

THE ASSOCIATIONS BETWEEN CHILD THERAPISTS' PERCEIVED WORKING
ALLIANCE AND THEIR TRAIT ANXIETY, ATTACHMENT QUALITY, AND
MULTICULTURAL COUNSELING COMPETENCE IN PLAY THERAPY
SETTINGS

by

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A dissertation submitted to the faculty of
The University of North Carolina at Charlotte
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy in
Counseling

Charlotte

2013

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ABSTRACT

REBECCA GAYLE SCHERER. The associations between child therapists' perceived working alliance and their trait anxiety, attachment quality, and multicultural counseling competence in play therapy settings. (Under the direction of DR. KOK-MUN NG)

Agreement exists that the therapeutic working alliance (TWA) is related to outcomes in therapy across both child and adult populations (Horvath, Del Re, Flückiger, & Symonds, 2011; Shirk, Karver, & Brown, 2011). However, what factors contribute to the formation of a successful therapeutic working relationship is less clear in the child therapy literature. Though trait anxiety, attachment quality, and multicultural counseling competence have all been found to relate with working alliance ratings (Black, Hardy, Turpin, & Parry, 2005; Chapman, Talbot, Tatman, & Britton, 2009; Fuertes et al., 2006), most of the extant literature is focused on adult counseling and none on child counseling. The present study sought to fill the gaps in the literature by exploring the relationships among therapists' trait anxiety, attachment quality, and multicultural counseling competence and therapist perceived therapeutic working alliance in child counseling.

One-hundred and thirty-six participants took part in the study. All variables investigated in this study were assessed through self-report measures. Pearson product-moment correlation was used to determine the relationships among the variables. A hierarchical multiple regression was used to analyze the unique contributions of therapist trait anxiety, therapist attachment-related anxiety and avoidance, and therapist multicultural counseling competence to the variance of therapist perceived TWA. Years of experience, dyadic matching gender and ethnicity were controlled in this study due to the possible confounding effects of these variables.

The Pearson product-moment correlation analysis indicated significant relationships between most of the variables; however, not all the relationships between the variables reached significance and the null hypothesis was not rejected. This study did show that there was a significant negative relationship between TWA and trait anxiety and attachment-related anxiety, and attachment-related avoidance. A positive significant relationship was found between TWA and multicultural counseling competence. Trait anxiety and attachment-related anxiety were found to be positively correlated. Attachment-related anxiety and avoidance were also found to be positively related. Multicultural counseling competence was inversely related to trait anxiety, attachment-related anxiety, and attachment-related avoidance.

The hierarchical multiple regression analysis indicated that the combination of predictor variables was significant in predicting the variance of the TWA; however, only trait anxiety was shown to be the only statistically significant predictor, explaining 8.7% of the variance in the TWA. Attachment-related anxiety and avoidance and multicultural counseling competence were not significant in predicting the TWA ratings beyond trait anxiety. These findings emphasize the need for further research on trait anxiety and TWA, trait anxiety and attachment quality, and influential variables on multicultural counseling competence.

ACKNOWLEDGMENTS

I would like to take a moment to thank the important individuals that have helped me arrive at the completion of my dissertation and doctoral program. First, I would like to thank my dissertation chair Dr. Kok-Mun Ng whose guidance and mentorship has influenced me to be the professional researcher and writer I am today. He has provided invaluable support and feedback throughout the program that helped me reach this very important milestone in my life. My committee members were also very important in providing support and direction in the completion of this momentous research project. I would like to thank Dr. Chuang Wang for his statistical knowledge and his sense of humor. I have appreciated the relationship we have developed through the research coursework of my doctoral program. I would like to thank Dr. Peggy Ceballos, who supervised me when this research idea began and for the sense of tranquility she provided throughout this process. I would like to thank Dr. Phyllis Post for her expertise in play therapy and her infectious energy for research and counselor education. I also want to acknowledge how she opened her home and office to me at any time, for anything, and how much her support throughout my program helped me finish strong. I would also like to thank Dr. Mark Ezell for his presence and support in both my defense and proposal. He went out of his way to make sure this process was easy and not too anxiety provoking.

I would also like to extend my gratitude and appreciation to my friends in Charlotte that became my family. Amy, Anya, Eli, Regina, and Bailey, your unconditional love and guidance means more to me than I can express. To the rest of my cohort, they helped provide an experience that I will cherish for years to come and have broken the mold for all future cohorts to come. Cohort 10 love!

Many thanks to my immediate and extended family for without, I would not have been able to accomplish so much in my life. The importance of education was instilled in me at a very young age and I am grateful to have reached this goal with your support. I would also like to thank Logan, who brought me to Charlotte and started me on this journey.

Lastly, I would like to thank the University of North Carolina at Charlotte's counseling program for the opportunities, support, and guidance that the faculty has provided. This faculty has provided me unconditional support and respect that allowed me to believe that one day I too could become a counselor educator.

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CHAPTER 1: INTRODUCTION

Research has established a strong link between the therapeutic working alliance (TWA) and positive outcomes in counseling with adults (Horvath, Del Re, Flückiger, & Symonds, 2011). Early theorists postulated on the importance of the alliance (Freud, 1912; Greenson, 1965; Zetzel, 1956) and research have consistently supported the association between the quality of the alliance and therapeutic outcome (Martin, Garske, & Davis, 2000). The TWA is believed to provide the presence of a trusting relationship for a client who facilitates their participation in the process of therapy (Bordin, 1979). The TWA has been widely accepted in the counseling research community as the common denominator across different types of counseling theories, techniques, and populations, to name a few (Horvath et al., 2011; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

Though research findings also indicate the importance of the therapeutic relationship in counseling young clients (Shirk, Karver, & Brown, 2011), there are significantly fewer publications on the TWA in young clients compared to adult clients. For example, Horvath et al.'s (2011) search of the literature in 2009 revealed over 7,000 articles on the TWA in adults; whereas, Shirk and Karver (2003) only found 23 studies on TWA in youth between 1973 and 2001. Adding to Shirk and Karver's (2003) previous analysis, Shirk, Karver, and Brown (2011) found an additional 13 published studies on TWA involving youth. The present study was designed to contribute to

filling the gap in the literature on the TWA between practitioners and their young clients.

In the following sections, the author will briefly describe the need and significance of the present study. Based on the literature, the author will address the following: (a) the need to study child therapists' work with their young clients, (b) trait-anxiety and TWA, (c) attachment and TWA, and (d) multicultural counseling competence and TWA. The author will also briefly describe the research questions that will guide this study as well as the methodology that will be employed to address these questions.

Background

Child Therapists and Therapeutic Working Alliance

Play therapy is a theoretically sound and empirically validated field that is emerging in importance due to the wide applicability of the therapeutic use of play (Lilly, O'Connor, & Krull, 2012). Play therapy is often used synonymously with therapy provided to children (Gil, 1994). For the purposes of this study, child therapists are defined as licensed or certified counselors or therapists who are using play materials (i.e., toys, puppets, art materials) in their work with young clients between the ages of 7 and 10 years. These individuals may work in settings such as schools and mental health counseling agencies. They do not have to be Registered Play Therapists, however.

In the child therapy literature, it has been widely accepted that the positive emotional bond between therapist and child constitutes a necessary component of effective therapy (Axline, 1947; A. Freud, 1936; Shirk & Saiz, 1992). Kazdin, Siegel, and Bass (1990) further reported a 90% endorsement rate of the therapeutic alliance by

child psychologists and psychiatrists as the most important factor of treatment when working with adolescents and children. In Kazdin et al.'s (1990) study, the therapeutic alliance was rated highest in importance compared to other study variables such as theoretical orientation of therapist, parent and family characteristics, and child characteristics. To my knowledge, very limited research on the factors that affect the formation of TWA in child therapy setting has been published in the literature.

Trait Anxiety and Therapeutic Working Alliance

Trait anxiety refers to the stable personality trait associated with feelings of anxiety, tension, and increased activity of the autonomic nervous system over time (Spielberger, 1972). Individuals high in trait anxiety perceive more situations as threatening and have higher state anxiety (Spielberger, 1972). Authors have argued that trait anxiety of the therapists affect their ratings of the TWA because therapists with higher levels of trait anxiety tend to experience relationships in a negative manner (Chapman, Talbot, Tatman, & Britton, 2009).

Chapman et al.'s (2009) research supports the theorized relationship between trait anxiety and the TWA. Chapman et al. collected data on counselor trainees' personality traits and clients and trainees' ratings of the working alliance in therapy. Trainees higher in neuroticism, a personality trait that is associated with trait anxiety, rated the alliance lower than did trainees with lower levels of neuroticism ($\beta = -0.33, p = 0.017$).

Peers and supervisors had also rated therapists with higher levels of trait anxiety negatively on perceived therapist competence (Bandura, 1956). This research described how anxious therapists struggled in the successful formation of relationships and in the

role of therapist. However, the correlational nature of the study limits the interpretation of causal effect of anxiety on the TWA. Though research has supported the negative relationship between trait anxiety and the TWA, no studies have examined the effects of therapist trait anxiety on the TWA in the context of child therapy. The present study sought to explore the influence of child therapists' trait anxiety on their perceived therapeutic relationship with their young clients.

Attachment and Therapeutic Working Alliance

Attachment refers to the enduring pattern of interaction and relation individuals learned early on (Bowlby, 1988). Such pattern of interaction can be broadly classified as secure or insecure. These patterns are hypothesized to form early in childhood (Bowlby, 1988) and remain stable over time (Mikulincer & Shaver, 2008). Attachment patterns are implicit and are known as internal working models (Bowlby, 1969). These models become people's way for interpreting themselves and others in intimate adult relationships. Generally, those with secure attachment view others and themselves positively in intimate adult relationships, and those with insecure attachment view others and themselves negatively in intimate adult relationships (Bartholomew & Horowitz, 1991).

Attachment researchers in the counseling literature argue that attachment security is positively related to the TWA because these securely attached individuals are presumed to be comfortable with closeness and intimacy (Sauer, Lopez, & Gormley, 2003). Whereas, insecurely attached individuals, who tend to experience "anxiety about separateness, discomfort with closeness, or a combination of these dispositions" (Sauer et al., 2003, p. 372) in close relationships, tend to experience the TWA more negatively

due to their implicit internal working models of others and self. Research findings support the theorized connection between the quality of attachment quality and ratings of TWA. For example, therapists with insecure attachment rated themselves negatively in the formation of a strong working alliance (Black, Hardy, Turpin, & Parry, 2005; Sauer et al., 2005). Black et al. (2005) found that therapists self-rated as secure had a significant moderately positive correlation with a strong working alliance in therapy ($r = .411, p < .001$). Insecurely attached therapists' attachment anxiety and attachment avoidance were respectively significantly and negatively correlated with therapeutic alliance scores. Sauer et al. (2003) found clients rated therapists with insecure-anxious attachment as significantly positive in the formation of a working alliance after the first session, but significantly negative over time.

Attachment theory provides a useful framework for exploring the quality of the therapist-client bond and empirical evidence is beginning to support this notion. Despite the findings on the association between therapists' attachment quality and their working alliance scores with their adult clients, research has yet to explore if similar association is found between therapists and young clients in general, and in the play therapy setting specifically. The present study sought to address this gap in the literature.

Therapist Multicultural Counseling Competence and Therapeutic Working Alliance

Multicultural counseling competence refers to:

A therapist's ability to integrate into his or her theoretical and technical approach to assessment and intervention relevant human diversity factors that are important to the process and successful outcome of therapy. These factors may be relevant to the therapist, client, and/or

the therapy relationship (Fuertes & Ponterotto, 2003, p. 23).

Researchers and theorists in the counseling literature argue that therapists who demonstrate multicultural counseling competence influence the TWA due to their ability to build relationships with a wide variety of clients (Fuertes et al., 2006). This goes back to Sue et al.'s (1982) tripartite model of multicultural competence that proposes that the more knowledgeable, aware, and skillful the counselor is in diversity issues the better the counselor is able to connect with a variety of individuals, not just the ones who are exactly like them.

Recent research has demonstrated the relationship between multicultural competence and the TWA in adult populations. Fuertes et al. (2006) examined multicultural competence and working alliance in 51 therapeutic dyads. Clients' ratings of therapist multicultural competence and their ratings of the working alliance were found to be highly significant ($r = .73, p < .001$), and therapists' multicultural competence and their ratings of the working alliance were found to be significant ($r = .68, p < .001$). In other words, therapist self-rated multicultural competence is closely associated with the working alliance making it an important variable to study (Fuertes et al., 2006). Although the research is limited because of its correlational and cross-sectional design, the association between therapist multicultural competence and the TWA was significant regardless of the racial composition of the therapeutic dyads under study. However, such research has not been replicated with child therapists and their young clients.

Statement of the Problem

Theory and research indicate an important link between the TWA and outcome in both child and adult populations (Horvath et al., 2011; Shirk et al., 2011). Even though there are fewer publications on factors associated with the alliance in youth, one would expect similar results for the alliance is part of most, if not all, theoretical foundations of youth psychotherapy (Axline, 1947; A. Freud, 1936). However, more research is needed to fill the gaps in the literature on the TWA in child therapy settings with therapists in general; particularly those who use play modality.

Researchers have attempted to identify what characteristics and behaviors of therapists help build the element of trust to engage in a successful TWA. Most of the extant research focuses on therapist factors that affect working alliance with adult populations. Such factors include therapist's personal attributes (i.e., confident, warm, and interested) and accurate use of therapeutic techniques (i.e., interpretation, noting past therapy success, and emotional exploration) (see Chapter 2 of this proposal and Ackerman & Hilsenroth, 2001, for a detailed review). Even though the abovementioned reviews exist, Elkin (1999) states that much of the research on therapist variables is secondary to client factors and involves small numbers of therapists. Therefore, more research on therapist factors in child therapy is needed to further shed light on the formation of the TWA in child therapy. Among many psychological variables, trait anxiety, attachment quality, and multicultural counseling competence have been found to relate to the TWA in the adult therapy. A recent literature search conducted in February 2013 using various databases (i.e., Google Scholar, PsycINFO, Academic Search Complete, ERIC, PsychARTICLES, Social Work Abstracts, and MEDLINE)

did not revealed any studies that had examined the abovementioned variables in the context of child therapy. As such the present study was designed to address the gaps in the literature by investigating the associations of these factors with child therapists' perception of their working alliance with their young clients in play settings.

Significance of the Study

The present study is believed to be significant to the research, training, and practice of counseling in general and play modality in particular. Based on the results of my recent search of the literature, the present study may be the first of its kind in the counseling literature that would provide empirical data to shed light on the influences of the abovementioned predictor variables on child therapists' perceived TWA with their young clients. The study is believed to contribute to the body of knowledge concerning the TWA and extend the generalizability of extant findings on the TWA that are mainly based on therapists and their adult clients.

I believe the data will help child therapists who use play to examine the impact of their psychological variables on their work with young clients. Specifically, such findings can be used to guide child therapists to increase their self-awareness on the impact of their trait anxiety, attachment quality, and multicultural counseling on their work with young clients.

The data is also believed to provide an empirical evidence for counselor educators and supervisors to inform their training of counselors in working with young clients in play therapy setting. Based on the findings, counseling trainers can develop training curriculum that will help trainees examine and address their relationship with

their clients as it relates to their attachment security, trait anxiety, and multicultural competence.

Overview of Methodology

A correlational cross-sectional design was used in this study. I received permission to conduct the study from the Institutional Review Board (IRB) of University of North Carolina at Charlotte (UNCC). Data was collected via a web-based survey consisting of four instruments and a short demographic questionnaire. Participants were recruited nationally from among the Association for Play Therapy (APT), the American School Counseling Association (ASCA), and the American Association for Marriage and Family (AAMFT). Additional participants were also recruited from the following listservs: CESNET-L, North Carolina Psychological Association (NCPA), Counsgrad, and UNCC's Department of Social Work Alumni and field instructors and therapists that attended UNCC Multicultural Play Therapy Conference. A zero-order correlation was used to analyze the relationships among the study variables and a hierarchical linear regression was used to examine the contributions of the predictor variables (i.e., trait anxiety, attachment-related anxiety and avoidance, and multicultural counseling competence) to the variance of the TWA, the outcome variable. Experience of the therapist, dyadic gender make-up, and dyadic ethnicity make-up were controlled for in this research due to possible confounding effects. A detailed explanation of the methodology is included in Chapter 3.

Research Questions

The present study sought to examine the associations of attachment quality, trait anxiety, and therapist multicultural counseling competence with child therapists' self-

perceived TWA with their young clients. The present study specifically addressed the following questions:

1. What are the relationships among child therapist trait anxiety, child therapist attachment-related anxiety, child therapist attachment-related avoidance, child therapist multicultural counseling competence, and child therapist-perceived TWA?
2. To what extent does child therapist trait anxiety predict therapist-perceived TWA after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?
3. To what extent do therapist attachment-related anxiety and attachment-related avoidance predict therapist-perceived TWA beyond the effect of therapist trait anxiety after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?
4. To what extent does therapist multicultural competence predict therapist-perceived TWA beyond the effects of therapist trait anxiety, attachment-related anxiety, and attachment-related avoidance after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?

Assumptions of the Study

The following assumptions were made concerning the implementation of this research:

1. Participants would be able to understand the study instruments.
2. Attachment orientation, trait anxiety, multicultural counseling competence, and working alliance could all be measured by self-report measures.
3. Participants would respond honestly to the instruments.

4. The instruments were valid and reliable.

Delimitations of the Study

Delimitations of the study included the following:

1. Data were based on self-report instruments.
2. Data were based on abovementioned definition of child therapists using play.
3. Research was conducted in the United States of America (US).
4. Data were based on correlational and cross-sectional research design.
5. The age range of the child clients of the participating therapists was between 7 and 10 years old.

Limitations of the Study

Several limitations were expected to impact the generalizability of the present study. First, recruiting from members of counseling related organizations resulted in a non-representative sample because not all counselors and therapists who are working with young clients are members of these organizations. Second, methodological issues related to common methods would impact the results of the study because it relied on self-report measures. Third, other sources of data such as observational data and clients' perception of their working alliance with their therapists were not be used; hence, the findings of this study were limited to therapist self-perception, which might have been influenced by social desirability. Fourth, because of the delimited age range of the child clients, the findings of the present study may not be generalized to therapeutic settings involving younger and/or older youth clients. Fifth, because of the focus of the present study on play modality, the findings may not be generalizable to therapy settings in which the therapists do not use play as a treatment modality. Sixth, the generalizability

of the findings of this study to other non-U.S. settings is limited. Finally, causal relationships among predictor variables and outcome variable cannot be established because of the correlational and cross-sectional nature of the study.

Definitions

For the purposes of the present study, child therapists' trait anxiety is measured by the trait scale of the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983), child therapists' attachment-related anxiety and attachment-related avoidance is measured by Experiences in Close Relationships Scale-Short Form (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007), child therapists' multicultural cultural competence is measured by Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), and child therapists' perceived TWA is measured by the therapist version of the Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992).

Because existing literature indicates that therapists' experience level, therapeutic dyad's gender make-up, and ethnicity make-up may affect the quality of the TWA (Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009; Hersoug, Høglend, Monsen, & Havik, 2001; Wintersteen, Menniger, & Diamond, 2005), these variables were held constant in this study to control for their possible confounding effects. The influence of trait anxiety was investigated first before the influence of attachment anxiety and avoidance because trait anxiety is considered an innate personality variable (Spielberger, 1966) and attachment variables are believed to be developed as a result of interactions with attachment figures after birth (Bowlby, 1969). The influence of

multicultural counseling competence was assessed last because it is believed to be developed as a result of professional training and practice (Sue et al., 1982).

This section provides definitions of variables in the present study.

Therapeutic Working Alliance

TWA refers to the perspective of the therapist's affective orientation towards the therapeutic relationship. Important to note is that the term TWA is interchangeably referred to in this paper as the therapeutic alliance, therapeutic relationship, or the working alliance.

Child Therapist

A child therapist in this study is defined as a licensed or certified counselor or therapist who is using play materials (i.e., toys, puppets, art materials) in his or her work with young clients between the ages of 7 and 10 years. These individuals may work in settings such as schools and mental health counseling agencies.

Trait Anxiety

Trait anxiety is defined as how anxious someone generally feels over time. It is suggested to be a stable trait in individuals (Spielberger, 1972).

Attachment Quality

Attachment quality is defined by how someone generally experiences themselves and others in intimate relationships, broadly defined as secure or insecure (Bartholomew & Horowitz, 1991). Attachment-related anxiety is defined by an individual who is fearful of rejection or abandonment in intimate relationships, requires constant need for approval from others, and experiences distress when his or her partner is unavailable or not responsive. It is also known as insecure preoccupied style of adult

attachment. Attachment-related avoidance is defined by an individual who is fearful of dependence on others in intimate relationships, and aspires to be self-reliant. It is also known as having an insecure avoidant style of adult attachment. A person who experiences both attachment-related anxiety and avoidance in intimate relationships is considered having an insecure fearful style of adult attachment. A secure style of adult attachment is defined as comfortable with closeness, intimacy, and depending on others in intimate relationships (Wei et al., 2007).

Multicultural Counseling Competence

Multicultural counseling competence is defined as therapists' cross-cultural competence skill level. Therapists are able to demonstrate culturally appropriate interventions based on cross-cultural counseling skill, sociopolitical awareness, and cultural sensitivity in sessions for all clients (LaFromboise et al., 1991).

Conclusion

The introduction briefly describes the purpose and goals of the present study as well as outlining the methodology that is used to address the research questions. The study sought to contribute to the counseling literature by examining the influences of child therapists' trait anxiety, attachment quality, and multicultural counseling competence on their perceived working alliance with their young clients. The study employed stepwise linear regression to analyze the unique contribution of the four study variables to the variance in the therapist-perceived TWA.

Organization of the Dissertation

Chapter 1 introduced the problem, described the background and significance of the present study, and presented the research purpose and questions. Chapter 2 is a

review of literature on the variables in the current research. The research variables include TWA, trait anxiety, attachment quality, and multicultural counseling competence. Chapter 3 provides information on the methodology related to procedures, research participants, data collection, and data analysis. Chapter 4 provides the results of the data and Chapter 5 describes implications of the research results.

CHAPTER 2: REVIEW OF THE RELATED LITERATURE

The present study sought to explore the relationships among child therapists' trait anxiety, attachment quality, multicultural counseling competence, and perceived therapeutic working alliance (TWA). The following review of the literature is divided into several sections focusing on the historical significance and relevant research on the study variables and their interrelations. The first section addresses child therapy, including an overview of the history and development of child mental health therapy. The second section addresses the TWA, including an outline of its history, measurement, and related empirical research in counseling and psychotherapy. The third section discusses trait anxiety and its associations with the TWA. The fourth section discusses attachment theory and its associations with the TWA. The fifth section addresses multicultural counseling competence of counselors and therapists and its relationships with the TWA. The literature review will conclude with a summary. Discussions relevant to child therapists who use play material with young clients will be included throughout the chapter.

Child Therapy and Play Modality

The TWA is an important variable when working with children as well as adults. Similar to the adult literature, the working alliance has been linked to therapeutic outcomes in the most recent meta-review on the subject (Shirk, Karver, & Brown, 2011). The following sections will elaborate on the history and importance of child

therapy, empirical evidence on working alliance with children, and the gaps in factors contributing to the TWA with children.

History of Child Therapy and Play Modality

One particular approach that has been recognized in the field of child and adolescent therapy is the use of toys in the therapy room. The differences between treating children and adults in therapy were recognized when psychoanalysts ran into the problem of trying to get a child to free associate in therapy (Dorfman, 1951). Anna Freud (1936) used children's play to build the relationship in therapy and gain access to the child's inner world. A. Freud described children as "not inclined to enter in free association," and that the "toy environment is manageable and amendable to the child's will" (p. 28).

Another seminal therapist in the psychoanalytic tradition, Melanie Klein (1969), described children using toys and games as an expression of fantasies, wishes, and actual experiences. Klein interpreted those expressions from the child's play. Both A. Freud and Klein developed their work with children based on the developmental psychodynamic theories of Sigmund Freud (Dorfman, 1951). However, A. Freud 1936 was critical toward Klein's use of interpretation of the child's play activities. Instead, A. Freud suggested that play should be used as a medium to build the relationship in therapy between the analyst and the child rather than being used as material for interpretation and analysis.

The second movement in the use of toys with children in therapy was called release therapy and was the work of David Levy (1938). Children were encouraged to interact with select toys to reenact experiences of traumatic events. The third movement

was relationship therapy with children and focused on the curative power of the relationship when working with children (Landreth, 2002).

The relationship therapy movement evolved into nondirective play therapy. Virginia Axline is considered a pioneer in nondirective play therapy with her 1964 publication of *Dibs: In Search of Self* that chronicled Axline's play therapy treatment of a young boy in which she clearly supported the benefit and desirability of nondirective play therapy. Axline (1947) described play as the natural medium of communication for children. She believed that children had the ability to work through emotional problems in therapy with the play materials provided, as long as the child felt the unconditional acceptance of the therapist.

Besides the nondirective approach to play therapy, directive therapies have also incorporated the use of toys when working with child clients. Examples of directive play therapy include behavior and Gestalt therapies. Gil (1994) best explains the primary difference between directive and nondirective play therapy: "A nondirective therapist might provide the child with ample opportunities for art work, or to tell stories with puppets, whereas a directive therapist might ask the child to draw specific things, or tell an exact story" (p. 13).

The nondirective and directive approaches to play therapy and use of toys in the therapy room with children have grown exponentially in the 1980s and 1990s due to various theorists and practitioners applying various theories and frameworks to play therapy (Bratton, Ray, Rhine, & Jones, 2005). The Association for Play Therapy (APT) was established in 1982 and was instrumental in establishing play therapy as a professional intervention for children in the mental health field. According to the APT's

(<http://a4pt.org>; 2012) website, there are currently over 5,700 members. There are also countless other professionals who incorporate toys in the therapy with their young clients. This current research is relevant and important for counselor educators, supervisors, and practitioners who are working with children using play.

The Efficacy of Child Therapy with Toys

As the practice of play therapy grew in recent decades, so has research attention on its efficacy. According to the most recent meta-review conducted by Bratton et al. (2005), play therapy was found to have a large treatment effect size across research. Bratton et al. calculated a weighted effect size based on treatment-control sample for each of the 93 articles included in the review. The average effect size was 0.80. Based on Cohen's (1988) guide for interpreting effect size, 0.80 is indicative of large overall treatment effects.

Bratton et al. (2005) in their review examined four possible treatment characteristics that might have impacted the overall treatment effectiveness of the 93 studies reviewed. Important to this review was the first treatment characteristic, "the type of therapy or theoretical model" (p. 380). Studies with sufficient description ($n = 85$) were coded into two broad categories: humanistic-nondirective or nonhumanistic-directive. Humanistic interventions were found to have a large effect size ($d = 0.92$), and nonhumanistic moderate effect size ($d = 0.71$). Even though statistically significant ($p < 0.03$), these results should be interpreted with caution due to the large difference between the number of humanistic studies ($n = 73$) and the number of nonhumanistic studies ($n = 12$).

Other reviews on the subject of play therapy and child psychotherapy efficacy indicate moderate to large treatment effect size (Karver, Handelsman, Fields, & Bickman, 2006; LeBlanc & Ritchie, 2001). Outcome research in the field of child psychotherapy is producing the same results as outcome research in adult psychotherapy. Similar to adult research, a major part of outcome research in child psychotherapy is directed at the importance of the TWA. The literature focuses on the efficacy of the TWA, but there is a dearth of research on what mechanisms influence the TWA. To my knowledge, no studies have looked at variables that influence child therapists who use toys to form an effective TWA in general; and no studies have specifically looked at the relationships among trait anxiety, attachment quality, multicultural counseling competence, and the TWA in play settings.

Therapeutic Working Alliance

The TWA is an important variable in counseling and psychotherapy and was included in the primary writings of the history of therapy (Freud, 1913). A positive alliance is found to relate to positive client outcomes across both child and adult populations (Horvath, Del Re, Flückiger, & Symonds, 2011; Shirk et al., 2011). The TWA is understood to affect counseling outcome because the intimate bond between counselor and client is believed to facilitate treatment outcome (Horvath et al., 2011). Recent neuroscience research has further supported the effects of a therapeutic relationship in providing an environment that instills optimism and hope that results in a positive relationship that facilitates the development of neural pathways that are related to treatment outcomes (Cozolino, 2010). Research has also indicated that specific therapist characteristics and therapeutic techniques are related to the quality of the

alliance formed between therapists and clients in therapy (Ackerman & Hilsenroth, 2001; 2003). The following section will elaborate on the history, definition, and measurement of the TWA.

History and Definition

Since the early writings of psychotherapy, the TWA has been considered a critical component to the working and success of psychotherapy. Freud (1913) discussed the importance of the bond between therapist and client in the process of psychoanalysis, calling the relationship transference neurosis in which the client projected unresolved issues onto the analyst. As treatment in psychotherapy evolved, so did the psychodynamic understanding of the working relationship between analyst and patient. The term transference neurosis shortened to transference, an unconscious process in therapy representative of resistance, and the working alliance became synonymous with the ability of a client to connect with the therapist (Greenson, 1965). In 1956, Zetzel was the first to formally articulate the helping relationship in terms of the therapeutic alliance. Her critique of the psychoanalytical definition based on the differences of interpretation of the therapeutic bond of object relations and child therapists provided the platform for Bordin (1979) to discuss the working alliance in ways not allied with any one psychological theory or technique.

Bordin (1979) described the importance of a strong therapeutic alliance as central to the effectiveness of any kind of therapy and operationalized the working alliance into bond, tasks, and goals. Bordin theorized the strength of the alliance to be a major factor of change in therapy. The strength of the alliance is hypothesized to be directly proportional to how well the therapist and client work with each other in

response to the demands of the working alliance contingent on meshing of personal characteristics. Emphasis is on collaboration and consensus through a mutual trust. In other words, if the client trusts the therapist, it is hypothesized they will be more likely to engage in therapeutic process.

Bordin (1979) introduced the working alliance as a generalizable, universal, and measurable function of therapy that is applicable to any and “all change situations” (p. 252). In order for the establishment of the TWA, there first must be a bond that facilitates the agreement on goals and tasks that are measurable in the therapeutic relationship. Goals are “prior bargains” (p. 253) that the patient enters treatment with, and is mutually agreed on by both client and therapist in the client’s treatment. Tasks involve “concrete exchanges” (p. 254) assigned to both the therapist and client. An example from the psychoanalytic tradition of therapy is the use of free association. Bordin described the rules of introduction on the part of the analyst and the resulting feedback a patient must provide as a task in therapy. The most important measurable part of the TWA is the bond between therapist and client, or the basic level of trust that must form for any therapeutic work to be accomplished (Bordin, 1979). When there is trust between client and therapist, the client will be able to engage in the therapeutic process.

Measurement

The movement towards measuring and operationalizing the TWA came from the deduction that all psychotherapy treatments can have a beneficial effect (Horvath & Greenberg, 1994). The common denominator among all instruments is the measurement of the intimate relationship between counselor and client. Researchers theorized that the

relationship must be present for the client to engage in the therapeutic process (Bordin, 1979; Gomes-Schwartz, 1978; Marmar, Weiss, & Gaston, 1989).

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was created in reference to Bordin's (1979) generic conceptualization of the TWA. Horvath and Greenberg (1989) argued that the assessment of the relationship in therapy "must be independent of the counselor's theoretical orientation, yet it must be based on a clear statement of the working alliance's constituents and the alliance's function within the helping process" (p. 225). Therefore, the alliance can be understood in terms of three subscales: *Bond*, *Tasks*, and *Goals*. The researcher who uses the WAI has the option to review a combined overall score of the working alliance, or three possible subscales from the client and/or counselor perspective.

The WAI (Horvath & Greenberg, 1989) can be used for therapist self-report as well as client report of the alliance in therapy. Horvath and Greenberg (1989) also created an observer-rating version of the WAI. Subsequently, Symonds and Horvath (2004) developed a couple's version of the WAI to assess couples counseling relationship. An adolescent version of the WAI was created by changing the reading level to be appropriate for a younger audience, but it was found inappropriate for use for younger clients in a factor analytic study that found no support for younger clients in the three content areas in the adult WAI (DiGiuseppe, Linscott, & Jilton, 1996).

The WAI is widely used in research on adult client populations. For example, in Martin et al.'s (2000) meta-analysis of the TWA and outcome in psychotherapy, the WAI was noted to be the most frequently used measure among the 79 studies that met inclusion criteria, followed by the California Therapeutic Alliance Rating System

(CALTRAS/CALPAS; Marmar et al., 1989). While the WAI presents itself as transtheoretical with a focus on tasks, goals, and bond, the CALPAS attempts to capture the “affective and attitudinal” aspect of the alliance (Marmar et al., 1989, p. 46).

The CALPAS is intended to be rated by clinical judges on four dimensions of therapist and client emotional aspects of the TWA, as opposed to specific therapeutic techniques (Marmar et al., 1989). The four dimensions include therapist positive contribution, therapist negative contribution, client positive contribution, and client negative contribution. Outside observers, or judges, evaluate the clinical relationship using the CALPAS. An assessment manual provides the operational definition of each dimension and scoring guidelines.

In the most recent empirical review of the TWA measures, Elvins and Green (2008) identified the Vanderbilt Psychotherapy Process Scale (VPPS; Gomes-Schwartz, 1978), the CALPAS, and the WAI as the three measures that have shown the strongest association between outcome and alliance across different types of treatment modalities and patient groups. The VPPS was a by-product of the Vanderbilt Psychotherapy Project (O’Malley, Suh, & Strupp, 1983). The study was designed as a systematic way of comparing trained therapists to college professors chosen for their ability to form empathic relationships with college students.

Gomes-Schwartz (1978) initiated the development of the VPPS based on the commonly believed factors of therapeutic change: “exploratory processes, the quality of the therapist-offered relationship, and the degree of the patient’s involvement in therapy” (O’Malley et al., 1983, p. 582). The therapist-offered relationship is based on early counseling theorist Carl Rogers’ (1951) prescriptions of what constitutes the

active components of a therapeutic relationship, which are warmth, unconditional positive regard, and empathy. Originally, uninvolved clinical judges rated the alliance based on a training manual on three domains: client characteristics, therapist characteristics, and interactions of client and therapist related to outcomes (O'Malley et al., 1983). In the development of the VPPS, it was found that patient involvement was the best predictor of outcome. Other research indicates that Rogerian therapist-offered conditions are not good indicators of the TWA because client perceptions of the therapist as an empathic individual, instead of therapist behaviors, have been linked to outcomes instead (Horvath & Luborsky, 1993). The VPPS has also been criticized in the literature due to its focus on patient and patient-therapist aspects of the instrument, rather than therapist influence (Elvins & Green, 2008).

All of the above-mentioned instruments require external raters of the alliance or subjective therapist and client ratings of the alliance during treatment. Elvins and Green (2008) cite methodological problems with these methods of measurement, namely, rater and method confounds, criterion validity, third factor confounds, therapist versus patient effects, psychometric properties, construct validity, and prediction of therapy effects. Important to the present research is what factors contribute to the therapists' perception to create a trusting environment for the TWA to be established.

Recent research on the topic has indicated that therapist ability to form an alliance is indeed worth investigating through instrumentation (Baldwin, Wampold, & Imel, 2007). In an investigation of between and within therapist and patient ratings of the WAI and outcomes, Baldwin et al. (2007) reported that regardless of client variability, the strongest predictor of outcome was therapist ability to form an alliance.

Ackerman and Hilsenroth (2003) provided a review of therapist characteristics and techniques that were related to positive TWA, including characteristics such as being flexible, honest, respectful, and trustworthy. Techniques included being reflective, supportive, noting past therapy success, and providing accurate interpretations. Therapists, in general, vary in the frequency of use of those characteristics and techniques, which might be a reason for the results in Baldwin et al.'s (2007) study discussed in the previous paragraph.

While some researchers have modified adult measures of the working alliance for children and adolescents, only a few measures are appropriate for use with children (Elvin & Green, 2008). Due to the developmental and conceptual differences between child and adult populations and respective working alliances (DiGiuseppe et al., 1996), researchers need to use measures specific to this population. The following section will describe the TWA scales for children in research.

Measurement of TWA with Children. There is very limited research on measures of therapeutic alliance with children. Meta-reviews on the subject (Shirk, Karver, & Brown, 2011; Shirk & Karver, 2003) highlight the limited amount of published research that used empirically validate alliance measure. Another problem found in the meta-reviews was an inability to generalize to specific populations due to the lack of separation in the different types of populations and respective instruments (e.g., child, adolescent, or family) reported in the studies.

Two trends have been found in measuring the TWA in children and adolescents: (a) instruments designed for the specific population and (b) instruments adapted from existing adult working alliance inventories (Elvins & Green, 2008). Because of the

differences in the conceptualization of the alliance when working with children compared to working with adults, Elvins and Green (2008) focused on the first trend. These authors highlighted two instruments: the Family Engagement Questionnaire (FEQ; Kroll & Green, 1997) and the Therapeutic Alliance Scales for Children (TASC; Shirk & Saiz, 1992).

The current research used the TASC. Developed by Shirk and Saiz (1992), this instrument is used to assess child therapists' self-report TWA. The affective component of the bond with play therapists and children has been commented on in the literature as both necessary and sufficient (Axline, 1947). Shirk and Saiz describe using Bordin's (1979) multifaceted concept of the alliance and empirical experience of child clinicians to create the instrument. The developers maintained that a positive bond between the child and the therapist would result in collaboration in the tasks of therapy. They, therefore, focused on capturing the affective component in therapy with children. This aligns with Bordin's transtheoretical notion of alliance, which asserts, "the affective quality of the therapy relationship is relevant to most forms and contexts of treatment" (p. 718).

In Shirk and Saiz's (1992) initial study, split-half reliability of the instrument and intercorrelations among the alliance subscales were computed. Two subscales, *Bond* and *Negativity*, were identified as the affective orientation to therapy. Cronbach's alpha for therapist and child ratings of the TASC were .88 and .72 respectively for the bond subscale, and .72 and .74 respectively for the negativity subscale. There was evidence for convergent validity between therapists' and clients' ratings of the affective subscales of bond and negativity. The correlation between therapist rating of the bond

and child rating of bond in therapy was $.42$ ($p < .001$). The correlation between therapist rating of negativity and child rating of negativity was $.37$ ($p < .01$). There was also an inverse significant relationship between child-rated measures of bond and negativity, $r = -0.57$, $p < .001$. Therapist ratings of bond and negativity were correlated with another measure used to assess therapist's report of child client's overall participation in therapy, $r = .57$, $p < .001$; $r = -.28$, $p < .05$, respectively. A third subscale, *Verbalization*, was identified as the collaboration on the therapeutic task of talking about problems. The third subscale, while reliable was not valid (Shirk & Saiz, 1992).

Based on the above review of the literature, it appears that while adult counseling research has clearly defined instruments to measure the construct of the alliance, child and adolescent research has yet to unite on a single construct of the alliance (Elvins & Green, 2008). Empirical evidence suggests the alliance with a child in therapy is different from the alliance with an adult therapy. The alliance in adult therapy can be measured in three components of bond, tasks, and goals (Horvath & Greenberg, 1989), while the alliance in child therapy is more reflective of one relationship construct (Shirk & Saiz, 1992). Instruments that have attempted to capture the alliance with children describe the TWA as a single construct, the bond in therapy. For the purposes of the current research, the TASC (Shirk & Saiz, 1992) was used due to its established psychometric properties of the affective component of the alliance in the population of interest.

The following section will evaluate the research on variables that effect the formation of the TWA in therapists who work with adults and children. The review will

cover research on the variables that influence the therapist's ability to build appropriate levels of trust for the formation of the bond in therapy. The section will elaborate on therapist contributions, demographic variables, and variables of interest to the current research.

Variables Effecting the Formation of the TWA

The quality of the TWA has consistently proven to relate to positive outcomes in counseling with adults (Horvath et al., 2011; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000). Early alliance theorists hypothesized that a positive alliance is essential for success (Greenson, 1965). Other researchers have identified the TWA as the common denominator across different types of effective therapies. For example, Horvath and Symonds (1991) found that the alliance was related to outcome across theoretical orientations using a variety of instruments.

Horvath et al. (2011) examined 190 articles in the most recent meta-review of the adult literature on the topic. Criteria of the meta-analysis required all studies considered to have "five or more adult patients participated in the study" (p. 12). Due to the moderate presence of heterogeneity ($I^2 = .56$), the authors investigated the impact of six categorical variables on the alliance: alliance measure, alliance rater, time of alliance assessment, outcome measure, type of treatment, and publication source. The overall aggregate effect size for the alliance-outcome measure for all articles reviewed was $r = .275$. In addition, none of the moderator variables had an effect on alliance-outcome correlations ($p < .001$). Thus, positive alliances are indicated to be related to positive outcomes in psychotherapy with adults.

Research supports the importance of the therapeutic relationship for positive treatment outcome for children as well (e.g., Axline, 1946; Landreth, 2002). Meta-reviews on the subject concluded that the working alliance is a moderate predictor of treatment outcome for children and adolescents (Shirk & Karver, 2003; Shirk et al., 2011). An overwhelming majority of child therapists – 90% of 1,100 who participated in a large-scale study – agreed that the TWA is the most important when working with child clients (Kazdin, Siegel, & Bass, 1990). Kazdin et al., 1990 did not theorize on the connection, possibly because the article was intended to identify priority areas of research with children and adolescents and the influence of working alliance on outcome is a consistent theme across the counseling research.

Though existing research provides a strong argument supporting the positive impact the alliance on therapeutic outcomes with children and adults (Horvath et al., 2011; Shirk et al., 2011), there remain gaps in the literature on which measurable therapist characteristics and behaviors definitively affect the formation of the bond in therapy (Elvins & Green, 2008). Based on research findings, Baldwin et al. (2007) contend that therapist variability in alliance measures, over client variability, is indicative of therapy outcome, making it an important domain to explore.

Baldwin et al. (2007) estimated therapist variability by calculating a grand mean of client-rated WAI and comparing the average WAI of each therapist ($N = 80$). Therapists were rated on average by four clients, from a caseload ranging from 2 to 18 clients. In a multilevel model examination of the data, patients of therapists with average scores of WAI one standard deviation above or below the grand mean had outcome scores approximately six points higher or lower respectively than average-

rated therapists did on the WAI. The research indicates that therapists, as rated by their clients, who had above-average or below-average WAI scores, had clients who had different outcome scores, pointing to a significant association between therapy outcome and the TWA.

Strupp (1960) was among the first to question the role the therapist played in the formation of the TWA by remarking on the lack of literature on personality features and technical skills of a good therapist. Strupp recognized that therapist qualities and behaviors must be reflective of a therapist who genuinely cares about his or her client. The factors that potentially influence this ability to convey genuine care to the child client in therapy is at the center of the present research. The following section will focus on therapist factors that contribute to the formation and quality of the TWA.

Following Beutler, Machado, and Neufeldt's (1994) categorization of domains of variables that impact the quality of the TWA, I will discuss the empirical research related to the TWA. The domains are:

1. *Observable traits* are characteristics include elements that can be checked, observed, and verified through means other than therapist self-report. Examples of these traits include age, sex, and ethnicity.
2. *Latent traits* are internal mechanisms related to personality and relationship quality. Also known as extra-therapy traits, these are enduring patterns that are not necessarily a major part of therapy, but by the nature of traits, are in concurrence with the therapist's essence. Examples of these are therapist personality patterns.

3. *Latent states* refer to variables that are primarily relied on internal self-report mechanisms that are specific to the therapy process. An example of this is multicultural counseling competence of therapists.

4. *Observable states* are also known as therapy-specific characteristics that are states specific to the therapeutic process. Examples of these include therapist training, experience, and skills specific in relation to the establishment of TWA.

Observable Traits

Much research has investigated the effects of therapists and clients' observable demographic variables on the TWA (Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009; Hersoug, Høglend, Monsen, & Havik, 2001). It is beyond the scope of this paper to review all the observable traits of therapists and clients that influence TWA ratings. Therefore, this section will focus on empirical research related to traits: (a) experience level of therapist, (b) gender composition of therapeutic dyads, and (c) ethnicity composition of therapeutic dyads.

Therapist Experience and TWA

Findings on the effects of therapist experience on client and therapist ratings of WAI are mixed. In Mallinckrodt and Nelson's (1991) examination of training level and alliance, counselor trainees with more experience, average three years out of a doctoral training program, had higher ratings on the tasks and goals subscales of the WAI as rated by both therapist and client. Contrary to Mallinckrodt and Nelson's results, Dunkle and Friedlander (1996) reported client-rated total alliance, client-rated task, bond, or goal of the WAI were not related to therapist experience. In Hersoug et al.'s (2001) examination of therapist variables and alliance, therapists with more years of

clinical practice were rated significantly lower by patients on early alliance ratings ($r = -.13, p < .05$). In short-term clients, there was a small negative correlation between years of experience and alliance ratings (Hersoug et al., 2001), but with clients who had varying length of service there was no significance (Hersoug et al., 2009); however, a trend was found among more years of experience and lower therapist ratings of the alliance over long-term therapy.

The results are mixed despite using the same instrument to measure TWA across the research in therapist experience. Hersoug et al. (2001) and Hersoug et al. (2009) used a single total score from the WAI, Mallinckrodt and Nelson (1991) chose to report the subscales from the WAI, and Dunkle and Friedlander (1996) chose to report total and subscales from the WAI. A critical weakness in Mallinckrodt and Nelson's report was assessing the WAI immediately after the initial intake session. Because it takes more than one session to form an alliance, this might not have provided a good assessment on the TWA. Horvath and Greenberg (1989) reported that while the WAI has been shown to be reliable in the early working alliance, it is recommended to be used after the third session.

Mallinckrodt and Nelson's (1991) examination was also limited by a small sample of experienced therapists ($N = 8$). Compared to the other articles on experience level of therapists, their results were hard to interpret and generalize. However, with larger samples of more experienced therapists, Hersoug et al. (2009) ($N = 61$, average years of experience = 9.8) and Hersoug et al. (2001) ($N = 59$, average years of experience = 10.1 years) were able to find a trend indicating therapists with more experience self-rated and were rated by clients lower over time in alliance scores. But

with similar average years of experience (i.e., 8.99 years) in 73 therapists, Dunkle and Friedlander (1996) reported therapist experience having no effect on client ratings of WAI.

All of the abovementioned studies used adults as client sample. In an adolescent sample, therapists with less years of experience self-reported higher scores on the WAI and were rated higher by the adolescent sample than therapists with more years of experience (Wintersteen, Menniger, & Diamond, 2005). However, inferences from this research was problematic due to the small sample size of therapists ($N = 14$). An interesting finding in the study was that bachelor's-level clinicians ($N = 3$), though very limited in number, reported highest ratings of the alliance.

It appears that inconsistencies in the findings related to children clients may be sample specific or due to methodological issues such as sample size. In addition, for children, it has been established that the TWA is more representative of the bond component of the alliance (Shirk & Saiz, 1992) and research has yet to investigate the influence of years of experience exclusively on the bond ratings of the TWA. There is, therefore, the need to further investigate the effects of therapists' length of experience on the TWA.

Gender and TWA

Findings on gender effects on the TWA are mixed and not simplistic. Among the research on adult clients and therapists, gender had been found to not influence the TWA (Dunkle & Friedlander, 1996; Hersoug et al., 2009; Hersoug et al., 2001). However, in the youth literature, matched gender of the client/counselor dyad had been found to impact the therapeutic processes. For example, in Wintersteen et al.'s (2005)

examination of gender matching among adolescent substance abusers and their therapists, matched gender pairs reported higher alliance scores as rated by clients but not by therapists. In further examination of the data, adolescent girls matched with female therapists reported significantly higher alliance ratings than male-matched therapeutic dyads. Problems with interpretations of this information include adolescent girls rating the alliance higher overall among gender-matched and gender-mismatched dyads. In fact, Wintersteen et al. reported that there was no significance among adolescent girls' ratings of the alliance and gender of their counselors. In addition, interpretation of this finding is hampered by the small therapist sample size, which was only 14. Although Wintersteen et al.'s findings suggest the need to consider the gender make-up of the therapeutic dyad when examining the TWA among adolescents, generalization of such findings among children in therapy has yet to be investigated.

Ethnicity and TWA

Few studies have directly examined the association between therapist-client racial make-up and the TWA in adult populations, but extant findings do indicate significant association. For example, Walling, Suvak, Howard, Taft, and Murphy (2012) examined whether client race/ethnicity affected ratings of the TWA over time. Half of the sample identified as Caucasian and half as minority clients, the majority of which and approximately 40% identified as African American. The Caucasian clients reported significant increases in alliance ratings over time, but the minority clients did not. In 2007, Constantine examined 40 African American clients' relationships with Caucasian therapists indirectly by measuring client ratings of perceived microaggressions, working alliance, general counselor competency, and multicultural competency of the therapist.

Results showed that greater perceived microaggressions predicted weaker alliance ratings, which in turn, resulted in lower ratings of general and multicultural competence of counselors.

Wintersteen et al. (2005) reported similar results among adolescent clients with primarily Caucasian therapists. Race matching in the predominantly Caucasian adolescent sample, approximately 60%, did not contribute to an early client-reported alliance; whereas, therapists reported that it did on their perception of the alliance. Matched or mismatched majority or minority race was not concluded to have an impact on adolescent's view of the alliance.

Summary. Observed traits in terms of years of experience as a therapist, therapist gender, therapist ethnicity, and compositional make-up of therapeutic dyads were reviewed. Though in the abovementioned research the WAI was used in every article, the influences of these variables on the TWA were inconsistent. However, some of the research findings were limited by small sample sizes and methodological issues. Due to the mixed results and lack of conclusive evidence in the abovementioned areas, the present study held these variables constant to control for possible confounding variables.

Latent Traits

Latent traits are enduring patterns of personality and belief systems. Information on these traits is primarily relied on self-report. In Beutler, Machado, and Neufeldt's (1994) examination of therapist variables and therapeutic outcome, they named personality and coping patterns, and emotional well-being as possible variables of interest in this domain. They cited the lack of research on subjective therapist traits. In a

follow-up examination of the literature a decade later, Beutler et al. (2004) noted a decreasing trend in research on therapist personality traits and therapeutic outcome due to the measurement overlap among personality dimensions and inability of correlational research to provide causal inference. However, other researchers have begun to identify the possible benefits of similarity and complementarity personality characteristics of client and counselor on therapeutic processes (Beutler et al., 2004), and only a few studies have examined the effects of therapist personality traits on working alliance, making the present research important.

Emotional well-being of therapists has been linked to therapeutic processes. For example, in Beutler et al.'s (1994) review of the research, it was reported that "level of personal distress, aspects of self-confidence, severity of symptomology, and strength of self-confidence have all served as indices of therapist well-being and adjustment in studies of therapist efficacy" (p. 238). In further examination of the data with youth clients, it was found that adolescent clients with healthy self-esteem lost self-confidence when treated by therapists with low self-esteem (Wiggins & Giles, 1984). However, the research in this area is limited (Beutler et al., 1994).

It is beyond the scope of this paper to review thoroughly all the personality traits and belief systems of therapists and clients that influence TWA ratings. Trait anxiety and attachment are two inferred traits that are relevant to the present study, a more detailed review and discussion on these traits and the TWA will be addressed in later sections.

Latent States

Latent states are self-report internal mechanisms that are specific to therapeutic processes, for example, therapist theoretical beliefs and orientation. These variables are important to the formation of the TWA as different theoretical orientations place different emphasis on the importance of the TWA. For example, person-centered theory purports the TWA is necessary and sufficient for change to occur (Rogers, 1951), while cognitive therapy does not place as much emphasis on the relationship to be present for change to occur (Beck, 1967). Treatment manuals in therapy are used to apply specific theoretical orientation and techniques in order to reduce variability among therapists; however, accumulated evidence indicates that these manuals do not eliminate variations among therapists' personality characteristics and ways of implementing therapy (Beutler et al., 2004).

It is beyond the scope of this paper to review all the latent states of client and counselors that influence TWA ratings. A more detailed review and discussion on multicultural counseling competence, a latent state variable, will be covered later.

Observed States

Variables that fall under observed states are specific to the therapy process, for example, professional background, therapeutic style, and therapist interventions; these can be checked, observed, and verified. For the purposes of the present study, the following review will focus on (a) client ratings and (b) observer ratings of observed states of therapists.

Client Ratings

Therapist characteristics observed by adult clients who positively related to the alliance were competence, respect, and flexibility (Bachelor, 1995; Kivlighan, Clements, Blake, Arnzen, & Brady, 1993). Bachelor (1995) examined the TWA in a qualitative inquiry of the client's perception of the alliance. Clients described a good working relationship with therapists that demonstrated respect, competence, and understanding. Kivlighan et al. (1993) reported therapist flexibility as significantly negatively correlated with client-rated WAI ($r = -.26, p < .05$). Rigid counselors scored higher on the flexibility instrument, accounting for the inverse relationship.

In contrast to the positive factors, therapist negative observable states, such as appearing distracted in session, were negatively associated with alliance ratings in Saunders' study (1999). Client information was collected after the first session of counseling. Clients were asked to fill out an instrument designed to elicit client experiences in therapy. One of the items, "Therapist distracted," operationalized as the client perceiving the therapist as bored, distracted, or tired in session, was inversely correlated with client-rated session quality ($r = -.29, p < .008$). This research described a relationship between therapist in-session behaviors that can affect clients' perception of their experience.

Observer Ratings

Therapist characteristics rated by observers external to the therapeutic setting that positively related to the alliance were warmth, understanding, supportive, and sensitive in both adult and child research (Najavits & Strupp, 1994; Truax, Altman, Wright & Mitchell, 1973). Sixteen therapists for 80 clients were rated on effectiveness

measures in Najavits and Strupp's (1994) research. Therapists rated as more effective were described as demonstrating more positive behaviors in-session and the alliance was significantly correlated with specific in-session behaviors. These behaviors were warmth, friendliness, affirmation, and understanding (Najavits & Strupp, 1994).

Independent judges evaluated other therapist interventions such as listening in the beginning phase of treatment, accurately interpreting in the middle phase of treatment exploration, providing information, and advising in the concluding phase of treatment. These were found to be related to a client-rated positive alliance (Sexton, Hembre, & Kvarme, 1996). Using repeated measures analysis of variance, therapists who were externally evaluated the ability to display accurate empathy, nonpossessive warmth, and genuineness, identified as therapist-offered conditions, in session with child clients (average age 9 years old) rated their clients as improving in function over time in a (Truax et al., 1973). The clients receiving therapy from therapists rated high on therapist-offered conditions had parents who rated their children an average a 32-point increase on the outcome measure, while children of low therapeutic conditions showed an 8-point decrease. However, these results should be considered with caution, only 16 practicing child psychotherapists participate in the research, and the group was split into providing high and low conditions, with 8 therapists in each group.

Diamond, Liddle, Hogue, and Dakof (1999) reported on therapist behaviors that improved external observer's alliance ratings for therapist and adolescents in family therapy. Five adolescent-therapist improved alliances were compared against five adolescent-therapist unimproved alliances. The behaviors that were found to improve external observer alliance ratings were related to trust, honesty, and confidentiality,

orientating the adolescent to the collaborative nature of therapy, attending skills, and goal directed interventions (Diamond et al., 1999).

A number of observed negative therapist behaviors were related to the TWA. Therapist characteristics noticed by external observers such as distance and aloofness of the therapist were related to negative alliance ratings by external observers with adult clients (Price & Jones, 1998). Adult clients rated the working alliance lower when external observers reported therapist uncertainty and tension in the middle phase of therapy (Sexton et al., 1996). External observers rated the alliance poorly for therapists who used techniques incorrectly (Eaton, Abeles, & Gutfrend, 1993), used belittling or blaming behaviors in session (Coady & Marziali, 1994), and brought personal emotional conflicts into the therapeutic relationship (Price & Jones, 1998).

Summary. Positive alliance building behaviors of therapists with both child and adult clients include warmth, understanding, and sensitivity (Najavits & Strupp, 1994; Truax et al., 1973). Negative alliance building behaviors of therapists with adult clients are counter opposite of positive behaviors. To my knowledge, no research exists on what play therapist behaviors contribute to negative alliance ratings. Most of the research conducted on therapist variables that contribute to alliance ratings is correlational and cross-sectional, making it difficult to generalize across populations and infer causal relationships. In the research that used repeated measures over time, findings were hampered by the use of small sample sizes of therapists.

While it is important to understand external observers and client-observed behaviors of therapists that work in-session, none of the extant research has examined the specific variables of interest to this research on the TWA with child therapists. The

present study will examine the contributions of therapists' trait anxiety, attachment quality, and multicultural counseling competence to the TWA in the context of play therapy. Further exploration of the constructs related to the independent variables will be described next.

Trait Anxiety

Anxiety is multidimensional in its expression and classified as state anxiety or trait anxiety (Pervin, 2003). As a personality trait, Spielberger (1966) describes trait anxiety as a proneness to anxiety, different from anxiety states that are the result of reactions to stimuli. Both trait anxiety and state anxiety had been found relevant to human interactions and functioning (e.g., Bandura, 1956; Kelly, Hall, & Miller, 1989). Individuals who score high on trait anxiety also score high on measures of state anxiety (Spielberger, 1972). However, state anxiety is not chronic like trait anxiety; it is a temporary response on the part of the individual to a stimulus (Grinker, 1966). For the purposes of the present study, the following discussion focuses on trait anxiety.

Trait anxiety is a significant variable that deserves the attention of researchers and trainers in counseling because it has been linked to personal and interpersonal well-being. For example, Unalan, Celikten, Soyuer, and Ozturk (2008) examined quality of life and anxiety among 276 university Turkish students. The authors found negative correlations between state anxiety and physical health, psychological health, and level of independence. The authors also reported positive correlations between trait anxiety and physical health, psychological health, social relationships, environment, and overall quality of life and general health perceptions.

Authors have theorized that trait anxiety affects individuals' ability to form positive interpersonal interactions because they are already primed toward negative emotional reactivity (Gunthert, Armeli, & Cohen, 1999). Gunthert et al. (1999) asked 197 college students to complete questionnaires on their perception of the most stressful event for 14 days. Individuals who scored high on neuroticism, a personality classification associated with trait anxiety, reported stressors that were more interpersonal in nature over the 14-day period compared to individuals who scored low on neuroticism.

Evidence also suggests an inverse relationship between counselor trait anxiety and counseling processes. A seminal piece on counselor anxiety and competence conducted by Bandura (1956) found therapists with higher levels of trait anxiety were rated as less competent compared to therapists with low levels of anxiety. Forty-two therapists, grouped by similar lengths of experience, rated each other on anxiety levels. The therapists' supervisors also provided competence level rankings. The results of the study showed a significant negative relationship between therapists' anxiety and competence level, indicating that therapists' competence is negatively related by their anxiety as rated by other professionals (Bandura, 1956).

Research on trait anxiety found counselor trainees who rated themselves high in neuroticism rated their alliances less favorably (Chapman, Talbot, Tatman, & Britton, 2009). On the contrary, in Chapman et al.'s study (2009), clients rated the counselor trainees with higher levels of trait anxiety more favorably, citing therapists' ability to withstand exploration of negative affect in session. This has been found to affect alliance ratings favorably in Ackerman and Hilsenroth's (2003) review.

In summary, trait anxiety was found to influence therapeutic processes (Bandura, 1956). Authors theorized and provided evidence indicating that individuals high in trait anxiety also report more interpersonal problems (Gunthert et al., 1999). In the counseling literature, though limited, extant research findings indicate that therapists' trait anxiety affect ratings of the TWA (e.g., Chapman et al., 2009). This present study seeks to investigate the relationship between trait anxiety and the TWA in play therapists.

Trait Anxiety and TWA

Chapman et al. (2009) suggested that less experienced clinicians might be more susceptible to personality patterns influencing their relationships with clients. They administered the WAI and personality measure to 34 counselors-in-training and the WAI to 62 of their respective clients. The only personality traits that reached significance in the sample were trainees' neuroticism, openness, and agreeableness. Relevant to this research and the only trait that was significantly related to both client and counselor-rated alliance was trainee neuroticism. Clients rated the alliance higher for trainees who rated themselves high in neuroticism. On the contrary, trainees who self-rated high in neuroticism rated the alliance lower.

Chapman et al. (2009) explained these contradictory findings in several ways. Most importantly, the researchers revealed results of a subcomponent analysis of the trait neuroticism and identified two subcomponents that were significant, namely, *Negative affect* and *Self-reproach*. Higher levels of negative affect in therapists, or the tendency to experience sadness and anxiety, were related to higher levels of client-rated alliance ($\beta = 0.36, p = .001$). Higher levels of self-reproach in therapists, or the

tendency to criticize oneself, were related to lower trainee ratings of alliance ($\beta = -0.37$, $p < .001$). As a result, Chapman et al. explained that therapists with higher levels of negative affect might be able to tolerate the exploration of negative emotions in therapy resulting in higher client-rated alliances. These results are important to the current research because these researchers found that specific traits linked to anxiety in trainee therapists were related to both client and therapist ratings of the alliance in therapy. Though existing findings support the theorized relationship between counselors' trait anxiety and the therapeutic process, such research is limited, especially as it relates to therapy with young clients. The current research, therefore, represents an attempt to fill the gap in literature on the association between therapist trait anxiety and their self-rated working alliance with their young clients in a play therapy setting.

Attachment Theory

Attachment theory is a developmental model of interpersonal relationships empirically validated by neuroscience (Bowlby, 1969; Cozolino, 2010). The theory hypothesizes that patterns of attachment are formed based on the quality of the emotional relationship between infant and caretaker (Bowlby, 1969). They are internalized into internal working models for important relationships across the lifespan. These early relationships build the brain structures we use for relating lifelong. Experiences in these early relationships affect the neural circuitry of our brains and these patterns become internal working models, rules, or schemas for how we interpret others and ourselves in intimate and important relationships. When conditions for the attachment relationship are less than ideal, those unconscious patterns are used to shape

the perceptions and responses of the brain to new relationship experiences in the primary patterns that were established (Cozolino, 2010).

Attachment anxiety and attachment avoidance are two latent dimensions that are believed to underlie attachment (Wei, Russell, Mallinckrodt, & Vogel, 2007).

Attachment-related anxiety is defined as a person who is fearful of rejection or abandonment in intimate relationships, requires constant approval from others, and experiences distress when his or her partner is unavailable or not responsive.

Attachment-related anxiety increases hypervigilance to rejection or acceptance.

Hypervigilance in anxious types is hypothesized to amplify negative emotions, which primes the individual for negative affect and thoughts (Mikulincer & Shaver, 2007).

Attachment-related avoidance is defined as a person who is fearful of dependence on others in intimate relationships, and aspires to be self-reliant and independent of others (Wei et al., 2007). Those who demonstrate avoidant patterns of attachment exhibit greater independence and emotional distance in relationships because of an inherent distrust of the intentions of others. When faced with perceived or actual relationship threats, avoidant types are hypothesized to use deactivating strategies such as minimizing the need for connection (Mikulincer & Shaver, 2007).

Attachment orientations are often cited as secure, preoccupied, avoidant, or fearful. Each of these attachment orientations has characteristic cognitive, behavioral, and emotional patterns that are related to internal working models of self and others (Bartholomew & Horowitz, 1991). For instance, adults with secure attachment score low on attachment anxiety and attachment avoidance measures (Mikulincer & Shaver, 2005), hold positive views of themselves and others, and have friends who rate them as

warm, intimate, confident, and involved in their relationships (Bartholomew & Horowitz, 1991).

Preoccupied adults rely on emotion-focused coping strategies when faced with stress (Mikulincer & Shaver, 2008), report lower levels of self-esteem (Park, Crocker, & Mickelson, 2004), and have more negative internal models of self (Bartholomew & Horowitz, 1991). Avoidant adults are more likely to rely on distance coping strategies when coping with stress (Mikulincer & Shaver, 2008); they tend to report high levels of self-esteem (Park, Crocker, & Mikelson, 2004) and hold more negative view of others (Bartholomew & Horowitz, 1991). Fearfully attached adults exhibit both anxious and avoidant strategies in intimate relationships. They hold both negative internal working models of self and others (Bartholomew & Horowitz, 1991). These individuals are fearful of intimacy and socially avoidant.

Attachment theory has been applied to the investigation of the TWA and therapeutic processes (Bowlby, 1988) because it is believed that the therapeutic relationship is a type of attachment relationship (Mallinckrodt, 2010). Based on attachment theory, Bowlby (1988) prescribed that therapists help their clients identify maladaptive interactional cycles as patterns of attachment and help clients change these patterns. A secure therapist is believed to provide a secure base in order for the client to experience corrective emotional experiences (Bowlby, 1988; Greenberg & Johnson, 1988). However, it is hypothesized that therapists will be unable to help a client modify his or her interactions if therapists do not attend to any of their own maladaptive attachment behaviors (Rubino, Barker, Roth, & Fearon, 2000). These therapists are unable to provide a corrective emotional experience based on their unconscious patterns

of relating (Cozolino, 2010). Therefore, it is important in the training and development of therapists to help them identify, understand, and mitigate any maladaptive attachment-related interactions between therapists and clients.

Counseling training researchers have in recent years investigated the influence of trainee attachment quality on the counseling process. For example, Rubino et al. (2000) investigated the attachment style of clinical graduate students and their responses to four clinical vignettes, representing each of the four attachment styles. The students' responses were rated on empathy and depth of interpretation by the principle researcher and two students from the same program as the research participants. Therapists who had self-reported anxious attachment provided less empathic responses compared to therapists who scored higher on attachment avoidance. Post hoc comparisons indicated that fearfully and securely attached vignettes elicited varied responses across trainees higher in attachment avoidance. There was no significant difference on depth of response for the interaction of therapist and patient attachment. While these results are important for consideration for therapists who identify as more anxiously attached and the resulting ability to be empathic in session, the study has some considerations. For example, the research was conducted in a non-naturalistic manner where the video vignettes were manipulated to clearly demonstrate an attachment style and the participants were evaluated on their response to the videos (Rubino et al., 2000).

In summary, attachment quality has been hypothesized to affect an individual's experience of interpersonal relationships due to implicit memories of his or her early attachment relationships (Bartholomew & Horowitz, 1991; Cozolino, 2010). Secure

style of attachment has been hypothesized to influence a person's experience of others and themselves positively. Individuals who fall in this category feel that they can connect with others and that their partners in intimate relationships are available. Insecure styles of attachment have been hypothesized to influence a person's experience of others and themselves negatively because of negative internal working models formed as a result of unresponsive or unavailable caregivers early in life (Bartholomew & Horowitz, 1991). In therapy, this can result in a person experiencing the TWA in a negative manner. Research findings have in general supported this hypothesized connection (Black et al., 2005). The following section will review information on the overlap of trait anxiety and attachment quality.

Trait Anxiety and Attachment Quality

Research has found an overlap between dispositions related to trait anxiety and insecure attachment. Watt, McWilliams, and Campbell (2005) and Weems, Berman, Silverman, and Rodriguez (2002) investigated attachment style and anxiety sensitivity. As cited by Watt et al. (2005) and Weems et al. (2002), anxiety sensitivity is an enduring condition related to fear of anxiety-related symptoms. Weems et al. investigated attachment beliefs and anxiety using a self-report measure of attachment and anxiety sensitivity among high school and college students. Results in Weems et al.'s study indicated that adolescents and young adults who self-identified as having fearful or preoccupied styles of attachment had significantly higher levels of anxiety sensitivity. In a 2 (high school versus college) by 4 (attachment style) analysis of variance, it was found in post hoc contrast that participants with attachment orientations of fearful and preoccupied had higher anxiety sensitivity scores than those

who self-identified as secure or dismissive ($p < .05$). Replicating this study more robustly, Watt et al. investigated attachment style and symptoms of anxiety sensitivity in a large sample of undergraduate students. Similar to Weems et al.'s results, the results in Watt et al.'s study indicated that participants who classified themselves as having fearful or preoccupied attachment styles scored significantly higher on measures of anxiety sensitivity and trait anxiety than participants classified as secure or dismissive. While the results imply an association between attachment styles, specifically preoccupied and fearful, and trait anxiety, Watt et al. (2005) warn about inferring causality due to the cross-sectional nature of the sample despite the strength of the study.

Attachment and TWA

Research has indicated that attachment orientations affect ratings of the TWA. In Sauer, Lopez, and Gormley's (2003) analysis of the therapist and client adult attachment orientation and the working alliance, it was reported that therapists who rated themselves as insecure-anxious in their attachment orientation had significantly higher client-rated WAI scores after Session 1 ($r = .40, p < .05$), but this decreased over time. No other combination of adult attachment orientation within the dyads reached significance. While these results are interesting, there are many limitations to this research including small sample size (13 therapists and 17 clients), timing of the measurement (after first session), and lack of information about clients' symptomology or presenting issues.

In a larger study of therapeutic dyads' ($N = 59$) attachment dimensions and alliance, Fuertes, Mislouack, Brown, Gur-Arie, Wilkinson, and Gelso (2007) reported

significantly lower alliances for therapists with insecure-avoidant attachment orientations ($r = -.31, p < .001$) and for clients with insecure-avoidant attachment orientations ($r = -.47, p < .001$). Therapist attachment orientation and client orientation did not have any significant interaction across therapist or client-rated WAI scores suggesting that individual self-rated attachment orientation is likely independently associated with ratings of the alliance. Both of the above-mentioned studies provide evidence suggesting that insecure attachment is linked to personal ratings of the alliance.

Other research has also indicated that insecurely attached therapists rate the alliance lower. In an examination of 491 psychotherapists, Black, Hardy, Turpin, and Parry (2005) reported a significant inverse relationship between self-reported insecure-anxious therapists and positive alliance scores. Conversely, self-rated secure therapists positively correlated with self-report positive alliance ratings. Black et al. (2005) also examined general personality features of the sample and respective effects on therapist-rated alliance scores. Therapists who rated themselves as high in neuroticism self-reported significantly more problems in therapy. Through a multiple aggression analysis, the authors concluded that therapists with insecure attachment reported more problems with therapy if the therapists also reported a significant amount of the personality trait neuroticism.

Summary

In conclusion, extant findings indicate that therapists' insecure attachment and trait anxiety both negatively affect the therapeutic relationship. Though researchers have examined the relationship between attachment and the TWA, between attachment

and trait anxiety, and between trait anxiety and the TWA, to my knowledge, no studies have examined concurrently the influences of attachment anxiety and trait anxiety on the TWA in general, and in child therapy settings in particular.

Multicultural Counseling Competence

Multicultural counseling competence (MCC) has become a forefront focus in counseling and psychotherapy in the last few decades (Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2008). Counselors and therapists are expected to practice in culturally sensitive manners. As such, counseling training programs have included the training of MCC as a core training component. For example, the American Psychological Association (APA; 2003) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) include the competencies in their guidelines for training, education, research, and practice. The multicultural counseling competencies are essentially the counselors' (a) awareness of their own cultural assumptions, values, and biases; (b) understanding of the worldview of the culturally different client; and (c) knowledge of culturally relevant interventions, strategies, and techniques (Sue et al., 1992).

Later amended by Arredondo et al. (1996), the competencies were established to prevent therapists' biases and prejudices from affecting the counseling relationship. They were also developed based on the understanding that current counseling theories and practices of counseling carry a Western, middle-class, Caucasian bias (Sue et al., 1992). Research has supported the importance of MCC in counseling and psychotherapy. For example, Fuertes et al. (2006) reported client perception of a multiculturally competent therapist was significantly positively correlated with working

alliance, therapist empathy, and satisfaction in therapy. The following section will provide empirical support for multiculturally competent counselors and therapists who work with young children.

Multicultural Counseling Competence and TWA

Authors have argued that therapists' MCC contributes positively to the building of therapeutic alliance (Fuertes et al., 2006). Existing research further supports this notion. For example, various researchers (Fuertes et al., 2006; Constantine, 2007; Li & Kim, 2004) have reported a significant association between therapist MCC and working alliance. The theorized connection between multicultural competence and establishing trust on the TWA is based on Sue et al.'s (1982) tripartite model of multicultural competence. A counselor who possesses racial and cultural self-knowledge, awareness of racial and cultural implications should be able to provide interventions and appropriate mental health services to a diverse array of clients. This implies a relationship between a counselor's multicultural competence and relationship building skills in therapy.

In Li and Kim's (2004) research, 52 Asian American students participated in counseling. The clients were classified as having either high or low adherence to Asian values using an Asian cultural value scale and then subsequently assigned to directive or nondirective counselors, who were trained by the researchers in these roles. Working alliance and cross-cultural competence of the counselor, as perceived by clients, were found to significantly correlate ($r = .72, p < .01$). However, there was no evidence to support the authors' hypothesis that clients with high adherence to Asian cultural values would rate the directive counselors better than clients with low adherence to Asian

cultural values. Similarly, clients with high adherence to Asian cultural values did not rate the nondirective counselors lower than did clients with low adherence. In fact, the results indicated that the directive counseling condition was favored overall. Significant to this research is that clients in the directive counseling style condition gave higher scores to cross-cultural competence of their counselors ($M = 4.84$, $SD = 0.65$) compared to nondirective counselor scores ($M = 4.40$, $SD = 0.57$). But, this study was limited in that the counseling was career in nature and that the directive style was highly structured, with the main goal to resolve uncertainty about career issues making the results logical in nature. More studies are needed to verify the relationship between counselor multicultural competence and the counseling process and outcomes in different settings and treatment issues including counseling children and adolescents.

While Li and Kim (2004) reported on a specific client cultural group's preferences in the study, Fuertes et al. (2006) examined 51 counselor-client dyads' perception of working alliance and counselor multicultural counseling competence. Important to note is that no differences were found on any measures included in Fuertes and colleagues' investigation between cross-cultural dyads or matched-culture dyads. Research results indicated that client-rated working alliance scores significantly correlated with client-rated therapist multicultural competence ($r = .73$, $p < .01$). Therapist-rated working alliance also significantly correlated with therapists' own rating of multicultural competence ($r = .68$, $p < .01$).

Both Li and Kim's (2004) and Fuertes et al.'s (2006) study illustrate the importance of the connection between working alliance and therapist multicultural counseling competence. However, Li and Kim used a specific minority group and

career counseling conditions making the generalizability of the results limited. In the 51 dyads examined, the therapists in Fuertes et al.'s (2006) study identified as primarily European American ($N = 34$) and clients were primarily minorities ($N = 39$) and the pairings were primarily cross-cultural in nature ($N = 37$). It is unsure if findings in Fuertes et al.'s study can be replicated in situations where the therapists are ethnic minority and clients are ethnic majority. Nevertheless, multicultural counseling research indicates a link between therapists' multicultural counseling competence and client and therapist ratings of TWA in adult cross-cultural dyads (Fuertes et al., 2006). However, such association has yet to be investigated in therapists and their young clients.

Multicultural Counseling Competence and Child Therapists

My search of the literature indicated that research on child therapists' MCC is limited. Only two studies examined self-reported MCC in Registered Play Therapists. First was Ritter and Chang's (2002) study that assessed 134 Registered Play Therapists' MCC using the self-report measure of the Multicultural Counseling Competence and Training Survey (MMCTS; Holcomb-McCoy & Myers, 1999). The MMCTS requires participants to rate survey questions on competency and adequacy of training on a 4-point Likert scale. The participants also reported how many multicultural classes they had taken in their preparation to become a play therapist. Of the five subscales in the MMCTS (*knowledge, awareness, terminology, racial identity development, skills*), the participants rated their competence highest in multicultural awareness ($M = 3.38$) and terminology ($M = 3.37$) and lowest in racial identity development ($M = 2.07$). The participants rated their adequacy of training low in terminology ($M = 2.84$) and lowest training in racial identity development ($M = 1.93$). In Penn and Post's (2012) research,

510 Registered Play Therapists reported on multicultural competence, training, and the degree that people accept, deny, or undervalue the existence of racism in the United States. One of the findings in this study shows that increased multicultural education is related to increased multicultural counseling knowledge.

In research examining elementary school counselors' perceived multicultural competence with the same measures as Ritter and Chang (2002), Holcomb-McCoy (2001) reported no differences in perceived MCC whether the participant took a course in multicultural counseling in their graduate degree or not. However, adequacy of training was not reported on in this study. In a study that compared school counselors and community counselors on their multicultural competence, it was found that school counselors had self-reported significantly ($\eta^2 = .06, p = .002$) lower levels of multicultural counseling competence than their community counseling colleagues (Bidell, 2012).

Though the importance of MCC has been noted for decades, a recent search of the literature revealed only a few studies had focused on multicultural competence of registered therapists (Ritter & Chang, 2002; Penn & Post, 2012). However, none of them examined the relationship between multicultural competence of child therapists using play and the TWA. Therefore, it is believed that this present research on multicultural counseling competence of child therapists and their perceived TWA is timely.

Conclusion

In summary, research on what variables affect play therapists' ability to form effective working alliances appears non-existent. I have not found one article that

examined interpersonal variables that affected the alliance between child therapists using play and their child clients. Outcome research indicates that the alliance in youth therapy is just as important in adult therapy. Furthermore, there is a dearth of literature on what can affect the building of the TWA. I believe that a study on the relationships among child therapists' attachment quality, trait anxiety, multicultural counseling competence, and their perceived working alliance with their child clients in play therapy setting fills the gaps in the literature. I further believe that the findings of the study have the potential to inform counselor training and practice in general and play therapy training and practice in particular.

CHAPTER 3: METHODOLOGY

A positive working alliance is important in outcomes in psychotherapy with adults (Horvath, Del Re, Flückiger, & Symonds, 2011). There is research on the efficacy of play therapy with children (Bratton, Ray, Rhine, & Jones, 2005) but no research on the characteristics of child therapists that affect the formation of the therapeutic working alliance (TWA). The purpose of this study was to address the gaps in the literature on child therapists and factors that contribute to their perception of their ability to form working alliances with their child clients. Specifically, the purpose of this study was to examine how trait anxiety, attachment quality, and multicultural counseling competence of child therapists using play predict their self-ratings of the working alliance.

Research Questions

The present study sought to examine the contributions of child therapists' trait anxiety, attachment quality, and multicultural counseling competence on their perceived TWA with their young clients. The study specifically addresses the following questions:

1. What are the relationships among child therapist trait anxiety, child therapist attachment-related anxiety, child therapist attachment-related avoidance, child therapist multicultural counseling competence, and child therapist-perceived TWA?

2. To what extent does child therapist trait anxiety predict therapist-perceived TWA after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?
3. To what extent do therapist attachment-related anxiety and attachment-related avoidance predict therapist-perceived TWA above and beyond the effect of therapist trait anxiety after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?
4. To what extent does therapist multicultural competence predict therapist-perceived TWA beyond the effects of therapist trait anxiety, attachment-related anxiety, and attachment-related avoidance after controlling for experience level, dyadic gender make-up and dyadic ethnicity make-up?

Statement of the Hypotheses

Based on the findings in the literature with adult client populations (e.g., Black, Hardy, Turpin, & Parry, 2005; Chapman, Talbot, Tatman, & Britton, 2009; Fuertes et al., 2006), the following hypotheses were proposed:

Research Question 1:

H_o : There are no relationships among child therapist trait anxiety, child therapist attachment-related anxiety, child therapist attachment-related avoidance, child therapist multicultural counseling competence, and child therapist-perceived TWA.

H_a : There are relationships among child therapist trait anxiety, child therapist attachment-related anxiety, child therapist attachment-related avoidance, child therapist multicultural counseling competence, and child therapist-perceived TWA.

Research Question 2:

H_o : After controlling for therapist training level, dyadic gender make-up, and dyadic ethnicity make-up, trait anxiety does not contribute significantly to the variance in therapist- perceived TWA.

H_a : After controlling for therapist training level, dyadic gender make-up, and dyadic ethnicity make-up, trait anxiety significantly contributes to the variance in therapist- perceived TWA.

Research Question 3:

H_o : After controlling for therapist training level, dyadic gender make-up, and dyadic ethnicity make-up, attachment-related anxiety and attachment-related avoidance do not contribute to the variance in therapist-perceived TWA.

H_a : After controlling for therapist training level, dyadic gender make-up, and dyadic ethnicity make-up, attachment-related anxiety and attachment-related avoidance contribute significantly to the variance in therapist-perceived TWA.

Research Question 4:

H_o : After controlling for therapist training level, dyadic gender make-up, and dyadic ethnicity make-up, multicultural counseling competence does not contribute significantly to the variance in therapist-perceived TWA.

H_a : After controlling for therapist training level, dyadic gender make-up, and dyadic ethnicity make-up, multicultural counseling competence contributes significantly to the variance in therapist-perceived TWA.

Research Design

The present study utilized a correlational research design. Four survey instruments and a brief demographic questionnaire were used to collect the information necessary to address the research questions. The predictor variables were the child therapists' trait anxiety, attachment-related anxiety and avoidance, and multicultural counseling competence. The criterion variable was child therapist-perceived TWA. Therapists sampled were expected to use play modality in counseling their young clients.

Sampling Method

The participants for this study were child counselors and mental health therapists recruited from among the members of the Association for Play Therapy (APT), American School Counselor Association (ASCA), and American Association for Marriage and Family (AAMFT). Participants were also recruited from the following listserv's: CESNET-L, North Carolina Psychological Association (NCPA), Counsgrad, University of North Carolina at Charlotte (UNCC) Department of Social Work Alumni and field instructors, and individuals who attended the UNCC 2013 Multicultural Play Therapy conference. Therapists were defined as licensed or certified counselors, therapists, or practitioners who are using play materials (i.e., toys, puppets, art materials) in their work with clients between the ages of 7 and 10 years. Participants were recruited from working settings such as schools and mental health counseling agencies. They did not have to be Registered Play Therapists.

Although it is widely accepted within the play therapy literature that play is appropriate for children as young as 3 years old (Landreth, 2002), for the purposes of

this research the minimum age of participant was 7 years old. Subjects will be asked to choose a child who is at least 7 years old because some of the questions found in the Therapeutic Working Alliance Scale for Children (TASC; Shirk & Saiz, 1992) require concrete operational cognitive functioning. At age 7, children enter in the concrete operational phase based on Piaget's (1929) theory of cognitive development. In the concrete operational phase, a child is thought to be able to logically reason about events and logic (Piaget, 1929). The cut-off age of 10 was based on Landreth's (2002) prescriptions for the oldest a child should be in play therapy. Landreth is a well-known researcher and practitioner in the field of play therapy and play modality.

A web-based study

(<https://www.surveymonkey.com/s/rschererdissertationresearch>) was employed to facilitate participant recruitment and data collection. Participants were asked to anonymously complete a demographic questionnaire and four research instruments designed to collect information on the study variables: (a) therapist's version of the TASC, (b) the trait scale of the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) (c) the Experiences in Close Relationships Scale-Short Form (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007), and (d) the Cross Cultural Counseling Inventory-Revised (CCRI-R; LaFromboise, Coleman, & Hernandez, 1991). Participants were asked to rate their working alliance with a current young client between the ages of 7 to 10 years old, with whom they had met a minimum of three times (Appendix A / Appendix F). In cases where participants had multiple clients, they were asked to select the client whose first name was closest to the letter

“C.” In order to encourage participation, participants were offered the opportunity to enter a sweepstake to win one of 20 \$20-online gift card awards.

A minimum sample size of 74 was required to meet the recommendations of the Tabachnick and Fidell (2007) for ratio of cases of independent variables in hierarchical multiple regression analysis. The minimum sample size was calculated by using the Tabachnick and Fidell’s recommended equation for required minimum sample size, $N \geq 50 + 8m$, where m = number of independent variables.

Recruitment of participants involved the following steps:

1. Obtained approval for the study from the UNCC Institutional Review Board (IRB).
2. Recruited possible participants electronically through membership associations and listservs with the recruitment letter (Appendix A):
 - i. APT: Members of APT are grouped by inside the US and outside the US. The majority of APT members are located in the US. I chose “All Play Therapists” listed as the credentials filter. I went through state by state in alphabetical order and chose the first 10 email addresses, also alphabetical. This list included District of Columbia, making the sample 518 because North Dakota has only 8 APT members. I added an additional 10 more email addresses from the “Outside of the US” member list as well making the total sample 520. A feature of the SurveyMonkey.com is that the system will alert you if an email address is invalid or has opted out of receiving any emails from SurveyMonkey.com. I replaced any email addresses the were reported invalid or opted out.
 - ii.- ASCA: I narrowed down my possible sample to Elementary School Counselors. Through an Excel program, I randomly selected 500 emails and sent my recruitment

letter via SurveyMonkey.com. I replaced the invalid or opted out number of email addresses until I had a total sample of 500.

iii. AAMFT: I emailed the state division leaders with my recruitment letter asking them to post to their respective listserv's.

iv. CESNET-L: Posted my recruitment letter to CESNET-L.

v. NCPA: Contacted the NCPA coordinator to send out recruitment letter on NCPA listserv.

vi. Counsgrad: Posted my recruitment letter to Counsgrad.

vii. UNCC Social Work Department Alumni and field instructors: Sent my recruitment letter to contact person for the Social Work Alumni listserv and to the contact person for the Social Work's field instructor program.

viii. Multicultural Play Therapy Conference (June 24-June 28, 2013): I handed out the recruitment letter at lunch time on three days (Tuesday, Wednesday, and Friday) of the Multicultural Play Therapy Conference held at UNCC.

4. Re-sent the recruitment letter to the APT and ASCA membership associations email list and reposted the recruitment letter to CESNET-L and counsgrad two weeks later.

5. Screened possible participants based on the present study's definition of child therapists.

6. Collected and analyzed data.

7. Randomly selected 20 names as winners to each receive a \$20-giftcard to Amazon.com.

8. Notified winners through Amazon.com

Descriptive Statistics of Participants

Demographic Survey

A short survey was used to obtain basic demographic data on participants. The questionnaire included information on the participant and their respective client of choice based on criteria mentioned below. The information that was collected was: (a) age, (b) gender, (c) ethnicity, (d) practice location, (e) type of licensure, (e) years of experience, (f) types of play material used, (g) theoretical orientation, and (h) hours of play therapy and child therapy training. Information that was collected on the therapist's client was: (a) gender, (b) age, and (c) ethnicity.

Participants Demographics

For the total sample, participants provided an answer to an age range. For example, participants could choose between the age ranges of 20-30, 31-40, and so on. The majority of participants in the sample ranged between 31-40 ($n = 37$, 27.2%) years of age. The second largest age group, 51-60, comprised of 23.5% ($n = 32$) of the sample. One-hundred and twenty-nine therapists (94.9%) were female and 7 (5.1%) were male, 0 participants reported as transgendered. One-hundred and twenty-one participants (89%) reported their ethnicity as White/Caucasian. Eight (5.9%) participants reported their ethnicity as Black or African American, 3 participants (2.2%) identified as Latino/a, 2 (1.5%) participants identified as Biracial/Multiracial, 1 (0.7%) participant identified as Asian or Asian American, and 1 (0.7%) identified as American Indian or Alaskan Native.

The age of majority of the child clients participants reported ranged from 7 (30.1%) to 8 (30.1%). Seventy-eight (57.4%) of the children were reported to be male,

and 58 (42.6%) were female. Eighty-nine (65.4%) of the children were identified as White/Caucasian, 23 (16.9%) as Black or African American, 12 (8.8%) as Biracial/Multiracial, 5 (3.7%) as American Indian or Alaskan Native, 3 (2.2%) as Latino/a, 2 (1.5%) as Pacific Islander or Native Hawaii, and 2 (1.5%) as Asian or Asian American.

The frequency of gender and ethnicity matching among therapist and child client dyads is as follows. When the gender between therapists and their child clients was matched, the cases were coded with 1. When the gender between the therapists and their child clients was not matched, the cases were coded with 0. Seventy-one cases (52.2%) did not report matching gender, 65 (47.8%) reported matching gender. When the ethnicity between the therapists and their child clients was matched, the cases were coded with 1. Cases were coded 0 when the ethnicity between therapists and their child clients was not matched. Forty-eight (35%) cases did not report matching ethnicity and 88 (65%) cases reported matching ethnicity.

The range of years of experience counseling children was 35 years, with a minimum of 1 year experience to a maximum of 36 years. The average reported years of experience was 11.7 ($SD = 8.5$). Other demographic information that was collected is presented in Tables 1, 2, and 3.

Table 1: Practice location

Location	Frequency	%
North Atlantic	24	17.6
North Central	32	23.5
Southern	54	39.7
Rocky Mountain	10	7.4
Western	10	7.4
Other	5	3.7

Note. $N = 135$. North Atlantic = Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. North Central = Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin. Southern = Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, Washington, D.C., and West Virginia. Rocky Mountain = Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming. Western = Alaska, Arizona, California, Hawaii, Nevada, Oregon, and Washington, as well as Pacific Rim countries.

Table 2: Toys used, theoretical orientation, and licensure

Variables	Category	Frequency	%
Toys Used	Real Life	125	91.9
	Sand Tray	98	72.1
	Art Materials	134	98.5
	Other	84	61.8
Theoretical Orientation	Child-Centered	54	39.7
	Gestalt	7	5.1
	Cognitive/Cognitive-Behavioral	26	19.1
	Psychodynamic	7	5.1
	Adlerian	2	1.5
	Eclectic	33	24.3
	Other	7	5.1
Licensure/Certification	LPC/LMHC/LPCA	60	44.1
	LCSW	37	27.2
	LP	7	5.1
	LMFT/LMFTA	18	13.2
	RPT/RPT-S	9	6.6
	School Counselor	11	8.0
	CCPT	2	1.4
	Other	9	6.6

Note. $N = 136$. Frequency equals more than population because participants were able to choose/respond to more than one category in Toys Category and Licensure/Certification. Eclectic = Participant chose more than one theoretical orientation or identified as eclectic. LPC/LMHC/LPCA = Licensed Professional Counselor/Licensed Mental Health Counselor/Licensed Professional Counselor Associate. LCSW = Licensed Clinical Social Worker. LP = Licensed Psychologist. LMFT/LMFTA = Licensed Marriage and Family Therapist/Licensed Marriage and Family Therapist Associate. RPT/RPT-S = Registered Play Therapist/Registered Play Therapist Supervisor. CCPT = Certification in Child Centered Play Therapy.

Table 3: Play therapy and child therapy graduate and post-graduate experience

Variable	Category	<i>n</i>	Range
Play Therapy: 3 hours or more graduate credit	Yes	45	
Play Therapy: More than one class	Yes	26	
	No	19	
Play Therapy: Post-graduate hours of training			0-3000 hours
Child Therapy: 3 hours or more graduate credit	Yes	76	
Child Therapy: More than one class	Yes	44	
	No	31	
Child Therapy: Post-graduate hours of training			0-3000 hours

Note. Participants were not required to provide information, information from those participants who provided information.

Instrumentation

Therapist Working Alliance Scale for Children-Therapist Form

The TASC is a 12-item inventory to assess the therapist's perception of the affective quality of the therapeutic relationship with children. In the initial research, the researchers attempted to develop two scales of the child's affective orientation to therapy, called bond and negativity (Shirk & Saiz, 1992). An example of the bond scale on the therapist form is, "The child likes spending time with you, the therapist." An example item from the negativity scale is "The child appears eager to have sessions end." The items are assessed on a 4-point Likert scale ranging from 1 = *Not Like My Patient* to 4 = *Very Much Like My Patient*. In the initial study, the Cronbach's alpha for the bond and negativity scales for the therapist version of the TASC were .88 and .72, respectively. Construct validity was established through solicitation of child psychiatrists and child psychologists input on the alliance measure. Content validity was also established through an exploratory factor analysis that yielded two components related to the bond component in child therapy (Shirk & Saiz, 1992). For the current research, internal consistencies of the instruments were also determined by Cronbach's

alpha. The internal consistency for the TASC was .859, which indicates a high level of consistency for this sample.

State-Trait Anxiety Inventory

The STAI is composed of two separate 20-item self-report scales that measure both state and trait anxiety. This research is interested in the trait anxiety scale. The trait anxiety scale assesses generally how anxious someone feels (Spielberger et al., 1983). Scores range from 20-80, with higher scores indicating more trait anxiety. Items are assessed on a 4-point Likert scale, ranging from 1 = *Almost Never* to 4 = *Almost Always*. An example from the inventory reads, "I feel nervous and restless." In a reliability generalization study of research that had used the STAI, Barnes, Harp, and Jung (2002) reported a mean of .89 for internal consistency and a mean of .88 for test-retest reliability for the trait scale across 58 studies. Spielberger and colleagues spent several years in the STAI's development to assess content, concurrent, and construct validity of the STAI (Spielberger, 1983). Content, concurrent, and construct validity was established by adapting items from other reputable anxiety scales and thus resulting in strong correlations with other anxiety scales. The internal consistency for the trait scale of the STAI for the current research is .864, which also indicates a high level of consistency for this sample.

Experiences in Close Relationships-Short Form

The ECR-S is a 12-item questionnaire to assess attachment-related anxiety and avoidance. The scale was created to assess an individual's general pattern of adult attachment in intimate relationships (Wei et al., 2007). Six items measure attachment-related anxiety and six items measure attachment-related avoidance. Items are rated on

a 7-point Likert scale, where 1 = *Strongly Disagree* and 7 = *Strongly Agree*. An example of an item on the anxiety subscale is “I’m afraid I will lose my partner’s love.” An example of an item on the avoidance subscale is “I prefer not to show a partner how I feel deep down.” Test-retest reliability for the ECR-S is .82 for the anxiety subscale and .89 for the avoidance subscale. Cronbach’s alpha ranged from .78 to .86 for the anxiety subscale and .78 to .88 for the avoidance subscale. Similar construct, concurrent, and content validity was established through comparison to the original form of the ECR-S (Wei et al., 2007). For the present study, the internal consistency for the Anxiety Scale of the ECR-S is .638 and the internal consistency for the Avoidance Scale of the ECR-S is .792. This indicates a moderate to high level of consistency for this sample.

Cross Cultural Counseling Inventory-Revised

The CCCI-R is a 20-item inventory to assess multicultural counseling competence. After three studies examined the CCCI-R’s (LaFromboise et al., 1991) instrument validity, interrater reliability, and factor structure, three scales were found to make up the questionnaire: cross-cultural counseling skill, sociopolitical awareness, and cultural sensitivity. The inventory is rated on a 6-point Likert scale ranging from 1 = *Strongly Disagree* to 6 = *Strongly Agree*. An example item from the inventory is phrased “Counselor is aware of his or her own cultural heritage.” Originally intended for external raters, LaFromboise et al. (1991) indicated that the scale is appropriate for self-evaluation use and has been successfully modified as a self-report instrument in other studies (e.g. Ladany, Inman, Constantine, & Hofheinz, 1997). In the initial validation sample, LaFromboise et al. reported a .95 internal consistency coefficient.

Content validity was established through the use of expert raters who identified the CCCI-R items into one of three multicultural competence areas: knowledge, skills, or awareness (LaFromboise et al., 1991). For the current study, the internal consistency for the CCCI-R is .829, indicating a high level of consistency for this sample.

Operational Definitions

The operational definitions are as follows:

1. Therapeutic working alliance is measured by the TASC. There are 12-items on the TASC, the average score of all the 12-items will be used as an indicator for TWA. The score ranges from 1 to 4.
2. Trait anxiety is measure by the TAI. There are 20-items on the TAI, the average score of all the 20-items was used as an indicator for trait anxiety. The score ranged from 1 to 4.
3. Attachment-related anxiety and attachment-related avoidance is measured by the ECR-S. There are 12-items on the ECR-S. Six questions make up the subscale of attachment-related anxiety and six questions make up the subscale of attachment-related avoidance. The average score of all the six-items on each subscale were used as an indicator of attachment-related anxiety or attachment-related avoidance. Originally, the score ranges from 1 to 7. For the purpose of this research, the score ranged 1 to 5 with the categories of “agree” and “disagree” dropped. This was to encourage participants to choose an increment of agreement or disagreement, rather than simply choosing agrees or disagrees.

4. Multicultural counseling competence is measured by the CCCI-R. There are 20-items on the CCCI-R, the average score of all the 20-items were used as an indicator of multicultural counseling competence. The score ranged from 1 to 6.

Data Analysis

Initial data screening for outliers, missing data, and the assumptions of multiple linear regression were performed with the Statistical Package for Social Sciences (SPSS) software. Descriptive and inferential statistics of the data were analyzed. Hierarchical multiple linear regression was used to determine the contribution of the independent variables (trait anxiety, attachment-related avoidance and anxiety, multicultural counseling competence) to predict the dependent variable (TWA).

The data were screened for the assumptions of multiple linear regression. The assumptions included normality, linearity, and homoscedasticity. The normality assumption is met when the data set has a normal distribution along the bell curve. Normality was tested by examining the residual scatterplots. The linearity assumption is met when there is a linear relationship between two variables, where one or both of the variables can be a combination of the research variables. Linearity was checked against the scatterplots of the original scores. Homoscedasticity is met when variance of error is the same across all independent variables. These assumptions were tested by examining the residual scatterplots. Residuals are the differences between obtained and predicted dependent variable scores. If the residuals have a straight-line relationship with predicted dependent variable scores and are normally distributed around the predicted dependent variable scores, then these assumptions are considered met and the data can be continued to be processed (Tabachnick & Fidell, 2007).

The primary purpose of multiple linear regression is to test the association between one dependent variable and several independent variables. In hierarchical multiple linear regression, independent variables in the research equation are entered in an order specified by the researcher in order to understand what the variable adds to the equation at its point of entry. Because experience levels of therapists, gender, and ethnicity have found to be inconclusive on ratings of the TWA, these variables were entered first to control for possible confounding issues, allowing the research to examine the unique contribution of the independent variables above and beyond these control variables. Step Two entered participants' trait anxiety in the regression equation. Step Three entered attachment-related anxiety and avoidance, and Step Four entered multicultural counseling competence in the regression equation model.

The contribution of trait anxiety was investigated first before the contributions of attachment anxiety and avoidance because trait anxiety is considered an innate personality variable and attachment quality is believed to be developed as a result of interactions with attachment figures after birth. The contribution of multicultural counseling competence was assessed last because it is believed to be developed as a result of professional training and practice.

Threats to Validity

Threats to validity are classified as internal or external. Internal validity is the degree to which observed effects on the dependent variable are a direct result of the manipulation of the independent variable(s) (Gay, Mills, & Airasian, 2008). External validity is the extent to which the results are generalizable to other populations or contexts (Gay et al., 2008). For the current research, threats to internal validity include

instrumentation, self-report data, Type I and II errors, and statistical significance versus practical significance. Threats to external validity include selection of subjects and ecology-related threats.

Instrumentation threat refers to the use of tests that are unreliable or lack consistency in scores across populations (Gay et al., 2008). The instruments in this study rely on self-report. Self-report can be influenced by social desirability of the participant to rate themselves in a more socially desirable response. The CCCI-R (LaFromboise et al., 1991) was administered with a social desirability scale; results were not significantly associated with the participants' social desirability score (Constantine & Ladany, 2000). The other measures have not been compared against social desirability measures.

Type I and type II errors refer to mistakes when testing a hypothesis in research. Type I error is a false positive, when the researcher concludes that there is a difference in the data when in fact there is no differences in the sample results. The null hypothesis is wrongly rejected. Type II error is a false negative, when the researcher concludes that there is not a difference in the sample results when in fact there is a difference in the data. Therefore, the null hypothesis is not rejected when it is false. Type I and type II errors are more likely to occur with small number of subjects or when using multiple statistical calculations on the data (Gay et al., 2008).

When the sample size is large enough, there is likely to be statistical significance among the results collected. However, in research, even if there is statistical research the results need to be analyzed to whether they provide any practical significance. Specific to this research, I had to assess whether the results are clinically relevant to

child therapists. One way to assess for practical significance is to report effect size to show how large or small the statistical significance really is (Gay et al., 2008).

Threats to external validity include the selection of subjects and ecology related threats (Gay et al., 2008). There was no random selection because the sample was a convenience sample of self-identified child therapists. This study examined a specific group of participants, with specific instruments, at a specific time; therefore, limiting its generalizability. Another external threat, ecology, was possible because this research asked therapists to report on a specific relationship with a child client. These therapists reported on the relationship in a reflective manner instead of answering the questionnaire during the counseling session. The therapists' answers, therefore, could be influenced by the lack of representativeness of the counseling setting and hard to generalize to active counseling sessions.

CHAPTER 4: RESULTS

The purpose of this present study was to examine the associations among trait anxiety, attachment quality, multicultural counseling competence, and child therapists' perceived therapeutic working alliance (TWA) with young clients in the play therapy setting. The following sections will cover: (a) descriptive characteristics of the study sample, (b) data preparation and screening, (c) correlation statistics for the study variables, and (d) results of hierarchical multiple linear regression. The Statistical Package for Social Sciences (SPSS) was used to conduct all statistical screening and analysis. This study addressed the following questions:

1. What are the relationships among child therapist trait anxiety, child therapist attachment-related anxiety, child therapist attachment-related avoidance, child therapist multicultural counseling competence, and child therapist-perceived TWA?
2. To what extent does child therapist trait anxiety predict therapist-perceived TWA after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?
3. To what extent does therapist attachment-related anxiety and attachment-related avoidance predict therapist-perceived TWA above and beyond the effect of therapist trait anxiety after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?

4. To what extent does therapist multicultural competence predict therapist-perceived TWA beyond the effects of therapist trait anxiety, attachment-related anxiety, and attachment-related avoidance after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?

Data Preparation

Research letters were distributed to members of Association of Play Therapy (APT) and American School Counselor Association (ASCA) through individual collector lists on surveymonkey.com. The recruitment letter is included in Appendix A. Five hundred and thirty-three email addresses were included in a list that sent a chance to participate in this research. Ninety-one (17% respondent rate) individuals responded. For ASCA, 499 email addresses were contacted for a chance to participate in this research. Thirty-one (6% respondent rate) individuals responded. Members from American Association of Marriage and Family Therapists (AAMFT), CESNET-L, North Carolina Psychological Association (NCPA), Counsgrad, University of North Carolina at Charlotte (UNCC) Department of Social Work Alumni and field instructors, and individuals that attended the UNCC Multicultural Play Therapy conference also received the recruitment letter (Appendix A) and were able to access the website (<https://www.surveymonkey.com/s/rschererdissertationresearch>).

In total, 185 participants responded to the call for research. Forty-nine response sets were excluded from the study. They included:

1. Ten participants who did not provide any information past the informed consent.
2. Thirteen participants who did not provide any information on their child clients.
3. One participant who self-identified as a student.

4. Twenty-one participants who reported on their working alliance with clients who were younger than 7 or older than 10.
5. Three participants who did not answer any of the instruments.
6. One participant was screened out the data because they were found to be an outlier.

The remaining sample was 136 participants.

Data Screening

To screen the data, scores of the TASC, Anxiety and Avoidance subscale of the ECR-S, and CCCI-R were examined for univariate and multivariate outliers, ratio of cases to independent variables, normal distribution, linearity and multicollinearity and equal variances. Examination of univariate outliers through creating z-scores for the average score of the instruments per participant did not reveal any scores over four standard deviations away from the mean. Multivariate outliers through Mahalanobis distance resulted in one participant that was deleted from the data set. The chi-square computation for the deleted participant indicated a *p*-value of .00027, less than the optimal *p*-value of .001.

Ratio of Cases to Independent Variables

The determination of adequate sample size is reported to rely on several factors, including desired power, alpha level, number of predictors, and expected effect sizes (Tabachnick & Fidell, 2007). The final sample size for the analysis of instruments were (a) 136 TASC scores, (b) 134 TAI scores, (c) 132 ECR-S scores, and (d) 131 CCCI-R scores. Analyses were conducted with missing values excluded.

Normal Distribution

Examination of the test of normality by the Shapiro-Wilk statistic at $p < .01$, indicated that the scores on the TASC ($p = .001$) and CCCI-R ($p = .004$) are significantly different from a normal distribution. In further examination of these variables, scores on the TASC and CCCI-R were moderately negatively skewed. By transforming those variables through a reflect and square root transformation, the normal distribution improved and skewness and kurtosis was closer to zero. The transformed TASC and CCCI-R were used in all further screenings and statistical computations.

Examination of the test of normality by the Shapiro-Wilk statistics at $p < .01$, indicated that the scores on the TAI ($p = .004$), Anxiety subscale of the ECR-S ($p = .001$), Avoidance subscale of the ECR-S ($p = .001$), and Years of Experience ($p = .001$) were significantly different from a normal distribution. In further examination of these variables, scores on the TAI, Anxiety subscales of the ECR-S, Avoidance Subscale of the ECR-S, and Years of Experience were moderately positively skewed. Through a square root transformation, the normal distribution improved and skewness and kurtosis was closer to zero. The transformed TAI, Anxiety subscale of the ECR-S, Avoidance subscale of ECR-S and Years of Experience were used in all further screenings and statistical computations.

Examination of residual scatterplots were used to determine if the data required any other deletion or transformation (Tabachnick & Fidell, 2007). Scatterplots of the residuals against predicted dependent variable, histograms with the normal curve imposed, and normal probability plot of the regression standardized residuals (Figures

1-9) indicated the assumptions of normality, linearity, and homoscedasticity were met in the data set for the research questions.

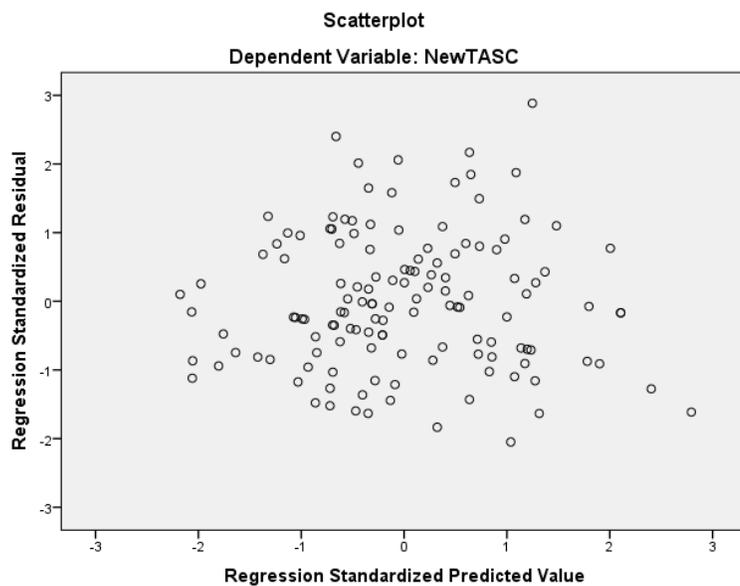


Figure 1: Scatterplot of standardized residual for research question 2

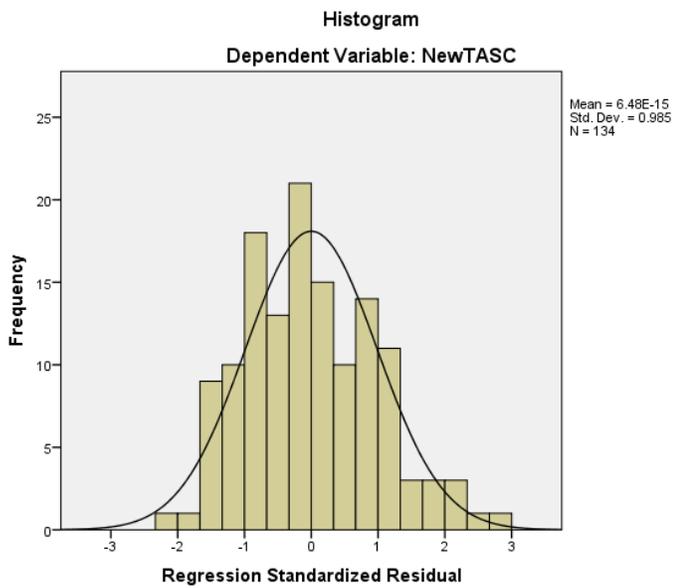


Figure 2: Normal distribution histogram for research question 2

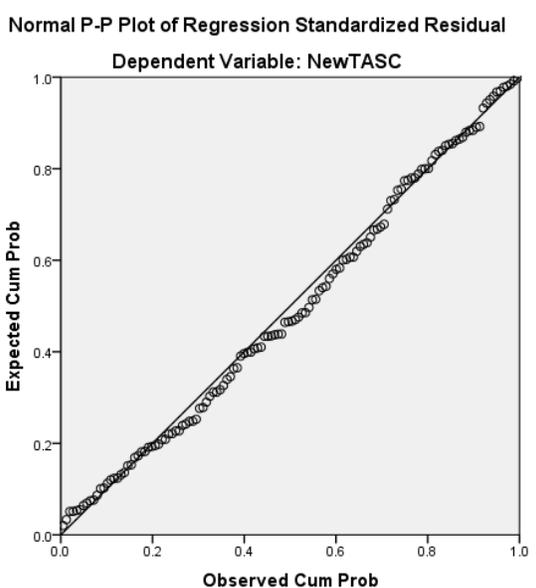


Figure 3: Normal probability plot for research question 2

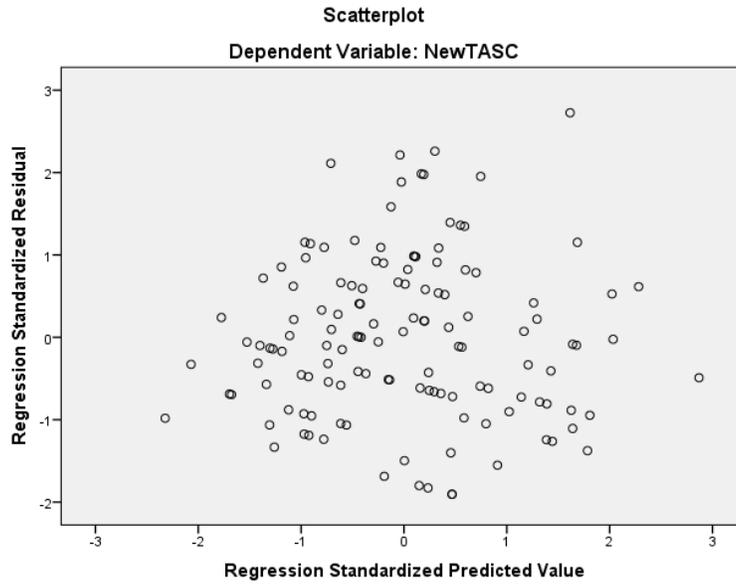


Figure 4: Scatterplot of standardized residuals for research question 3

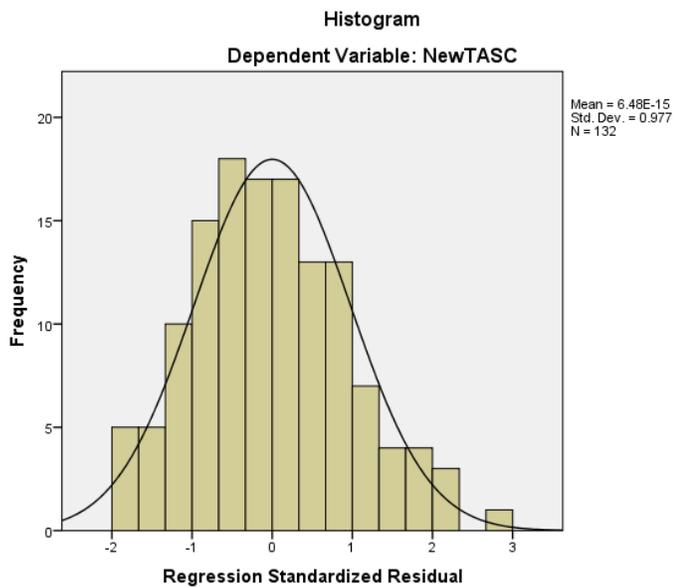


Figure 5: Normal distribution histogram for research question 3

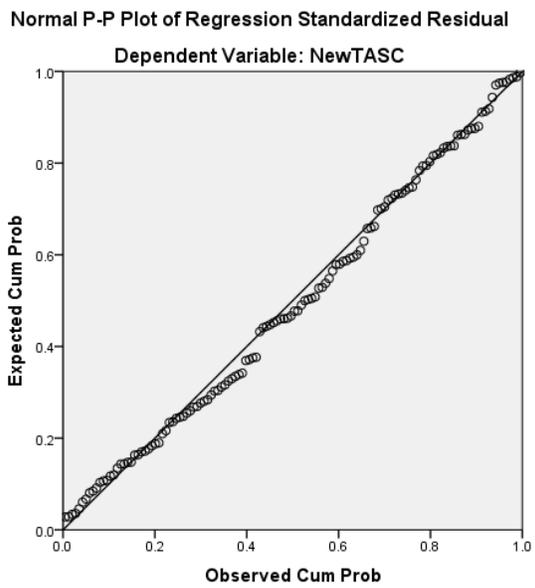


Figure 6: Normal probability plot for research question 3

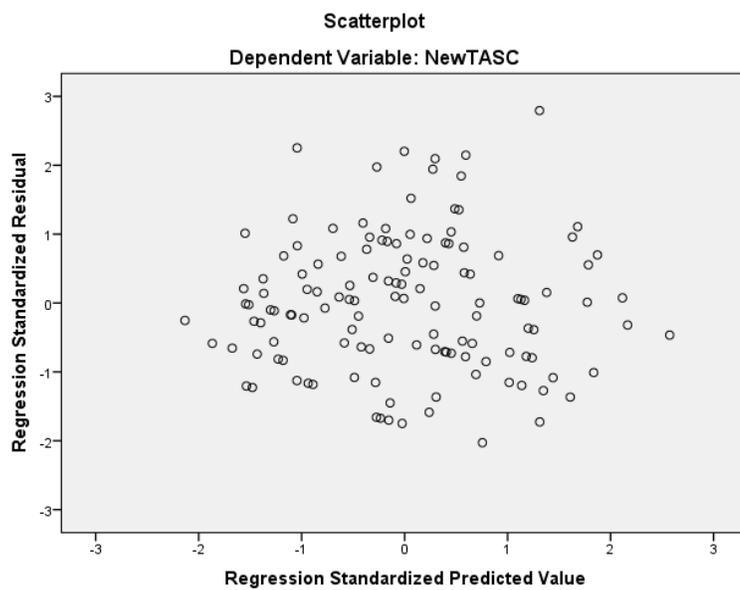


Figure 7: Scatterplot of standardized residuals for research question 4

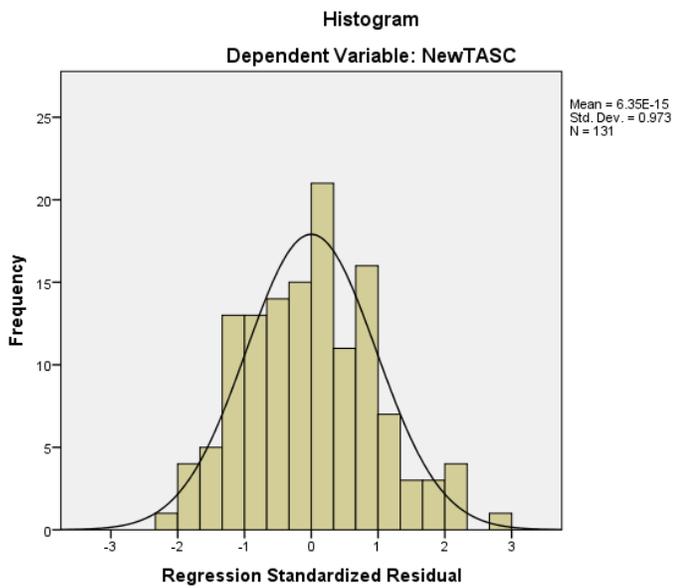


Figure 8: Normal distribution histogram for research question 4

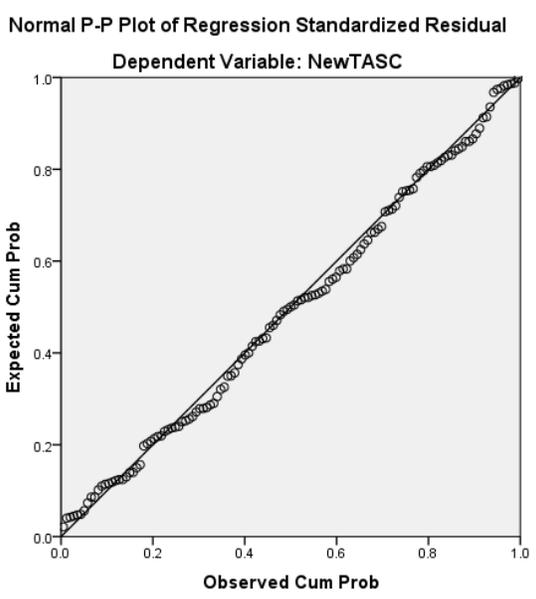


Figure 9: Normal probability plot for research question 4

Correlation Statistics

Pearson product-moment correlations were calculated for each pairing of study variables and to screen for multicollinearity and singularity. Neither multicollinearity was met because the variables do not have high correlations ($r = .90$) nor was singularity because the predictor variables are not perfectly correlated ($r = 1.00$). See Table 4 for the means, standard deviations, and intercorrelations of all study variables.

Table 4: Means, standard deviations, and intercorrelations of all study variables

Variables	<i>M</i>	<i>SD</i>	<i>N</i>	1	2	3	4	5	6	7
1. TWA _{IR}	1.28	.17	136							
2. YrsExp _i	3.20	1.24	136	.005						
3. MGender	.48	.50	136	-.162*	-.017					
4. MEthnicity	.65	.48	136	.048	.067	-.094				
5. TAnx _i	1.26	.13	134	.265**	-.181*	-.220*	.014			
6. AnxS _i	1.41	.24	132	.162*	-.192*	-.119	-.192*	.320**		
7. AvdS _i	1.21	.23	132	.199*	.049	-.183*	-.142	.106	.367**	
8. MCC _{IR}	1.29	.14	131	.246**	-.017	-.147*	.058	.401**	.199*	.243**

Note. TWA = Therapeutic Working Alliance. YrsExp = Years of Experience. MGender = Gender Matching. MEthnicity = Ethnicity Matching. TAnx = Trait Anxiety. AnxS = Attachment-related Anxiety. AvdS = Attachment-related Avoidance. MCC = Multicultural Counseling Competence. _{IR} = Reflect and square root Transformed Scale. _i = Transformed Scale.

** $p < .01$, * $p < .05$.

The direction of correlations of TWA and MCC must be reversed when interpreting the correlation coefficients due to the reflected transformation of the variables. Two of the three variables held constant in the study, therapist years of experience, matched gender, and matched ethnicity were not significantly correlated with TWA. Therapist years of experience and matched ethnicity were not significantly correlated with TWA, while matched gender was significantly correlated with TWA, $r = .16, p < .05$. This result can be interpreted as dyads with matched gender had higher ratings on the TWA. Other significant correlations were found between the predictor variables and constant variables.

Trait anxiety was significantly and negatively correlated with therapists years of experience ($r = -.18, p < .05$). As years of experience increase, trait anxiety decreases. Attachment-related anxiety was negatively correlated with therapist years of experience ($r = -.19, p < .05$). In other words, as years of experience increase, attachment-related anxiety decreases. MCC was positively correlated with matched gender ($r = .15, p < .05$), or matching gender between the therapeutic dyads was related to higher scores on MCC.

The first research question was addressed by examining the zero-order correlations between the study variables of child therapist trait anxiety, child therapist attachment-related anxiety, child therapist attachment-related avoidance, child therapist multicultural counseling competence, and child therapist-perceived TWA. The results indicate a statistically significant relationship between child therapist TWA and trait anxiety ($r = -.27, p < .01$), MCC ($r = .25, p < .01$), attachment-related anxiety ($r = -.16, p < .05$), and attachment-related avoidance ($r = -.20, p < .05$). For this sample, levels of

trait anxiety, attachment-related anxiety and avoidance increase when the levels of the TWA decreases. As MCC increases, so does TWA.

The results also indicate a statistically significant relationship between trait anxiety and attachment-related anxiety ($r = .32, p < .01$). The relationship is moderate in size and indicates that the level of trait anxiety increases with the level of attachment-related anxiety. The results also indicate a statistically significant relationship between attachment-related anxiety and avoidance ($r = .37, p < .01$), describing a positive moderate relationship between attachment-related avoidance and anxiety.

To my knowledge, prior to the current research, the relationship between attachment quality and MCC had not been investigated. Results in this study showed that attachment-related anxiety and attachment-related avoidance were negatively correlated with MCC, $r = -.20, p < .01$ and $r = -.24, p < .01$, respectively. Interpretation of these relationships needs to reverse direction because MCC was reflected before transformation. In other words, as attachment-related anxiety and avoidance increase, MCC decreases.

Another relationship found in the current research that has not been replicated, to my knowledge, is the relationship between trait anxiety and MCC, $r = -.40, p < .01$. Again the relationship had to be reversed because MCC was reflected before transformation. As trait anxiety increases, MCC decreases to a moderate degree.

All of the abovementioned relationships reached significance at the $p < .05$ or $p < .01$ level, meaning the results were highly unlikely to be related to random chance. Through the examination of zero-order correlations, the majority of the research findings were able to reject the null hypothesis that there were no relationships among

the variables. There was only one relationship, trait anxiety and attachment-related avoidance that did not reach significance.

Multiple Regression Analysis

Research Questions 2, 3, and 4 addressed the strength of trait anxiety, attachment-related anxiety and avoidance, and MCC to explain variance in therapist-rated TWA scores after controlling for experience level, dyadic matching gender, and dyadic matching ethnicity. Matching gender was coded 0 = No and 1 = Yes, and matching ethnicity was coded 0 = No and 1 = Yes. Hierarchical multiple regression was used to enter the variables due to its theoretical applicability to the dependent variable (TWA). Question 2 explored to what extent child therapist trait anxiety predicted therapist-perceived TWA after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up. The control variables were entered in Block 1 and trait anxiety was entered in Block 2. The results indicated that the control variables made up 2.8% of variance of the TWA ratings, but were not significant ($\Delta R^2 = .03$, $\Delta F(3,130) = 1.25$, $p = .30$). However, trait anxiety explained an additional 8.7% variance in the TWA. The change in variance explained was statistically significant at $p < .01$ ($\Delta R^2 = .06$, $\Delta F(1,129) = 8.01$, $p = .005$). Thus, after controlling for experience, matched gender and ethnicity, trait anxiety contributed to explaining the variance in the TWA, at the .01 level. Table 5 shows the results of hierarchical multiple regression for Research Question 2.

Table 5: Hierarchical regression results for research question 2

Model	Variable	B	β	SE	t	p	Part r	Partial r	r^2
1	YrsExp	.000	-.020	.012	-.20	.984	-.002	-.002	.028
	MGender	-.053	-.160	.029	-1.839	.068	-.159	-.159	
	MEthnicity	.011	.033	.030	.376	.707	.033	.033	
2	YrsExp	.006	.044	.012	.508	.612	.043	.045	.085
	MGender	-.035	-.105	.029	-1.211	.228	-.102	-.106	
	MEthnicity	.011	.032	.029	.373	.709	.032	.033	
	TAnx	.325	.250	.114	2.843	.005**	.239	.243	

Note. $N = 131$. TWA = Therapeutic Working Alliance. YrsExp = Years of Experience. MGender = Gender Matching.

MEthnicity = Ethnicity Matching. TAnx = Trait Anxiety. B = Unstandardized coefficients. β = Standardized Coefficients. SE = Standard Error. t = t-value. p = p-value. Part r = Part Correlations. Partial r = Partial Correlations. r^2 = Coefficient of determination.

** $p < .01$.

Question 3 explored to what extent therapist attachment-related anxiety and attachment-related avoidance predicted therapist-perceived TWA above and beyond the effect of therapist trait anxiety after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up. Hierarchical multiple regression was used to address the additional contribution of attachment-related anxiety and avoidance. Block 1 and Block 2 remained the same as above; and, attachment-related anxiety and avoidance were entered in Block 3. After trait anxiety, attachment-related anxiety and avoidance did not contribute to model fit, $\Delta R^2 = .06$, $\Delta F(2,125) = 1.95$, $p = .15$. Thus, after controlling for experience, matched gender and ethnicity, attachment-related anxiety and avoidance did not predict therapist-perceived TWA above and beyond the effect of trait anxiety. Table 6 shows the results of Research Question 3.

Table 6: Hierarchical regression results for research question 3

Model	Variable	B	β	SE	t	p	Part r	Partial r	r^2
1	YrsExp	-.003	-.022	.012	-.247	.805	-.022	-.022	.024
	MGender	-.049	-.149	.029	-1.696	.092	-.148	-.148	
	MEthnicity	.007	.021	.030	.236	.813	.021	.021	
2	YrsExp	.004	.028	.012	.320	.750	.027	.028	
	MGender	-.033	-.101	.029	-1.149	.253	-.098	-.101	.075
	MEthnicity	.008	.024	.030	.276	.783	.024	.024	
3	TAnx	.309	.237	.116	2.655	.009**	.227	.229	
	YrsExp	.003	.021	.012	.237	.813	.020	.021	.103
	MGender	-.023	-.069	.029	-.781	.436	-.066	-.070	
	MEthnicity	.020	.057	.030	.656	.513	.056	.059	
	TAnx	.276	.212	.120	2.295	.023*	.194	.201	
	AnxS	.031	.044	.068	.452	.652	.038	.040	
	AvdS	.112	.154	.067	1.653	.101	.140	.146	

Note. $N = 131$. TWA = Therapeutic Working Alliance. YrsExp = Years of Experience. MGender = Gender Matching. MEthnicity = Ethnicity Matching. TAnx = Trait Anxiety. AnxS = Attachment-related Anxiety. AvdS = Attachment-related Avoidance. B = Unstandardized coefficients. β = Standardized Coefficients. SE = Standard Error. t = t-value. p = p-value. Part r = Part Correlations. Partial r = Partial Correlations. r^2 = Coefficient of determination. ** $p < .01$, * $p < .05$

Question 4 examined to what extent therapist multicultural competence predicted therapist-perceived TWA beyond the effects of therapist trait anxiety, attachment-related anxiety, and attachment-related avoidance after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up. Block 1, 2, and 3 remained the same as above; and, MCC was entered into Block 4. After trait anxiety and attachment-related anxiety and avoidance, MCC did not contribute to model fit, $\Delta R^2 = .07$, $\Delta F(1,123) = 1.73$, $p = .19$. Thus, MCC did not predict therapist-perceived TWA after controlling for experience, matched gender and ethnicity, above and beyond the effect of trait anxiety and attachment-related anxiety and avoidance. Table 7 shows the results of Research Question 4.

Table 7: Hierarchical regression results for research question 4

Model	Variable	B	β	SE	t	p	Part r	Partial r	r^2
1	YrsExp	-.004	-.028	.012	-.319	.750	-.028	-.028	.025
	MGender	-.050	-.152	.029	-1.729	.086	-.152	-.152	
	MEthnicity	.005	.015	.031	.175	.862	.015	.015	
2	YrsExp	.003	.020	.012	.227	.820	.019	.020	.077
	MGender	-.035	-.105	.029	-1.193	.235	-.102	-.106	
	MEthnicity	.006	.017	.030	.198	.843	.017	.018	
3	TAnx	.313	.239	.117	2.675	.008**	.229	.232	
	YrsExp	.002	.011	.012	.127	.899	.011	.011	.107
	MGender	-.024	-.074	.029	-.832	.407	-.071	-.074	
4	MEthnicity	.017	.051	.030	.578	.564	.049	.052	
	TAnx	.277	.212	.120	2.302	.023*	.195	.202	
	AnxS	.036	.052	.068	.533	.595	.045	.048	
4	AvdS	.114	.157	.068	1.681	.095	.143	.149	
	YrsExp	.001	.005	.012	.057	.995	.005	.005	
	MGender	-.023	-.071	.029	-.799	.426	-.068	-.072	.120
	MEthnicity	.014	.040	.030	.458	.648	.039	.041	
	TAnx	.215	.165	.129	1.670	.097	.141	.149	
	AnxS	.033	.048	.068	.493	.623	.042	.044	
	AvdS	.096	.132	.069	1.389	.167	.118	.124	
	MCC	.154	.125	.117	1.314	.191	.111	.118	

Note. $N = 131$. TWA = Therapeutic Working Alliance. YrsExp = Years of Experience. MGender = Gender Matching. MEthnicity = Ethnicity Matching. TAnx = Trait Anxiety. AnxS = Attachment-related Anxiety. AvdS = Attachment-related Avoidance. MCC = Multicultural Counseling Competence. B = Unstandardized coefficients. β = Standardized Coefficients. SE = Standard Error. $t = t$ -value. $p = p$ -value. Part $r =$ Part Correlations. Partial $r =$ Partial Correlations. $r^2 =$ Coefficient of determination.

* $p < .05$

The interpretation of the part and partial r is important in understanding how much each variable uniquely contributes to the coefficient of determination (r^2) over and beyond that which can be accounted for by the other predictor variables (Tabachnick & Fidell, 2007). For this research, the part correlation of trait anxiety, or the unique contribution, is .239 (see Table 5) and the partial correlation is .243 (see Table 5). The partial correlation determines each predictor variable's participation in determining the correlation coefficient (Tabachnick & Fidell, 2007). The part and partial correlation of attachment-related anxiety is .038 and .040, respectively (see Table 6) and the part and partial correlation of attachment-related avoidance is .140 and .146, respectively (see Table 6). The part and partial correlation of MCC is .111 and .118, respectively (see Table 7). Clearly, trait anxiety as a predictor provides the most amount of unique variance in this data set.

Summary

In summary, the statistical analysis results are as follows:

1. For Research Question 1, the null hypothesis was rejected because there were significant relationships between the variables TWA, trait anxiety, attachment-related anxiety and avoidance, and MCC. Trait anxiety and attachment-related avoidance was the only relationship that did not reach significance. All other relationships were significant at the $p < .01$ and/or $p < .05$.
2. For Research Question 2, trait anxiety explained a significant amount of variance (8.7%) in the TWA ($p < .01$), after controlling for therapist years of experience, matched gender and matched ethnicity.

3. Research Questions 3 and 4 did not produce any statistical significance. Neither attachment-related anxiety nor avoidance statistically significantly predicted therapist-perceived TWA above and beyond trait anxiety, after controlling for therapist years of experience, matched gender and matched ethnicity. MCC did not predict therapist-perceived TWA above and beyond trait anxiety and attachment-related anxiety and avoidance, after controlling for therapist years of experience, matched gender and matched ethnicity.

4. The best model of fit is Model 2 because Model 3 and Model 4 did not contribute much to the variance in the TWA. Specifically, trait anxiety was the only predictor variable that resulted in a significant change in variance of the TWA ($p = .005$). With one unit of change in trait anxiety, the perceived TWA increased by .25. Because trait anxiety was significantly and negatively correlated with TWA, this result indicates that as trait anxiety increases by one point in an individual therapist's response, ratings on the TWA will decrease by approximately .25, or the standardized coefficient, which is close to two standard deviations away from the sample's TWA mean ($M = 1.28$, $SD = .17$). Model 2 clearly demonstrates that trait anxiety is related to the dependent variable, TWA.

CHAPTER 5: DISCUSSION

The study investigated the relationships among child therapists' trait anxiety, attachment-related anxiety and avoidance, multicultural counseling competence and the therapeutic working alliance (TWA) in play therapy settings. A review of research suggests that building a strong therapeutic working alliance is important among child practitioners who use play therapy in relation to outcomes (Bratton, Ray, Rhine, & Jones, 2005). The literature also suggests that trait anxiety, attachment-related anxiety and avoidance, and multicultural counseling competence can influence ratings of the TWA in adult populations (e.g., Black, Hardy, Turpin, & Parry, 2005; Chapman, Talbot, Tatman, & Britton, 2009; Fuertes et al., 2006). Although recent research has focused on child practitioners and the TWA, this study is the first of its kind to examine the contribution of the abovementioned predictor factors in combination in predicting therapist-perceived TWA in play therapy setting.

Discussion of Findings

Results in Chapter 4 showed partial support for the study hypotheses. The following sections will discuss these findings in the context of the current literature on the TWA and the correlates that influence its rating among child practitioners. The research questions were as follows:

1. What are the relationships among child therapist trait anxiety, child therapist attachment-related anxiety, child therapist attachment-related avoidance, child therapist multicultural counseling competence, and child therapist-perceived TWA?
2. To what extent does child therapist trait anxiety predict therapist-perceived TWA after controlling for experience level, dyadic gender make-up and dyadic ethnicity make-up?
3. To what extent do therapist attachment-related anxiety and attachment-related avoidance predict therapist-perceived TWA above and beyond the effect of therapist trait anxiety after controlling for experience level, dyadic gender make-up, and dyadic ethnicity make-up?
4. To what extent does therapist multicultural competence predict therapist-perceived TWA beyond the effects of therapist trait anxiety, attachment-related anxiety, and attachment-related avoidance after controlling for experience level, dyadic gender make-up and dyadic ethnicity make-up?

Discussion of Relationships among Study Variables

There are several notable correlational relationships in this study. First, research Question 1 explored the correlations among trait anxiety, attachment-related anxiety and avoidance, multicultural counseling competence (MCC), and TWA. Correlational analysis provided support for an inverse relationship between trait anxiety, attachment-related anxiety and avoidance, and TWA in this current research. Support was also found for a positive relationship between MCC and TWA. All the relationships were at a significance level of $p < .05$ or $.01$ in the current sample of child therapists. The relationships found in the current research are replications of empirical evidence found

with adult therapist samples (Black et al., 2005; Chapman et al., 2009; Fuertes et al., 2006). These results support the idea that the formation of a successful TWA can be compromised or enhanced based on therapist factors in both child and adult therapists.

Secondly, another significant correlation found among the current research and supported in the literature was the association between trait anxiety and attachment-related anxiety. Correlational analysis indicated a positive association between trait anxiety and attachment-related anxiety, same as what other researchers have reported (Watt, McWilliams, & Campbell, 2005; Weems, Berman, Silverman, & Rodriguez, 2002). Watt et al. (2005) suggested that the overlap between trait anxiety and attachment-related anxiety is a result of a shared variance among these variables. This overlap can be explained by the theory behind the two concepts.

Attachment quality is theorized to influence emotional regulation (Bowlby, 1980). Attachment-related anxiety is associated with a negative model of self where individuals tend to desire intimate relationships, but are susceptible to depression and distress from interpersonal sources (Bartholomew, 1990). Trait anxiety is theorized to be a personality trait associated with feelings of anxiety and tension (Spielberger, 1972), that can influence interpretation of interpersonal processes negatively (Gunthert, Armeli, & Cohen, 1999). The negative self-schema of attachment-related anxiety coupled with trait anxiety's influence on interpersonal processes primes individuals for negative feelings and thoughts about interpersonal relationships such as the TWA.

Research describes a decline in trait anxiety and attachment-related anxiety over time. Magai (2008) describes that attachment in middle and later life is distinctly different from attachment in samples of younger adults. Specifically, preoccupied

attachment, which is defined by having higher levels of attachment anxiety and lower levels of attachment avoidance (Brennan, Clark, & Shaver, 1998), is less representative while adult dismissive attachment style, which is defined by having lower levels of attachment anxiety and higher levels of attachment avoidance (Brennan et al., 1998), is more representative in samples of older adults compared to samples of younger adults (Magai, 2008). Similarly, the contextual perspectives on personality and change demonstrate that neuroticism, the personality classification associated with trait anxiety, decreases over time (Srivastava, John, Gosling, & Potter, 2003). This relationship further supports the theorized relationship between trait anxiety and attachment-related anxiety.

Findings peculiar to the current study are the associations between MCC and trait anxiety and attachment quality. MCC was found to be negatively associated with trait anxiety, attachment-related anxiety, and attachment-related avoidance. To the best of my knowledge, these findings had not been reported in previous literature. Due to the lack of empirical evidence supporting this connection, the relationship is difficult to interpret. However, one way to understand the connection is linking the construct of MCC with the idea that it is a measurement of capability in a specific area. The moderate correlation ($r = -.40$) between MCC and trait anxiety indicates a moderate relationship between the two constructs. An individual with trait anxiety is theorized to be primed for negative affect and thoughts (Spielberger, 1973); therefore, self-ratings of competence might be affected by these negative affect and thoughts. In other words, a therapist with higher levels of trait anxiety may tend to self-perceive lower levels of MCC and rate themselves lower on an instrument measuring competence. But, the

causal relationship between MCC and trait anxiety cannot be established by the current correlational study. Future study needs to investigate if causal relationship exists between these two variables.

Attachment-related anxiety and avoidance also negatively correlated with MCC. A possible explanation for the inverse relationship between attachment-related anxiety and avoidance and MCC could be the moderate overlap ($r = .36$) between attachment-related anxiety and avoidance. Conceptually, attachment-related anxiety and attachment-related avoidance are orthogonal but research indicates a mild correlation (Wei, Russell, Mallinckrodt, & Vogel, 2007). A possible explanation for the inverse relationship between attachment insecurity and MCC is that individuals with insecure attachment are hypothesized to have lower self-esteem compared to individuals with secure attachment (Park, Crocker, & Mickelson, 2004). Lower self-esteem could prime an individual to rate themselves as less competent in areas such as cross-cultural counseling. Future research should be explored to examine the correlational evidence between interpersonal variables and MCC.

The non-significant relationship between years of experience and matched ethnicity and the TWA, and significant relationship between matched gender and the TWA provide support for inclusion of the control variables in this study. Similarly, other research found mixed results for the control variables on TWA ratings (Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009; Hersoug, Høglend, Monsen, & Havik, 2001; Wintersteen, Menniger, & Diamond, 2005) which was the primary reason for controlling for these variables. In Wintersteen et al.'s (2005) study, matched gender and the TWA was significant for adolescent client ratings and TWA, while this research

found support for therapist ratings and the TWA. The mix of significance and non-significance among the control variables and TWA further encourage holding these variables constant in future research of a similar nature. Additional research is needed to clarify the effects of dyadic make-up on the TWA.

Discussion of Multiple Regression Findings

Research Questions 2, 3, and 4 study explored through a hierarchal regression analysis the extent trait anxiety, attachment-related anxiety and avoidance, and MCC predicted therapist-perceived TWA after controlling for years of experience, dyadic match gender and ethnicity make-up. The primary and only significant finding from the regression analyses was Model 2 derived from Research Question 2. It was found that trait anxiety explained 8.7% of the variance in the TWA ratings, meaning that as trait anxiety increased one unit, therapist ratings of the TWA decreased by the unstandardized coefficient of .325. These results suggest that trait anxiety of child therapists significantly related to self-perceived TWA. Understanding this result is meaningful because trait anxiety has been found to prime individuals for negative emotional reactivity in interpersonal relationships (Gunthert et al., 1999). This implies the importance of mitigating the potentially negative effects of personality traits of child therapists because some traits, such as trait anxiety, have the tendency to impact therapists' perception of a therapeutic relationship, which has been linked to therapeutic outcomes (Bratton et al., 2005).

The rest of the variables in combination did not predict any change in the TWA scores. For example, the control variables years of experience and dyadic matched gender and ethnicity did not significantly predict TWA, indicating that these variables

were not predictive of TWA ratings in this sample. Therefore, this research indicates that years of experience and dyadic matched gender and ethnicity did not predict TWA ratings, even though a significant zero correlation was found between matching gender and therapist perceived TWA. In research on adult therapists and adult clients, gender was found not to influence the ratings of TWA (Dunkle & Friedlander, 1996; Hersoug et al., 2009; Hersoug et al., 2001); however, research with adolescents found matched gender, specifically female therapist and female client, was related to client-rated TWA (Wintersteen et al., 2005). This research found therapist-rated TWA with matched gender clients was significantly related to TWA; but, important to note is that the majority of the therapist sample was female (95%) and the majority of the dyads (71 of 136) did not report matched gender. As such, additional studies are needed to further clarify the association between the dyadic gender make-up and the TWA.

Research Questions 3 addressed the respective contributions of attachment-related anxiety and attachment-related avoidance in predicting the variance in the TWA above and beyond trait anxiety, after controlling for years of experience and dyadic matching gender and ethnicity. It was hypothesized that attachment-related anxiety and avoidance would significantly predict TWA scores above and beyond trait anxiety and the control variables, consistent with other correlational research (Black et al., 2005; Fuertes, Mislouack, Brown, Gur-Arie, Wilkinson, & Gelso, 2007). Fuertes et al. (2007) concluded that attachment orientation of therapists and clients in adult dyads were independently associated with alliance ratings, which were supported by the significant relationships between attachment-related anxiety and avoidance and TWA. However, this research did not support the hypothesized predictive relationship of attachment-

related anxiety and avoidance above and beyond the predictive validity of trait anxiety, contrary to Black et al.'s multiple regression results of both neuroticism and attachment insecurity significantly predicted more perceived problems in therapy. A possible explanation for the current research not finding similar results is the smaller sample size compared to Black and colleagues research (136 versus 491). In addition, different instruments were used in Black et al.'s research, including instruments measuring attachment quality, working alliance, and personality traits. Important to note and relevant to this research, Black et al. excluded therapists who worked with families and children.

Research Question 4 addressed the respective contribution of MCC in predicting TWA above and beyond attachment-related anxiety and avoidance and trait anxiety, after controlling for therapist years of experience and dyadic matching gender and ethnicity. It was hypothesized that MCC would predict TWA ratings above and beyond attachment-related anxiety and avoidance, trait anxiety, and the control variables assuming the order of entering the predictor variables in the regression equation made theoretical sense. This research did not support this hypothesis, even though there was a moderate positive zero correlation found between MCC and TWA. A possible explanation for this is that a moderate correlation does not mean causality, just that the two constructs are related. Other research has reported that trait anxiety and attachment quality have been theorized to be more predictive of relationship quality (Nofle & Shaver, 2006), while MCC requires more research on how influential it is on predicting perceived relationship quality. This research also indicated no evidence of matching or non-matching ethnic dyads influencing TWA or MCC, similar to other research that

found significant correlations between therapist-perceived MCC and TWA regardless of dyadic matching and non-matching ethnicity (Fuertes et al., 2006).

Limitations

There are several limitations of this research study. The first issue is the limited generalizability of this study. This study focused on a specific population of therapists who were accessed through association membership and listservs. Not all therapists who work with children are members of these associations or listservs. However, attempts were made in the present study to recruit participants from across the country so to improve the representativeness of the study sample.

A second limitation in this study concerns the delimited age range of child clients of the participating therapists. This means that the results cannot be generalized to the relationship between therapists who work with children younger and/or older than the age range. Future study should consider investigating working alliance between therapists and their clients who are less than seven years and/or older than 10 years old. Another limitation related to the participation distribution is the low level of male therapists. Future research would benefit from including a more diverse sample of therapists.

Another limitation is the use of self-report, a methodological implication of this study. Therapists were asked to self-report on three variables, as well as report on a relationship with a child client. Self-report can be susceptible to social desirability influence, where participants represent themselves in a more positive light than reality. Also, the fact that the child clients' experience of therapy was not included in this study makes the information one-sided, thus limiting its interpretation. Future studies should

consider both the therapist and child client input, when assessing for strength of the TWA.

A third limitation is the nature of the correlational relationships found in the study. Casual inference cannot be made based on correlational evidence. Hence, the significant correlations listed above do not infer that one causes another, just that they are related, and do not rule out the causal influences of other variables. Future studies should consider observational designs in conjunction with client and therapist report.

Despite the limitations listed above, this study has notable strengths. This study was a direct response to a need in the counseling training literature focusing on child therapists in the realm of correlates on building a successful TWA. The study's quantitative instruments were attempts aimed at overcoming numerous challenges related to measuring influential variables on the TWA in counseling. To the best of my knowledge, this study is the first of its kind in examining the combination of predictors and constant variables in relation to the TWA in child therapists using play therapy. It stands a needed supplement to consider the effect therapist personality traits have on the formation of a successful alliance, as well as contributes new research to the literature on child therapists.

Implications for Future Research

Beutler et al. (2004) noted a declining trend in research between therapist personality traits and outcome due to inability to provide casual inference. However, in the literature, the TWA has been found to conclusively relate to outcomes in both child and adult populations. The current research provided further support indicating therapist's personality traits are associated with the ratings of the TWA. Findings in the

present study suggest that personality traits, specifically trait anxiety of therapists, should be reexamined to see how they specifically influence the building of alliances in therapy in both child and adult therapists. Also, with the recommendation to focus on what factors influence working alliance ratings, recommendations for future research also include examining the influence to what degree theoretical orientation has on a clinician's understanding and rating of the working alliance.

Additional research should be conducted to examine the overlap between the constructs of trait anxiety and attachment-related anxiety and their respective implications on the formation of successful TWA. This research found a significant overlap between the two constructs, yet attachment-related anxiety did not predict TWA ratings. It is recommended to expand the focus of future research to understand how much shared variance these constructs have, and what implications they may have on theoretical and practical understandings.

Also, it would be beneficial to the counselor education community for research to inquire into what processes influence MCC. In this study, trait anxiety and attachment-related anxiety and avoidance were all inversely related to MCC. Research should be conducted to examine what interpersonal factors contribute to shaping the ability of therapists and therapists-in-training to master multicultural competence.

In line with the above reasoning, future research would benefit both child therapists and adult therapists in replicating this study with a more diverse sample of participants. This sample from the current research consisted of primarily Caucasian female therapists. Inclusion of male therapists and other ethnicities would strengthen this line of research and increase generalizability across the counseling field. However,

this type of research is limited by how counselor education program attract diverse student samples. It would further benefit future research to be more inclusive of diverse populations of counseling students, who would then represent a more diverse working therapist population to pull from.

In closing, this research was conducted to provide empirical evidence for counseling training programs to develop training curriculum that will help trainees examine and address their relationship with their clients as it relates to their attachment security, trait anxiety, and multicultural competence, as well as highlight areas of self-awareness important to practicing therapists. In a recent meta-analysis on helping skills training models, Hill and Lent (2006) found only one model that included addressing anxiety as a training component. Future research would benefit from inclusion of addressing anxiety and therapeutic processes. Other recommendations of research from this study include examining trait anxiety and attachment quality on TWA and interpersonal processes that influence MCC.

Conclusion

This study replicated significant correlations that have been found in the extant research with adult therapists. This research also found that trait anxiety explained a significant amount of variance in perceived TWA ratings among child therapists. The study is unique in counselor education research for likely being the first to examine a unique subset of child therapists. The study also highlighted the need to look at therapists' traits that influence the TWA in general and in child counseling and play therapy specifically. The findings in this study indicate the importance of examining the effects of trait anxiety on the formation of the TWA, the overlap between trait anxiety

and attachment-related anxiety, and what interpersonal factors influence MCC. In light of the current research, counselor educators may need to pay attention to helping counseling trainees in mitigating the possible effects of personality traits in general and trait anxiety in specific in therapeutic processes. The study supports further examination of the relationship between trait anxiety and the TWA in child therapy and adult therapy. Additional studies should also be conducted to clarify why the lack of effect of attachment quality on the TWA when trait anxiety is taken into consideration. Lastly, based on the brand new findings in this research of trait anxiety and attachment quality influencing MCC ratings, the field of counselor education would benefit from examining how to build competence in counselors in the development of MCC.

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APPENDIX A: STUDY RECRUITMENT LETTER

Dear Participants,

I am currently conducting a study for my dissertation on the characteristics of child therapists. I am looking for participants to engage in an online survey. To participate in the study, participants should be child therapists that are using play materials (i.e., toys, puppets, art materials) in their work with clients between the ages of 7 and 10 years. As an incentive to participate in the study, participants may choose to be entered into a sweepstakes where they can win 1 of 20 \$20 gift cards to Amazon.com.

The survey is conducted online and will take about 20 minutes to complete. Interested individuals please access the study's website (<https://www.surveymonkey.com/s/rschererdissertationresearch/>) for more details on the study and the research materials.

Thank you very much.

Rebecca Scherer MA, LPCA, NCC
University of North Carolina at Charlotte
(rschere2@uncc.edu)

APPENDIX B: RECRUITMENT LETTER FOR PARTICIPANTS AT THE
MULTICULTURAL PLAY THERAPY CONFERENCE, UNIVERSITY OF NORTH
CAROLINA AT CHARLOTTE, JUNE 24TH-JUNE 28TH, 2013

(Printed on a 4X6 piece of paper)

Dear Participants,

I am currently conducting a study for my dissertation on the characteristics of child therapists. I am looking for participants to engage in an online survey. To participate in the study, participants should be child therapists that are using play materials (i.e., toys, puppets, art materials) in their work with clients between the ages of 7 and 10 years. As an incentive to participate in the study, participants may choose to be entered into a sweepstakes where they can win 1 of 20 \$20 gift cards to Amazon.com.

The survey is conducted online and will take about 20 minutes to complete. Interested individuals please access the study's website (<https://www.surveymonkey.com/s/rschererdissertationresearch>) for more details on the study and the research materials.

Thank you very much.

Rebecca Scherer MA, LPCA, NCC
University of North Carolina at Charlotte
(rschere2@uncc.edu)

APPENDIX C: INFORMED CONSENT



The University of North Carolina at Charlotte
Education
9201 University City Boulevard
Counseling
Charlotte, NC 28223-001
8960

College of
Department of
704/687-

Dear Participant,

You are invited to participate in a study being conducted by Rebecca Scherer, a doctoral student from the Department of Counseling in the College of Education at the University of North Carolina at Charlotte. For my dissertation project, I am conducting research on child therapists. The project focuses on certain variables that might impact a child therapist's ratings of the working alliance in therapy. Specifically, this project will look at the relationship between child therapists' trait anxiety, attachment quality, and multicultural counseling competence on the therapeutic working relationship.

Findings in this study are expected to enhance the understanding of the elements that may impact the therapeutic working alliance in child counseling/therapy. This knowledge will contribute to the training and research of child therapists. If you decide to participate, you will complete four research instruments and a short demographic questionnaire at a convenient time and place for you. The completion time for the measures should take approximately 20 minutes. The research instruments are designed to gather information on trait anxiety, attachment quality, multicultural counseling competence, and the working alliance.

You are a volunteer and are under no obligation to participate. If you do, your responses will be completely anonymous and confidential. The questionnaires are coded such that participant identities are never identified. You may choose to terminate participation should you experience emotional discomfort while completing the materials. No adverse actions will be taken against you for opting out. All data collected will be stored in a secure place. Only my dissertation committee and I will have access to them.

I am inviting licensed or certified counselor and therapists who are using play materials (i.e., toys, puppets, art materials) in their work with clients between the ages of 7 and 10 years. I expect to recruit approximately 200 participants.

If you meet the inclusion criteria and wish to participate in either the initial administration, simply click on the link titled “continue to survey” and you will be sent to the survey’s website

(<https://www.surveymonkey.com/s/rschererdissertationresearch>). By clicking on the link and agreeing to participate in the study you are acknowledging that you have read and understand the informed consent document. No additional information will be required from you unless you wish to participate in the drawing for 20 \$20 gift cards in which case you will provide your email address at the completion of the online survey.

No risk or negative consequence is expected from your participation. Your participation may contribute to the improvement of counselor training and our understanding of counselor factors that influence the therapeutic working alliance.

Any information about your participation, including your identity, will be kept confidential. If you have any questions about the study, please contact me, or you may contact my dissertation chair, Dr. Kok-Mun Ng at 704-687-8693 or the Office of Research Compliance at 704-687-1871 and uncc-irb@uncc.edu .

By replying to this recruitment and informed consent document, you acknowledge that:

1. You are at least 18 years old
2. You meet the participant criteria: Licensed or certified counselors or therapists who are working in various settings with children using play materials.
3. You have read and understood the aforementioned information
4. Your decision to participate in this study was completely up to you and your information will be kept confidential, and
5. You have been given an opportunity to ask the researchers questions concerning this research and your participation.

Sincerely,

Rebecca Scherer MA, LPCA, NCC

Doctoral Candidate

University of North Carolina at Charlotte

Contact: rschere2@uncc.edu; 704-251-9323

APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE

Please answer the following questions:

- *1. Your age (check one): 20-30 31-40 41-50 51-60 61-70 71-80 80+
- *2. Your gender (check one): Male Female Transgendered
- *3. Your race/ethnicity (check one):
- | | |
|--|--|
| <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> American Indian/Alaskan Native |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Pacific Islander or Native Hawaii |
| <input type="checkbox"/> Latino/a | <input type="checkbox"/> Biracial/Multiracial |
| <input type="checkbox"/> Asian or Asian American | <input type="checkbox"/> Other (please specify): _____ |
4. Where are you practicing (check one):
- | |
|--|
| <input type="checkbox"/> North Atlantic (Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont) |
| <input type="checkbox"/> North Central (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin) |
| <input type="checkbox"/> Southern (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia, Washington, D.C., and West Virginia) |
| <input type="checkbox"/> Rocky Mountain (Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming) |
| <input type="checkbox"/> Western (Alaska, Arizona, California, Hawaii, Nevada, Oregon, and Washington, as well as Pacific Rim countries) |
| <input type="checkbox"/> Other (please specify): _____ |
- *5. Certifications/ licensure (check one):
- | | |
|-----------------------------------|--|
| <input type="checkbox"/> LPC/LMHC | <input type="checkbox"/> LMFT |
| <input type="checkbox"/> LCSW | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> LP | |
- *6. Years of experience counseling children: _____
- *7. Please select from the following the toy categories you use in therapy with children:
- | |
|--|
| <input type="checkbox"/> Real-life toys (e.g., doll family, dollhouse, puppets, and nondescript figures) |
| <input type="checkbox"/> Sand-tray (e.g., sand-tray, water, and figurines) |
| <input type="checkbox"/> Art supplies (e.g., crayons, markers, scissors, and paper) |
| <input type="checkbox"/> Other: please specify _____ |
8. Theoretical orientation (pick the best that describes your work):
- | | |
|--|--|
| <input type="checkbox"/> Child-centered | <input type="checkbox"/> Gestalt/Experiential |
| <input type="checkbox"/> Cognitive/ Cognitive-Behavioral | |
| <input type="checkbox"/> Psychodynamic | <input type="checkbox"/> Other (please specify): _____ |
9. While in graduate school, did you take any courses for graduate credit (at least 3 credit hours per course) that **focused only on Play Therapy**? Yes No
- a. If yes, how many courses? 1 More than one.

10. How many hours of **post-graduate play therapy** training (i.e. workshops, continuing education opportunities, conferences) have you taken? Estimate: _____ hours
11. While in graduate school, did you take any courses for graduate credit (at least 3 credit hours per course) that **focused only on Child Therapy**? Yes No
- a. If yes, how many courses? _ 1 more than 1
12. How many hours of post-graduate child therapy training (i.e. workshops, continuing education opportunities, conferences) have you taken?
Estimated: _____ hours

*Answer required.

APPENDIX E: INSTRUCTIONS FOR INSTRUMENTS

Please answer the following instruments based on the instructions provided. In recording your response, please keep the following points in mind:

- a. Please select the appropriate rating for each statement.
- b. Please select only one response for each statement.
- c. Be sure you check every scale even though you may feel that you have insufficient data on which to make a judgment—please do not omit any.

APPENDIX F: THERAPIST ALLIANCE SCALE FOR CHILDREN

Please rate the following questions based **on a CURRENT child client** age between 7 and 10 who you have seen for a minimum of **three times**. If you are working with more than one client, please select the client with the first letter of his or her first name closest to the letter "C".

Please provide the following information on child client/patient you have selected to provide ratings to these set of item:

1. My child client's Gender (check one): Male Female
2. My child client's age _____
3. My child client's race/ethnicity (check one):

<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> American Indian/Alaskan Native
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Pacific Islander/Native Hawaii
<input type="checkbox"/> Latino/a	<input type="checkbox"/> Biracial/Multiracial
<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Other: _____

Please rate your child client's/patient's current presentation in therapy on the following scales. Select the number corresponding to your rating for each item.

1. The child likes spending time with you, the therapist.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

2. The child finds it hard to work with you on solving problems in his/her life.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

3. The child considers you to be an ally.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

4. The child works with you on solving his/her problems.

1	2	3	4
Not Like My Patient	A Little Like My Patient	Mostly Like My Patient	Very Much Like My Patient

5. The child appears eager to have sessions end.

1	2	3	4
---	---	---	---

- | | | | |
|------------------------|-----------------------------|---------------------------|------------------------------|
| Not Like My
Patient | A Little Like My
Patient | Mostly Like My
Patient | Very Much Like My
Patient |
|------------------------|-----------------------------|---------------------------|------------------------------|
- 6. The child looks forward to therapy sessions.**
- | | | | |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
| 1
Not Like My
Patient | 2
A Little Like My
Patient | 3
Mostly Like My
Patient | 4
Very Much Like My
Patient |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
- 7. The child feels that you spend too much time focusing on his/her problems/issues.**
- | | | | |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
| 1
Not Like My
Patient | 2
A Little Like My
Patient | 3
Mostly Like My
Patient | 4
Very Much Like My
Patient |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
- 8. The child is resistant to coming to therapy.**
- | | | | |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
| 1
Not Like My
Patient | 2
A Little Like My
Patient | 3
Mostly Like My
Patient | 4
Very Much Like My
Patient |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
- 9. The child uses his/her time with you to make changes in his/her life.**
- | | | | |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
| 1
Not Like My
Patient | 2
A Little Like My
Patient | 3
Mostly Like My
Patient | 4
Very Much Like My
Patient |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
- 10. The child expresses positive emotion toward you, the therapist.**
- | | | | |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
| 1
Not Like My
Patient | 2
A Little Like My
Patient | 3
Mostly Like My
Patient | 4
Very Much Like My
Patient |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
- 11. The child would rather not work on problems/issues in therapy.**
- | | | | |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
| 1
Not Like My
Patient | 2
A Little Like My
Patient | 3
Mostly Like My
Patient | 4
Very Much Like My
Patient |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
- 12. The child is able to work well with you on dealing with his/her problems/issues.**
- | | | | |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|
| 1
Not Like My
Patient | 2
A Little Like My
Patient | 3
Mostly Like My
Patient | 4
Very Much Like My
Patient |
|-----------------------------|----------------------------------|--------------------------------|-----------------------------------|

APPENDIX G: TRAIT SCALE OF STATE-TRAIT ANXIETY INVENTORY

A number of statements which people have used to describe themselves are given below. Read each statement and then write the number in the blank at the end of the statement that indicates *how you generally feel*. There are no right or wrong answers.

Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

1 = Almost Never

2 = Sometimes

3 = Often

4 = Almost Always

1. I feel pleasant _____
2. I feel nervous and restless _____
3. I feel satisfied with myself _____
4. I wish I could be as happy as others seem to be _____
5. I feel like a failure _____
6. I feel rested _____
7. I am "calm, cool, and collected" _____
8. I feel that difficulties are piling up so that I cannot overcome them _____
9. I worry too much over something that really doesn't matter _____
10. I am happy _____
11. I have disturbing thoughts _____
12. I lack self-confidence _____
13. I feel secure _____
14. I make decisions easily _____
15. I feel inadequate _____
16. I am content _____
17. Some unimportant thought runs through my mind and bothers me _____
18. I take disappointments so keenly that I can't put them out of my mind _____
19. I am a steady person _____
20. I get in a state of tension or turmoil as I think over my recent concerns and interests _____

APPENDIX H: EXPERIENCES IN CLOSE RELATIONSHIPS SCALE-SHORT
FORM

The following statements concern how you feel in romantic relationships. I am interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Mark your answer using the following rating scale:

1 Strongly Disagree

2 Slightly Disagree

3 Neutral

4 Slightly Agree

5 Strongly Agree

1. It helps to turn to my romantic partner in times of need.
2. I need a lot of reassurance that I am loved by my partner.
3. I want to get close to my partner, but I keep pulling back.
4. I find that my partner(s) don't want to get as close as I would like.
5. I turn to my partner for many things, including comfort and reassurance.
6. My desire to be very close sometimes scares people away.
7. I try to avoid getting too close to my partner.
8. I do not often worry about being abandoned.
9. I usually discuss my problems and concerns with my partner.
10. I get frustrated if romantic partners are not available when I need them.
11. I am nervous when partners get too close to me.
12. I worry that romantic partners won't care about me as much as I care about them.

APPENDIX I: CROSS-CULTURAL COUNSELING INVENTORY—REVISED

The purpose of this inventory is to measure your perceptions about your cross-cultural counseling competence. I am interested in your opinion so please make a judgment on the basis of what the statements in this inventory mean to you.

Rating Scale: 1 = strongly disagree 4 = slightly agree
2 = disagree 5 = agree
3 = slightly disagree 6 = strongly agree

1. I am aware of my own cultural heritage.
1 2 3 4 5 6
2. I value and respect cultural differences.
1 2 3 4 5 6
3. I am aware of how my own values might affect this client.
1 2 3 4 5 6
4. I am comfortable with differences between counselor and client.
1 2 3 4 5 6
5. I am willing to suggest referral when cultural differences are extensive.
1 2 3 4 5 6
6. I understand the current socio-political system and its impact on the client.
1 2 3 4 5 6
7. I demonstrate knowledge about client's culture.
1 2 3 4 5 6
8. I have a clear understanding of counseling and therapy process.
1 2 3 4 5 6
9. I am aware of institutional barriers which might affect client's circumstances.
1 2 3 4 5 6
10. I elicit a variety of verbal and non-verbal responses from the client.
1 2 3 4 5 6
11. I accurately send and receive a variety of verbal and non-verbal messages.

- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
12. I am able to suggest institutional intervention skills that favor the client.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
13. I send messages that are appropriate to the communication of the client.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
14. I attempt to perceive the presenting problem within the context of the client's cultural experience, values, and/or lifestyle.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
15. I present my own values to the client.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
16. I am at ease talking with this client.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
17. I recognize those limits determined by the cultural differences between client and counselor.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
18. I appreciate the client's social status as an ethnic minority.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
19. I am aware of the professional and ethical responsibilities of a counselor.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|
20. I acknowledge and am comfortable with cultural differences.
- | | | | | | | |
|--|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
|--|---|---|---|---|---|---|

APPENDIX J: SWEEPSTAKES DRAWING

Thank you for participating in my research. If you choose to, at the conclusion of taking the survey, you may submit your email address into a drawing for a chance to win 1 of 20 \$20 gift cards to Amazon.com. If you choose to submit your email address, it will be entered into an Excel spreadsheet. Two weeks after the final administration is complete, winners of the gift cards will be randomly selected through Excel and will be contacted by me at the email address you provided for this study. At that time I will include a link for how you can receive the money over the internet. At that point, the Excel spreadsheet, all of its contents, and any email correspondence between you and I will be immediately destroyed via computer software that destroys data permanently. Only the winners of the gift cards will be notified. Please feel free to contact me if you have any questions regarding these procedures. If at any point during this study you decide you would like to opt out, simply exit the survey by closing your web browser's window. There will be no adverse action taken against you for opting out of this study. Thank you again for your participation in the survey.

Sincerely,
Rebecca Scherer MA, LPCA, NCC
Doctoral Candidate
University of North Carolina at Charlotte
Contact: rschere2@uncc.edu; 704-251-9323

APPENDIX K: SWEEPSTAKES DRAWING NOTIFICATION

Thank you for participating in my research titled ‘The association of trait anxiety, attachment quality, multicultural counseling competence and child therapists’ perceived working alliance with their young clients using play.’ You have been randomly selected to receive a \$20 gift card to Amazon.com. Please feel free to contact me if you have any questions or concerns. Thank you very much for your participation!

Sincerely,
Rebecca Scherer

Contact: rschere2@uncc.edu; 704-251-9323