

The Effects of Adlerian Play Therapy on Maladaptive Perfectionism and Anxiety in Children: A Single Case Design

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In recent years, an increasing number of mental health research focused on perfectionism as a concept that impacts psychosocial and behavioral wellbeing of individuals from different age groups (Morris & Lomax, 2014). In contrast with adaptive perfectionists, individuals with maladaptive perfectionism set unrealistically high standards and show rigidity in behaviors toward achievement (Stoeber & Otto, 2006). Research results support that maladaptive perfectionism is associated with a host of psychological problems throughout the life span such as depression, low self-esteem, eating disorders, interpersonal problems, and personality disorders (Boone, Soenens, Vans-teenkiste, & Braet, 2012; Gnilka, Ashby, & Noble, 2013; Kenney-Benson & Pomerantz, 2005; Rice, Ashby, & Gilman, 2011; Stoeber, Feast, & Hayward, 2009). Anxiety is 1 of the most recognized mental health problems associated with perfectionism, which can start in early years due to experiencing criticism and high standards for performance (Damian, Stoeber, Negru, & Băban, 2013). Although there is an increase in the number of research studies focused on maladaptive perfectionism in adults, research regarding the mental health treatment of perfectionism in children is in its infancy (Morris & Lomax, 2014). Ashby, Kottman, and Martin (2004) proposed a play-based intervention grounded in Adlerian principles as a developmentally responsive approach that focused on helping children modify maladaptive thoughts and behavior. This single-case design study aimed to investigate the effect of Adlerian play therapy (AdPT) on children's maladaptive perfectionism and anxiety. Results showed AdPT as a promising intervention that needs to be further studied for its effectiveness in treating children's maladaptive perfectionism and related anxiety issues.

Keywords: play therapy, Adlerian theory, maladaptive perfectionism, anxiety, developmentally appropriate treatment for children

The increase in the number of research studies targeting perfectionism over the past decade reveals interest in perfectionism as a relevant construct in mental health (Morris & Lomax, 2014). Alfred Adler (1956) was one of the first authors to describe a multidimensional view of perfectionism in relation to mental health, emphasizing its adaptive and maladaptive aspects. Adler proposed the main difference of neurotic/maladaptive perfectionism from normal/adaptive perfectionism as unrealistically high standards and rigidity in be-

haviors toward achievement. Consistently, research results support that maladaptive perfectionism is associated with a host of psychological problems throughout the life span (Asseraf & Vaillancourt, 2015; Essau, Conradt, Sasagawa, & Ollendick, 2012; Flett & Hewitt, 2007; Rice, Choi, Zhang, Morero, & Anderson, 2012; Soreni et al., 2014; Stoeber et al., 2009; Tsui & Mazzocco, 2007), including anxiety related issues (Afrunti & Woodruff-Borden, 2016; Bas, 2011; Handley, Egan, Kane, & Rees, 2015; Miloseva & Vukosavljevic-Gvozden, 2014; O'Connor, Rasmussen, & Hawton, 2010).

Nationally, government reports over the past decade (Centers for Disease Control & Prevention, 2013; Mental Health America, 2011) emphasized the importance of early mental health intervention to prevent unnecessary suffering and costs associated with long-term effects of untreated psychological problems in childhood.

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However, regardless of the increased number of research studies focused on maladaptive perfectionism in adults, research on the mental health treatment of perfectionism in children is still in its infancy (Morris & Lomax, 2014).

Perfectionism

Adler (1956) stated that, “the striving for perfection is innate in the sense that it is a part of life, a striving, an urge, a something without which life would be unthinkable” (p. 104). According to him, the goal of rising from an inferior to superior state starts in early childhood and proceeds until the end of life. Adler suggested that perfectionism has the potential to help individuals advance themselves and their society by working toward improvement. On the other hand, perfectionism can become unhealthy when individuals show rigidity in behaviors that aim to reach high standards. Several other researchers supported a multidimensional structure of perfectionism (Hamachek, 1978; Rice & Mirzadeh, 2000; Sironic & Reeve, 2015; Zhou, Wu, Zhu, & Cai, 2016). Research results showed that whereas maladaptive perfectionism is associated with a variety of psychological problems (Rice et al., 2011; Stoeber et al., 2009; Tsui & Mazzocco, 2007), adaptive perfectionism may facilitate positive outcomes (Rice et al., 2011; Rice & Mirzadeh, 2000).

There is limited literature on classification and definition of perfectionism in children. However, Ashby et al. (2004) reported their observations related to specific behaviors of adaptively perfectionist children at home and school settings. According to the authors, adaptive perfectionism promotes children’s psychological and social well-being in several areas, such as self-esteem, interpersonal relationships, and life satisfaction. In the school environment, children may manifest adaptive perfectionism through high standards and need for order without extreme self-criticism (Kottman & Ashby, 2000).

According to observations of Ashby et al. (2004), parents and teachers usually refer maladaptively perfectionist children to counseling because they look “‘overly serious’ about their schoolwork or other endeavors (e.g., giving up recess or playtime to finish a task or assignment); they are easily frustrated when things do

not go just as they would like (e.g., drawings that do not meet their standards, resulting in numerous crumpled pieces of paper); or they may be hesitant to engage in activities that might result in a “mess” of some sort (e.g., baking or finger-painting)” (p. 36). In addition, parents and teachers may identify maladaptively perfectionist children by their extremely self-critical behaviors and psychological symptoms such as anxiety and depression. Perfectionist children may see themselves as failures because they excessively focus on one less than perfect score and disregard all their past achievements. In school settings, maladaptively perfectionist students may be discouraged from trying in school assignments (Kottman & Ashby, 2000). These children may avoid working on their school tasks and participating in class discussions to prevent less than perfect results that cause feelings of extreme disappointment, anger toward self and others, and sadness. Adderholt-Elliott (1989) suggested the term *paralyzed perfectionism* to explain discouragement of children to try new activities or start projects because of their excessive fear of failure.

Adlerian Play Therapy

Kottman and Meany-Walen (2016) integrated the Individual Psychology concepts of Adler (1927) with play therapy principles to develop AdPT as a therapeutic intervention for children. AdPT incorporates nondirective and directive play techniques to help children to gain a deeper understanding of how they view themselves, others, and the world, and facilitates rehearsal of their changing perceptions (Kottman, 2009). According to Kottman, Adlerian play therapists also need to pay attention to the *Crucial Cs*, which Lew and Bettner (1998) defined as the areas that every child needs to master for healthy development. Lew and Bettner defined *Crucial Cs* as the need to (a) connect with others, (b) perceive oneself as capable, (c) feel like one counts in his or her environment, and (d) have courage. Adlerian play therapists use a variety of toys, materials, and playful interventions, such as art techniques, storytelling, and puppetry to help children learn socially appropriate ways to feel significant.

Adler (1927) emphasized children's need for support from their caregivers to deal with difficulties of life. Consistent with Adler's emphasis on the family atmosphere in healthy development, an essential component of AdPT is the involvement of parents in the change process (Kottman & Meany-Walen, 2016). Furthermore, Kottman and Meany-Walen suggested that teachers exert significant influence on the lives of school-age children, and that they can provide important information about children's learning styles and interactional styles.

Ashby et al. (2004) suggested that Adlerian play therapists might help perfectionist children develop strategies for "dealing more easily with life in all of its glorious imperfection" (p. 52). Ashby et al. defined the goals of AdPT as helping perfectionist children to

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

Furthermore, Adler (1929) proposed that excessive feelings of inferiority may result in lack of interest in the world and others. Thus, Kottman and Meany-Walen (2016) suggested a therapeutic goal for perfectionist children of improving their sense of social interest, which Adler defined as the concern for others' well-being as well as one's own.

Among all theoretical approaches, Adlerian theory is one of the most commonly used theoretical approaches with which child counselors align (Lambert et al., 2007; Muro & Kottman, 1995). However, a review of the literature revealed limited number of research studies that explored the effectiveness of AdPT (Meany-Walen, Bratton, & Kottman, 2014; Meany-Walen, Bullis, Kottman, & Dillman-Taylor, 2015; Meany-Walen, Kottman, Bullis, & Dillman-Taylor, 2015b; Meany-Walen & Teeling, 2016), and revealed no studies examining the effectiveness of AdPT with perfectionist children. Given the strong link of perfectionism to psychological problems, the current gap in the literature related to effective treatments, and the developmentally appropriate and systemic na-

ture of AdPT, the purpose of this study was to examine the effect of AdPT on children identified with maladaptive perfectionism. Specifically, this study was designed to investigate the effects of school-based AdPT on reducing maladaptive perfectionism and anxiety in elementary schoolchildren.

Method

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

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

Instruments

For study purposes, we used the revised Children's Manifest Anxiety Scale, 2nd ed. (RCMAS-2; Reynolds & Richmond, 2008) Total Anxiety score as the twice-weekly repeated measure for anxiety, and the Child-Adolescent Perfectionism Scale (CAPS; Flett, Hewitt, Boucher, Davidson, & Munro, 2002) Self-Oriented Perfectionism (SOP) and Socially Prescribed Perfectionism (SPP) subscales as the twice-weekly repeated measure for maladaptive perfectionism. We used parent and teacher report on the Conners Rating Scales—Revised (CRS-R; Conners, Sitarenios, Parker, & Epstein, 1998) Perfectionism and Anxious-Shy

subscales to qualify children to the study and as a measurement of children's perfectionism and anxiety levels over 5 points of measurement throughout the study.

CAPS. Flett et al. (2002) developed the CAPS as a 22-item self-report perfectionism scale for children and adolescents up to age 18 with a minimum Grade 3 reading level. The CAPS measures two dimensions of perfectionism: socially prescribed and self-oriented. The SPP subscale consists of 10 items (e.g., "My family expects me to be perfect"), and the SOP subscale consists of 12 items (e.g., "I want to be the best at everything I do").

One-week interval test-retest correlation was .82 for SPP and .75 for SOP (Castro et al., 2004), and 5-week test-retest correlation was .74 ($p < .01$) for SOP and .66 ($p < .01$) for SPP (Flett et al., 2002). Flett et al. reported internal consistency of .86 for SPP and .85 for SOP subscales. Statistically significant ($p < .05$) correlations between the CAPS subscales and perfectionism related questions in the Academic Reasons Survey (Ryan & Connell, 1989), as well as the Eating Disorder Inventory Perfectionism Scale (Garner, Olmstead, & Polivy, 1983) were present.

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

According to Reynolds and Richmond (2008), the alpha reliability internal consistency coefficient for the RCMAS-2 was .92 for Total Anxiety. At a 1-week interval, test-retest reliability was highest for the Total Anxiety scale (.76). Lowe, Grumbein, and Raad (2011) established convergent validity (.70) for the RCMAS-2 with the Test Anxiety Scale for Elementary Students. C. Reynolds (personal communication, September 29, 2012) indicated appropriateness of the instrument for repeated measures.

CRS-R. The CRS-R (Conners et al., 1998) includes 80-item parent-report and 59-item

teacher-report scales that assess psychopathology and problem behaviors in children and adolescents between ages of three and 17. The Conners Parent Rating Scale—Revised (CPRS-R) included seven factors: Oppositional, Cognitive Problems/Inattention, Hyperactivity, Anxious-Shy, Perfectionism, Social Problems, and Psychosomatic. The Conners Teacher Rating Scale—Revised (CTRS-R) included six factors: Oppositional, Cognitive Problems/Inattention, Hyperactivity, Anxious-Shy, Perfectionism, and Social Problems.

For the CPRS-R, coefficient alphas ranged from .75 to .94 for males and .75 to .93 for females (Conners et al., 1998). At a 6-week interval, test-retest correlations were .42 ($p < .05$) for Anxious/Shy and .60 ($p < .05$) for Perfectionism. We did not provide validity information for the subscales.

Participants

Teachers and school counselors identified children with maladaptive perfectionism according to a checklist that Sinem Akay developed using the list of behaviors Ashby et al. (2004) and Adderholt-Elliott (1989) defined. The list included statements such as "Avoids difficult projects, assignments, or tasks," "Sees one or two errors as a complete failure," and "Is hesitant to engage in activities that might result in a mess of some sort." We introduced the checklist to teachers and school counselors as the Perfectionism Behavior Checklist for the purpose of helping teachers identify children for the study. Identified children who received the necessary parental consent qualified for the study based on clinical scores on the Perfectionism subscale of the CRS-R (Conners et al., 1998). To reduce the likelihood that comorbid factors contributed to the identified children's behaviors that might influence treatment outcome, we excluded children who had clinical scores on any *DSM* subscales of the CRS-R other than the Total Anxiety subscale. Additional inclusion criterion included (a) parents and children speaking and comprehending English, and (b) children identified by their teachers as reading at a third-grade level. Referred children who did not meet all criteria were eligible to receive play therapy services outside of the study.

Parents of five children consented to participate in the study and their children signed assent forms. Two children did not meet the inclusion criteria and one dropped out. Therefore, two out of five children participated in the research study. One of the participants was a 7-year-old Caucasian female and the other was a 10-year-old Hispanic American male. The participants met the inclusion criteria for the study by scoring in the clinical range for perfectionism on CTRS-R and/or CPRS-R. Teachers of both children agreed to attend teacher consultations. Because of time limitations, the 7-year-old participant did not complete all the phases in Adlerian play therapy. Thus, only the results of the 10-year-old participant are included in the present article.

Treatment

The participant received 30-min individual AdPT sessions, twice per week, and his teacher and mother participated in consultations based on their availability. The participant left his classroom during the school day twice a week for 45 min to receive AdPT in a specially equipped playroom at school. The participant's mother and teacher were available to attend consultations at the school every other week for 15 to 20 min.

As a doctoral candidate specializing in play therapy, Sinem Akay conducted the play therapy sessions and teacher and parent consultations according to Kottman's (2009) AdPT treatment protocol. Sinem Akay has received extensive supervised training in play therapy and participated in several AdPT trainings and workshops with Terry Kottman, the developer of AdPT. To ensure treatment fidelity for Adlerian play therapy, the author video recorded all sessions, received weekly supervision, and submitted video recordings of 10% of the sessions to an expert in AdPT who checked 15 min of randomly selected sessions for adherence to the AdPT protocol. To check treatment fidelity, the AdPT expert used the Adlerian Play Therapy Skills Checklist (Kottman, 2009) and Adlerian Play Therapy Parent Consultation Skills Checklist.

Data Collection

Upon receiving parental consent for the child to participate in the study, his teacher completed

the CTRS-R and his parent completed the CPRS-R. In order to prevent assessment bias, a doctoral research assistant administered the CAPS and RCMAS-2 to all participants. The research assistant was a doctoral candidate specializing in play therapy. She had extensive supervised training in child and adolescent assessments. Sinem Akay also interviewed the mother to gather detailed background information and support the qualification criterion of exhibiting maladaptive perfectionism.

Consistent with the single-case A-B-A experimental research design, the doctoral research assistant administered the CAPS and RCMAS-2 to the participant twice per week during the three phases of the study: (a) baseline, (b) treatment, (c) and maintenance. Horner, Sugai, Todd, and Lewis-Palmer (2005) suggested documentation of five or more data points to establish baseline patterns. In the present study, the research assistant collected baseline and maintenance data over 3-week periods in the beginning and at the end of the study, resulting in six data points in each phase. The teacher completed the CTRS-R and the parent completed the CPRS-R five times: (a) prior to study, (b) following baseline/prior to treatment, (c) mid-point of treatment, (d) following treatment, and (e) following maintenance phase.

Data Analysis

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

case research designs. Thus, we evaluated the data both between and within conditions, and analyzed an ascending or descending trend in data.

We calculated least-squares regression lines according to Kennedy's (2005) description to provide an effect size statistic of R^2 and examine variability of data. Cohen (1988) provided guidelines to examine practical significance of research results: $R^2 = .25$ demonstrates a "large" effect, $.09$ demonstrates a "medium" effect, and $.01$ demonstrates a "small" effect. To explore the effectiveness of AdPT, we also computed percent of data exceeding the median (PEM; Ma, 2006). PEM involves drawing a horizontal median line through baseline phase and extending it through intervention phase. Calculation of percentage of intervention phase data above that extended line yields effect size. According to Ma's guidelines, 50% or less indicates no effect, 50–70% indicates a questionable effect, 70–90% indicates a moderate effect, and 90% and above indicates a strong effect. Furthermore, we analyzed the quantitative data collected from the parent and the teacher via CPRS-R and CTRS-R Perfectionism and Anxious-Shy subscales over 5 points of measurement to examine the clinical significance of AdPT on participant's maladaptive perfectionism and anxiety.

Results

In this section, pseudonyms are used to protect the participant's identity. Dillon was a 10-year-old Hispanic American male, referred to play therapy by his teacher for his extreme concern over mistakes, excessive frustration when things did not go the way he wanted, avoidance of difficult schoolwork, negative self-statements when he did not live up to his standards, extreme focus on negative qualities about himself, vigilance to external evidence to support his negative self-evaluation, extreme sadness and disappointment when he has less than perfect results, perception of one or two errors as being complete failure, and unwillingness to participate in group discussions or activities based upon his fear of being wrong. Dillon qualified for this study because of his markedly atypical results in CTRS-R perfectionism subscales and his borderline score in the CPRS-R Perfectionism subscale. Dillon attended 21 play sessions. Dillon's mother attended six parent consultations and Dillon's biological father attended the final parent consultation. Dillon's teacher attended six teacher consultations.

CAPS

Figure 1 represents Dillon's scores on the CAPS across baseline, treatment, and maintenance

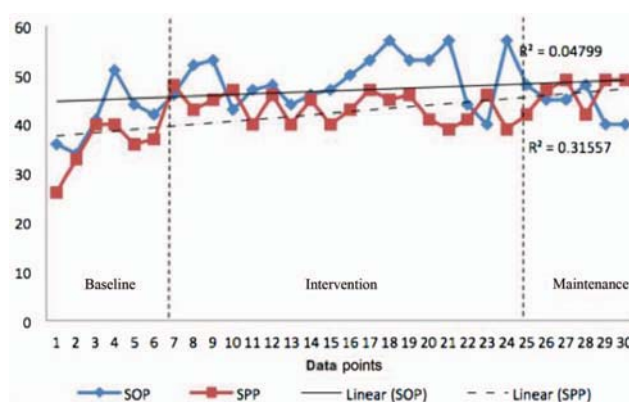


Figure 1. Dillon's perfectionism scores on the Child-Adolescent Perfectionism Scale (CAPS) throughout the three study phases. Decrease in the CAPS scores demonstrates improvement in perfectionism. The highest (ceiling) score on Self-Oriented Perfectionism is 60, and the highest score on Socially Prescribed Perfectionism is 50. See the online article for the color version of this figure.

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

According to PEM statistics, for SOP scores, median of the baseline phase was 41.5 and none of the data points in intervention phase was below the median. For SPP scores, median of the baseline phase was 36.5 and none of the data points in intervention phase was below the median. The PEM statistic results indicated that AdPT was ineffective in reducing maladaptive perfectionism. According to Cohen's (1988) guidelines, there was a small negative relationship for SOP ($R^2 = .05$) and large negative relationship for SPP ($R^2 = .32$) between the treatment phases and data points, indicating worsening of Dillon's maladaptive perfectionism over time. However, individual phase analysis for SPP demonstrated a large upward trend

($R^2 = .42$) in baseline, followed by a moderate downward trend ($R^2 = .14$) in treatment phase, indicating moderate improvement in Dillon's SPP as a result of the AdPT intervention phase. This improvement is followed by a large upward trend ($R^2 = .28$) in maintenance phase, indicating regression toward pretreatment levels of SPP. The individual phase analysis for Dillon's SOP demonstrated a large upward trend ($R^2 = .38$) in baseline, followed by a small upward trend ($R^2 = .06$) in the treatment phase, and a large downward trend ($R^2 = .59$) in the maintenance phase. According to these results, Dillon's SOP demonstrated an improvement during the maintenance phase, but not the intervention phase.

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

According to Dillon's mean score on the RCMAS-2 Total Anxiety subscale, the level of phases indicated a minor decrease in anxiety from baseline to maintenance. Figure 2 shows Dillon's RCMAS-2 Total Anxiety scores. The level was 38.83 in the baseline phase, 37.94 in the intervention phase, and 35.16 in the follow up phase. Visual analysis demonstrated a slight downward trend, which indicated a small improvement in his anxiety as a result of AdPT. According to Cohen's (1988) guidelines, there

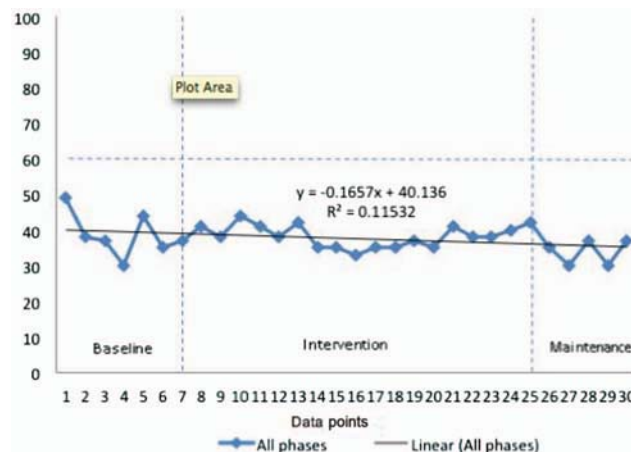


Figure 2. Dillon's anxiety scores on the revised Children's Manifest Anxiety Scale, 2nd ed. (RCMAS-2) throughout the three study phases. Decrease in the RCMAS-2 scores demonstrates improvement in anxiety. The scores higher than 60 demonstrate clinical anxiety. See the online article for the color version of this figure.

was a moderate relationship for anxiety ($R^2 = .12$) between the treatment phases and data points. However, individual phase analysis demonstrated a moderate improvement ($R^2 = .22$) in Dillon's anxiety during baseline phase, indicating that his anxiety was decreasing before the intervention. PEM statistic was also calculated for the Total Anxiety subscale. Median of the baseline for the total score was 37.5, and eight out of 18 data points in the intervention phase were below the mean. The PEM statistic result was 44%, indicating no effect for AdPT on anxiety.

Conners Rating Scales-Revised (CRS-R)

Sinem Akay explored the clinical significance of AdPT on Dillon's daily functioning via Perfectionism and Anxious-Shy subscales in the CRS-R for parents CPRS-R and teachers (CTRS-R). Figure 3 represents Dillon's CPRS-R and CTRS-R scores. According to Parent Report on the CPRS-R Perfectionism subscale, Dillon demonstrated borderline perfectionism prior to the study

and following baseline. Dillon's perfectionism scores decreased to the normative range at the midpoint of treatment and stayed in the normal range following the end of treatment and following the maintenance phase. Dillon's CPRS-R Anxious-Shy subscale scores were on low end of the normal range prior to the study. At the midpoint of treatment, his anxiety scores showed a decrease and remained constant from midpoint to end of treatment and through the maintenance phase.

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

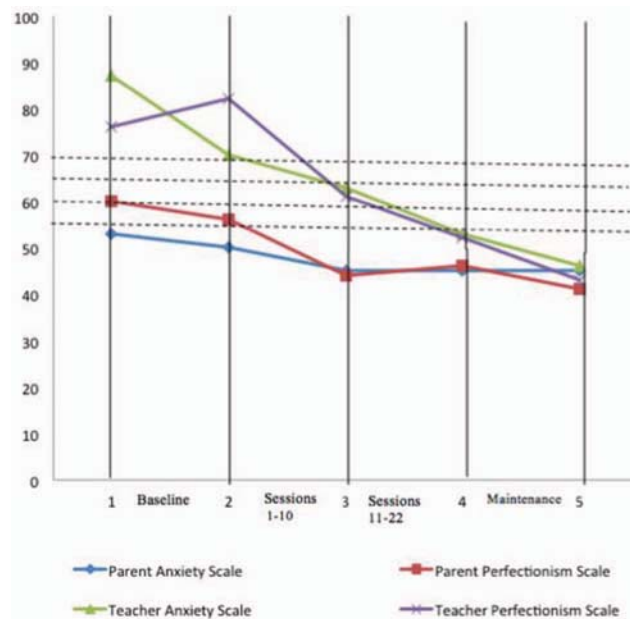


Figure 3. Dillon's perfectionism and anxiety scores on the Conners Rating Scales—Revised throughout the three study phases. 70+ is markedly atypical, 66–70 is moderately atypical, 61–65 is mildly atypical, and 55–60 is borderline. Decrease in the Conners Parent Rating Scale—Revised and Conners Teacher Rating Scale—Revised scores demonstrate improvement in maladaptive perfectionism and anxiety. See the online article for the color version of this figure.

midpoint of the intervention. Dillon's anxiety score declined to the normal range following the end of treatment and stayed at the normal range following the maintenance phase. In summary, AdPT demonstrated clinically significant reduction in Dillon's maladaptive perfectionism and anxiety, as reported by the parents and the teachers.

Discussion

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

Although the results of the individual phase analyses, which indicated improvement in Dillon's SPP score, were encouraging, the majority of child self-report results were inconsistent with parent and teacher reports making it difficult to interpret findings. One explanation for the discrepancy between child self-report and reports of the parent and the teacher is social desirability bias. Given the potential for perfectionists to be sensitive about reporting their own imperfections, children's self-report might have resulted in invalid findings (Rice et al., 2011). This reasoning is supported by Dillon's moderately problematic defensiveness scores on the RCMAS-2, as well as his lower than normal anxiety subscale scores. In addition, using negative items in instruments is one of the main factors that reduce reliability and validity (Dimitrov, 2012). The presence of reverse items in the CAPS that were not capitalized or boldface might have impacted reliability and validity of the results in the present study. Less than adequate psychometrics of the CAPS might also have influenced accuracy of the results.

Another explanation for the discrepancy between Dillon's self-assessment results and the parent and teacher reports is the potential resis-

tance of perfectionistic beliefs to change. According to Flett and Hewitt (2007), perfectionist individuals often have difficulties giving up their perfectionistic beliefs because their need to be perfect is an important part of their identities. In the present study, in addition to formal and informal parent and teacher reports, Sinem Akay observed Dillon improve in his dysfunctional behaviors related to maladaptive perfectionism. Main differences that the author observed in play sessions were Dillon's increased willingness to open up about negative situations in his life, decreased worry about messiness, and improved ability to work on challenging tasks.

Although the overall findings for the child self-report were not promising regarding AdPT's effectiveness, the results from parent and teacher report, along with parent and teacher comments and my observations, suggest that AdPT demonstrated beneficial effects on the children's maladaptive perfectionism and anxiety. It is plausible that Adlerian techniques and strategies, such as facilitation of insight into problematic thoughts and attitudes, attention to Crucial Cs, and encouragement of functional behaviors facilitated Dillon's behavioral change reported by teachers and parents. Throughout this study, Sinem Akay focused on the Crucial Cs (courage, connect, capable, and count) to understand the child's strengths and needs as well as his change process. According to Adler (1956), individuals who come to therapy lack the courage to deal with life's difficulties. Encouraging clients to overcome their hesitant attitudes toward life is the main road to improvement and change. The use of encouragement throughout the four phases of AdPT (Kottman & Meany-Walen, 2016) facilitated the child's "courage" to take risks and learn from his mistakes, which resulted in decreased maladaptive perfectionism and anxiety. According to the informal reports during parent and teacher consultations, throughout the therapy process Dillon showed increased effort to work on difficult assignments, try new behaviors, and complete tasks on time. In addition, the parent and the teacher verbally reported continued improvement throughout the maintenance phase. It seems reasonable to believe that the change in parent and teacher attitudes after receiving Adlerian consultations contributed to the children's improvement during the intervention

phase and extended the effects of their overall improvement during intervention through the maintenance. Dillon's mother and teacher stated that encouragement was the skill that they found most helpful because he seemed to respond to encouragement with increased cooperation and effort on challenging tasks.

According to Adler (1929), perceived imperfection can be a burden for children and cause excessive feeling of inferiority, which may generate lack of interest in the world and others. Adler believed that striving for adaptive perfectionism requires a sense of social interest, which he defined as the concern for others' wellbeing as well as one's own welfare. Prior to the intervention phase, parents and teachers reported that the participants were preoccupied with avoiding imperfect outcomes, resulting in isolation from their classmates. These statements indicated that the child had limited ability to "connect" and feel "capable" (Lew & Bettner, 1998). In the teacher consultation following the intervention phase, Dillon's mother reported his increased willingness to help his brother with challenging homework and school related tasks. Dillon's mother also stated that Dillon began to use encouragement statements with his brother when his brother felt discouraged. Based on these anecdotal reports, Dillon's reduction in maladaptive perfectionism and improved courage resulted in increased social interest and ability to connect with others.

During the reorientation phase, Dillon began to express his negative feelings more openly rather than shutting down and withdrawing. During parent consultations, his parent expressed concern over Dillon's expression of negative emotions. Sinem Akay worked with the mother to accept and encourage Dillon's verbalization of negative feelings and understand his underlying concerns. In addition, the parent worked on changing the family atmosphere from one that overly focused on high standards for performance into a more democratic family environment, in which the parents communicated love and respect in ways that encouraged the Crucial Cs (Kottman, 2001). As he felt more accepted and encouraged, Dillon demonstrated more self-enhancing ways to "count" in his environment that involved pursuing high standards with increased courage and reduced self-criticism. These observations and informal reports are consistent with Kott-

man and Ashby's (2000) suggestion that play therapists can encourage adaptive aspects of perfectionism as they facilitate reduction in self-criticism and fear over mistakes.

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

In their study examining the relationship between parenting styles and perfectionism, Enns, Cox, and Clara (2002) demonstrated that perfectionist parenting style is correlated with perfectionism in children. The result is consistent with Kottman's (2001) suggestion to work with the parents and other significant caregivers, such as teachers, to alter their perceptions and behaviors that maintain children's maladaptive perfectionism. In the beginning of the study, Dillon's mother reported struggling with her own perfectionist tendencies. At the end of the study, Dillon's mother reported improved understanding of her roles in maintaining the child's maladaptive perfectionism and anxiety through having high expectations for herself and modeling fear of being perceived as imperfect by others. Consistent with Kottman's suggestion to work with the system, teacher consultations seemed to impact the therapeutic process. Dillon's teacher indicated increased use of encouragement rather than negative consequences when Dillon failed to complete his class assignments.

In summary, although there is discrepancy in the findings, parent and teacher reports were consistent in indicating the clinical significance of AdPT on Dillon's day to day functioning at home and school. According to parent and teacher reports, AdPT demonstrated a beneficial effect on reducing maladaptive perfectionism and anxiety. This finding is consistent with Meany-Walen et al.'s (2014) results regarding the beneficial effect of school-based AdPT on children's classroom behavior. Furthermore, parent and teacher statements were in line with the Adlerian view of the therapeutic change

process, specifically the importance of encouragement, facilitating Crucial Cs, and nurturing social interest. Consistent with the emphasis of AdPT on systemic change, parent and teacher consultations were integral to the treatment process.

Limitations and Recommendations for Future Research

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

A major limitation in single-case design research is the inability to generalize findings (Heppner et al., 2008). According to Kazdin (2003), replication of single case research with a variety of participants is required to show generalizability. In addition, although establishing a stable baseline is an essential requirement in single-case studies to demonstrate experimental control within a single participant (Kennedy, 2005), it was challenging to establish a stable baseline in the present study due to school schedule and time limitation. A rigorous study with stable baseline would provide more reliable and valid results, offering potential implications for informing effective practices with children who exhibit maladaptive perfectionism and anxiety.

Experimenter bias was another limitation of the present study. According to Heppner et al. (2008), one disadvantage of intensive single-

case design is that researchers may overlook the information that contradicts the results that they expect to find. Expectations of the researcher may cause the contrary data to be undetected during analysis of the data. Future researchers would benefit from utilizing additional research team members or blinded raters to provide assessment to further remove themselves from the treatment and research activities.

Implications for Practice

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

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

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

In the present study, both parents and teachers showed relative consistency in attending consultations. However, involvement in the therapy process is a significant commitment for parents and teachers. Researchers, clinicians, and school counselors may benefit from providing flexible consultation schedules and educating parents and teachers regarding importance of their roles in the therapeutic process. Considering that delivery of counseling services is only one of the several responsibilities of school counselors (American School Counselor Association, 2016), they may also benefit from conducting group consultations for parents and teachers rather than scheduling individual meetings.

Conclusion

Perfectionism is an overlooked trait that has short and long term impacts on children's psychological well-being. With its focus on encouragement and modification of maladaptive thoughts and behaviors, as well as its strong emphasis on systemic change, AdPT offers potential as a treatment for children with maladaptive perfectionism and anxiety (Ashby et al., 2004). Adlerian theory has historically been used in the school environment to create an atmosphere that facilitates healthy development in children (Kottman & Meany-Walen, 2016; Watts, 2006). Kottman and Ashby (2000) suggested the use of AdPT to facilitate a shift from maladaptive to adaptive perfectionism in children. However, there is only one study to date that explored and demonstrated effectiveness of AdPT on behavioral problems (Meany-Walen et al., 2014). Prior to the present study, the claim of AdPT's impact on maladaptive perfectionism and anxiety (Ashby et al., 2004) was an assumption without any research support. Although there is discrepancy in the present findings between the children's self-report and reports of the parents and teachers, AdPT demonstrates initial promise as an intervention for children with maladaptive perfectionism and anxiety that warrants future research.

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