

CONGRUENCE, UNCONDITIONAL POSITIVE REGARD, AND EMPATHIC  
UNDERSTANDING IN CHILD-CENTERED PLAY THERAPY

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Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

August 2013

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Jayne, Kimberly M. Congruence, Unconditional Positive Regard, and Empathic Understanding in Child-Centered Play Therapy. Doctor of Philosophy (Counseling), August 2013, 163 pp., 5 tables, 3 figures, references, 88 titles.

The purpose of this study was to explore how the therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding were experienced and conveyed in child-centered play therapy (CCPT). Although the therapist-provided conditions are considered essential to the therapeutic process in CCPT, a gap exists between child-centered theory and empirical exploration of the process and dynamics of these relational variables in CCPT. Due to the limited research in this area, a grounded theory approach was utilized to explore how the three variables emerge in CCPT. Participants included four advanced doctoral students, all Caucasian females with extensive training in CCPT, and 12 children ranging from 4 to 8 years of age receiving weekly, individual CCPT. One individual CCPT session was observed and video-recorded for each therapist-child dyad ( $n = 12$ ). Following each observation, play therapists were interviewed regarding the observed play session ( $n = 12$ ). During each interview, the researcher and therapist watched the recorded play session in its entirety and discussed noteworthy interactions between the child and therapist. The video-recorded play therapy sessions and therapist interviews were analyzed using a multiphasic, constant comparative method. Results of the analysis included a process-model of the therapist-provided conditions in CCPT, examples of play therapists' internal experiences and external behaviors associated with the presence and absence of the therapist-provided conditions, and a model of the process play therapists utilize to respond to breaks and barriers to congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard in CCPT. Implications for clinical practice, training, supervision, and research are discussed.

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## ACKNOWLEDGEMENTS

Who I am today is a reflection of many people, family, friends, teachers, mentors, supervisors, students, and clients, who have nurtured, supported, and inspired me throughout my lifetime. I dedicate this work and my life's work to you. To Abigail, Scarlet, Elizabeth, Luke, and Benjamin, for inspiring me daily to be my best self and to make the world a better place for you and for all children. To my parents, for supporting me in a multitude of ways and instilling within me a love for learning. To Loren, for demonstrating persistence and dedication in all you do and looking out for me at every turn. To Heather, for loving me unconditionally and being the person I have always looked up to and aspired to be like my whole life. To Rodger, without whom I would not have started this journey and whose strength and courage I continue to admire. To JFT, for your incredible generosity, enduring patience, and persistent hopefulness. You are the reason I believe in the healing power of relationships. To Marty, for your unwavering confidence and passionate support of me as a student, scholar, and human being. To Dee Ray, for truly seeing me and believing wholeheartedly in the person I am becoming; for honoring my fragile process; and giving me the gift of your presence, vulnerability, and authenticity. To Sue Bratton, for your warmth, attunement, and creativity and for always seeing the best in me and in the world. To Jan Holden, for challenging me to reflect deeply and to seek answers to ill-structured problems. To Leslie Jones, for your gentle presence, kind heart, and faithful encouragement. To Garry Landreth, for first inspiring me to enter the world of play therapy and being a true teacher, mentor, and friend. To my cohort, for embracing me and sharing all the joys and sorrows of this journey with me, for being there when I needed you most, and for knowing and loving me in all my various forms. And to my clients, my greatest teachers, for showing me the true meaning of genuineness, empathy, and unconditional positive regard.

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## CONGRUENCE, UNCONDITIONAL POSITIVE REGARD, AND EMPATHIC UNDERSTANDING IN CHILD-CENTERED PLAY THERAPY (CCPT)

Child-centered play therapy (CCPT) is a developmentally responsive intervention for children based on the philosophy of Carl Rogers' person-centered approach (Axline, 1947; Landreth, 2012; Ray, 2011). Although it is one of the most widely used approaches in the United States and has been shown to be an effective treatment for children with a variety of emotional and behavioral issues, there has been limited research on the therapeutic process, relational variables, and therapeutic relationship in CCPT (Bratton, Ray, Rhine, & Jones, 2005; Lambert et al., 2005; Ray & Bratton, 2010; Shirk & Karver, 2003). The process of CCPT follows the conditions set forth by Rogers (1951) to facilitate client movement toward personality change.

Rogers (1951) provided a comprehensive framework for understanding human development, psychological maladjustment, and personality change in his 19 propositions (Ray, 2011; Wilkins, 2010) and described the environment necessary for constructive personality change to occur when he outlined six necessary and sufficient conditions for therapy: (1) the therapist and the client are in psychological contact, (2) the client experiences incongruence, (3) the therapist is congruent in the relationship, (4) the therapist experiences unconditional positive regard towards the client, (5) the therapist experiences and communicates empathic understanding towards the client, and (6) the client perceives the therapist's unconditional positive regard and empathic understanding (Rogers, 1957). The third, fourth, and fifth conditions are often referred to as the attitudinal or therapist-provided conditions as they address the therapist's experience and communication of congruence, unconditional positive regard, and empathic understanding within the therapeutic relationship. Essential to effective therapeutic practice, the attitudinal conditions are provided by the therapist with the primary purpose of



creating a non-threatening environment that allows the actualizing tendency of the client to be realized and growth to occur. Although minimally explored in research and therapeutic practice, understanding how these three conditions are defined, experienced, and conveyed in CCPT is central to providing effective interventions for children and understanding the process and outcome of CCPT.

In person-centered literature, congruence has often been defined as a therapist's ability to be genuine, open, aware, and integrated within the therapeutic relationship (Mearns & Thorne, 2000; Rogers, 1957; Wyatt, 2001). Congruence includes consistency between the therapist's internal awareness and external expression and facilitates empathy and acceptance towards the client (Bozarth, 2001c; Greenberg & Geller, 2001). In CCPT, congruence is described as "being real" (Landreth, 2012, p. 70) and is expressed through the play therapist's openness and genuine empathy toward and acceptance of the child (Cochran, Nordling, & Cochran, 2010; Van Fleet et al., 2010). Although research on congruence is somewhat limited, several researchers have found a positive correlation between therapist congruence and therapeutic outcome (Kirschenbaum & Jourdan, 2005; Kolden, Klein, Wang, & Austin, 2011).

Unconditional positive regard is understood as complete and total acceptance of each and every aspect of the client's experience and self-structure (Mearns, 2003; Rogers, 1957; Tolan, 2012). In CCPT literature, unconditional positive regard has most often been described as acceptance and includes valuing and accepting children as they are without wanting the child to be different in any way (Axline, 1947; Landreth, 2012; Ray, 2011). Although few researchers have explored unconditional positive regard apart from congruence and empathic understanding, Farber and Doolin (2011) found a positive relationship between unconditional positive regard and therapeutic outcome in their meta-analytic review.

Defined most often as “self-acceptance,” many contemporary person-centered theorists have highlighted the relationship between unconditional positive self-regard and one’s ability to provide unconditional positive regard for clients (Bozarth, 2001c, 2001e; Tolan, 2012; Wilkins, 2010). Landreth (2012) identified therapist self-acceptance and belief in the child’s capacity for growth as fundamental to the process and outcome of CCPT. Similarly, Ray (2011) argued that a lack of self-acceptance inhibits a therapist’s ability to provide acceptance to children. No known studies have been conducted on unconditional positive self-regard in person-centered therapy or CCPT.

Rogers (1975) defined empathic understanding as a process of “entering the private perceptual world of the other and becoming thoroughly at home in it . . . being sensitive, moment to moment, to the changing felt meanings which flow in this other person” (p. 4). Empathy is distinguished from the therapeutic skill of reflection (Bozarth, 2001a, 2001b; Rogers, 1975; Schmid, 2001) and considered to involve both cognitive and affective understanding of the client’s experience (Tengland, 2001). In CCPT, empathy is defined as being open and sensitive to the child’s experience and able to enter fully into the child’s world (Cochran et al., 2010; Landreth, 2012; Ray, 2011). In a meta-analysis of 57 studies, Elliot, Bohart, Watson, and Greenberg (2011) found a positive correlation between therapists’ empathy and therapeutic outcome.

Although the therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding are often considered separately, many person-centered authors proposed that the three constructs are inextricably linked (Truax & Carkhuff, 1967) and should be considered together as one meta-condition (Mearns & Thorne, 2000; Mearns & Cooper, 2005; Wilkins, 2010). Bozarth (1998; 2007) described the relationship of the three as follows: (a)

congruence is a state of readiness within the therapist that allows the therapist to experience the client through empathic understanding, (b) empathic understanding is the way the therapist conveys unconditional positive regard for the client, and (c) unconditional positive regard is the 'curative factor' in person-centered counseling.

Lambert and Barley (2002) provided a summary of research on the therapeutic relationship and outcome and noted that 40% of the change in therapy was accounted for by extratherapeutic factors, 30% by common factors, 15% by clients' expectancy, and 15% by specific therapeutic techniques. They defined common factors as variables that would be found in the majority of therapies regardless of theoretical orientation including empathy, warmth, acceptance, the therapeutic alliance, or process factors. Lambert and Barley stated that "it is readily apparent . . . that of the factors most closely associated with the therapist, the therapeutic relationship is central in contributing to positive therapy outcome" (p. 18). In their extensive review of process-outcome research over the previous 50 years, Orlinsky, Ronnestad, and Willutski (2003) also found that the therapeutic alliance or bond had a positive correlation with therapeutic outcome. Researchers have repeatedly found a positive correlation between relationship variables and therapeutic outcome. However, challenges related to measurement and methodology have made it difficult to isolate and understand these variables (Bozarth, 1998; Greenberg & Elliot, 1997; Truax & Carkhuff, 1967).

Although most research on relational variables has been conducted with adults (Darr, 1994; Harnish, 1983; Siegel, 1972; Truax & Carkhuff, 1967), Shirk and Karver (2003) conducted a meta-analytic review of 23 studies that examined the outcome of treatment for children and adolescents based on relationship variables and found a positive correlation between the therapeutic relationship and outcome variables. Siegel (1972) examined the relationship

between therapist-offered conditions and changes in play therapy behaviors and found a positive modeling effect for the children who experienced the highest level of therapist-offered conditions. Harnish (1983) studied the effects of children's perceptions of therapist-expressed conditions on the process and outcome of non-directive play therapy and found that higher levels of therapist-expressed conditions were positively related to children's empathy and self-concept and negatively related to children's aggressiveness. Darr (1994) studied the development of the therapeutic relationship in client-centered play therapy and how the "core conditions" manifest themselves through analysis of therapists' verbal responses. She provided a descriptive analysis of the therapeutic relationship and recommended sequential provision of the conditions through the course of play therapy.

Although experts in both person-centered and CCPT emphasized the importance of the therapist-provided conditions (Cochran et al., 2010; Mearns & Thorne, 2000; Ray, 2011; Wilkins, 2010) in the therapeutic process and relationship, limited research has been conducted to explore how these conditions are demonstrated and actualized in child-centered play therapy.

Additionally, researchers who have conducted studies on the therapist-provided conditions in play therapy have relied primarily on textual analysis and focused almost exclusively on the therapist's verbal responses and skills (Darr, 1994; Harnish, 1983; Siegel, 1972). Similarly, the majority of authors and experts in the field of CCPT have emphasized the training and use of verbal skills in CCPT without significant consideration of nonverbal modes of communication or attention to the therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding in CCPT (Ray, 2011).

Due to the limited research on Rogers' conditions for constructive personality change in CCPT, there is a lack of knowledge and understanding as to how these essential therapeutic

dimensions emerge and are actualized within the therapeutic relationship. The lack of research on the therapist-provided conditions in CCPT reflects a significant gap between child-centered theory and child-centered practice. A more complete understanding of the therapeutic environment, relationship, and process in CCPT is necessary to provide effective interventions for children, to train competent mental health professionals in child counseling, and to advance research on the efficacy of CCPT. The purpose of this study was to explore how the therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding are experienced and conveyed in CCPT.

### Methods

I utilized grounded theory methodology in order to explore how the essential attitudes of congruence, unconditional positive regard, and empathic understanding are experienced and conveyed in CCPT. Glaser and Strauss (1967) developed grounded theory as an inductive, constant comparative methodological approach through which researchers generate theory that is grounded in research. The purpose of a grounded theory approach is to construct abstract theoretical explanations of social process through a systematic analysis of data (Charmaz, 2006). Charmaz recommended a grounded theory approach when the purpose of the research is to generate theory in an area where there is little existing knowledge or to expand existing theoretical knowledge. A qualitative, grounded theory approach is recommended to develop a holistic understanding of complex human phenomena such as the therapist-provided conditions in child-centered play therapy (Creswell, 2013; Glazer & Stein, 2010).

### Research Team

The research team consisted of two advanced doctoral students and one faculty member with extensive experience in CCPT practice, training, supervision, and research. The primary

researcher is a 31-year-old, White, female; a Licensed Professional Counselor intern; and an advanced doctoral student with four courses in CCPT, four courses in person-centered theory, three years of CCPT supervision, and advanced training in qualitative analysis and grounded theory methodology. The second research team member is a 29-year-old, White female; a Licensed Professional Counselor intern; and an advanced doctoral student in counselor education with two classes in CCPT, three years of play therapy supervision, and advanced training in person-centered theory and qualitative analysis. A faculty member served as an expert consultant and peer reviewer throughout the research process. The faculty member is a licensed professional counselor supervisor and a registered play therapist supervisor with 17 years of clinical practice in CCPT and 14 years of experience teaching and supervising CCPT. She has conducted numerous quantitative and qualitative research studies in CCPT.

## Participants

I used theoretical sampling as the primary sampling method in this study (Charmaz, 2006). The main principle of theoretical sampling is that the emerging categories and developing theory guide sampling (Morse, 2007). I also used purposeful sampling, as recommended by Creswell (2013), to select participants who experienced the phenomenon being explored. Following IRB approval, I recruited child-centered play therapists from a mental health clinic on a university campus in the Southwestern United States. Four ( $n = 4$ ) advanced doctoral students with at least three courses in play therapy, at least two years of clinical experience in play therapy, and weekly supervision of their play therapy facilitation participated in this study. All therapists were White females. In order to participate in the study, each play therapist affirmed her beliefs in the basic philosophy of CCPT by signing a theoretical statement that included a

summary of Rogers' (1951;1957) philosophy of human development and conditions for constructive personality change and Axline's (1947) principles for child therapists.

Each participating play therapist was asked to identify three children they were currently seeing in individual CCPT ( $n = 12$ ). Child demographics are summarized in Table 2. Children met the following criteria for inclusion: (a) age 4 to 8 years; (b) attend play therapy on a weekly basis; (c) completed at least six play therapy sessions with the same therapist; and (d) demonstrated incongruence, anxiety, or vulnerability at initiation of therapy. In order to meet Rogers' second condition for therapeutic change, the children had to demonstrate some level of incongruence, anxiety, or vulnerability as exhibited through problematic behaviors at the initiation of play therapy (Ray, 2011). The presence of problematic behaviors was assessed through an initial parent consultation prior to the initiation of play therapy. The therapists identified children on their caseloads who met inclusion criteria, were consistent in their weekly attendance, and appeared responsive to CCPT. Participating children's demographics are summarized in Table 1.

Table 1

*Child Demographics*

Therapist	Child	Age	Grade	Gender	Ethnicity	Observed Session #
Therapist A	Child 1	5	Pre-K	Male	White	7
	Child 2	8	2 <sup>nd</sup> Grade	Female	Asian	51
	Child 3	8	2 <sup>nd</sup> Grade	Male	White	46
Therapist B	Child 4	4	Pre-K	Male	Bi-racial	13
	Child 5	4	Pre-K	Male	White	10
	Child 6	5	-----	Female	White	52
Therapist C	Child 7	8	3 <sup>rd</sup> Grade	Male	Bi-racial	15
	Child 8	7	1 <sup>st</sup> Grade	Female	White	9
	Child 9	6	1 <sup>st</sup> Grade	Male	African-American	11

*(table continues)*

(continued)

Therapist	Child	Age	Grade	Gender	Ethnicity	Observed Session #
Therapist D	Child 10	8	3 <sup>rd</sup> Grade	Male	White	28
	Child 11	7	2 <sup>nd</sup> Grade	Female	White	8
	Child 12	6	1 <sup>st</sup> Grade	Female	White	35

*Note.* Observed Session # = the number of times child had been seen in CCPT by the participating play therapist at the time of observation.

#### Data Collection

Therapists were asked to complete a brief demographic self-questionnaire and a demographic questionnaire on each of their participating clients. I observed one individual CCPT session with each therapist and child. Each child was observed once and each therapist was observed three times. Children were observed after their sixth session or more of CCPT with no maximum limit on the total number of CCPT sessions (see Table 1). Observations were conducted using two-way mirrors in order to maintain the integrity of the therapeutic interaction between the therapist and child. Each observed session was video-recorded using multiple cameras. I wrote field notes during the live observations regarding the observed processes and interactions between the play therapist and the child. Immediately following the play session, the therapists made brief notes regarding their impressions, thoughts, and feelings about the session. Within three days of the live observation, I conducted a 90 to 120-minute, semi-structured interview with the therapist about the observed play therapy session. Therapist interviews were audio- and videotaped. During the interviews, the play therapists were asked to describe and reflect on their relationship with the child and their experiences in the session with the child as they watched the video-recorded play session. My field notes and the therapist's brief session notes were used to inform the interview process. I also wrote field notes during the therapist interviews, noting when therapists stopped the play sessions to discuss their interactions and



experience with the child and significant statements or ideas. Throughout the data collection and analysis processes, I wrote analytic memos to promote constant comparison, categorical analysis, and overall theory development.

## Data Analysis

The multiphasic comparative data analysis procedures are summarized in Table 2.

Table 2

### *Steps in Qualitative Data Analysis*

Steps	Procedures
<b>Introduction and Discussion of Procedures</b>	Introduced the coding team to study and methods for data collection and analysis. Oriented the coding team to the research question and facilitated a discussion of potential biases, values, and experiences that may influence data analysis (Charmaz, 2006).
<b>Open Coding of Play Sessions: Phase I</b>	The coding team independently analyzed four of the video-recorded play sessions. A 15-minute segment of each play session was coded minute-by-minute. The coding team coded each minute twice, first focusing on the child's behavior and second focusing on the therapist's behavior. Additional minutes of each play session were identified for coding based on the therapist interviews. The researchers also watched each play session in its entirety to develop global impressions of the sessions.
<b>Comparison</b>	The coding team met to discuss the coding process and compare codes. The research team compared their codes to observational field notes and developed initial analytic memos.
<b>Open Coding of Play Sessions: Phase II</b>	The coding team independently analyzed the remaining 8 video-recorded play sessions utilizing the same procedures as in Phase I.
<b>Comparison</b>	The coding team met to discuss the coding process and compare codes on the remaining 8 play sessions. The coding team compared their codes to observational field notes and continued to develop analytic memos.
<b>Open Coding of Therapist Interviews: Phase I</b>	The coding team independently analyzed four of the video-recorded therapist interviews. Therapist interviews were coded in their entirety idea-by-idea.

*(table continues)*

(continued)

Steps	Procedures
<b>Comparison</b>	The coding team met to discuss the coding process and compare codes. The coding team compared their codes to interview field notes and play session codes and developed analytic memos.
<b>Open Coding of Therapist Interviews: Phase II</b>	The coding team independently analyzed the remaining 8 video-recorded therapist interviews utilizing the same procedures as in Phase I.
<b>Comparison</b>	The coding team met to discuss the coding process and compare codes. The coding team compared their codes to interview field notes and play session codes and developed analytic memos.
<b>Focused Coding</b>	The coding team compared codes and categories from the play sessions to codes and categories from the therapist interviews. The team identified the most frequent and significant categories to analyze larger segments of data and to compare the participants' experiences, actions, and interpretations.
<b>Theoretical Coding</b>	The coding team compared and diagrammed focused codes and utilized analytical memos to identify relationships between the substantive categories.

## Results

The purpose of this study was to explore how the therapist-provided conditions are actualized in CCPT. Through open, focused, and theoretical coding of the play therapy sessions and therapist interviews, I developed a grounded theory of the therapist-provided conditions in CCPT that expands our current understanding of how congruence, unconditional positive regard, and empathic understanding are experienced and conveyed in CCPT. Results included definitions of congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard in CCPT and a process-model of the therapist-provided conditions in CCPT.

## Defining the Therapist-Provided Conditions in CCPT

Part of understanding how the therapist-provided conditions are experienced and conveyed in CCPT includes defining congruence, unconditional positive regard, and empathic understanding in terms of the real experiences and interactions of children and play therapists. Definitions of the therapist-provided conditions emerged through the analysis and comparison of the play sessions and therapist interviews.

**Congruence.** The definition of congruence that emerged from the data analysis was “being aware and open to one’s moment-to-moment experience, thoughts, and feelings and expressing one’s self in a real, natural, and free-flowing way in relationship with the child.” The therapists described their experiences of congruence using terms including feeling “genuine, natural, spontaneous, free, in the moment, self-accepting, confident, being myself, being more immediate,” and “having self-awareness.” Additionally, when therapists experienced greater congruence in their play sessions with children, their verbal and nonverbal responses to children appeared to flow more freely and fluidly in the moment and to reflect the therapists’ natural ways of speaking and relating to others. By contrast, during moments the therapists experienced less congruence, their responses were often delayed or characterized by a robotic tone and more rigid body position and movement.

**Unconditional positive regard.** Based on the results of our analysis, unconditional positive regard was defined as “valuing and accepting all aspects of the child’s experience, feelings, thoughts, behavior, and play.” The play therapists described their experiences of unconditional positive regard most often in terms of “acceptance” of various aspects of a child’s personality, perspective, ways of interacting with the therapist, needs and motivations, verbalizations, behavior, and play. Play therapists commonly expressed a strong desire to

experience and communicate acceptance to children especially in moments when children expressed negative feelings, struggled to accomplish tasks, made mistakes, or broke limits. Additionally, the therapists shared a common rationale for allowing children to direct the course of therapy sessions and their own play, avoiding corrective or instructional responses to children, avoiding attempts to rescue children from a negative or challenging situations in session, and avoiding setting inflexible limits based on a strong desire to communicate acceptance of all aspects of the child's experience and ways of being in the relationship. Unconditional positive regard was often expressed through the therapists' verbal reflections of children's negative and positive feelings and behaviors and through their physical openness and proximity to children even in moments of messiness and aggression such as a child flinging sand or wildly punching and kicking a bop bag.

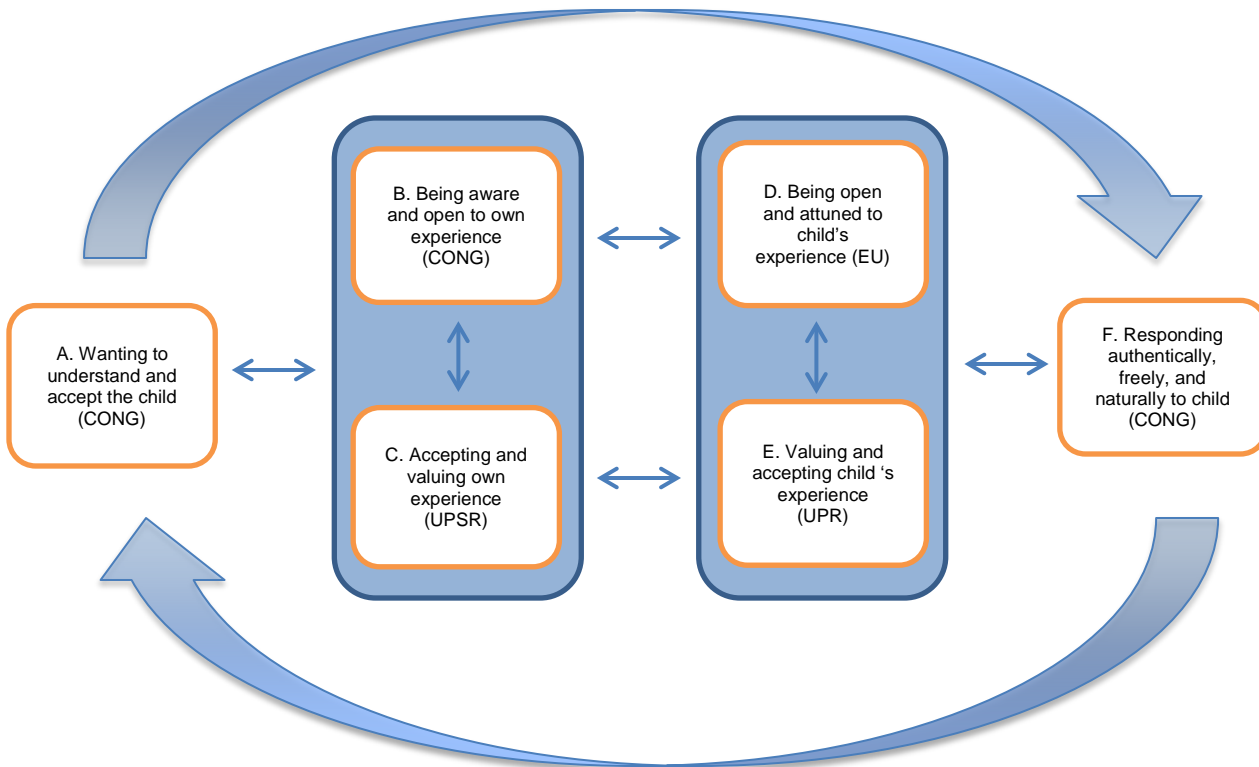
Empathic understanding. The definition of empathic understanding that emerged from the comparative analysis of the play therapy sessions and therapist interviews was "being open and attuned to the child's moment-to-moment experience, intentions, perceptions, and meanings." The play therapists described empathic understanding in terms of feeling "connected, engaged, attuned", and "in sync" with the child and as being fully "present" or "with" the children in their experience. The therapists also recognized that they experienced greater empathy when they understood a child's motivation for playing or behaving in a particular way, understood a child's developmental background, and understood the dynamics of a child's home environment. Empathic understanding was most often conveyed from therapist to child through the matching of facial expression, physical movement, affect, vocal tone and inflection, and energy level.

Unconditional positive self-regard. In addition to the three therapist-provided conditions, unconditional positive self-regard emerged as a key concept in understanding how congruence,

unconditional positive regard, and empathic understanding are experienced and conveyed in CCPT. Through the constant comparative method, unconditional positive self-regard was defined as “valuing and accepting all aspects of one’s own experience, feelings, thoughts, and actions.” The therapists described unconditional positive self-regard as “accepting and trusting self,” and an absence of “self-questioning, self-doubt,” and “self-criticism.” Therapists were readily able to identify moments when they experienced a lack of unconditional positive self-regard most often when they recognized that they had made an inaccurate verbal response to a child, missed the opportunity to respond empathically or genuinely to a child, or misunderstood a child in some way. When therapists were experiencing greater unconditional positive self-regard they were more receptive to a child’s correction or criticism.

#### Process-Model of Therapist-Provided Conditions in CCPT

The grounded theory emerging from the constant comparative methodological analysis of the play sessions and therapist interviews is a process-model of the therapist provided conditions in CCPT. Figure 1 illustrates the process, relationships, and multidirectional flow of congruence, unconditional positive self-regard, unconditional positive regard, and empathic understanding in CCPT. The multidirectional arrows are included to demonstrate the fluid progression and relationships between the conditions.



*Figure 1. Process-model of therapist-provided conditions in CCPT*

*Note.* CONG = congruence; UPSR = unconditional positive self-regard; EU = Empathic understanding; UPR = unconditional positive regard

The participants most often experienced and demonstrated congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard as a dynamic, flowing process with overlapping, simultaneous dimensions. Three dimensions of congruence emerged from the constant comparative analysis of the data. The first dimension of congruence was the play therapists' (A) genuine desire to experience and demonstrate congruence, unconditional positive regard, and empathic understanding. Wanting to be genuine and to convey acceptance, empathy, and regard for the child facilitated the play therapists' abilities to experience and demonstrate the therapist-provided conditions in CCPT. The therapists repeatedly expressed a genuine desire to be honest and real with the child; to be trustworthy and consistent;

to understand the child and communicate understanding; to be accepting of the child's needs, behavior, and play and communicate their acceptance; and to communicate their regard and valuing of the child. Congruence, empathic understanding, and unconditional positive regard were facilitated by a therapist's desire and intention to be congruent, empathic, and accepting.

A second dimension of congruence that we found was play therapists' (B) openness and awareness to their own self-experiencing. Congruence was experienced and communicated when therapists were aware and open to their own thoughts, feelings, and reactions in the relationship. Through the data analysis, we also found a special relationship existed between congruence and unconditional positive self-regard. Congruence was facilitated by play therapists' abilities (C) to accept and value their own experiences. The more accepting play therapists were of their own experiences, thoughts, feelings, and actions in the play therapy sessions, the more open they were to their own experiences, thoughts, feelings, and actions. Likewise, the greater openness play therapists had to their own experiences the more they accepted and valued their experiences. Alternately, congruence was inhibited when therapists lacked unconditional positive self-regard and rejected or distorted their experiences.

Play therapists most often described this second dimension of congruence in terms of having awareness of their own negative thoughts, feelings, or actions during the play sessions, including wanting a child to discontinue playing in a certain way, feeling anxious about a child's doll play, feeling frustrated by a child's demands on the therapist, feeling tired or physically uncomfortable during session, and making inaccurate verbal responses to a child. When the therapists were able to acknowledge and accept their experiences they described a process of becoming more aware and open to their own moment-to-moment experience with the child. For example, one play therapist described feeling repulsed when a child sneezed in her face. The

play therapist's awareness and receptivity to her feelings of disgust in that moment allowed her to accept herself fully in her relationship with the child and, hence, remain open to her feelings of warmth and intimacy immediately following when the child connected with her by putting dress up clothes on the therapist. When play therapists judged, doubted, or questioned their thoughts, feelings, or actions, they described being distracted by self-critical thoughts, disengaged from their own experience in the moment, and disconnected from the child.

The play therapists' (B) openness and (C) acceptance of their own thoughts, feelings, actions, and experiences in the play sessions facilitated their abilities to (D) be open and (E) accepting of the child's experiences, thoughts, feelings, behaviors, and play. The more congruence and unconditional positive self-regard the therapists experienced the more empathic understanding and unconditional positive regard they experienced and demonstrated for the child. For example, one therapist expressed that her ability to accept her own desire for control and orderliness in her environment allowed her to be more accepting of a child's bossy demeanor, demands, and perfectionism in their play therapy session. Likewise, the less accepting the play therapist was of her own desire to be in charge or to be perfect the less acceptance she experienced for the child's bossiness and perfectionism.

Results of the data analysis revealed a strong relationship between empathic understanding and unconditional positive regard. As the play therapists experienced (D) greater openness and attunement to the child's moment-to-moment experience, they experienced greater (E) valuing and acceptance towards all aspects of the child's experience. Likewise, as the play therapists experienced increased unconditional positive regard for the child, they also experienced increased empathic understanding. For example, one play therapist acknowledged



that her ability to accept the child's physical and verbal rejection towards the play therapist helped her to enter more fully into the child's own experience of isolation and vulnerability.

Through the analysis of the play therapy sessions and therapist interviews, a third dimension of congruence emerged. As the play therapists experienced more (D) empathic understanding and (E) unconditional positive regard towards a child, they also (F) responded to the child in an authentic, natural, and free manner. The play therapists identified a direct relationship between their ability to understand and accept a child's experience and their confidence in their ability to accurately and genuinely respond to the child. Play therapists further described this phenomenon as knowing in the moment what a child needed from them and being able to give freely and fully of themselves in that moment. Congruence as (F) a free-flowing, authentic, and natural response to the child promoted the play therapists' (B) unconditional positive self-regard and (A) continued openness to their own experiencing. Congruent responses reflected the unique person of the therapist and her true experience of herself and the child in that moment.

## Discussion

Based on the results of multiphasic, comparative analysis of the play therapy sessions and therapist interviews, congruence, unconditional positive regard, empathic understanding are experienced and demonstrated in CCPT as a dynamic, flowing process with overlapping, simultaneous dimensions. Although separate aspects of each condition emerged through the grounded theory, the conditions were highly interrelated and essential to one another. I found that each of the therapist provided-conditions played a critical role in how the other conditions were experienced and conveyed in CCPT and that no individual therapist provided condition could be experienced or conveyed apart from the other conditions. These findings are consistent

with the concept of a meta- or super-condition of which congruence, empathic understanding, and unconditional positive regard are each considered a part (Bozarth, 1998, 2007; Mearns & Thorne, 2000; Mearns & Cooper, 2005; Wilkins, 2001). The results of our analysis and the process-model of congruence, unconditional positive regard, and empathic understanding in CCPT affirm that the therapist-provided conditions cannot be experienced or conveyed in isolation and that they are mutually influenced and inextricably linked together. Although it may be helpful to evaluate and identify the therapist-provided conditions individually in therapeutic interactions, it is essential to consider how they relate, facilitate, and influence each other as a process.

Although all of the therapist-provided conditions were related and essential, congruence emerged as a layered condition with nuances addressed minimally in person-centered and child-centered literature. The process-model of the therapist-provided conditions in CCPT included three dimensions of congruence: (a) wanting to experience and convey empathic understanding and unconditional positive regard to the child, (b) being aware and receptive to one's own experiencing, and (c) responding to the child in an authentic, natural, and free-flowing manner. Desiring to be genuine in the relationship, attuned to the child's experience, and accepting of the child was essential to play therapists' actual provision of congruence, empathic understanding, and unconditional positive regard. The therapist's genuine intention and desire to experience and convey congruence, unconditional positive regard, and empathic understanding facilitated the actualization of those conditions in CCPT and provided the context for genuine expression of acceptance and empathy. This dimension of congruence is consistent with Bozarth's (2001c) definition of congruence as a "state of readiness" that enables the therapist to experience empathic understanding and unconditional positive regard towards the client. Cornelius-White

(2007b) and Bozarth (2001c) also identified a therapist's genuine experience of empathic understanding and unconditional positive regard towards the client as essential aspects of congruence. Additionally, Landreth (2012) implied this primary dimension of congruence in his description of the intentional commitment of child-centered play therapists to a philosophy and way of being with children. Congruence as a genuine desire to be real, accepting, and empathic in one's interactions with a child is rooted in the play therapist's belief in the child and in the healing potential of a relationship characterized by congruence, unconditional positive regard, and empathic understanding.

The identification of three dimensions of congruence within the grounded theory process-model of the therapist-provided conditions lends empirical support to Cornelius-White's (2007a) integrative five-dimensional model of congruence. Cornelius-White identified similar dimensions of congruence including: (a) the genuine experiencing of empathy and unconditional positive regard, (b) awareness and openness to one's experience, (c) authentic communication in the therapeutic relationship, and (d) flow that includes receptivity, presence, and a loss of self-consciousness in the therapeutic relationship. In both models, congruence extends beyond the consistency between the therapist's self-awareness and real experience to include genuine communication and presence in the therapeutic relationship. As Cornelius-White described, congruence is "the unity of being and doing" (p. 235) and is realized in the genuine, flowing receptivity and responsiveness of the therapist. Flow is realized in both models as the fulfillment and expression of the therapist's congruence, unconditional positive self-regard, unconditional positive regard, and empathic understanding in the therapeutic relationship.

Within the process-model, unconditional positive self-regard emerged as a core category and proved essential to therapist congruence. The more play therapists accepted and valued their

experiencing in the moment, the more aware and open they became to their experiencing. Likewise, the therapists' awareness and receptivity to their own experiences facilitated their self-acceptance. Bozarth (2001c) described the special relationship between congruence and unconditional positive regard as a 'conditions loop' in which, "congruence represents to varying degrees the therapist's UPSR [unconditional positive self-regard] but is also a manifestation of UPSR" (p.191). He emphasized their mutual influence, noting that "increased freedom of self in relationship fosters higher degrees of UPSR which is then manifested by greater congruence" (p. 192). As play therapists experienced greater freedom to be their real selves in relationship with a child, they valued and accepted themselves more. As they became more self-valuing and self-accepting, they felt freer to respond with empathy and unconditional positive regard in a genuine manner and to give of themselves more fully and freely in the relationships. In these moments, play therapists' verbal and nonverbal responses reflected both the person of the therapist and the experience of the child more deeply and fully.

Similarly, empathic understanding and unconditional positive regard also emerged as highly interrelated and simultaneously promoted the experience and communication of one another. Play therapists' openness and attunement to a child's whole experience facilitated their acceptance and regard towards the child. Valuing and accepting a child's experience also facilitated therapists' receptivity and attunement to a child's experience. Bozarth (2001d) identified empathic understanding as the 'vessel' through which unconditional positive regard is expressed to the client. Ray (2011) acknowledged the strong relationship between empathic understanding and unconditional positive regard noting that, "when a therapist enters the world of the client, there is an underlying message that the client's world is a valuable world" (pp. 66-

67). In this way, play therapists' empathy for the child conveys their value and acceptance of the child.

Through analysis, we found a strong relationship between a play therapist's congruence and unconditional positive self-regard and her experience and communication of empathic understanding and unconditional positive regard for the child. The more aware, open, attuned, valuing, and accepting play therapists were of their own thoughts, feelings, and experiencing, the more aware, receptive, attuned, valuing, and accepting they were of children's thoughts, feelings, and experiencing in CCPT. Wilkins (2001) identified a similar relationship between congruence and unconditional positive self-regard emphasizing that one's unconditional positive regard towards clients depends on one's attitude towards one's self and therefore the hardest of the conditions to develop. Landreth (2012) and Ray (2011) also identified self-acceptance and positive self-regard as critical to a play therapist's experience and communication of unconditional positive regard and acceptance for a child. Landreth (2012) acknowledged that the play therapist's acceptance of the child is an extension of the therapist's self-understanding and self-acceptance and emphasized the challenge of accepting an aspect of the child's experience or personality that the therapist has not accepted within one's self. Ray (2011) further acknowledged the inhibitory nature of the play therapists' own conditional or negative self-regard on their provision of unconditional positive regard and the potential for the therapist to want to change in the child what one wants to change in one's self. Our findings support the position that a play therapist's unconditional positive self-regard is directly related to one's ability to provide unconditional positive regard for a child.

In addition to providing a better understanding of how the therapist-provided conditions are experienced, conveyed, and interrelated in CCPT, the process-model that emerged from this

study (Figure 1) can also be utilized to help play therapists identify potential areas for growth and development and to conceptualize their experiences and relationships with children. For example, a play therapist may consider if they are entering into relationships and individual play therapy sessions with the desire and intention to be genuine, empathic, and accepting. Through self-reflection and evaluation, one may recognize a deficit in the first dimension of congruence and recognize either a need to evaluate their underlying beliefs about children and the therapeutic process or to schedule clients with more time between sessions to allow the therapist time to access their desire to provide congruence, unconditional positive regard, and empathic understanding, and to intentionally focus on doing so with the child. Additionally, play therapists and supervisors may utilize the process model to compare and more deeply reflect their experiences with children and their own flow in session in experiencing and conveying the conditions in order to promote further development as a play therapist and effective practice with children in CCPT.

### Limitations

Although the therapist-child interactions and mutual responding were analyzed through the live observations and multiphasic coding of the recorded play sessions, the children's perspectives and experience of congruence, unconditional positive regard, and empathic understanding were not fully represented. Children were not interviewed due to developmental considerations, the primary rationale for using a nonverbal, play-based approach with children in CCPT, and the unreliability of interview and self-report methods with children. However, additional methods for understanding children's perspectives and experiences of the therapist-provided conditions need to be explored in future research.

An additional limitation of this study was the lack of diversity among the participating play therapists. The sample of therapists in this study was largely homogenous as all of the play therapists were female, White, 26-28 years of age, and had similar educational backgrounds and training experiences in CCPT. However, in grounded theory research, theoretical sampling is used to guide data collection and the relevance of demographic data is not assumed (Glaser, 1998). Rather than seeking a representative sample, grounded theorists seek and collect data that is relevant to clarify and elaborate the emerging categories and grounded theory (Charmaz, 2006). Additionally, the sample of therapists included in this study was consistent with prior demographic surveys of play therapists in the U.S. In their survey of 958 play therapists, Lambert et al. (2005) found that 92% of play therapists were female and 85% of play therapists were White.

The primary focus of this study was on congruence, unconditional positive regard, and empathic understanding in CCPT. The therapist-provided conditions represent three of the six necessary and sufficient conditions for constructive personality change that Rogers (1957) originally identified. Exploration of the therapist-provided conditions apart from the other three conditions, psychological contact, client incongruence, and client perception, provides an incomplete picture of the therapeutic process in CCPT particularly in regard to the client's contribution and experience of the therapeutic process. Additional research is essential for understanding how all six conditions are experienced and conveyed in CCPT.

#### Implications for Training and Supervision

Given the important role of unconditional positive self-regard in play therapists' provision of congruence and unconditional positive regard, personal development should be a focus of training and supervisory experiences. Play therapists' development of unconditional-

positive self-regard may be promoted through personal therapy, personal growth or development groups, and supervisory experiences that include intentional focus on the counselor's personal experience and process in relationship with the client (Landreth, 2012; Ray, 2011; Tolan, 2012; Wilkins, 2010).

### Implications for Research

Continued research is needed to more fully understand and explore children's experiences and perceptions of therapist congruence, unconditional positive regard, and empathic understanding in CCPT. Utilizing observational methods and visual analysis with attention to microbehaviors and subtle processes may be useful in gaining a better understanding of children's experiences in CCPT. Child-focused research studies and developmentally responsive assessments are needed to provide greater insight into the process of CCPT and relational variables that impact therapeutic outcome and efficacy.

The complex, multidimensional process of how the therapist-provided conditions are experienced and conveyed in CCPT presents many challenges to quantification and measurement of these important relational variables. Many questions remain as to whether congruence, unconditional positive regard, and empathic understanding can be measured independently or as one meta-condition and how both the external behaviors and the internal attitudes associated with each condition can be accurately evaluated. Further research is necessary to explore if and how congruence, unconditional positive regard, and empathic understanding can be measured quantitatively and examined using qualitative methods in order to develop our understanding of how CCPT works, and why CCPT is an effective intervention for children, as well as to further establish the efficacy of CCPT.



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APPENDIX A  
EXTENDED LITERATURE REVIEW

Child-centered play therapy (CCPT) is a developmentally responsive intervention for children based on the philosophy of Carl Rogers' person-centered approach (Landreth, 2012; Ray, 2011; Wilson & Ryan, 2005). Virginia Axline (1947), who was both a student and colleague of Rogers, applied his client-centered philosophy to her work with children and developed what was first known as nondirective play therapy and is currently known as child-centered play therapy in the U.S. Rogers' philosophy of human development, psychological maladjustment, and process of change provide the theoretical foundation for CCPT and is the starting place for understanding the therapeutic processes of CCPT.

### Person-Centered Theory

#### Rogers' 19 Propositions

Carl Rogers (1951) provided a comprehensive framework for understanding human development, psychological maladjustment, and personality change in his 19 propositions (Ray, 2011; Wilkins, 2010):

1. Every individual exists in a continually changing world of experience of which he or she is the center.
2. The organism reacts to the field as it is experienced and perceived. This perceptual field is, for the individual, "reality."
3. The organism reacts as an organized whole to this phenomenal field.
4. The organism has one basic tendency and striving-to actualize, maintain, and enhance the experiencing organism.
5. Behavior is basically the goal-directed attempt of the organism to satisfy its needs as experienced, in the field as perceived.

6. Emotion accompanies and in general facilitates such goal-directed behavior, the kind of emotion being related to the seeking versus the consummatory aspects of the behavior, and the intensity of the emotion being related to the perceived significance of the behavior for the maintenance and enhancement of the organism.
7. The best vantage point for understanding behavior is from the internal frame of reference of the individual.
8. A portion of the total perceptual field gradually becomes differentiated as the self.
9. As a result of the interaction with the environment, and particularly as a result of the evaluational interaction with others, the structure of the self is formed – an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the “I” or the “me,” together with the values attached to these concepts.
10. The values are attached to experiences, and the values are part of the self-structure, in some instances are values experienced directly by the organism, and in some instances are values introjected or taken over from others, but perceived in distorted fashion, as though they had been experienced directly.
11. As experiences occur in the life of the individual, they are (a) symbolized, perceived, and organized into some relationship to the self, (b) ignored because there is no perceived relationship to the self-structure, or (c) denied symbolization because the experience is inconsistent with the structure of the self.



12. Most of the ways of behaving that are adopted by the organism are those that are consistent with the concept of the self.
13. Behavior may, in some instances, be brought about by organismic experiences and needs that have not been symbolized. Such behavior may be inconsistent with the structure of the self, but in such instances the behavior is not “owned” by the individual.
14. Psychological maladjustment exists when the organism denies to awareness significant sensory and visceral experiences, which consequently are not symbolized and organized into the gestalt of the self-structure. When this situation exists, there is a basis for potential psychological tension.
15. Psychological adjustment exists when the concept of the self is such that all sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of the self.
16. Any experience that is inconsistent with the organization or structure of the self may be perceived as a threat, and the more of these perceptions there are, the more rigidly the self-structure is organized to maintain itself.
17. Under certain conditions, involving primarily complete absence of any threat to the self-structure, experiences that are inconsistent with it may be perceived and examined, the structure of the self-revised to assimilate and include such experiences.
18. When the individual perceives all his sensory and visceral experiences and accepts them into one consistent and integrated system, then he is necessarily more understanding and accepting of others as separate individuals.

19. As the individual perceives and accepts into his self-structure more of his organic experiences, he finds that he is replacing his present value system-based so largely on introjections that have been distortedly symbolized with a continuing organismic valuing process. (Rogers, 1951, pp. 481-533)

According to Rogers (1951), the individual is the center of a constantly changing world of experience and the individual responds to the perceptual field, his or her reality, as an organized whole. The individual has one basic actualizing tendency to move towards growth; the actualizing tendency is expressed through goal-directed behavior. Behavior is accompanied and facilitated by emotion and is best understood from within the individual's internal frame of reference. As one interacts with the environment, a part of the perceptual field is differentiated into the self. The self-structure is based on one's perception of experiences and values attached to those experiences. Values are experienced directly by the individual or introjected from others as if they were experienced directly. As one experiences conditional positive regard, one develops conditions of worth that one is only valuable or acceptable if one behaves, thinks, or feels in certain ways. Experiences are symbolized and organized into the self-concept, ignored because they have no relationship to the self-concept, or denied and distorted because they are inconsistent with the self-concept.

Most behavior is consistent with the self-concept, but some behavior may be brought about by needs and experiences that are not symbolized in the self-structure (Rogers, 1951). Denial of one's experiences leads to psychological maladjustment, whereas integration of one's experiences into the self-concept leads to psychological adjustment. Experiences that are inconsistent with the self-concept may be perceived as a threat. Under threat, the self-concept becomes more rigid in order to maintain itself. In the absence of threat, the structure of the self

can be revised to integrate one's experiences. When all experiences are symbolized in the self-concept, the individual becomes more understanding and accepting of others and abandons previously introjected values for an organismic valuing process.

#### Rogers' Necessary and Sufficient Conditions

Rogers' 19 propositions serve as the foundation for understanding human development and the process of change and growth in therapy. Rogers' Proposition 17 is further illuminated by what Rogers defined as the "necessary and sufficient conditions for constructive personality change" (Rogers, 1957).

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (Rogers, 1957, p. 96)

Rogers (1957) clearly stated that all six conditions must be met in order to promote constructive personality change. The first condition refers to the necessity that the client and the therapist are in contact with one another in such a way that each individual is experienced by and makes a perceptual difference to the other. The first condition is often overlooked or assumed in therapy (Warner, 2002; Wilkins, 2010). However, Wilkins (2010) argued that successful therapy

depends upon a relationship between the therapist and the client and that each must be aware of the presence of the other. Sanders and Wyatt (2002) asserted that both the client and the therapist must have the desire and the intention to be in contact with one another. Prouty (2002) termed the process of fostering psychological contact pre-therapy and asserted that psychological contact must be achieved before therapy can begin. Warner (2002) argued for a more fully developed definition of psychological contact that moves beyond mere perception of the other and requires achievement of meaningful contact between the client and therapist in order for the first condition to be met. Warner defined contact as the “fundamental adaptation of the human organism that allows human beings to feel they are meaningfully present, both verbally and non-verbally, to themselves and to each other” (p. 80). According to Warner, in order to achieve psychological contact one must have the capacity to perceive and experience oneself as meaningfully present and to perceive and experience others as meaningfully present. Without psychological contact between the client and the therapist, the subsequent conditions (2-6) cannot be realized in therapy.

The second condition refers to the client’s state of tension as a result of incongruence between the client’s self-concept and his or her experience. This state of incongruence is often the primary reason the client has sought counseling (Rogers, 1957). According to Wilkins (2010), incongruence is defined as the discrepancy between one’s self-perception and one’s actual experience. This state of incongruence often results in confusion, anxiety, and distress because there is a conflict between one’s feelings and behavior and one’s conscious desires. Sanders (2006) interpreted Rogers’ second condition to mean that the client knows that something is wrong and wants help. He posited that although the client may not be able to identify what is wrong, the client must have some awareness that he or she needs help. Sanders

argued that the client cannot change against his or her will and that the client must be motivated to some degree in order for constructive change to occur through the therapeutic process.

The third, fourth, and fifth conditions, often referred to as the therapist-provided, -offered, or -expressed conditions (Wilkins, 2010; Ray, 2011) or as facilitative therapeutic attitudes (Rogers, 1986), are provided by the therapist with the primary purpose of creating a non-threatening environment that allows the actualizing tendency of the client to be realized. Though Rogers identified congruence, unconditional positive regard, and empathic understanding as separate conditions, many person-centered theorists argue that these attitudinal qualities are essentially one super or meta-condition (Mearns & Cooper, 2005; Mearns & Thorne, 2000; Wilkins, 2010). Because they are the focus of this study, the therapist-provided conditions will be explored in depth in the following section.

The sixth condition refers to the client's ability to perceive the therapist-provided conditions of empathic understanding and unconditional positive regard. In the sixth condition, Rogers identified the critical role of the client in determining the course of therapy and emphasized the reciprocal nature of the therapeutic process (Sanders & Wyatt, 2002; Toukmanian, 2002). Like his treatment of the first condition, Rogers provided limited attention to the sixth condition and no clear definition of perception (Toukmanian, 2002). Toukmanian defined perception as "the construction of 'reality' not as it actually is but as it is represented and interpreted as being 'meaningful' by the individual" (p. 115). Toukmanian developed a perceptual-processing model to explain how individuals create meaning about themselves and the world. Within this model, it is understood that characteristics implicit to the client impact the client's perception of the therapist's empathy and acceptance towards the client. The client's perception of the therapist's empathy and unconditional positive regard depends on the

therapist's actual experience of empathy and acceptance towards the client, on the therapist's ability to effectively convey and communicate this experience, and on the client's ability to perceive the therapist's empathy and unconditional positive regard.

### Therapist-Provided Conditions

Many person-centered and child-centered authors agree that congruence, unconditional positive regard, and empathic understanding are not skills or techniques to be employed; rather they are essential attitudes (Mearns & Thorne, 2000; Ray, 2011), a process (Wilson & Ryan, 2005), presence (Freire, 2007), an extension of the therapist's essential self (Mearns & Thorne, 2000), and "a way of being" (Rogers, 1980, p. 3). As such, the therapist-provided conditions are multidimensional, dynamic, and difficult to measure (Bozarth, 1998; Ray, 2011; Wilkins, 2010). Several authors have attempted to define and elucidate the therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding.

#### Congruence

Congruence is frequently and interchangeably referred to as genuineness throughout person-centered literature. Rogers (1957) defined congruence as the therapist ability to be genuine, integrated, and "freely and deeply himself, with his actual experience accurately represented by his awareness of himself" (p. 97) within the therapeutic relationship. He extended this definition to include a close matching between the therapist's experience, what is present in the therapist's awareness, and what the therapist expresses to the client (Rogers, 1980). According to Rogers, congruence is the consistency between the internal experience, self-awareness, and external expression of the therapist within the therapeutic relationship. Congruence includes a genuine experience of unconditional positive regard and empathy towards the client. Although therapists may not always verbally or explicitly express congruence in

therapy, Rogers acknowledged that direct congruent expression might be necessary if the therapist's ability to be present or empathic with the client is disrupted by the therapist's own experience and feelings.

Barrett-Lennard (1962) was one of the first to develop an instrument to measure the therapeutic conditions proposed by Rogers. He defined congruence in keeping with Rogers' original definition of a close matching between the therapist's experience, awareness, and expression and provided examples of both incongruence and congruence. According to Barrett-Lennard, highly congruent individuals are more honest, direct, and sincere in what they convey. Incongruence is most often demonstrated through inconsistency between what individuals say and what they imply through gestures, expression, or tone of voice or indications of anxiety, discomfort, or tension.

In an effort to operationalize the condition of congruence, Truax and Carkhuff (1967) defined genuineness as being "real" and stated that "genuineness implies most basically to a direct personal encounter, a meeting on a person-to-person basis without defensiveness or a retreat into facades or roles, and so in this sense an openness to experience" (p. 32). While developing and validating a measure of therapist genuineness, Truax and Carkhuff recognized that "the best operational definitions of genuineness revolve around describing its absence, it is clearly not easy to describe or to achieve" (p. 34).

Mearns and Thorne (2000) accepted Rogers' definition of congruence with the qualifier that the therapist's expression of feelings or attitudes is always done in such a way that the therapeutic relationship is served or enhanced. They emphasized that congruence is not a free license for the therapist to express to the client any thought, feeling, or attitude that arises within

the therapist. Mearns and Thorne also defined congruence in terms of the therapists openness to their experience and willingness to be aware of that experiencing in the moment.

Wyatt (2001) recommended a holistic approach to defining and understanding congruence and challenged a dualistic conceptualization of the internal state of congruence and the external expression of congruence. According to Wyatt, congruence is multifaceted and complex and includes both the therapist's internal experience of congruence and the therapist's outward expression of congruence within the therapeutic relationship. In Wyatt's model of congruence, the core of congruence is the therapist's ability to be one's self and is reflective of both the therapist's psychological maturity and personal style. The facets of congruence include the therapist's openness to one's own experience, the therapist's awareness of one's experience without distortion or denial, the therapist's behavior, and the therapist's ability to provide genuine unconditional positive regard and empathy. What Wyatt describes as "the whole beyond the facets" (p. 94) is the healing potential that can be realized through the therapist's openness to the self-actualizing tendency within the therapist's self, the client, and the therapeutic relationship.

Greenberg and Geller (2001) noted that congruence is most likely the most complex and least explained of the therapist-provided conditions. The authors acknowledged that congruence "has been misinterpreted either as being a license for the therapist to openly express all of his or her feelings or needs in an undisciplined manner, or has been viewed as condoning what psychodynamic therapists would view as negative counter-transference" (p. 131). Recognizing that congruence involves both internal awareness and external expression, Greenberg and Geller emphasized that in order for congruence to be therapeutic it must arise from specific attitudes, beliefs, and intentions and must be coupled with empathic understanding and unconditional



positive regard. The authors termed the internal awareness component of congruence “therapeutic presence” (p. 134) and described it as “being receptively open and sensitive to one’s own moment by moment, changing experience; being fully immersed in the moment; feeling a sense of expansion and spaciousness; and being with and for the client” (p. 134). According to the authors, the communication component of congruence is more complicated and requires many complex interpersonal skills that are grounded within a set of therapeutic attitudes. In order for congruent communication to be facilitative, the therapist must express congruence with empathy and unconditional positive regard with intentionality, therapeutic purpose, discipline, and comprehensiveness.

Cornelius-White (2007b) proposed that congruence is the most difficult to understand, most important, and hardest condition to measure. He presented a five-dimension model of congruence in which he defined congruence as 1) being real and having a genuine experience of empathic understanding and unconditional positive regard towards the client; 2) having an awareness and accurate symbolization of one’s experience and unconditional self-regard; 3) consistency between one’s experience, self, and communication or connection with the client; 4) systematic consistency and connection between experience, self, other and the world, and; 5) being entirely focused and present within the shared relational experience and open to the flow of the process (Cornelius-White, 2007a). Cornelius-White’s five dimensional model of congruence illustrated the complex and multifaceted dynamics of being genuine and congruent in the client-counselor relationship.

Cornelius-White (2007b) argued that congruence is ultimately rooted within the therapist’s own process of self-understanding and self-acceptance and is an extension of the therapist’s ability to have empathy and unconditional positive regard for his or her own

experience. Cornelius-White stated that congruence allows for the therapist and the client to be mutually vulnerable and influenced within the therapeutic relationships and allows for an authentic relationship encounter. He defined congruence in experiential terms and noted that congruence is most often communicated through body language rather than words.

Bozarth (2001c) recommended a reexamination of congruence and proposed a new model of the therapist-offered conditions. He defined congruence as a “state of therapeutic readiness . . . that enables the therapist to better experience empathic understanding of the client’s internal frame of reference and unconditional positive regard towards the client” (p. 189). Although Rogers asserted that congruence was the most important condition, Bozarth argued that unconditional positive regard is the curative factor in person-centered therapy based on Rogers’ conceptualization of the self-structure and the need for positive regard to facilitate self-actualization. Bozarth posited that congruence is not in itself primary to empathic understanding and unconditional positive regard; rather it is comprised of the other two conditions in what he called a “conditions loop” (p. 190). Therefore, congruence is necessary for the therapist to be able to experience empathy and acceptance towards the client. Bozarth also highlighted the relationship between congruence and the therapist’s unconditional positive self-regard stating “the increased freedom of self in relationship fosters higher degrees of unconditional positive self-regard, which is then manifested by greater congruence, matching and accepting of organismic experiences” (p. 192).

Tolan (2012) described therapist congruence as a primary agent in the facilitation of a client’s movement from an external locus of evaluation to an internal locus of evaluation. As the counselor relates to the client in a congruent manner, the client learns to trust his or her own experiences and perceptions of the counselor without distortion or denial. As the therapist

congruently conveys empathy and UPR, clients can trust their experiences of being understood and accepted. Tolan further defined congruence as therapists' awareness, openness, and receptivity to all aspects of their client's and their own experiences within the therapeutic relationship. Congruent counselors are simultaneously aware and accepting of their own thoughts, feelings, and reactions to their client and to their client's thoughts, feelings, and reactions to the counselor. Tolan identified developing self-awareness and learning to authentically and appropriately communicate one's awareness to the client as the major tasks for developing congruence.

### Research on Congruence

Research on congruence has been less extensive and conclusive than research on the other therapist-provided conditions of empathy and unconditional positive regard in part due to the complex and abstract nature of congruence and the difficulties related to measuring and observing the match between the therapist's internal experience and awareness (Grafanaki, 2001; Kirschenbaum & Jourdan, 2005). Additionally, the co-occurrence and correlation between congruence, unconditional positive regard, and empathy have made it difficult to measure congruence as a separate construct. In her review of congruence research, Grafanaki (2001) identified several limitations of prior research on congruence: Research has not been grounded in therapist and client experience and behaviors, researchers have focused on the impact of congruence on therapy outcome rather than on the process of being congruent, there has been no consideration of the appropriateness and timing of congruent responses, there has been limited attention given to the client's experience of congruent and incongruent responses, and there has been limited consideration of the process of congruence as a dynamic, interactional process between the client and the therapist. Furthermore, Grafanaki recommended that future

researchers focus on how and why congruence contributes to therapy outcomes and that research on congruence be firmly grounded in the behavior and experience of both the therapist and the client.

Several studies have demonstrated a positive correlation between therapist congruence and positive outcome in therapy (Kirschenbaum & Jourdan, 2005; Kolden, Klein, Wang, & Austin, 2011). Kolden, Klein, Wang, and Austin (2011) conducted a meta-analysis on research studies conducted to explore the relationship between therapist congruence or genuineness and client outcome. The authors reported estimates of effect sizes ranging from  $-.26$  to  $.69$  and an overall aggregate effect size of  $.24$  for congruence. The authors interpreted this as a small to medium effect for congruence and concluded that congruence was an important dimension of the therapeutic relationship. Although Kolden et al. recognized the limitations of inconsistent methodology in the original studies, the small number of studies included, researcher bias, and restricted access to unpublished studies, they concluded that there is a positive relationship between therapist congruence and psychotherapy outcome. The authors encouraged further exploration of congruence in person-centered therapy and provided several recommendations for fostering congruence in therapeutic practice.

Grafanaki (2001) conducted a qualitative study to explore the experiential, interpersonal, and relational processes at work in moments of congruence and incongruence within client-centered therapy sessions. Grafanaki interviewed six clients and six counselors regarding their first, sixth, and final counseling sessions to identify the moments the clients and the counselors found to be the most helpful and the most hindering during each counseling session. The analysis of the participant interviews revealed that congruence and incongruence were experienced in a variety of ways and that congruence was not a single phenomenon. The participant interviews

also revealed that congruence and incongruence were experienced in conjunction with other phenomena such as empathy and differed both in their intensity and impact on the therapeutic encounter. Grafanaki concluded that congruence should be understood as a relational and intersubjective experience and that being congruent is an active process of relating to others and to one's self. In addition, the participants' experience of moments of incongruence in the therapy sessions seemed to reveal important shifts in the therapeutic process.

### Unconditional Positive Regard

Rogers (1957) defined unconditional positive regard as warm acceptance of every aspect of the client's experience. For Rogers, unconditional positive regard meant providing as much acceptance for the client's expression of negative feelings as for the client's expression of positive feelings. Rogers also emphasized that unconditional positive regard included caring for the client as a separate person in a warm, prizing, and non-possessive manner.

In developing his Relationships Inventory, Barrett-Lennard (1962) divided Rogers' original concept of unconditional positive regard into two concepts: level of regard and unconditionality of regard. He defined level of regard as the affective reactions of one person to another including both positive and negative feelings and unconditionality of regard as the degree of constancy of one's affective response to another. Truax and Carkhuff (1967) termed the condition of unconditional positive regard 'non-possessive warmth' and described it as a warm, nonjudgmental, respectful, even loving stance towards the client without condition.

Unconditional positive regard has also been defined as the therapist's deep valuing of the client's humanity (Mearns & Thorne, 2000). Mearns (2003) described unconditional positive regard as valuing and accepting the client in his or her totality. Accepting both the client's

struggle towards a more meaningful and fulfilling existence and the many self-protective defenses the client uses to distance him or herself from the feared threat of other people.

Bozarth (2001d) defined unconditional positive regard as complete acceptance of the person's momentary frame of reference and all that entails, including the person's feelings and perceptions. Unconditional positive regard is understood as complete and total acceptance of each and every aspect of the client's experience and self-structure. Bozarth provided a reconceptualization of unconditional positive regard as the primary change agent in person-centered therapy and provided an integrated model of the three therapist-offered conditions. According to his reconceptualization, genuineness allows the therapist to experience empathic understanding and unconditional positive regard towards the client. Empathic understanding is the 'vessel' through which unconditional positive regard is expressed towards the client.

Like congruence, unconditional positive regard has been considered in terms of both an internal attitude and an outward expression (Wilkins, 2001). Wilkins (2001) and Bozarth (1998; 2001d) identified unconditional positive regard as the change agent or curative factor in person-centered therapy. Both agreed that congruence and empathy provide a framework for unconditional positive regard to be experienced and believed by the client and that congruence and empathy precede and include unconditional positive regard. Wilkins (2001) concluded further that because unconditional positive regard "depends on the attitude individuals hold towards themselves, it is the hardest therapeutic attitude to develop" (p. 42) and the most crucial and powerful to promote constructive change. According to Wilkins, unconditional positive regard demands the absence of prejudice, respect for the full person of the client, and acknowledgement that clients are self-determining beings.

Lietaer (2001) defined unconditional positive regard as the constant and unchanging “affective attitude of the therapist toward his client: the extent to which he values his client and welcomes his coming, believes in his potentialities and engages him in a non-possessive way” (p. 88). Acknowledging that the concept of unconditionality has been questioned and challenged since the inception of Rogers’ theory, Lietaer distinguished between unconditional acceptance of the whole of the client’s experience and acceptance of all of the client’s behavior. He distinguished that “the attitude of receptivity toward the inner experiential world of my client does not mean that I welcome all behavior equally” and that “unconditionally means that I keep on valuing the deeper core person, what she potentially is and can become” (p. 92-93). Lietaer also recognized several limitations to unconditionality including the therapist’s personal vulnerabilities and incongruence, the consequences of the other’s life on the life of the therapist, and the fundamental goal of therapy to facilitate change in one’s clients.

Highlighting unconditional positive regard as the distinguishing feature and primary goal of person-centered therapy, Friere (2001) considered the therapist’s belief and trust in the self-actualizing tendency as the foundation for unconditional positive regard. According to Friere, the therapist’s capacity for unconditional positive regard towards the client reflects the degree of trust the therapist has in the client’s actualizing tendency. She contended that therapists express conditionality most often by taking the lead in therapy and/or by providing unnecessary support to the client. Similar to congruence, the therapist’s unconditional positive regard towards a client parallels the therapist’s own unconditional positive self-regard. Friere concluded that unconditional positive regard is expressed both in the therapist’s presence with and empathic experience of the client.

## Research on Unconditional Positive Regard

Unconditional positive regard has been primarily studied in conjunction with the other five conditions. Few researchers have explored unconditional positive regard as a separate phenomenon (Bozarth, 2007). Multiple assessments have been created to measure unconditional positive regard (Watson & Steckley, 2001). Utilizing a definition of unconditional positive regard as a non-possessive caring and warmth, Truax and Carkhuff (1967) developed the Non-Possessive Warmth Scale (NPW) to evaluate therapists' verbal responses on a 5-point likert scale based on the degree to which the therapist communicated non-possessive warmth. Inter-rater reliability has been shown to be inconsistent with the use of the NPW (Watson & Steckley). The Barrett-Lennard Relationship Inventory (BLRI; 1962) was a self-report assessment developed to measure the client's experience of the therapist as empathic, congruent, and accepting and prizing on a 7-point scale as rated by both the client and by the therapist. Although the BLRI has been shown to have strong split-half reliability ranging from .82 to .96, and client ratings is poor. Although used in many studies, Watson and Steckley the correlation between therapist identified several problems related to measuring unconditional positive regard using the NPW and the BLRI including the inherent challenges of trying to measure a dynamic, interpersonal process, little correlation between the NPW and BLRI, reliance on verbal responses from the therapist rather than nonverbal and other behavioral responses, and limited focus on the client's experience of unconditional positive regard. They recommended that unconditional positive regard be considered as an interactive, relational phenomenon between the client and the therapist and recommended utilizing a qualitative, process-oriented research approach to gain a deeper understanding of unconditional positive regard.



Farber and Doolin (2011) provided a review of research on positive regard and conducted a meta-analysis of research on the correlation between counselor's provision of positive regard and therapeutic outcome. The authors included 18 studies that evaluated the relationship between positive regard and therapeutic outcome and reported an aggregate effect size of .27 and concluded that positive regard has a moderate association with therapy outcomes. The authors considered the small number of studies included in the meta-analysis to be a limitation of the study and noted that their stringent inclusion criteria and the decrease in research on positive regard within the last 20 years as factors that influenced the sample size. The authors concluded that the therapist's "ability to provide positive regard is significantly associated with therapeutic success" (p.62) but interpreted the moderate effect size as indicative of the reality that many other relational factors influence therapy outcomes. Farber and Doolin made several recommendations for clinical practice including the continued provision of positive regard, kindness, and warmth towards clients across theoretical approaches and therapist self-awareness of their provision and communication of unconditional positive regard to clients and therapist awareness of the unique needs of individual clients for unconditional positive regard.

#### Unconditional Positive Self-Regard

Although not included in his original formulation of the 'necessary and sufficient conditions' (Rogers, 1957), Rogers (1959) explored the relationships of unconditional positive regard and unconditional self-regard in his conceptualization of how person-centered theory applied to family life:

1. The greater the degree of unconditional positive regard which the parent experiences toward the child:
  - a. The fewer the conditions of worth in the child.

- b. The more the child will be able to live in terms of a continuing organismic valuing process.
  - c. The higher the level of psychological adjustment of the child.
2. The parent experiences such unconditional positive regard only to the extent that he experiences unconditional self-regard.
  3. To the extent that he experiences unconditional self-regard, the parent will be congruent in the relationship.
  4. To the extent that conditions 1, 2, and 3, exist, the parent will realistically and empathically understand the child's internal frame of reference and experience an unconditional positive regard for him (p. 253).

Defined most often in terms of self-acceptance, many contemporary person-centered theorists have acknowledged the relationship between unconditional positive self-regard and the therapist-provided conditions (Bozarth, 2001c, 2001e; Tolan, 2012; Wilkins, 2010). Bozarth discussed unconditional positive self-regard in the context of congruence. Bozarth argued "increased freedom of self in relationship fosters higher degrees of unconditional positive self-regard, which is then manifested by greater congruence. Congruence becomes represented by unconditional positive self-regard" (p. 191). Likewise, Wilkins recognized a direct relationship between one's unconditional positive self-regard and one's ability to provide unconditional positive regard for a client stating that "the extent to which any of us can offer another unconditional positive regard relies directly on our ability to accept ourselves" (p. 229). Although many person-centered theorists have identified the impact of unconditional positive self-regard on congruence and unconditional positive regard, no known research has been conducted on unconditional positive self-regard and therapeutic outcome.

## Empathic Understanding

Empathy is the most widely known and well-researched condition of the six conditions Rogers proposed (Bozarth, 2001a). Raskin (2001) described it as the most important concept in person-centered therapy. Initially, Rogers (1957) defined empathic understanding as a process of experiencing the client's private world as if it was the therapist's own. He further elaborated his definition of empathic understanding as

entering the private perceptual world of the other and becoming thoroughly at home in it . . . being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living in his/her life, moving about in it without making judgments, sensing meanings of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware. . . It includes communicating your sensings of his/her world as you look with fresh or unfrightened eyes at elements of which the person is fearful. It means frequently checking with him/her as to the accuracy of your sensings, and being guided by the responses you receive. (Rogers, 1975, p. 4)

Rogers stressed that empathy was not a skill or a technique to use in therapy but rather a way of being with clients in therapy. He also described empathic understanding as valuing and caring for the client and as experiencing nonjudgmental acceptance and sensitivity towards the client. In this way, Rogers' concept of empathic understanding overlapped with his definitions of unconditional positive regard and congruence (Bozarth, 2001a). Rogers (1975) concluded that the experience of such empathic understanding would promote the client's development of greater self-acceptance, empathic self-understanding, and congruence

In creating an instrument to measure empathic understanding, Barrett-Lennard (1962) defined empathic understanding as a twofold process of 1) empathic recognition through which one has experiential recognition of another's' perceptions or feelings and 2) empathic inference through which one senses the implied or indirectly communicated content of the other's awareness. Truax and Carkhuff (1967) considered empathy more in terms of its expression and communication from the therapist to the client and less in terms of the therapist's attitude towards or experience of the client's inner world. In operationalizing the condition of empathy, Truax and Carkhuff (1965) moved towards a definition of empathy that was both observable and measurable. They defined accurate empathy as "the skill with which the therapist is able to know and communicate the client's inner being" (p. 5). Following Truax and Carkhuff's model, the majority of researchers examining the provision of empathy in therapy have focused on empathy as a skill, primarily verbal reflections of content and feeling (Bozarth, 1998).

Hackney (1978) provided a critique of operational definitions of empathy that emphasized observable, verbal expressions of empathic understanding and the communication skills training that followed in counseling programs. He encouraged researchers, educators, and practitioners to abandon the idea that empathy is a communication process and argued that true empathy involves firstly an awareness of the client's emotional nuances and secondly the communication of that affective awareness.

Empathy has often been confused with identification and interpretation in therapy (Schmid, 2001). Schmid described identification as the therapist "ignoring the boundaries between oneself and the other person, to feel in the same way as he or she does and therefore to dissolve or be wrapped up in his or her emotions" (p. 54). In identification, the counselor loses the 'as if' quality of entering the client's internal frame of reference. Schmid defined

interpretation as judging “what the other person thinks, feels, or expresses to form an evaluation about him or her from an outer frame of reference and thus objectify him or her” (p. 54).

According to Schmid, active listening is a precondition for empathic understanding. Furthermore, empathic understanding is a process rather than an achievement the defining feature of which is the intention and effort to understand the other person. Additionally, Schmid recognized that empathy is communicated both verbally and nonverbally through body and sensory awareness, gestures, body movements and postures, and intonation. He concluded that “interpretations of empathy as plain mirroring, as the technique of reflection of feelings . . . qualify themselves as absurd and as a technical misunderstanding and missing of the dialogical quality of person-centered therapy” (p. 64).

Bozarth (2001a) argued against the narrow and limited definition of empathy as a skill or technique stating “reflection is not empathy. . . Empathy is not reflection” (p. 138). He admonished the dangerous equation and operationalization of empathy as a therapeutic response or reflective technique stating that “therapeutic training has increasingly focused upon specific counseling skills and techniques while missing the essence of the person-centered approach: that the individual is the source of his or her own resources and expertise when empathically understood and unconditionally accepted by a congruent person” (p. 132). Bozarth argued that reflection is for the benefit of the therapist rather than the client and he expressed concerns that emphasis on reflection versus an attitude or way of being with clients may promote the misguided perception that the therapist is the authority or expert in the therapeutic relationship. In an addendum to his original work, Bozarth (2001b) developed his definition of empathy further in terms of its relationship to congruence and unconditional positive regard. He concluded that “empathy in client-centered therapy is a manifestation of and a way of

communicating unconditional positive regard” (p.147) and that “it is when the therapist experiences high and consistent levels of unconditional positive self-regard that the empathic understanding of the client’s internal frame of reference is achieved” (p. 149). Similarly, Friere (2007) described empathic understanding as a process and an attitude rather than a technique to be applied. She emphasized that true empathy is always free of any evaluative or diagnostic quality and, like Bozarth, connected the therapist-provided conditions of empathic understanding and unconditional positive regard.

Tengland (2001) argued that empathic understanding includes not only cognitive and affective understanding of the client’s experience, but also a pro-attitude, wanting the best for the client, and concern for the client’s wellbeing. For Tengland, empathic understanding is characterized by the therapist’s care and concern for the client.

Raskin (2001) emphasized the tentative nature of empathic understanding. He defined empathy as a process by which

the counselor, as much as possible, assumes the client’s internal frame of reference, to perceive the world and the client’s own sense of self in the way the client does, and to communicate this empathic understanding with the implicit attitude, “Did I understand you correctly? (p. 2)

According to Raskin, empathic understanding includes a dimension of humility and checking with the client for accuracy and guidance.

Bohart and Greenberg (1997) provided a three-part definition of empathy that accounts for the experience of entering and exploring the client’s world:

1. Empathy includes the making of deep and sustained psychological contact with another in which one is highly attentive to, and aware of, the experience of the other as unique.
2. Empathic exploration includes deep sustained empathic inquiry or immersing oneself in the experience of the other.
3. Empathic exploration includes a resonant grasping of the edges or implicit aspects of a client's experience. (p. 5)

Greenberg and Elliot (2001) extended this definition of empathy as they described the two-fold function of empathy in client-centered therapy: 1) to help clients learn to trust and accept themselves and 2) to increase clients' awareness. They introduced a process-experiential view of empathy in which empathic attunement and verbal communication of empathic attunement are guiding principles. According to Greenberg and Elliot, empathic attunement is an experiential process that involves the therapist resonating and moving toward or into the client's experience. Empathic attunement is then communicated through five types of empathic responses:

1. Empathic understanding- the therapist communicates understanding of the explicit felt experience or what is just implied but not yet stated. The intention is to communicate an understanding of experience.
2. Empathic evocation- the therapist brings the client's experience to life through the use of metaphor, expressive language, evocative imagery, or speaking as the client. The intention is to elicit, arouse, or evoke experience so that it is re-experienced in the moment.

3. Empathic exploration- the therapist encourages the client to search around the 'edges' of his or her experience to symbolize it in a differentiated fashion. The intention is to promote an experiential search for new internal information.
4. Empathic conjecture- the therapist attempts to clarify the client's experience by tentatively offering information from his or her own perspective about what might be the client's current experience in the form of a hunch or a guess. The intention is to offer the client a possible symbol to capture the aspect of his or her current experience.
5. Empathy-Based interpretation- empathy is used to help the therapist build an internal model of the client to help understand unconscious dynamics. The intention is to tell the client something new about himself or herself or to offer information to the client about his or her experience that is not already know by the client. (pp.176-178)

They concluded that the experiential process of empathic attunement should be distinguished from the communications that flow from that attunement and identified empathic understanding as only one form of that communication.

#### Research on Empathic Understanding

Like unconditional positive regard, empathy was operationalized and measured by Truax and Carkhuff (1967) through the use of trained observers and the Accurate Empathy Scale. Client and therapist ratings were also used to measure empathy through the empathy scale on the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962; Elliot, Bohart, Watson, & Greenberg, 2011). Empathic accuracy has also been measured through the comparison of therapist and client ratings of the client on various personality scales or lists of symptoms (Elliot et al., 2011). However, the intercorrelations between different empathy measures have been



weak and capturing the multifaceted process of empathy has remained a challenge (Elliot et al., 2011). In addition, distinguishing empathy from other relational constructs has been difficult and empathy has been highly correlated with congruence and positive regard in several research studies.

In a meta-analysis of research relating empathy to therapy outcome, Elliot et al. (2011) included 224 separate tests of empathy related to therapy outcome and 57 studies in total. The authors' analysis of the studies yielded a medium effect size of  $r = .31$ . The authors also considered the relationship of therapists' theoretical orientation and specific types of empathy measures on therapy outcome. The authors found that there was no difference in therapy outcome related to therapists' theoretical orientation. Client measures of empathy predicted outcome better than observer rated measures and therapist measures. Elliot et al. noted that the degree of similarity between therapist and client and several nonverbal and behavioral factors impact the level of empathy perceived by the client. Additionally specific client factors were identified related to therapist empathy including the client's psychological dysfunction, openness and ability to communicate, and client's reactions to empathic responding. The authors concluded that clients' perceptions of empathic understanding by their therapists relate to therapy outcome and recommended that therapists make efforts to understand their clients and respond empathically to their clients by responding verbally and nonverbally to their clients experience. The authors recommended that therapists offer empathy to their clients with respect and humility and in the context of positive regard and genuineness.

Although there is a long history of research on the therapist-provided conditions, there is recognition that the operational definitions of the attitudinal conditions, measurement of the conditions and therapeutic relationship variables, and methodological rigor have been

problematic. Furthermore, Bozarth (2001b) concluded that “quantitative research has been a double-edged sword for the understanding of client-centered therapy. Such research has helped identify effectiveness and lent scientific credibility to the practice. However, it has also misdirected the meaning of the theory by failing to identify the integral aspects of the concepts” (p. 150). Additionally, the majority of research on the therapist-provided conditions has been focused almost exclusively on talk therapy with adults and on the verbal responses without regard for nonverbal communication and behavior.

### One Meta-Condition

Although the therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding are often considered separately, many person-centered authors proposed that the three constructs are inextricably linked (Truax & Carkhuff, 1967) and should be considered together as one meta-condition (Mearns & Thorne, 2000; Mearns & Cooper, 2005; Wilkins, 2010). Bozarth (1998; 2007) described the relationship of the three as follows: (a) congruence is a state of readiness within the therapist that allows the therapist to experience the client through empathic understanding, (b) empathic understanding is the way the therapist conveys unconditional positive regard for the client, and (c) unconditional positive regard is the ‘curative factor’ in person-centered counseling. Although Bozarth emphasized unconditional positive regard as the most fundamental condition to which congruence and empathic understanding lead, he concluded that congruence, unconditional positive regard, and empathic understanding are so interrelated that they are “ultimately and functionally one sole condition” (p. 80). Likewise, Wilkins (2010) proposed that the three therapist-provided conditions are truly one “super-condition” of which congruence, empathic understanding, and unconditional positive regard are all a part.

Many authors and researchers have defined and re-defined the therapist provided conditions of congruence, unconditional positive regard, and empathic understanding since Rogers first presented his theory of the necessary and sufficient conditions. The definitions of the three essential therapeutic attitudes often overlap. Likewise, each condition is declared as the most important of the three and inseparable from the other two conditions. Although there are many theoretical and operational definitions and models for congruence, unconditional positive regard, and empathic understanding in person-centered literature, much is still unknown about these essential, complex, and dynamic attitudes that are at the heart of the Rogers' theory and the therapeutic process.

#### Research on Therapeutic Process and Outcome

Following Rogers (1957) landmark article, "The Necessary and Sufficient Conditions of Therapeutic Personality Change," research in client-centered therapy (CCT) shifted from examining strictly CCT to exploring the attitudinal conditions of therapists of all theoretical persuasions (Bozarth, Zimring, & Tausch, 2002). During this period, both Barrett-Lennard (1962) and Truax and Carkhuff (1967) developed instruments to measure the attitudinal conditions and found a positive correlation between high levels of congruence, empathy, and unconditional positive regard and therapeutic outcome through their research (Bozarth, et al., 2002).

Rogers, Gendlin, Kiesler, and Truax (Rogers, 1967) conducted research examining the effectiveness of CCT approach with schizophrenics. The purpose of the study was to examine the factors involved in the process of personality and behavior change with schizophrenics and non-schizophrenics during psychotherapy. In particular, the researchers were interested in exploring what elements within the therapeutic relationship facilitated change and predicted that there would be a positive correlation between the extent to which the conditions of therapy

existed in the relationship and therapeutic outcome. Sixteen chronic schizophrenics, 16 acute schizophrenics, and 16 persons without psychological disturbance were randomized into treatment and control groups, and a total of 24 clients were provided CCT by eight therapists (Gendlin & Rogers, 1967). The therapeutic conditions, therapeutic process variables, and therapeutic outcome were assessed at pre- and post-treatment and at three-month intervals throughout the course of treatment.

Based on the results of the study, Rogers (1967) concluded the following: that it was possible to test a theory of change by designing instruments to measure the constructs of the theory; regardless of the degree of genuineness, understanding, or acceptance offered to schizophrenics, they perceived a relatively low level of these conditions in the therapeutic relationship; attitudinal elements of the therapeutic relationship seem to stabilize early in therapy and remain consistent throughout therapy; the different dimensions of the therapeutic relationship (empathy, congruence, and positive regard) that were measured while positively correlated to one another appeared to be distinct dimensions within the therapeutic relationship; unbiased raters and clients evaluated the therapist similarly; however, there was a negative correlation between the therapists' ratings and the other two ratings especially in less successful cases; all clients in the treatment group demonstrated improvement following individual therapy, but there was not a significant difference between the treatment and control groups; the deeper the level of the therapist's understanding and genuineness, the more the client exhibited deeper levels of self-experiencing and self-exploration; the degree of empathy demonstrated by the therapist was associated with the immediacy of experiencing in the client; the clients perceiving the highest levels of empathy showed the greatest reduction in schizophrenic tendencies; and the characteristics of the client or patient influenced the quality of the therapeutic relationship.

Although results from the Wisconsin project were mixed and there were no statistically significant findings, the project provided support and direction for continued research on the necessary and sufficient conditions in CCT.

Following the 1970s, research on CCT and the conditions declined in the US but continued in Europe (Bozarth et al., 2002). Rudolph, Langer, and Tausch (1980) conducted a study with 149 clients and 80 person-centered therapists and found that clients experienced positive change through the course of therapy when they had therapists who demonstrated high levels of at least two of three therapist-provided conditions. Additional research on CCT continued to yield results that indicated that the attitudinal conditions had a positive relationship to therapeutic outcome and change in therapy and that “relationship variables that are most often related to effectiveness are the conditions of empathy, genuineness, and unconditional positive regard” (Bozarth et al., 2002, p. 168).

Lambert and Barley (2002) provided a summary of research on the therapeutic relationship and outcome and noted that 40% of the change in therapy was accounted for by extratherapeutic factors, 30% by common factors, 15% by clients’ expectancy, and 15% by specific therapeutic techniques. They defined common factors as variables that would be found in the majority of therapies regardless of theoretical orientation including empathy, warmth, acceptance, the therapeutic alliance, or process factors. Lambert and Barley stated that “it is readily apparent . . . that of the factors most closely associated with the therapist, the therapeutic relationship is central in contributing to positive therapy outcome” (p. 18). In their extensive review of process-outcome research over the previous 50 years, Orlinsky, Ronnestad, and Willutski (2003) also found that the therapeutic alliance or bond had a positive correlation with therapeutic outcome. Additionally, they concluded that the therapist factors that contributed the

most to positive therapeutic outcome included “empathic, affirmative, collaborative, and self-congruent engagement” with the client (p. 324). Although not specific to person-centered therapy, Lambert and Barley (2002) and Orlinsky et al.’s (2003) work demonstrates the centrality of the therapeutic relationship and therapist variables including empathy, acceptance, and congruence to the therapeutic process and outcome.

#### Limitations of Research on the Therapist-Provided Conditions

Truax and Carkhuff (1967) worked to operationalize and measure the therapist-provided conditions of genuineness, unconditional positive regard, and empathic understanding and developed the Genuineness Scale (GS), Accurate Empathy Scale (AES), and the Nonpossessive Warmth Scale (NPS). The authors acknowledged that they moved away from Rogers’ original definitions of unconditional positive regard and empathy towards definitions that were largely informed by psychoanalysis identifying unconditional positive regard as nonpossessive warmth and empathic understanding as accurate empathy. Truax and Carkhuff defined accurate empathy as “the therapist’s sensitivity to current feelings and his verbal facility to communicate this understanding in a language attuned to the client’s current feelings” (p. 46). Nonpossessive warmth was described as a range of acceptance from a high level of warm acceptance of the client’s experience without imposing conditions to a low level of warmth in which the therapist evaluates a client, “expresses dislike or disapproval, or expresses warmth in a selective and evaluative way” (p. 58). Truax and Carkhuff acknowledged that operationalizing and measuring genuineness presented the most significant challenges. They developed the genuineness scale based on degrees of congruence from “a very low level where the therapist presents a façade of defends and denies feelings; and continuing to a high level of self-congruence where he therapist

is freely and deeply himself” (p. 69). The three scales were used to rate therapist’s verbal responses to clients as measured by the client, the therapist, and objective raters.

The majority of the early research on the therapeutic conditions was focused on talk therapy and was conducted with adult clients. Wright, Truax, & Mitchell (1972) recognized the limitations of using the Accurate Empathy, Non-Possessive Warmth, and Genuineness Scales with children in psychotherapy given the high proportion of nonverbal communication and behavior in child therapy. They found that that the reliability of ratings of empathy and warmth were much lower with children than those obtained with adults.

### Child-Centered Play Therapy

Virginia Axline (1947) was the first to apply the philosophy and concepts of Carl Rogers’ person-centered approach to children. She developed what she termed non-directive play therapy and provided eight basic principles for enacting the philosophy and conditions of person-centered theory with children:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflect those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child’s ability to solve his own problems if given the opportunity to do so. The responsibility to make choices and to institute change is the child’s.

6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (Axline, 1947, p. 73-74)

Axline's principles provided a framework for the therapeutic environment, the therapeutic relationship, and the role of the therapist in CCPT.

Guernsey (2001) and Landreth (2012) extended the person-centered, non-directive approach to working with children into what is presently known as child-centered play therapy (CCPT) in the United States. Landreth developed specific facilitative responses based on Axline's basic principles including tracking, returning responsibility, esteem building, and limit setting and presented tenets for relating to children from a child-centered approach. Following Landreth's seminal work in CCPT, many authors and experts in CCPT have focused heavily on the verbal skills of play therapist with limited discussion of the therapeutic conditions or attitudes necessary to facilitate children's growth in therapy. Although the philosophy and principles of person-centered theory may be implied, few authors explicitly discuss and explore the Rogerian philosophy, concepts, and conditions that provide the framework for CCPT. This absence of a strong theoretical foundation in CCPT training literature and research creates a problematic widening gap between theory and practice in CCPT (Ray, 2011).

In their work on nondirective play therapy, Wilson and Ryan (2005) acknowledged that the relationship of nondirective play therapy and Rogerian psychotherapy have been



incompletely explored and that the principles of person-centered therapy on which non-directive play therapy is based are often misconstrued and imprecisely practiced. The authors stated that the therapist's belief in the actualizing tendency of the child was central to the practice of non-directive play therapy and briefly mentioned essential therapist characteristics in nondirective play therapy. Wilson and Ryan listed genuineness and authenticity, non-possessive warmth, and accurate empathy as primary elements of the therapeutic relationship but provided limited definition and discussion of these fundamental characteristics.

Cochran, Nordling, and Cochran (2010) stated that the primary goal of CCPT is to “create an atmosphere wherein the child has an authentic relationship with his therapist, one where he is deeply understood and valued, and free to express all feelings without judgment or reproach” (p. 58). The authors presented Axline's eight principles as the foundation for child-centered practice and discussed the therapist's expression of deep empathy, warmth, acceptance, prizing, and authenticity in relationship to the child but ultimately focused on translating Axline's principles into specific therapeutic behaviors and skills.

Likewise, in their book on child-centered play therapy, VanFleet, Sywulak, Sniscak, and Guerney (2010) presented Axline's eight principles as the foundation of CCPT and addressed each principle individually. The authors highlighted the process of building the relationship and communicating acceptance through high levels of attunement and empathy towards the child. VanFleet et al. emphasized the importance of establishing permissiveness in the playroom and maintaining a non-directive approach. Empathic recognition and the reflection of feelings are described as the “essence of CCPT” (p. 26) and recommended as the primary response to the child in the playroom. The authors emphasized the centrality of respecting the child's ability to

solve his or her own problems to facilitate the child's self-esteem, sense of personal responsibility, and trust in him or herself.

Although VanFleet et al. (2010) discussed Axline's eight principles in some detail, the authors focused primarily on logistics and techniques in CCPT but neglected to ground the approach and therapeutic skills within a person-centered theoretical context. The authors identified structuring, empathic listening, child-centered imaginary play, and limit setting as the four primary skills employed in CCPT. VanFleet et al. explored the condition of congruence in the context of empathic listening and provided a two part definition of congruence as: 1) the therapist's genuine care for the child's feelings and perspective and 2) consistency between the therapist's verbalizations and what is actually felt and communicated nonverbally from the therapist. The authors identified empathic listening as the central process in CCPT and defined it as a "skill of attunement, beginning with the recognition of feelings and culminating in a response that actively conveys the identified feelings in an accepting and nonjudgmental manner to the child" (p. 26). Although the authors clarified that empathic listening is not a mechanical repetition of what the child says or does, they emphasized verbal reflection of the child's feeling as a skill to be applied in CCPT. Furthermore, the authors gave no explicit attention to the therapist attitudes or conditions necessary for facilitating effective child-centered play therapy.

Distinguished from the majority of authors on CCPT, Ray (2011) argued that it is a necessity for child-centered play therapists to understand Rogers' 19 propositions and core conditions in order to work effectively with children. Ray critiqued the trend in psychotherapy training to focus almost exclusively on skills or techniques rather than focusing on the person of the therapist and the conditions that are necessary to provide a therapeutic and truly growth-promoting environment. Ray argued that play therapists must be firmly grounded in person-

centered theory and understand the process of change in order to be effective in their work with children in CCPT. She provided an in-depth discussion of Rogers' 19 propositions and the core conditions and applied them directly to work with children in CCPT. Ray recommended that child-centered play therapists operate with a deep understanding and integration of Rogers' theory of development and change and the core conditions; however, her treatment manual for CCPT focused primarily on the play therapist's use of verbal skills with limited discussion of the essential characteristics and attitudes of the play therapist. Additionally, Ray's inclusion of the Play Therapy Skills Checklist (PTSC) provided in the CCPT treatment manual to evaluate treatment integrity does not reflect the necessity for play therapists to experience and demonstrate of congruence, empathic understanding, or unconditional positive regard in CCPT.

#### Therapist-Provided Conditions in CCPT

##### Congruence

Though discussion of congruence in CCPT literature is somewhat limited, several authors attempted to define congruence in the context of CCPT. Landreth (2012) defined genuineness as "being real" (p. 70) and described genuineness as a way of living and being in relationship with others. Wilson and Ryan (2005) defined congruence similarly to Rogers (1980) as a matching between the therapist's outward responses and the therapist's inner feelings toward the child. VanFleet et al. (2010) stated that congruence is expressed in relationship to empathic listening as the therapist's genuine regard for the child's perspective and feelings. VanFleet et al. emphasized that the therapist's voice intonations and body language should be consistent with the therapist's spoken words. The authors included the therapist's awareness of his or her own feelings in their definition of congruence but concluded that the therapist would rarely express his or her feelings or reactions to the child. Similarly, Cochran et al. (2010) emphasized that congruence is

demonstrated when the therapist is an integrated person, open and available to connect with the child, and congruently empathic and accepting towards the child.

Ryan and Courtney (2009) discussed the limited expression of congruence by play therapists trained in the United States. The authors argued for the verbal expression of congruence in play therapy and distinguished between the therapist's personal feelings and feelings that arise within the therapeutic relationship. Ryan and Courtney noted that congruence is demonstrated through consistency between the therapist's verbal expression and what is expressed nonverbally through the therapist's tone of voice, body language, eye contact, and movement away and toward a child. Furthermore, they acknowledged that congruence is expressed differently within each therapeutic relationship and cannot be fully prescribed though they provided examples of how and when it may be expressed verbally within play therapy through the therapist's use of "I" statements in role-plays, in conversations, and in setting limits. Ray (2011) acknowledged the challenges and potential risks of expressing congruence in the play therapy relationship and discussed congruence as an advanced skill largely correlated with the play therapist's own self-regard and self-awareness.

### Unconditional Positive Regard

Unconditional positive regard is often described or referred to as acceptance in CCPT literature; and few authors have explored it fully. Axline (1947) captured the essence of unconditional positive regard in her second principle in which she encouraged the therapist to accept the child fully as he or she is without wanting the child to be different in any way. In his discussion of the therapeutic conditions for growth, Landreth (2012) described the necessity for warm caring and acceptance of the child that is experienced by the child as being genuinely valued and prized by the therapist. Cochran et al. (2010) identified unconditional positive regard

as an attitude of treasuring and prizing the child and discussed the benefits of unconditional positive regard in CCPT. Ray (2011) presented unconditional positive regard as the antidote to the child's conditions of worth and described the play therapist's unconditional positive self-regard and self-acceptance as the door to complete acceptance and unconditional positive regard for the child.

### Empathic Understanding

Empathic understanding is most frequently discussed in terms of tracking, empathic listening, reflective listening, or reflections of feeling in CCPT (Landreth, 2012; VanFleet et al., 2010; Wilson & Ryan, 2005). However, empathic understanding is not a skill or a technique to be employed by the therapist. Furthermore, A skill-focused definition of empathy lacks the depth and essence of Rogers' fifth condition (Cochran et al., 2010; Ray, 2011). Landreth (2012) described empathy in terms of a sensitive understanding towards the person of the child. According to Landreth, sensitive understanding is realized when the play therapist is "in full emotional contact with the child's perceptual, experiential world of reality" (p. 77) without questioning, evaluation, or analysis of the child's experience. Cochran et al., coined the term "deep empathy" to describe the shared experience between the child and the therapist. They argued that deep empathy is not a thought process or the therapist's attempt to figure out what the child is feeling rather it is the process of the therapist feeling the emotion and the full experience of the child in the moment. Ray (2011) defined empathic understanding as the process of "entering the client's world as if it were your own without losing a sense of self as the therapist" (p. 65) and described the emotional process of the therapist being open to and experiencing the child's world.

## Unconditional Positive Self-Regard

CCPT authors discussed UPSR most often in terms of therapist self-acceptance (Landreth, 2012; Cochran et al., 2010). Landreth identified therapist self-acceptance and belief in the capacity of the child for growth as fundamental to the process and outcome of CCPT. Furthermore, Landreth acknowledged the necessity of the play therapist to be in a continual process of developing self-awareness and self-acceptance in order to be open and accepting of the child's experience and process in play therapy. The therapist's ability to accept the child's weaknesses is a reflection of the therapist's ability to accept his or her own weaknesses. Similarly, Cochran et al. briefly explored the need for self-acceptance, self-empathy, and self-care to be an effective play therapist. Ray (2011) made a direct connection between play therapists ability to provide unconditional positive regard and the therapist's own self-regard and acknowledged that a lack of self-acceptance inhibits a therapist's ability to provide acceptance for one's clients. Although CCPT authors have not explored unconditional positive self-regard in as much depth as person-centered theorists, many have recognized that often a therapist's capacity to provide unconditional positive regard for a child is a direct reflection of the therapist's own self-regard.

The therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding are largely unexplored in CCPT training literature. There is a chasm between the theory and practice of CCPT and an increasing emphasis on skills and techniques in CCPT rather than the essential conditions and characteristics of the play therapist (Ray, 2011). Furthermore, research on the process of CCPT and the therapist-provided conditions has been limited both in scope and depth.

## Research in Child-Centered Play Therapy

CCPT has been shown to be an effective treatment for children with a variety of emotional and behavioral issues (Bratton, Ray, Rhine, & Jones, 2005). Furthermore, CCPT is recognized as the most popular approach to play therapy in the United States, one of the most well-researched approaches in play therapy, and one of few play therapy approaches with a treatment manual (Lambert et al., 2005; Ray, 2011). Sixty-two studies on the effectiveness of CCPT were conducted between 1947 and 2010 (Ray, 2011). Researchers have demonstrated that CCPT is an effective treatment for children with externalizing/disruptive behaviors, attention deficit hyperactivity disorder, internalizing behavior problems, anxiety, depression, self-concept/self-esteem, social behavior, parent/teacher relationship, sexual abuse/trauma, academic achievement/intelligence, and speech/language skills. In addition to effectiveness studies, researchers have also explored the process and experience of CCPT through qualitative analysis. However, there is limited exploration of Rogers' conditions and the interactional, relational process between the therapist and the child in CCPT research (Ray, 2011). Researchers have focused primarily on parents', children's, and therapists' perceptions of the play therapy process and stages, patterns, and themes in the play therapy. Few researchers have explored the characteristics of an effective play therapist and the therapist-provided conditions in play therapy.

### Relational Process of CCPT

Hendricks (1971) provided a descriptive analysis of the process of CCPT. She used observations and audio recordings of CCPT sessions to identify categories of play, nonverbal expression, and verbal expression of children in play therapy. Hendricks included 10 boys between the ages of 8 and 10 years old with social or emotional maladjustment problems in the study. Each child had 12 sessions with a client-centered play therapist that were observed and

audio-recorded. The sessions were transcribed and nonverbal behaviors and expressions were described in a narrative format. Utilizing content analysis, the frequency of play activities, nonverbal expressions, and verbal comments were identified. Hendricks provided a description of the play therapy process beginning with exploratory play, expressions of curiosity, and creative play. The next pattern that emerged was an increase in creative play, aggressive play, and self-disclosure from the child. As play therapy continued, the child's play became more dramatic and included role-play. Additionally, feelings of anger, frustration, and anxiety became more focused and specific. Finally, the children demonstrated a greater interest in developing a relationship with the therapist. Hendricks concluded that client-centered play therapy was effective in helping children communicate their feelings verbally, non-verbally, and through play. Furthermore, Hendricks concluded that though there were recognizable patterns in the children's therapeutic process, there were no discernible, universal stages in CCPT; and she recommended further research on the process of play therapy utilizing video-recordings.

#### Essential Characteristics of Play Therapists

In an effort to understand child mental health practitioners' perspectives on the essential characteristics of child therapists, Courtney and Gray (2011) conducted a content analysis of pictures drawn by the therapists. Courtney and Gray asked the practitioners to draw pictures of a child therapist before and after a developmental play therapy training workshop. Blind raters coded the pictures using pre-established criteria. The analysis revealed that child therapists consider open posture, security and stability, attentiveness toward the child, identification with the client, and play materials as essential qualities of the play therapy relationship. The authors considered the drawing task a limitation of the study because most adults cease to draw in middle childhood and the therapists may not have been able to adequately convey their perspective. In



addition, the child therapists' theoretical orientation was not identified or considered in the study. Several of the essential characteristics identified through the analysis of the child therapists' artwork were directly related to the person and presence of the child therapist indicating that child therapists recognize the importance of the therapist's attitudes and nonverbal communication towards the child which is consistent with a child-centered approach.

Nalavany, Ryan, Gomory, and Lacasse (2005) used concept mapping to identify therapist qualities, competencies, and skills that play therapists considered necessary for successful play therapy outcomes. Play therapists' perceptions were explored using a nationally distributed survey and a Q-sort exercise. Surveys were distributed to play therapists ( $N = 4338$ ) that were members of the Association for Play Therapy. Of the 891 survey responses gathered, 306 survey completers consented to participate in the study. The authors reduced the 918 qualitative statements generated by the 306 respondents and reduced the statements to 75 through a systematic random selection process. For the sorting task, participants were instructed to group the 75 statements into conceptual groups and write a short phrase or title that described each conceptual group. Participants were also asked to rate each of the 75 statements according to its degree of importance as a characteristic of an effective play therapist and its degree of difficulty to acquire that skill. From the randomly selected respondents who consented to participate in the sorting task ( $n = 39$ ) a total of 28 completed and returned the sorting task. The authors used concept mapping to analyze the concept groups identified by the play therapists through the sorting task. Through the concept mapping process, Nalavany et al. found that therapists considered genuineness, acceptance, empathy, self-awareness, self-growth, ability to teach parenting skills, and knowledge of therapeutic theories and techniques as the most necessary qualities, skills, and competencies for the effective practice of play therapy. Nalavany et al.

found that play therapists considered therapist relationship building skills and the facilitative conditions to be the most important skills for play therapists to possess. Furthermore, their research indicated that play therapists consider skills associated with the core conditions and sensitivity to the child as the most challenging skills for play therapists to develop. Likewise, clinical interventions were considered a much less important set of skills for play therapists to possess but easier to develop. The authors recommended continued research toward understanding the development of the therapeutic relationship and facilitative conditions in play therapy, the nature of the interaction between the therapeutic relationship and the therapist's interpersonal processes skills, and how to teach relationship building and interpersonal skills to play therapists.

#### Relationship Variables in Child Therapy

Shirk and Karver (2003) conducted a meta-analytic review of 23 studies that examined the outcome of treatment for children and adolescents based on relationship variables. The researchers coded the studies based on sample, design, and treatment characteristics and calculated both weighted and unweighted effect sizes. The researchers reported an unweighted effect size of  $r = .25$  and a weighted effect size of  $r = .22$  for the association between therapeutic relationship and outcome in child and adolescent therapy which is identical to alliance-outcome estimates found with adults. Shirk and Karver also found that associations between therapeutic relationship variables and therapeutic outcome were moderated by patient type. Specifically, there was a stronger correlation between therapeutic outcome and therapeutic relationship for patients that were classified as externalizing. Furthermore, the researchers found that measures of the relationships gathered later in therapy were more strongly associated with outcomes than earlier measures and that reports from treatment providers were more strongly associated with

outcomes than reports from children or adolescents. The researchers concluded that relationship formation may take longer with children and that later relationship measures may be more accurate and that children may not have the cognitive skills to accurately evaluate the therapeutic relationship and tend to provide a more positively skewed evaluation than adults.

#### Therapist-Provided Conditions in Child Therapy

Truax, Altmann, Wright, and Mitchell (1973) explored the effects of the therapeutic conditions of accurate empathy, non-possessive warmth, and genuineness with children. Sixteen psychotherapists saw 16 child clients of the average age of 9 years and 3 months in therapy. Three 5-minute segments were selected from two therapy sessions for each therapist and child and were analyzed by objective raters using the AE, NPW, and GEN scales. Several instruments were used to evaluate the children's psychological adjustment towards the beginning and end of treatment. The authors reported that the children showed positive outcomes following treatment and that there was a positive correlation between high therapeutic conditions of AE, NPW, and GEN and therapeutic outcome with children. Major limitations of this study included the absence of a control group, the small sample size, and the use of outcome measures that were not created or normed with children, exclusive measurement of therapists' verbal expression of the therapeutic conditions without regard for nonverbal expression, and no consideration of the children's or therapists' rating of the therapeutic conditions.

Siegel (1972) examined the relationship between therapist-offered conditions and changes in play therapy behaviors across time. One therapist saw 16 children diagnosed with learning disabilities for 16 sessions. Three observers rated the therapist's verbal responses and skills during four selected sessions with each child using Truax and Carkhuff's (1967) Accurate Empathy, Unconditional Positive Regard, and Genuineness Scales. Siegel found a positive

modeling effect for the children who experienced the highest level of therapist-offered conditions as evidenced by an increase in the child's positive self-statements through the course of therapy. However, Siegel's measurement of the therapist-offered conditions focused exclusively on the verbal responses of one therapist, and he did not consider non-verbal responses and interactions between the therapist and child as part of the study. Furthermore, Siegel did not report the validity or reliability of the Accurate Empathy, Unconditional Positive Regard, and Genuineness Scales used to measure the therapist-provided conditions.

Harnish (1983) studied the effects of children's perceptions of therapist-expressed conditions on the process and outcome of non-directive play therapy. She used eight minimally trained undergraduate students as play therapists to conduct non-directive play therapy sessions with eight aggressive and eight non-aggressive children. Harnish revised the Barrett-Lennard Relationship Inventory and had both the play therapists and children complete the revised questionnaires to identify the therapist's level of expression of genuineness, empathy, and unconditional positive regard following 16 sessions of play therapy. Harnish also analyzed recorded play sessions and categorized the therapist's verbal responses to the child. The children's teachers completed the Missouri Children's Behavior Checklist, and the children completed the Piers-Harris Children's Self-Concept Scale and the Children's Manifest Anxiety Scale pre- and post-treatment. Results of multiple regression analyses indicated that higher levels of therapist-expressed conditions were positively related to children's empathy and self-concept and negatively related to children's aggressiveness. The children's perceptions of the level of therapist-expressed conditions were better predictors of therapeutic outcome than the therapist's ratings of the therapeutic conditions. Whereas Harnish concluded that children who perceived higher levels of the therapist-expressed conditions had better therapy outcomes, her measurement

of genuineness, unconditional positive regard, and empathy were based on assessments originally designed and validated for use with adults that she revised for use with the therapists and children in her study. In addition, her observations of the therapist's responses focused solely on verbal responses or skills. Furthermore, students who had no graduate training or supervised experience in counseling or non-directive play therapy provided the intervention. Many experts in the fields of person-centered counseling and child-centered play therapy recognize that developing high levels of congruence, empathy, and unconditional positive regard requires intentional practice, commitment to personal growth, and supervised experience (Cornelius-White, 2007; Landreth, 2012; Mearns, 2003; Ray, 2011; Wilkins, 2010).

Darr (1994) studied the development of the therapeutic relationship in client centered play therapy and how the "core conditions" manifest themselves in play therapy. Darr utilized live observations of play sessions, video recordings of play sessions, therapist session critiques and reflections, supervision with the therapists, and therapist and child interviews to analyze relationship development and the counselor's use of core conditions in client centered play therapy. Four graduate students trained in client-centered play therapy conducted a total of 42 play sessions. Darr provided a descriptive analysis of the development of the play therapy relationship through three case studies. In the analysis of the verbatim transcripts of the play sessions, Darr focused primarily on the verbal skills and techniques used by the therapists to demonstrate the core conditions. The therapist's verbal responses were coded according to the established categories of empathy, unconditional positive regard, and congruence to understand how the core conditions are manifested in client centered play therapy. The therapist's verbal responses were coded a second time according to the focus of their statements. Five categories of responses were identified including content, feelings, relationship, underlying meaning, and

generalization. The frequencies of the therapist's responses were analyzed according to the focus of their statements and the three identified conditions of empathy, unconditional positive regard and congruence.

Based on her analysis of the session transcripts and the three case studies, Darr (1994) concluded that the activity of the therapist enhances or detracts from the development of the relationship between the child and the therapist, that content-focused responses decreased over time, that feeling-focused and relationship-focused responses increased steadily through the course of therapy, underlying meaning responses began later in therapy and increased gradually over time, and that generalization-focused responses were present and increased toward the conclusion of therapy. Darr provided numerous examples of the therapist's statements that exemplified empathy, congruence, and unconditional positive regard and a rationale for the kinds of verbal responses that accurately displayed each condition. The therapist's frequency of these responses varied widely. Based on these findings, Darr recommended that therapists follow an outline of responses through the course of therapy beginning with content, feelings, relationship, underlying meaning, and finally generalization to most effectively facilitate relationship development and promote a therapeutic environment. Similarly, Darr recommended a sequence for providing the conditions with children through the course of play therapy. Unconditional positive regard should be emphasized at the beginning of therapy to support relationship development and the child's process and again towards the end of therapy. Darr concluded that empathic understanding was essential to the working stages of the play therapy relationship and that congruence was most important towards the end of therapy when the child is integrating and generalizing the therapeutic experience to his or her life. Although Darr recognized that the three

therapist-provided conditions are necessary throughout the play therapy process, she advocated a sequential and intentional use of the conditions.

Although Darr (1994) provided an in-depth description of the relationship development process through the use of case studies and presented detailed analyses of the type and frequency of therapist responses through the course of therapy, a major limitation of her study was the absence of consideration or analysis of the therapist's nonverbal responses to the child and the child's verbal and nonverbal responses to the therapist. Furthermore, Darr also conducted interviews with the therapists and the children that were not analyzed for themes or utilized in the development of her theory of the sequential use of therapeutic responses to facilitate the therapeutic relationship and growth. Darr also neglected to consider all six 'necessary and sufficient' conditions in her study and focused on empathy, unconditional positive regard, and congruence as independent phenomena.

Researchers who have conducted studies on the therapist-provided conditions in play therapy have relied primarily on textual analysis and focused almost exclusively on the therapist's verbal responses and skills (Darr, 1994; Harnish, 1983; Siegel, 1972). Although the researchers utilized recorded play therapy sessions in their studies, they did not conduct any analysis of visual data or of the nonverbal communication and interactions between the therapist and child. The exclusive reliance on verbal communication is a major limitation within CCPT research due to the primarily nonverbal nature of play therapy. Although the play therapist often communicates and makes contact with the child verbally, children communicate primarily through the language of play. Furthermore, nonverbal communication between the child and the therapist is often more critical than verbal communication (Landreth, 2012; Ray, 2011).

Furthermore, the therapist-provided conditions cannot be reduced to skills or techniques and are most often demonstrated nonverbally.

### Qualitative Research Methods

Qualitative research continues to gain increased acceptance and validation in social, behavioral, and health sciences (Charmaz, 2006; Creswell, 2013). Creswell (2003, 2013) recommended the use of qualitative research methods when the focus of research is exploration of a concept or phenomenon and when a complex, detailed understanding of the issues is needed. Qualitative methods are also used when “partial or inadequate theories exist for certain populations and samples or existing theories do not adequately capture the complexity of the problem we are examining” (p. 48). Qualitative methods allow researchers to investigate concepts or processes, such as human interactions, that extend beyond quantitative inquiry or measurement. In qualitative research, the researcher makes knowledge claims based on the lived experiences of individuals and groups with the intent of developing a pattern or theory. Denzin and Lincoln (2011) presented qualitative research as a method in which the focus is on the “qualities of entities and on processes and meanings that are not experimentally examined or measured in terms of quantity, amount, intensity, or frequency” (p. 8). Furthermore, qualitative researchers seek answers to questions that emphasize *how* social experience is created.

McLeod (2001) identified a parallel process between the practice of therapy and qualitative counseling research. McLeod noted that, “the application of qualitative methods to topics within counseling and psychotherapy inevitably leads in the direction of the deconstruction and reconstruction of therapy theory and practice” (p. 16). Although qualitative methods do not yield statistical significance or effect sizes, they often have stronger clinical and practical significance than quantitative methods. McLeod also identified several consequences of



outcome-focused, quantitative research including randomized control trials (RCTs). In RCTs, client, therapist, and supervisor voices are often unheard; research strategies reinforce the medicalization of therapy; due to the expense and complexity of RCTs they are primarily conducted in elite establishments and rarely focus on forms of therapy that are not well-represented in the academic institution; and the social, cultural, and political context of the research is rarely explained or clarified (pp. 164-165). McLeod emphasized that qualitative methods play a critical role in psychotherapy outcome research because “attention to the meaning of treatment and the development of understanding of therapeutic gain are important goals” (p. 178) for establishing the effectiveness of therapeutic interventions.

Similarly, Nelson & Quintana (2005) argued that qualitative research provides information that is more useful and accessible for practitioners than quantitative research. Nelson & Quintana argued that, “quantitative researchers need to be concerned about their operational definitions and whether these definitions reflect the ways in which underlying psychological constructs operate outside of the research setting” (p. 345). Qualitative research can be used to explore and identify important variables and processes in counseling that can lead to better operational definitions and instrumentation.

Glazer and Stein (2010) recommended the use of qualitative methods for understanding the process of play therapy and the therapeutic relationship in play therapy. The authors suggested that a qualitative approach allows researchers to build a holistic picture of the play therapy process and to understand complex human phenomena such as the therapeutic relationship and therapist-provided conditions in child-centered play therapy.

Several distinguishing features set qualitative research apart from quantitative methodologies (Creswell, 2013). Qualitative research is conducted in a natural setting in which

researchers interact closely with data sources. The researcher is the primary instrument in data collection; and multiple methods are used to collect data including observations, field notes, and interviews. Qualitative methods involve a complex flow of inductive and deductive reasoning. Qualitative researchers focus on participants' perspectives, meanings, and subjective perspectives. Qualitative research is reflective and interpretive and incorporates the researcher's experiences and social identities. Qualitative research presents a holistic, complex picture of the studied phenomenon.

Creswell (2013) also identified several defining features of “good” qualitative research (pp. 53-55):

1. The researcher employs rigorous data collection procedures, collecting multiple forms of data and spending adequate time in the field.
2. The researcher frames the study within the assumptions and characteristics of the qualitative approach to research.
3. The research uses a recognized approach to qualitative inquiry.
4. The researcher begins with a single focus or concept being explored.
5. The study includes detailed methods, a rigorous approach to data collection, data analysis, and report writing.
6. The researcher analyzes data using multiple levels of abstraction.
7. The researcher writes persuasively so that the reader experiences a sense of “being there” by using clear and engaging style accurately reflecting the complexities that exist in real life.
8. The study reflects the history, culture, and personal experience of the researcher.

9. The study is ethical.

## Grounded Theory

Glaser and Strauss (1967) first developed grounded theory as an inductive, qualitative approach for social research. In direct response to social positivism, Glaser and Strauss emphasized the generation of theory through research that was grounded in data rather than using research to verify existing theories (Charmaz, 2006; Glaser & Strauss, 1967). The purpose of a grounded theory approach is to generate theory that is grounded in data and emerges from the lived experiences of the participants. Creswell (2013) recommended a grounded theory approach to generate theory where there is little existing knowledge and/or to provide a new perspective on existing knowledge that is grounded in the lived experiences of those who participate in the phenomena of inquiry.

Glaser and Strauss (1967) outlined critical components for conducting grounded theory including simultaneous cycles of data collection and analysis, constant comparison, theoretical sampling, theoretical saturation, inductive and emerging codes and theory that accurately reflects the data, and a developed analytical theory that expands beyond description. Creswell (2013) also identified several defining features of grounded theory methods (p. 85):

1. Researcher focuses on process or an action that has distinct steps or phases that occur over time.
2. The researcher seeks to develop a theory of this process or action.
3. Memoing becomes part of developing the theory as the researcher writes down ideas as data are collected and analyzed.

4. The primary form of data collection is often interviewing in which the researcher is constantly comparing data gleaned from participants with ideas about the emerging theory.
5. Data analysis can be structured and follow the pattern of developing open categories, selecting one category to be the focus of the theory, and then detailing additional categories to form a theoretical model (open coding followed by focused coding and then theoretical coding).

Charmaz (2006) emphasized the importance of collecting and analyzing rich, substantial, and relevant data and entering the research participants' worlds and demonstrating respect to research participants through one's efforts to learn about and understand their lived experiences to ensure quality and credibility in qualitative research. Several other dimensions of grounded theory methodology are critical for valid and rigorous research including theoretical sensitivity, reflexivity, theoretical sampling and saturation, coding, and memo-writing.

Corbin and Strauss (2008) defined sensitivity as "having insight, being tuned in to, being able to pick up on relevant issues, events and happenings in the data" (p. 32). Corbin and Strauss emphasized that background, experience, and knowledge enable the researcher to be sensitive to concepts in the data and to see relationships between the data. Knowledge of both theory and literature in one's field of study can promote theoretical sensitivity.

Central to the qualitative approach of grounded theory is the concept of reflexivity (Corbin & Strauss, 2008; Creswell, 2013). Reflexivity refers to the researcher's awareness, scrutiny, and honest appraisal of one's own pre-existing knowledge, beliefs, values, culture, and experiences and how these may influence the process and outcome of inquiry (Charmaz, 2006; McGhee, Marland, & Atkinson, 2007). Reflexivity incorporates a self-aware, self-questioning

approach by the researcher and an openness that allows one's biases to be eliminated when challenged or opposed by the data (McGhee et al., 2007). Finlay (2002) considered reflexivity a valuable tool in qualitative research:

to examine the impact of the position, perspective and presence of the researcher;  
promote rich insight through examining personal responses and interpersonal dynamics;  
empower others by opening up a more radical consciousness; evaluate the research  
process, method, and outcomes; and enable public scrutiny of the integrity of the research  
through offering a methodological log of research decisions (p. 532)

Reflexivity is practiced through data collection and analysis and is demonstrated through the process of memo writing, allowing the researcher to reflect on one's initial reactions and analytic process. Memo-writing also aids the development of theory as researchers reflect upon the data collection and analysis process and emerging categories. Memo-writing is a crucial step in moving from description to categories to theory.

Morse (2007) explained that the main principle of theoretical sampling is that the emerging categories and developing theory dictate sampling. Rather than seeking a random or representative sample as in quantitative research, grounded theorists utilize purposeful sampling to select participants who have experienced the phenomenon or concept being studied. Once data collection and analysis have begun, the researcher selects participants or cases as needed to inform, explicate, or defined the boundaries and relevance of the categories and emerging theory (Charmaz, 2006). Sampling continues to "the point at which gathering more data about a theoretical category reveals no new properties nor yields and further theoretical insights about the emerging grounded theory" (Charmaz, 2006, p. 189) and theoretical saturation is achieved.

In grounded theory, data are analyzed through a multi-stage coding process including initial coding, focused coding, and theoretical coding (Charmaz, 2006; Creswell, 2013; Glaser & Strauss, 1967). The first stage of coding in grounded theory is open or initial coding during which the researcher remains open, stays close to the data, creates simple, short, and precise codes, and focuses on actions and processes in the data (Charmaz, 2006). According to Charmaz, initial codes should be grounded in data, provisional, and comparative. Coding is conducted line-by-line, word-by-word, or incident-by-incident to ensure codes closely reflect the data. Focused coding is the second phase of coding in a grounded theory approach. Focused codes are more selective and conceptual than initial codes. During focused coding, the researcher uses the most meaningful or frequent codes to analyze large amounts of data. According to Charmaz, “the researcher makes decisions about which initial codes make the most analytic sense to categorize the data incisively and completely” (pp. 57-58). The final stage of coding in grounded theory is theoretical coding. Theoretical coding involves conceptualizing and integrating focused codes to specify relationships between categories developed during focused coding. Theoretical codes provide coherence and move the analysis towards a developed theory. Throughout each phase of the coding process, the researcher compares data with data.

#### Coding Visual Data and Nonverbal Processes

Although visual data is coded through the same phases as textual data, there are some unique aspects to the coding of nonverbal processes. Coding nonverbal behavior is a useful approach when researchers seek to understand how “micromomentary actions contribute to interaction dynamics” (White & Sargent, 2005, p. 8). Coding provides a high level of accuracy and reliability and allows researchers to explore separate behaviors, combined behaviors, and interactions. Most research on nonverbal processes involves circumstances where two or more

individuals are interacting and researchers must decide if they will code the nonverbal behavior of individuals or the combined behavior of participants (White & Sargent, 2005). Coding the behavior of individuals allows researchers to determine how the behavior of one person affects the other. Examining the combined behavior of participants allows researchers to better understand features of the interaction that are collaboratively produced.

White and Sargent (2005) recommended that researchers employ interval coding “to examine the occurrence of microbehaviors . . . and to isolate and examine extremely small, but meaningful changes” in nonverbal behavior (p.17). In interval coding, researchers limit the sampling of nonverbal processes to segments of the interaction. Researchers must decide the number of intervals and length of intervals for coding based on the frequency with which the process is likely to occur and how long it takes participants to enact a behavior. Following, interval coding, White and Sargent recommended that researchers reexamine video recordings to code for more global impressions and meanings.

Due to the dynamic nature of the play therapy process and relationship between child and therapist, the complex and interrelated dimensions of congruence, unconditional positive regard, and empathic understanding, and the lack of substantive research on the therapist-provided conditions in child-centered play therapy, I utilized a qualitative, grounded theory approach for this study. In order to explore the interactional dynamics and primarily nonverbal processes in CCPT, the therapist-provided conditions were explored through analysis of visual data.

APPENDIX B  
COMPLETE METHODOLOGY



The purpose of this study was to explore how the therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding are experienced and conveyed in child-centered play therapy. The primary research question for the study was: How do congruence, unconditional positive regard, and empathic understanding emerge in Child-centered play therapy?

I utilized a qualitative, grounded theory approach for this study in order to build a theory of how the essential attitudes of congruence, unconditional positive regard, and empathic understanding are experienced and conveyed in CCPT. Glazer and Stein (2010) identified qualitative methods as the most appropriate approaches for play therapy research in which the purpose is to develop a deeper understanding of the therapeutic process and the relationships in counseling and to construct models and theories of the process of growth and change in play therapy. Glaser and Strauss (1967) developed grounded theory as an inductive methodological approach through which researchers generate theory that is grounded in research. The purpose of a grounded theory approach is to construct abstract theoretical explanations of social process through a systematic analysis of data (Charmaz, 2006). The purpose of this study is to develop a theory of how the conditions of congruence, empathic understanding, and congruence emerge in child-centered play therapist utilizing a grounded theory methodology.

#### Research Team

The research team consisted of two advanced doctoral students with advanced training in person-centered theory and play therapy and one faculty member with extensive experience in CCPT practice, training, supervision, and research. I am a 31-year-old, White female. I am a Licensed Professional Counselor intern and an advanced doctoral student with four courses in CCPT, four courses in person-centered theory, three years of CCPT supervision, and advanced

training in qualitative analysis and grounded theory methods. I self-identify as a person-centered counselor and child-centered play therapist. I have a strong personal commitment to person-centered theory and practice in counseling and believe that Rogers' core conditions are essential for effective therapeutic practice and outcome. In addition to my own practice of CCPT, I have supervised and provided training in CCPT to masters' students for three years. Both in my experiences as a student and teacher of CCPT, I have experienced an instructional deficit in teaching play therapists to use specific skills in CCPT without having a solid theoretical understanding of person-centered theory and the attitudinal conditions. Furthermore, as a contributor to multiple research studies on the efficacy of CCPT, I recognized that CCPT researchers have conducted minimal exploration of the specific variables in CCPT that positively impact treatment outcome. All of these experiences contributed to my interest in this study and commitment to explore and to contribute to a developing theory of how the therapist-provided conditions emerge in CCPT.

The second research team member is a 29-year-old, White female. She is an advanced doctoral student in counselor education, a Licensed Professional Counselor intern, with two classes in CCPT, three years of play therapy supervision, and advanced training in person-centered theory and qualitative analysis. The second researcher identified as a non-directive play therapist with a strong interest and dedication interpersonal variables and facilitative conditions in child counseling.

A faculty member served as an expert consultant and peer reviewer throughout the research process. The faculty member has a doctorate in counselor education. The faculty member is a licensed professional counselor supervisor and a registered play therapist supervisor with 17 years of clinical practice in CCPT and 14 years of experience teaching and supervising

CCPT. She has conducted numerous quantitative and qualitative research studies in CCPT and authored several book chapters and books on CCPT. She identified as child-centered in her approach to play therapy and expressed a commitment to the teaching and practice of Rogers' (1957) core conditions and person-centered philosophy.

### Participants

I used theoretical sampling as the primary sampling method in this study (Charmaz, 2006). The main principle of theoretical sampling is that the emerging categories and developing theory dictate sampling (Morse, 2007). I also used purposeful sampling, as recommended by Creswell (2013), to select participants who experienced the phenomenon being explored. Once data collection and analysis began, I selected additional child participants and play sessions to inform and clarify the emerging theory of how congruence, unconditional positive regard, and empathic understanding emerge in CCPT (Charmaz, 2006).

Following approval from the University of North Texas Institutional Review Board (IRB), I recruited child-centered play therapists from a mental health clinic on a university campus in the Southwestern United States. I asked four ( $n = 4$ ) advanced doctoral students with at least three courses in play therapy, at least two years of clinical experience in play therapy, and weekly supervision of their play therapy facilitation to participate in this study. All of the therapists were White females and they ranged in age from 26-28. Participating therapist demographics are summarized in Table 1.

Table B.1

*Therapist Demographics*

Therapist	Age	Gender	Ethnicity	# PT Courses
Therapist A	27	Female	White	6
Therapist B	26	Female	White	6
Therapist C	28	Female	White	7
Therapist D	26	Female	White	3

In order to participate in the study, each play therapist affirmed belief in the basic philosophy of CCPT by signing a theoretical statement that included Rogers’ fundamental philosophy of the self-actualizing tendency, Rogers’ necessary and sufficient conditions for constructive personality change, and Axline’s principles for child therapists (Appendix E). I presented the play therapists with a written copy of the theoretical statement and explained it verbally. I invited the therapists to read the statement in its entirety and answered their questions regarding the statement. I asked the therapists to acknowledge their agreement or disagreement with the theoretical statement verbally and to sign the form if they indicated they agreed with the statement. The purpose for asking for a signed statement was to affirm that each of the play therapists involved in this study identified with a unified child-centered philosophy of working with children. I recruited therapists from one university mental health clinic due to the convenience of an appropriate sample of child-centered play therapists and resources within the clinical setting to observe and record play therapy sessions.

Each participating play therapist was asked to identify three children they were currently seeing in individual CCPT ( $n = 12$ ). Child demographics are summarized in Table 2. Children met the following criteria for inclusion: (a) age four to eight years; (b) attended play therapy on a weekly basis; (c) completed at least six play therapy sessions with the same therapist; and (d)

demonstrated incongruence, anxiety, or vulnerability at initiation of therapy. In order to meet Rogers' second condition for therapeutic change requiring that the client be in a state of incongruence, the children demonstrated some level of anxiety or vulnerability at the initiation of play therapy. Because children may not be consciously aware of their own incongruence, Ray (2011) recommended that this condition be assessed through a child's exhibition of problematic behaviors. Problem behaviors often demonstrate incongruence between a child's self-concept and the environment or incongruence between the child's self-concept and the child's actual experience. The presence of problematic behaviors was assessed through an initial parent consultation prior to the initiation of play therapy. The therapists identified children on their caseloads who met inclusion criteria, were consistent in their weekly attendance, and appeared responsive to CCPT.

The participating children ( $n = 12$ ) ranged in age from 4-8 years old with a mean age of 6.3. Of the participating children, 7 were male, 8 were White, 2 were bi-racial, 1 was Asian, and 1 was African-American. Each child had participated in at least six sessions of CCPT prior to inclusion in the study and the number of sessions of CCPT ranged from 7-52, with a mean of 23.8 sessions. Child demographics are summarized in Table 2.

Table B.2

*Child Demographics*

Therapist	Child	Age	Grade	Gender	Ethnicity	Observed Session #
Therapist A	Child 1	5	Pre-K	Male	White	7
	Child 2	8	2 <sup>nd</sup> Grade	Female	Asian	51
	Child 3	8	2 <sup>nd</sup> Grade	Male	White	46
Therapist B	Child 4	4	Pre-K	Male	Bi-racial	13
	Child 5	4	Pre-K	Male	White	10
	Child 6	5	-----	Female	White	52
Therapist C	Child 7	8	3 <sup>rd</sup> Grade	Male	Bi-racial	15
	Child 8	7	1 <sup>st</sup> Grade	Female	White	9
	Child 9	6	1 <sup>st</sup> Grade	Male	African-American	11
Therapist D	Child 10	8	3 <sup>rd</sup> Grade	Male	White	28
	Child 11	7	2 <sup>nd</sup> Grade	Female	White	8
	Child 12	6	1 <sup>st</sup> Grade	Female	White	35

*Note.* Observed Session # = the number of times child had been seen in CCPT by the participating play therapist at the time of observation.

## Recruiting Procedures

During the initial meeting with each participating therapist, I provided the therapist with a written informed consent (Appendix E), explained it verbally, and answered each therapist's questions regarding participation in the study. The therapist informed consent explained the purpose of the study, emphasized the voluntary nature of the research, and clarified the potential benefits and risks of participation in the study. Therapists who agreed to participate in the study were asked to meet with their clients' parents and provide them with the therapist statement to parents (Appendix E).

I met with parents who expressed interest in participating in the study and provided each parent with a written informed consent (Appendix E), read it aloud, and answered their questions regarding participation in the study. The Parent Informed Consent Form explained the purpose of

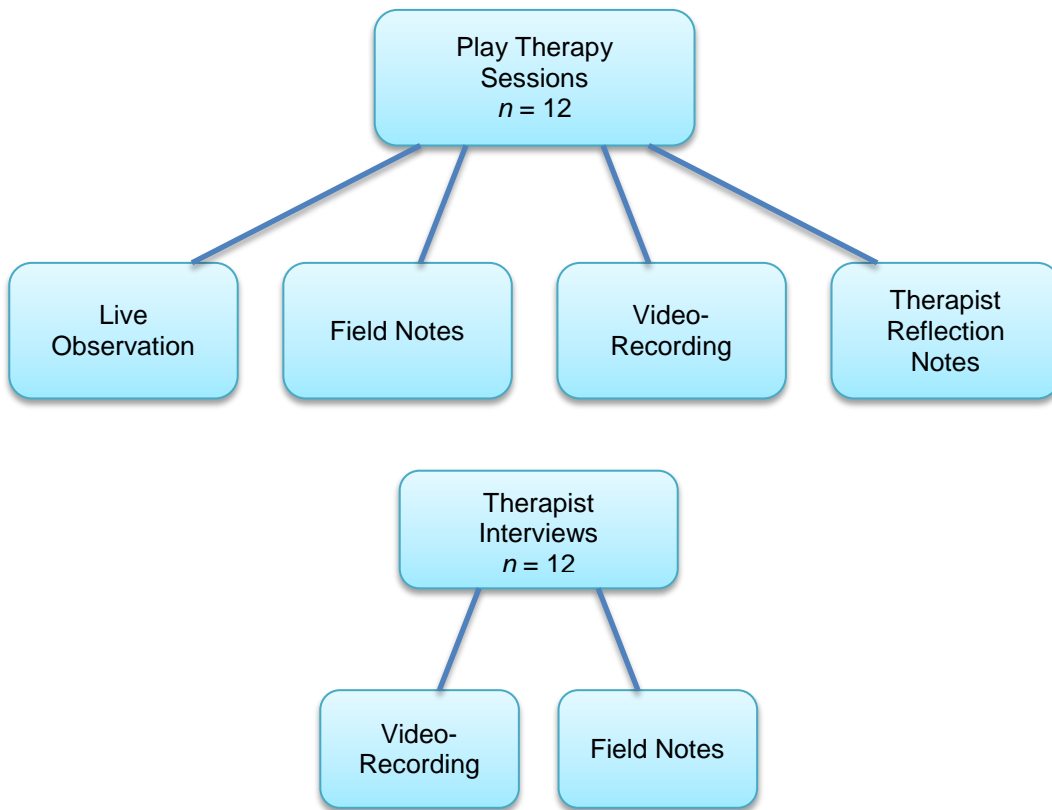
the study, described the risks and benefits of participation, and highlighted the voluntary nature of the research. Once parents provided consent for their child to participate, I met with each child with the capability to provide assent and gave the child a written informed assent form and verbally described the purpose and nature of the study in developmentally appropriate language. Parents were asked to waive their child's assent as needed due to the child's age, maturity, or psychological state.

#### Data Collection

Therapists were asked to complete a brief demographic self-questionnaire (Appendix E) and a demographic questionnaire on each of their participating clients (Appendix E). I observed one individual CCPT session with each therapist and child. Each child was observed once and each therapist was observed three times. Children were observed after their sixth session or more of CCPT with no maximum limit on the total number of CCPT sessions (see Table 2).

Observations were conducted using two-way mirrors in order to maintain the integrity of the therapeutic interaction between the therapist and child. Each observed session was video-recorded using multiple cameras. I wrote field notes during the live observations regarding the observed processes and interactions between the play therapist and the child. Immediately following the play session, the therapists made brief notes regarding their impressions, thoughts, and feelings about the session (Appendix E). Within three days of the live observation, I conducted a 90 to 120-minute, semi-structured interview with the therapist about the observed play therapy session (Appendix E). Therapist interviews were audio- and video-recorded. During the interviews, the play therapists were asked to describe and reflect on their relationship with the child and their experiences in the session with the child as they watched the entire video-recorded play session. Observation field notes and the therapist's brief session notes were used to

inform the interview process. I also wrote field notes during the therapist interviews, noting when therapists stopped the play sessions to discuss their interactions and experience with the child and significant statements or ideas. Throughout the data collection and analysis processes, I wrote analytic memos to promote constant comparison, categorical analysis, and overall theory development. Figure 1 depicts data collection procedures.



*FigureB.1 Data collection procedures*

#### Data Analysis

Two members of the research team coded the recorded play sessions ( $n = 12$ ) and therapist interviews ( $n = 12$ ) in three phases including: 1) open coding, 2) focused coding, and 3) theoretical coding (Charmaz, 2006; Glaser & Strauss, 1967). Data analysis procedures are summarized in Table 3.



Open coding. During the initial phase of open coding, the coding team focused primarily on actions and processes to develop provisional and comparative codes that closely reflected the source data (Charmaz, 2006; Corbin & Strauss, 2008). The coding team coded the video-recorded play sessions in order to attend first to the processes and interactions of the therapeutic encounter between the child and therapist. After open coding of the play sessions was completed, the coding team coded the video-recorded therapist interviews. Therapist interviews were used to inform the emerging categories and themes from the analysis of the recorded play sessions.

*Play sessions.* Interval coding was used to code the play sessions in order to allow the coding team to closely examine the children and the therapists' microbehaviors, subtle changes in nonverbal behaviors, and interactional dynamics (White & Sargent, 2005). The coding team coded a 15-minute segment of each play session, starting at minute 15 of each session and ending at minute 30 of each session. I utilized theoretical sampling to identify additional minutes of each play session for coding based on the therapist interviews (Charmaz, 2006). After the play therapists watched the entire play session, they were asked to identify significant moments in their interaction with the children (see Appendix E). The coding team coded the video-recorded play sessions in one-minute data units in order to attend to subtle nonverbal processes and microbehaviors. Given the challenges of attending to both the child and the therapist's nonverbal processes and their combined interactional process, the coding team coded each one-minute segment first with a focus on the child and then coded the same one-minute segment with a focus on the therapist. For each of the 12 video-recorded play sessions, the coding team coded a range of 22-33 minutes with a mean of 26.4 minutes. Following interval coding of the video-recorded play sessions, the coding team watched each play session in its entirety to code for more global impressions and meanings (White & Sargent, 2005).

Each member of the coding team coded four of the video-recorded play sessions independently. The coding team met to discuss the coding process and compare codes. The coding team members independently coded the remaining eight play sessions. Following independent, open coding of the video-recorded play sessions, the coding team met to discuss and compare codes.

*Therapist Interviews.* The video-recordings of the therapist interviews were coded idea-by-idea. Each member of the coding team coded four of the video-recorded therapist interviews independently. The coding team met to discuss the coding process and compare codes. The coding team members independently coded the remaining eight therapist interviews. Following independent, open coding of all of the video-recorded therapist interviews, the coding team met to discuss and compare codes.

Focused coding. Following open coding of both the video-recorded play sessions and the therapist interviews, the coding team compared the codes from the play sessions to the codes from the therapist interviews. An example of the coding comparison is provided in Appendix D. In the focused coding phase, the coding team developed more selective and conceptual codes and used the most significant and frequent codes to analyze larger segments of data. Categories were reconceptualized and the properties that informed each category were identified.

Theoretical coding. Once core categories were developed, the coding team used theoretical coding in order to analyze the relationships between categories and subcategories and further refine and elaborate the properties and dimensions of each category. The objective of theoretical coding was to explore the relationships between focused codes and to move towards a coherent theory of the process being explored (Charmaz, 2006). The coding team compared and integrated analytical memos and diagrammed major categories to explore the relationships

between concepts. The coding team utilized constant comparison by re-examining open and focused codes and comparing the codes and categories to the theoretical concepts and processes identified in the theoretical coding process.

Peer review. The coding team met with a faculty member with expertise in CCPT and qualitative analysis following each phase of open, focused, and theoretical coding to control for researcher bias (Creswell, 2013). The faculty expert critically evaluated the researchers' data collection and analysis procedures; open, focused, and theoretical codes and categories; and the developing grounded theory. The peer reviewer provided feedback at each phase of data collection and analysis. The primary researcher maintained written field notes documenting the content of each peer debriefing session.

Membercheck. The primary researcher presented the preliminary results of the data analysis to the participating play therapists in a focus group. The primary research audio-recorded and wrote field notes regarding the participants' discussion, questions, and comments during the focus group. The play therapists were asked to evaluate the accuracy and credibility of the initial findings and to provide their own observations of gaps, limitations, or inaccuracies in the analysis and resulting grounded theory. The participating therapists discussed the preliminary results and provided feedback regarding the core categories and relationships. The primary researcher integrated the play therapists' feedback into the final grounded theory of the therapist-provided conditions in CCPT.

Table B.3

*Steps in Qualitative Data Analysis*

Steps	Procedures
<b>Introduction and Discussion of Procedures</b>	Introduced the coding team to study and methods for data collection and analysis. Oriented the coding team to the research question and facilitated a discussion of potential biases, values, and experiences that may influence data analysis (Charmaz, 2006).
<b>Open Coding of Play Sessions: Phase I</b>	The coding team independently analyzed four of the video-recorded play sessions. A 15-minute segment of each play session was coded minute-by-minute. The coding team coded each minute twice, first focusing on the child's behavior and second focusing on the therapist's behavior. Additional minutes of each play session were identified for coding based on the therapist interviews. The researchers also watched each play session in its entirety to develop global impressions of the sessions.
<b>Comparison</b>	The coding team met to discuss the coding process and compare codes. The research team compared their codes to observational field notes and developed initial analytic memos.
<b>Open Coding of Play Sessions: Phase II</b>	The coding team independently analyzed the remaining 8 video-recorded play sessions utilizing the same procedures as in Phase I.
<b>Comparison</b>	The coding team met to discuss the coding process and compare codes on the remaining 8 play sessions. The coding team compared their codes to observational field notes and continued to develop analytic memos.
<b>Open Coding of Therapist Interviews: Phase I</b>	The coding team independently analyzed four of the video-recorded therapist interviews. Therapist interviews were coded in their entirety idea-by-idea.
<b>Comparison</b>	The coding team met to discuss the coding process and compare codes. The coding team compared their codes to interview field notes and play session codes and developed analytic memos.
<b>Open Coding of Therapist Interviews: Phase II</b>	The coding team independently analyzed the remaining 8 video-recorded therapist interviews utilizing the same procedures as in Phase I.

*(table continues)*

(continued)

Steps	Procedures
<b>Comparison</b>	The coding team met to discuss the coding process and compare codes. The coding team compared their codes to interview field notes and play session codes and developed analytic memos.
<b>Focused Coding</b>	The coding team compared codes and categories from the play sessions to codes and categories from the therapist interviews. The team identified the most frequent and significant categories to analyze larger segments of data and to compare the participants' experiences, actions, and interpretations.
<b>Theoretical Coding</b>	The coding team compared and diagrammed focused codes and utilized analytical memos to identify relationships between the substantive categories.

To establish trustworthiness and credibility, I utilized several qualitative strategies throughout data collection and analysis.

- Field notes- I wrote field notes during each play session observation, during the therapist interviews, during peer-debriefing sessions, and during the therapist membercheck (Charmaz, 2006; Creswell, 2013).
- Memos- I wrote analytic memos throughout data collection and analysis in order to facilitate the generation of theory through constant analysis, reflection, and interaction with the data (Lempert, 2007). Memos were utilized to capture emerging concepts and relationships between categories. The memos also served as a means to promote researcher reflexivity and accountability.
- Triangulation- I utilized multiple data sources including live observations of play sessions, video-recorded play sessions, therapist interviews, field notes, and therapist session notes to inform theoretical sampling methods, coding procedures, and overall theory development (Creswell, 2013). Additionally, two team members, with varied

backgrounds and experiences in play therapy, independently coded the video-recorded play sessions and therapist interviews. The research team utilized constant comparative methods to compare data from multiple sources throughout data collection and analysis.

- Peer debriefing- To provide an external check of the research process, I met with an expert in CCPT and qualitative analysis multiple times throughout the phases of data collection and data analysis (Creswell, 2013).
- Membercheck- I met with the participating therapists as a focus group to present preliminary results of the data analysis, to solicit their perspectives on the emerging categories and grounded theory, and to check for accuracy and ‘goodness of fit’ of the theory.
- Literature review- I also conducted a secondary literature review to compare the research findings to the existing literature and to identify disparities or limitations in the emerging theory.

APPENDIX C  
UNABRIDGED RESULTS

## Results

The purpose of this study was to explore how the therapist-provided conditions are actualized in CCPT. Through open, focused, and theoretical coding of the play therapy sessions and therapist interviews, I developed a grounded theory of the therapist-provided conditions in CCPT that expands our current understanding of how congruence, unconditional positive regard, and empathic understanding are experienced and conveyed in CCPT. Results included: (a) definitions of congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard in CCPT; (b) a process-model of the therapist-provided conditions in CCPT; (c) examples of play therapists' internal experiences and external behaviors when the therapist-provided conditions are present in CCPT; (d) examples of play therapists' internal experiences and external behaviors when the therapist-provided conditions are absent/limited; (e) and a model of the process play therapists utilize to respond to breaks and barriers to congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard in CCPT.

### Defining the Therapist-Provided Conditions in CCPT

Part of understanding how the therapist-provided conditions are experienced and conveyed in CCPT includes defining congruence, unconditional positive regard, and empathic understanding in terms of the real experiences and interactions of children and play therapists. Definitions of the therapist-provided conditions emerged through the analysis and comparison of the play sessions and therapist interviews.

**Congruence.** The definition of congruence that emerged from the data analysis was “being aware and open to one’s moment-to-moment experience, thoughts, and feelings and expressing one’s self in a real, natural, and free-flowing way in relationship with the child.” The



therapists described their experiences of congruence using terms including feeling “genuine, natural, spontaneous, free, in the moment, self-accepting, confident, being myself, being more immediate,” and “having self-awareness.” Additionally, when therapists experienced greater congruence in their play sessions with children, their verbal and nonverbal responses to children appeared to flow more freely and fluidly in the moment and to reflect the therapists’ natural ways of speaking and relating to others. By contrast, during moments the therapists experienced less congruence, their responses were often delayed or characterized by a robotic tone and more rigid body position and movement.

Unconditional positive regard. Based on the results of our analysis, unconditional positive regard was defined as “valuing and accepting all aspects of the child’s experience, feelings, thoughts, behavior, and play.” The play therapists described their experiences of unconditional positive regard most often in terms of “acceptance” of various aspects of a child’s personality, perspective, ways of interacting with the therapist, needs and motivations, verbalizations, behavior, and play. Play therapists commonly expressed a strong desire to experience and communicate acceptance to children especially in moments when children expressed negative feelings, struggled to accomplish tasks, made mistakes, or broke limits. Additionally, the therapists shared a common rationale for allowing children to direct the course of therapy sessions and their own play, avoiding corrective or instructional responses to children, avoiding attempts to rescue children from a negative or challenging situations in session, and avoiding setting inflexible limits based on a strong desire to communicate acceptance of all aspects of the child’s experience and ways of being in the relationship. Unconditional positive regard was often expressed through the therapists’ verbal reflections of children’s negative and positive feelings and behaviors and through their physical openness and proximity to children

even in moments of messiness and aggression such as a child flinging sand or wildly punching and kicking a bop bag.

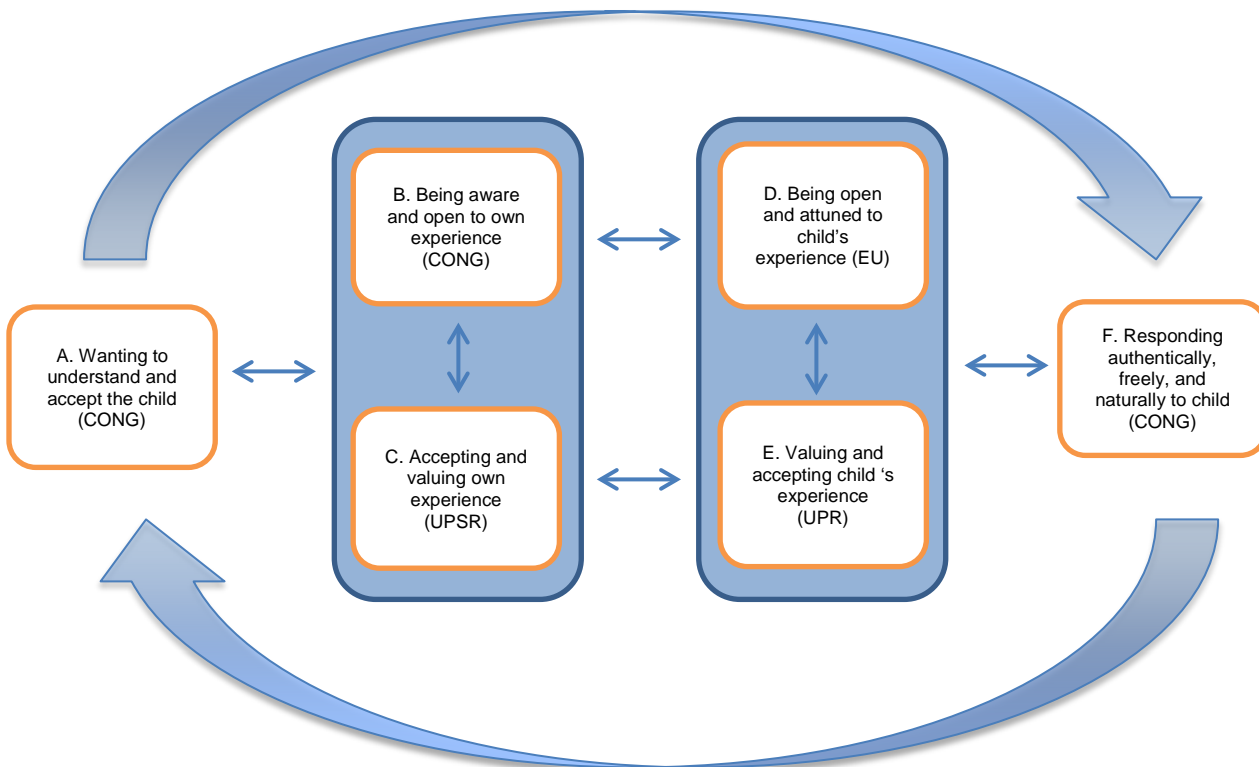
Empathic understanding. The definition of empathic understanding that emerged from the comparative analysis of the play therapy sessions and therapist interviews was “being open and attuned to the child’s moment-to-moment experience, intentions, perceptions, and meanings.” The play therapists described empathic understanding in terms of feeling “connected, engaged, attuned”, and “in sync” with the child and as being fully “present” or “with” the children in their experience. The therapists also recognized that they experienced greater empathy when they understood a child’s motivation for playing or behaving in a particular way, understood a child’s developmental background, and understood the dynamics of a child’s home environment. Empathic understanding was most often conveyed from therapist to child through the matching of facial expression, physical movement, affect, vocal tone and inflection, and energy level.

Unconditional positive self-regard. In addition to the three therapist-provided conditions, unconditional positive self-regard emerged as a key concept in understanding how congruence, unconditional positive regard, and empathic understanding are experienced and conveyed in CCPT. Through the constant comparative method, unconditional positive self-regard was defined as “valuing and accepting all aspects of one’s own experience, feelings, thoughts, and actions.” The therapists described unconditional positive self-regard as “accepting and trusting self,” and an absence of “self-questioning, self-doubt,” and “self-criticism.” Therapists were readily able to identify moments when they experienced a lack of unconditional positive self-regard most often when they recognized that they had made an inaccurate verbal response to a child, missed the opportunity to respond empathically or genuinely to a child, or misunderstood a

child in some way. When therapists were experiencing greater unconditional positive self-regard they were more receptive to a child’s correction or criticism.

### Process-Model of Therapist-Provided Conditions in CCPT

The grounded theory emerging from the constant comparative methodological analysis of the play sessions and therapist interviews is a process-model of the therapist provided conditions in CCPT. Figure 2 illustrates the process, relationships, and multidirectional flow of congruence, unconditional positive self-regard, unconditional positive regard, and empathic understanding in CCPT. The multidirectional arrows are included to demonstrate the fluid progression and relationships between the conditions.



*Figure C.1 Process-model of the therapist-provided conditions in CCPT*

*Note.* CONG = congruence; UPSR = unconditional positive self-regard; EU = Empathic understanding; UPR = unconditional positive regard

The participants most often experienced and demonstrated congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard as a dynamic, flowing process with overlapping, simultaneous dimensions. Three dimensions of congruence emerged from the constant comparative analysis of the data. The first dimension of congruence was the play therapists' (A) genuine desire to experience and demonstrate congruence, unconditional positive regard, and empathic understanding. Wanting to be genuine and to convey acceptance, empathy, and regard for the child facilitated the play therapists' abilities to experience and demonstrate the therapist-provided conditions in CCPT. The therapists repeatedly expressed a genuine desire to be honest and real with the child; to be trustworthy and consistent; to understand the child and communicate understanding; to be accepting of the child's needs, behavior, and play and communicate their acceptance; and to communicate their regard and valuing of the child. Congruence, empathic understanding, and unconditional positive regard were facilitated by a therapist's desire and intention to be congruent, empathic, and accepting.

A second dimension of congruence that we found was play therapists' (B) openness and awareness to their own self-experiencing. Congruence was experienced and communicated when therapists were aware and open to their own thoughts, feelings, and reactions in the relationship. Through the data analysis, we also found a special relationship existed between congruence and unconditional positive self-regard. Congruence was facilitated by play therapists' abilities (C) to accept and value their own experiences. The more accepting play therapists were of their own experiences, thoughts, feelings, and actions in the play therapy sessions, the more open they were to their own experiences, thoughts, feelings, and actions. Likewise, the greater openness play therapists had to their own experiences the more they accepted and valued their experiences.

Alternately, congruence was inhibited when therapists lacked unconditional positive self-regard and rejected or distorted their experiences.

Play therapists most often described this second dimension of congruence in terms of having awareness of their own negative thoughts, feelings, or actions during the play sessions, including wanting a child to discontinue playing in a certain way, feeling anxious about a child's doll play, feeling frustrated by a child's demands on the therapist, feeling tired or physically uncomfortable during session, and making inaccurate verbal responses to a child. When the therapists were able to acknowledge and accept their experiences they described a process of becoming more aware and open to their own moment-to-moment experiences with the child. For example, one play therapist described feeling repulsed when a child sneezed in her face. The play therapist's awareness and receptivity to her feelings of disgust in that moment allowed her to accept herself fully in her relationship with the child and, hence, remain open to her feelings of warmth and intimacy immediately following when the child connected with her by putting dress up clothes on the therapist. When play therapists judged, doubted, or questioned their thoughts, feelings, or actions, they described being distracted by self-critical thoughts, disengaged from their own experiences in the moment, and disconnected from the child.

The play therapists' (B) openness and (C) acceptance of their own thoughts, feelings, actions, and experiences in the play sessions facilitated their abilities to (D) be open and (E) accepting of the child's experiences, thoughts, feelings, behaviors, and play. The more congruence and unconditional positive self-regard the therapists experienced the more empathic understanding and unconditional positive regard they experienced and demonstrated for the child. For example, one therapist expressed that her ability to accept her own desire for control and orderliness in her environment allowed her to be more accepting of a child's bossy demeanor,

demands, and perfectionism in their play therapy session. Likewise, the less accepting the play therapist was of her own desire to be in charge or to be perfect the less acceptance she experienced for the child's bossiness and perfectionism.

Results of the data analysis revealed a strong relationship between empathic understanding and unconditional positive regard. As the play therapists experienced (D) greater openness and attunement to the child's moment-to-moment experience, they experienced greater (E) valuing and acceptance towards all aspects of the child's experience. Likewise, as the play therapists experienced increased unconditional positive regard for the child, they also experienced increased empathic understanding. For example, one play therapist acknowledged that her ability to accept the child's physical and verbal rejection towards the play therapist helped her to enter more fully into the child's own experience of isolation and vulnerability.

Through the analysis of the play therapy sessions and therapist interviews, a third dimension of congruence emerged. As the play therapists experienced more (D) empathic understanding and (E) unconditional positive regard towards a child, they also (F) responded to the child in an authentic, natural, and free manner. The play therapists identified a direct relationship between the ability to understand and accept a child's experience and their confidence in ability to accurately and genuinely respond to the child. Play therapists further described this phenomenon as knowing in the moment what a child needed from them and being able to give freely and fully of themselves in that moment. Congruence as (F) a free-flowing, authentic, and natural response to the child promoted the play therapists' (B) unconditional positive self-regard and (A) continued openness to their own experiencing. Congruent responses reflected the unique person of the therapist and her true experiences of herself and the child in that moment.

## Presence of the Therapist-Provided Conditions in CCPT

Through the comparative analysis of the play therapy sessions and the therapist interviews, I identified specific internal thoughts, feelings, and attitudes play therapists experienced when they were communicating and demonstrating congruence, unconditional positive regard, and empathic understanding in CCPT. I also identified specific verbal and nonverbal behaviors that play therapists demonstrated when they were experiencing the therapist-provided conditions. Identification of these example behaviors provides greater insight into how the therapist-provided conditions are demonstrated and communicated to children in CCPT. Table 4 includes examples of therapists' internal experiences and external behaviors associated with those internal experiences when each of the therapist-provided conditions is present in CCPT. Although some experiences and behaviors are linked exclusively to one of the therapist-provided conditions, several of the therapists' internal experiences and external behaviors overlap across multiple categories. Furthermore, the play therapists' behaviors must be considered within the context of their internal experiences. Behaviors may be demonstrated in CCPT, but do not convey genuineness, empathy, or acceptance without a corresponding internal experience of congruence, empathic understanding, or unconditional positive regard.

Table C.1

### *Therapist Experiences and Behaviors When Therapist-Provided Conditions are Present*

Condition	Internal Experience of Play Therapists	Sample Behaviors of Play Therapists
CONG	Feeling free, spontaneous, and natural in interactions with child Being aware of own thoughts, feelings, and experiences in play session Being open to own thoughts, feelings, and experiences in play session Accepting own thoughts, feelings, and experiences in play session Considering and balancing own needs with child's needs	Talking in a natural tone and rhythm Moving and responding in a fluid, spontaneous, and natural manner Expressing therapeutically relevant personal feelings and experiences to child Making "I" statements that reflect therapist's real experience in the relationship

*(table continues)*

*(continued)*

Condition	Internal Experience of Play Therapists	Sample Behaviors of Play Therapists
	Being aware of breaks or deficits in congruence, empathy, upr, or upsr Wanting to understand child Wanting to accept child Wanting to be present and attentive to child	
UPSR	Accepting own feelings, thoughts, and experiences in session Accepting breaks or deficits in own congruence, upr, empathy, or upsr Accepting own mistakes Accepting own inaccurate responses to child Feeling free, spontaneous, and natural in interactions with child Feeling capable of responding to child's needs, experience, play, and/or behavior	Acknowledging child's feelings, experiences, and/or perception without judgment Refocusing attention on child Accepting correction, criticism, and/or feedback from child Accepting child's verbal, physical, or emotional rejection of therapist Accepting child's description and/or perception of experience, play, and/or therapist Appreciating correction from child Changing verbal response due to child's correction or clarification
UPR	Valuing all aspects of child's play and self-expression Trusting child to direct or lead play Trusting child to direct or lead therapist Trusting child's motivation or reasons for play and/or behavior Accepting ambiguity of child's play and/or process Understanding how child perceives and experiences therapist	Responding verbally to child's positive and negative feelings and behavior Following child's directions Asking for direction or guidance from child Moving in closer physical proximity to child Openly receiving toys and/or objects from the child Being physically open to child Accepting criticism and/or correction from child Accepting disruptions or changes in child's play Accepting child's verbal, physical, or emotional rejection of therapist Accepting child's negative and/or positive perception of therapist Reflecting or avoiding concrete answers to child's questions Allowing child to struggle with a task or experience Leaning towards child Tilting head to see child and/or child's play Avoiding teaching or correcting child Avoiding setting nonessential limits Changing verbal response due to child's correction or clarification
EU	Wanting to be present and attentive to child Wanting to understand child's experiences Understanding meaning and/or significance of child's play Being open to child's negative or painful experiences	Matching child's physical movements Matching child's facial expression Matching child's affect with tone, inflection, and volume Matching child's paraverbal expressions Matching child's energy and/or activity level

*(table continues)*



(continued)

Condition	Internal Experience of Play Therapists	Sample Behaviors of Play Therapists
	Wanting to avoid disrupting child's play and/or process	Reflecting child's feelings in a manner that matches child's experience
	Understanding child's intentions	Reflecting child's feelings to better understand child's experience
	Understanding child's needs	Leaning towards child
	Understanding child's behavior is motivated by child's needs	Making eye contact with child
	Understanding the impact of the child's external (home, school, etc.) environment on the child	Answering child's questions honestly and openly
	Wanting to help child when child is struggling	Helping child when they ask for assistance
	Being more concerned with process of child's play than the outcome	Staying in child's metaphor and/or symbolic play
	Knowing what child needs from therapist in the moment	Responding to objects and character's actions
	Understanding how child perceives therapist verbal responses and/or behaviors	Responding to objects and character's feelings
	Understanding how child experiences therapist setting limits	Adapting quickly to change or movement in child's play
		Seeking clarification or direction from child
		Accepting child's description and/or perception of experience, play, and/or therapist
		Appreciating correction from child
		Avoiding setting nonessential limits
		Changing verbal response due to child's correction or clarification
		Turning towards child
		Using previous experience with child to respond in the moment
		Attending to child's face and body during play

*Note.* CONG = congruence; UPSR = unconditional positive self-regard; EU = Empathic understanding; UPR = unconditional positive regard

### Absence of the Therapist-Provided Conditions in CCPT

Through my comparative analysis, I also identified specific internal thoughts, feelings, and attitudes play therapists experienced when they encountered barriers or deficits in their experiences and communication of congruence, unconditional positive regard, and empathic understanding in CCPT. Table 5 includes examples of therapists' internal experiences and external behaviors associated with those internal experiences when congruence, unconditional positive self-regard, unconditional positive regard, and empathic understanding are limited or lacking in CCPT.

Table C.2

*Therapist Experiences and Behaviors When Therapist-Provided Conditions are Absent*

Conditions	Internal Experience of Play Therapists	Sample Behaviors of Play Therapists
CONG	Questioning self Criticizing self Doubting self Being dismissive or avoidant of own experience/feelings Feeling distracted by external environment and/or factors Feeling distracted by own thoughts	Setting limits that are nonessential Avoiding setting limits that are essential Responding to child in a rote, robotic, or flat manner Responding automatically to child with prepared or practiced responses Moving in a stiff, inflexible manner Fidgeting or shifting body position frequently
UPSR	Expecting self to provide conditions perfectly for duration of play session Expecting self to meet all of child's needs Expecting self to always respond effectively to child Expecting self to always make accurate verbal reflections to child Expecting self to always understand child's experience, play, and/or behavior Comparing self to external authority or prior instruction Questioning own competence or abilities Being self-critical Being self-focused Rejecting own experiences and/or feelings Rejecting aspects of self	Becoming less verbally responsive to child Paying less attention to the child in the moment Thinking excessively about responses to child Making less eye contact with child Not responding verbally or nonverbally to certain aspects of child's experience Tensing body Responding more slowly or out-of-sync with child
UPR	Valuing some aspects of child's play, behavior, and/or experience more than others Wishing child would behave or play differently Wishing child would be or feel differently Feeling reluctant to follow child's lead Feeling threatened emotionally or physically by child or child's play Feeling bored or disengaged from child or child's play	Responding exclusively or primarily to child's positive or negative feelings Responding exclusively or primarily to child's positive or negative behavior Dismissing or ignoring child's play and/or behavior Dismissing or ignoring child's experience Moving away from child physically Setting arbitrary or rigid limits
EU	Needing to understand meaning of child's play Expecting child to play or behave in certain ways based on own values or prior experiences with child Being confused or distracted by differences in child's play or behavior	Thinking about child's background or external environment during session Returning responsibility automatically when child asks for help Conceptualizing child during session Interpreting child's play during session Over or under-responding verbally to child Responding to child in a rote, robotic, or flat

*(table continues)*

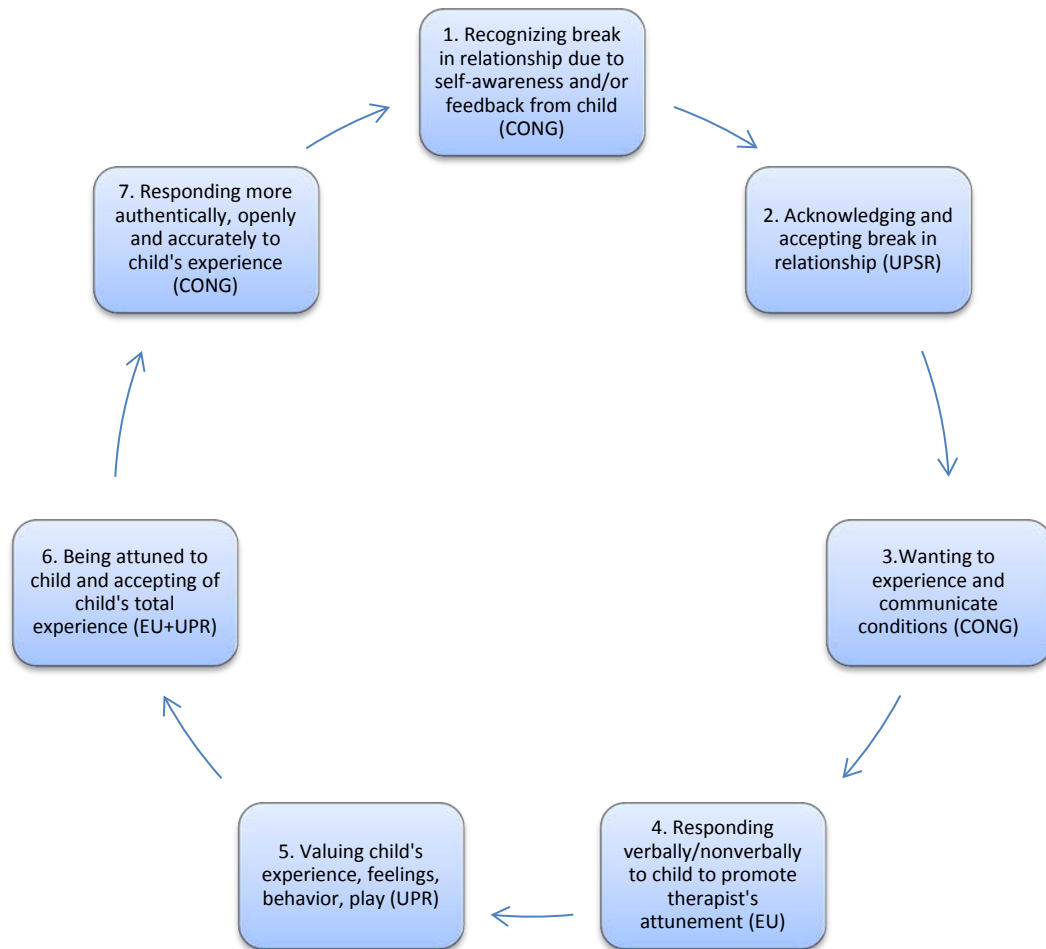
(continued)

Conditions	Internal Experience of Play Therapists	Sample Behaviors of Play Therapists
		manner Responding automatically to child with prepared or trained responses

*Note.* CONG = congruence; UPSR = unconditional positive self-regard; EU = Empathic understanding; UPR = unconditional positive regard

### Responding to Breaks in Relationship

Though the constant comparative method, I identified a process of how play therapists respond to barriers or disruptions in congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard. Figure 3 illustrates the process play therapists utilize to repair breaks in the therapeutic relationship and overcome barriers to the therapist-provided conditions.



*Figure C.2 Responding to breaks in relationship*

*Note.* CONG = congruence; UPSR = unconditional positive self-regard; EU = Empathic understanding; UPR = unconditional positive regard

The first step in this process is for the play therapist to recognize a rupture in the relationship, disengagement from the child and/or the child’s experience, and/or a lack of genuineness, empathy, or acceptance. Play therapists recognized barriers to the therapist-provided conditions through their own self-awareness or through direct verbal or nonverbal feedback from the child. Play therapists frequently described having an awareness in session that their verbal responses to a child were “wrong,” that they had responded inaccurately to a child’s experience, or that they misunderstood a child’s directions, intentions, or desire for the therapist

to behave or participate in the child's play in a specific way. Furthermore, several children corrected and/or disagreed with their therapists' verbal reflections of their feelings, thoughts, or behavior. Often when therapists were feeling a lack of empathy or acceptance for the child, they recognized that their verbal and nonverbal responses or their understanding of the child's intention and meaning were inaccurate. The therapists' abilities to be open to their own experience and open to the child's experience, allowed the therapists to identify obstacles to their provision of the conditions in the moment.

Following identification of a break in the relationship, the therapists' abilities to re-engage and respond therapeutically to the child was facilitated by their acknowledgement and acceptance of their disengagement or lack of congruence, unconditional positive regard, empathic understanding, and/or unconditional positive self-regard. Acknowledging and accepting disruptions or limitations in their provision of the therapist-provided conditions was facilitated by the play therapists' experiences of unconditional positive self-regard. For example, the more self-doubting and self-critical a play therapist felt, the more difficult it was to respond to barriers in the therapeutic relationship and reconnect to the child genuinely and empathically. One play therapist acknowledged that the more she questioned, doubted, or judged herself for making a mistake or responding less ideally to the child, the more difficult it was to be attuned to the child's experience and respond genuinely and accurately. Many of the play therapists described becoming distracted by their own thoughts and overly self-focused when they had difficulty accepting their thoughts, feelings, and reactions to a child. The more self-critical and judgmental they became, the more pressure and anxiety they felt and the more incongruent they became in relationship to the child.

Analysis of the data revealed that once play therapists recognized and accepted a break in the relationship, the process of reconnecting with the child was facilitated by their desires to experience and convey the attitudinal conditions to the child. The therapists' genuine desires to understand and accept the child facilitated their movement towards reengaging, reconnecting, and understanding the child's experience. Once a therapist experienced self-awareness, self-acceptance, and a congruent desire to be empathic and accepting towards the child, she intentionally made a verbal or nonverbal response to become more present and focused on the child. Most frequently play therapists would reflect the child's nonverbal behavior or feelings in order to move themselves back into an empathic frame of reference and re-enter the child's world of experience. In addition to verbal responding, the therapists leaned towards the child, tilted their heads or shifted their body positions to more clearly see the child or the child's play, or parallel the child's movement with their own bodies in order to become re-attuned to the child's experience in the moment. Through the play therapists' intentional, focused verbal and/or nonverbal responses to the child, they valued and became more attuned to the child's experience, play, and behavior. Play therapists described then being able to re-join children in their experience and to see the significance of the child's play for the child. As they experienced empathy and unconditional positive regard for the child, the play therapists were able to once again respond to the child in a more fluid, natural, and genuine manner.

APPENDIX D  
EXTENDED DISCUSSION

The purpose of this study was to explore how congruence, unconditional positive regard, and empathic understanding are experienced and conveyed in CCPT. Through constant comparative methods, I developed a grounded theory of the therapist-provided conditions in CCPT that includes definitions of congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard; a process-model of the therapist-provided conditions in CCPT; examples of play therapists' internal experiences and external behaviors when the therapist-provided conditions are present and absent in CCPT; and a model of how play therapists respond to breaks in the therapeutic relationship. I will consider how the resulting grounded theory of the therapist-provided conditions in CCPT supports, challenges, and expands existing literature and explore implications for clinical practice, training, supervision, and research.

#### Therapist-Provided Conditions in CCPT

Results of the comparative analysis included definitions of congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard in CCPT. The grounded theory definitions provide support and are supported by Rogers' original definitions of the attitudinal conditions while also providing clarity and illuminating distinctive aspects of the therapist-provided in CCPT. The definition of congruence in CCPT that emerged from this study was "being aware and open to one's moment-to-moment experience, thoughts, and feelings and expressing one's self in a real, natural, and free-flowing way in relationship with the child." The resulting definition of congruence shares several dimensions with Rogers' (1957,1980) original definition of congruence as a close matching and consistency between the therapist's actual experience, self-awareness, and self-expression (Rogers, 1980). Both definitions include attention to one's receptivity and awareness of self and experience and genuinely reflecting one's



real experience and self in the relationship. Based on the results of the comparative analysis, I found the additional and vital dimension of congruence best described as “flow” in which a therapist was able to be fully present and respond freely without self-consciousness to the child in the moment.

Through the analysis, unconditional positive regard in CCPT was defined as “valuing and accepting all aspects of the child’s experience, feelings, thoughts, behavior, and play.” Rogers (1957) defined unconditional positive regard as warm acceptance of every aspect of the client’s experience and emphasized the provision of equal acceptance for the client’s expression of negative and positive feelings. Rogers focused additionally on caring and accepting the client as a separate individual in a non-possessive manner. Both definitions include the dimensions of valuing and accepting all aspects of the client’s experience. Though the aspect of non-possessive warmth was not emphasized in the grounded theory definition of unconditional positive regard in CCPT, valuing all aspects of the child’s experience includes valuing the child’s independence, autonomy, and unique ways of seeing and being in the world as an individual.

The definition of empathic understanding in CCPT that emerged from this study was “being open and attuned to the child’s moment-to-moment experience, intentions, perceptions, and meanings.” Rogers (1957) defined empathic understanding as experiencing the client’s world as if it was the therapist’s own and “being sensitive, moment to moment, to the changing felt meanings which flow in this other person” (1975, p. 4). Rogers also included the communication of empathy and the process of checking for understanding with the client in his definition of empathic understanding. Although similar in many ways, the grounded theory definition has more explicit connections to congruence in that both require “openness” to one’s own or the child’s experience in the moment. Additionally, I found that a key aspect of empathic

understanding in CCPT was not only the therapists' abilities to understand what children's experiences mean for them, but also their abilities to understand how individual children view themselves and others and to understand children's needs and intentions for relating, behaving, and playing in specific ways.

In addition to the three therapist-provided conditions, unconditional positive self-regard emerged as a core category through the constant comparative analysis. Unconditional positive self-regard in CCPT was defined as "valuing and accepting all aspects of one's own experience, feelings, thoughts, and actions." Rogers (1957) did not identify or define the role of unconditional positive self-regard in his original presentation of the "necessary and sufficient conditions." Rogers (1959) later acknowledged a direct relationship between a one's experience of unconditional positive self-regard and one's ability to provide unconditional positive regard for another within the framework of the parent-child relationship and his developmental philosophy, but he did not explicitly discuss unconditional positive self-regard within the context of the therapeutic relationship. Many other person-centered theorists have defined unconditional positive self-regard in terms of being able to accept and unconditionally value oneself and emphasized the relationship between unconditional positive self-regard, congruence, and unconditional positive regard (Bozarth, 1998, 2001c, 2001e; Tolan, 2012; Wilkins, 2001). The grounded theory definition of unconditional positive self-regard in CCPT closely parallels the grounded theory definition of unconditional positive regard in CCPT as both emphasize valuing and accepting all aspects of one's own and the child's experiencing.

#### Process-Model of Therapist-Provided Conditions in CCPT

Based on the results of multiphasic, comparative analysis of the play therapy sessions and therapist interviews, I found that congruence, unconditional positive regard, empathic

understanding are experienced and demonstrated in CCPT as a dynamic, flowing process with overlapping, simultaneous dimensions. Although separate aspects of each condition emerged through the grounded theory, the conditions were highly interrelated and essential to one another. I found that each of the therapist provided-conditions played a critical role in how the other conditions were experienced and conveyed in CCPT and that no individual therapist-provided condition could be experienced or conveyed apart from the other conditions. These findings are consistent with the concept of a meta- or super-condition of which congruence, empathic understanding, and unconditional positive regard are each considered a part (Bozarth, 1998, 2007; Mearns & Thorne, 2000; Mearns & Cooper, 2005; Wilkins, 2000). The results of our analysis and the process-model of congruence, unconditional positive regard, and empathic understanding in CCPT affirm that the therapist-provided conditions cannot be experienced or conveyed in isolation and that they are mutually influenced and inextricably linked together. Although it may be helpful to evaluate and identify the therapist-provided conditions individually in therapeutic interactions, it is essential to consider how they relate, facilitate, and influence each other as a process.

Although all of the therapist-provided conditions were related and essential, congruence emerged as a layered condition with nuances addressed minimally in person-centered and child-centered literature. The process-model of the therapist-provided conditions in CCPT included three dimensions of congruence: (a) wanting to experience and convey empathic understanding and unconditional positive regard to the child, (b) being aware and receptive to one's own experiencing, and (c) responding to the child in an authentic, natural, and free-flowing manner. Desiring to be genuine in the relationship, attuned to the child's experience, and accepting of the child was essential to play therapists' actual provision of congruence, empathic understanding,

and unconditional positive regard. The therapist's genuine intention and desire to experience and convey congruence, unconditional positive regard, and empathic understanding facilitated the actualization of those conditions in CCPT and provided the context for genuine expression of acceptance and empathy. This dimension of congruence is consistent with Bozarth's (2001c) definition of congruence as a "state of readiness" that enables the therapist to experience empathic understanding and unconditional positive regard towards the client. Cornelius-White (2007b) and Bozarth (2001c) also identified a therapist's genuine experience of empathic understanding and unconditional positive regard towards the client as essential aspects of congruence. Additionally, Landreth (2012) implied this primary dimension of congruence in his description of the intentional commitment of child-centered play therapists to a philosophy and way of being with children. Congruence as a genuine desire to be real, accepting, and empathic in one's interactions with a child is rooted in the play therapist's belief in the child and in the healing potential of a relationship characterized by congruence, unconditional positive regard, and empathic understanding.

The identification of three dimensions of congruence within the grounded theory process-model of the therapist-provided conditions lends empirical support to Cornelius-White's (2012) integrative five-dimensional model of congruence. Cornelius-White identified similar dimensions of congruence including: (a) the genuine experiencing of empathy and unconditional positive regard, (b) awareness and openness to one's experience, (c) authentic communication in the therapeutic relationship, and (d) flow which includes receptivity, presence, and a loss of self-consciousness in the therapeutic relationship. In both models, congruence extends beyond the consistency between the therapist's self-awareness and real experience to include genuine communication and presence in the therapeutic relationship. As Cornelius-White described,

congruence is “the unity of being and doing” (p. 235) and is realized in the genuine, flowing receptivity and responsiveness of the therapist. Congruence as a flowing, expansive process may also be described as synergy in which the interaction of the therapist-provided conditions transcends the individual dimensions of each condition. Flow is realized in both models as the fulfillment and expression of the therapist’s congruence, unconditional positive self-regard, unconditional positive regard, and empathic understanding in the therapeutic relationship.

Within the process-model, unconditional positive self-regard emerged as a core category and proved essential to therapist congruence. The more play therapists accepted and valued their experiencing in the moment, the more aware and open they became to their experiencing. Likewise, the therapists’ awareness and receptivity to their own experiences facilitated their self-acceptance. Bozarth (2001c) described the special relationship between congruence and unconditional positive regard as a ‘conditions loop’ in which, “congruence represents to varying degrees the therapist’s UPSR [unconditional positive self-regard] but is also a manifestation of UPSR” (p.191). He emphasized their mutual influence emphasizing “increased freedom of self in relationship fosters higher degrees of UPSR which is then manifested by greater congruence” (p. 192). As play therapists experienced greater freedom to be their real selves in relationship with a child, they valued and accepted themselves more. As they became more self-valuing and self-accepting, they felt freer to respond with empathy and unconditional positive regard in a genuine manner and to give of themselves more fully and freely in the relationships. In these moments, play therapists’ verbal and nonverbal responses reflected both the person of the therapist and the experience of the child more deeply and fully.

Similarly, empathic understanding and unconditional positive regard also emerged as highly interrelated and simultaneously promoted the experience and communication of one another.

Play therapists' openness and attunement to a child's whole experience facilitated their acceptance and regard towards the child. Valuing and accepting a child's experience also facilitated therapists' receptivity and attunement to a child's experience. Bozarth (2001d) identified empathic understanding as the 'vessel' through which unconditional positive regard is expressed to the client. Ray (2011) acknowledged the strong relationship between empathic understanding and unconditional positive regard noting that, "when a therapist enters the world of the client, there is an underlying message that the client's world is a valuable world" (pp. 66-67). In this way, play therapists' empathy for the child conveys their value and acceptance of the child.

Through analysis, I also found a strong relationship between a play therapist's congruence and unconditional positive self-regard and her experience and communication of empathic understanding and unconditional positive regard for the child. The more aware, open, attuned, valuing, and accepting play therapists were of their own thoughts, feelings, and experiencing, the more aware, receptive, attuned, valuing, and accepting they were of children's thoughts, feelings, and experiencing in CCPT. This finding is similar to Wilkins (2001) proposition that one's unconditional positive regard towards clients depends on one's attitude towards one's self and therefore the hardest of the conditions to develop. Landreth (2012) and Ray (2011) also identified self-acceptance and positive self-regard as critical to a play therapist's experience and communication of unconditional positive regard and acceptance for a child. Landreth (2012) acknowledged that the play therapist's acceptance of the child is an extension of the therapist's self-understanding and self-acceptance and emphasized the challenge of accepting an aspect of the child's experience or personality that the therapist has not accepted within one's self. Ray (2011) further acknowledged the inhibitory nature of the play therapists' own

conditional or negative self-regard on their provision of unconditional positive regard and the potential for the therapist to want to change in the child what one wants to change in one's self. Our findings support the position that a play therapist's unconditional positive self-regard is directly related to one's ability to provide unconditional positive regard for a child.

In addition to providing a better understanding of how the therapist-provided conditions are experienced, conveyed, and interrelated in CCPT, the process-model that emerged from this study (Figure 2) can also be utilized to help play therapists identify potential areas for growth and development and to conceptualize their experiences and relationships with children. For example, a play therapist may consider if they are entering into relationships and individual play therapy sessions with the desire and intention to be genuine, empathic, and accepting. Through self-reflection and evaluation, one may recognize a deficit in the first dimension of congruence and recognize either a need to evaluate their underlying beliefs about children and the therapeutic process or to schedule clients with more time between sessions to allow the therapist time to access their desire to provide congruence, unconditional positive regard, and empathic understanding, and to intentionally focus on doing so with the child. Additionally, play therapists and supervisors may utilize the process model to compare and more deeply reflect their experiences with children and their own flow in session in experiencing and conveying the conditions in order to promote further development as a play therapist and effective practice with children in CCPT.

#### Internal Experiences and External Behaviors of Play Therapists

Results included examples of play therapists' internal experiences and external behaviors when the therapist-provided conditions were present and absent in CCPT. Although we identified numerous external behaviors play therapists use to demonstrate congruence,

unconditional positive regard, and empathic understanding to children, the behaviors cannot be separated from the therapists' internal experience of the conditions. Identical behaviors disconnected from the internal attitudes of congruence, unconditional positive regard, and empathic understanding do not convey those conditions. The internal experience of congruence, unconditional positive regard, and empathic understanding precedes and facilitates the expression and communication of those attitudes to the child. An exclusive focus in training and clinical practice on therapeutic skills or behaviors is insufficient for developing and communicating congruence, unconditional positive regard, and empathic understanding in CCPT.

Through the analysis, I found that even experienced therapists with advanced training in CCPT used minimally helpful, practiced, or automatic verbal and nonverbal responses at times. Although breaks in the therapeutic relationship are expected and therapists' cannot provide the conditions perfectly at all times, it is important to recognize that utilizing specific skills such as tracking, reflections of feeling, leaning towards a child, or turning to follow a child's movement are insufficient if the therapist is not genuinely experiencing empathy and acceptance for the child. In these moments of automatic or rote responding, the therapist is incongruent. Although communication of the attitudinal conditions to the child is essential to facilitate growth in CCPT, verbal and nonverbal responses are minimally beneficial and empty unless they are a genuine expression of the therapists' congruence, unconditional positive regard, and empathic understanding.

The results of the study also revealed that therapists often make intentional decisions about responding verbally and/or nonverbally to a child based on how their responses will facilitate and communicate congruence, unconditional positive regard, and empathic understanding. Depending on a therapist's internal attitude or intention, the same behaviors or



responses can convey multiple or different conditions in the moment. A therapist's response to a question posed by a child or to a limit being broken may vary widely based on the therapist's sense of what the question or limit-breaking means for a specific child in a specific moment, how a specific child will experience the therapist setting or not setting the limit in a specific moment, and what it will mean for the individual therapist to respond in a certain way in a specific moment. Part of conveying the therapist-provided conditions in CCPT, includes an awareness of how specific responses are experienced and perceived by the child and by the therapist.

Understanding play therapists' internal experiences and external behaviors when congruence, unconditional positive regard, and empathic understanding are present and absent in CCPT may help therapists and supervisors identify gaps between a play therapist's attitudes and responses to a child in play therapy. When play therapists' are demonstrating specific behaviors, it may be helpful to reflect on the attitude or internal experience the play therapist was having in that moment or to help build self-awareness and intentionality behind therapeutic responding in session. Within the context of a well-established supervisory relationship characterized by congruence, empathic understanding, and unconditional positive regard, it may also be helpful for supervisors to notice the identified behaviors symptomatic of the absence of the therapist-provided conditions or a break in the relationship in their supervision of supervisees' play therapy sessions. The examples of therapists' internal experiences and external behaviors may be utilized to help play therapists gain awareness of moments with children where they are more or less genuine, accepting, and/or empathic.

The essential nature of the therapists' internal experience and attitudes to the therapeutic process in CCPT has implications for evaluation and measurement of the therapist-provided conditions. The majority of studies on therapeutic outcome in person-centered therapy and CCPT

are based on the measurement of therapeutic behaviors or verbal responses. Ongoing research is necessary to explore if and how therapists' internal experiences and attitudes can be measured or assessed through self-report, observational, or multiple reporter methods.

#### Experiencing and Demonstrating the Therapist-Provided Conditions in CCPT

Congruence. Based on results, therapist incongruence was easier to identify than congruence in CCPT. I found the fewest examples of therapist behaviors for the category of congruence. This finding is consistent with how congruence has been defined and discussed throughout person-centered literature as one of the most complex and challenging conditions to define, communicate therapeutically, and measure within the therapeutic relationship (Cornelius-White, 2007b; Greenberg & Geller, 2001; Truax & Carkhuff, 1967; Wyatt, 2001). Incongruence was demonstrated most frequently through therapists' automatic, rote, and robotic verbal responses and through rigid, stiff, slow, body movements and fidgeting. These findings are consistent with Barrett-Lennard's (1962) findings that incongruence was demonstrated through inconsistency between verbal and nonverbal communication and indications of discomfort and anxiety.

Setting limits and returning responsibility with children appeared to pose the biggest challenges to therapist congruence and unconditional positive self-regard. Play therapists experienced more self-doubt and became more self-critical in these moments and often compared their responses to external authorities or play therapy training models. Although providing models for setting limits or facilitating children's self-expression and self-direction can be helpful, it is important for play therapist's to develop their own genuine ways of responding based on their own empathic and accepting experiences of the child in the moment.

Unconditional positive regard. Unconditional positive regard was most often expressed through a play therapist's trust in the child, in the child's intentions and motivations, in the child's process, and in the child's self-direction. Several key aspects of communicating unconditional positive regard in CCPT emerged from the analysis. Reflecting or responding to the total experiencing of the child was essential to the communication of unconditional positive regard. When play therapists experienced and conveyed unconditional positive regard they responded verbally to both positive and negative aspects of a child's experience and/or behavior rather than focusing exclusively on positive aspects of the child's being. Tolan (2012) described this dimension of unconditional positive regard in terms of the therapists attending to both the client's self-actualizing tendency as positive and forward-moving and to the client's potentially negative or limiting self-structure. Unconditional positive regard was also conveyed consistently through play therapists' openly receiving and accepting children's' criticism, correction, feedback, and perceptions of the therapist and through play therapists' accepting changes or disruptions in the child's play.

Empathic understanding. Essential to the experience and communication of empathic understanding was the concept of matching. When empathic understanding was realized in CCPT, play therapists matched the child's movements, tone, affect, volume, facial expression, and paraverbal expressions. The play therapists' physical movements and nonverbal and verbal expressions paralleled the child in a natural and flowing manner. Hatfield, Rapson, and Le (2011) highlighted the mechanisms of facial mimicry, vocal mimicry, and postural mimicry to increase empathy based on the evidence that "people tend to feel emotions consistent with the facial, vocal, and postural expressions they adopt" (p. 24). According to Hatfield et al., the natural processes of emotional contagion and feedback allow people to enter into one another's

emotional experience. Although the play therapists' were often unaware of their tendencies to match a child's physical movement, facial expression, posture, and tone of voice in the moment, this imitation and mirroring served to promote their experience and demonstration of empathy.

Cognitive aspects of empathic understanding also emerged as central to the play therapist's ability to enter into the child's world and to communicate empathy. When play therapists could not understand the purpose or meaning behind a child's behavior or play or the child's play was notably different than the therapist expected or had experienced in previous session with a child, they had more difficulty experiencing and conveying empathic understanding. Alternatively, understanding contextual factors such as a child's developmental history or family dynamics often facilitated therapists' experience and demonstration of empathy. Therapists' prior knowledge and experience with a child served as both a facilitator and a barrier to empathic understanding within CCPT. Therapists often used their understanding of a child's home environment, family relationships, or previous play behaviors to more fully enter into the child's present frame of reference and experience in the moment. Therapists were able to identify connections between a child's play or behavior and their experiences at home or to identify themes across sessions that allowed them to connect and respond more empathically to the child. However, when children acted or played in a manner that was inconsistent or very different from previous sessions play therapists' often struggled to stay within the child's present experience. At times, therapists' awareness of how a child's home environment or developmental background was impacting them in the moment made it more difficult for the therapist to stay present and focused on the child as they began thinking about the child's parents, history, or past experiences and behaviors rather than being in the moment with the child.

Empathic understanding was most often conveyed to children through the therapists' nonverbal and paraverbal responses to the child. Although verbal reflections of feeling and meaning were utilized to convey empathic understanding, they often served to promote the play therapists' experiences of empathic understanding as reflecting the child's feelings, thoughts, or actions facilitated the therapist's movement into fuller contact with the child's experience.

Bozarth (2001a) similarly argued against the equation of empathy with reflective responding and identified reflection as being for the benefit of the therapist rather than the client. Empathy may be the intention behind the reflective response, but is not the primary means by which empathic understanding is conveyed in CCPT.

#### Responding to Breaks in Relationship

Through constant comparative analysis, I found that child-centered play therapists commonly experience momentary breaks or barriers to their congruence, unconditional positive regard, and empathic understanding. Therapists became aware of breaks in the relationship through their own awareness and through verbal and nonverbal communication from children. The most common barriers to therapist congruence were self-criticism, self-doubt, and conditional positive self-regard. Common barriers to unconditional positive regard included feeling bored, viewing aspects of children's play as more therapeutic or significant than others, and feeling emotionally or physically threatened by a child or child's play. Empathic understanding was most often limited when play therapists could not see a child's play or make visual contact with a child, children engaged in repetitive play, and when children faced away from or maintained physical distance from the therapist for extended periods of time. A lack of unconditional positive self-regard was the most frequent and significant barrier to therapists' experiences and communication of congruence, unconditional positive regard, and unconditional

positive self-regard. However, in spite of all the barriers to the therapist-provided conditions play therapists' encountered, their responses to barriers and ability to respond to and repair the relationship was more critical than the initial break in the relationship.

A critical element of repairing breaks in relationships with children in CCPT was accepting the break or barrier in the relationship. When therapists recognized they were not being genuine, accepting, or empathic they often got stuck in the process due to their own self-criticisms, judgments, and regrets. Being able to move forward toward reconnecting with the child and providing empathy and acceptance was facilitated by the therapists' abilities to accept their own limitations or failures in the relationship and their genuine desires to repair the relationship. Normalizing play therapists' experiences of barriers or breaks in CCPT and helping play therapists develop greater unconditional positive self-regard may facilitate ability to more effectively and quickly respond to breaks in the therapeutic relationship and facilitate the child's growth. Additionally, helping play therapists expect breaks in the relationship as a natural phenomenon may help therapists experience greater self-acceptance and focus not on self-recrimination but on reestablishing contact with the child.

Another critical step in responding to barriers in the relationship was the therapists' intentional uses of verbal and nonverbal responses to move them back into contact with the child's experience and to facilitate their internal experiences of unconditional positive regard and empathy. In isolation, a verbal or nonverbal response was insufficient for repairing the break in the relationship. However, in conjunction with the therapist's awareness and acceptance of the break in the relationship and genuine desire to repair the break in the relationship, using reflective responding and nonverbal skills facilitated the therapist's ability to reconnect with the

child and to once again experience and convey unconditional positive regard, empathic understanding, and congruence.

The provided model (Figure 3) for responding to breaks in relationship may be utilized to help play therapists' gain awareness of barriers they experience with children in CCPT and to develop strategies for repairing the therapeutic relationship. Play therapists and supervisors can use the model to identify stages in the process that are more challenging for a play therapist and to focus their efforts in supervision and personal therapy. Understanding the process and identifying how specific attitudes, thoughts, and actions may either exacerbate or repair breaks in the therapeutic relationship ultimately allows therapists to be more effective and facilitative in their work with children.

#### Limitations

Although the therapist-child interactions and mutual responding were analyzed through the live observations and multiphasic coding of the recorded play sessions, the children's perspectives and experience of congruence, unconditional positive regard, and empathic understanding were not fully represented. Children were not interviewed due to developmental considerations, the primary rationale for using a nonverbal, play-based approach with children in CCPT, and the unreliability of interview and self-report methods with children. However, additional methods for understanding children's perspectives and experiences of the therapist-provided conditions need to be explored in future research.

An additional limitation of this study was the lack of diversity among the participating play therapists. The sample of therapists in this study was largely homogenous as all of the play therapists were female, White, 26-28 years of age, and had similar educational backgrounds and training experiences in CCPT. However, in grounded theory research, theoretical sampling is

used to guide data collection and the relevance of demographic data is not assumed (Glaser, 1998). Rather than seeking a representative sample, grounded theorists seek and collect data that is relevant to clarify and elaborate the emerging categories and grounded theory (Charmaz, 2006). Additionally, the sample of therapists included in this study was consistent with prior demographic surveys of play therapists in the U.S. In their survey of 958 play therapists, Lambert et al. (2005) found that 92% of play therapists were female and 85% of play therapists were White.

The primary focus of this study was on congruence, unconditional positive regard, and empathic understanding in CCPT. The therapist-provided conditions represent three of the six necessary and sufficient conditions for constructive personality change that Rogers (1957) originally identified. Exploration of the therapist-provided conditions apart from the other three conditions, psychological contact, client incongruence, and client perception, provides an incomplete picture of the therapeutic process in CCPT particularly in regard to the client's contribution and experience of the therapeutic process. Additional research is essential for understanding how all six conditions are experienced and conveyed in CCPT.

#### Implications for Training and Supervision

Although specific behaviors were associated with each of the therapist-provided conditions, a play therapist's internal attitude and experience of congruence, unconditional positive regard, empathic understanding, and unconditional positive self-regard were central to how those conditions were conveyed to children in CCPT. Specific therapeutic skills or verbal responses that most play therapists learn early in training did not necessarily communicate genuineness, acceptance, or empathy. Utilizing practiced or automatic responses that were not reflective of a play therapist's true experience of congruence, unconditional positive regard, or



empathic understanding was often an indication of limitations or an absence of the therapist-provided conditions in CCPT. In many instances, prescriptive or skills-focused training inhibited the play therapist's experience and ability to convey congruence, unconditional positive regard, and empathic understanding and at times challenged therapists' unconditional positive self-regard as they questioned and criticized themselves based on their original play therapy training experiences. Although teaching specific verbal and nonverbal skills may be helpful for play therapists to learn potential means to communicate and express the therapist-provided conditions, skills and therapeutic behaviors are insufficient for promoting the therapist-provided conditions in CCPT and secondary to the therapists' real experiences of genuineness, acceptance, and empathy. In introductory play therapy and skills courses, it is important for educators to teach the attitudinal conditions and emphasize the internal experiences necessary to facilitate growth in addition to helping play therapists and counselors in training develop and cultivate those attitudes. It is essential that educators and supervisors focus on the person of the play therapist and personal development of facilitative attitudes in addition to helping play therapists' develop genuine verbal and nonverbal responses that convey these attitudes to children.

Additionally, given the important role of unconditional positive self-regard in play therapists' provision of congruence and unconditional positive regard, personal development should be a focus of training and supervisory experiences. Play therapists' development of unconditional-positive self-regard may be promoted through personal therapy, personal growth or development groups, and supervisory experiences that include intentional focus on the counselor's personal experience and process in relationship with the client (Landreth, 2012; Ray, 2011; Tolan, 2012; Wilkins, 2010).

## Implications for Research

Though substantial research has been conducted to explore the impact of relational variables and the therapist-provided conditions on therapeutic outcome, researchers have primarily utilized self-report instruments and measures of verbal communication between counselor and therapist to examine the role of congruence, unconditional positive regard, and empathic understanding. Due to the primarily nonverbal dynamics of play therapy and the primacy of nonverbal behaviors in experiencing and communicating the therapist-provided conditions, continued use of visual analysis methods in child counseling research is recommended to further develop understanding of the processes, experiences, and key relational variables at work in within the therapeutic relationship.

Continued research is needed to more fully understand and explore children's experiences and perceptions of therapist congruence, unconditional positive regard, and empathic understanding in CCPT. Utilizing observational methods and visual analysis with attention to microbehaviors and subtle processes may be useful in gaining a better understanding of children's experiences in CCPT. Child-focused research studies and developmentally responsive assessments are needed to provide greater insight into the process of CCPT and relational variables that impact therapeutic outcome and efficacy.

The complex, multidimensional process of how the therapist-provided conditions are experienced and conveyed in CCPT presents many challenges to quantification and measurement of these important relational variables. Many questions remain as to whether congruence, unconditional positive regard, and empathic understanding can be measured independently or as one meta-condition and how both the external behaviors and the internal attitudes associated with each condition can be accurately evaluated. Further research is necessary to explore if and

how congruence, unconditional positive regard, and empathic understanding can be measured quantitatively and examined using qualitative methods in order to develop our understanding of how CCPT works, why CCPT is an effective intervention for child, and to further establish the efficacy of CCPT.

APPENDIX E  
OTHER ADDITIONAL MATERIALS

## Theoretical Statement

I believe that children have an inherent tendency towards growth and self-actualization and are capable of positive self-direction (Rogers, 1951; Landreth, 2012; Ray, 2011). The goal of CCPT is to provide an environment that is characterized by the following conditions:

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard for the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved. (Rogers, 1957, p. 96)

In order to facilitate a growth-promoting environment:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflect those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given the opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (Axline, 1947, p. 73-74)

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Therapist's Signature

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Date

## University of North Texas Institutional Review Board

### Therapist Informed Consent Form

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

**Title of Study:** Emergence of Congruence, Unconditional Positive Regard, and Empathic Understanding in Child-Centered Play Therapy

**Investigator:** Kimberly Jayne, MEd., LPC-Intern University of North Texas (UNT) Department of Counseling & Higher Education. **Supervising Investigator:** Dee Ray, PhD., LPC-S, NCC

**Purpose of the Study:** You are being asked to participate in a research study that involves exploring how child-centered play therapists express the attitudes of genuineness, acceptance, and empathy to children in play therapy.

**Study Procedures:** As part of the study, your permission will allow three of your play therapy sessions to be observed by the student investigator and videotaped. These videotapes will be coded without a name or other identifying information on them and will be used to identify how therapists express genuineness, acceptance, and empathy to children in play therapy. Your permission will also allow the student investigator to conduct four 60-90 minute interview with you following each of your observed play sessions. Interviews will be audio and videotaped. You will also be asked to complete a brief demographic questionnaire.

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

**Benefits to the Subjects or Others:** The results of this study are expected to provide play therapists with knowledge that helps them improve child therapy and provide an optimal therapeutic environment for children in therapy.

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

**Questions about the Study:** If you have any questions about the study, you may contact Kimberly Jayne at 940-565-2066 or Dee Ray at 940-565-2066.

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

**Research Participants' Rights:**

Your signature below indicates that you have read or have had read to you all of the above and that you confirm all of the following:

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

\_\_\_\_\_  
Printed Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

**For the Student Investigator or Designee:**

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

\_\_\_\_\_  
Signature of Student Investigator

\_\_\_\_\_  
Date

### **Therapist Statement to Parents**

"At the clinic, we are starting a research study that looks into the types of responses and interactions that take place in play therapy sessions. The purpose of this study is to explore how therapists express the attitudes of genuineness, acceptance, and empathy to children in play therapy. If you are okay with your child participating, you can contact Kimberly Jayne who you can reach here at the clinic at (940) 565-2066. If you wish not to participate, it's not a problem, we will still continue play therapy as scheduled."



## University of North Texas Institutional Review Board

### Parent Informed Consent

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

**Title of Study:** Emergence of Congruence, Unconditional Positive Regard, and Empathic Understanding in Child-Centered Play Therapy

**Investigator:** Kimberly Jayne, MEd., LPC-Intern University of North Texas (UNT) Department of Counseling & Higher Education. **Supervising Investigator:** Dee Ray, PhD., LPC-S, NCC

**Purpose of the Study:** You are being asked to allow your child to participate in a research study, which involves exploring how therapists express the attitudes of genuineness, acceptance, and empathy to children in play therapy. Child-Centered play therapy is an interpersonal, dynamic relationship between a child and counselor trained in play therapy procedures. Play therapists seek to provide a safe, non-threatening environment where children can express their emotions, learn coping skills, develop self-control, and build self-esteem.

**Study Procedures:** As part of the study, your permission will allow your child's regularly scheduled play therapy sessions to be observed by the student investigator and videotaped. These videotapes will be coded without a name or other identifying information on them and will be used to identify how therapists express genuineness, acceptance, and empathy to children in play therapy.

**Foreseeable Risks:** There are no foreseeable risks directly involved in this study. Your child's participation is completely voluntary. You may withdraw your child at any time during the course of the study. Your decision or your child's decision to withdraw from the study will not affect your child's status as a client of the counseling center. There are no risks involved in this study beyond discomfort that might occur during play therapy, which may include one of the following:

1. Anything that is said or done during play therapy is considered confidential, meaning that the therapist will not reveal anything that happens in the session to another adult. However, if your child discloses child abuse, neglect, exploitation or intent to harm another person, the therapist is required by law to report it to the appropriate authority.
2. Because play therapy is a counseling method, your child will be expressing emotions that could be strong for him or her. The therapist will help your child talk through these emotions and will stop therapy if any harmful effects upon your child are noted. Harmful effects would include inability to maintain self-control or being in a distraught state of mind.

**Benefits to the Subjects or Others:** The results of this study are expected to provide play therapists with knowledge that helps them improve child therapy and provide an optimal therapeutic environment for children in play therapy.

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

**Questions about the Study:** If you have any questions about the study, you may contact Kimberly Jayne at 949-565-2066 or Dee Ray at 949-565-2066.

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

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

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

\_\_\_\_\_  
Printed Name of Parent or Guardian

\_\_\_\_\_  
Printed Name of Child

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

**For the Student Investigator or Designee:** I certify that I have reviewed the contents of this form with the parent or guardian signing above. I have explained

the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the parent or guardian understood the explanation.

\_\_\_\_\_  
Signature of Student Investigator

\_\_\_\_\_  
Date

**Child Assent Form**

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

This study involves recording your play session.

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

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

\_\_\_\_\_  
Printed Name of Child

\_\_\_\_\_  
Signature of Child

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student Investigator

\_\_\_\_\_  
Date

**Waiver of Assent**

The assent of \_\_\_\_\_ was waived due to:

\_\_\_\_\_ Age

\_\_\_\_\_ Maturity

\_\_\_\_\_ Psychological State

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Demographic Information Form-Counselor**  
(To be completed by the Counselor)

1. Counselor's Name \_\_\_\_\_
2. Counselor's Gender (circle) \_\_\_\_\_
3. Counselor's Age M      F
4. Counselor's Year in Doctoral Program \_\_\_\_\_ years
5. Counselor's Race/Ethnicity (circle) 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup>  
African-American  
Asian  
White  
Hispanic/Latin American  
Native American  
Bi-racial  
Other \_\_\_\_\_
6. Counselor's Licensure (circle) \_\_\_\_\_
7. Play Therapy Classes Completed (circle) LPC    LPC-Intern    Other \_\_\_\_\_  
Intro to Play Therapy  
Group Play/Activity Therapy  
Filial Therapy  
Advanced Play Therapy  
Special Problems in PT \_\_\_\_\_  
Special Problems in PT \_\_\_\_\_

**Demographic Information Form-Child**  
(To be completed by the Counselor)

- 1. Counselor's Name \_\_\_\_\_
- 2. Child's Name \_\_\_\_\_
- 3. Child's Gender (circle)            M      F
- 4. Child's Age                            \_\_\_\_\_ years
- 5. Child's Grade Level in School (circle)    Pre-K   K    1    2    3
- 6. Child's Race/Ethnicity (please circle)  
  
African-American  
  
Asian  
  
White  
  
Hispanic/Latin American  
  
Native American  
  
Bi-racial  
  
Other \_\_\_\_\_

### **Therapist Reflection Notes**

Therapist Name \_\_\_\_\_ Child's Name \_\_\_\_\_

Session Date \_\_\_\_\_ Session Time \_\_\_\_\_ Session # \_\_\_\_\_

Briefly describe your thoughts, feelings, and impressions from your sessions. Note any interactions or moments that stood out to you.

## Therapist Interviews

Therapist Name \_\_\_\_\_ Date of Interview \_\_\_\_\_

Child's Name \_\_\_\_\_ Session # \_\_\_\_\_

1. Describe your relationship with this child.
2. What were you doing in the session?
  - a. Why did you do \_\_\_\_\_ ?
  - b. What was your rationale for doing that?
  - c. What was your intention for doing that?
3. How did you feel in the session?
  - a. What were you thinking/feeling when you did/said \_\_\_\_\_ ?
4. What were you trying to convey to the child?
  - a. Why were you trying to convey that to the child?
5. What was happening for you in that moment/interaction with the child?
6. What was your experience of the child in that moment/interaction?
7. When did you feel most connected to the child?
8. When did you feel most disconnected from the child?
9. When did you feel most/least like yourself in the session?
10. When did you feel most/least in tune with the child's experience?
11. When did you feel most/least accepting of the child?

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