</i> = 28)
Female	7	10
Race/Ethnicity		
African American	4	7

Caucasian	12	12
Hispanic/Latino	8	3
Asian	0	1
Biracial	1	5

Instruments

Revised Children’s Manifest Anxiety Scale

The Revised Children’s Manifest Anxiety Scale, Second Edition (RCMAS-2; Reynolds & Richmond, 2008) is a 49-item self-report measure of anxiety for children 6 to 19 years old. Each question is answered by circling either “yes” or “no” in response to a statement. The RCMAS-2 consists of six scales, two validity scales and four anxiety scales. The validity scales are Inconsistent Responding Index and Defensiveness. The anxiety scales are Total Anxiety, Physiological Anxiety, Worry, and Social Anxiety.

Defensiveness (DEF) addresses whether responses have been given to present a positive image of the respondent that is probably not realistic and is dissimilar from the respondent’s true state. Physiological Anxiety (PHY) assesses physiological responses that often accompany anxiety. The Worry (WOR) scale assesses children’s level of fear, nervousness, or oversensitivity to environmental pressures. The Social Anxiety (SOC) scale measures concern about self in relation to others. The Total Anxiety (TOT) score encompasses all questions related to physiological anxiety, worry, and social anxiety. All of the scales were used as qualifying criteria for this research study, including defensiveness as children who are responding defensively may be more anxious than they are reporting (Reynolds & Richmond, 2008).

When scoring the RCMAS-2, raw scores are calculated then translated into T scores. T scores above 60 fall in the significant range, suggesting that the respondent has difficulties with anxiety. T scores that are 71 or higher are categorized as extremely problematic while T scores from 61 to 70 are considered moderately problematic. T scores above 50 indicate elevated levels of anxiety. T scores below 40 indicate that respondents are unusually anxiety free.

Reliability estimates for the RCMAS-2 are considered strong. Reynolds and Richmond (2008) reported a Cronbach's alpha of .92 for Total score of the RCMAS-2, with subscale scores ranging from .75 to .86. When examining test-retest reliability, they reported Total score at .75, with ranges from .64 to .73 for the subscale scores. Internal consistency scores for Total Anxiety range from .90 to .92 for children ages 6 to 8, males and females, and Black/African American and Hispanic. The Cronbach's alpha estimates, test-retest reliabilities, and internal consistency score ranges for each subscale can be found in Table 3. Reynolds and Richmond reported that validity of the RCMAS-2 has been thoroughly examined through theoretical considerations in creation and careful construction of items. Convergent validity indicates high correlation between the RCMAS-2 and the trait anxiety measure of the State-Trait Anxiety Inventory for Children at $r = .85, p < .05$.

Table B.3

Reliability Estimates for RCMAS-2

Scale	Cronbach's alpha	Test-retest	Internal Consistency
Total	.92	.76	.90 - .92
Physiological	.75	.73	.70 - .77
Worry	.86	.71	.81 - .87
Social	.80	.64	.75 - .83
Defensiveness	.79	.67	.60 - .80

Teacher Report Form

The Teacher Report Form (TRF; Achenbach & Rescorla, 2001) assesses children's level of functioning as reported by teachers. The TRF can be used with children ages 6 to 18 years old.

The TRF consists of an Adaptive Functioning Profile and Syndrome Profile. The Adaptive Functioning Profile examines characteristics such as working hard, behaving appropriately, learning, and happy. The Syndrome Profile includes the following scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior. Additionally, the TRF groups syndrome scales into Internalizing and Externalizing. For the purpose of this research, the Anxious/Depressed subscale was utilized. The Anxious/Depressed subscale measures children's behaviors that may be indicative of anxiety or depression if displayed in excess of that observed with other children.

The syndrome scales are comprised of 113-items that are rated as either not true, somewhat or sometimes true, or very true or often true. Teachers completing the TRF rated their students' behaviors according to these classifications. T scores are produced from teachers' responses. For the Anxiety/Depressed subscale, T scores below 64 are considered normal. T scores between 65 and 69 are in the borderline range. T scores 70 and above are considered to fall in the clinical range.

The TRF reports strong psychometric properties. The TRF has internal consistency ratings from .54 to .96 on subscales and test retest reliability ranging from .86 to .89. Achenbach and Rescorla (2001) reported test-retest reliability estimate for the Anxious/Depressed subscale at $r = .68$. Content validity is supported by research indicating that the items discriminate between children who were referred for services and demographically similar children who were

not referred. Significant discrimination (71%, $p < .05$) was established for referred and non-referred children supporting criterion-related validity on the problem scales. Criterion-related validity and construct validity of the scales has been well-established (Achenbach & Rescorla, 2001).

Barrett-Lennard Relationship Inventory

Barrett-Lennard (1962) developed the Barrett-Lennard Relationship Inventory (BLRI) to quantitatively measure the therapeutic conditions between client and counselor in person-centered therapy. The BLRI has been revised many times. The original BLRI contained 85 items deriving from the Relationship Q-Sort (Brown, 1954) and was revised to contain only 64 items (Barrett-Lennard, 1978). Barrett-Lennard (2002) further revised the BLRI to a 40 item assessment.

The BLRI also has many forms within its revisions. The client form of the BLRI OS is the Other-to-Self form, measuring client's perspective of the therapeutic relationship. The therapist form, BLRI MO, Myself-to-Other, is similar to the client form except questions are worded in first person as it measures the therapist's perspective of the relationship. For this research study, the BLRI MO-40 items was utilized.

The BLRI is a self-report measure with a six point bipolar rating scale, ranging from -3 (no, strongly not true) to 3 (yes, strongly true). Therapists complete the assessment based on their relationship with a specific client. The BLRI MO-40 consists of 40 items, with 10 items being categorized into each subscale. The four subscales of the BLRI are; Empathic Understanding, Level of Regard, Unconditionality, and Congruence. Empathic Understanding is the level of consciously being aware of another's immediate experiences. Level of Regard is defined by the

affective response of one person to another. Unconditionality measures the level of change in one person's level of regard in response to another's thoughts, feelings, or behaviors.

Congruence is the degree to which one person is consistent within a relationship with another, including being consistent in awareness and experiences (Barrett-Lennard, 1962).

The BLRI is the most frequently used instrument to measure therapeutic relationship in person-centered research, primarily being utilized in therapeutic settings (Freire & Grafanaki, 2013). Validity has been asserted through many studies, specifically through studies demonstrating associations between the BLRI and therapy outcome (Barrett-Lennard, 1998). Additionally, construct validity is further supported by content-validation procedures at the formation of the instrument, during which theoretical experts analyzed and checked items for accurate representation of the constructs (Barrett-Lennard, 1978). Ponterotto and Furlong (1985) concluded that the validity of the BLRI remains unclear due to the many versions of the BLRI used in research. Reliability of the BLRI has been heavily researched. Gurman (1977) summarized 14 reliability studies with various versions of the BLRI. The mean internal consistency reliabilities were .91 for Level of Regard, .88 for Congruence, .84 for Empathy, .74 for Unconditionality, and .91 for the total score. These numbers were developed from the 85 and 64 item BLRI versions. The estimated reliabilities for the 40-item version are speculated to be lower due to the decrease in number of items per subscale (Freire & Grafanaki, 2013). However, Barrett-Lennard (personal communication, 2013) recommended utilizing the 40-item version for research purposes. For the current study, reliability estimates indicated a Cronbach's alpha of .969 for the total BLRI with subscale reliability estimates of .752 for Level of Regard, .984 for Empathy, .898 for Unconditionality, and .727 for Congruence.

Procedures

Study procedures are outlined in Figure B.1. Human subjects approval was obtained from the University of North Texas Internal Review Board and Denton Independent School District prior to the recruitment of participants for this study. I spoke with administrators and school counselors of the schools to begin to identify children who displayed anxious behaviors. Additionally, I spoke with teachers in kindergarten through second grade to help them identify students who displayed anxious behaviors. Teachers were asked to identify children who seemed anxious and exhibited problems in school such as picking their skin, having frequent headaches, or crying. Teachers made referrals to the school counselors for children who they believed would qualify for the study. I gave school counselors consent forms (see Appendix E), including a full explanation of the purpose, procedures, and foreseen risks of the study to the parent or guardian of all identified students, to send home with children for their parents to sign. Demographic information such as age, ethnicity, and race of the child was collected at the time of obtaining consent from parents. Consent forms were returned to school counselors for me to collect.

After consent forms were received from parents, I obtained assent from children and assessed them utilizing the RCMAS-2 to determine eligibility. Teachers of children who qualified for the study were given consent forms to participate in the research study (see Appendix E). After teachers gave informed consent, they were given the TRF to complete for each child. Additionally, I obtained consent from doctoral-level play therapists who conducted play therapy sessions for this research study and completed weekly assessments (see Appendix E).

An a priori power analyses was conducted for both ANOVA and Multiple Regression analyses. Results indicated that in order to have a power of .95 with a medium effect size for a

factorial ANOVA, 36 participants were needed. To run a regression with 4 predictors at a power of .95, 53 participants were needed. Fifty-three participants were recruited for the study.

After receiving informed consent, I administered the RCMAS-2 to each child individually. I read the questions to the children and asked them to respond either verbally or by pointing to their answer choice. I also administered the TRF to teachers; however, they completed these as self-report measures on their own. I collected and scored both the RCMAS-2 and the TRFs to determine eligibility for the study prior to randomizing participants into experimental groups.

In accordance with randomized controlled trial procedures, children who met criteria were randomly assigned into a treatment or active control group. I utilized the block randomization technique to account for differences in time for when consent forms were received. Participants were randomized per school to ensure equal amounts of participants in each group. Once I received 8 consent forms for qualifying students in a school, I randomized participants into either the experimental or control group utilizing a random number generator with numbers 1 through 8. I listed out the names of the 8 children in order of received consent and then assigned numbers based on the random number generator. Children who were assigned even numbers were included in the experimental play therapy group and odd numbers to the activity control group. Children began treatment the following week for 8 weeks in their respective groups. After receiving an additional 8 qualifying children, I utilized the randomization procedures and another 8 participants would begin the 8-week treatment phase. Towards the end of recruitment, I lowered the number of qualifying participants to 4 or 6 per school prior to randomizing as I began to reach my ideal sample size. Children in the experimental group received two 30 minute individual child centered play therapy sessions per

week for the period of 8 weeks. The play therapy sessions were held in the student's school in a fully equipped playroom in accordance with the CCPT manual (Ray, 2011). Participants in the active control group participated in 30 minutes of weekly small group coloring activity groups.

The experimental group was designed to provide 16 CCPT sessions over 8 weeks. Due to student and counselor absences and inclement weather, children in CCPT received between 12 and 16 sessions of play therapy with a mean of 15.32 sessions. To control for attention, children in the active control group participated in an activity group once a week over the 8-week period. Due to student and counselor absences and inclement weather, children in the control group received between 6 and 8 groups with a mean of 7.32.

Beginning with the third week, counselors completed the BLRI-MO weekly, i.e. after 2 play therapy sessions or 1 group session. I distributed the BLRI-MO forms to counselors and allowed them to complete them on their own, then return them to me weekly throughout the study.

At the completion of the 8-week period, the RCMAS-2 and TRF were administered as post-test measures. The same procedures for post-testing were utilized as for pre-testing. Additionally, children in the active control group were given play therapy services at the conclusion of the 8 weeks.

All information collected was kept confidential. Names of the children, teachers, and therapists were excluded from any documentation or reports of the study. Information collected at pretest and posttest was recorded by the use of a code number for each participant. These numbers were only available to me to serve as a master list. Clinical files were retained in compliance with human subjects approval.

Experimental Group Procedures

Children assigned to the treatment group participated in 12 to 16 sessions of CCPT over 8 weeks. Children received 30 minutes of individual child-centered play therapy at the children's school. CCPT uses children's natural language of play to provide a therapeutic environment that is developmentally appropriate for young children. Treatment was provided according to the protocol as outlined in CCPT treatment manual (Ray, 2011). Counselors responded with verbal and nonverbal communication to develop the therapeutic relationship including empathic responses, limit setting, returning responsibility, and facilitating emotional expression. Counselors used these skills to facilitate a warm, empathic, and non-judgmental environment. Playrooms were assembled and materials chosen based on recommendations by Landreth (2012) and Ray (2011). The toys in the playrooms were selected to match the developmental age of children and to allow for maximum communication potential. Toys were representative of many categories, such as nurturing, mastery, aggression, imaginary, and creative expression in order to facilitate a wide range of emotional expression. Protocol adherence was assessed through fidelity checks of video-recorded sessions utilizing the Play Therapy Skills Checklist (PTSC; Ray, 2011). One session per counselor was randomly selected and reviewed in its entirety by the researcher. Sessions adhered to CCPT protocol over 90% of the time with an average of 96.64% adherence to protocol per session.

The counselors were University of North Texas doctoral level counseling students and one faculty member experienced in play therapy. All participating counselors met minimum criteria of a master's degrees in counseling and had conducted play therapy for at least one year prior to participating in the study. Each counselor completed at least two play therapy courses and a counseling practicum with supervision in play therapy. Counselors included 9 females who

identified as Caucasian ($n = 7$), Asian ($n = 2$), and African American ($n = 1$). Counselors participated in a two hour training prior to delivering play therapy services to explain the protocol for conducting play therapy in the schools and emphasizing the use of CCPT skills and attitudes (see Appendix E). Additionally, counselors received weekly supervision by advanced play therapists.

Active Control Group Procedures

Children assigned to the active control group received a coloring based weekly activity group facilitated by a doctoral level counselor. Students participated in groups of 2 to 4 students with one counselor. The purpose of the active control group was to address the internal validity threat of attention provided to children in the experimental group. Hence, the active control group participated in a task-oriented relationship with the counselor. Groups were designed to simulate typically activities conducted in schools.

The counselors for the small activity groups were doctoral level counselors with training in school guidance. Guidance training consisted of a university course on school counseling, including guidance delivery. Further, group counselors were required to attend training conducted by the investigator on coloring activity protocol (see Appendix E).

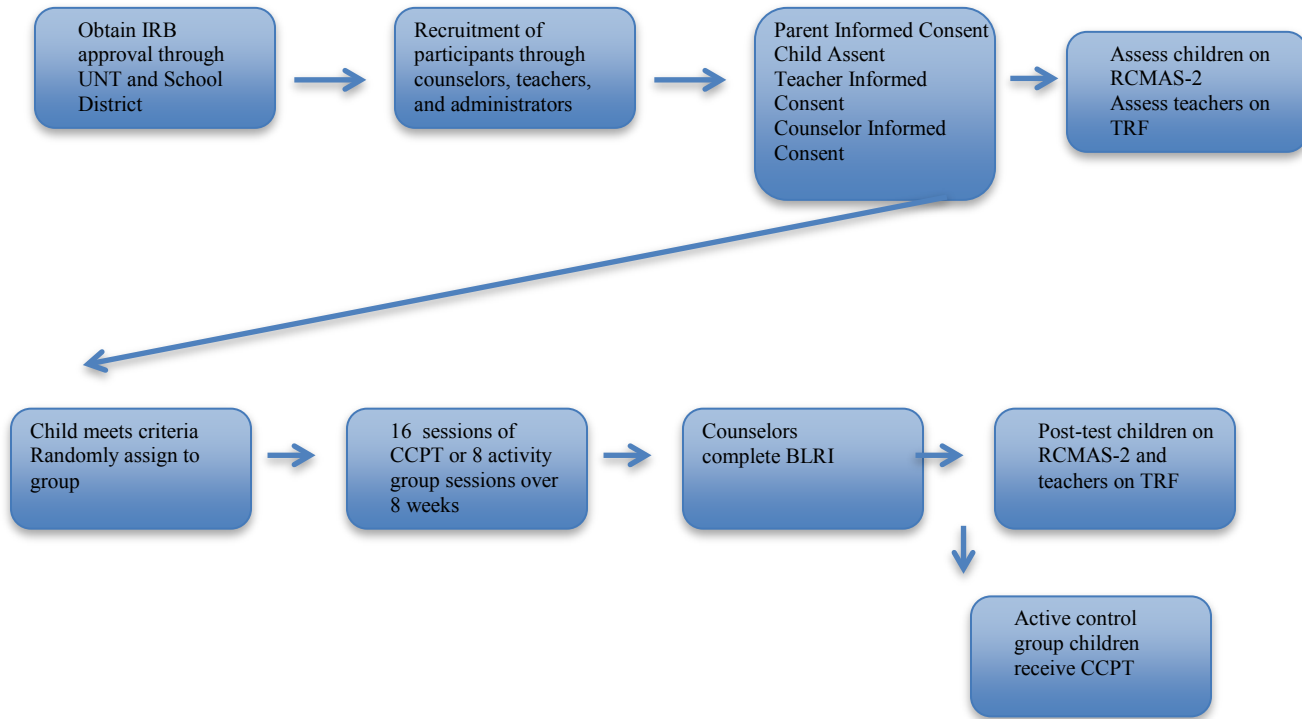


Figure B.1. Study flow.

Statistical Analysis

Figure B.3 represents the statistical analyses used for this study. The statistical analyses utilized for this study are listed according to research question. Before conducting data analysis, all assessments were scored and entered into SPSS.

Research Question 1: Effectiveness

Prior to examining mediation, it is important to investigate whether a statistically significant change occurred; otherwise, no change exists to explain through mediation. In order to determine the efficacy of play therapy on anxiety scores, 6 2x2 factorial ANOVAs were conducted. Initially, only Total Anxiety on the RCMAS-2 and Anxious/Depressed on the TRF were utilized as the dependent variables in two ANOVAs. However, following the initial analysis with Total Anxiety, a series of repeated measures analysis of variances were conducted

as post hoc analyses with treatment group as the independent variable and the remaining RCMAS-2 scales as the dependent variables to gather more information regarding the change in anxiety scores. Participants' scores were examined across time (pre and post test), between groups (play therapy or active control group), and the interaction effect between time and groups. Anxiety scores before and after treatment and in children who received play therapy or the active control group were differentiated and compared. The ANOVAs utilized all subscales on the RCMAS-2 as dependent variables, Total, Defensiveness, Physiological Anxiety, Worry, and Social, in addition to the Anxious/Depressed subscale on the TRF. All subscales in the RCMAS-2 were utilized as dependent variables due to the independent nature of the subscales' interpretations and the construction of the Total Anxiety scale resulting from totaling the other subscales (Reynolds & Richmond, 2008). In all ANOVAs, group was the independent variable. Changes in children's self-reported anxiety was assessed in addition to changes in teacher's observation of children's anxious behaviors. Statistically significant differences between the means across time were tested at the .05 alpha level for Total Anxiety on the RCMAS-2 and Anxious/Depressed subscale on TRF. The alpha level for the remaining RCMAS-2 subscales was lowered to .025 to control for Type 1 error.

Null hypothesis statistical testing only has the capability of determining if there is an effect to be found; however, effect sizes help determine whether the differences matter in a more practical way (Henson, 2006). The Task Force on Statistical Inference (1999) and the American Psychological Association's *Publication Manual* (APA, 2001) recommended examination of effect sizes in quantitative research in order to show strength of relationship instead of an arbitrary and dichotomous, there is or is not statement (Trusty, Thompson, & Petrocelli, 2004; Henson, 2006). For this study, an effect size was computed for each analysis using Cohen's *d* to

assess practical significance of findings, specifically the quantifiable difference between the outcome of the two groups. Cohen's (1988) guidelines for interpretation of practical significance was utilized. Cohen's d of .2 was small, .5 was medium, and .8 was large. Clinical significance was evaluated by examining the percentage of participants who no longer fell in the elevated range on the RCMAS-2.

Research Question 2: Relationship Differences

The second research question focused on the differences in therapeutic relationship between the two groups. To examine this question, 4 t -tests were conducted with group as the independent variable and the relationship variables, regard, empathy, unconditionality, and congruence, as the dependent variables. In order to accurately represent the therapeutic relationship, BLRI scores from the fifth, and final, measurement point were used in the dependent variable. Practical significance was examined using Cohen's d to quantify difference between the groups.

Research Question 3: Mediation

To examine the relationship as a statistical mediator, the regression model proposed by Baron and Kenny (1986) was conducted. The BLRI was administered throughout treatment to capture any differences that may occur as a result of the relationship developing. Due to the lack of significant change across administration times, the final administration of the BLRI was utilized in mediation analyses. Each BLRI subscale was investigated as a potential mediator of Total scores on the RCMAS-2. Multiple regression analyses were conducted and coefficients analyzed as different parts of the model were examined. The first multiple regression analysis is

represented in Path A of Figure 2, by utilizing group membership as the predictor variable and Total post-test scores as the dependent variable. The second analysis, Path B of Figure B.2, uses group membership as the predictor variable and relationship scores as the dependent variable. The third analysis, Path C of Figure B.2, utilizes relationship scores as the predictor variables with Total post-test scores as the dependent variable. The last regression analysis uses group membership and relationship scores to predict anxiety post-test scores to calculate the magnitude of mediation. The first three analyses were examined first to determine if statistically significant relationships are found between the variables.

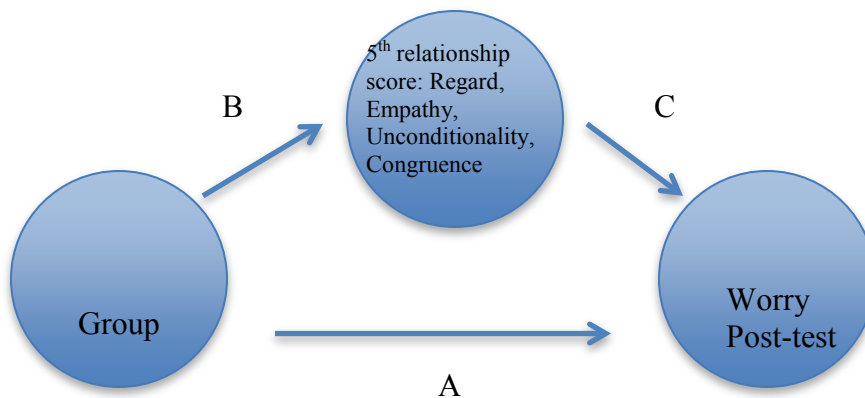


Figure B.2. Mediation model.

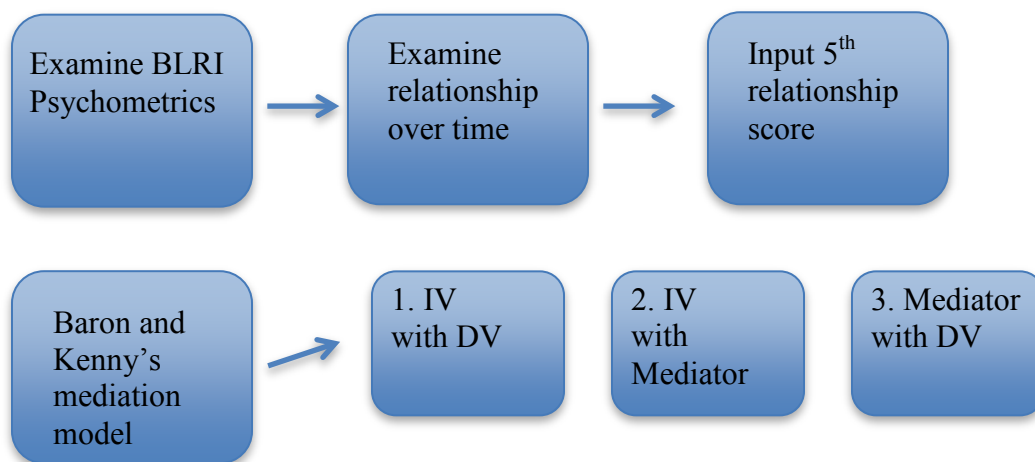


Figure B.3. Statistical analysis process for mediation.

APPENDIX C
UNABRIDGED RESULTS

Results

The following results are intended to answer the three research questions; 1) What impact does CCPT have on young children who report elevated levels of anxiety symptoms?; 2) Is there a difference in therapeutic relationship between children who participate in play therapy and those in an active control group?; 3) Can therapeutic relationship be considered a statistical mediator of anxiety outcomes, and if so, to what degree does the therapeutic relationship mediate anxiety symptoms of young children? The results are divided by the first research question addressing effectiveness, second addressing therapeutic relationship between groups, and the third research question addressing mediation.

Research Question 1: Effectiveness

In order to address the first research question of determining play therapy’s effectiveness on children’s anxiety, a series of repeated measures analyses of variance were conducted with treatment group as the independent variable and RCMAS-2 scales and TRF anxiety subscale as the dependent variables. Mean scores for pre and post RCMAS-2 total and subscale scores for experimental groups are provided in Table C.1.

Table C.1
Mean Scores on Dependent Variables for Each Group

RCMAS-2 Total Subscale	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	53.40	9.77	54.54	11.79
Post-Test	49.36	10.52	56.54	11.29
RCMAS-2 Defensiveness	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>

Pre-Test	53.00	9.52	52.79	9.00
Post-Test	53.36	10.09	52.36	8.62
<hr/>				
RCMAS-2 Physiological	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	53.28	9.72	54.57	10.59
Post-Test	50.24	9.71	56.21	8.13
<hr/>				
RCMAS-2 Worry*	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	52.52	9.40	53.68	11.64
Post-Test	47.68	10.24	55.50	12.53
<hr/>				
RCMAS-2 Social Anxiety	Play Therapy Group (<i>n</i> = 25)		Control Group (<i>n</i> = 28)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Pre-Test	53.00	10.26	53.61	11.73
Post-Test	51.16	10.01	55.93	11.93

* Statistically significant at $p < .025$.

Total Anxiety on the RCMAS-2

The first ANOVA assessed the impact of play therapy and an active control group on participants' total scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. When examining the means of the groups over time (see Figure C.1), observation indicates a trend in which scores of

the play therapy experimental group decreased (marking improvement) and scores of the active control group increased (marking deterioration).

There was a statistically significant interaction between treatment group and time, $F(1, 51) = 6.569, p = .013$, with an approximately large effect size of Cohen's $d = .715$ and power of .71. There was no significant effect for time, $F(1, 51) = .749, p = .391$, with a small effect of Cohen's $d = .230$. The main effect comparing the two groups was not significant, $F(1, 51) = 2.265, p = .139$, with a moderate effect size of Cohen's $d = .424$.

Table C.2

ANOVA for RCMAS-2 Total Score as Dependent Variable.

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Cohen's <i>d</i>
Group	1	456.188	456.18	2.265	.139	.424
Time	1	27.482	27.482	.749	.391	.230
Group*Time	1	240.916	240.91	6.569	.013*	.715
Within cells	51	1870.480	36.676			
Total	54	2595.066				

* Statistically significant at $p < .05$.

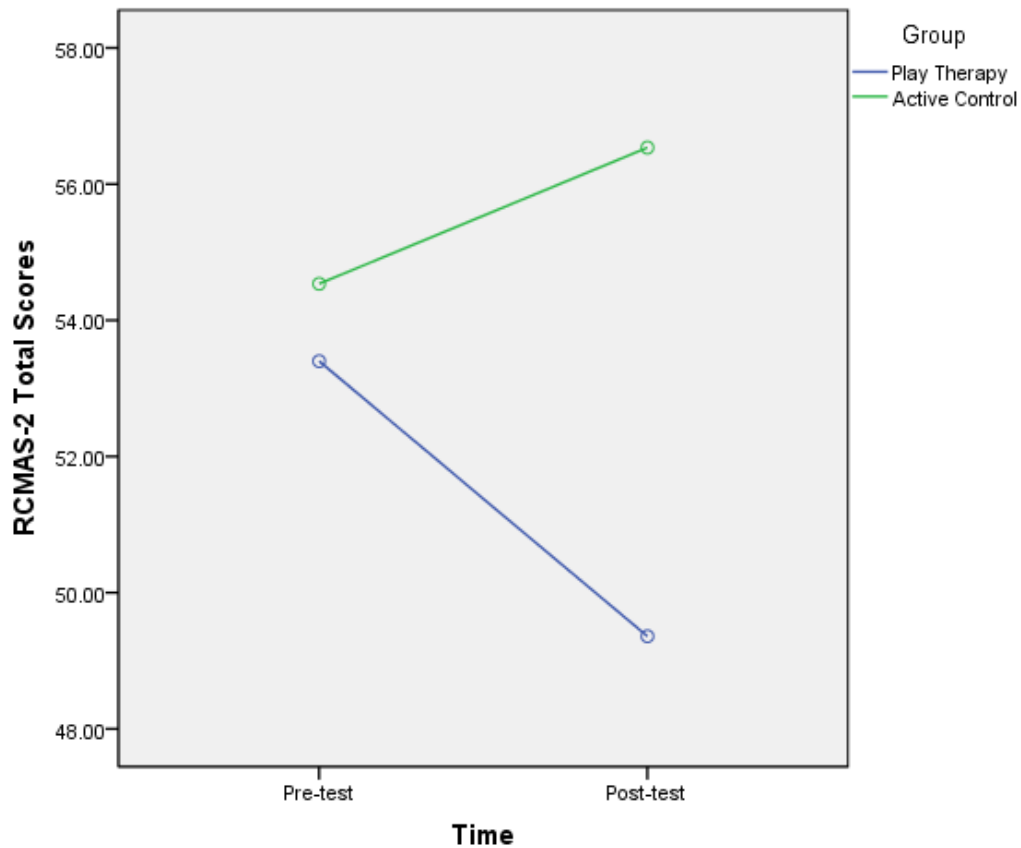


Figure C.1. Means between groups over time on RCMAS-2 Total Score.

Defensiveness scores on RCMAS-2

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' defensiveness scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. Means and standard deviations are reported in Table C.1.

There was no significant interaction between treatment group and time, $F(1, 51) = .140$, $p = .710$, with a small effect size of Cohen's $d = .110$. There was no significant effect for time, F

(1, 51) = .001, $p = .974$, with a small effect of Cohen's $d = .009$. The main effect comparing the two groups was not significant, $F(1, 51) = .068, p = .795$, with a small effect size of Cohen's $d = .063$.

Table C.3

ANOVA for RCMAS-2 Defensiveness Scores as Dependent Variable.

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Cohen's <i>d</i>
Group	1	9.783	9.783	.068	.795	.063
Time	1	.031	.031	.001	.974	.009
Group*Time	1	4.107	4.107	.140	.710	.110
Within cells	51	1494.309	29.300			
Total	54	1508.23				

* Statistically significant at $p < .025$.

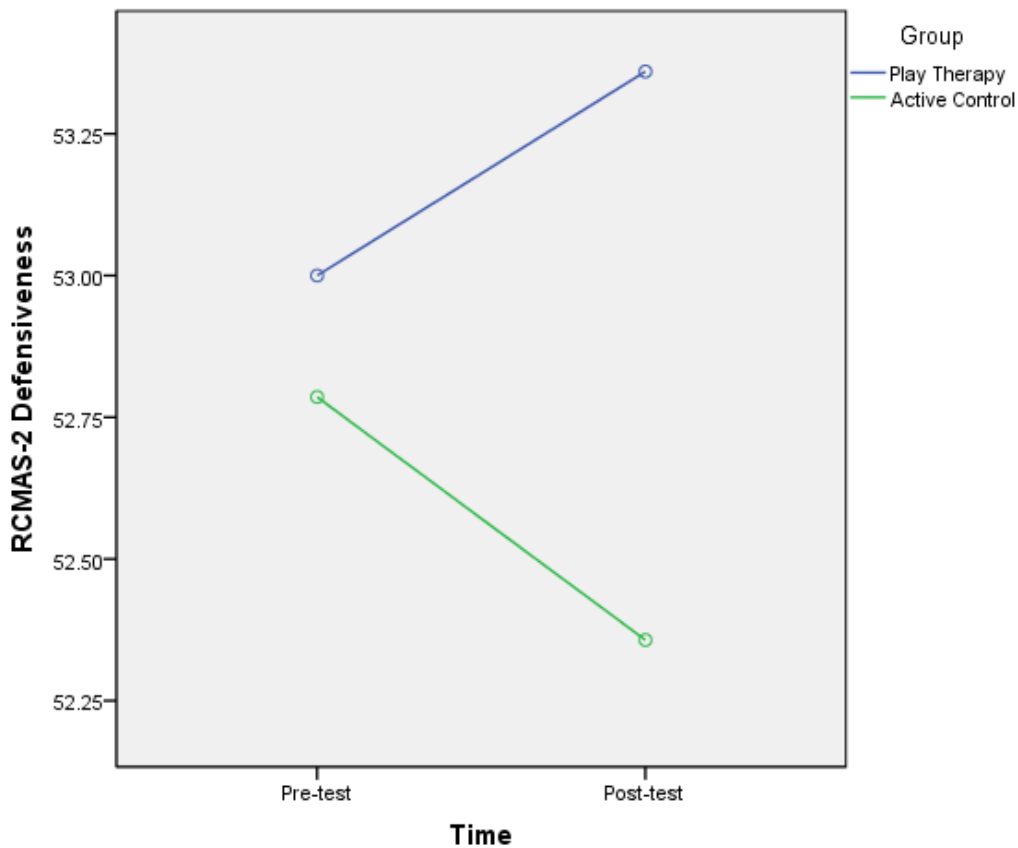


Figure C.2. Means between groups over time on RCMAS-2 Defensiveness.

Physiological Anxiety scores on RCMAS-2

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' physiological anxiety scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. Means and standard deviations are reported in Table C.1. When examining the means of the groups over time, there is a noticeable trend of the play therapy group scores decreasing in Physiological Anxiety and the control group scores increasing (see Figure C.3).

There was no significant interaction between treatment group and time, $F(1, 51) = 3.276$, $p = .076$, with a moderate effect size of Cohen's $d = .506$. There was no significant effect for time, $F(1, 51) = .292$, $p = .592$, with a small effect of Cohen's $d = .146$. The main effect comparing the two groups was not significant, $F(1, 51) = 2.505$, $p = .120$, with a moderate effect size of Cohen's $d = .445$.

Table C.4

ANOVA for RCMAS-2 Physiological Anxiety as Dependent Variable.

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Cohen's <i>d</i>
Group	1	348.617	348.617	2.505	.120	.445
Time	1	12.891	12.891	.292	.592	.146
Group*Time	1	144.815	144.815	3.276	.076	.506
Within cells	51	1870.480	36.676			
Total	54	2595.066				

* Statistically significant at $p < .025$.

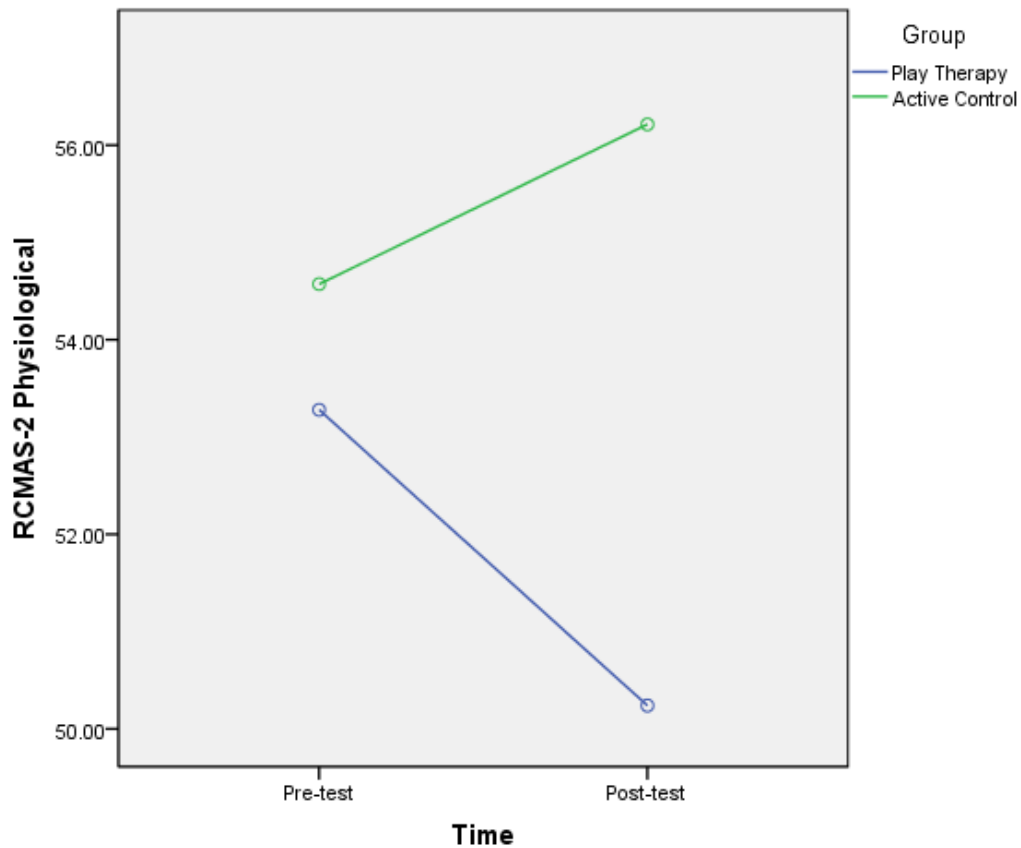


Figure C.3. Means between groups over time on RCMAS-2 Physiological Anxiety.

Worry scores on the RCMAS-2

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' worry scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. Means and standard deviations are reported in Table C.1. When examining the means of the groups over time, there is a noticeable trend of the play therapy group scores decreasing in Worry and the control group scores increasing (see Figure C.4).

There was a statistically significant interaction between treatment group and time, $F(1, 51) = 8.318, p = .006$, with a large effect size of Cohen's $d = .795$ and power of .81. There was no significant effect for time, $F(1, 51) = 1.708, p = .197$, with a small effect of Cohen's $d = .340$. The main effect comparing the two groups was not significant, $F(1, 51) = 2.527, p = .118$, with a moderate effect size of Cohen's $d = .445$.

Table C.5

ANOVA for RCMAS-2 Worry as Dependent Variable

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Cohen's <i>d</i>
Group	1	532.362	532.362	2.527	.118	.445
Time	1	60.172	60.172	1.708	.197	.340
Group*Time	1	293.040	293.040	8.318	.006*	.795
Within cells	51	1796.734	35.230			
Total	54	2682.308				

* Statistically significant at $p < .025$.

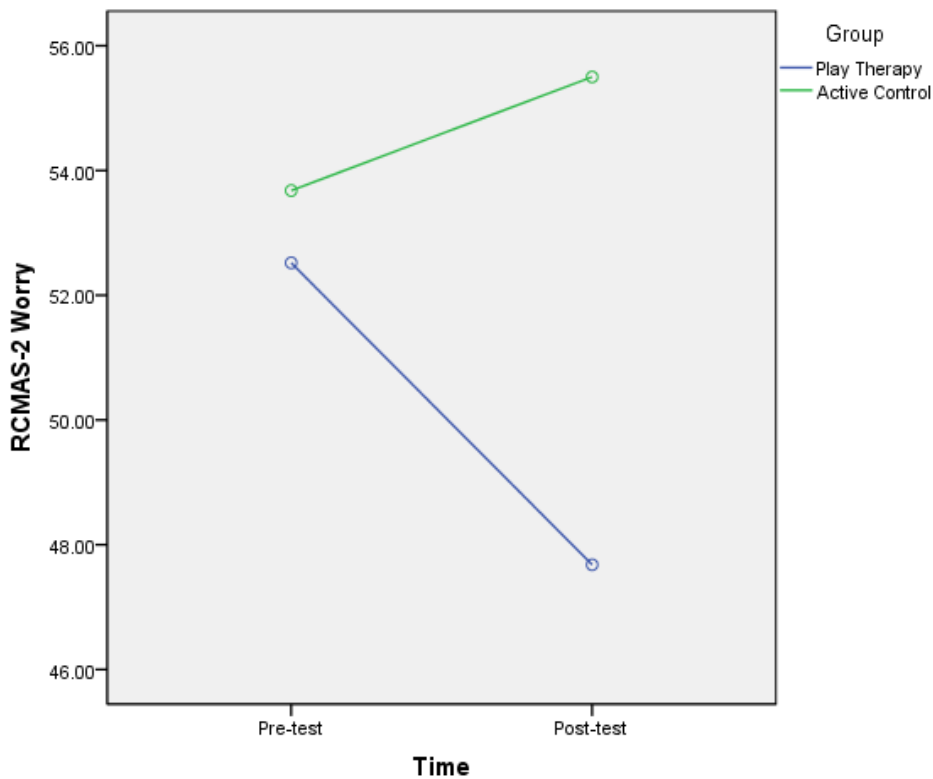


Figure C.4. Means between groups over time on RCMAS-2 Worry.

Social Anxiety scores on RCMAS-2

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' social anxiety scores on the RCMAS-2 across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. Means and standard deviations are reported in Table C.1. When examining the means of the groups over time, there is a noticeable trend of the play therapy group scores decreasing in Social Anxiety and the control group scores increasing (see Figure C.5).

There was no significant interaction between treatment group and time, $F(1, 51) = 2.018$, $p = .162$, with a small to medium effect size of Cohen's $d = .398$. There was no significant effect for time, $F(1, 51) = .027$, $p = .870$, with a small effect of Cohen's $d = .045$. The main effect comparing the two groups was not significant, $F(1, 51) = 1.014$, $p = .319$, with a small effect size of Cohen's $d = .279$.

Table C.6

ANOVA for RCMAS-2 Social Anxiety as Dependent Variable.

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Cohen's <i>d</i>
Group	1	190.838	190.838	1.014	.319	.279
Time	1	1.531	1.531	.027	.870	.045
Group*Time	1	114.361	114.361	2.018	.162	.398
Within cells	51	2890.734	56.681			
Total	54	3197.464				

* Statistically significant at $p < .025$.

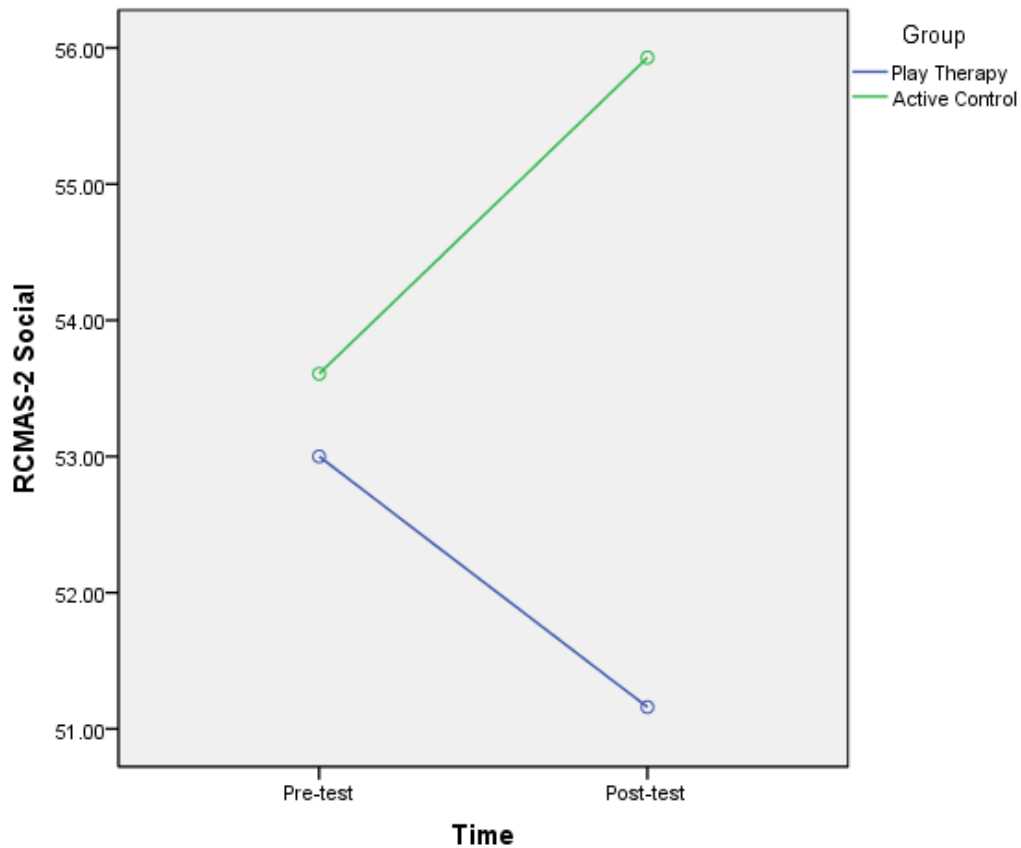


Figure C.5. Means between groups over time on RCMAS-2 Social Anxiety.

Clinical Significance

Clinical significance is indicated when participants demonstrate a substantive change in relationship to participation in treatment. Due to statistical and practical significance findings, clinical significance was investigated on Total Anxiety and Worry on the RCMAS-2.

Prior to intervention, 5 children in the play therapy experimental group presented in the moderately ($n = 4$) or extremely problematic ($n = 1$) range; 10 children in the active control group presented in the moderately ($n = 8$) or extremely problematic ($n = 2$) range for the Total subscale of the RCMAS-2. Following intervention, 3 out of the 5 children in the clinical range at pre-test who participated in play therapy scored improvement at post-test while the other 2

children's scores remained the same. Two children moved into the non-clinical range and one child moved from extremely problematic to moderately problematic. The mean decrease for children in the clinical range on the Total subscale who participated in play therapy was 7.4 points. For the 10 children in the active control group who scored in the clinical range, 7 children scored in the same range at post-test with a mean change score of 1.2 points improvement. Three children's scores improved by 6 or more points but remained in the clinical range, 6 children's scores improved between 2 and 5 points, and 1 child improved to a non-clinical range. Additionally, 4 active control group children who were not clinical at pre-test, fell in the clinical range at post-test on Total Anxiety scores.

Prior to intervention, 5 children in the play therapy experimental group presented in the moderately ($n = 4$) or extremely problematic ($n = 1$) range; 8 children in the active control group presented in the moderately ($n = 6$) or extremely problematic ($n = 2$) range for the Worry subscale of the RCMAS-2. Following intervention, 4 out of the 5 children in the clinical range at pre-test who participated in play therapy scored improvement at post-test while the fifth child's scores remained the same. Two children moved into the non-clinical range and one child moved from extremely problematic to moderately problematic. The mean decrease for children in the clinical range on the Worry subscale who participated in play therapy was 9.4 points. For the 8 children in the active control group who scored in the clinical range, all children scored in the same range at post-test with a mean change score of .25 improvement. Five children demonstrated no change in scores, one child worsened by 4 points, one child improved by 2 points, and one child improved by 4 points.

Anxious/Depressed on TRF

A repeated measures ANOVA was conducted to assess the impact of play therapy and an active control group on participants' Anxious/Depressed scores on the TRF as reported by teachers across pre and post tests. The assumptions for level of measurement, random sampling, independence of observations, homogeneity of variance, normal distribution, and homogeneity of intercorrelations were all reasonably met. Means and standard deviations are reported in Table C.7.

There was no significant interaction between treatment group and time, $F(1, 51) = .500$, $p = .483$, with a small effect size of Cohen's $d = -.195$. There was no significant effect for time, $F(1, 51) = 1.473$, $p = .230$, with a small effect of Cohen's $d = .339$. The main effect comparing the two groups was not significant, $F(1, 51) = .258$, $p = .614$, with a small effect size of Cohen's $d = .142$.

Table C.7

Descriptive Statistics for Both Groups Over Time on TRF Anxious/Depressed Subscale.

Time Period	Play Therapy Group			Control Group		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Pre-Test	25	60.88	10.54	28	62.93	10.34
Post-Test	25	60.40	10.78	28	61.11	10.16

Table C.8

ANOVA for TRF Anxious/Depressed as Dependent Variable.

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	Cohen's <i>d</i>
Group	1	50.149	50.149	.258	.614	.142
Time	1	34.977	34.977	1.473	.230	.339
Group*Time	1	11.883	11.883	.500	.483	.195
Within cells	51	1211.174	23.749			
Total	54	1278.183				

* Statistically significant at $p < .05$.

Research Question 2: Therapeutic Relationship Between Groups

In order to address the second research question, examining whether there is a difference in therapeutic relationship scores as reported by counselors between children who participated in play therapy and those in the active control group, I ran independent *t*-tests with each relationship variable as the dependent variable and group as the independent variable. BLRI scores from the fifth measurement point were used in the dependent variable. See Table 9 for the results of all *t*-tests.

Level of Regard

An independent samples *t*-test was conducted to compare the Level of Regard scores for play therapy and control group relationships. There was a statistically significant difference in scores for play therapy counselors ($M = 48.43$, $SD = 3.65$) and active control group counselors ($M = 37.48$, $SD = 5.15$; $t(44) = 8.163$, $p < .001$, two-tailed). The magnitude of the differences in the means (mean difference = 10.95, 95% *CI*: 8.25 to 13.65) was very large ($d = 2.494$). The play therapy group relationship scores are over two standard deviations higher than the active control group relationship scores indicating that play therapists reported experiencing higher levels of regard for children than counselors in the active control group.

Table C.9

Group Differences on Relationship Variables

Relationship Variable	Play Therapy Group		Control Group		<i>t</i> (44)	<i>p</i>	Cohen's <i>d</i>
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Regard	48.43	3.65	37.48	5.14	8.163	<.001*	2.494
Empathy	46.19	10.05	15.96	18.47	6.707	<.001*	2.029
Unconditionality	47.19	5.49	25.88	9.60	8.99	<.001*	2.724
Congruence	39.57	7.07	21.72	7.20	8.448	<.001*	2.556

* Statistically significant at $p < .05$.

Empathy

An independent samples *t*-test was conducted to compare the Empathy scores for play therapy and control group relationships. There was a statistically significant difference in scores for play therapy counselors ($M = 46.19$, $SD = 10.05$) and active control group counselors ($M = 15.96$, $SD = 18.47$; $t(44) = 6.707$, $p < .001$, two-tailed). The magnitude of the differences in the means (mean difference = 30.23, 95% *CI*: 21.14 to 39.31) was very large ($d = 2.029$). The play therapy group relationship scores are over two standard deviations higher than the active control group relationship scores, indicating that play therapists reported experiencing increased levels of empathy towards children than counselors in the active control group.

Unconditionality

An independent samples *t*-test was conducted to compare the Unconditionality scores for play therapy and control group relationships. There was a statistically significant difference in

scores for play therapy counselors ($M = 47.19$, $SD = 5.49$) and active control group counselors ($M = 25.88$, $SD = 9.60$; $t(44) = 8.999$, $p < .001$, two-tailed). The magnitude of the differences in the means (mean difference = 21.31, 95% *CI*: 16.54 to 26.08) was very large ($d = 2.724$). The play therapy group relationship scores are over two standard deviations higher than the active control group relationship scores, indicating that play therapists reported experiencing higher levels of unconditionality towards children than active control group counselors.

Congruence

An independent samples *t*-test was conducted to compare the Congruence scores for play therapy and control group relationships. There was a statistically significant difference in scores for play therapy counselors ($M = 39.57$, $SD = 7.07$) and active control group counselors ($M = 21.72$, $SD = 7.20$; $t(44) = 8.448$, $p < .001$, two-tailed). The magnitude of the differences in the means (mean difference = 17.85, 95% *CI*: 13.59 to 22.11) was very large ($d = 2.556$). The play therapy group relationship scores are over two standard deviations higher than the active control group relationship scores, indicating that play therapists reported experiencing higher levels of congruence when with children than active control group counselors.

Research Question 3: Mediation

In order to answer the third research question, mediation analysis was utilized to determine the mediating effects of therapeutic relationship on children's anxiety. Mediation can only be determined when a statistical change has occurred and certain conditions have been met. The Total Anxiety subscale on the RCMAS-2 was the focus of the mediation analysis.

The BLRI was administered 5 times to the counselors throughout the counseling process. Higher scores indicate stronger presence of the subscale condition. To determine which

subscales of the BLRI changed over the course of counseling, descriptive statistics were calculated for each administration by group in Tables C.10 and C.11.

Table C.10

Descriptive Statistics for Play Therapy Group BLRI Subscales Over Time.

Time	Regard	Empathy	Unconditionality	Congruence
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
1	45.96(5.99)	40.64(8.87)	43.36(7.15)	36.24(6.35)
2	46.56(5.41)	41.40(8.71)	43.64(7.43)	36.52(6.47)
3	45.96(6.91)	42.64(10.18)	45.72(5.75)	37.36(8.16)
4	46.80(7.08)	44.80(10.62)	45.92(6.51)	38.28(8.67)
5	48.43(3.65)	46.19(10.05)	47.19(5.49)	39.57(7.07)

Table C.11

Descriptive Statistics for Control Group BLRI Subscales Over Time.

Time	Regard	Empathy	Unconditionality	Congruence
	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>	<i>M(SD)</i>
1	36.19(8.42)	20.46(15.90)	25.81 (11.15)	20.81(6.49)
2	36.62(6.40)	17.65(17.55)	24.23(11.16)	20.92(6.69)
3	36.19(6.97)	16.58(18.14)	25.92(11.67)	20.65(7.34)
4	36.73(7.06)	16.85(19.98)	25.50(12.52)	21.08(7.64)
5	37.57(5.11)	15.39(18.05)	25.35(9.46)	21.52(7.08)

Following Baron and Kenny's (1986) model of investigating mediation, each potential mediator was run through the following assumptions: treatment (group) is significantly

correlated with outcome (post-test RCMAS-2 Total scores), treatment is significantly correlated with mediator (relationship scores), mediator (relationship scores) is significantly correlated to outcome (post-test RCMAS-2 Total scores), and correlation between intervention and change must be reduced after controlling for mediator.

In Table C.12, the independent variable (IV) is treatment group, the outcome (DV) is RCMAS-2 Total post-test scores, and the mediator investigated is listed. The column, IV with DV, demonstrated significance for the first assumption; treatment was significantly correlated with outcome. The column, IV with Mediator, demonstrated significance for the second assumption; treatment was significantly correlated with mediator (relationship scores). The last column, Mediator with DV, demonstrated a failure to meet the third assumption; the mediator (relationship scores) would be significantly correlated to outcome. None of the variables were able to continue to be considered as a mediator of worry scores due to violating one of the assumptions of mediation; the proposed mediator of relationship scores was not significantly related to outcome. Therefore, mediation examination was discontinued.

Table C.12
Mediation Examinations

Mediator	IV with DV			IV with Mediator			Mediator with DV		
	R^2	F	p	R^2	F	p	R^2	F	p
Regard	.100	5.685	.021*	.602	66.634	<.001*	.020	.893	.350
Empathy	.100	5.685	.021*	.506	44.983	<.001*	.037	1.689	.200
Uncondition.	.100	5.685	.021*	.648	80.989	<.001*	.056	2.612	.133
Congruence	.100	5.685	.021*	.610	71.372	<.001*	.039	1.809	.186

* Statistically significant at $p < .05$.

APPENDIX D
EXTENDED DISCUSSION

The current study sought to determine the efficacy of CCPT with young children who are anxious, the differences in relationships between counselors and children who are in play therapy and children who are in an active control group, and whether the therapeutic relationship can be deemed a mediator of change of anxiety. To date, there has been no play therapy study found in review specifically designed to identify and treat children with clinical levels of anxiety. Additionally, there have been no play therapy quantitative studies that sought to explore relationship variables as statistical mediators of treatment. Results of the current study indicated that play therapy was an effective intervention in reducing self-reported anxiety symptoms for young children. This finding provides evidentiary support for the use of CCPT with clinically anxious children. CCPT appears to be an appropriate intervention for both anxiety and worry in children in addition to offering prevention for the worsening of anxiety in children.

In the current study, the therapeutic relationship between counselor and child was explored through the use of counselor report on relationship variables. Results indicated that counselors in play therapy reported higher levels of regard, empathy, unconditionality, and congruence, specifically when compared to counselors implementing an activity based group. However, the link between relationship and treatment outcome was not supported by the current study and deserves further exploration. Although therapeutic relationship was not deemed a mediator of anxiety outcomes, measurement of the therapeutic relationship may have served as a limitation to holistic assessment of relationship between counselor and child.

Effectiveness of CCPT with Children Who Are Anxious

Over the course of the present study, children who participated in play therapy demonstrated statistically significant improvement over children who participated in the active

control group on total anxiety and the worry subscale of the self-reported RCMAS-2. Statistical, practical, and clinical significance found for total anxiety speaks to the level of effectiveness of CCPT for young children who were identified as clinically anxious. Mean differences on all subscales of the RCMAS-2 indicated that children who participated in play therapy demonstrated a trend of improvement while children in the active control group demonstrated deterioration of symptoms. Although no previous studies concentrated solely on anxiety and play therapy, these results are consistent with group play therapy studies with young children who were homeless (Baggerly, 2004) and children who experienced trauma (Shen, 2002) that showed statistically significant reductions in anxiety after participating in child-centered group play therapy.

Specifically, children who participated in play therapy had statistically significantly lower scores on the Worry subscale of the RCMAS-2 when compared to their active control group counterparts. This result mirrors other literature regarding the link between children's experience of worry and higher levels of anxiety (Silverman et. al, 1995; Weems, Silverman, & La Greca, 2000). Silverman et. al (1995) surveyed children regarding their level of worry, types of worries, and number of worries, and found a correlation between an increased number or intensity of worries and higher anxiety. Similarly, Weems et al. (2000) confirmed these results with a sample of 119 children and adolescents, discovering that the frequency, intensity, and number of worries that children experienced was significantly correlated with self-reported anxiety levels.

In the present study the control group children continued to increase in their levels of worry and anxiety, while the children who received play therapy decreased in both their worry and total anxiety at a significant level, supporting the idea that the two concepts are correlated, especially in younger children. Results also indicated that anxious children who did not receive

CCPT continued to increase their worries over time. CCPT appears to be an effective means of reducing both worry and anxiety in young children.

Richmond and Reynolds (2008) described the Worry subscale of the RCMAS-2 in the following way: “A high WOR score suggests the respondent is afraid, nervous, or in some manner oversensitive to environmental pressures. A high score on this scale may indicate a child or adolescent who internalizes much of the anxiety he or she experiences and who may thus get overburdened with trying to relieve this anxiety” (p. 18). Richmond and Reynold’s conceptualization of the worry scale as an indicator of oversensitivity to environmental pressures supports the person-centered conceptualization of anxiety as an outcome of incongruence between person and environment. Hence, CCPT offers an intervention that provides an environment that supports the child’s ability to explore, change, or strengthen the self in connection to the perceived environment. Theoretically, as children are in a warm, understanding, and accepting environment, their developmental capabilities are released, allowing for greater self-exploration and expression (Landreth, 2012). Prior to play therapy, children’s behavior may be rigid in an attempt to defend the self-concept. Rigidity through worry and general anxiety may be one defense to protect the self-concept. Through the process of play therapy, and specifically in the presence of the attitudes provided by the play therapist, children are able to experience a reduced level of threat and begin to assimilate experiences into the self-concept (Landreth, 2012; Ray, 2011). Children begin to try out new behaviors and express new feelings, including taking risks, within the safety of the therapeutic relationship. Children may experience their own strengths and mistakes and accept themselves more fully in the presence of a play therapist who is providing this acceptance as well for them. The acceptance provided from a play therapist may allow a child to develop greater inner strength and security within the self.

Children develop a greater valuing of themselves as they reduce their fears and negative sense of self-worth. They begin to live more in the present, reducing levels of worry and anxiety for the future. Additionally, they begin to experience more of a feeling of control through experiencing the attitudinal conditions from their play therapists. Through the therapeutic relationship, children become more integrated in their self-structures and develop skills to function effectively within their environments, freeing children of the burden of internalization of anxiety (Landreth, 2012; Ray, 2011).

Additionally, worry has been conceptualized as an intrusive cognitive component of anxiety, which shuts down emotional processing of the fear or anxiety that is present for children (Silverman et al., 1995). Children are unable to integrate emotions effectively when under threat, increasing the need for an environment that facilitates emotional growth and integration for children, such as CCPT (Ray, 2011). Through the therapeutic relationship, characterized by Rogers' six conditions, children and play therapists are able to connect on an emotional level. Rogers' conditions are discussed as more than skills, but attitudes that are deeply felt in the inner person of the play therapist while being emotionally sensed by the child (Landreth, 2012). CCPT seeks to help a child feel understood and accepted at a holistic level. The person of the child is understood and valued, including her or his feelings of anxiety. Children are able to fully experience their anxiety within the presence of a congruent, empathic, and unconditionally accepting person, allowing them to integrate this experience on an emotional level. Child-centered play therapists seek to facilitate emotional growth through their therapeutic responses and attitudes.

Consistent with the anxiety literature (Albano et al., 2003; Kendall, et al., 2010; Paul & Barrett, 2010; Pollock et al., 2006; Rapee et al., 2000; Seligman & Ollendick, 1998; Silverman &

Kurtines, 1996), children in the current study who did not receive mental health intervention began to show trends of further decline through reported levels of increased anxiety. Previous researchers have found that anxiety symptoms that begin in childhood and are left untreated are more likely to continue and be exacerbated in adulthood, culminating in other psychopathology and comorbidity (Albano et al., 2003; Kendall et al., 2010; Rapee et al., 2000). Additionally, children with untreated anxiety are also at a higher risk for developmental delays (Kendall, et al., 2010; Paul & Barrett, 2010; Pollock, Rosenbaum, McLoone, Hudson, & Rapee, 2006; Seligman & Ollendick, 1998; Silverman & Kurtines, 1996). Due to the early onset of anxiety and the high risks associated with untreated anxiety, early-intervention programs are crucial to change the trajectory for anxious children (Pollock et al., 1995).

The results of this study further emphasized the need to begin intervening as early as possible with anxiety. Although statistical significance was only achieved for the Total and Worry subscales, means of physiological and social subscales also decreased for children who received play therapy and increased for children who participated in the active control group. This result demonstrates a trend that children receiving play therapy improved while children who did not receive an intervention continued to experience deteriorated symptoms. Similarly, Flahive and Ray (2007) and Post (1999) found this effect of play therapy acting as a way of preventing further decline and maintaining or improving current status. Flahive and Ray (2007) examined the effects of 10 group sand tray play therapy sessions with 56 fourth and fifth grade students. They found that behavioral problems of children in the control group increased at a statistically significant rate compared to children in the experimental group who were reported as having demonstrated little change. Post (1999) conducted a play therapy intervention study with 77 at-risk fourth, fifth, and sixth grade students, examining their levels of self-esteem and locus

of control, compared to a control group. Students who participated in a mean of 4 play therapy session did not significantly improve over the course of the intervention; however, the students who were in the control group significantly decreased in their levels of self-esteem and internal locus of control. Flahive and Ray and Post concluded that findings of improvement in the experimental groups may have been limited by the low number of play therapy sessions. Trends of the current study indicated that the control group reported increased symptoms of anxiety as in the previous studies. However, in this study, children who participated in 16 sessions of play therapy reported statistically significant improvement in symptoms.

Prior to this study, CBT had been deemed the only appropriate intervention for children with anxiety (Compton et al., 2004; McClellan & Werry, 2003; Silverman, Pina, & Viswesvaran, 2008; Weisz, Jensen, & McLeod, 2005), despite the reported inherent flaws and developmental inappropriateness for young children in addition to the high percentages of children who do not improve as a result of successfully completing treatment (Cartwright-Hatton et al., 2004; Grave & Blissett, 2004; McKay & Storch, 2009; Rey et al., 2011; Silverman et al., 2008). The prevalence rates of anxiety in children and the adverse effects of not intervening early further increases the importance of utilizing an intervention that meets the developmental needs of young children and can effectively improve symptoms of anxiety. CCPT intervention is substantially different from CBT, the traditional method of treating childhood anxiety. CBT may be contraindicated for young children with anxiety due to the coexistence of worry, which tends to consume children's thinking and thwart further emotional processing. The cognitive ability to simultaneously hold negative emotions and examine problematic thoughts is a higher order ability and may be limited in young children. Typically, in CBT, children are exposed to an anxiety-provoking stimulus and taught to cognitively work through their anxious thoughts;

however, this approach may be difficult with young children (Silverman et al., 1995). CCPT provides an intervention directed toward a child's developmental level, providing an emotional process outlet through the use of play and relationship, as opposed to cognitively working through thoughts.

Teachers' Views of Anxious Children

Although children in play therapy self-reported significant and substantive decreases in anxiety symptoms, teacher report failed to demonstrate change in observed anxiety symptoms. Identification of children for participation in this study was conducted through parents, school counselors, teachers, and administrators. It should be noted that means of the TRF Anxious/Depressed scale fell below the borderline/clinical range both at pretest and posttest, indicating that teachers were not observant of symptoms typically associated with anxiety. Hence, it appears that the teachers experienced difficulty in identifying the behaviors of children who seemed generally anxious or who others deemed generally anxious.

Another difficulty in the teacher assessment of childhood anxiety is the availability of accurate instruments. The current study used the anxiety scale of the TRF to measure the teacher's observation of anxiety symptoms. Kendall, Puliafico, Barmish, Choudhury, Henin, and Treadwell (2007) found that the Child Behavior Checklist (CBCL) and the TRF might not be the best indicators of anxiety in children. By creating an instrument specified to anxiety, Kendall et al. concluded that the newly developed instrument concentrated only on anxiety was a stronger predictor of an anxiety disorder than using subscales of the CBCL or TRF. Although the TRF Anxious/Depressed scale is used throughout the literature, instruments specific to an anxiety disorder may be a better screening tool for anxiety.

The lack of teacher report of changes in students' behavior is consistent with previous research on internalizing behaviors (Garza & Bratton, 2005). Garza and Bratton (2005) conducted a play therapy study with Hispanic children, using teacher and parent ratings of children's behavior on both internalizing and externalizing behaviors. Parents reported a statistically significant difference in children's internalizing behavior; however, teacher report did not demonstrate a significant difference on internalizing behaviors. Because anxiety presents as an internalized problem, teachers may find it difficult to observe and note behavioral symptoms associated with high levels of anxiety experienced by children. Additionally, in challenging classroom environments such as classes with many at-risk students, teachers may be more attuned to child behaviors that are disruptive to others over behaviors that are less externally problematic.

Therapeutic Relationships

The relationship between therapist and child in CCPT is characterized by Rogers' core conditions (1957) and is seen as crucial to therapeutic success (Landreth, 2012; Ray, 2011). Some authors have attempted to capture the importance of the therapeutic relationship within a CCPT framework, but they did not examine the relationship as a statistical mediator and instead focused on the relationship as it correlates to outcome or related to changes or movement in therapy (Darr, 1994; Harnish, 1983; Siegel, 1972; Truax, Altmann, Wright, & Mitchell, 1973). When researchers explore the impact of interventions, identification of mediating variables is crucial to understanding outcomes after establishing a strong evidence base (Kazdin & Nock, 2003; La Greca, Silverman, & Lochman, 2009). Information gleaned from investigating potential

mediators within an intervention can help researchers promote enhanced treatment outcomes and develop more stringent training for the intervention.

In the present study, the relationship, as reported by counselors, was significantly different between the relationships of counselor and play therapy children and the relationships of counselor and active control group children. This research question was designed to begin examining the rationale behind the theory of CCPT, distinguishing the differences in types of relationships adults typically have with children. Statistical significance and practical significance were found for all subscales of the BLRI, including Level of Regard, Empathy, Unconditionality, and Congruence. The counselors in the play therapy group self-reported higher levels of each of these relationship attitudes than the counselors in the control group. Therefore, it appears as if the relationships between children and counselors were different based on experimental group, with counselors facilitating play therapy self-reporting higher levels of the attitudes than counselors leading the activity groups. This finding indicates that counselors were able to experience more of the conditions of a person-centered counseling relationship in the environment of CCPT than counselors who led activity groups.

Although definitive conclusions cannot be made when comparing the groups due to the inherent differences in the structures of the experimental and active control groups, it is interesting to view the trends in relationship over time. The most demonstrable trend in the relationship scores occurred with counselors' experiences of empathy towards their clients. Counselors who facilitated play therapy reported increased levels of empathy toward their clients as the sessions continued. Counselors who led the activity groups reported decreased levels of empathy toward their clients over time. Although play therapists reported higher levels of all relationship attitudes over activity group counselors, this trend for empathy scores was unique in

that it was the only subscale to show a distinct negative trend for the control group. For all other relationship scales, scores either remained the same or increased regardless of group membership of the counselor. Results may be attributed to the nature of the groups considering that the experimental group reflected individual therapist-child relationships and the active control group reflected structured small group facilitator-child relationships. Yet, these findings confirm that counselors experience a qualitatively different relationship with children based on working within a modality, CCPT, that specifically focuses on the provision of therapeutic conditions.

Empathy or empathic understanding has been viewed as the primary force of change due to an increased level of regard, congruence, and decreased conditionality as a result of higher levels of empathy (Barrett-Lennard, 1986; Barrett-Lennard, 1988; Raskin, 2001; Wilkins, 2010; Zimring, 2001). Bozarth (2001) claimed that empathic understanding is the ‘vessel’ through which unconditional positive regard is expressed. Through empathic understanding, clients’ experience unconditional positive regard as they experience acceptance of their world (Bozarth, 1998). Although person-centered literature lacks agreement on the significance between the therapist attitudinal conditions, Raskin (2001) ranked empathy as the most important concept in person-centered counseling. Zimring (2001) conceptualized empathic understanding as the agent in person-centered counseling that promotes change in clients’ self-structures and experiences. These views have been developed based on Rogers’ (1975) assertion that empathic understanding enhances clients’ self-acceptance, self-understanding, and congruence. As empathy or empathic understanding increases, level of unconditional positive regard increases, allowing for greater growth and change in a client’s self-structure.

CCPT literature mirrors this concept of the interrelatedness of empathic understanding as a vehicle for unconditional positive regard and facilitative processes in children. Ray (2011)

described the facilitation of growth through empathic understanding as, “experiencing his level of pain helped me be in full contact with him and move around in his world, helping to unleash his actualizing tendency that would allow him to survive, possibly thrive, through his circumstances” (p.65). Furthermore, she described entering the world of the client in CCPT as, “an underlying message that the client’s world is a valuable world, one in which the therapist has the utmost respect for the client’s experience and abilities” (p. 66-67). Landreth (2012) argued that sensitively understanding children could potentially be one of the most important attitudes of the therapeutic relationship because children share more of themselves as they feel understood. They continue to feel safe enough to engage further in the therapeutic relationship as a result of feeling understood, allowing for changes in their perceptions and worldviews. Increases in counselors’ levels of empathy can be facilitative of clients’ increases in perceived unconditional positive regard, and therefore, further integration of their experiences and self-concept.

Relationship Variables as Potential Mediators of Anxiety

When examining the Level of Regard, Empathy, Unconditionality, and Congruence subscales of the therapeutic relationship as mediators, none of the proposed mediators could be considered after accounting for initial assumptions. As established in the first research question and the beginning of the mediation model, treatment was statistically significantly correlated with outcome. The children who participated in play therapy decreased their levels of anxiety, while children who participated in the activity groups increased their levels of anxiety.

The second research question regarding differences in relationship scores by group participation also served to complete the second assumption of mediation, that the proposed mediator is significantly related to the independent variable. In this case, the relationship

subscales were significantly correlated to treatment group as was expected from the findings of research question two that counselors who facilitated play therapy reported higher quality relationship scores than counselors who led activity groups.

However, the mediation analysis was stopped after a non-significant correlation between the proposed mediators and outcome. The relationship subscales of Level of Regard, Empathy, Unconditionality, and Congruence were not correlated with Total Anxiety outcome. Therefore, higher or lower relationship scores were not correlated to higher or lower anxiety scores. Kendall (1994) and Kendall et al. (1997) found similar results in their investigations of children's perceptions of the therapeutic relationship when correlated with therapeutic outcome in CBT. They found that children's perception of the relationship scores did not produce enough variance to correlate significantly with outcome.

One possibility for this outcome might be that the therapeutic relationship is not a mediator of outcome. However, there are several other possibilities. From a statistical standpoint, the lack of mediation may be due to the relatively small strength of the correlation between the independent and dependent variable. Although there was a significant correlation between treatment group and anxiety outcome, the correlation was fairly small. If the differences between the groups on anxiety were as stark as the discrepancies in the relationship scores, the relationship variables may have been found to be statistical mediators. Additionally, the BLRI, used to report therapist perception of relationship variables, has historically reported questionable factor structure (Freire & Grafanaki, 2013; Ponterotto & Furlong, 1985), which may have impacted the findings in this study.

The theoretical rationale behind investigating the therapeutic relationship as a statistical mediator stems from Rogers' (1957) six necessary and sufficient conditions for change. The

BLRI was created in order to measure three of the six conditions, unconditional positive regard, empathy, and congruence, through its four subscales of Level of Regard, Empathy, Unconditionality, and Congruence (Barrett-Lennard, 1962). However, the BLRI negates the other three necessary and sufficient conditions for change.

As an inherent part of this study, two of the remaining three conditions were met. The first condition, two people are in contact with each other, was satisfied through the child and counselor being in each other's perceptual fields. The children acknowledged the counselors and the counselors acknowledged the children. The second necessary and sufficient condition, one person needs to be in a state of incongruence or anxiety, was also met through children meeting criteria to participate in the study. Children who qualified to participate self-reported elevated levels of anxiety on the RCMAS-2.

The sixth condition, that the client perceives empathy and unconditional positive regard from the counselor, is unaccounted for in this current study. The therapeutic relationship was only measured according to counselor report. Relationship is determined by two people, both client and counselor. Currently, there are no psychometrically sound instruments for young children to measure the therapeutic relationship. Although the three therapist attitudinal conditions were present and differentiated in the groups, no account of children's perceptions of these conditions was assessed through the BLRI. In person-centered counseling, it is hypothesized that all six conditions are necessary even at a minimal level for change to occur (Rogers, 1957). Therefore, data gathered on therapeutic relationship was limited in its representation of only one participant in the relationship. Focusing primarily on the therapist attitudinal conditions is a major limitation of this study, and one that may have potentially ruled out the possibility of examining the therapeutic relationship as a mediator.

Because change occurred in children who received play therapy, and the theoretical underpinning of play therapy suggests that the six necessary and sufficient conditions for change are what is facilitative (Cochran et. al, 2010; Landreth, 2012; Ray, 2011), it may be assumed that children were receptive to counselors' empathy, unconditional positive regard, and congruence while children in the control group did not have this experience. Theoretically, children's perceptions would explain the change in the play therapy group and would be the mediating factor in the relationship, which could potentially have large implications for CCPT. However, this is only a theoretical conclusion and was not verified by statistical findings.

Limitations

Although participants were selected for the study based on teacher and self-reports of elevated anxiety, inclusion criteria did not require that each child met diagnostic criteria as an anxiety disorder. Thus, generalizability of results was limited due to utilizing a screening measure as opposed to a diagnostic interview. Although play therapy was targeted as an intervention, the participants may not have met criteria for a generalized anxiety disorder.

Therapeutic relationship was being tested as a mediator; however, the relationship in CCPT was compared to the relationship in an active control group. The study could have been improved through utilizing another mental health approach as a comparison or similar levels of time and attention across groups. Testing mediation in CCPT is in the beginning stages and can be strengthened after gathering initial data through this study.

As addressed earlier, the therapeutic relationship was only measured from counselors' perspectives, ignoring the child's perspective and Rogers' sixth condition that clients must perceive the therapist attitudinal conditions in order for change to occur. The study could be

strengthened by investigating children's perspectives of the therapeutic relationship. However, no developmentally appropriate measure currently exists to measure the therapeutic relationship characterized by the six conditions for young child clients.

Additionally, the BLRI does not have strong psychometric properties compared to the other assessments utilized for the study. The BLRI is an established and frequently utilized assessment to measure a person-centered therapeutic relationship, but the psychometric properties could be stronger to place more validity on the results.

Implications

The results of this study present important implications for practice and research in the area of child-centered play therapy. The effectiveness of CCPT as an intervention with young children who are anxious could present alternative treatment modalities that are developmentally appropriate. Additionally, new avenues for research can be explored as a result of this study.

Implications for Practice

CCPT is a developmentally appropriate intervention for young children and results from the current study support its effectiveness with children who are anxious. Historically, person-centered counseling for anxious clients has not been supported by the research when compared to other interventions. In Elliott's (2013) meta-analysis of 19 studies examining the effects of person-centered counseling with mostly adult clients who were anxious, person-centered counseling was deemed effective when compared to no treatment or pre-post testing; however, person-centered counseling was seen as less effective for treating this population when compared to other methods, primarily CBT, even when accounting for researcher alliance. The current

study brings hope and promise for the application of person-centered counseling to the treatment of anxiety, specifically with children. CCPT may serve as a preventative measure for further emotional and behavioral decline in children who are exhibiting symptoms of anxiety.

Additionally, CCPT may help improve or relieve anxiety symptoms, specifically overall levels of anxiety and worry. CCPT appears to be a well-suited intervention for young children who are anxious based on the emotional and developmental emphasis of CCPT through the therapeutic relationship, in addition to the current conceptualization of anxiety and worry in children. CCPT seems to provide an environment for children where they are able to express their anxiety within a safe and accepting relationship, allowing children to develop their self-concept and strengthen their ability to cope with anxiety.

Additionally, CCPT appears to be a viable and practical option for mental health intervention with children who are anxious. In the current study, all participants who began treatment also completed treatment. No students withdrew from the study for any reason, promoting the viability of treatment. CCPT for children who are anxious seems to be a treatment that children are responsive to and continue to participate in throughout the course of the treatment phase. In addition to demonstrable effectiveness of CCPT in reducing anxiety symptoms, CCPT appears to be accessible and non-threatening to participants, as evidenced by the completion rate of participants. Typically in intervention research in the schools, children are sent to alternative schools or move throughout the duration of the study. The total participant completion rate speaks to the viability of CCPT as a treatment option for children with anxiety.

Another implication for practice is the successful implementation of play therapy within a school setting. This study was conducted across four Title 1 elementary schools, with effective results in reducing children's levels of anxiety. Children receiving two 30-minute play sessions

twice a week for 8 weeks, showed statistically significant improvement. This short-term counseling experience can be implemented in school settings, providing another intervention for school counselors or other school mental health professionals to utilize with children who are anxious.

Implications for Research

As this was the first study designed to specifically examine CCPT with children who are anxious, it is important to conduct further studies with this population to demonstrate that results can be replicated. Additionally, due to previous inconsistent research results regarding person-centered approach and anxiety, it is especially important to seek consistent similar results. Once replicated, it would be important to continue examining the reasons behind the effectiveness of CCPT with children that are anxious. Furthermore, effectiveness research with children who are anxious should be extended into long-term research, examining the lasting effects of CCPT on anxiety. Determining the effectiveness of CCPT immediately after treatment is a positive finding; however, demonstrating long-term maintenance of the effects would strengthen the supporting evidence for CCPT as an effective intervention.

Recommendations for future research include the need for research on the therapeutic relationship that encompasses both participants within the relationship. In order to address the limitation of this study regarding the lack of client report of the relationship, future studies are needed in two areas. The development of a child instrument to measure relationship is needed, along with research to support the psychometric properties of such an instrument. Secondly, future research would include the child as a reporter of relationship variables.

To further expand on the knowledge of CCPT effectiveness with children who are anxious, it would be important to examine other mediating and moderating effects of CCPT. The research base and therefore knowledge of educators, supervisors, and practitioners could be enhanced by truly understanding the mechanisms of change that are operating in CCPT. Although the therapeutic relationship, as measured in this study, was not considered a statistical mediator of change, the evidence of outcome change indicates that other mediators could be examined. Additionally, moderators, or inherent characteristics that affect responsiveness to interventions, could be investigated to determine if CCPT is more effective with certain types of children or other therapeutic conditions.

Conclusion

This study sought to explore the effects and mediating factors of child-centered play therapy (CCPT) on young children with symptoms of anxiety. The therapeutic relationship, characterized by Rogers' core conditions has been deemed the agent of change in CCPT theory. Theoretically, CCPT could be an intervention to intervene effectively with young children who are anxious. Anxiety is considered one of the most current and pervasive childhood disorders, with a poor prognosis if left untreated. Furthermore, traditional methods of treating anxiety have been less effective with young children. This study examined the effect of CCPT on 53 children who were anxious compared to children participating in an active control group. Statistically significant differences were found in total anxiety and worry, suggesting that children who received play therapy decreased their overall levels of anxiety and worry while children who were in the active control group increased their levels of anxiety and worry. Although the groups were different in their relationships, the relationship was not a mediator of anxiety due to the

lack of correlation between relationship scores and outcome. Overall, children seemed to benefit from CCPT and it may be considered a viable treatment for children who are anxious. Due to the lack of mediation of relationship found in this study, further research is encouraged to consider other mediating and/or moderating effects in addition to examining all six of Rogers' therapeutic conditions when attempting to investigate the therapeutic relationship as a mediator.

APPENDIX E
OTHER ADDITIONAL MATERIALS

University of North Texas Institutional Review Board

Parent Informed Consent

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

Title of Study: Behavioral Outcomes and Mediating Processes in Play Therapy

Principal Investigator: Dee Ray, Ph.D., LPC-S, NCC, RPT-S, University of North Texas, Department of Counseling and Higher Education University of North Texas (UNT), Department of Counseling and Higher Education.

Purpose of the Study:

You are being asked to allow your child to participate in a research study which involves determining if play therapy is effective in helping children improve the way they act and feel at school. The study will also look at whether play therapy for children helps decrease behavior problems and improve learning and behavior at school.

Study Procedures:

Your child will be asked to participate in play therapy. Play therapy is a counseling intervention designed for children to express themselves in the developmentally appropriate way of playing with toys. Elementary-age children have difficulty working through problems with words, so play therapy facilitates the process by providing a play environment from which they can work through those issues that impede their academic progress. Your child decides what materials to play with and what to discuss in play therapy. Your child will not be asked invasive questions or forced to play. The play sessions will be video-recorded. The research team will observe the recordings to ensure the quality of play therapy services and the integrity of the study.

For this study, your child will be placed in one of two groups:

Group 1: Children will begin play therapy immediately and will receive two 30-minute sessions of play therapy each week for 8 weeks.

OR

Group 2: Children will be placed in small groups with a therapist once a week for 30 minutes to complete a structured activity during the 8 weeks of the study. Children in this group will begin play therapy in January and will receive at least 8 sessions of play therapy.

Your child will also be administered a brief assessment which requires approximately 10 minutes to complete. The assessment will be administered at two points in the study, beginning and end of the 8 week period. An additional assessment will be administered weekly which requires approximately 10 minutes per administration, totaling 100 minutes for the entire study.

Your permission also allows your child's homeroom teacher to fill out an assessment which asks the teacher to report on your child's behaviors within the classroom environment. Your child's teacher will be asked to complete this instrument before and after the 8 week period.

Foreseeable Risks:

There are no significant personal risks foreseen as likely from involvement in this study. Your child's participation is completely voluntary. You may withdraw your child at any time during the course of the study. However, possible risks may include one or more of the following:

1. Anything that is said or done during play therapy is considered confidential, meaning that the therapist will not reveal anything that happens in the session to another school official or adult. However, if your child discloses child abuse, neglect, exploitation or intent to harm another person, the therapist is required by law to report it to the appropriate authority.
2. When your child participates in play therapy, he or she will be pulled from another school activity upon the approval of the teachers. It is possible that your child might miss an academic or extracurricular experience. However, because your child's principal and teacher have agreed to their participation in this study, your child will not be placed at academic risk.
3. Because play therapy is a counseling method, your child will be expressing emotions that could be strong for him or her. The therapist will help your child talk through these emotions and will stop therapy if any harmful effects upon your child are noted. Harmful effects would include inability to maintain self-control or being in a distraught state of mind.

Benefits to the Subjects or Others:

We expect the project to benefit children by possibly improving anxiety and functioning including self-esteem, behavioral difficulties, emotional difficulties, social interaction and skills, and academic progress. The results of this study may provide school counselors across the nation with knowledge that helps them improve child behavior so that children are happier and more successful in public school.

Compensation for Participants: You will not receive compensation for your participation in this study.

Procedures for Maintaining Confidentiality of Research Records:

All information will be kept confidential in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Names of parents and children will not be disclosed in any publication or discussion of this material. Information obtained from the instruments will be recorded with a code number. Only the research team will have a list of the participants' names. The play sessions will be video-recorded. The research team will observe the recordings to ensure the quality of the study. At the end of this study, the videos may possibly be shown in professional presentations for educational purposes. Identity information such as name, place of living, and other specific information will not be revealed when videotapes are shown in educational settings. However, you may choose to withdraw your consent at any time and the video recordings of your child will not be used.

Questions about the Study

If you have any questions about the study, you may contact Dr. Dee Ray at (940) 565-2066 or Dee.ray@unt.edu.

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 for 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:

- You understand 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 Child

Printed Name of Parent or Guardian

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 involves looking at whether play therapy is helpful to you. Play therapy is a time when you will come to a playroom with a counselor who will ask you to play with the toys in lots of the ways you like. Sometimes for children it is hard to share feelings with words and it helps to play with toys to express how you feel.

You will be asked to come to play therapy two times a week for 8 weeks which will take about 1 hour per week, or you might be asked to come to play therapy one time a week later in the school year.

If you decide to be a part of this study, please remember you can stop participating any time you want to and nothing bad will happen.

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

Printed Name of Child

Signature of Child

Date

Signature of Principal Investigator

Date

Waiver of Assent

The assent of (insert name of child) was waived due to:

_____ Age

_____ Maturity

_____ Psychological State

Signature of Parent/Guardian

Date

University of North Texas Institutional Review Board

Teacher Informed Consent Form

Before agreeing to participate 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: Behavioral Outcomes and Mediating Processes in Play Therapy

Investigator: Dee Ray, PhD, LPC-S, NCC, RPT-S, University of North Texas (UNT)
Department of Counseling and Higher Education.

Purpose of the Study: You are being asked to participate in a research study which involves determining if play therapy is effective in helping children improve the way they act and feel in school. The study will also look at whether play therapy for children helps decrease behavior problems and improve learning and behavior at home and school.

Study Procedures: Children from your class may be participants in this study. They will participate in play therapy. Play therapy is a counseling intervention designed for children to express themselves in the developmentally appropriate way of playing with toys. Elementary-age children have difficulty working through problems with words, so play therapy facilitates the process by providing a play environment from which they can work through those issues that impede their academic progress.

For this study, a child who is a participant in this study from your class will be placed in one of two groups:

Group 1: Children will begin play therapy immediately and will receive two 30-minute sessions of play therapy each week for 8 weeks.

OR

Group 2: Children will be placed in small groups with a therapist once a week for 30 minutes to complete a structured activity during the 8 weeks of the study. Children in this group will begin play therapy in January and will receive at least 8 sessions of play therapy.

You will be asked to complete one brief assessment on each child in your class that participates in the study. You will be asked to complete the assessment at two points in the study, beginning and end of the 8 week period. It will take approximately 20 minutes to complete the assessment, totaling 40 minutes of your time for the entire study.

Foreseeable Risks: No foreseeable risks are involved in this study.

Benefits to the Subjects or Others: This study is not expected to be of any direct benefit to you, but we hope to benefit children from your class by possibly improving impairment including

self-esteem, anxiety, behavioral difficulties, emotional difficulties, social interaction and skills, and academic progress.

Procedures for Maintaining Confidentiality of Research Records: All information will be kept confidential in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Names of teachers, parents, and children will not be disclosed in any publication or discussion of this material. Information obtained from the instruments will be recorded with a code number. Only the research team will have a list of the participants' names. You may choose to withdraw your consent at any time and the data you provided will not be used.

Questions about the Study: If you have any questions about the study, you may contact Dr. Dee Ray at (940)565-2066 or dee.ray@unt.edu.

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:

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

Printed Name of Participant

Signature of Participant

Date

For the Investigator or Designee:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

Signature of Investigator or Designee

Date

University of North Texas Institutional Review Board

Therapist Informed Consent Form

Before agreeing to participate 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: Behavioral Outcomes and Mediating Processes in Play Therapy

Investigator: Dee Ray, PhD, LPC-S, NCC, RPT-S, University of North Texas (UNT)
Department of Counseling and Higher Education.

Purpose of the Study: You are being asked to participate in a research study which involves determining if play therapy is effective in helping children improve the way they act and feel in school. The study will also look at whether play therapy for children helps decrease behavior problems and improve learning and behavior at home and school.

Study Procedures: As part of the study, your permission will consent to participation in completing assessments regarding your therapeutic relationship with each child you see in play therapy. You will be asked to complete the assessment weekly which takes approximately 10 minutes to complete per administration, totaling 80 minutes for the entire study.

Foreseeable Risks: There are no foreseeable risks directly involved in this study. Your participation is completely voluntary. You may withdraw your participation at any time during the course of the study without affecting your status as a therapist in the center or as a student in the counseling program at UNT.

Benefits to the Subjects or Others: We expect the project to benefit children by possibly improving anxiety and functioning including self-esteem, behavioral difficulties, emotional difficulties, social interaction and skills, and academic progress. The results of this study are expected to provide play therapists with knowledge that helps them improve child therapy and provide an optimal therapeutic environment for children in therapy.

Procedures for Maintaining Confidentiality of Research Records: All information will be kept confidential in a locked cabinet in the clinic of the Counseling Program at the University of North Texas. Names of participants will not be disclosed in any publication or discussion of this material. Demographic information that is collected as part of this study will be given a code number and kept separately from the participant's names. The play sessions will be videotaped. The research team will observe the videotapes to ensure the quality of the study. At the end of the study, the videotapes may possibly be shown in professional presentations for educational purposes. Identity information will not be revealed when videotapes are shown in educational settings.

Questions about the Study: If you have any questions about the study, you may contact Dr. Dee Ray at (940) 565-2066 or Dee.ray@unt.edu.

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:

- You have had the study explained to you and all of your questions answered. 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 take part in this study, and your refusal to participate or your decision to withdraw will involve no penalty or loss of rights or benefits. The study personnel may choose to stop your participation at any time.
- Your decision whether to participate or to withdraw from the study will have no effect on your grades or standing in the counseling program.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to participate in this study.
- You have been told you will receive a copy of this form.

Printed Name of Participant

Signature of Participant

Date

For the Student Investigator or Designee:

I certify that I have reviewed the contents of this form with the subject signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the participant understood the explanation.

Signature of Student Investigator

Date

Child & Family Resource Clinic Play Therapy in Elementary Schools

GUIDELINES

Know where you're going! – Know the address of your school and know how to get there.

Arrive 10-15 minutes before your first session to get settled, set-up the room, and start the recording. Don't assume the room is ready to go. If you're arriving for an 8 am session, be aware of slow school traffic.

Signing in and out- When you arrive at the school it is **mandatory** that you **sign in** using the computer at the front desk. Sign is as a **visitor** and state your reason as **UNT play therapy**. The computer will print a **name tag** that you wear while you are in the school. Don't forget to **sign out** when you leave. Be sure to have your UNT ID. Many schools now require some sort of ID.

Introduce yourself to the staff at the front desk and ask for the **key** to the playroom. Different schools have different rules about the key. You may get to keep the key while you're in the school, or you may have to return the key right after you unlock the door. Do what they ask. Don't lose the key. Be aware that some of the doors lock when they close.

Introduce yourself to the school counselor. They'll be your lifeline in the school. Know where their offices are and go to them if you need help.

Ask the front desk or the school counselor for a **map** of the school. This will help you find the playroom, the school counselor's office, the classrooms, and other areas of the school.

Introduce yourself to each child's teacher. Inform the teacher that you'll be seeing the child twice a week for 30 minutes. They should already know this but they have a lot on their plate and some of their students will be participating in the study and some will just receive normal play therapy services. Make sure you have the teacher's attention and he/she is aware each time the children leave for session and when they are back in the classroom. Don't assume the teacher will remember your session time or know where the kids are. Attempt to get the child in and out of the room as quickly as possible and without disruption. Use responses like, "it's time to go now," rather than asking the child if they want to go.

Respect the school climate. Unlike CFRC, schools do not allow running or yelling in the hallways. Help the child to distinguish between the special rules in the playroom and the rules of the school. Creative choice-giving may be helpful in the hallway, as is casual conversation that shows your interest in the child. You also need to follow any drills that occur in the school. Please be sure to know the procedures.

Know the child's school day schedule. You may need to pick up or drop off a child from the library, lunch room, computer lab, specials area, etc. I will try to get this information to you if I have it, but that is ultimately your responsibility. Know where the children should be and use the

map to find your way around the school. Always make sure someone always knows where the kids are, and make sure they're actually where they're supposed to be.

Accompany your child back to the classroom following every session. If a child gets to classroom before you, make sure you still look in the classroom to make sure the child made it back in and the teacher acknowledges that. Don't drop children off in the cafeteria without seeing their teachers or watching them join others from their class.

Don't allow children to go back to their classroom covered in **glue, paint**, etc. Teachers and classmates aren't always as accepting as play therapists! Walk with the kids to the bathroom and encourage them to wash up before you take them back to their classroom.

The schedule allows for **10 minutes in between sessions** to return the child back to their classroom, clean the playroom, go get the next child, and take them back to the playroom. If sessions are extremely messy, end early to allow yourself more time to clean the room before the next session. If you need to end more than 5 minutes early, make sure to contact Hayley or Andrea immediately. If you're picking up or dropping off the kids later you may have to take them to a different location. **Know the child's school day schedule!**

When something is broken or needs to be replaced in the playroom please email me, Hayley.stulmaker@unt.edu or Andrea- andrea.godwin@unt.edu

You are expected to **keep a file** for each of your school clients at CFRC. You should complete a **"school session summary" form** for each individual session, or a **"group play therapy session summary" form** for each group session. We also have a **"school session visit summary form"** that needs to be completed to document each session, cancellation, and meaningful teacher interaction. You should complete a **"school client treatment summary"** when you terminate with each school client. Files must be completed as a requirement in your clinical course.

You are **required** to complete a **DISD background form** before you will be allowed to see clients in the schools, which should be completed already.

Parent/Teacher Contact. The study requires minimum to no contact with teachers and parents once play therapy sessions begin. You should only make contact with teachers to pick up or drop off the child. You can engage in small talk but nothing about the child specifically. If the teacher insists on talking with you, listen to what they have to say and then remind them that you will be able to talk in more detail in # weeks. The same is true for parents. Affirm that you will talk with teachers and parents in more detail and reassure them that you think you'll be able to provide some recommendations once play therapy is completed.

Video Camera Procedures

1. Leave a \$200 deposit for Denise (that will be returned as soon as you return the camera).
2. Sign out the camera on the sign out sheet
3. Bring the camera back to the CFRC to burn the recording. Denise and the work studies should be able to help you with this if you are not sure how to do so. Cameras need to be returned within 24 hours of being checked out (burning occurs in real time so it is a somewhat lengthy process, please plan accordingly)
5. Return the camera charged and empty to Denise.
6. Receive your deposit.

Extra notes about videotaping:

- I need your DVDs from your sessions right after you have them. If you need them for supervision purposes, please let me know. Otherwise, when you turn in your camera, please turn in your DVD.
 - DVDs should be labeled with your name, child initials, session numbers, and date
- EVERY session needs to be recorded
- There will be a place in my office to drop off DVDs
- I will be checking every week to make sure that I have your sessions

Play Therapy Research Checklist:

- Know school rules
- Make sure you have a recording device
- See your kids on the days and times you are supposed to go. If you have to reschedule, contact BOTH me and Andrea. All schedule changes need to go through both of us.
- Record your sessions
- Return camera if checked out
- Burn DVDs ASAP
- Log your time with your kids on the hours log and when you do the BLRI after each session
- After every 2 sessions after the 6th session (so after the 6th, 8th, 10th, 12th, 14th, and 16th session), fill out the BLRI-MO per child
- Turn in DVDs and BLRIs as soon as they are completed to me. There will be a place in my office to return completed BLRIs.
- Complete all file paperwork weekly!
- Communication is critical. Please let me know anything and everything that does not go according to plan. (ex. Were you late? Was child absent? Did you miss? Did teacher get upset? Did child get upset? Did teacher insist on talking with you?, etc.)

Active Control Group Manual- Coloring Guide

General Directions:

1. One coloring sheet per child per week
2. All children have the same sheet
3. Children must follow directions that you give
4. You must give the following directions as stated
5. Your goal is to ensure that the children finish the artwork correctly
6. Children meet in groups to accomplish artwork goal once a week for 30 minutes

Prior to meeting the children, set up a space for each child with the coloring sheet and necessary colors available to them all.

Bring children in their set groups of 3 to 4 to the specified location in the school. Once all children are present and seated, introduce the activity.

Introduce children to the activity with the following script:

Hi, my name is leader's name. We'll be coming here each week on day of week to have some fun time to color. I'll pick the coloring sheet each time but you'll get to pick the colors you use for most pictures. The coloring sheets have dots to connect so do your best to connect them and then you can start coloring. Try to finish each coloring sheet before our time is up each week. If you finish early, I'll give you a new one. Most of the time, I will sit quietly while you color. You can whisper to each other while you color but no loud talking or not coloring.

Each week, you'll read the instructions for the current week's picture. If children aren't listening please call them by name and re-state the directions. If you still don't believe that they understood, make them repeat the instructions to you.

You will be provided with coloring sheets for each week from the following site <http://www.coloring.ws/coloring.html> (specifically color by numbers, connect the dots, and color by dot pictures)

For each page, give directions as to what the child is to do:

Color by Number:

"You have a picture in front of you. You need to color it in based on the colors it tells you. For example, color all spaces with a number 1, blue. Continue following directions for all other colors. Keep coloring until you finish or I tell you to stop. Remember, stay inside the lines"

Connect the Dots:

"You each have a picture in front of you with dots, numbers, and some other drawings. Start with dot number one and connect it to number two, then number three and so on. When you have connected all of the dots, color in the rest of the picture. Remember, stay inside the lines."

Color by Dot:

"You each have a picture in front of you. Color the spaces with dots in green. Color the other spaces in a different color. Remember, stay inside the lines."

Reminder phrases:

"Stay inside the lines"

"Only use blue in that space"

"You need to go in order with the numbers"

"Don't skip any numbers"

"Don't skip any spaces"

"Make sure you aren't copying someone else's work"

"Write your name at the top"

Remember to bring extra coloring sheets for when children finish early. If children become distracted or disruptive, use the following limit setting:

"You need to continue to work on your picture"

"Now is not the time for talking, playing, walking, you need to work on your coloring."

"We can leave in a few minutes but for now, you need to finish your picture."

"I'd like for you to sit down/be quiet/work on your picture."

You might have to repeat these phrases many times until group time is over. Avoid initiating individual conversations with students. If students ask you questions, answer briefly and re-direct back to the picture.

After 20 minutes, give a 10 minute warning. And then a 5 minute warning.

"Everyone, we have 10 minutes left of coloring time and then we go back to the classroom"

At the end of 30 minutes, stand up and say,

Everyone turn in your pictures to me and stand in line by the door so we can head back to the classroom.

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