ABSTRACT

Fantasy-Exposure Life-Narrative Therapy (FELT) for Anxious Children:
A Pilot and Feasibility Study

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A small, pilot study was conducted for the development of the Fantasy-Exposure Life-Narrative Therapy (FELT) treatment manual. One primary objective of the study is to investigate initial promise of efficacy of training therapists to use case conceptualization, analyze play themes, and use play interventions within a manualized play therapy. Child participants between the ages of 6 and 11 who presented with pathological anxiety that was neither trauma-related nor of the obsessive-compulsive type participated in the study. Initial screening included multirater-multimethod assessment and involved numerous broad- and narrow-band instruments (BASC-2, RCMAS-2, PSWQ-C) as well as a diagnostic and clinical interview. Of 9 potential recruits, 6 met full inclusion criteria, and 5 completed the full treatment program. Therapy lasted for 12 consecutive weeks, and assessment was conducted pre- and post-treatment and at 6-week follow-up. Qualitative feedback was also gathered using a structured format from all participants. Small sample size limited statistical power; however, effect sizes (Cohen's *d)* were calculated and found to be large or medium and ranged from 0.5 to 1.26,

depending on the measure used. Additionally, a content analysis of qualitative data provided additional indicators of positive response to treatment. FELT displays promise as a potentially efficacious treatment for anxious children. Future randomized, controlled studies is needed are currently being planned.

Fantasy-Exposure Life-Narrative Therapy (FELT) for Anxious Children:
A Pilot and Feasibility Study

by

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A Dissertation

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CHAPTER ONE

Introduction

Fantasy-Exposure Life-Narrative Therapy is a new, play-based psychotherapy for anxious children. It uses an integrative approach combining components of non-directive and directive play therapy, psychodynamic therapy, and cognitive-behavior therapy. As its name implies, the primary therapeutic components of FELT are fantasy play, exposure, and the personal life narrative.

Play in Child Therapy

Play has been a part of child therapy since the 1930s, when Melanie Klein and Anna Freud first began using play techniques to help children in need. Play represents the primary manner in which children express themselves, interact with others, and make sense of their internal and external worlds (Axline, 1947; Freud, 1965; Chethik, 1989; Erickson, 1963; Klein, 1955; Meichanbaum, 1974; Moustakas, 1953; Russ, 1995). Because of the importance of play to children, play techniques have always had a major influence in the way clinicians help children. In fact, the majority of clinicians who perform child therapy today use some kind of play in their therapeutic interventions (Koocher & D'Angelo, 1992).

Throughout this paper, "play" refers to fantasy or pretend play, which assumes symbolism to be at the core of observable behavior (see Fein, 1987; Russ, 2004). Thus, the first criterion for play (in therapy) is that it uses metaphor and symbolism. Otherwise neutral objects (including the air, in the case of imaginary characters) become something else within the context of pretend play. Second, play therapy does, as its "play" definition

implies, carry an air of enjoyability. Play therapy need not always be fully enjoyable, nor defined by absolutely positive affect. The therapy portion of play therapy assumes the presence of negative affect; however, the association of play with joy allows children enough "space" in therapy such that difficult emotions are no longer quite as difficult. The play lifts some of the seriousness out of the challenge of working through individual difficulties and thereby makes the intervention more enjoyable than it would be if accessed via a more direct route. In this manner, play therapy is more enjoyable than other kinds of (non-play) therapy.

The third criterion of play therapy is that the play is *not* avoidant; it is therapy. Even young children can tell the difference between fantasy play and reality (Golomb & Galasso, 1995; Golomb & Kuersten, 1996). Therefore, children carry some awareness when their symbolic play within the therapy room has a connection with reality, and when it does not. An assumption of this third criterion is that children's play *always* has a specific purpose and meaning. Russ (2004) listed some of those general purposes within realms of cognitive, affective, interpersonal, and problem-solving/conflict-resolving processes. Benedict and colleagues (1996, 1998) developed an extensive database of themes used by children in their play that span themes of aggression, attachment and family, safety, exploration and mastery, sexualized play, "non play" (includes art, rule-based games, talk therapy, written worksheets, or otherwise uncodable data), interpersonal/relationship processes, ambivalence, and disorganization. The presence of this database, others like it, and associated research (see Holmberg, Benedict, & Hynan, 1998) implies that all play is meaningful in some way. Therefore, criterion three states that all play is meaningful, and, by virtue of having meaning, has therapeutic potential.

The key for clinicians is to correctly interpret and respond to that meaning in a therapeutic manner.

Within FELT, clinicians learn a standardized approach for analyzing play themes and for responding therapeutically to maladaptive themes. This approach is described in the next section.

Themes in Play Therapy

As stated previously, themes in play therapy may be used to guide therapy with children. Analysis of play themes may sometimes reveal important information about a child's personal narrative and generalized world view. However, analysis of play is often complicated by a number of clinical issues. Most prominently, unless analysis is conducted in a standardized, reliable manner, clinicians may exhibit interpreter biases deriving from their own theoretical orientation, training background, or other personal characteristics. As a result, clinicians must exercise extreme caution in their analysis and interpretations of play. Analysis should never become solely a therapist-driven enterprise. That is, therapists should be wary not to become overconfident in any interpretation, regardless of how much logical sense that interpretation may seem to make. Further, analyses should never be used to coerce play. It is relatively easy, for example, for a clinician to develop a hypothesis and then inadvertently coerce the child into play that confirms that hypothesis. Rather, interpretations should always be client-responsive. They must only occur in response to child-driven play. Therapists may use interactions to test hypotheses, but should nonetheless maintain ultimate responsiveness to the child.

Because of all of the complications that may arise from clinician-bias in interpreting play, several researchers have developed standardized coding systems for

identifying themes in play therapy. One particular line of relatively recent, well-developed research derives from the creation of the MacArthur Story Stem Battery (MSSB, Bretherton, Oppenheim, Buchsbaum, Emde, and the MacArthur Narrative Group, 1990; see also, Emde, Wolf, & Oppenheim, 2003). The MSSB, used in research since 1990, consists of 14 standard story stems introduced to children using toys. The children then are asked to complete the story as they see fit. As a psychometrically sound research and clinical instrument, introductions and prompts by the administrator are highly structured and well-defined. Also, stem completions by children can be coded with great detail using a specified system, giving the MSSB a strong presence as a tool to be used in research. By organizing play through story stems, the MSSB allows for standardized analysis of play themes. Given the strong research behind the MSSB and its associated story stems, it has become clear that play-based story stems serve as an empirically supported way of revealing practical information about the internal states of children.

Out of the tradition generated by the MSSB, story stems have garnered use in clinical practice as well as in research (Hodges, Steele, Hillman, & Henderson, 2003; Robinson, 2007). Over the past two decades, story stems have been widely used to assess children's relationships with others, using attachment theory as a basis. Story stems have also provided information about children referred for a maltreatment history, for depression and mood symptoms, and for defiance and conduct problems. For a more in-depth discussion of the clinical utility of story stems, the reader is referred to the article by Robinson (2007), where the relevant literature is reviewed.

Like the MSSB, FELT also uses story stems to add standardization to play themes. Furthermore, the standardized coding systems developed in research also inform ongoing assessment/conceptualization of children through play. In its current form, FELT identifies several themes as being relevant in the play of anxious children. Many of these themes are borrowed from the Narrative Emotion Coding System (NEC), an empirically validated instrument developed specifically for the purpose of focusing on emotion regulation, anxiety, and responses related to internalizing disorders (Warren, 2003). The story stems used in forming the NEC "describe fear-inducing and anxiety-provoking situations as well as situations that may provoke feelings of anger, conflict, and loss" (Warren, 2003, p. 92).

The following themes are outlined in the FELT manual. Detailed descriptions of each can be found in Appendix A.

Aggregate of Themes Predicting Anxiety

In a study conducted by Warren, Emde, and Sroufe (2000), an aggregate of seven factors/codes in play therapy were found to predict anxiety symptoms in young children (5-6 years of age). The seven factors included: 1) not seeking parental help as an initial response, 2) a negative initial response in stories for separation (usually meant the child doll did not separate from parents when this was directed by the story stem), 3) a negative final response, 4) a non-positive final response, 5) child saying he or she felt happy after forced separation in separation stories, 6) not competent self-representations, and 7) self-representations in which the child doll assumed the parent role (parentification of self). Considering these data, it is *very* important for FELT clinicians to intervene when any of these seven responses are noted during play.

Table 1. *Important Play Themes in FELT*

Theme	Description
Initial response	The child's immediate response to the story stem. May include aggression, denial/avoidance, help seeking, help arriving, self resolution, fear/anxiety, positive content, and negative content
Final content	How the story ends. Possible responses generally divided into positive, negative, or non-resolution (considered more negative than positive)
Deus ex machina resolution	Occurs when child resolves conflict or affect by simply having it go away. Interpreted as an escape, rather than a positive resolution of events. Represents a lack of knowledge about appropriate coping responses.
Emotional shift	Any change in emotion that occurs during play
Incongruent affect	Displayed or reported affect is inappropriate or incongruent with story being told.
Reactions to inescapable fear/anxiety	Some fear cannot be escaped. For example, a child may exhibit fear from a tornado, which would not be expected to dissipate until the tornado is gone. A lack of fear in a dangerous situation would be maladaptive. Hence, a positive outcome in such a situation would be to negotiate fear management, rather than eradication of fear.
Danger	Child maintains, worsens, or introduces danger into the story stem.
Neediness	Child exhibits a preoccupation with fulfilling needs. Primarily important when needs are *not* being met.
Labeling of emotions and symptoms	Child identifies emotion by name or identifies symptoms.
Self/ "Other" representations	Toys or objects child uses to represent the self or others (family members, therapist, etc.)

To be faithful to the FELT program, clinicians must demonstrate a reliable ability to identify each of these seven responses and must display an ability to employ direct, play-based interventions to assist the child toward a more favorable direction.

Therapist Characteristics in FELT

One unique aspect of FELT is that it requires therapists to adhere to several core therapist characteristics. These therapist characteristics derive from research analyzing therapist techniques that guide mechanisms of change from various theoretical orientations. A complete review of these mechanisms can be found in Russ (2004).

Mechanisms of Change in Individual Child Therapy

Expression, catharsis, and labeling of feelings. Expression, catharsis, and labeling of feelings as mechanisms of change is a point of view held by many of the originators of play therapy interventions, including Anna Freud (1965), Virginia Axline (1947), and Clark Moustakas (1953). Clinicians who follow this theory take a largely "hands off" approach in therapy. Axline (1947) is well-known for her belief in a child's ability to heal the self through play. She and her followers took an absolutely non-directive approach to play therapy and considered the clinician's singular duty was to facilitate play. They assumed that every child naturally strove toward self-development; he or she only needed adults and other life events to "get out of the way." The purpose of Axlinean play therapy, then, is to provide an environment where nothing impedes the child's natural developmental processes. Although this may oversimplify the Axline approach, the major techniques arising out of such an approach are to give permission and to label feelings. The child has permission to engage in self-healing, and the labeling of affect is meant to

help those feelings seem less overpowering and more understandable, so that self-healing is more likely to occur.

Corrective emotional experience. Many theorists believe that a corrective emotional experience occurs when a therapist simply accepts the child's thoughts and feelings as being valid, rather than immediately trying to correct or teach the child appropriate behavior (Kessler, 1966). The proposed mechanism of change is similar to that described in the previous section: a child's self-healing power will appear once the primary barrier is lifted. Whereas the first mechanism explains the change through the simple expression of emotion, the second mechanism specifies that the emotion must be experienced as being accepted and contained. The major therapeutic techniques are largely the same as above. Emotions are labeled and the therapist communicates acceptance and understanding of the emotion. Feelings are separated from the associated maladaptive behavior. There is acceptance of the feeling, but the maladaptive response is discouraged.

Insight, re-experiencing, and working through. Another major mechanism of change in psychotherapy comes through the emotional resolution of psychic conflict or trauma. A more psychodynamically based approach, the primary goal of this theory is that therapists help their clients re-experience major developmental "traumas" within therapy, helping the clients gain insight and work through those conflicts so that they can be understood and conquered. With adults, much work is done toward achieving cognitive insight; however, children are rarely capable of the higher order cognitive sophistication needed for such an endeavor. Thus, with children, the focus often revolves

around an emotional re-experiencing, working through, and mastery through play. Mastery is an important concept in which the child uses play to gain mastery over traumatic events and other conflicts by readdressing and reprocessing those events until they become manageable (Erikson, 1963; Freedheim & Russ, 1992; Waelder, 1933). The child essentially re-enacts meaningful events through play until those events no longer feel so overwhelming. The therapist helps facilitate this process by labeling thoughts, feelings, and events and making interpretations that link thoughts and feelings to behavior or that clarify cause and effect (Russ, 2004).

Object-relations, internal representations, and interpersonal development. From this theoretical standpoint, therapeutic change is fostered through the child's development of healthy, stable object-relations structures. Based primarily on the theories of Mahler (1975) and Kohut (1977), the therapist works to stimulate healthy object-relations by being a "stable, predictable, caring, and empathic" object in the child's life (Russ, 2004, p. 41). Because of the focus on object-relations, the major focus within this theory is on the relationship formed between therapist and child. Play is seen as a realm of communication through most children build relationships. For therapists, the major techniques used within this theoretical approach are measures aimed at communicating intersubjective, stabilizing attunement, which often take the form of empathy expression, genuine curiosity, and unconditional acceptance (Hughes, 2007).

Problem-solving techniques and coping strategies. A more directive, cognitive-behavioral approach, the mechanism of change here is that the child learns real, useful coping skills that can facilitate positive problem-solving and alternative solution-making.

Within play therapy, therapists utilize role-playing and modeling of coping strategies. The child then often practices self-expressions and externalized behaviors that are helpful to address his or her individual problem areas. Programs like these focus on symptom reduction, rather than on transformation of the narrative, per se (though, conceptually, symptom reduction is a form of narrative transformation). Kendall's *Coping Cat* (Kendall & Hedtke, 2006) is a manualized example of this program, which is targeted toward children with anxiety difficulties. Knell (1993, 1999) also discusses cognitive-behavioral based play therapy.

Summary of Techniques Derived From the 5 Mechanisms of Change: The Acer Therapist

In the above overview of mechanisms of therapeutic change, several different techniques were outlined as being useful for helping to facilitate change. These techniques include facilitating play, labeling, giving permission, communicating acceptance, empathy, and care, interpreting, modeling, problem-solving, teaching coping strategies, and rehearsing. Research also supports that all of the above-described theoretical approaches actually do stimulate change, (see Russ, 2004); thus, an effective play therapy should be one that integrates as many of the above techniques as possible. In that spirit, FELT defines a good play therapy as one that, in addition to meeting the basic criteria of play therapy (outlined previously), is also conducted by a therapist who employs effective techniques. Those effective techniques are summarized within FELT under four therapist characteristics: attunement, concern, expertise, and responsiveness (ACER). These four characteristics combine to define the ACER therapist.

The Attuned Therapist

Attunement may be described as "at-one-ment." Thus, the attuned therapist is constantly striving to be "at one" with the internal state of the child. The attuned therapist will communicate acceptance, be empathic, be caring, and, most importantly, will always be aware of the internal state of the child. This awareness is an essential part of attunement, because it is through that awareness that the therapist knows how to be appropriately respectful and responsive to the child's needs. Examples of techniques used by an attuned therapist include appropriate and accurate labeling, attentiveness to the child, communicating positive regard, and accurate responsiveness. A well attuned therapist typically interprets play accurately; when interpretations are wrong, the attuned therapist acknowledges his[1] mistake and validates and accepts the child's point of view.

The Concerned Therapist

The concerned therapist wants to facilitate change. He conveys his concern both directly and indirectly by 1) communicating to the child the reason(s) for therapy, 2) expressing that he wants to help the child, and 3) directing therapy in healthy directions as necessary. Importantly, the concerned therapist is not serene but is playfully curious, seeking to understand the child. He does not make interpretations, per se, but interpretive guesses; therefore, he is also cautious.

Examples of techniques used by the concerned therapist include developing a therapeutic contract, directly inquiring about the child's thoughts, feelings, and other covert behaviors, communicating a desire to understand the child's internal state and

[1] To increase readability, I use masculine pronouns (instead of "he/she") to refer to any therapist of either gender and feminine pronouns to refer to the child client.

external behaviors, and making clear that fantasy play is perceived by the therapist as having some sort of real meaning to the child. Within FELT, therapeutic contracts are verbal, and represent simply an agreement by child and therapist the purposes and goals of treatment. Also by investigating the child's internal and external states, as well as the meanings of play, the therapist indirectly shows the child a desire to make play therapeutic.

The Expert Therapist

The therapist is an expert on both children and therapy. He knows how to approach children in a developmentally appropriate manner. He also knows how to conduct therapy in a manner that is helpful to the child. Sometimes, this expertise involves problem-solving strategies and positive coping skills. Sometimes, the expertise required is in the way the child's play is understood as metaphor and knowing what is a child's purpose in engaging in a particular play theme. The expert therapist, then, knows what should be helpful in addressing a child's particular problems. He also knows *when* to intervene. Despite being an expert, the therapist is not overly confident in his own interpretations or ideas. When it comes to the individual child client, the concerned, curious, cautious therapist often overrides the expert. As a result, the expert therapist must always strive to be scientifically investigatory. When an expert technique, such as labeling, is performed, it is done so inquisitively, allowing for the child to provide extra guidance or confirmation as needed. In this way, the direction of therapy is always a collaborative process.

The Responsive Therapist

Finally, the therapist is also responsive. The responsive therapist acknowledges each child's own self-expertise. Expert interpretations are frequently wrong within metaphor-rich play therapy. Sometimes, for example, the therapist may mistake the object of identification[2] within play therapy, (i.e. thinking the child is the victim, when she is actually the attacker). When mistakes occur, the therapist is responsive to a child's (sometimes subtle) attempts at redirection. Also, the responsive therapist gauges the level of his directiveness or non-directiveness based on the expressed needs of the child (Benedict, 2003). Each intervention, then, "occurs in attuned responsiveness to the child's play and patterns of interaction with the therapist" (Benedict, 2003, p. 289). This means that when a child falters during play or seeks help, the therapist can direct play toward therapeutic directions as needed. It also means that, in some cases, children may need less direction from the therapist, as may occur if a child engages in healthy play on her own. The responsive therapist, then, should feel free but not compelled to direct according to the demands of each play scenario. By being responsive, the therapist simultaneously communicates respect, concern, understanding, and intersubjectivity toward the child. The responsive therapist also gives permission to the child to engage in play as she feels comfortable and to lead the therapist at times along the endeavor of conducting therapy.

In summary, the ACER therapist is one who maximizes his therapeutic potential by integrating a multitude of therapeutic techniques derived through theory and empirical evidence.

[2] Within symbolic play therapy, the object of identification is defined as the toy, puppet, drawing, character, etc. that the child is using as a representation of the self.

Exposure

Principles of exposure therapy originated in Wolpe's (1958) systematic desensitization of phobias. In its original form, systematic desensitization was achieved by "easing" the patient through anxiety. Thus, the patient was first taught progressive relaxation techniques and then lead through a hierarchy of brief, anxiety-provoking situations. Patients began low on the fear hierarchy and continued through successive iterations of exposure plus relaxation until full desensitization was achieved. Wolpe's approach was highly influenced by behavioral principles, and the goal, therefore, of desensitization was to decondition anxious responses and replace them by conditioning relaxed responses.

As a result of Wolpe's work, and following decades of subsequent studies on exposure principles, clinicians discovered that exposure worked reliably and remarkably well when performed properly (McNally, 2007). Later theorists (i.e. Foa & Kazak, 1986) presented analyses of the mechanisms through which exposure works to reduce fear/anxiety, and these mechanisms are discussed thoroughly by McNally (2007). For the purposes of FELT clinicians, it is sufficient to simply know that exposure is successful only when distress related to the exposure is allowed to diminish while still in relative contact with the fear/anxiety-invoking stimulus. This principle means that one of the primary tasks of the FELT therapist is to engage in active measures during play, when necessary, to help anxious children achieve relief from apparent distress. One of the benefits of fantasy play is that fantasy can be readily used to provide distress reduction within therapy. For example, if a child displays fear of a dog in play, the therapist may suggest placing the dog in a cage, erecting a safe barrier between the two toys, thereby

allowing the child to experience real distress relief through play. As therapy progresses, and as the child displays increased comfort with dogs through play, interventions may move up the child's anxiety hierarchy. Thus, the dog may be released from the cage, but kept on a leash. Then, the dog is taken off leash, but kept distant. In the end, the goal is to allow the child to be near the dog and not exhibit or express distress. In such a manner, basic principles of exposure therapy may be readily used in play therapy.

The Personal (Life) Narrative

Psychotherapy has long incorporated the use of the personal narrative. Almost all therapeutic approaches require clients at some time to recount their personal histories to varying degrees. The personal narrative is what clinicians traditionally use to aid in their understanding of the etiology of a client's problems. In many theories (including that underlying FELT), certain features of a person's personal narrative play a vital role in the development of his or her psychological functioning. Depending on the underlying theory used, sometimes the root of a psychological problem is thought to be in the "holes" in a person's personal narrative. Sometimes, the narrative reveals problematic interpersonal relationship patterns. Sometimes clinicians look for unhealthy object-relations, and sometimes, therapists may listen for maladaptive thought patterns. Regardless of the influence of the underlying theory, the content of the narrative guides the process of therapy. For this reason, the personal narrative is the most vital piece of information obtained through the therapeutic exchange, and it is through alteration of the narrative that lasting psychological changes are made.

Children readily share features of their own personal narratives through symbolic play (Emde, Wolf, & Oppenheim, 2003). Thus, therapists must understand the symbolism

in the play in order to fully understand each child's personal narrative. Then, therapists can communicate with the child, through play, in whatever way necessary to facilitate the development of a healthy personal narrative in the child. It is thought that it is through the development of healthy personal narratives that ultimate psychological health is promoted.

CHAPTER TWO

Why Develop FELT? An Introduction to the General Treatment Model

The application of effective treatments in "the real world" (that is, outside of efficacy/laboratory studies) involves a complex process. In this section, the complexities of formulating effectiveness of treatments are discussed. First, current evidence on efficacy and effectiveness of child treatments is reviewed. Then, a discussion of applicability of treatments follows.

Evidence on Child Psychotherapy

Empirical support for the effectiveness of child therapy has had a mixed history. Early reviews by Levitt (1957, 1963) found no significant differences between the mean improvement rate of children who received therapy and that of untreated controls. Additional analyses by Barrett, Hampe, and Miller (1978) and by Hartmann, Roper, and Gelfant (1977) made the same conclusion, that there was no sound empirical evidence for the effectiveness of child psychotherapy. However, Barrett et al. (1978) critiqued the nature of those analyses, in that the studies looked at highly variable populations being treated with highly variable therapeutic approaches and rarely used sound outcome measures. These conclusions led Barrett et al. to ask, instead of "Does psychotherapy work?", "Which set of procedures is effective when applied to what kinds of patients with which sets of problems and practiced by which sorts of therapists?" (1978, p.428).

Research in global psychotherapy with children is also complicated by increased issues with demographic differences during the young age range. That is, the difference between a 4-year-old and a 5-year-old is much greater than that between a 34-year-old

and a 35-year-old (see Heinicke & Strassman, 1975). Thus, lumping different-aged children together into one treatment group can be problematic and creates more variance than if the same procedure is used with adults. It is because of those kinds of issues that research into the effectiveness of child psychotherapy needed to become more targeted and well-specified.

With the development of the technique of meta-analysis, researchers have been able to look at effect sizes for child psychotherapy. Results of meta-analytic studies revealed effect sizes between 0.71 and 0.88, which were comparable to those found in similar studies conducted with adult therapy (Weisz and Weiss, 1993), offering evidence that psychotherapy is more efficacious than no treatment (Kazdin, 1990). However, Weisz and Weiss (1993) noted that a limitation of most of the studies analyzed in the meta-analyses they reviewed were, by nature, efficacy studies and that they, therefore, may not be generalizable to "real world" conditions. Thus, Weisz, Donenberg, Han, and Weiss (1995) conducted a review of effectiveness studies, and found no evidence for the effects of psychotherapy. Kazdin (2000) was able to conclude that there are a few empirically supported treatments for children and that these are mainly cognitive-behavioral treatments. According to Russ (2004), studies that focused on a specific problem with careful planning of the intervention showed the most support for therapeutic effects. She critiqued a problem with many of the above-cited studies as continuing to ask the wrong questions. What was needed instead was for researchers to figure out what specific processes are involved in the development of clinically important behaviors and feelings and what specific techniques help change those processes toward healthier functioning (Freedheim & Russ, 1992; Russ, 2004).

Evidence on Cognitive-Behavioral Treatments for Children

Weisz and Kazdin (2010) reviewed the evidence-based psychotherapies for children and adolescents and described an overwhelming majority of cognitive-behaviorally based programs. Of the 24 different treatments reviewed, 15 were specifically described as CBTs. The rest were either family-based or multisystemic (both of which more often than not included CBT principles as key parts of the treatment). Of the treatments for internalizing disorders, 6 of 7 were CBTs, and the remaining one used an interpersonal theoretical model. Based on the research, there is clear evidence for using a CBT-like approach in psychotherapy with children and adolescents. No other approach has received the same standard of empirical support.

Based on meta-analyses, effect sizes for CBT on anxious children are typically large. In-Albon and Schneider (2006) reviewed 24 CBT studies using a mixture of individual, group, child, and family approaches and found an effect size (Cohen's *d*) of 0.86. Ishikawa, Okajima, Matsuoka, and Sakano (2007) found similar results, with an overall effect size of 0.94.

Evidence on Play

Much of the evidence on play therapy has been criticized for its methodological flaws. As a result, the evidence on play is difficult to interpret. Bratton and Ray (2000) described 82 studies covering 6 decades of research on the efficacy and effectiveness of play therapy. Despite generally positive results supporting play therapy as an effective treatment, some methodological issues in a majority of studies were described by the authors as limiting "credibility in…hard research" (p. 81). Some of the issues they described included the tendency for researchers to test play therapy against no

intervention rather than against other proven techniques. They also cited a lack of research into what aspects of play therapy that actually make it effective; that is, many studies contained poor descriptions of the procedures used during intervention. Notably, Bratton and Ray restricted their findings only to articles with significant, positive findings. They did not report findings where no change was found, although they admitted there were some examples.

Despite the methodological issues described above, a meta-analysis by Bratton, Ray, Rhine, and Jones (2005) on the efficacy of play therapy found an overall effect size (Cohen's *d*) of 1.04 derived from 43 published studies on play therapy. When play therapies added a parent component, effect sizes increased to 1.15 Thus, play therapy has generally been found to have a large effect, with increased effect if parents are included in the therapeutic process.

Russ (2004) distinguished between play therapy and play interventions. Play interventions are defined as being much more specifically targeted than generalized play therapy. Russ described play interventions as being typically characterized by lasting "only a few sessions with no emphasis on forming a 'relationship' with a therapist" (p. 70). At the time of the publication of her book (2004), Russ stated that whereas play therapy has not yet been evaluated in well-controlled studies, play interventions have received more empirical support. The classic play intervention studies were targeted toward surgery-related anxiety and separation anxiety. One study (Johnson & Stockdale, 1975) used puppet play to reduce anxiety in children facing surgery. In that study, puppets were used to play out the surgery before it occurred. Johnson and Stockdale found decreased anxiety both before and after surgery in the puppet-play group compared

to a no-intervention group. Other studies have found similar effects (Cassell, 1965; Rae et al., 1989). Another classic study utilized play to aid preschoolers dealing with separation anxiety. Milos and Reiss (1982) investigated the effects of targeted play on 64 high-separation-anxious children and found several different play techniques targeted toward themes of separation (free play, directed play, and modeled play) to be superior to non-targeted play in reducing separation anxiety. Barnett (1984) also found similar results in another sample of separation-anxious children.

Based on the findings from well-controlled play-intervention studies, Russ (2004) concluded that play appears to help children to reduce anxiety and that the involvement of symbolic fantasy appears to form a primary basis through which anxiety may be reduced through play. Nonetheless, what is needed within play therapy literature are formalized treatment approaches that can be more reliably applied across therapists, thereby increasing researcher's ability to perform sound efficacy studies and increasing scientific ability to analyze exactly what therapeutic factors contribute to positive change in play therapy. In other words, play therapy needs to find a way to live up to the scientific rigor of its cognitive-behavioral counterpart. FELT was created to begin to bridge that scientific gap.

Applicability, Tolerability, and Palatability of Treatments

As discussed above, there are already a number of treatment options available for anxious children, and several have been shown to be efficacious in clinical trials. Since practically all of these treatments are cognitive-behavioral in nature, they gravitate towards a cognitive-behavioral model of etiology and treatment. While these other treatment options are certainly effective with a significant portion of anxious children,

there are also a portion of children for whom they may *not* be clinically warranted or useful (Addis & Waltz, 2002). Thus, effectiveness of therapies in "real world" clients may often be complicated by *individual* client factors. Primarily, effectiveness of any treatment is largely guided by issues of applicability, tolerability, and palatability of the treatment.

Applicability of a treatment refers to how well the etiological model underlying treatment premises fit any individual client being offered that treatment. As a very basic example, a treatment designed for anxious children may not be applicable to children who are not anxious and/or who do not struggle with any of the etiological concerns common to anxious children (i.e. worried thoughts). As another example, a cognitive-behavioral treatment may not be applicable to a patient with limited cognitive ability (such as a young child), due to concerns that the patient may not be able to follow the treatment plan or modality. Likewise, a non-directive, play-based approach may not be appropriate for a child with poor fantasy play skills (Russ, 2004), since that child would not be expected to engage in spontaneous, therapeutic fantasy play.

Tolerability of treatment refers to any treatment factors that may influence a client's decision or ability to withstand and complete treatment. Factors influencing tolerability may include duration of treatment, accessibility of treatment (i.e. whether a patient must travel long distances to access a clinician who can offer the treatment), or, more commonly, side effects of treatment. A treatment with many adverse side effects may not be tolerated well by patients. In psychotherapy, tolerability is also affected by therapist factors. For example, a patient who dislikes her therapist is unlikely to tolerate treatment, given that psychotherapy requires relatively frequent, direct contact with a

therapist. In sum, tolerability can generally be conceived as any client's (and/or her parents') receptivity to treatment.

Palatability is similar to tolerability, but palatability of treatment is believed to be a higher standard. Palatability is affected by many of the same factors as tolerability, but palatability refers to the level of enjoyment a patient experiences while undergoing treatment. Thus, whereas tolerability only requires patients to experience a greater benefit than cost, resulting in overall patient satisfaction, palatability aspires to achieve maximal enjoyment of the therapeutic enterprise. A palatable psychotherapy should be one that a patient looks forward to attending. Consequently, palatability is expected to increase adherence to treatment over time.

One of the primary reasons for developing FELT was to create a therapy that maximizes applicability, tolerability, and palatability for any anxious children for whom other treatments may fall short on one or more of those dimensions. It is believed that by using the play modality, applicability to younger children is increased. Furthermore, tolerability and palatability are expected to increase, due to the usage of fantasy and play. Additionally, it is hoped that by adding and requiring certain therapist factors (ACER) in the protocol – something that makes FELT unique among other manuals – therapist relationship factors will also be able to add to each of these important dimensions of treatment effectiveness. Finally, another aspiration of FELT is to increase applicability by increasing thoroughness and utilizing a contextual approach to therapy.

Another basis behind the critique of the current efficacious treatments is a question of thoroughness. As stated previously, most of the currently available efficacious treatments for anxiety base treatment approach upon a single etiological

model, and are predominantly concerned with biology, information processing, and learning history. However, several other etiological perspectives address the development of childhood anxiety, and, generally speaking, each has received adequate support within the professional literature.[1] FELT, then, seeks to be an integrative treatment that considers several etiological models to have equal plausibility in conceptualizing anxious children. A major part of FELT is the thorough, but efficient, assessment of individual child clients, such that the etiology of every child's particular anxiety is individualized and appreciated. Then, treatment is applied in a targeted manner that attempts to remediate etiological concerns to the greatest extent possible. In this way, the child benefits from learning the techniques from multiple theoretical approaches, thereby eliminating the need for excessive anxiety across all relevant domains.

A final consideration in applying empirically supported-treatments (ESTs) is therapist adherence and allegiance to the treatment model (Wampold, 2001). If a therapist is using an EST that follows a particular theoretical model, but does not himself experience fidelity toward that model, allegiance to that particular treatment is likely to be minimal. Further, ability to adhere to treatment protocol is likely to be compromised. As a result, that therapist may never employ said efficacious treatment, or, when he does, may do so poorly and ineffectively. One way that such therapists have worked around this issue is to employ a "contextual model" for treatment (Wampold, 2001), in which therapists select the "ingredients" from an EST which they believe will be beneficial

[1] The author's goal, here, is not to denigrate these treatments (mostly CBTs) in any way. Rather, the empirical data clearly support that such an approach leads to positive treatment outcomes in a large portion of patients, and consequently, such treatments have set an admirable standard to which other approaches must strive to reach or exceed. The author's goal here is simply to highlight the presence of other models and to suggest that by integrating additional models, a more efficacious and effective treatment may be produced.

within their client's individual context. This approach has been critiqued by proponents of the "medical model" (which champions adherence to manualized ESTs) for reasons of concern about clinical acumen. From the medical model, only a relatively small number of clinical decisions have been tested and verified as efficacious, and thus, only by controlling those decisions with a tested manual can one be reasonably certain about predictable outcomes of those decisions. "Medicalists," then, would criticize "contextualists" for employing questionable treatment ethics. In other words, by changing manualized protocols, contextualists may be changing treatment outcome, which may, in turn, produce dangerous, unevaluated consequences. Contextualists, on the other hand, would criticize medicalists for haphazardly, and perhaps dangerously, using the same treatment with every individual, even with those who may, for some reason, not tolerate that treatment particularly well. While the above description is a dramatic oversimplification of what has become a serious debate among practitioners of clinical psychology, the point is that both sides of the debate present sound arguments. Considering both sides of the argument, FELT seeks to find a middle ground. Thus, FELT was designed to manualize a contextual approach, presenting multiple etiological and treatment models and integrating them into a single treatment manual. As part of the treatment program, clinicians are taught multiple conceptual models for the development of anxiety. They are then taught how to identify how each individual client fits different aspects of the integrated model. Finally, FELT clinicians employ standardized treatment principles which are designed to be adaptable and modifiable in order to address diverse etiological concerns among clients. In this way, clinicians can use contextual considerations and still be perfectly adherent to the FELT manual.

CHAPTER THREE

Case Conceptualization in FELT

With the above-described goals and considerations in mind, case conceptualization is a vital component of the contextual model of treatment used in FELT. The case conceptualization is another aspect of FELT that makes it unique among many manualized psychotherapies. Within FELT, a standard model of anxiety is used to guide case conceptualization. This multifactorial FELT model of anxiety is described in detail below.

Etiological Models of Anxiety: Background for the FELT Model

The following section reviews the major etiological models of anxiety that are considered when conceptualizing children using FELT. A complete review of these models is beyond the scope of this paper, but interested readers are referred elsewhere for more information (e.g. Albano et al., 2003; Beidel & Turner, 2005; Brown & Lawrence, 2009; Morris & March, 2004; Taylor, Cox, & Asmundson, 2009).

The Developmental Psychopathology Perspective (McClure & Pine, 2006)

Multifinality and equifinality are key components of FELT. Within the developmental psychopathology perspective, the central tenet is an "assumption that multiple factors interact in a dynamic, transactional fashion to affect how a disorder emerges" (p. 470). Thus, a given etiological factor can produce several different effects (multifinality), while a wide range of factors can lead to similar symptom presentations of anxiety (equifinality). These issues significantly complicate attempts by clinical scientists

to identify common factors in pathological individuals. Likely, the more common case is that no two individuals take congruent pathways to pathological anxiety. Thus, the concepts of multi- and equifinality highlight the importance of developing individualized etiological models for every anxious child treated in FELT. However, individualized models cannot be produced without first understanding known risk factors for developing anxiety. Each of the risk factors considered in FELT is described below.

The "Triple Vulnerability" Model (Barlow, 2000)

Barlow's triple vulnerability model considers anxiety to develop from an interaction of 1) a generalized biological diathesis (tendency) for anxious arousal, 2) a generalized psychological vulnerability, and 3) specific psychological vulnerabilities that predispose an individual to focus anxiety on some particular object or event. By combining aspects of emotion theory, cognitive science, neuroscience, developmental psychology, and learning theory, Barlow's model is an integrative model of anxiety that has received much support within the empirical literature (see Brown & Lawrence, 2009, and Southam-Gerow & Chorpita, 2010). The model provides sound structural framework for understanding anxiety and other emotional disorders; however, the intricacies of Barlow's model are not discussed thoroughly here. Rather, the Barlow model is mentioned here primarily to highlight its influence on and similarity to the FELT model. For example, risk factors considered in FELT include both genetic and psychological risks. Additionally, both Barlow's and the FELT models are comprehensive and integrative. However, there are differences between the models regarding the structure of factors contributing to anxiety. Also, the FELT model is structured to be a "therapist's model." As a result, each factor/vulnerability is described with the specific purpose of

outlining a baseline for intervention. Furthermore, the division of variables in FELT is slightly different than the division used by Barlow. These divisions are outlined in the following sections below.

The FELT Etiological Model

Genetics and Biology

In much of the professional literature, genetic heritability estimates are calculated by comparing individuals who have both shared genes and shared environment (monozygotic twins raised together) with those individuals who share only environment (dizygotic twins raised together) and/or those who share only genes (monozygotic twins raised apart). Using this definition, genetic risk for anxiety is well documented, with heritability estimates generally finding that approximately 30% of phenotypic variation in anxiety is related to genetic factors (Kendler, Neale, Kessler, Heath, & Eaves, 1992). In other words, particular genetic patterns significantly predict the presence of excessive anxiety in humans. Unfortunately, clinical understanding of those genetic patterns is not yet well-developed, though the field and associated research are burgeoning. The biological phenotype of anxious people, however, is better understood.

Before discussing the clinical effects of genetics on the experience and expression of anxiety, it is important to first define how the term "genetics" is understood within FELT. Within the FELT etiological model, the primary concern of therapists is *genetic expression.* Scientists are now well aware that gene expression is a complex procedure that can be altered both prenatally and postnatally by environmental influences, including, but not limited to, sex, drugs and chemicals, temperature, light, viruses, and

early rearing (Lobo, 2008).Thus, the influence of genetics cannot be adequately or accurately understood without also appreciating the influence of environment on gene expression (called gene by environment (GxE) interactions). This complexity is an important one, especially in the FELT treatment model, because it means that environmental influences can have a significant impact on how a clinician understands his client's biological vulnerability to anxious states. This also means that a responsible clinician practicing FELT should create hypotheses about what environmental conditions lead to vulnerabilities in every individual case, such that measures can be taken to remediate vulnerabilities and maximize the chance for a positive treatment response.

Another important implication of GxE interactions is that the expression of genetic liabilities can be changed. Research has shown that psychotherapy can be just as effective as pharmacotherapy in altering brain functioning and biological vulnerabilities to anxiety. Porto and colleagues (2009) conducted a systemic review of literature documenting neurobiological changes that occur in adults treated for various anxiety disorders. They identified 10 studies that found that psychotherapy (CBT) did produce identifiable neurobiological changes across five anxiety disorders (OCD, PTSD, specific phobia, panic disorder, and SAD). A similar review, conducted by Linden (2006), found that post-treatment neurobiological effects were similar for both psychotherapy (CBT) and pharmacotherapy (SSRIs) on both OCD and specific phobia. Both of these reviews indicate techniques used in cognitive-behavior therapy for anxious patients are successful at actually changing how the adult brain works. Unfortunately, similar studies in children have not been thoroughly conducted, and most of the work that has been done has focused on trauma (Kay, 2009). Thus, the current lack of translation of the above findings

into child research is a limitation in applying that knowledge toward clinical work with children, and more research in the area needs to be conducted. Nevertheless, the promise for non-pharmacological interventions to produce significant neurological changes in individuals has a profound impact on the power of the psychotherapeutic enterprise. More importantly, the above findings mean that genetic (biological) predispositions to anxiety are not insurmountable and can (and should) be addressed during psychotherapy.

One of the best-understood phenotypes of anxious people is fear, due to the ability of scientists to create and study animal models of fear. A state of fear is characterized by activation of the hypothalamic-pituitary-adrenal (HPA) axis (see Nestler, Hyman, & Malenka, 2009**)**. When activated, the HPA axis ultimately releases the hormone cortisol into the bloodstream, which causes the body to enter a catabolic state, suppressing inflammatory responses and heightening autonomic arousal. Such autonomic arousal is characterized most prominently by vasoconstriction and increased need for oxygen (which cause increased heart rate, increased blood pressure, and heavier breathing). Other associated autonomic responses include sweating, muscle tension, gut motility/disrupted digestion, and diuresis (Parker, Hamlin, Coleman, & Fitzpatrick, 2003). To stimulate the release of cortisol from the adrenal gland in humans, the hypothalamus begins by releasing corticotrophin-releasing factor (CRF), which communicates with the pituitary gland to release adrenocorticotropic hormone (ACTH), which finally communicates with the adrenal gland to release cortisol. CRF is important because it also serves as a neurotransmitter and is received by neurons in the central nucleus of the amygdala, which then projects to other areas of the brain to activate other fear responses including pain suppression, defensive behavioral responses (i.e. behavioral freezing), enhanced

vigilance, and the formation of memories under which the danger has occurred. Projections from the amygdala also allow humans to identify the subjective experience of fear ("I am afraid!") and plan the appropriate response. These normal fear responses are all adaptive for survival, and are thus hardwired, to some extent, in all humans; however, individual differences regarding both automatic and planned fear responses do exist (likely along a rather normally distributed continuum) and individuals whose responses approach or reach the extreme end of the spectrum are those who are most susceptible to pathological anxiety.

Individuals with excessive anxiety exhibit abnormal autonomic arousal (i.e. excessive or prolonged arousal), maladaptive behavioral and cognitive responses, and overly generalized or poorly specified memory activation and encoding (see Nestler, Hyman, & Malenka, 2009). Thus, during acute cortisol release in response to anxiety-provoking situations, excessively anxious persons may physiologically show panic (heart racing, shortness of breath, sweating) and/or they may show more subtle effects, such as muscle soreness/tightness, headaches, or stomach aches. Behaviorally, they may find themselves "keyed up," as a "fight" response, may avoid situations, as a "flee" response, or may become indecisive and stuck, as in a "freeze" response. With excessively anxious individuals, such responding occurs even in the absence of an objective threat or danger. Thus, cognitively, they often perceive threats in situations where others do not. In these situations, the HPA axis responds just the same. Therefore, one key area of intervention for the FELT clinician is to help regulate the HPA axis.

There are several ways to regulate HPA activity. HPA depression (or augmentation) can be achieved quite efficiently and effectively with pharmacology.

However, pharmacological interventions have side effects, and, because of the dangers of those side effects, pharmacological interventions for anxiety are generally avoided with children. Fortunately, a number of psychobiobehavioral techniques have been established that allow people learn to take better control of their physiological responsiveness to stress. Several of these techniques are used throughout FELT and are described in the manual.

Traits and Temperament

Clark and Watson (1991) developed a tripartite model of anxiety and depression that has garnered a tremendous amount of research and theoretical support since it was proposed. The three parts of the tripartite model include negative affect (NA), autonomic arousal (AA), and positive affect (PA). In the tripartite model, Clark and Watson suggested that a single factor, NA, was common to both anxiety and depression. The other two factors, anxious hyperarousal (high AA, discussed above in *Genetics and Biology*) and anhedonia (or low PA), differentiated anxiety from depression. In the Clark and Watson model, anxious individuals show high rates of NA and AA, while depressed individuals possessed high NA and low PA. Brown, Chorpita, & Barlow (1998) further outlined a model identifying relationships among the tripartite model and various anxiety disorders. They found that NA was common to all of the emotional disorders, while AA was present in GAD and panic disorder, but not in OCD or SAD. Additionally, low PA was found to be a significant component of SAD, which is consistent with clinical findings that children with SAD show higher rates of depressed mood and a low sense of self-competence (see above). Based on these findings, NA has typically been described as

a “higher order” factor in all of the anxiety disorders, whereas lower-order factors contribute to specificity among the various disorders (Barlow, 2000).

Negative affect, also commonly referred to as neuroticism (Eysenck, 1967), represents a fundamental trait that results in being high strung, nervous, or overly emotional. Individuals with high NA experience more feelings of dysphoria, worry, and irritability (Denollet, 2005). They also tend to have a negative self-view and tend to be hypervigilant to signs of impending danger or turmoil (Watson & Pennebaker, 1989). This trait has been found to have a significant genetic component (Clark, Watson, & Mineka, 1994), with heritability estimates ranging from 30% to 50% (Barlow, 2000). NA being classified as a trait/temperament suggests NA to be a construct with stability in individuals across time and situations. This means that the set of behaviors associated with NA are expected to be displayed in a variety of situations and are believed to be a component of personality.

As a general construct, NA is useful for developing relatively parsimonious hypotheses about factors in emotional disorders. As the common factor in emotional disorders, high NA successfully differentiates anxious people from non-anxious people. However, from a treatment perspective, NA as a broad construct does little to inform clinicians about what kinds of vulnerabilities are demonstrated by high-NA individuals. In other words, although NA appears to capture a substantial portion of anxious vulnerabilities, the construct lacks the specificity necessary to inform clinicians about what cognitions, behaviors, and systemic liabilities should be targeted during treatment. Thus, in the FELT treatment model, NA is broken down into four parts, each of which is

targeted separately during treatment. These four parts include: anxiety sensitivity, anxiety avoidance, reduced self-efficacy, and persistent anxious cognitions.

Anxiety sensitivity. Reiss, Peterson, Gursky, and McNally (1986) defined anxiety sensitivity (AS) as the belief that symptoms of anxiety will have harmful physical, psychological, or social consequences for the individual experiencing them. As a result, people with AS tend to become quite distressed by the simple presence of anxiety symptoms. When they perceive anxious symptoms, highly anxiety-sensitive people tend to engage in catastrophic misinterpretations of those symptoms (see Clark, 1986), which then lead to more anxiety and, if unchecked, eventual panic. As a result, AS has been most traditionally associated in the scientific literature with panic disorder (Noel & Francis, 2011; Taylor, Cox, & Asmundson, 2009). Nonetheless, AS also relatively strongly correlates with other anxiety symptoms in youth (Joiner et al., 2002). Furthermore, a meta-analysis of the relevant literature found that AS reliably differentiates anxiety disordered youth from non-clinical youth (d=0.64, Noel & Francis, 2011). Such findings have led many scientists to believe that anxiety sensitivity is one of the key features of pathological anxiety in youth (and adults). Consequently, anxiety sensitivity is a primary treatment target for the FELT clinician. A vital component of most FELT sessions is in allowing the child to experience anxiety as being tolerable and manageable.

Avoidance of anxiety: The behavioral inhibition system. Gray (1982) originally described a behavioral inhibition system (BIS) that has been linked to trait anxiety and anxiety disorders in adults and children (Kimbrel, 2008; MacAndrew & Steele, 1991;

Vervoort et al., 2010). The BIS is a term used to describe a neural system that is sensitive to punishment and, as a result, organizes responses intended to avoid aversive stimuli. It is this latter function that makes the BIS important here (as sensitivity to punishment is captured under anxiety sensitivity, described above). In order to minimize the frequency and intensity of unpleasant experiences, the BIS stimulates avoidance of those unpleasant experiences. In order to avoid those stimuli, a person must be able to predict how and when they might occur, which leads to vigilance. At high levels, such vigilance becomes hypervigilance, or, anxiety. Thus, paradoxically, efforts meant to reduce anxiety about the occurrence of unpleasant stimuli lead to more anxiety (this model is described thoroughly by Borkovec, 1994). If the person experiencing that anxiety is also anxiety-sensitive, he or she will experience the very act of avoiding aversion as being aversive. Such a person is then found in a no-win situation, and anxiety increases exponentially. Thus, another major goal of the FELT clinician is to target this behavioral inhibition and reduce anxiety avoidance. This goal, however, cannot be accomplished without first reducing anxiety sensitivity. Only after being given an opportunity to experience anxious-like states as being tolerable and manageable can a child feel comfortable with *approaching* anxiety, instead of avoiding it. By approaching anxiety, the child activates the other system in Gray's model, the behavioral approach system (BAS), which is linked with reward and positive feelings (Gray, 1982). The goal of such an approach is to "rewire" the brain into perceiving anxiety as an adaptive emotion meant to alert a person that something in the internal or external environment needs to be solved. If anxiety is viewed as adaptive, not aversive, it can be used as a tool to promote ultimately positive outcomes. Therefore, in FELT, children are encouraged to approach anxious topics and

are explicitly instructed about the adaptive nature of anxious feelings. In this manner, children come to understand anxiety as a normal emotion, that, when optimized, actually promotes positive and constructive performance (Yerkes & Dodson, 1908).

A word of caution, however, is warranted in that clinicians should be careful not to stimulate overgeneralization of the approach tactic. Children must not confuse the goal of approaching anxiety with the goal of approaching anxiety-provoking situations. Although some situations may be approachable (i.e. testing), others may be dangerous (i.e. wandering away from parents in a crowded mall). Thus, if children overgeneralize the principle of approach, they may run the risk of engaging in risky or dangerous behavior. The approach to anxiety means only that the emotion itself is sought to be understood with regard to how that emotion interacts with achieving optimal outcomes in various situations. It does *not* mean that anxiety is ignored or subjugated for the sake of achieving a certain goal (i.e. being independent from parents). The goal is to remain "in contact" with, and accept, the internal experience (Hayes, Strosahl, & Wilson, 1999).

Reduced self-efficacy. As stated previously, individuals with high negative affect frequently struggle with low views about the self. A frequent problem for anxious individuals is not only that they are anxious, but that they also feel as if they have little control over their symptoms (Barlow, 2000; Kent & Gibbons, 1987). Furthermore, anxious children generally engage in more negative self-evaluations and less positive self-evaluations than their non-anxious cohorts (Zatz & Chassin, 1985). Thus, a key issue in the treatment of negative affectivity is to engage in measures meant to combat the sense of powerlessness that individuals are likely to feel regarding their anxiety. By promoting self-efficacy, FELT clinicians seek to help anxious children learn that they can

manage anxiety in a variety of situations. A number of activities used in FELT are designed specifically to increase recognition of self-efficacy. Additionally, the usage of fantasy play in general often allows children to experience efficacy using fantasy, which, over time, is believed to transfer over to reality as well.

Persistent anxious cognitions. Anxious cognitions (worry) are thought to be one of the most defining features of NA (Brown & Lawrence, 2009). Within the FELT model, anxious cognitions fall under the rubric of negative conditional logic. Statements in conditional logic are traditionally divided into two parts: the condition/antecedent (*if*... statement) and the consequent (*then*… statement). Pathological worriers frequently struggle with a narrow focus on negative consequences. In anticipating a given condition (i.e. "*if a storm occurs*…"), pathological worriers assume a negative consequent (i.e. "…*it might become a tornado*."). The persistence of such anxious cognitions means that, more often than not, an anxious person will conclude the negative consequent, which ultimately leads to negative affect. A major clinical goal, then, would be to help clients more frequently entertain alternative possible consequents (i.e. "…*it might not become a tornado.*").

Within FELT, clinicians rarely engage in direct instruction about thought stopping or alternative thought production (as may be done in CBT treatments, see Kendall & Hedtke, 2006). Rather, fantasy play is used to illustrate positive outcomes to a variety of anxiety-invoking situations. As a part of FELT, children make a habit out of using fantasy in this manner. By habitually practicing positive conditional resolution, it is believed that children in FELT will tend to broaden their previously narrow focus on

negative outcomes. As a result, the persistence of negative conditional logic is expected to fade away.

Parents

A key component of the FELT treatment model is to understand how parental factors influence the child client's current anxiety levels, such that those factors can be addressed in treatment to the greatest extent possible. There is a firmly documented association between parental and child anxiety (Beidel & Turner, 1997). Components of the association include genetic predispositions passed from parent to child, parental psychopathology in general, parenting decisions, and other parent-child interactions (see Francis & Chorpita, 2011). For the most part, parental risk factors are the same as those for children (described above), except that those factors are present in the parent instead of the child. Because the parent also displays anxiety sensitivity, anxiety avoidance, reduced self-efficacy, and persistent anxious cognitions, these behaviors are often modeled for the child. Thus, a key vulnerability for some children is that they may *learn* anxious behaviors from their parents.

In addition to mediational effects of parental anxiety on their children's anxiety, having a child with anxiety also has moderational effects on parental behaviors. For example, Aschenbrand and Kendall (2012) conducted a study in which they showed parents of anxiety-disordered children and parents of non-disordered children a vignette of a parent-child interaction. Half of the participants were told the child was anxious, while the other half were given a neutral description. The study found that parents of anxiety-disordered children showed no differences in response, regardless of whether they were told the child was anxious or not. Instead, they displayed significant increases

in state anxiety after watching the vignette. In other words, parents of anxiety-disordered children appeared to tend to perceive that the child in the vignette was anxious, even if they were told otherwise. Clinically, this means that parents of excessively anxious children tend to be hypervigilant toward signs of anxiety in children. Furthermore, they appear to be more likely to become agitated by everyday, non-anxious interactions with their children, likely due to anxious vigilance. The likely result of such responding is propagation of anxiety in their children. Therefore, when treating anxious children, clinicians should be aware of this tendency in parents, so that, when working with parents, efforts can be undertaken to mitigate the anxiety sensitivity of parents as well, which should, in turn, promote adaptive responding in children.

Overall, the key treatment principle to be taken from this section is that parents may also benefit from being incorporated into treatment with their children. Consequently, any reasonable measures that can be taken to include parents in treatment are advised within FELT. Specific parental interventions are described more thoroughly in CHAPTER 7 of the manual.

Psychodynamic Factors

Within the psychodynamic/psychoanalytic tradition, anxiety is characterized by Freud (1926/1959) as the manifestation of an individual's internal attempts/defenses to ward off unconscious conflict. According to Freud, once the unconscious conflict was resolved, so would be the presenting anxiety. From the psychodynamic point of view, different symptomatic manifestations (i.e. obsessions, phobic avoidance, etc.) are the result of the various defensive mechanisms employed by the anxious individual (Gabbard, 2000). Thus, anxiety is believed to be a *symptom* of unconscious conflict,

rather than an illness in and of itself. The task of the psychodynamic clinician, then, is to determine the source of the conflict, and then work to remediate the conflict.

To assist in determining the sources of conflict, Gabbard (2000) outlines a developmental hierarchy of anxiety. With psychoanalytic theory, various sets of "crises" occur at critical developmental periods. From this perspective, anxiety can arise from any of the following sources, ordered from developmentally most advanced to most primitive: superego anxiety, castration anxiety, fear of loss of love, fear of loss of the object (separation anxiety), persecutory anxiety, and disintegration anxiety. Superego anxiety describes anxiety that occurs as a result of "guilt" about not living up to an internal standard of moral behavior. Castration anxiety describes metaphorical loss of power and/or fear of physical injury. Loss of love and loss of the object are similar constructs, but they are considered to be independent of each other. A child can lose a sense of love without losing the object (for example, mom punishes child, and child thinks this is because mom does not love her). Similarly, a person can lose an object without losing a sense of love (as may occur in death of a parent). Persecutory anxiety leads to paranoia, while disintegration anxiety refers to a fear of losing the sense of self, which, in an extreme form, may, for example, lead to dissociation. In a less extreme form, persecutory and disintegration anxiety are well represented in normative adolescent anxiety, as described previously, when teens become increasingly concerned about what others think of them and struggle significantly with self-development. It is by considering these factors that the FELT clinician incorporates psychodynamic theory into treatment of anxious children.

Within FELT, clinicians make careful assessments of their clients' anxiety and construct a working model of psychodynamic factors contributing to anxiety (of course, other factors are considered as well in the full working model, including those already described above). For example, if working with a child with test anxiety, the FELT clinician may incorporate psychodynamic theory by investigating how this fear is influenced by all of the above factors. Is the anxiety about fear of physical harm ("castration") (i.e. "if I fail, I will get a spanking")? Do they worry about parental approval (fear of loss of love and/or fear of loss of the object)? Are they afraid they will be ridiculed for being "stupid" (persecutory anxiety)? Or are they simply appalled by the idea that they could be a failure (superego anxiety)? By investigating all these factors, the FELT clinician may come to understand his client's anxiety as a symptom of a deeper conflict, and therefore, may be able to implement interventions meant to correct that conflict.

Timing of Emotional Responses

In a model proposed by Davidson (1998), a key emphasis in affect regulation is the issue of time (as cited in McClure & Pine, 2006). In this model, pathology is described as a perturbation in the normal, adaptive temporal sequence of emotion processing. Some disorders are characterized by disruptions that occur early in the response, while other disorders are characterized by later disruptions. By using temporal dynamics, clinicians can develop a working knowledge about when to intervene during the course of an anxious response. For example, worry occurs *before* a stimulus. Thus, potential worried thoughts should be identified and worked on prior to introduction of the anxiety-provoking stimulus. Alternatively, fear occurs *after* the stimulus. Therefore, fear

responses can only be regulated after the introduction or in the presence of the feared stimulus. Within FELT, temporal dynamics play their most significant role in therapist's formulation of therapeutic stories used in FELT. Astute FELT therapists must be assiduous in their decisions about any therapeutic interactions in which they engage during the course of a therapeutic story.[1] They must pay close attention to the goal of the intervention, the targeted symptom, and to the timing of that intervention, which will vary depending on the targeted symptom.

Summary of the FELT Model of Anxiety

It should be clear from the above discussion that anxiety constitutes a multifactorial construct. No longer can anxiety be understood simply as "worried thoughts" or "physiological hyperarousal" or, from a much older tradition, "unresolved, unconscious developmental crises." Anxiety is now known to constitute the equifinal result of an array of "vulnerabilities." Taken together, those vulnerabilities integrate into the FELT model of anxiety, depicted in Figure 1 below.

As is shown in Figure 1, the FELT model begins with developmental vulnerabilities, including genetics, parental issues, and developmental factors from psychodynamic theory. Together, these issues are called "propagating factors" in the FELT model. When maladaptive forms of these factors are present, they produce a "program" of anxious reactions (depicted in middle box, above), which are called "manifest factors". Over time, GxE interactions program HPA reactivity, which is further divided in this model into sympathetic arousal and central arousal. Sympathetic arousal includes autonomic activity: increased heart rate, rapid breathing, muscle tension,

[1] Therapeutic stories are discussed in CHAPTER 4 of the full FELT manual.

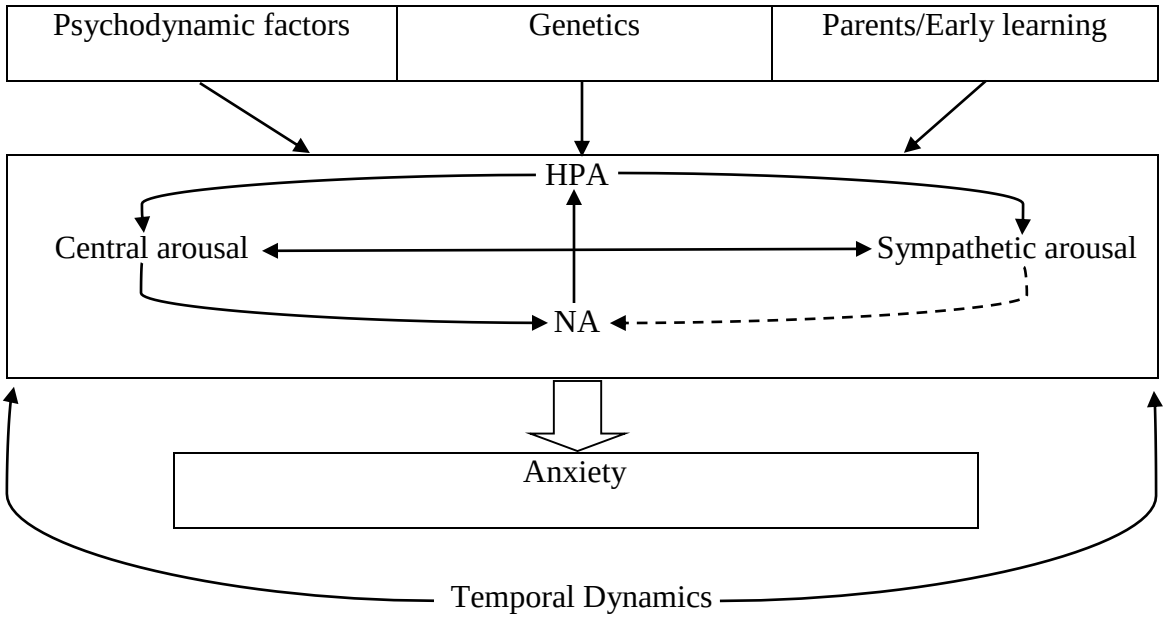

Figure 1. The FELT model of anxiety

perspiration, and so on, while central arousal includes the activities of CRF as a neurotransmitter, discussed above in the *Genetics* section – that is, pain suppression, defense responding, vigilance, selective formation of memories, and recognition of affect. Central and sympathetic arousal interact with and influence each other, such that sympathetic arousal causes central arousal and central arousal causes sympathetic arousal. They do not operate independently of each other. Over time, patterns of maladaptive central and sympathetic arousal respectively lead directly and indirectly to negative affect, which includes the four parts as described previously: anxiety sensitivity, anxiety avoidance, decreased self-efficacy, and persistent anxious cognitions. The presence of NA is aversive, which leads to increased HPA activity, propagating a cycle of anxious responding. The end result of developmental vulnerabilities (propagating factors) and anxious responding (manifest factors) is anxiety. Finally, temporal dynamics play a role in how specific difficulties with anxiety (i.e. worry, fear) manifest behaviorally.

One responsibility of the FELT clinician is to gain a sufficient understanding of what vulnerabilities each anxious client possesses, using the FELT model as a guideline. Then, clinicians work within therapy to help each child take control of those vulnerabilities and then, to the greatest extent possible, move beyond them. Therapeutic interventions are applied at all parts of the FELT working model. These interventions are described more thoroughly in FELT manual itself (Appendix A).

CHAPTER FOUR

The FELT Treatment Development Study

After developing a formal FELT manual based on the theories and assumptions described above, the current study was designed in order to form a pilot evaluation of the promise of FELT as a treatment for anxious children. It included a qualitative analysis of applicability, tolerability, and palatability of FELT. The study also included some quantitative results of outcome data. The study was approved by the Baylor University Institutional Review Board.

Rounsaville, Carrol, and Onken (2001) propose a stage model for treatment development in behavioral therapies research. The first stage in that model is manual development. During the manual development phase, a new treatment is pilot tested with a small number of cases, usually without a control group, in order assess patient response to the treatment and empirical promise of the treatment's ability to produce desirable outcome (Rounsaville et al., 2001). This first phase is necessary to prepare the treatment for more rigorous testing in later clinical trials. In addition to testing patient responsiveness to the treatment, researchers can also use this phase for development of rating scales for therapist competence and adherence. Additionally, initial psychometric properties of those instruments can be determined. Furthermore, materials for training later therapists may also be produced (i.e. exemplary sessions can be recorded).

Methods

Participants and Recruitment

Participants were recruited from the Waco community and surrounding areas in Central Texas. Patients were recruited through referrals from a variety of community resources, including the Baylor Psychology Clinic, local pediatricians, other mental-health practitioners, schools, and local churches.

Inclusion criteria for participation in the study included the following:

1. Child was between the ages of 6 and 11.
2. Child was identified as being anxious and scored at least 1 standard deviation above the mean at baseline on any of the outcome measures used.

Exclusion criteria included:

1. Child's anxiety was trauma related (i.e. meets criteria for Post-Traumatic Stress Disorder, Acute Stress Disorder, or Disorders of Extreme Stress Not-Otherwise Specified).
2. Child had a diagnosis of Obsessive-Compulsive Disorder.
3. Child had a comorbid condition that clinically contraindicated their ability to benefit from FELT. This exclusion had to be agreed upon by three separate, well-informed clinicians, and included the PI and two licensed child psychologists.

All participant screenings were performed by the PI and his immediate clinical supervisor (Helen Benedict, Ph.D.). Furthermore, Christine Limbers, Ph.D., served as the third independent reviewer of cases.

A total of 12 eligible children were sought for this study. Recruitment began in November 2011 and was to continue until 12 eligible participants were determined, until March 2012, or until saturation of data occurred. By March 2012, during the recruitment period, only 9 children presented for evaluation for candidacy. Of the 9 possible candidates, 6 were determined eligible for the study. Two were excluded due to trauma history, and one was excluded due to presenting with depression, but not anxiety at time of recruitment period. The 6 eligible participants consisted of 5 girls and 1 boy. Ages ranged from 7 to 11 years, and ethnicity was 84% non-Hispanic Caucasian and 16% African American. Participants were split into two iterative groups for the purposes of conducting focus groups (described below). Group A included four girls and Group B included one boy and one girl. The boy ended up being removed from the study after eight sessions after the therapist became increasingly aware of the presence of significant obsessive-compulsive traits (which was an exclusionary criterion). Thus, only 5 children completed FELT through to the end. Nonetheless, some qualititative data provided by the boy is reported in results. Despite only getting half of the original 12 planned participants, the PI decided to cease recruitment in March 2012 due to time constraints. Even so, it was felt that saturation of data was achieved with these 6 participants.

Procedures

After all legal guardians gave informed consent, and after the clinician obtained assent from each child, eligible participants began initial screening to determine their appropriateness to continue in the study. The measures used for screening are described below.

Behavior Assessment System for Children, 2nd edition (BASC-2). The BASC-2 (Reynolds & Kamphaus, 2004) "is a multimethod, multidimensional system used to evaluate the behavior and self-perceptions of children and young adults aged 2-25 years" (Reynolds & Kamphas, 2004, p.1). It contains several methods of report, including teacher report, parent report, self-report, and observational report. It provides information about a number of childhood behaviors, including adaptive skills, behavioral symptoms, externalizing problems, internalizing problems, and school problems. The BASC-2 has sound psychometric properties and has been used in a large number of research studies in both its original (BASC) and current (BASC-2) forms (see Reynolds & Kamphaus, 2004; Mash & Barkley, 2007). In this study, the self- and parent-report versions were used.

Revised Children's Manifest Anxiety Scale, 2nd edition (RCMAS-2). The RCMAS-2 (Reynolds & Richmond, 2008) is used clinically to identify the source and level of anxiety in children. It is a self-report instrument containing 49 yes/no items. It can be completed in 10-15 minutes and contains norms for children ages 6-19 years. It has several scales, including physiological anxiety, worry, social anxiety, defensiveness, and an inconsistent responding index. It also gives a Total Anxiety score. The RCMAS-2 also contains a short from, which is composed only of the first 10 items. Reliability estimates for the RCMAS-2 range from a Cronbach's alpha of 0.75 to 0.92, depending on the scale (Reynolds & Richmond, 2008). Covergent validity has also been estimated as high as r=0.93 (see Southam-Gerow & Chorpita, 2010). In the current study, the standard (full) form of the RCMAS-2 was used.

Penn State Worry Questionnaire for Children (PSWQ-C). The PSWQ-C (Chorpita, Tracey, Brown, Collica, & Barlow, 1997) is a 14-item self-report questionnaire that assesses worry in children ages 7-17 years. Respondents use a 4-point Likert scale to indicate their level of worry across a variety of domains. Scores are summed to provide a total score ranging from 0-42. Higher scores indicate a greater tendency to worry. Norms are available for children as young as age 5 (Southam-Gerow & Chorpita, 2007). Internal consistency and test-retest reliability for the PSWQ-C are both high (approximately 0.9), and convergent validity is adequate as well (Southam-Gerow & Chorpita, 2010).

Interview. A standard clinical interview was conducted with all children and parents who participated in FELT. The interview was structured to fulfill two purposes: 1) to assist in accurate diagnosis, and 2) to provide data for the case conceptualization. The researcher's original intent was to use a well-validated structured diagnostic – the Anxiety Disorders Interview Schedule for Children and Parents (ADIS-IV-C/P, Silverman & Albano, 1996) – for diagnostic purposes. The ADIS-IV-C/P was chosen in order to provide diagnostic reliability and validity; however, it also contains dimensional ratings for severity, intensity, interference, avoidance, and uncontrollability of symptoms, which would have provided a very useful manner to monitor symptom progression or reduction over time. However, the ADIS-IV-C/P requires specific training to administer, which the researcher was not able to obtain prior to beginning the study. Instead, semi-structured diagnostic questions were embedded into the standard clinical interview, and the researcher used clinical supervision to corroborate diagnostic impressions about all clients. For the purposes of case conceptualization, the clinical interview also included

information about early (including prenatal) development, physiology (i.e. sleeping/eating patterns, somatization), other (non-anxious) emotional functioning, social relationships, and family history/functioning (including child-parent relationship patterns). In order to keep the interview as brief as possible, questioning was targeted and hypothesis driven, as guided by the format of case conceptualization discussed previously.

After the initial screening procedure, eligible participants began FELT as described in the current manual. The therapy was conducted by the principal investigator (Jason Steadman) under the supervision of Dr. Helen Benedict, a licensed child psychologist and registered play therapist-supervisor. The PI initiated individual therapy with each child in Group A (n = 4). After 4 sessions, and one focus session with Group A, individual therapy was also initiated with each child in Group B (n = 2).

Over the course of treatment, children completed the PSWQ-C before every other session (every two weeks). This measure was used to monitor changes in anxiety during treatment. At the end of treatment, all children and parents completed all measures completed during intake, excluding the generalized clinical interview. This same process was repeated at 6-week follow-up. The results were compared with pre-treatment scores to determine if any statistically significant changes (increases, reductions, or no changes) in anxiety occurred over the course of therapy. At this stage (manual development), no control group was used. Procedures for data analysis are outlined in a later section.

Focus Groups

Focus groups were held every four sessions to discuss with clients and their parents their thoughts and feelings about therapy. These focus groups served as

subjective “check-ups” to ascertain reactions and any potential problems to the current manual. Focus groups were held outside of normal therapeutic procedures (meaning, they did not interfere with regularly scheduled therapy sessions). Each focus group was comprised of the PI, all clients in the group, and their parents. Each one was scheduled to last one hour and was broken apart into two segments. First, the children met without their parents for a 30-minute segment with the PI. Then, the parents did the same, without their children. During the parent segment, childcare was provided for the children by other graduate students.

The focus groups followed a semi-structured format. A pre-prepared set of questions was used to invite discussion about clients’ reactions to FELT. First, participants were asked to focus their responses only on their reactions to the four sessions preceding the focus group. Then, reactions to the therapy as a whole were considered. A list of pre-prepared questions is provided in Appendix B.

Focus groups were all fully transcribed and subjected to a content analysis following procedures described in Elo and Kyngäs (2008). Content analysis was performed by three independent reviewers, who analyzed transcripts for themes among the feedback of children and their parents.

Data

Interested readers may find additional information pertaining to procedures for data management and analysis in Appendix C.

CHAPTER FIVE

Results and Discussion

Quantitative data is available for 5 female participants between the ages of 9 and 11. The sample was 80% Caucasian and 20% African American, and primary anxiety diagnoses included three children with generalized anxiety disorder and two children with a specific phobia. Two of the children with GAD also had comorbid anxiety disorders of specific phobias. Two other children also had comorbid diagnoses of separation anxiety disorder. Four participants fell in the middle class of socioeconomic status (SES) (based on information gleaned from clinical interview), and were the children of single mother families, with heavy involvement from maternal grandparents. The other participant lived with both parents and fell in the upper-middle class of SES.

Because of small sample size, the data violated the statistical assumptions of normality and sphericity for parametric statistical tests; therefore, a non-parametric equivalent of a repeated measures ANOVA was used. Friedman tests were significant for each of the outcome measures tested; however, post-hoc Wilcoxon signed-rank tests revealed no significant pairwise differences comparing baseline scores to either post-treatment or follow-up scores on any outcome measures (using a Bonferroni corrected p-value of 0.025). However, significance of statistics was largely affected by small sample size (n=5). There was simply not enough power to determine pairwise statistical significance. However, effect sizes are one way to show practical significance, even when statistical power is otherwise inadequate. Therefore, effect sizes (Cohen's *d*) were

calculated to compare baseline to post-treatment anxiety and baseline to six-week follow-up. Descriptive statistics and effect sizes are reported in Table 2 below:

Table 2. *Effect Sizes When N=5*

Measure	Comparison	N	Mean 1	Mean 2	Mean diff	Pooled sd	Cohen's *d*
RCMAS-2	BL-POST	5	55.6	50.6	-5.0	13.15	0.38
	BL-FU	5	55.6	47	-8.6	13.22	0.65
BASC-2 SRP	BL-POST	5	58.6	50.2	-8.4	14.40	0.58
	BL-FU	5	58.6	48.6	-10.0	13.85	0.72
BASC-2 PRS	BL-POST	5	70.0	53.8	-16.2	11.74	1.38
	BL-FU	5	70.0	51.4	-18.6	14.96	1.24
PSWQ-C	BL-POST	5	20.8	16.8	4.0	9.00	0.44
	BL-FU	5	20.8	14.2	6.60	8.21	0.80

*Note: Mean 1 = Baseline anxiety (BL), Mean 2 = Post treatment (POST) or 6 week follow-up (FU). RCMAS-2 represents T-score on TOTAL ANXIETY scale from RCMAS-2; BASC-2 SRP and PRS are both T-scores for the ANXIETY scale from each measure; PSWQ-C is total RAW SCORE on the PSWQ-C.

Most overall effect sizes were found to be medium or large except when comparing baseline and post-treatment anxiety using the RCMAS-2 and PSWQ-C, in which cases effect sizes were small. The largest effects were found on parent report measures, which appears to be largely due to parents' higher baseline ratings when compared to self-report measures. There was also a significant effect of one subject

(#2761022), whose baseline self-report ratings were in the very low range (most T-scores < 40). This outlier had the effect of simultaneously decreasing mean baseline scores and increasing variance, thereby also significantly decreasing effect sizes on self-report measures. Although this subject did not meet quantitative cutoffs for reported anxiety on self-report measures, she also scored high (T=64) on defensiveness, suggesting self-reported anxiety may have been low due to defensive responding. Parent-reported anxiety was consistently high in her case, and clinical interview revealed significant impairment related to a specific phobia and mild separation anxiety. Therefore, subject #2761022 was still accepted into the study. Nevertheless, her scores on self-report measures significantly affected overall findings across all subjects. Therefore, Table 3, below, shows descriptive statistics and effect sizes for all subjects excluding #2761022.

As can be seen from Table 3, after removing the effects of participant #2761022, effect sizes increased as measured by the RCMAS-2 and by the BASC-2 SRP. Now, all effect sizes are medium or large, with several effects approaching or exceeding a full standard deviation. Thus, examination of overall results show FELT to have significant promise as an effective treatment for childhood anxiety. However, replication of findings with a larger sample size is desirable before making any definitive conclusions about efficacy. The effect sizes as calculated in this study will serve as a useful means to calculate the sample size needed for adequate power in future studies.

In addition to quantitative analysis, a content analysis was performed by three independent reviewers to identify common themes from qualitative feedback. An additional participant, who was withdrawn from the study (see *Methods)* and thus did not complete treatment, nevertheless did provide informative qualitative data. Therefore,

Table 3. *Effect Sizes When N=4*

Measure	Comparison	N	Mean 1	Mean 2	Mean diff	Pooled sd	Cohen's *d*
RCMAS-2	BL-POST	4	60.75	55.75	5.00	7.34	0.68
	BL-FU	4	60.75	51.25	9.50	9.18	1.04
BASC-2 SRP	BL-POST	4	64.25	53.75	10.50	11.32	0.93
	BL-FU	4	64.25	52.25	12.00	10.24	1.17
BASC-2 PRS	BL-POST	4	70.75	53.75	17.00	13.49	1.26
	BL-FU	4	70.75	54.75	16.00	16.10	0.99
PSWQ-C	BL-POST	4	22.50	18.00	4.50	9.67	0.47
	BL-FU	4	22.50	14.75	7.75	8.90	0.87

*Note: Mean 1 = Baseline anxiety, Mean 2 = Post treatment or 6 week follow-up.

qualitative feedback was received from a total of 6 participants, and the data revealed that saturation and informational redundancy were achieved, with 100% agreement among the three independent reviewers. Content from feedback is presented below and includes all feedback given as clients progressed through FELT. Feedback was taken after sessions 4 and 8, as well as post treatment and at 6-week follow-up.

Responses to Therapy Through Session 4

Several prominent themes were notable through the first third of FELT. First, about half of children were described as being more emotional and emotionally

expressive. Parents of these children typically actually stated they felt their children got "a little worse" with regard to emotionality. The other half of children were said to have begun to demonstrate an initial usage of some relaxation skills. Two of the children were able to describe specific recent incidents in which they used relaxation techniques to calm. All children were said to have improved in ability to communicate emotions in general, not just regarding anxiety, but also regarding anger, sadness, and other intense negative emotions. All children also stated they noticed some decrease in somatic symptoms of anxiety, particularly regarding stomach aches and/or headaches. However, children also were able to state that they felt they still had some worries. Finally, all children stated that they enjoyed therapy so far, and parents all stated that their children look forward to coming.

Responses to Therapy Through Session 8

By session 8, participants began to describe significant changes in anxiety symptoms across the board. Only one participant (the one with whom the therapist was unable to adhere to the FELT model and who was removed from the study due to identification of significant obsessive-compulsive traits) failed to show progress. All others described noticeable decreases in anxiety sensitivity and anxiety avoidance. In fact, by session 8, all participants and their parents expressed pride about no longer feeling nervous about feeling nervous and that when they do feel nervous, "it's no big deal" and they "know how to handle" the worry. Thus, an increase in self-efficacy was also noted. Finally, decreases in the persistence of anxious cognitions were outlined by several participants, although most participants acknowledged that some worries did still persist. Furthermore, children with multiple fears (i.e. of dogs, of storms, and of clowns)

typically identified reductions or disappearances of some fears (i.e. dogs and storms) but not of others (i.e. clowns). In other words, although significant progress had been made through session 8, it was clear that additional sessions were needed in most cases.

Additionally, by session 8, children began to show expanding knowledge and usage of coping skills and anxiety reduction techniques. At session 4, children and their parents stated primary reliance on progressive muscle relaxation as their skill of choice (which is a skill learned in session 4); however, by session 8, children were able to identify several anxiety reduction techniques that they use when anxious. Particularly, several children noted using fantasy. One child reportedly "had a very anxious night" one night, without knowing why. Thus, she "went to the beach in her mind," which reportedly resulted in her feeling better. Another child, who feared storms, endured a severe thunderstorm by using fantasy to pretend the thunder was simply the sound of her relatives cheering for something in heaven. Other children discussed using distraction to reduce anxiety, including listening to music, watching television, or drawing. In all cases, techniques reflected those that children tended to use in their stories they told in therapy.

Regarding their enjoyment of therapy, children all stated that they still like therapy, but that now, they sometimes wish they could just go home and rest instead. All but one specifically stated that they like coming, and that they have fun once they do come. One child, who had previously stated she did not like the toys offered in therapy, called the therapy boring. In her case, the therapist switched to using an art-based approach, instead of a toy-based approach at session 8, which she later reported liking much better.

Responses to Therapy Post Treatment

At the end of all 12 sessions of therapy, feedback was very similar to that obtained after session 8. There were significant reductions in anxiety sensitivity, anxiety avoidance, and anxious cognitions. Perceived self-efficacy was also reported to have improved in all participants. All participants declared substantial improvements in all original presenting complaints, and all parents noted no more functional impairment related to anxiety. Three participants had a fear of storms, and all three of them described specific incidents of enduring storms without experiencing any fear. One child was even present in therapy during a severe hailstorm. Hail could be seen pounding against and bouncing off the window, and this child displayed no signs of fear or worry about the storm. In fact, she watched the hail with some joy and proudly noted how she did not feel scared anymore. She reportedly later told her mother that her therapist was scared, but she was not. Another mother described her daughter as follows, "I think [my daughter] has calmed enough that now she can listen to reason [during previously anxiety-provoking events]. She doesn't have that 'fear wall' anymore."

Several parents stated that they felt the most noticeable change in their children was that they can now understand the changes that occur in their body when anxious, which removes the scariness of what is happening to them when anxiety does happen. They also expressed that their children's perception that they have control over their anxiety symptoms was a powerful component of treatment. Additionally, a number of parents also described generalization of symptom-reduction in other areas. For example, one participant who was treated specifically for test anxiety showed consequent reductions also in mild separation anxiety, even though separation anxiety was not

particularly targeted in treatment. Another parent noted that her daughter asked and was able to sleep in her own bed for the first time in her life (previously, the girl shared a bed with her mother). Again, in her case, nighttime anxieties were not specifically targeted in treatment. Such generalization is one of the most promising findings from this initial FELT study and shows FELT to have great potential on par with other evidence-based treatments for anxiety.

Responses to Therapy at 6-Week Follow-Up

Findings from post-treatment were maintained at 6-week follow-up for all children. All children and parents described preservation of healthy functioning, with no impairments from anxiety. All participants acknowledged that some worry and some fear would "come and go now and again," but all felt equipped to manage anxiety when it did occur. Again, overall findings were resoundingly positive and revealed FELT to show promise as a treatment able to promote gains that can be maintained for some time after therapy.

Findings from the Treatment Non-Responder

As stated previously, one child in this study exhibited a poor tolerance and adherence to FELT. His initial presentation was that of a 7-year-old child with significant separation anxiety from his mother. However, he also had a history of oppositionality. Furthermore, during interview, he described possible hallucinations, some of which caused him fear, some of which did not. He even reported having a hallucination while present with the interviewer. It was unclear whether these reported hallucinations were real or malingered. His history was positive for some aspects of prodromal symptoms of

psychoticism (see Mash & Barkley, 2007), but not for others. Furthermore, his reports of hallucinations could have been explained by his oppositionality. Given his anxiety, he was tentatively accepted into the FELT study, pending further evaluation.

An independent evaluation by another clinician did not find evidence of psychoticism, but did feel his presentation was somewhat unorthodox. Nonetheless, he did not meet any exclusionary criteria for the study, and thus he was fully accepted into the study and started in therapy. As his therapist attempted to engage him in FELT, the boy's oppositionality proved to be a difficult challenge to overcome. Although the boy participated quite well in fantasy play and although he developed elaborate play scenes, his desire to use pre-prepared story stems was minimal at best. Therefore, the therapist had to consistently design new story stems, using the scenes the boy himself developed. This procedure in itself was not a very significant aberrance from the overall FELT protocol, since therapeutic narratives could still be formed. Thus, therapy progressed through the first four sessions without missing any therapeutic goals.

However, over time, as therapy progressed, what proved most difficult was that this child displayed an extreme concern with orderliness and detail in his play scenes. Thus, setting up scenes became, at times, a 40-minute ordeal for him (out of a 50-minute session). He became noticeably distraught if every toy he chose and placed was not placed perfectly, or if it did not stay in its perfect spot (i.e. if it fell over). Additionally, he was largely unable to tolerate direction from the therapist to try to "speed things along" in any way. In fact, the boy demanded that the therapist not touch the toys at all, but only assist in telling the stories. As a result, the therapist became stuck in a conflict of constantly trying to provide therapeutic direction to the stories without overly violating

the core FELT guideline of being child responsive and respectful of the child's direction. Furthermore, because of the duration of attempts to structure the setting up of stories, little time was left for the actual development of the stories themselves. Consequently, therapeutic content became very limited with this child after session 4.

Over time, the therapist became more and more aware that this boy's obsessive-compulsive tendencies impeded FELT such that therapy was no longer progressing at all. Therefore, after 8 sessions, the boy was removed from the study and placed into a different kind of treatment with a different therapist. Even though the boy did not complete therapy, a tremendous amount was learned from his participation in the FELT study. First of all, his initial sessions provided a superb example of how a therapist can generate therapeutic stories based on solely child-created scenes. Mostly though, his case presented clear indications of the type of client for whom FELT may not work. Based on work with this boy, it seems that FELT may be challenging to implement with oppositional children, as the directive nature of many FELT interventions may be met with resistance from oppositional children. Certainly more study would be necessary to determine if all oppositional children respond similarly. Furthermore, as anticipated prior to the study, FELT is not currently indicated for children with any of the obsessive-compulsive disorders.

Overall Summary of Qualitative Data

Excluding lessons learned from the boy described in the previous section, qualitative feedback was consistent across all participants in the study. All five participants provided virtually identical feedback regarding the changes that occurred over the course of therapy, which largely revolved around notable improvements in all

four components of negative affect as well as in somatic and physiological reactivity to stressors. Conscious awareness of a reduction in anxiety sensitivity appeared to be the most common factor of treatment success. In fact, every child and parent who participated in FELT explicitly stated that one thing they found "most helpful" was that they learned to recognize anxious symptoms and learned that while these symptoms were important indicators that something was wrong, they were "no big deal." Improvements in self-efficacy also appeared to be one of the more common, important factors of treatment success.

Another purpose of qualitative data was to inform changes to the manual; however, no data was reported to suggest significant changes to the manual were needed. Minute changes to some session materials and descriptions were made, though. Changes were limited to the addition or subtraction of activities in order to ensure activities filled a 50-minute session. Also, some additional directions for therapists were added in order to clarify procedures for trainees. Finally, some session examples include real data obtained through interaction with children in the FELT development study. These data are used only with the express written permission of participants, and all identifying information has been removed or changed.

The most significant change warranted to the manual is a better description of how cultural and ethnic background of clients becomes factored into treatment approach. In its original form, the FELT paradigm considered cultural factors within the "Parents/Early learning" component of the FELT etiological model. However, given the unique role that cultural factors may play in case conceptualization and in a therapist's approach to treatment, it was decided to rename the factor in question "Parents/Early

learning/Culture," and to provide a more substantial focus within the text of the manual about how cultural factors may be considered within FELT. Specifically, the therapist is now instructed to identify culturally-based risk and protective factors for anxiety. When cultural risk factors are noted, the therapist is instructed to proceed judiciously from a culturally-responsive framework. In this case, cultural responsiveness follows the same definition as client responsiveness, as defined in the FELT manual. Therefore, the client herself is understood to be the ultimate expert on her own culture. Nevertheless, the over-arching goal for therapists is to minimize cultural risk factors, just as they would minimize any other risk factor. Hence, therapists may attempt to reframe cultural risk factors into healthier patterns; however, they strive to do so while maintaining respect for clients' cultural norms.

Cultural factors are also more specifically integrated into toy selection for FELT. Although the original selection of toys available to FELT clients was racially mixed, the toys were predominately White. Although neither children nor parents reported lack of diversity amongst toys to be an issue, it is still believed that sufficient toys of various racial backgrounds should be made available to allow children who wish to use them to do so. Therefore, within the manual, materials suggest a racially diverse group of people toys.

Treatment Feasibility and Acceptability/Compliance

Recruitment of children for this study was not as successful as expected. Most children who participated in the study were obtained through referral from local professionals or from other participants. Only one participant learned of the study solely through the posted flyer. Therefore, in future studies, recruitment is likely to be most

successful if a high number of local professionals are alerted to the study and send referrals. A number of additional potential referrals came through after the study was closed and after word of the study began to spread through the community. It is expected, therefore, that future studies may be able to successfully acquire more participants through "word of mouth," as well as through referrals.

Most children who did participate in the study expressly enjoyed therapy and said it was fun. One child stated she disliked most of therapy, and preferred an art approach, as opposed to play. In her case, adaptations were made to the modality to make the therapy more palatable, which was reportedly successful. Therefore, based on qualitative feedback, FELT met its goal in this study of being a palatable therapy. Furthermore, most clients were fully compliant with FELT. None exhibited undue resistance to therapy as a whole.

Mechanisms of Change in FELT

A major goal of the current study was to develop a treatment that is different in some real way from the currently available evidence-based treatments. Not only is FELT intended to be different in approach to treatment, but the proposed mechanisms of change are understood to be more inclusive/integrative than other treatments (which, to review, are overwhelmingly cognitive-behavioral). In the cognitive-behavioral tradition, the techniques used reflect a primary focus on using systematic desensitization and cognitive restructuring to produce change. Like FELT, effective CBTs improve all four components of negative affect and also reduce physiological arousal. Thus, both FELT and effective CBTs reduce the manifest factors of anxiety, and it is likely that they do so through similar mechanisms. FELT also uses exposure, desensitization, and cognitive

restructuring; however, what makes FELT differ, based on data from this study and on the experience of the PI, is the FELT does so in a manner that is more applicable, tolerable, and palatable to children (and their parents). Children who participated in this study invariably stated they looked forward to therapy each week. They did not view the therapy as "work," but rather described play as "fun." They were never assigned homework, as often occurs in effective CBTs, yet findings indicate, based on parent report, that children invoked therapeutic play in their play at home, especially during the latter half of the FELT program. According to parent report, this therapeutic play continued even *after* conclusion of therapy. Furthermore, parents reported that this play appeared to occur spontaneously and without intent, meaning that parents felt that children were not making a conscious decision to "continue their homework," but were just playing in a similar way to the play that was used in therapy. Thus, it appears that the FELT program may address a common issue in some other treatment programs, in that children actually appear to voluntarily continue the program on their own, after the conclusion of the therapist-client relationship.

On a more theoretical basis, FELT is also unique in its employ of a specifically defined "master therapist." Most other manualized therapies very successfully and extensively describe *what is therapeutic;* however, by defining the ACER therapist, instructing therapists on the formation of therapeutic stories, teaching how and when to intervene through play, and codifying through individualized case conceptualizations the areas needing to be changed in each client, FELT systematically also informs clinicians *how to be therapeutic.* These are very important factors because effective techniques can easily be "ruined" by ineffective therapists. Therefore, an essential mechanism of change,

in any therapy, lies as much in the "how" of therapy as in the "what" of therapy. Both are understood to function independently to effect change. Hence, it is believed that much of what made FELT effective in this study is bound by the components of FELT that describe "how" clinicians conduct therapy. Although at this point, data is not sufficient to adequately investigate the role of the "how" factors in FELT, the following quote[1] from a participant's mother to the therapist provides some insight into the issue: "[My child] had been in therapy before for anxiety. That therapist seemed to try to teach her all the same techniques you did, but they didn't work. Something, I think, about the way you did things with her just worked."

Finally, FELT appears at this point to be able to generate positive changes using fantasy exposure without requiring "in vivo" exposure. In other exposure therapies, the therapist, at some point, invite clients to undergo "in vivo" exposure during sessions. Thus, for example, a client with a dog phobia would be required, at some point, to endure a therapy session with a dog in the room. FELT appears to be able to achieve significant positive results without requiring this "in vivo" component. Given that children readily use play as a reflection of reality (as discussed previously in this paper), it makes sense why "in vivo" exposure may not be necessary: the play, itself, is experienced by the child to reflect real world experiences, and, therefore, generalizes to real world experiences. While it is certainly true that several participants in the study did undergo "in vivo" exposure outside of therapy sessions, the fact that they were able to do so without the presence of a therapist is significant. In other words, the children in the study felt enough mastery over their symptoms that they voluntarily approached "in vivo" exposure without

[1] This statement was given at 6-week follow-up.

the therapist ever specifically assigning them "homework" to do so. If this finding is replicated in future studies, it could have profound implications for the power and role of play interventions for children and their generalization to real-world scenarios.

Therapist Adherence and Competence Rating Form

Another part of this study was to establish initial psychometric properties (reliability and factor structure) of a rating form designed to rate therapist competence and adherence to the FELT treatment model. In order to do so, all sessions of FELT were videotaped (with parental consent). From those tapes, one session was randomly chosen. That session was then viewed and rated by a group of professional psychologists and doctoral students using the FELT rating form. A total of eight clinicians provided ratings for the form; however, after receiving feedback from those who completed the form, the principal investigator decided to restructure the form into a criterion checklist, rather than a rating form. This decision resulted in the creation of a significantly different, but improved procedure for assessing competence and adherence of FELT therapists. Because the original form will no longer be used in FELT, reliability and factor analyses were not conducted. Instead, a separate study is currently being designed to further develop procedures for training therapists in using FELT. Analysis of the new rating form will be conducted through that study, and not on the current one.

Future Directions

Future directions for FELT involve continued preparation for randomized controlled trials with larger samples. Given the preliminary strong positive results from the current study, the manual is now ready to be used to train other therapists. It is

anticipated that FELT development will progress next into a therapist training phase, during which issues related to training other therapists will be worked out through a controlled research study. This study is expected to begin around September 2012 and to be completed by June 2013, if possible, at which point FELT will be ready to begin implementation in clinical trials. Recruitment for therapists interested in learning FELT for the purposes of the next study are currently underway.

In the future, it is also hoped that FELT could be expanded and adapted for application to other populations. Adaptation would be easiest for anxiety-related disorders, including adjustment to chronic illness, functional vomiting, and maltreatment/trauma, to name a few. The FELT treatment model could also presumably someday be used to treat depressive disorders. In all adaptations, necessary changes to the treatment program would need to be made to reflect disease-specific etiological models and how those different models are addressed through treatment. Nonetheless, it is this author's view that the overall treatment paradigm is versatile enough to be able to address a number of childhood psychological/psychiatric disorders, and it is hoped that, over time, the lessons learned from FELT can influence development of other manualized play therapies for a wide range of disorders.

APPENDICES

APPENDIX A

Remaining Components of FELT Manual

This Appendix derived from Steadman, J. L. (2012). Fantasy-Exposure Life-Narrative Therapy treatment manual. Unpublished manuscript.

Much of the material from the first two chapters of the FELT training manual are described within the text above. Chapter 1 is an introductory chapter, and its content is reprinted in its entirety above. Chapter 2 provides a broad overview of childhood anxiety, including evaluation and treatment implications. It contains detailed descriptions of various childhood anxiety disorders and normative presentations of anxiety in children. It also describes etiological models of anxiety, as reprinted elsewhere in this paper. Given the large overlap of Chapters 1 and 2 with material from this paper, they are not reprinted again below. Instead, this appendix begins with Chapter 3 of the manual, which describes assessment of anxiety.

CHAPTER 3: ASSESSMENT OF ANXIETY

According to Southam-Gerow and Chorpita (2010), the purpose of assessment is to inform treatment planning. They define assessment as informing three major decisions: 1) identification-screening, 2) triage-treatment planning, and 3) outcome assessment. In the first step, a developmentally inappropriate level of anxiety is identified and determined to impair functioning in some way. In the second step, the nature of anxiety is determined, so that treatment can be tailored to address specific problems. In the third step, assessment continues throughout treatment to monitor progress. These three steps constitute the basic process through which assessment of anxiety is conducted during

FELT. In conducting assessment, FELT clinicians should strive to form an individualized working model of each child client's anxiety (in other words, a case conceptualization), following the model described in the previous chapter. Then, as treatment progresses, clinicians implement treatments targeted toward each problematic area of functioning within that working model. In this chapter, general issues and methods for performing assessment within FELT are reviewed.

Pre-treatment Assessment

In general, clinical assessment of children should follow a multimethod-multirater format. Assessment methods typically include a clinical/diagnostic interview, observation, and questionnaires completed by multiple raters. Although physiological assessment (i.e. HPA reactivity) is sometimes conducted in research studies, at this point, such assessment is not clinically practical. Typical raters in child assessment almost always include self-report by the child and parent/guardian report. Teachers can also provide useful data in many cases.

Clinicians should be aware of several issues related to concordance of multirater questionnaires. Agreement among clinicians, parents, and children has been shown to be moderate at best in clinical samples, with variations by specific disorder (Wood, Piacentini, Bergman, McCracken, & Barrios, 2002). Symptom ratings typically show the best convergence, but conformity among specificity of anxiety disorders is weak (Boyle et al., 1993; Comer & Kendall, 2004; Schniering, Hudson, & Rapee, 2000). There is also frequent discordance between parent- and self-report measures of child anxiety (Kenny & Faust, 1997; Nauta et al., 2004). Such lack of consistent agreement among raters highlights the importance of using multiple sources of data for assessment purposes. The

combination of interview, questionnaires, and observational methods increases validity and reliability of assessment significantly (Southam-Gerow & Chorpita, 2010). Also, report of *symptoms* is considered to be the most reliable form of data from parents and children. Thus, when conducting assessment, clinicians would be wise to focus on questioning about specific symptoms, rather than generalizing about overall anxiety.

Review of measures

A full review of available measures of childhood anxiety, including reliability and validity data for each, is available in Southam-Gerow and Chorpita (2010). In this manual, only the measures selected and used for the FELT manual-development pilot study are reviewed. These measures were selected primarily due to their sound psychometric properties combined with the wider range of norms compared to some of the other, similar instruments. For the FELT development study, norms had to extend at least as low as 5 years of age and at least as high as 11. Each of the specific measures is described in detail within the Methods section above, and include the BASC-2, RCMAS-2, PSWQ-C, and Clinical interview.

Ongoing Assessment

Ongoing assessment occurs during FELT in a number of ways. First, conceptualization continues to develop over the course of treatment, as the clinican gets to know the client better during sessions. Conceptualization is guided by analysis of themes presented through play. This analysis can be a complex endeavor; hence, an entire section below is devoted to discussion of themes in play therapy. Ongoing assessment also occurs through direct monitoring of progress during therapy. For example, a child

with SAD may exhibit extreme nervousness and performance anxiety during the initial stages of treatment. However, as treatment progresses, that child may become observably more relaxed with the therapist and become more comfortable with performance during treatment sessions. In an analogous process, ongoing assessment is also conducted via feedback from the child or parent. Structured feedback sessions are designed to occur after every four sessions of FELT, but non-structured feedback often occurs too. For example, a mother may excitedly comment during treatment that her previously socially anxious daughter made a decision to audition for a solo in a church performance. This kind of positive feedback would provide sound data to the clinician that something about the treatment appears to be working. Common feedback documented as part of the FELT manual development study is shared in CHAPTER 9.

Themes in Play Therapy

[Some content removed here to reduce redundancy with other material within main text]

Relevant play themes to watch for during FELT

Initial response

The initial response refers to the child's play directly following the presentation of the story stem. Possible initial responses may include aggression, denial/avoidance of the stem/situation, help seeking, help arriving (help comes, without child seeking it), self resolution (child resolves problem on own), fear/anxiety, positive content, and negative content. In research conducted by Warren (2003), aggression as an initial response is correlated with parental reports of externalizing symptoms. Additionally, lack of help-

seeking and negative responses to separation predict anxiety (Warren, Emde, and Sroufe, 2000).

Final content

Final content refers to how the child ends the stories. Possible responses are generally divided into positive and negative responses. Non-resolutions are generally considered as negative final contents. It is most desirable that stories be resolved in a positive manner. In the study conducted by Warren and colleagues (2000), negative or non-positive endings correlated significantly with anxiety. Furthermore, aggressive final content generally correlates with both internalizing and externalizing symptoms. As part of final content, final affect should also be noted.

Deus ex machina resolution

Deus ex machina is a Latin term meaning "god from the machine." It is a term that comes from Horace's *Ars Poetica,* in which Horace instructs poets to never resort to a god from the machine to solve their plots. The term refers to a common device used in Greek tragedy that lowered an actor onto the stage as if to represent a god. In literature, *Deus ex machina* describes a resolution of the plot that usually disregards the story's internal logic and allows the author to conclude a story safely and usually more palatably. An example might be that a character who has been captured by the mafia is rescued when aliens suddenly and inexplicably arrive and abduct the captors (when aliens have not previously been mentioned at all in the story), leaving the main character free.

Within play therapy, a *Deus ex machina* resolution is a theme that occurs when a child resolves conflict or affect by simply having it go away. The resolution is interpreted

as being a "cop-out" rather than a positive resolution of events. It represents a lack of knowledge about appropriate coping responses. This theme does not necessarily always occur simply because a "magical" solution is provided. For example, an anxious child may narrate that an anxious character "prays away her fears." If the child says only the above, and nothing more, a *Deus ex machina* resolution has occurred, because there is no logical description to explain what has occurred. However, if the child specifies that prayer worked by helping the child relax through spiritual support, or simply through taking her mind off the anxiety, this would *not* be considered a *Deus ex machina.* Rather, this resolution would be considered a positive usage of a coping skill.

Emotional shift

Any shifts in emotion during play should be noted by the therapist. Furthermore, the means for accomplishing that shift may be informative to therapy. For example, a child that shifts from sad to happy in the presence of parents would suggest that that child values the presence of family. Thus, introducing parental figures in play may be a way to help the child experience comfort during anxiety-provoking story stems.

Incongruent affect

Anytime a child responds with affect that is considered inappropriate or incongruent with the story being told, it should be noted and investigated by the clinician.

Reactions to inescapable fear/anxiety

Some children in FELT develop stories around situations in which fear/anxiety is normative and/or inescapable. For example, one standard stem used in FELT begins with two burglars breaking into a child's home while the child is home alone. This is a

situation in which the child is expected to experience significant fear, and, in fact, a lack of fear may be considered maladaptive. In such a situation, the child may respond by simply acknowledging the fear, which would be a reasonable outcome. However, a child may also deny fear, and may attempt to subdue the robbers on her own, for example. Such a reaction would be considered a negative one, as the scene is intended to invoke inescapable fear (therapeutically, the therapist's goal in such a stem is to stimulate *management* of fear, rather than *escape* from it). As a note, in this example, the child may still choose to subdue the robbers on her own while simultaneously acknowledging that she was afraid. This is not necessarily a negative reaction within the realm of fantasy play (though it would be ill-advised in reality); rather, such a reaction is a means of demonstrating somewhat of an ability to manage anxiety through fantasy. So long as the distinction between fantasy and reality is maintained, subduement of the robbers is not necessarily unhealthy in and of itself. What was unhealthy in this example was the denial of fear in a situation that should always invoke at least some fear.

Danger

In this theme, the child maintains, worsens, or introduces danger, which often leads to injury or aggression and relates significantly with externalizing symptoms (Warren, 2003).

Neediness

In this theme, a child exhibits a preoccupation with fulfilling needs. Needs may be basic (i.e. food, sleep, affection) or more complex (i.e. pride, self-worth). This theme is only important in FELT when needs are *not* being met. Such neediness may highlight

several psychodynamic factors (for example, anxiety about loss of the object). It also may reflect difficulty with self-efficacy.

Labeling of emotions and symptoms

This theme occurs when a child labels her emotions and/or symptoms. A child may identify the emotion by name ("This toy feels anxious") or may identify symptoms ("He has butterflies in his stomach"). Differences in labeling across the course of therapy can often indicate growth. Alternatively, a lack of labeling may warrant an area in need of more work during therapy.

Self representations

The child's "self-toy" or "object of identification" (defined in CHAPTER 1) is always important to note. Often children like to use the same toys to represent the same characters over the course of play therapy. In FELT, the child's selection of a self-toy is specifically used to garner information about the child in Session 1. Furthermore, that self-toy, if selected, is used throughout therapy as needed. Sometimes, a child's object of identification changes depending on the story stem. Thus, some children may vacillate between identification with victim and aggressor across stories. In many cases, the child's identification with a self-toy shares very important information about the child's view of the self. In the Warren et al. (2000) study, children who represented their self-toy as not competent or as having to assume parental roles or responsibilities were more likely to be anxious than those that did not.

"Other" representations

In addition to choosing self-toys, children also frequently select toys to represent other significant people in their lives. Similar analyses as described in "self representations" may also be applied here.

Mnemonic for remembering 11 themes

The following mnemonic is suggested for remembering these 11 themes, "In Finland, Dogs Eat Meat and Eggs. In Rome, Dogs Need Lots of Spaghetti and Olives." Each word in the mnemonic represents the first letter (or first few letters) of each theme, with a few exceptions: "Dogs Eat Meet" is a single theme: *Deus ex machina;* while each "and" and the "of" do not represent themes but simply improve the flow of the mnemonic.

Aggregate of themes predicting anxiety

In a study conducted by Warren, Emde, and Sroufe (2000), an aggregate of seven factors/codes in play therapy were found to predict anxiety symptoms in young children (5-6 years of age). Most of these factors were mentioned separately above. However, they are listed again here, in order to highlight their importance. The seven factors included: 1) not seeking parental help as an initial response, 2) a negative initial response in stories for separation (usually meant the child doll did not separate from parents when this was directed by the story stem), 3) a negative final response, 4) a non-positive final response, 5) child saying he or she felt happy after forced separation in separation stories, 6) not competent self-representations, and 7) self-representations in which the child doll assumed the parent role (parentification of self). For ease of use, these seven themes are

understood in FELT as falling into three broad categories: 1) Non-positive or negative response to or resolution of situations (1-4 above), 2) Non-positive or negative resolution of affect (5 above), and 3) Lack of confidence of the self (6-7 above). Further analysis of these categories suggests that such responding is consistent with the four components of negative affect outlined in CHAPTER 2; that is, each theme reflects some kind of interaction of anxiety sensitivity, anxiety avoidance, anxiety persistence, and reduced self-efficacy. Considering this data, it is *very* important for FELT clinicians to intervene when any of these seven responses are noted during play. When any of these seven responses occur, the therapist should employ direct, play-based interventions to assist the child toward a more favorable direction. Examples of play interventions are provided within FELT session descriptions (CHAPTER 6). It should be noted that sometimes therapist intervention in response to these maladaptive themes may not need to be immediate. This is especially true of the first theme, since it involves an initial response. Usually, it is not advised to intervene at the initial response unless the child demonstrates being "stuck" in that response. Most times, it is best to give the child an opportunity to resolve the initial response on her own before intervening. Additionally, rather than intervene immediately, therapists can allow maladaptive stories to be completed in order to get a full assessment of the child's coping. Then, if necessary, they can return to those stories later and help the child toward more positive resolutions. The key guiding principle in deciding when to intervene is to simply ensure that the child does not completely leave a particular story without having an opportunity to experience a relief from the negative affect in that story.

End-of-treatment assessment

End-of-treatment assessment is a term used here to describe the assessment process that occurs once a decision to end treatment has been reached. Assuming that the decision to end treatment has not occurred prematurely, end-of-treatment assessment focuses on identifying documentable, positive changes in a child's presenting problem. In the case of FELT, this means that all measures administered at pre-treatment are administered again at end of treatment to monitor outcome. By engaging in this process, clinicians can produce data which shows the efficacy and effectiveness of FELT. Furthermore, results can be used to offer clients' feedback about their progress over time. If appropriate, such evidence of progress may be presented to patients as an additional means of promoting self-efficacy. Thus, patients can see visual representations of the "fruits of their labor."

CHAPTER 4: THE THERAPEUTIC NARRATIVE

In addition to using play themes to add standardization to assessment during play, FELT also uses common principles of the therapeutic narrative to help standardize therapy. The design of the interventions used in FELT was influenced by the clinical and research literature regarding the use of metaphor and other evocative strategies in psychotherapy with children (Crenshaw, 2006; Emde et al., 2003; Mills & Crowley, 1986; Pernicano, 2010). Most of the work in this realm comes from the knowledge base of experienced clinicians, who have based their recommendations on techniques they have found useful in their work. Often, the techniques utilized come from a theoretical, albeit empirically-informed standpoint. Rarely (if ever) have specific techniques using therapeutic metaphors been subjected to well-controlled empirical research testing their efficacy and effectiveness at stimulating change. To that end, the majority of the available knowledge base for the types of interventions used in FELT comes from clinical experience, rather than empirical research. Hence, one major purpose of the creation of FELT was to establish a means to test the efficacy of therapeutic metaphors through controlled research.

Mills and Crowley (1986) wrote a frequently cited book about therapeutic metaphors for children. Within that book, the authors described the difference between literary and therapeutic metaphors. They discussed the differential function of the two types of metaphor. Literary metaphors are intended to be descriptive. Therapeutic metaphors, on the other hand, are intended to alter, reinterpret, or reframe something. Mills and Crowley also discussed the difference in what the metaphors evoke. Literary metaphors evoke imagery in order to give the reader or listener a sense of the experience

of the object described by the metaphor. Therapeutic metaphors, however, evoke a relational familiarity, in addition to the imagistic familiarity of the literary metaphor. By "relational familiarity," the authors mean that the therapeutic metaphor should speak to the personal experience of the person who is listening to or receiving the metaphor. In other words, the therapeutic metaphor has personal meaning to clients and relates to their personal experience of their lives. This can also be described as the child being allowed to develop a "sense of identification" with the characters and events portrayed in the metaphor.

Before engaging in the use of therapeutic metaphor, Mills and Crowley emphasize the importance of gathering relevant information that can be used to create metaphors that will be well-received by the individual child being treated. Relational familiarity, after all, cannot be achieved without first having an intimate knowledge of what is familiar to the child. The first step in this process is to elicit positive experiences for the child, which can later be utilized as a "ticket for admission into the child's unique inner world of resources" (p. 86). This is analogous to rapport and relationship-building. It is one way of establishing an environment in which the child feels relatively safe to engage in therapeutic work. Part of this rapport-building stage is the development of positive interactions meant to be used to understand individual preferences of the child (i.e. what kind of characters does this child like, what characters seem to take on the role of bad guy, and so on). Next, based on the interactions that occur during the information-gathering stage, metaphors can be designed such that they reflect the unique personal interests and communication style of the child being treated.

Pernicano (2010) composed a list of characteristics of metaphors that could be therapeutic, and this list has large similarities with the above-described work by Mills and Crowley. Pernicano wrote that therapists should "select and use a story:

1. With a character that resembles the client in some way based on personality, behavior, or diagnosis
2. Whose theme is parallel to some event in the client's own life
3. That portrays a character with the client's struggle, ambivalence, or decision area
4. That models someone solving a problem similar to the client's
5. That models a character coming to some insight about his or her life (client has need for insight in that area)
6. That plants a suggestion the therapist sees as potentially useful for the client (to get past resistance or help client see something in a new way).
7. That gives the client or family a message the therapist would like to give but the therapist suggests it will be rejected if offered "directly"
8. That gives a child opportunity to notice his or her parent's behavior in the story
9. That gives a parent an opportunity to notice himself or herself in the story
10. That gives a parent an opportunity to notice his or her child in the story

11. That gently opens up as-yet unrecognized, non-conscious emotional material." (p. 3-4)

These eleven characteristics can be mixed and matched to inform the development of metaphors to be used in therapy with children. A major part of the FELT approach is to ensure that therapists understand the above characteristics of therapeutic narratives and that they can apply directive interventions to guide (but not coerce) therapy toward healthy directions. A rating form to measure therapist fidelity to this approach is currently under development.

The astute reader may note that the essential components of the therapeutic narrative mirror the components of an effective exposure therapy. Thus, the "relational familiarity" of the therapeutic narrative is analogous to the principle of exposure. In fact, the very identification with the story is a form of exposure in and of itself. Additionally, the narrative is only therapeutic if it models or suggests a course of action which leads to a healthy outcome. Similarly, exposure therapy is only effective if the emotional response that occurs during exposure is allowed to dissipate to a manageable intensity. In both cases, the major therapeutic aspect is in the positive resolution of the initial emotional response.

Story stems in FELT

Because of the empirical support behind story stems (discussed in CHAPTER 3), FELT utilizes a story-stem approach as the intervention of choice with children. In FELT, however, rather than using story stems solely to inform therapy, which is the role they typically fulfill, the stems actually facilitate and stimulate therapy. Thus, FELT is

composed of 12 sessions, each of which contains a number of story stems that are introduced to the child to complete within therapy. Each story stem contained in each session is intended to evoke a particular theme consistent with the goal(s) of each session. The research associated with the MSSB, as well as the works regarding therapeutic narratives, cited above, are used to inform the construction of each stem. The benefit of using story stems, rather than full therapeutic stories, is that stems allow children an opportunity to provide their own input to the therapeutic story. In beginning stages, such an input allows clinicians to evaluate typical responses utilized by the child in anxious situations. As therapy progresses, however, and as the child learns healthier responses, the child herself can begin to formulate therapeutic outcomes of her own, thereby minimizing the child's reliance on the therapist to produce a healthy narrative. The therapist's role in responding during each story stem is informed by the therapeutic philosophy outlined in this manual as well as by the goal(s) of each session.

A note about flexibility within play therapy

The "Play-Therapy Decision Grid" (Crenshaw & Mordock, 2005) is a tool that also partially informs the process and structure of FELT. Crenshaw and Mordock describe a need to cater the pace of therapy to each individual child client's needs and ego strengths. Children differ among each other as to their readiness to engage in therapy that can at times become quite strenuous and emotionally demanding. The same child may even differ across sessions, or even within a single session, about his or her own readiness to engage. Crenshaw and Mordock, then, describe two "tracks" of therapy that may be chosen based on an individual child's readiness at any given time. The Coping Track is described as "primarily psychoeducational, with emphasis on teaching adaptive

defenses, pro-social and problem-solving skills, and building genuine self-esteem by highlighting strengths" (Crenshaw, 2006, p. 33). It is the track reserved for the child with weak ego resources, that is, one who is less ready for more intense work. The Invitational Track, on the other hand, is described to involve "more direct work with painful or trauma-related events" and "should be undertaken only after the child has been carefully assessed and judged to be ready for this more challenging and emotionally taxing level of therapy" (Crenshaw, 2006, p. 34).

The two tracks described by Crenshaw and Mordock (2005) are seen as hierarchical in nature, where the coping approach is meant to stabilize a child emotionally and functionally and the invitational approach is meant to evoke change (the terms, thus, are similar to the supportive-expressive continuum in psychodynamic psychotherapy). Crenshaw (2006) rightfully describes the decision to move toward invitational work, or to return to coping work, to be an ongoing process. Therapy with each individual child often moves back and forth along this continuum as guided by the child's reactions to therapist attempts at invitational work. Within clinical work, this "negotiation" is wise practice. However, manualized approaches used in research often avoid such flexibility, since the therapeutic process should be as similar as possible across all subjects. Thus, such a "back and forth negotiation" may inject too much variance into the therapeutic approach. This is where a "manual-based, but flexible" approach becomes necessary (see Kendall, Chu, Gifford, Hayes, and Nauta, 1999). FELT approaches this flexibility by making a contextual approach a hallmark of the manual. Furthermore, the ACER therapist characteristics require attuned responsiveness to clients' needs, which, in turn, requires some negotiation at times of how intensely to apply invitational therapy. Therefore, some

measure of flexibility is an inherent part of FELT, and is perfectly consistent with the FELT manual. In fact, to lack flexibility, and to simply follow session scripts without attention to the needs and direction of the child, is absolutely proscribed by and counter to the tenants of this manual.

CHAPTER 5: PREPARATION

The following materials will be necessary throughout the course of FELT. The table below lists a generic category description of necessary objects on the left, with a specific description of the objects actually used in the development of FELT on the right.

Table 4. *List of Items/Toys Needed for FELT*

Category	Specific
People toys	Multiple adults, male and female; Multiple children, male and female; Doctor(s); Police; Robbers
Buildings	Clinic; House; School; Tent; Fences; Cage
Plants	Trees; Flowers; Bushes
Animals	Gorilla (A, B); Elephant (A, B); Zebra; Lion; Tiger; Alligator; Snake; Rhinoceros; Bear; Horse; Peacock; Birds; Dogs; Rabbits
Furniture/Tools	Tables; Chairs; Desks; Computer; Playground equipment; Kitchen tools; School-related tools; Medical supplies (casts, scalpel, shots, etc.); Nurturing supplies (i.e. food, bottles); Valuables (jewels, crown, painting, etc.); Weapons (knives, gun, clubs)
Vehicles	Jeep; Convertible spy car
Other	Stethoscope (2); Blue cloth; Partitions (i.e. folded cardboard); Large, stackable blocks; Large piece of paper (tall enough for 5 stackable blocks); Sticky notes

CHAPTER 6: THERAPIST PROTOCOL FOR 12 FELT SESSIONS

All sessions

It would be impractical to allow space within this manual to describe within each individual session steps the therapist should take toward continuously building and solidifying rapport and the therapeutic relationship. Therefore, it should be understood from the onset that the continued development of the relationship between child and therapist is of utmost importance and should always remain a focus of the therapist during every session. Also, the reader is reminded here that the 3 characteristics of play therapy and the ACER therapist characteristics (see Chapter 1) should be maintained as well throughout every session. Finally, the therapist should exercise clinical judgment in executing and responding appropriately to the activities described in each session.

Also, in all sessions, a certain amount of free play and exploration by the child is permissible. If a child seems eager to play with the toys on her own, you may allow this, as long as you are maintaining fidelity to the treatment core values and session goals. For example, it is expectable that a child may initiate some fantasy play that keys in to an anxious issue for the child, even before you intended to discuss that issue in therapy. If this occurs, you should respond accordingly and follow the child's lead in helping her with that issue. Do not discourage this kind of play simply because it occurs "too early" in therapy. However, you should not deviate from the play modality in responding, as doing so is imperative to maintaining fidelity to the manual. If a deviation occurs, it should be documented.

Each activity and story-stem requires certain toys. As much as possible, the child may be allowed to choose which toys she wants to use in the story, with the stipulation that the therapist tells the child what kind of characters are needed. For example, if an activity requires a "child" toy, the child may choose which toy she wants to use to be the "child" in the respective activity. This should be allowed as long as the child is not consistently spending inordinate amounts of time choosing her toys. If the child has difficulty choosing, the therapist may assist by reducing the amount of options (i.e. choose from 2 child toys, instead of 4).

The therapist should expect the child's play to exhibit certain themes, some positive, some maladaptive (as discussed in CHAPTER 3). Therefore, the therapist should be prepared to note themes associated with each play scene, as awareness of those themes will help the therapist decide how to intervene appropriately. Some therapists may have enough experience and skill to note those themes mentally. Others may prefer some kind of manual notation. In FELT, therapists are encouraged to use whatever notation method seems most helpful to their work with each individual child being treated with FELT. It is suggested that beginning therapists do some form of manual notation over time to help them become accustomed to searching for themes. This notation may be done post-session or during sessions. Some examples of thematic notations and associated interventions are provided as part of session descriptions.

Adapting play to the interests of the child

Session descriptions have been written from the basis that toys are used to create scenes and therapeutic narratives. However, occasionally, some children may express

dislike of the particular toys available. When this occurs, reasonable efforts may be made by the therapist to adapt the modality of play to fit the specific interests of the individual child. For example, if available to the therapist, puppets may sometimes be used in FELT without detracting from the basic approach of using story stems to direct fantasy play toward therapeutic interventions. Similarly, art approaches may be used. For example, one participant in the FELT development study stated she did not like the toys being used, and, as a result, struggled significantly in her ability to formulate therapeutic fantasy narratives with those toys. This particular participant, however, loved to draw. So, to adapt FELT and make it more palatable and useful for her, the therapist had her draw pictures of a scene and then engaged in telling therapeutic narratives about the characters in the picture. In the case of this particular participant, this adaptation of FELT marked a stark change in her participation in therapy and her subsequent ability to benefit from the therapeutic stories. Both the client and her mother noted that when the change was made to using "pictures," instead of toys, the client became more excited about coming to therapy, which resulted in noticeably better internalization of the lessons learned during each session. Therefore, a key guideline for therapists as they proceed through the session materials that follow is to remember that the guiding principles of FELT as outlined in previous chapters take precedence over what materials are actually used when conducting therapy. As long as FELT principles are followed, the actual mode of fantasy play used can be changed as needed in order to achieve maximum participation and enjoyment by the child.

Session 1

Purpose: To get to know one another. To explain and model basic information about the treatment. To begin to gather information about situations that make the child anxious and the child's reactions to signs of anxiety.

Goals:

1. Build rapport
2. Orient child to the program
3. Gather information about child's preferences and style of play and communication.

Methods:

Begin by introducing yourself in a calm, child-responsive manner. Anxious children are often avoidant, fearful or wary, and may not be comfortable with direct questions made too quickly in the course of therapy. As therapist, you should be attentive to the child's cues and should approach in a manner that is respectful of those cues. Once a basic introduction is made, ample time should be devoted to establishing a trusting relationship in which the child can begin to feel safe when in your presence as the therapist.

At some point during the first session, you may verbally orient the child to the structure of the FELT. When the child seems ready, you should communicate 3 "rules" about the play therapy, in order of importance:

1. Everyone must always be safe, all the time.

2. The therapist and the child both get to decide what feels safe and what does not.

3. (Communicated as the therapist begins to prepare the first story stem) "You can play anything you want, as long as you use the toys I give you and as long as you finish the story in some way."

The purposes of these 3 rules are as follows. First, it is made clear that the therapist is concerned with helping the child feel safe. Second, the therapist communicates that the child's point of view matters, and that the therapist will respect the child's fears when appropriate. Third, the general structure of the play intervention is described. Structured free-play is encouraged.

Activity 1: Getting to know each other

Rapport may be built in whatever way feels comfortable for you and for the child. The following exercise is suggested, as it simultaneously meets all 3 goals of this session.

To begin the session, allow the child to sort through all of the toys that may be used throughout FELT (listed in CHAPTER 5). The child is told that she is going to play a game where "I (the therapist) get to learn about you. Instruct the child to "Choose a toy from the box that will tell me about you." If the child asks to choose more than one toy, this is permissible. While the child is searching, consider toys to choose to represent yourself, but do not make your choice until the child has settled upon her own choice(s). You should not offer comments while the child is choosing, but should be responsive to any questions or comments the child makes herself. The child may play with or explore any of the toys briefly, but if this detracts too much from the task, a gentle reminder may

be applied such as, “Is that the one you wanted to choose to be you?” Once the child has chosen, make benign inquisitions about the toy, using your own toy to speak to the child’s toy (except for the first question, see below). The following are some potential questions/invitations to ask:

1. As therapist (not as toy you chose) open with “Tell me about this toy.” (if necessary, add, “…and how it is like you.”)
2. (Using toy) What’s your middle name?
3. How old are you?
4. How many brothers and sisters do you have?
5. What’s your favorite TV show?
6. Do you have any favorite heroes (or superheroes)?
7. And so on.

The child may ask you similar questions about your own toy. Be prepared to provide answers as appropriate.

Make a note of the toy chosen by the child as the self. This toy will be used throughout FELT to represent the self in other story stems. This toy will be referred to as the “self toy” throughout this manual. The child may also ask if she can pick toys to represent his/her family members. The child may be allowed to do so if she asks.

This exercise builds rapport in that it should be fun for the child to explore all the toys. It also orients the child a bit to what therapy will be like, in that she will be using toys to represent other things. It also sets a precedent that the therapist will be curious/concerned

about the child. Finally, it provides information about the child that can be used later in therapy (based on how she describes herself in describing the toy).

Activity 2: Introduction to therapy

Now is the time to begin to introduce story stems, as they will be used throughout FELT. The first story stem is meant primarily to orient the child to the program. You will want to make the following points during this activity:

1) The program is a joint effort between the therapist and child

2) There are reasons the child is coming to see the therapist, which may be described with some variation of any of the following:

   a. "Some kids need help with ____, and I am here to try to help them…"

   b. "All kids worry about something. My job is to help them figure out what they worry about and try to help them not worry so much."

3) Begin to discuss goals for treatment, including being able to identify anxious feelings and making sense of how those feelings fit into the child's life.

4) Stress that the child's point of view is very important.

To make these points, the following story stem was designed:

Toys needed: Child's self toy, therapist's self toy, Clinic, other environment-specific toys

Introduction: [As you collect relevant toys] "When you come here to see me, we're going to do something special. Often when you come here, I'm going to take certain toys from this box, and I'm going to make up a story for you to finish for me. I'll start the story, and

then it will be your turn to tell me how it ends. We'll play with the toys together until we both feel like the story is finished. Let's do the first one now so you can get an idea of what it's like."

Story: The point of this story-stem is to attempt to recreate the child's experience of entering the current treatment environment. Thus, extra toys may be chosen as necessary to help simulate any child-specific or environment-specific factors (i.e. if the child was seated with the mother before coming into therapy, you may ask the child to help you choose a "mommy toy" to be the mother in this story). The first part of the story stem will be to set up the toys to reflect how you met the child (that day), how you retrieved her from the waiting room, and how you brought her back to the therapy room. Thus, the first part of the story stem will vary depending on the environment and how the child reacted and so on. You will narrate the story as you remember it, using the relevant toys to enact the scene. The child may change features to match her own perspective, and this should be allowed and responded to accordingly. After the characters move inside the Clinic, the following story stem should be played:

[Key: T=Therapist's self toy; C=Child's self toy]

T: "Hello [name]. How are you today?"

C: "I'm okay, but I'm not sure why I'm here."

T: "You're not? Well, do you know what I do?"

C: "No"

T: “A lot of kids worry about things. My job is to help them figure out…” [see points and variations above]. Why don’t you tell me about what you’d like to do in here…”

[Hand over control to child by saying] “Now you finish this story.”

As the child finishes, you should be responsive and interact as necessary, helping to make the points listed previously. Use the play to communicate treatment goals and how story stems will be used to address those goals.

Activity 3: A happy time

Builds rapport. Introduces task of playing about feelings, but uses a “safe” feeling.

Toys needed: Child chooses

Introduction: “Let’s play about a happy time. Let’s choose some toys to play a happy time. What kind of happy time do you want to play?”

Child may inquire if the happy time has to be personal. This activity does not require the happy time to be about the child. This is simply any happy time.

Work with and follow the child to create a happy scene. Have the child narrate you through what happens, as the child simultaneously enacts the narration. Her scene may be very detailed or may be quite basic. Make a mental note of how skilled the child appears to be at engaging in fantasy play. “Good” players are expected to benefit more from play therapy than “poor” players. If the child is a “poor” player, you, as therapist, may need to take a more directive lead throughout FELT to engage the child in play and teach the child important play skills. Thus, the information you obtain about the quality of the child’s fantasy will serve to inform your therapeutic process later.

Session 2 – "Feelings are important"

Purpose: To review goals of treatment. To help the child identify different types of feelings and to distinguish anxious, worried feelings from other kinds. To normalize feelings of fear and anxiety. To explore the child's sense of anxiety.

Goals:

1) Introduce that different feelings have different expressions
2) Normalize fears and anxiety
3) Begin to construct anxiety hierarchy

Activity 1: A positive feeling

Introduction: "Remember last session when we ended by playing about a happy time. Today, we are going to do something similar, but this time, we will play about other kinds of feelings. Let's start with a good feeling. What are some different kinds of good feelings?"

For some children, it may be helpful to provide a list of potential feelings from which the child can choose. During the treatment development study, the following feelings were most frequently used, but other positive feelings may be chosen by the child if desired.

1) Excited
2) Loved
3) Playful
4) Surprised

Be sure to have the child label how she knows she feels the chosen emotion. You may ask, for example, "What does excited feel like?" or "What happens inside [the character's] body when he/she is excited?" Also be sure to leave enough time in the session for activities 2 and 3.

Activity 2: Worry time

Introduction: "We just played about times when kids are [happy, excited, loved, playful, etc.]. But sometimes kids get scared feelings too. Sometimes they worry about things. All kids do it. I'm going to start a story about a time when a kid might be worried, and I want you to finish it for me."

Toys needed: Child, mother, father, dog, table, container (for juice)

Story Stem (Spilled juice): The child is playing with his dog. Says to self, "I'm thirsty." Picks up cup and spills juice all over the floor. Says "Oh no. Mom and Dad are going to be mad. I hope they don't find out!" Immediately afterward, mom and dad enter. Child finishes story.

Questions to ask/points to cover. These are not questions you should necessarily ask the child, per se, but you want to garner this information through the play

1) What did the child think would happen?
2) What did he feel?
3) How did he know he felt that feeling?
    a. May include an internalized "sense" of the feeling, somatic cues, behavioral manifestations, etc.

4) How did he act in response to how he felt?

5) Be sure to differentiate the child's feelings in the spilled juice story from those described in the "positive feelings" story.

If anxious themes arise, and the child does not herself do anything through the play to resolve those feelings of anxiety, the therapist should use suggestions in symbolic play to model how the child might address her anxiety. For example, consider the following scenario:

Example 1:

The child finishes the story as follows, "The boy blames the dog. Parents scold the boy. Boy insists the dog did it. Parents ground the boy for lying. Boy kicks the dog as he walks to his room."

Several themes are apparent in this scene. First the boy shows anxiety, and copes by denying himself the experience and propagating blame elsewhere. His parents are misattuned and fail to respond to the child's emotional needs by simply punishing the behavior without making an effort to communicate attunement, concern, and responsiveness. As a result, the boy becomes more distressed. Not knowing how to manage that distress, he kicks the dog in frustration and leaves the situation.

So, in summary, the therapist should note maladaptive themes of anxiety, subjugation/avoidance of the anxiety, punitiveness (the boy expects it and the

parents execute it), lack of responsiveness, and finally, surrender (that it won't get better, so just give up and leave). Given these themes, the therapist should now strive to develop a play-based intervention that introduces alternatives to the child. In the current scenario, a primary source of the problem is the parental misattunement and lack of responsiveness. If this problem is a recurring one in the child's life, the therapist should expect to work with the parents to instruct them how they may respond better. Accordingly, part of the intervention in the current play can model for the child what the therapist may do with the parents to teach them how they may help the child.

So, the therapist may introduce another character in the play, preferably the "therapist-self" toy, although others could be used. That character may come speak to the parents about what happened, and may talk with them about the child's experience and teach them how to respond better.

Therapist: "I was watching everything and I wonder if maybe [name] spilled the juice on accident and then he got really worried that he was going to get in trouble. I don't think he knew that it was okay to be that worried."

Parents: "He was worried? Then why didn't he just tell us? Instead he lied and then hurt the dog."

T: "Well, I wonder if maybe he just didn't really know. Do you think he was just thinking about the mess he made? Maybe he was so worried you'd be mad that he couldn't even figure out what to say? Maybe there is some way we can all help him figure it out? Why don't we try the scene again and see how we can help."

Then, the scene can be repeated, with the therapist guiding the parents and child toward a healthier resolution. Similar interventions should be repeated as necessary throughout FELT.

Activity 3: Client-specific anxiety

Introduction: "We just played a scene that I made up where the boy in the scene was worried. Now I wonder if maybe you want to try to make one up? You can use any of the toys to show me what "scared" or "worried" is like. What do you think?"

If the child agrees, proceed accordingly, helping to set up the scene as you did for the happy scene. As above, if maladaptive responses to anxiety become apparent through the play, respond accordingly. Example 2, below, shows a potential response and intervention by the therapist.

If the child disagrees, or detracts from the task in some way, it could be a sign that the child is not yet ready to explore such an avenue into her own negative emotional state. If this occurs, reassure the child that that is okay, that maybe she will want to do one later, and that she can let you know if she changes her mind. Then, offer a second scene of your own. You may use the one described in Example 2, or you may create one of your own. If you do create one of your own, you should avoid creating a scene that you might expect to relate too directly to an anxiety-provoking reality for the child, as she has just made clear that she is not ready to delve into her own realm just yet.

Example 2**:**

Toys used: Alligator, snake, gorillas (adult and baby), tree, fence

The child creates a scene where the baby gorilla is positioned inside the tree trunk, with the adult gorilla watching closely. A cobra is wrapped in the tree above, with his head lingering above the gorillas. The alligator is positioned in front of the tree, also glaring toward the gorillas. A fence separates the alligator from the others. The child says about the scene. *"The baby monkey is hiding in his house from the alligator. The fence is keeping the alligator out, but the baby is still scared and she doesn't want to leave. The mommy monkey says she wants the baby to come out and play, but the baby is too scared. She doesn't know it, but there is even a snake above her just waiting for her to come out."*

In this scene, the following themes may be noted: fear, limited protection, nurturance and concern (by parent), fear of the unknown, feeling "trapped" by fear. The therapist may respond by discussing some of these themes with the child by asking or "wondering" about the characters in the scene. You may say, for example, "That baby gorilla looks so scared it's like she can't do anything. She's afraid of the alligator, and even though she doesn't know the snake is there, she's afraid it might be. So I bet she thinks it's just safer to stay inside where nothing can hurt her. Hmmmm? I wonder how she will ever feel okay with all of these things out there." You may then follow-up by saying, "Hey, I have an idea about what we can do with this alligator. I have a cage that it can't get out of it. Let's put it in that where it can't get to the baby. [You put the alligator in a cage].

There, now the baby is safe from the alligator. Now, what about this snake though? What can we do with it?"

In this case, the child is given a chance to decide what to do about the snake. If she does not come up with a solution, you may offer some options (i.e. the snake can be baited away with a tasty treat, the mother gorilla beats up the snake, a blanket is place over its eyes so it can't see, etc.). In some cases, the child may decline all options, as a way of communicating a sense of hopelessness. If this occurs, you should take an emotion-focused, rather than problem-focused approach, and empathize with the baby gorilla's predicament and construct a "container" for the baby's emotions ("Whew, it feels like there are some things no one can fix. That sure must be hard. No wonder baby needs her mommy close by! Does mommy know how hard it is for baby to feel like that? I wonder if baby just needs a hug from mommy, instead of being asked to come out. Maybe if mommy holds her long enough, baby will start to feel safe again."). This intervention, or some similar variant, is constructed to communicate an understanding of the intensity of the child's fear and a willingness to help her figure out how to manage a feeling of such intensity. <u>It is often necessary early in therapy,</u> before a child has learned coping skills or been able to internalize some of the therapeutic interventions<u>, to acknowledge that fear cannot always be eliminated, but that, over time, the child can expect to find hope in being able to manage and cope with it.</u>

To close the session, review the session with the child. Review how you talked about several types of feelings, both positive ones and scary ones. Highlight that the point of

the play was to show how feelings are important, and worth paying attention to. Use your play interventions as an example of how the importance of feelings means that feelings of anxiety need to be attended to.

Session 3 – Somatic anxiety

Purpose: To review and elaborate distinguishing anxious feelings from other types of feelings. To learn more about somatic responses to anxiety. To introduce relaxation training (through play).

Goals:

1. Help the child become aware of different signs of anxiety
2. Help child relax herself
3. Help child relax herself in an anxious situation

Activity 1: Signs of worry

Introduction**:** "Do you remember last time we played about times when kids have different feelings like happy, excited, and worried [insert any other emotions played with particular child]? Today, we are going to do some more of that. What feeling do you want to start with?"

It might be helpful to have available a list of different kinds of feelings.

The child may play whatever feeling she chooses. For the chosen feeling, repeat the activity as done in *Session 2,* ensuring to cover the relevant points as listed under the "Spilled juice" story stem. Be sure to focus on bodily sensations cueing to the feeling, in addition to whatever other signs may be displayed or described.

After the child has played her chosen feeling, you may invite her to play a "worried scene" (provided below, that is, if she did not already choose a worried scene on her own). Repeat the sequence as before. Focus your play interactions on helping the child

identify somatic signs of worry. You may choose to do so by modeling with a character of your own (i.e. speaking as a toy character, "I feel scared. I have butterflies in my stomach. My hands are shaking. My face feels flushed.") or by inquiring to the child directly (i.e. "How does her [the toy being used as the object of identification] body feel when she is scared? Does she feel it in her stomach? Her hands? Her face?"). You should help the child differentiate these feelings from those associated with happiness or excitement (as played earlier).

The following scene is provided for use if the child does not come up with her own story about anxiety [*Note: The following scene is meant to elicit an obvious and strong sense of fear. If the scene is similar to any occurrences in the child's real life or if the child has shown a strong negative reaction to past attempts at confronting fear within therapy, sound clinical judgment should be used in determining the appropriateness of using this scene in the current session. In those cases, such a scene may be better withheld until later in treatment*.]

Story: Robbers

Toys needed: Child, 2 robbers, 2 parents, chair, computer, valuables, thieves' kit

Story stem: If a play house with at least two rooms is available, it should be used for this story. If no such house is available, partitions are placed to create two rooms. In one room, a chair is set up in front of computer. In the other room, place valuables. To start, the parents are standing next to each other, and both are facing the child. All are standing within the room with the computer.

Key**:** D= Dad, M=Mom, C=Child, R1=Robber 1, R2=Robber 2, N: Narrator

D**:** Okay son, I'm going to work. You have a good day with mom. [Dad leaves]

C**:** Okay, bye dad.

M**:** Son, I'm going to go outside to work in the garden. You stay here and play on the computer. If you need something, just come out and get me. [Mom leaves]

N**:** So the boy goes to play on the computer. After a little while, 2 robbers come in the other room to steal [whatever valuables are used]. They come in through a window, but they don't know the boy is just in the other room. When they start to go through things, the boy hears a noise. What happens next?

The child should now be allowed to finish the story. Respond appropriately as described previously. If/when signs of anxiety occur within the play, the therapist may use one of the adult characters to suggest some relaxation techniques (deep breathing, progressive muscle relaxation, etc.) that may be helpful to the child character, and the child may be asked to perform those techniques along with the therapist. For example, after the robbers have been taken care of in the above scene, the parents may rejoin the boy and discuss how scared he must be and may coach him in how to calm down.

Note: It is hoped that the child will be able to identify some signs of fear in the boy. Regardless of how the boy responds (he may flee in terror, call for his mom, call the police, or beat up the robbers all on his own), you should attempt to elicit some reference to the boy's bodily experience of anxiety that occurred before,

during, and after his response. You should also help the child differentiate these feelings from those associated with happiness or excitement (as played earlier).

Throughout this activity, you should monitor the child for signs that she may be starting to feel overwhelmed by her own anxiety. If this occurs, you should respond to the child's immediate emotional needs in a manner that is consistent with the play modality and ACER characteristics. You may, for example, say something similar to the following: *"Whoa, even though this is all pretend in here, it still seems like it is a little hard for you and that you are having some of these scared and worried feelings even right now? You know, I noticed you were worried because I saw _____. I wonder if you noticed that. [Give child chance to respond]. Do you think maybe we can use the toys here to figure out how to get back to feeling okay? I'll be you and you be me."*

By switching roles, the child is immediately allowed to be placed into a role where she can be calm and collected while you take on the child's anxiety. Also, by taking the child's anxiety, you can demonstrate attunement by naming how the child might be feeling. You also serve as a "container" for the child's anxiety, which allows the fear to be present without "overflowing" and overwhelming the child. Finally, the child may be able to suggest coping skills, which are likely to help solidify her own coping mechanisms. Each of the roles are also allowed to be fluid, meaning you and the child may switch back and forth between roles as necessary and/or you or the child may offer direction to the "actor" in the other role (i.e. child says, "No, I get shaky when I feel worried," or you might say, "Hey, I wonder if you told me to_____ I would feel better").

Activity 2: Child-specific anxiety story

If the child did not already provide one in Activity 1, she may now be given an invitation to create a story/scene that specifically resembles a situation that gives her anxiety in reality ("Now let's play a time when you have been worried before"). You should start by asking the child if she would like to make up that story on her own or if she would like you to help. In the event that you must create a story on your own, you should be prepared with a scene or story stem that reflects an area of struggle for your client. That narrative should be formed using the principles outlined in CHAPTER 4 of this manual.

Interventions as described previously may be used as necessary during this process. *Additional* questions to ask may be:

1. Does the child in this story feel the same, better, or worse than the child in the last story? (This helps the client begin to differentiate between different levels of anxiety)
2. How does the child know if she has "too much" anxiety? Or when it is "not too bad"? (This helps the child begin to delineate which levels of the hierarchy are manageable and which are not)
3. How does the child calm down? Or how does the child keep the anxiety from getting "too much?"
    a. Within this realm, you may make suggestions for how the child can calm.

Closing remarks

Before the close of the session, the child should be notified that the next meeting will be held between the parents and you, but that this will not replace the child's time with you. The child is informed that this process is designed so that you can teach the parents how they can help the child too. You should also tell the child that she may expect the parents to participate in some joint sessions at some point as well, so that they can learn even better about how to help her with her anxiety by watching how you help. You should gauge the child's reaction to this possibility and answer any questions she may have about what role the parents may play (the parent component of FELT is outlined in CHAPTER 7).

Session 4

Purpose: To introduce relaxation training. To review somatic cues that show the child is anxious

Goals:

1) Acknowledge parent session
2) Review somatic feelings of anxiety, with a focus on muscle tension.
3) Teach relaxation through symbolic play

Activity 1: Talking about the parent session

Briefly tell the child you met with the parent(s) as planned and offer reassurance (if applicable) that they seemed happy to learn about how well the child is doing and they would be proud of the skills she's starting to learn. Explain that today the parents are going to be invited for the end of the session so that you and the child can show them and tell them the story you create today. Tell the child that the story will be about relaxing and that it would be good for the parents to know it so that they can help the child practice at home. Invite and respond to questions appropriately.

Activity 2: Physiological reactivity

Introduction: "So, all the other times you've come here, we played with toys to make stories and scenes about different things. This time, I thought that instead of using toys, we could make a story where you and I get to be the characters. What do you think? Let's give it a shot. I know last time we played about times when you were worried and we talked about how you know when you are worried and you said that you _____. Those

are times when you are not relaxed. Let's see if we can do something silly that will make your body feel jumpy, kind of like when you're worried. I wonder if we can make your heart beat fast and make your muscles tighten and maybe even make your face feel flushed."

You may choose to exercise with the child by doing jumping jacks, running in circles, doing push-ups, sit-ups, etc. You may also perform a silly dance with the child or do some other lively activity. Only do the activity long enough to produce a noticeable physiological change. If you are unable to participate in these activities with the child due to physical or health reasons, you may simply watch the child. If the child is unable to perform these activities for physical or health reasons, skip this activity and move to the next, making accommodations as necessary.

Also, for this activity, it is suggested that you use a stethoscope and stopwatch (or clock) to measure heart rate immediately after exercise. Typically, the therapist keeps one inexpensive stethoscope for use by children and uses another stethoscope for himself. Both child and therapist count number of heart beats for 30 seconds, and then therapist multiplies by two to determine beats per minute. It is preferred that the child become accustomed to measuring her own heart beat, since doing so will help reinforce taking notice of her own physiological state. Furthermore, taking physiological measurements is a useful exercise in that it also provides a quantitative measure of physiological arousal that can be used to show children how arousal can be manipulated with relaxation (see next activity). If a child has difficulty counting her own heart beats, you may consider listening with her and counting for her. However, it is still recommended that the child practice listening to and measuring her own physiological arousal as much as possible.

Activity 3: Relaxing

Introduction: This story is going to be about relaxing. Let's make up a story about being happy and calm and relaxed. Do you have any ideas to start?"

This story will best serve its purpose if it is individualized to the client. Therefore, no stems or examples are provided here. Each child should have his or her own idea about what constitutes a happy, relaxing, or calm scene. As therapist, you should work with the child to develop a story that is relaxing for her. You should each describe the scene with as much detail as possible. Try to provide only as much direction as the child obviously requires. Your primary role in this activity is to follow the child's lead and commands toward a relaxing scene. The story can be simple and descriptive (perhaps the child describes a relaxing beach and nothing more) or can be relatively complex, with a beginning, middle, and end, following a specific plot. The only requirement is that the story be about relaxing. If necessary, you should elicit sensory features (smells, sounds, colors, etc.) of the relaxation story as well.

Immediately after the relaxing story is complete, ask the child about her experience – whether she feels different now than she did just before the story, what feels different, etc. Discuss the differences briefly. Then, transition to the next activity.

If heart rate was recorded after the previous activity, you should record it again to show the child how much her heart rate slowed after the relaxing activity.

Note about physiological reactivity and relaxation: Some astute children may "catch on" that they do not actually require a relaxation story to calm their physiology; rather, their heart rates slow simply as a result of ceasing exercise. For this reason, children should

always be instructed that the activities completed in session are meant to *practice* for when anxiety actually occurs. Thus, the first activity is used to *mimic* what happens to the body when people become afraid, and the second activity is used to *practice* telling a story to help relax the mind and body when somatic reactions to anxiety occur. Using practice helps children become good enough to be able to use the skills when they really need them.

Activity 4: Progressive muscle relaxation story

Introduction: "Hey, you know what I realized. A few minutes ago, we were all worked up. Our hearts were racing, our blood was pumping hard, and [any other signs mentioned]. Then, we did the relaxing story and everything went back to normal. That's pretty cool. I wonder if we can do the same thing when you feel worried. This time, I'm going to make up a story about "Worrying William" (for boys) or "Worrying Wendy" (for girls). It will work a lot like when we use toys, but this time, we'll just use our words instead. I'll start the story, and then I'll ask you to finish it. Ready?"

Next, you will tell a story that sets up your client into a scenario that has been revealed as being an anxious situation for the child. The story should utilize symbolic fantasy, and should follow the same procedures as any other therapeutic narrative used in FELT. Three example stories are provided after this session as guidelines. Each was written for and used with children who participated in the treatment development study.

After the story, you should ask the child, "Do you have any ideas how William/Wendy might calm down?" Hopefully, the child may suggest using the relaxation story created earlier. If the child does not spontaneously make this suggestion, you may lead the child

toward that idea (i.e. “Remember that story we told earlier about relaxing?”). Once the child mentions the relaxation story, tell her, “That’s a good idea. I bet he *could* do that. Let’s tell another relaxation story for William.”

After the relaxation story is told introduce the idea of progressive muscle relaxation. Say, “*I think William feels almost relaxed now, but I think he needs one thing. Did you know that sometimes when people worry too much, their muscles get all tight without them even knowing it. I wonder if we can make up a story or a game that will help William loosen up a little. Do you have any ideas?* [Allow response] *If not, I have one. It’s called ‘Righty Tighty, Lefty Loosey.’ Do you know how to play?”*

You may then teach the child how to play, which basically involves a systematic effort to first tighten muscles on the right side of the body while keeping those on the left loose and relaxed (and then switching after a count to 5). With each muscle, you alternately tighten and loosen each side for a 5-count each time. The game is for two (or more) players, and players take turns calling out a muscle to be tightened. The game can become fun/difficult by calling out muscles that are difficult to contract (i.e. ears).

After the game, review the reasons for the game and how it may be used therapeutically when indicated. Be sure to emphasize that the game helps the child learn how to *relax* certain muscles, which she may need to do when feeling anxious. With some children, it may be particularly helpful to use imagery regarding their somatic symptoms. So, I child who gets “knots in her stomach” when nervous, can practice “untying the knots” with her stomach muscles. Similarly, that child may “catch the butterflies” in her stomach using

her stomach muscles. Some children even enjoy counting the butterflies as they catch them.

Activity 5: Parents

To close the session, invite the parents to join you and allow the child to share his relaxation story and the "Righty Tighty, Lefty Loosey" game with them. Be sure to cover the reasons/indications for the techniques and encourage the parents to help the child practice the techniques at home or with friends.

Worrying William/Wendy Story Stems

Storms

Wendy was a little girl who loved being outside. She loved to lie outside and look at the clouds. She loved to pick flowers and smell them. And she especially loved playing in the rain. She loved to run around in her bright yellow raincoat, to feel the water run down her cheeks, and to splash in the mud puddles with her rain boots. One day, Wendy was sitting inside coloring a picture, and it began to sprinkle outside. Getting excited, Wendy jumped up from her seat and asked her mom if she could play outside. Her mom said that she could, as long as she put on her rain clothes first. So Wendy put on all her rain clothes: her big yellow jacket, her yellow hat, her old muddy pants, and her striped boots, and then she ran outside to play.

As she was playing outside, the rain began to pick up – it started raining harder. Dark, scary-looking clouds moved in, and the wind started blowing really hard. Wendy didn't mind though, this just meant she could have more fun playing in puddles. She splashed in puddles and stood under the rain. She even stuck out her tongue to catch the big, giant raindrops that were now falling. Then, Wendy started hearing thunder, and the wind started blowing *really* hard. Wendy's mom opened the door and shouted, "Wendy! Get inside now. There's a tornado coming!" Wendy immediately felt scared. [What did that scared feel like?] Wendy ran inside and her mom said, "Come on, let's get in the hallway, away from windows." Wendy and mom hid in the hallway. That's when Wendy REALLY started getting worried. All that time, she was thinking _____?

Do you have any ideas about how Wendy can relax?

Sports/Performance Anxiety

Note: Details may be changed to be made more appropriate for different kinds of sports.

Wendy was a little girl who loved to dance. She loved turning spinning, and twirling, and jumping, and bouncing, and running on her tippy toes, and all the other things that little girls do when they dance. She even liked the cute little outfits that little dancers wear. Her big sister was a dancer and she saw her sister perform on stage and thought it was so beautiful. So she wanted to learn how to dance like that. Wendy decided to join a class to help her learn how to dance better. She asked her mom if she could sign up, and mom said that she could. So mom took her to visit a dance studio where she could take a class with other girls her age. Wendy was so excited at first because she knew that she would soon be getting to do something she loved.

Wendy's first day of class, she met some of the other girls and they talked before class. Wendy thought they were all really nice, and she even made friends with some of them. Then, the class started, and the teacher was really nice too. She smiled a lot, and was a really good helper with all the girls in the class. She even gave extra help to Wendy, since it was her first day and all. As Wendy was learning how to do all the moves, she began to notice that she wasn't as good as the other girls. She couldn't do some of the moves they could. Still, she kept trying and finished the class. After the class was over, the teacher told her that she did a good job, and Wendy smiled.

Still, she worried that she wasn't as good as the others and she thought that maybe some of the other girls' moms who were watching the class were thinking that Wendy wasn't very good. Next week, when it came time for class again, Wendy felt kind of funny in her

tummy. She felt like it was tying itself in knots. She was really nervous. She almost felt like throwing up. [Why was her tummy acting like that?] She told her mom she didn't feel well, and her mom didn't know what was wrong. She told her mom, "I feel nervous," and mom knew that Wendy must be nervous about her new class. Mom wanted to help Wendy relax.

Do you have any ideas about how Wendy can relax?

Test Anxiety

Once upon a time, a boy named William wanted to be an astronaut. He loved to fly and he wanted to see the Earth from space. One day, he went to space camp and he LOVED it. They had space shuttles for him to get in and a little spacesuit for him to wear. It was AWESOME. Then, at the end, the grown-ups that worked at the camp told William how hard it was to become an astronaut and that he would have to take lots of tests. They even had a test for him to take right then and there that would say if he would be a good astronaut or not. But William HATED tests [blech!]! He was always afraid he would do badly on the test, and he would get so nervous that he could never think of the answers, even to the easy questions that he knew the answer to the night before. William started to feel butterflies in his stomach [you should use child-specific somatic symptoms] because he knew he would fail this test and never become an astronaut.

Do you have any ideas how William might relax?

Session 5 – Self-talk and maladaptive thought patterns

Purpose: To review relaxation training. To focus intervening at the realm of self-talk and maladaptive thought patterns.

Goals:

1) Help reinforce child's ability to achieve relaxation
2) Help child identify anxiety-related thought patterns
3) Help child identify positive alternatives to anxiety-related thought patterns
4) Help child begin to gain mastery over anxious symptoms

Activity 1: Physiology and relaxation review

Begin this session with another short active game meant to stimulate physiological activity. This can be the same activity as last time, or can be a different one. Allow the child to choose. Immediately afterward, have the child develop another relaxation story as done before – it may be a different story or the same one. Alternatively, you and the child may play the "Righty Tighty, Lefty Loosey" game. The child may choose one or both. For time constraints, limit the entire process to approximately 10 minutes. Remember to discuss how the child feels during each stage, highlighting physiological signs.

Activity 2: Vet visit

You will need to make some kind of statement to transition the child from the previous activity to this one. Then, introduce the story stem.

Toys needed: Animal clinic, Vet, Dogs, Vet supplies (medicines, casts, carts, etc.)

Story stem: "*Now let's play a story about three dogs who are sick. They are all going to the vet to find out what is wrong with them. The brown dog is very worried, the white dog is only a little worried, and the black dog is not worried at all* [Some toy dogs have heads that can be raised and lowered; thus, if using such dogs, you could lower the head of the brown dog, place the white dog's head mid-level, and the black dog's head raised high and proud]. *Each one goes to see the vet one at a time. Which one goes first?"*

The child may then choose the order that each dog goes to see the vet, and should finish the story for each consecutive dog. Ask the child to complete the story, telling how each dog goes through the vet and what is found to be wrong with each one. Invite the child to explore some of the somatic signs of the dogs. Also, inquire about the thoughts of each dog and monitor for positive or negative patterns. Based on the thoughts each dog has, respond in such a way to highlight the state of worry of each dog. If necessary remind the child of the association. For example, you might say, "This is the dog who is *very* worried. I wonder what kinds of things this dog is thinking?" If the child doesn't readily make logical connections, you may help (by perhaps having the vet say, "This machine tells me what you're thinking and it says you're so worried because you're thinking you might die. Is that right?" or, for the black dog, "You don't seem too worried at all. You must be thinking that everything is going to turn out okay"). The point is that the child uses the dogs to identify different levels of anxiety-related thinking, and the vet is available to both facilitate that process and to introduce and/or reinforce healthy thought patterns as necessary. Be sure to spend adequate time with each of the 3 dogs so that there are ample opportunities for the child to play about different strategies and approaches.

Activity 2: Vet visit, reversed roles

Now, you and the child should reverse roles, where you display anxiety through play and the child helps you through the anxiety. To make the transition, close the last activity by having the vet say goodbye appropriately to the dogs (i.e. if their illness seems to require a check-up later, perhaps the vet can set another appointment with them), at the end, have the vet say *"Now I need to go check on some bird friends of mine. I have to drive to go see them."*

Then, get the jeep and the three wild birds (2 parrots + toucan). Place the 3 birds on their perches and set them across the table or room. Then, have the vet load the jeep with any supplies that will fit and drive to see the birds. Set up the scene as follows:

> [Key: R=red bird, B=blue bird, T=toucan, N=Narrator]
>
> *N: The vet is driving to go visit the birds, but the birds are very far away, so it takes him a while to get there. Meanwhile, the birds are talking to each other.*
>
> *R (to T): "Hey, did you ever ask a doctor to look at your beak for you?"*
>
> *T: Not yet. I don't know why it is so much bigger than yours, but it's really freaking me out man*
>
> *B: Yeah dude, that thing is HUGE! I hope that doctor gets here soon before something bad happens*
>
> *T: Like what?*

R: I don't know man, but that can't be good! That's the most crazy, big beak I've ever seen on a parrot.

N: The vet is here now. [To child] *You be the vet, and I'll be the birds. How does the story end?*

Hopefully, the child will attempt to resolve the problem with only minimal guidance from you. However, you should be prepared to guide the play as necessary to assist the child in making recommendations to calm the birds. You should apply some mild resistance to the child's attempts to calm the birds, elaborating on the fear that something is really wrong with the toucan (who thinks he is a parrot). This scene is meant to evoke a sense of irrationality to some fears. Since the only "problem" is that the toucan is a toucan, not a parrot, the birds are really afraid for no reason. If this theme is apparent for the child, your goal, then, should be to help the child identify that irrationality. You can then work with the child to normalize that feeling (i.e. after the story is completed, you may say, "You see, a lot of birds and people have the problem where they worry or get nervous because they think something is really bad when it's really not bad at all. Once they figure out it's not so bad though, they don't have to worry anymore and can finally just go on and live their lives. But sometimes, they need someone to help them realize it's not so bad"). If the child does not identify the irrationality, you may consider leading her toward that conclusion. If the child is still resistant to your invitations, this likely indicates that the child perceives fears to be real and well-founded. In that case, you should help the child explore that sense of realness and help remind her of ways to cope with that fear or use other play-based interventions (as described in previous sessions) to help "contain" that fear.

Activity 3: Child-specific scene

If time remains, you may invite the child to develop a story/scene of her own that shows something she worries about. You would then essentially repeat the same process as before, but playing within the child's scene instead.

Session 6

Purpose: Review previously learned material. To gauge child's perception of progress so far. To encourage self-evaluation and self-reward in the child. To solidify/further practice skill acquisition

Goals:

1) Review physiology and relaxation
2) Review anxious cognitions and coping strategies
3) Assess child's evaluation of what she has learned and whether she has practiced outside of therapy
4) Stimulate self-reward
5) Practice material presented previously

Activity 1: Physiology and relaxation

Invite child to repeat physiology and relaxation activity as performed in previous sessions.

Activity 2: Anxious thoughts review

Use the following story stem to work with the child on anxiety as described in session 5.

Story: Missing baby elephant

Toys needed: Elephant mother, elephant baby, African predators (i.e. lion, tiger, gator, snake), Friendly African animals (i.e. rhino, zebra, gorilla, friendly lion, etc.), tree, watering hole (a blue cloth, in this case).

Set up the scene such that several friendly animals are gathering around the watering hole for a drink and/or bath. Feel free to use whatever animals you like, just as long as several are placed. Set up the tree just to the side of the watering hole, and place gorillas or other apes/monkeys around that area. Away from this scene, but not too far off, place some predators. The predators should be placed within a relatively short "roaming" distance, as in this story, the baby elephant will roam away from its mother, risking being caught by the predators. However, they should not be placed so close that one might expect all the animals at the watering hole to realize their presence. As you are setting the scene, begin the story as follows:

> *One very hot day, all the animals were gathering around this watering hole where they could drink some water or get in the water to cool down. There was a ____, and a ____, and,* _____ [you should name each of the animals present as you place them]. *The mama elephant is getting water in her trunk and spraying it all over herself while the baby plays in the water nearby. Then, while the mama is spraying herself, the baby gets out of the water and decides to go explore. The baby wandered off, and before she knew it, she was lost! Then, the mama realized the baby was gone, and she started to get worried! How does the story end?"*

In this story, there are several characters who might show anxiety. You already stated within the story that the mother elephant was worried; however, the baby elephant could become worried as well (especially if separation anxiety is an issue for your child client). Furthermore, some of the friendly animals around the watering hole could share in the worry.

Likewise, there are several possible "helpers" in this story. The friendly animals may assist in calming the mother, trying to help reassure her and offering emotional support. They may also provide instrumental assistance and could help find the baby for the mother.

There are also several expectable ways for the story to end. The mother could find the baby immediately. The baby could hide playfully behind the tree, waiting to jump out and "scare" the mother. The baby could also wander toward the predators and put itself in danger. Whatever the case, your task in this story will be to help the child explore any anxiety present in any of the characters, and guide the child toward the identification of any potential anxious thoughts and/or feelings. You should also use characters in the play as much as necessary to guide the child toward healthy coping skills in response to demonstrated anxiety. Interventions should take a form similar to those explained previously within this manual.

Activity 3: Assessment and reward

This activity is designed to stimulate the child to assess responses to anxiety and reward demonstrations of positive coping skills as necessary. To that end, guidance and suggestions you offer as therapist should attempt to lead the child to identify healthy and maladaptive coping skills and to reward any efforts toward positive coping.

<u>Part 1: Self-efficacy – The mountain of worry</u>

The first part of this activity is meant to evoke a sense of self-efficacy in the child. This is done to "prime" the child toward identifying personal strengths. In this part, the child is asked to identify characteristics of the self that are good using toys as representations of

those characteristics. The scene invites the child to accomplish a presumably difficult task and identify strengths as she goes about accomplishing that task.

Toys needed: Piece of paper (8.5 x 11 or bigger), Child's "self-toy," stackable blocks, strips of paper, tape

(This activity was adapted from a strategy suggested in Crenshaw, 2006)

In this activity, you will draw a mountain on a piece of paper for the child to climb using her self-toy. Tell the child that the mountain is the "Mountain of Worry" and have the child label the mountain with several worries. Usually, the child simply states different worries, while the therapist writes them on sticky notes. Then the therapist gives the notes to the child to post onto the mountain. Often, children use the mountain to create a hierarchy of anxiety, with less significant fears/worries at the bottom and more bothersome ones at the top. The child may include associated symptoms and thoughts as well.

After labeling the Mountain of Worry, the child will then "climb" the mountain by stacking blocks from the base toward the top. With each block, the child should name a strength or other good quality, which will be written on a piece of paper and taped to the block. Alternatively, children may name coping skills used in previous FELT activities. As each block is labeled, it is placed atop another (or at the bottom of the mountain, if the first block), and the child places her self-toy on top of the block. The idea is that the child will "stand on" her strengths to overcome the climb to the top of the mountain.

As therapist, you should explicitly note to the child that the only way to conquer/"climb over" the whole mountain of worry was to use several blocks/skills and combine them

together. Although some worries (i.e. those at the bottom of the mountain) could be conquered with only a few blocks, all of them were needed to overcome the entire mountain. Your goal is to make it clear to the child that sometimes she may need to use an array of combined skills to successfully master her anxiety fully.

Preparation for this activity should occur before the current session, as the size of the paper chosen will depend on the size of the blocks used and the size of the child's self toy. Since every child's self toy may be a different size, it is difficult to have a standard size of block to use. It is usually safest to have large enough blocks available that the largest toy in your inventory could fit on an edge when the blocks are stacked stepwise. Additionally, you should strive to have paper of a sufficient size that the mountain will be a somewhat challenging climb, but not too difficult. As a general rule, the size of the mountain should probably not exceed five "levels" of stacked blocks. You want to ensure not to require the child to list more strengths than she actually feels she has. If necessary, you may provide a list of personal talents or qualities from which the child may choose.

At the end of the activity (when the child has reached the top of the mountain), you may congratulate the child on her climb or provide some other verbal reward. Also, collect the notes used to label the mountain and allow the child to keep them. Then, you should begin to introduce the next part of the activity by saying,

> *"In this activity, you used things that you are good at to accomplish something hard. You had to think about yourself and figure out what you are good at so those could be your blocks to stand on. Now, I want to see if you can help someone else do something hard by kind of doing the same thing. Do you*

remember a long time ago you made up a story to show me what "scared" or "worried" was like? Now we're going to do that again. Do you want to make up a new one or use one you have done before?

[If the child wants to use a previous scene, you may help by describing the story as necessary to help the child remember. You may reference any story created by the child in which a character exhibited anxiety. Usually, earlier examples are better, because such examples are expected to represent more maladaptive responses to anxiety, as they occurred before the child began to learn healthier coping responses. A good reference point may be the story created in Session 2, Activity 3. Nonetheless, any prototype may be used here].

Part 2: Encouragement and self-assessment

Whatever story the child chooses or creates, you should facilitate its development as much as necessary, continuing to use the overarching principles of FELT as in other sessions. This time, however, at appropriate points within the story, you should invite the child to come up with ways that the anxious character can address his/her anxiety. You, may, for example, say, *"I wonder what ____ should do about being worried in this story?"* If necessary, you may press further, *"Do you remember what has worked for you so far to help when you start to have/think* [insert appropriate symptom, i.e. "butterflies in the stomach", or thought, i.e. "Oh no, I'm going to mess everything up"]? Your primary concern here should be to elicit the child to demonstrate what she has learned. You should then invite the child to reward herself for displaying her skills (i.e. *"Do you think _____ did a good job in this story?"* or *"Do you think ____feels any better?")*. If the

child answers no, you should invite discussion about why not and allow the child to construct ways to help ____ feel better. This discussion should help lead you, as therapist, to learn what areas in which the child may be still seeking aid and what concepts may need to be reviewed more extensively in subsequent sessions.

Session 7

This is a review session. In this session, you will review with the child all of the coping skills developed in the previous 6 sessions. Most of the activities will resemble those performed in Session 6. Intervention strategies should continue to mirror those utilized throughout FELT.

Before this session, be sure to speak with the child's parents about how she has used skills outside of therapy (at home, school, etc.). Try to find out about a specific incident that the parents remember, as that incident (if available) will be used in Activity 3. If no such example is named, ask the parents about any times the child has struggled with anxiety recently. That example can still be of use in Activity 3. Also, tell the parent(s) they may be invited to join you with their child at the end of the session.

Purpose: To review all previously learned material in preparation for the prolonged practice stage.[1] To continue to strengthen child's ability cope with anxiety.

Goals:

1. Review previous skills, including physiology and relaxation, changing anxious thoughts, and recognizing and rewarding the self for a job well done.
2. Determine what skills, if any, the child tends to struggle with more, so that you may focus on strengthening those skills in remaining sessions

[1] In reality, the child has been practicing skills throughout FELT. However, after the final review conducted here in Session 7, the child will enter a stage in which new skills are no longer introduced, but the child is allowed multiple opportunities to practice those skills for the remainder of therapy. This is what is meant by "prolonged" practice.

Activity 1: Physiology and Relaxation

Repeat as before.

Activity 2: Anxious thoughts

Use the following stem to review anxious thoughts (as in previous sessions).

Stem: Music group

Toys needed: 4 children with musical instruments

Set up the children in a circular pattern, each holding a different musical instrument. Each child will be "assigned" a different level of confidence. One child should feel confident about his/her skill. Another should be "only a little nervous, but thinks he/she can't get by okay." One child should be "very nervous," and the last should be "very nervous like the other one, but has had help (from a therapist) and knows how to deal with his/her worried feelings." You should pair with your child client to decide which toy gets assigned which role. Then, have the child play out the scene, explaining each character's experience (as done in previous sessions). As before, you should invite the child to elaborate on each experience such that the child is able to explore the different components of the various levels of anxiety. This time, you may also add an evaluatory component, where the "child who has had help" also comments on good things the other children are doing or helps the child(ren) who is/are struggling.

Activity 3: Self-efficacy review

Invite the child to use the toys to show you a time during the past week (or any other time) that she has used the skills learned in therapy to help herself. If she cannot think of

one, use the example given by her parents. If a positive example is not available from home, school, etc., focus on examples from past therapy sessions. A previously used scene may even be repeated, if necessary. If no positive examples can be found in any environment, you may choose the example given by the parents of a time the child struggled with anxiety. You can then ask the child to use the toys to show you the scene and what she would do differently.

Sessions 8-12

These sessions are lumped together as "practice" sessions. For the remainder of therapy, your goal as therapist is to invite the child to practice her skills in as many different environments and scenarios as possible and necessary. Use the creative nature of play to design several symbolic representations of anxiety-ridden situations, and work with the child through play to practice healthy coping responses in those various situations. You should continue to invite the child to perform activities previously repeated (i.e. physiology and relaxation). Most of these sessions will greatly resemble session 7, though with different story stems and scenarios used.

Your goals throughout these sessions are as follows:

Goals:

1. Practice previously learned skills including relaxation, changing anxious thoughts, and self-evaluation and reward.
2. Child moves toward and exhibits mastery of these skills.
3. Child demonstrates utilization of skills outside of therapy and/or demonstrates measurable decreases in anxiety outside of therapy.

You should continue therapy to the extent necessary to achieve these goals.

Below are listed a variety of potential story stems that may be used in this final stage as deemed appropriate by you and the child. The story stems set-up potentially anxious scenarios for the child to complete. The child should be invited and allowed to practice all of the skills in some way to reduce character anxiety throughout each of the story

stems. The child should have the freedom to decide which skill(s) seem(s) more helpful for her. In some cases, stories may be completed such that the characters do not exhibit any anxious behaviors. When this occurs, you should emphasize what a good job characters did at healthily avoiding anxiety (i.e. you might say, "He never even started to worry because he was controlling his thoughts and feelings right from the start!"). You may also ask the child to "replay" any of the scenes, but with a different ending (i.e. "Now show me how it would go if ____ were to use some more of the skills we learned in here").

Note: Throughout these stories, characters are arbitrarily named for the sake of simplicity. In presenting the stories yourself, you may choose a different name, allow the child to name characters, or simply describe the characters by their generic name (i.e. the boy, the dog, etc.).Also, unless otherwise specified, the toys used may be set-up in any logical manner that fits the story stem.

Story Stems

Going to the doctor

Toys needed: Clinic, doctor, child, parents, medical supplies, table

Introduction: "Jimmy has been feeling really sick for a few days. His head hurts very badly. His parents decided to take him to the doctor for a checkup. Jimmy and his parents went into the doctor's office and the doctor told him to sit on the table. Jimmy was pretty nervous because he thought something was really wrong with him. He had all kinds of nervous feelings and thoughts and didn't know what to do with them. What happens next?"

Parental Quarrel

Toys needed: Parents, furniture, 2 children

Introduction: "Molly and her friend Grace were playing in Molly's room at Molly's house. Grace had come over today after school. Molly's parents were in the other room. Molly and Grace were playing with their dolls when they heard Molly's parents start to argue. They heard Molly's mom yell, "I can't believe you did that!" Molly's parents don't usually argue. They are usually very happy and love each other very much. She didn't know what to do. She started thinking to herself. [To the child] Now show me what she was thinking and what happens next?"

The speed test

Toys needed: Lion, tiger, bear, zebra

Introduction: "The lion, tiger, bear, and zebra were walking home from school together. They were all talking about a big test they had tomorrow. It was called the "Speed test," and it was a really important test because they all had to pass it to go on to the next grade. To pass the test, you had to be able to run 30 mph. The lion, tiger, and zebra were all talking about how they would pass the test easily. The lion said, "I can run 50 mph, so I'll beat that by a long shot!" The tiger said, "I can run 45, so I'll be fine too." The zebra said, "I can only run 40, but that's definitely enough to pass." The bear was quiet. He knew the fastest he had ever run was 30 mph, and that was only one time! He wasn't sure if he could do it again.

What happens next?

Stealing

Toys needed: Bear, bunny, safari man, tent, computer, "General goods" (flowers, food, supplies – anything that could be sold to animals in a general store).

Safari man should be standing under tent, facing toward outside. The computer should be just in front of him. It should resemble a kiosk, with the computer functioning as a "checkout". Place some goods around the kiosk.

Introduction: "Bob has a store where he sells _____ [list things]. He has two shoppers in his store today: a bunny and a bear. Bob was looking down on his computer while the animals shopped. The bunny was smelling some flowers when he saw the bear take (something relatively valuable) and put it in his pocket. The bunny looked at Bob to see if he was watching, but Bob wasn't. He didn't see anything. The bunny knew that it was wrong for the bear to steal, but the bunny was afraid that if he told, the bear would get mad and eat him. He wanted to do the right thing, but he was scared.

What happens next?"

Child-specific stories

You should prepare at least one child-specific story stem for each session. You should create some situations that would be expected to evoke low-anxiety in the child, and some that would evoke high-anxiety. These should progress in frequency and intensity over time and as the child reaches skill mastery. The closer the child gets to the end of treatment, the more often that targeted, child-specific stories should be used.

Also, you should invite the child to create stories of her own and respond accordingly.

Repeated or unused stories

Finally, you may feel free to repeat stories used in previous sessions or use any that were listed, but unused in previous sessions. You may also create stems from some of the examples given in this manual.

CHAPTER 7: PARENT COMPONENT

Studies have shown the addition of a parent component to significantly increase the effect of psychotherapy on children (Bratton, Ray, Rhine, & Jones, 2005). Parental involvement in FELT is meant to help improve the child's overall response to therapy by utilizing the inherent closeness of the parent-child relationship to facilitate the child's overall sense of security and to increase generalization of skills outside the "therapy room." As a result, parents' involvement in FELT takes place both at home and within actual sessions between the child and therapist. The therapist helps the parents learn skills they may teach their child when anxiety-provoking stimuli inevitably arrive so that they may help the child when the therapist cannot be present. The therapist also helps the parents foster a sense of security in their own ability to help the child when she struggles with anxiety (and other high emotionality). Parents learn how to encourage and facilitate their child's fantasy play so that its potential therapeutic benefits are maximized.

In this chapter, a parent-only session is described relatively loosely. Following that description is a portrayal of how parents are expected to interact with children during a joint session and during "homework."

<u>Parent only session (after session 3 with child)</u>

Purpose: To encourage parental cooperation in the treatment program.

Goals and Tasks:

1. To provide additional information about the treatment. Outline the treatment program and explain generally where child is in treatment and what will happen

next. Invite and answer questions from parents. Remind parents not to expect an immediate reduction in anxiety, but that over time, changes should occur.

2. To give parents an opportunity to discuss concerns about the child or other factors that could influence treatment. Use open-ended questions to invite additional history or current information that may be pertinent to treatment or to understanding the child.
3. To learn more about specific anxiety-provoking situations for the child and her specific reactions to such events. Use information garnered from initial sessions to discuss general impressions so far and to inform the discussion about client-specific anxiety. Parents are encouraged to provide their own impressions as desired.
4. To outline how parents may be involved in the program. Parents are advised that they will be invited to sit in on their child's next therapy session (session 4), so that they can witness the treatment model and learn useful interventions that they can implement with their child. Parents are informed that such participation is not mandatory, but are encouraged that doing so should be reasonably expected to greatly improve their child's response to therapy and is likely to facilitate progress through the program. They are then encouraged to practice skills learned through their involvement with their child at home.
5. To further interview parents about parenting styles in order to identify patterns that might be considered risk or protective factors with respect to their child's anxiety and to prepare parents to potentially make changes to their interactions

with their children in order to stimulate their child's adherence to treatment recommendations. You should assess for features within the following realms:

a. Punitiveness (how do they respond when their child does something wrong?)
b. Avoidance of affect (in general and specific to anxiety)
c. Anxiety about their child's anxiety (vicarious anxiety)
d. Parental knowledge of healthy personal coping skills
e. Availability
f. Willingness to follow treatment recommendations
g. Ability to follow treatment recommendations
h. Other specific factors that may have come up in play-themes with child during initial sessions

Notes:

Parents should also be reminded about the nature of confidentiality with respect to treatment of their child. They are told that although they have a right to be informed about the therapy with their child, therapy with children typically goes more smoothly if the child knows to expect that what she shares in therapy may not necessarily have to be shared with parents. Parents are reassured that the clinician will inform them if the child reveals material that might present a danger to herself or others, but that otherwise, it is better to not necessarily share everything the child does in therapy. Parents are also taught to respect the child's autonomy in choosing whether or not to discuss with them what she does in therapy. In other words, they should refrain from asking the child about topics discussed or material covered when they were not in the room. These are all things

that should have been described in detail during the initial intake session; however, this session serves as a useful time to remind parents about these issues.

Parents' involvement in session 4 with child

With the child's permission, parents are invited to observe and/or participate in a review of the *Physiology and Relaxation* activity performed at the end of Session 4. Parents may participate totally throughout each step (physiological activation, relaxation, and progressive muscle relaxation), or may simply listen/observe. Parents are particularly encouraged to play the "Righty Tighty, Lefty Loosey" game, as additional players may add to the fun and their presence will allow them to be consistently reminded of the therapeutic purpose of the game.

Parents should also be continuously consulted about their child's progress and utilization of skills outside of therapy. Parental input can be very beneficial in assisting the therapists' decision making about how and where to intervene. Parents should also be reminded often to note and reward their child's progress whenever possible. It is suggested that a formal, brief discussion with parents occur at least every four sessions for the purpose of evaluating child's progress at home, identifying parental reactions to the therapy, and answering any lingering questions parents may have about how they can participate further in their child's treatment. Typically, such discussions can take place during the first five minutes of a regularly scheduled session with their child.

Preventing premature termination

A wealth of research on premature termination of psychotherapy with children has determined several major predictors of early termination. These predictors include

avoidance behavior (Chasson, Vincent, & Harris, 2008) and parent factors, attitudes, and expectations such as less education, feeling that problems should be handled within the family, and using increased disciplinary tactics to respond to emotional/behavioral problems (McCabe, 2002). The latter-described factors can usually be easily identified and averted early in therapy by appropriately informing and educating parents about what they can expect from the treatment plan and involving them in at least some therapeutic interactions. Therefore, an essential part of the parent component of FELT is to ensure communication of a coherent, well-described treatment plan with parents so that the plan is clear and expectations are reasonable. The preliminary research on the FELT manual provides information about what kinds of behavioral changes parents can expect in their children and when they can expect those to occur. Communicating findings from previous research may help to alleviate uncertainties parents may have about what to expect from FELT.

The other factor that predicts early termination, avoidance behavior, is a factor that is important to consider both for children *and* for their parents. Although the child may influence parents' decision to terminate, the parents do ultimately have the final decision to end or continue therapy. The current research has focused so far solely on avoidance behavior of the child (Chasson, Vincent, & Harris, 2008), and seems to indicate that when avoidance behavior begins to increase during therapy, anxiety also increases, and termination may begin being considered. Theoretically, though, avoidance behavior of the parent may be considered the true factor in the decision to terminate, since parents ultimately make the decision to consent or withdraw from treatment. The decision to terminate prematurely can be considered a manifestation of an avoidance of

therapy. The parents may wish to avoid their anxiety about therapy itself (Hembree et al., 2003), or they may be avoiding the therapist (Woo & Pardeck, 1995). Parents themselves may feel vicarious anxiety about their child's anxiety about attending therapy (Chasson, Vincent, & Harris, 2008), which may lead them to terminate therapy prematurely. On the contrary, parents may display a different form of avoidance behavior. Some parents may prioritize their own anxiety about confrontation from the therapist over their inclination to terminate for their child's sake, and may "force" their children to persevere through therapy because they do not want to inconvenience the therapist by quitting. Regardless of the type of avoidance behavior occurring, one major purpose of regular parent contact by the FELT therapist is to reduce avoidance behavior by parents and to promote a healthy level of approach behavior instead. By encouraging parents to approach issues and/or concerns directly with the therapist, FELT clinicians can better target therapy to the entire context of their child clients. They can also respond appropriately to any parent factors that may be contributing to the propagation of anxiety in the child. Finally, they can help parents model approach behavior for their children, which, as stated previously, is a core feature in reducing anxiety.

Regardless of the complex influence of various factors related to anxiety about therapy, the point for FELT is that part of the therapist's job throughout FELT is to also help the parent's negotiate their own feelings about having their child in therapy. Doing so will not only facilitate therapist-parent interactions, but it will also reduce the likelihood that parents will remove their children from treatment before the child is ready. It will also maximize the parents' ability to participate in their child's therapy and to foster positive, healthy coping that the child is learning through therapy. Finally, by

engaging in frequent interactions with parents, FELT clinicians can better understand and direct therapy toward any parental factors that may be propagating anxiety in their children (see CHAPTER 2).

CHAPTER 8: TERMINATION

In this chapter, procedures for termination of FELT are described. Within this chapter, termination is defined as successful, planned termination that occurs as a result of a child having demonstrated a mastery of all skills learned during FELT such that symptoms of anxiety are no longer reported by the child or parent(s) as being unmanageable and/or clinical in nature. Under this definition, successful termination is never premature. Although procedures for premature termination may follow a similar format as those described below, this chapter's primary intention is to delineate a successful termination of psychotherapy. Within FELT, successful termination occurs when a child has met all goals of FELT as outline in session guides, has demonstrated mastery over skills learned during FELT, and has reported a significant enough decrease in anxiety symptoms that the presenting problem is no longer described as an unmanageable issue that frequently interferes with daily functioning.

For most children, termination of psychotherapy can be an uncertain time in which several ambivalent feelings may be experienced. Although a child approaching successful termination may feel pride at having overcome anxiety and consequently may experience a readiness to move forward, that same child may simultaneously also feel a sense of sadness at the culmination of the therapeutic relationship that has been built between her and therapist over the past 12+ weeks. Because of this ambivalence, termination of therapy requires the same amount of sensitivity and care as initial rapport-building during the initiation of therapy. Termination marks a new era of uncertain expectations about the future. Children are likely to wonder, "Will I get worse or will I stay better?" "Will I ever see my therapist again?" "Will my therapist remember me?"

and so on. Acknowledgement of ambivalence is an important step in beginning termination with children, especially younger children (<8 years old), who have not yet developed the cognitive sophistication to fully understand the simultaneous presence of opposite-valence emotions (Harter & Buddhin, 1987). Helping children navigate through the mysteries of these ambivalent feelings is a key component of termination in FELT. With that consideration in mind, the following session was designed as the final session of FELT.

Note: It is very important for clinicians to note that termination of psychotherapy does NOT occur in one session, but is rather better understood as a process that occurs over time. Termination actually begins with a preparatory stage 2-3 sessions before the actual final session in which children are informed of the impending end of therapy. At that point, ambivalent feelings begin to be explored, discussed, and normalized. Therapists may, for example, express that "*most kids feel kind of proud and relieved to have finally reached the end, but at the same time, kids usually don't really know what to think about how things might change now that they've gotten used to coming to therapy*." Responses are elicited briefly from the child, and it is made clear that there will be time in the next several sessions to talk/play more about feelings about the end of therapy if the child wants to do so. Successful termination should never be abrupt.

Termination activities:

Goals:

1. Promote permanence of therapy techniques
2. Promote object permanence of therapist

3. Promote maintenance of gains
4. Promote continued practice and mastery of skills

Underling each of these goals, again, is the desire of the therapist to help the child negotiate ambivalence about the end of therapy. Each goal is meant to alleviate worry about how things might change after therapy, thus driving internal attributions of the child to a state of "things will be alright, as they are now." Thus, the termination session as a whole is meant to celebrate gains, stimulate a sense of self-efficacy, and to share memories that the therapist has about time spent with the child. This latter component is a core feature that is meant to promote an internalization of the therapist object. Theoretically, this therapist object is hoped to accompany child through life. Internalization means that children can use this "imaginary therapist" as a means to work through anxious situations as they grow into adulthood.

Activity: Termination Book

The entire termination session is devoted to the co-creation of a termination book. Together, therapist and client construct a book that records memories from FELT. The book is about the child, and the title of the book always includes the child's name. The therapist prepares materials for the book before the final session. A plain cover page introduces the book and contains only the child's name. Inside, the book consists of pictures of scenes created during therapy, with a written narrative depicting how each scene describes the child and/or her progress across therapy. Each section of the book is described in more detail below

Pre-session preparation

Before the termination session, the therapist must prepare all materials so that the actual time in the session can be spent reading through and constructing the book with the child. Preparation typically requires approximately 1-hour for each client, though the usage of templates often reduces this prep time considerably. Additional time is necessary if photos are developed (see below). The majority of prep time involves reconstructing some of the essential scenes used for the book, followed by a constructing a written description of each scene. The book is written by the therapist, from the therapist's perspective, and tells about the child. First, the therapist must select scenes to use for the book. Then, the therapist builds that scene to match the child's story. Finally, the therapist takes a picture of each scene. Some stories may require multiple pictures to tell the whole story. It is suggested that the multiple-picture option be reserved only for certain stories (these are identified in Table 2, below). Next, a short caption is written to accompany each scene. The chosen scenes and associated captions should be developed in such a way as to allow a narration about the "story" of the child's time in therapy. The story should include an introduction (sets the scene, identifies the protagonist), a description of the problem (the child's anxiety), a section of scenes used to teach skills, a section showing child's utilization of skills in therapy/at home, and a final section regarding maintenance of post-treatment gains. Table 2 below is provided to show a typical page-by-page progression of the scenes typically used for each child's story.

Table 5. *Guide for Termination Book*

Page	Scene/Page Description	Purpose
Cover	None	
1	Introduction to therapy (1.2[2])	Introduces protagonist and setting of the book.
2	Happy time (1.3)	Shares a positive memory
3	Worry time (2.2)	Indicates reason child came to therapy.
4	Signs of worry (3.1)	Reviews somatic/physiologic symptoms of anxiety
5	Physiological arousal and relaxation	Reviews relaxation techniques
6-9	Vet visit (5.2)	Reviews self-talk and anxious thought patterns. Usually require 3-4 pictures. Includes information about interventions used through play.
10	Mountain of Worry (6.3)	Usually child draws and re-labels mountain on this page. Reviews lessons from session 6.
11	Music group (7.2)	Depicts a scene in which child effectively managed anxiety through play.
12-18	Child-specific scenes	Depict additional scene(s) in which child demonstrated effective anxiety management

[2] Here, activities are coded by session number, then activity number. Session 1, Activity 2, then, is coded as 1.2. Session 2, Activity 3 would be 2.3, and so on.

19	Wrap-up	Wraps up book by noting ways child has improved during therapy and expresses confidence that similar skills can be used in future.
20	Picture of child and therapist	Final page. Contains farewell statement. Promotes object permanence of therapist.

APPENDIX B

Focus Group Questions

During each focus group, at least these eight questions were addressed. Follow-up questions were also asked as necessary.

1) What do you think of therapy up to this point?
2) What did you like about therapy?
3) What did you not like about therapy?
4) What did you learn from therapy?
5) Have you noticed any change in anxiety symptoms?
6) What has been the most helpful so far?
7) Least helpful?
8) Have you noticed any other changes?

APPENDIX C

Data Management Methods

Data Management

Clients were administered a code upon acceptance into the research study. These codes were the only client identification used in all data analyses. Any protected health information (PHI) about clients and their families were stored separately from the research data. Any information linking codes to PHI were destroyed upon participant completion or withdrawal from the study. The remaining (unlinked) PHI is currently stored and treated as clinical records in accordance with the policies and procedures of the Baylor Psychology Clinic. Therefore, patients who wish to obtain their records may do so through the Baylor Psychology Clinic.

Data Analysis

Most of the data used was qualitative in nature. Information obtained from patient feedback and focus groups was used to inform changes to the manual. Therefore, most of the data was descriptive in nature. However, some data used to measure outcomes was quantitative and could be subjected to statistical analysis. Quantitative data was double-entered into an SPSS database. The double entries allowed the PI to check and resolve discrepancies to ensure accurate data entry. Descriptive statistics were calculated on client demographics (i.e. age, gender), on baseline anxiety rates as measured by the BASC-2, RCMAS-2, and PSWQ-C, and on baseline scores on other scales from the

BASC-2. Comparative analyses were performed within subjects only, and a repeated measures ANOVA was used.

Production and Identification of Exemplars for Training

For the purposes of training later therapists to conduct FELT, videotapes that were determined by the principal investigator as being highly faithful to the treatment model were identified as "exemplars" for training. Parental consent was obtained to keep those tapes indefinitely for later use in training therapists to implement FELT. All participants and their parents consented to such usage of tapes.

REFERENCES

Addis, M. E. & Waltz, J. (2002). Implicit and untested assumptions about the role of psychotherapy treatment manuals in evidence-based mental health practice. *Clinical Psychology: Science and Practice, 9*(4), 421-424.

Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978). *Patterns of attachment*. Hillsdale, NJ: Erlbaum

Albano, A. M., Chorpita, B. F., & Barlow, D. H. (2003). Childhood anxiety disorders. In E. J. Mash and R. A. Barkley (Eds.), *Child psychopathology* (2nd ed., pp. 279-329). New York: Guilford Press.

American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry 46* (2), 267- 283.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. text rev). Washington, DC: Author.

Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders Work Group. (2012). DSM-5 proposed revisions. Retrieved from http://www.dsm5.org/MeetUs/Pages/Anxiety.aspx

Applebaum, S. (1978). Pathways to change in psychoanalytic therapy. *Bulletin of Menninger Clinic, 42,* 239-251.

Aschenbrand, S.G., & Kendall, P.C. (2012). The effect of perceived child anxiety status on parental latency to intervene with anxious and nonanxious youth. *Journal of Consulting and Clinical Psychology*. Advance online publication. Retrieved on April, 4th, 2012.

Astendig, K.D. (1999). Is selective mutism an anxiety disorder: Rethinking its DSM-IV classification. *Journal of Anxiety Disorders, 13*(4), 417-434.

Axline, V. M. (1947). *Play therapy.* Boston: Houghton Mifflin.

Barlow, D. H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist, 55(11),* 1247-1263.

Barlow, D. H. (Ed.) (2001). *Clinical handbook of psychological disorders: Third edition.* New York: Guilford.

Barnett, I. (1984). Research note: Young children's resolution of distress through play. *Journal of Child Psychology and Psychiatry, 25,* 477-483.

Barrett, C., Hampe, T. E., & Miller, L, (1978). Research on child psychotherapy. In S. Garfield & A. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (pp. 411-435). New York: Wiley.

Beidel, D. C., & Turner, S. M. (1997). At risk for anxiety: I. Psychopathology in the offspring of anxious parents. *Journal of the American Academy of Child and Adolescent Psychiatry, 36,* 918–924.

Beidel, D. C., & Turner, S. M. (2005). *Childhood anxiety disorders: A guide to research and treatment.* New York: Routledge.

Benedict, H. E. (2003). Object-relations/thematic play therapy. In C. E. Schaefer (Ed.), *Foundations of play therapy* (pp. 281-305). New York: Wiley.

Benedict, H. E., Chavez, D., Holmberg, J., McClain, J., McGee, W., Narcavage, D., et al. (1996). *Benedict play therapy theme code.* Unpublished Working Paper, Baylor University, Waco, TX.

Benedict, H. E., Hastings, L., Ato, G., Carson, M., & Nash, M. (1998). *Revised Benedict play therapy theme code and interpersonal relationship code.* Unpublished Working Paper, Baylor University, Waco, TX.

Borkovec, T. D. (1994). The nature, functions, and origins of worry. In G. Davery & F. Tallis (Eds.), *Worrying: Perspectives on theory, assessment, and treatment* (pp. 5-33). New York: Wiley.

Boyle, M.H., Offord, D.R., Racine, Y., Sanford, M., Szatmari, P., Fleming, J.E., et al (1993). Evaluation of the Diagnostic Interview for Children and Adolescents for use in general population samples. *Journal of Abnormal Child Psychology, 21,* 663–681.

Bowlby, J. (1960). Separation anxiety. *International Journal of Psychoanalysis, 41,* 89-113.

Bratton, S., & Ray, D. (2000). What the research shows about play therapy. *International Journal of Play Therapy, 9, 47-88.*

Bratton, S., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice, 36(4),* 376-390.

Bretherton, I., Oppenheim, D., Prentiss, C., Buchsbaum, H., Emde, R., Lundquist, A., et al. (1990). *The MacArther Story Stem Battery.* Unpublished manuscript.

Brown, T. A., Chorpita, B. F., & Barlow, D. H. (1998). Structural relationships among dimensions of the DSM-IV anxiety and mood disorders and dimensions of negative affect, positive affect, and autonomic arousal. *Journal of Abnormal Psychology, 107,* 179-192.

Brown, T. A., & Lawrence, A. E. (2009). Generalized anxiety disorder and obsessive-compulsive disorder. In P. Blaney and T. Millon (Eds.), *The Oxford textbook of psychopathology* (*2nd edition,* pp. 146-175). New York: Oxford U Press.

Brown, T. A., O'Leary, T.A., and Barlow, D. H. (2001). Generalized anxiety disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders (3rd edition,* pp. 154-208). New York: Guilford.

Casey, R. J., & Berman, J.S. (1985). The outcome of psychotherapy with children. *Psychological Bulletin, 98,* 388-400.

Chethik, M. (1989). *Techniques of child therapy: Psychodynamic strategies.* New York: Guilford.

Chorpita, B. F., Tracey, S. A., Brown, T. A., Collica, T. J., & Barlow, D. H. (1997). Assessment of worry in children and adolescents: An adaptation of the Penn State Worry Questionnaire. *Behavior Research and Therapy, 35,* 569–581.

Clark, D. M. (1986). A cognitive approach to panic. *Behaviour Research and Therapy, 15,* 75-84.

Clark, L. A., Watson, D., & Mineka, S. (1994). Temperament and personality in mood and anxiety disorders. *Journal of Abnormal Psychology, 103,* 103-116.

Cohan, S. L., Chavira, D. A., & Stein, M. B. (2006). Practitioner review: Psychosocial interventions for children with selective mutism: A critical evaluation of the literature from 1990-2005. *Journal of Child Psychology and Psychiatry, 47*(11), 1085-1097.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: Guilford.

Comer, J.S., Kendall, P.C. (2004). A symptom-level examination of parent-child agreement in the diagnosis of anxious youths. *Journal of the American Academy of Child Psychiatry 43,* 878–886.

Cooley, C. H. (1902). *Human nature and the social order.* New York: Charles Scribner & Sons.

Cox, F. N., & Campbell, D. (1968). Young children in a new situation with and without their mothers. *Child Development, 39,* 123-131.

Crenshaw, D. A. (2006). *Evocative strategies in child and adolescent psychotherapy.* Lanham, MD: Jason Aronson.

Crenshaw, D. A., & Mordock, J. B. (2005). *Handbook of play therapy with aggressive children.* Lanham, MD: Rowman & Littlefield.

Davidson, R. J. (1998). Affective style and affective disorders: Perspectives from affective neuroscience. *Cognition and Emotion, 12*(3), 307-330.

Elo, S. & Kyngäs, H. (2008), The qualitative content analysis process. *Journal of Advanced Nursing, 62,* 107–115.

Emde, R. N., Wolfe, D. P., & Oppenheim, D. (2003). *Revealing the inner worlds of young children: The Macarthur Story Stem Battery and parent-child narratives.* New York: Oxford.

Erikson, E. (1963). *Childhood and society.* New York: Norton.

Esbjørn, B.H., Hoeyer,M., Dyrborg, J., Leth, I,. & Kendall, P.C. (2010) Prevalence and co-morbidity among anxiety disorders in a national cohort of psychiatrically referred children and adolescents. *Journal of Anxiety Disorders, 24,* 866-872.

Fein, G. (1987). Pretend play: Creativity and consciousness. In P. Gorlitz & J. Wohlwill (Eds.), *Curiosity, imagination, and play* (pp. 281-304). Hillsdale, NJ: Lawrence Erlbaum Associates.

Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2009). *Effective treatments for PTSD (2nd ed.): Practice guidelines from the International Society for Traumatic Stress Studies.* New York: Guilford.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99,* 20−35.

Francis, S.E., & Chorpita, B.F. (2011). Parental beliefs about child anxiety as a mediator of parent and child anxiety. *Cognitive Therapy & Research, 35,* 21-29.

Franklin, M. E., Freeman, J., & March, J. S. (2010). Treating pediatric obsessive-compulsive disorder using exposure-based cognitive-behavioral therapy. In J. R. Weisz and A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 80-92). New York: Guilford.

Freedheim, D., & Russ, S. W. (1992). Psychotherapy with children. In C. Walker & M. Roberts (Eds.), *Handbook of clinical child psychology (*2nd ed., pp. 765-781). New York: Wiley.

Freud, A. (1965). *Normality and pathology in childhood: Assessment of development.* New York: International Universities Press.

Freud, S. (1926). Inhibitions, symptoms and anxiety. In S. J. London (Ed.), *The standard edition of the complete psychological works of Sigmund Freud: Volume 20.* (1959) (pp. 75-175). London: Hogarth Press.

Furth, G. M. (2002). *The secret world of drawings: A Jungian approach to healing through art.* Toronto: Inner City Books.

Gabbard, G. (2000). *Psychodynamic psychiatry in clinical practice* (3rd ed.). Washington, DC: American Psychiatric Press.

Garfield, W. (1980). *Psychotherapy: An eclectic approach.*. New York: Wiley.

Gershaw, N. J., & Schwarz, J. C. (1971). The effects of a familiar toy and mother's presence on exploratory and attachment behaviors in young children. *Child Development, 42,* 1662-1666.

Ginsburg , G.S., Kendall, P.C., Sakolsky, D., Compton, S.N., Piacentini, J., et al. (2011). Remission after acute treatment in children and adolescents with anxiety disorders: Findings from the CAMS. *Journal of Consulting and Clinical Psychology, 79* (6), 806-813.

Golomb, C., & Galasso, L. (1995). Make believe and reality: Explorations of the imaginary realm. *Developmental Psychology, 31,* 800-810.

Golomb, C., & Kuersten, R. (1996). On the transition from pretense play to reality: What are the rules of the game? *British Journal of Developmental Psychology, 14,* 203-217.

Grant, B. F., Stinson, F. S., Dawson, D. A., Chou, P., Dufour, M. C., Compton, W., et al. (2004). Prevalence and co-occurrrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 61,* 807-816.

Guberman, C., & Manassis, K. (2011).Symptomatology and family functioning in children and adolescents with comorbid anxiety and depression. *Journal of the Canadian Academy of Child & Adolescence Psychiatry, 20*(3), 186- 195.

Hammerness, P., Harpold, T., Petty, C., Menard, C., Zar-Kessler, C., & Biederman, J. (2008). Characterizing non-OCD anxiety disorders in psychiatrically referred children and adolescents. *Journal of Affective Disorders, 105*, 213–219.

Harter, S. (2006). Self-processes and developmental psychopathology. In D. Cicchetti and D. Cohen (Eds.) *Developmental psychopathology* (2nd ed., Vol. 1: Theory and method, pp. 370-418). Hoboken, NJ: Wiley.

Hassan, I., & Ali, R. (2011). The association between somatic symptoms, anxiety disorders and substance use: A literature review. *Psychiatric Quarterly, 82*(4), 315-328.

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change.* Reno, NV: Context Press.

Hembree, E. A., Foa, E. B., Dorgan, N.M., Street, G.P., Kowalski, J., & Tu, X. (2003). Do patients drop out prematurely from exposure therapy for PTSD? *Journal of Traumatic Stress, 16*(6), 555-562.

Holmberg, J. R., Benedict, H. E., & Hynan, L. S. (1998). Gender differences in children's play therapy themes: Comparisons of children with a history of attachment disturbance or exposure to violence. *International Journal of Play Therapy, 7*, 67-92.

Hughes, D. (2007). *Attachment-focused family therapy.* New York: Norton.

In-Albon, T. & Schneider, S. (2006). Psychotherapy of childhood anxiety disorders: A meta-analysis. *Psychotherapy & Psychosomatics, 76(1),* 15-24.

Ishikawa, S., Okajima, I., Matsuoka, H., & Sakano, Y. (2007). Cognitive behavioural therapy for anxiety disorders in children and adolescents: A meta-analysis. *Child & Adolescent Mental Health, 12(4), 164-172.*

Johnson, P. A., & Stockdale, D. E. (1975). Effects of puppet therapy on palmar sweating of hospitalized children. *Johns Hopkins Medical Journal, 137,* 1-5.

Joiner, T. E., Schmidt, N. B., Schmidt, K. L., Laurent, J., Catanzaro, S. J., Perez, M., et al. (2002). Anxiety sensitivity as a specific and unique marker of anxious symptoms in youth psychiatric inpatients. *Journal of Abnormal Child Psychology, 30,* 167–175.

Kay, J. (2009). Toward a neurobiology of child psychotherapy. *Journal of Loss and Trauma: International Perspectives on Stress and Coping, 14(4),* 287-303.

Kazdin, A. (1990). Psychotherapy for children and adolescents. In M. R. Rosenweig & L. W. Potter (Eds.), *Annual review of psychology* (pp. 21-54). Palo Alto, CA: Annual Review.

Kazdin, A. (2000). *Pscyhotherapy for children and adolescents*. New York: Oxford University Press.

Kearney, C. A., Albano, A. M., Eisen, A. R., Allan, W. D., & Barlow, D. H. (1997). The phenomenology of panic disorder in youngsters: An empirical study of a clinical sample. *Journal of Anxiety Disorders, 11, 49-62.*

Kendall, P. C., Furr, J. M., & Podell, J. L. (2010). Child-focused treatment of anxiety. In J. R. Weisz & A. E. Kazdin, *Evidence-based psychotherapies for children and adolescents (2nd ed.)* (pp. 45-60). New York: Guilford.

Kendall, P.C. & Hedtke, K.A. (2006) *Cognitive-behavioural therapy for anxious children: Therapist manual (3rd ed.).* Ardmore: Workbook Publishing.

Kendler, K. S., Neale, M. C., Kessler, R. C., Heath, A. C., & Eaves, L. J. (1992). Generalized anxiety disorder in women—A population-based twin study. *Archives of General Psychiatry, 49,* 267–272.

Kenny, M.C., Faust, J. (1997). Mother-child agreement on self-report of anxiety in abused children. *Journal of Anxiety Disorders, 11,* 463–472.

Kent, G. & Gibbons, R. (1987). Self-efficacy and the control of anxious cognitions. *Journal of Behavior Therapy and Experimental Psychiatry, 18*(1), 33-40.

Kessler, J. (1966). *Psychopathology of childhood.* Englewood Cliffs, NJ: Prentice Hall.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikanga, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62,* 593–602.

Kimbrel, N. A. (2008). A model of the development and maintenance of generalized social phobia. *Clinical Psychology Review, 28,* 592 – 612.

Kirk, R. (1995). *Experimental design: Procedures for the behavioral sciences.* Pacific Grove, CA: Brooks/Cole.

Klein, M. (1955). The psychoanalytic play technique. *American Journal of Orthopsychiatry, 25,* 223-237.

Knell, S. (1993). *Cognitive-behavioral play therapy.* Northvale, NJ: Aronson.

Knell, S. (1999). Cognitive-behavioral play therapy. In S. Russ & T. Ollendick (Eds.), *Handbook of psychotherapies with children and families* (pp. 395-404). New York: Kluwer Academic Plenum Publishers.

Kohut, H. (1977). *The restoration of the self.* New York: International Universities Press.

Koocher, G., & D'Angelo, E. J. (1992). Evolution of practice in child psychotherapy. In D. K. Freedheim (Ed.), *History of psychotherapy* (pp. 457-492). Washington, DC: American Psychological Association.

Kronmüller, K.T., Postelnicu, I., Hartmann, M., Stefini, A., Geiser-Elze, A., Gerhold, M. et al. (2005). *Zur Wirksamkeit psychodynamischer kurzzeitpsychotherapie bei kindern und jugendlichen mit angststörungen* (Efficacy of psychodynamic short-term psychotherapy for children and adolescents with anxiety disorders). *Praxis der Kinderpsychologie und Kinderpsychiatrie*, *54(7)*, 559-577.

Langer, D. A., Wood, J. J., Bergman, L.R., & Piacentini, J. C. (2010). A multitrait–multimethod analysis of the construct validity of child anxiety disorders in a clinical sample. *Child Psychiatry & Human Development 41*, 549-561.

Lenze, S. N., Pautsch, J., & Luby, J. (2011). Parent-child interaction therapy emotion development: A novel treatment for depression in preschool children. *Depression & Anxiety, 28(2), 153-159.*

Levitt, E. E. (1957). The results of psychotherapy with children: An evaluation. *Journal of Consulting Psychology, 21*, 189-196.

Levitt, E. E. (1971). Research in psychotherapy with children. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (pp. 474-484). New York: Wiley.

Linden, D. E. J., (2006). How psychotherapy changes the brain – the contribution of functional neuroimaging. *Molecular Psychiatry, 11,* 528-538.

Lobo, I. (2008) Environmental influences on gene expression. *Nature Education*, *1*(1).

MacAndrew, C. & Steele, T. (1991). Gray's behavioral inhibition system: A psychometric examination. *Personality and Individual Differences, 12*(2), 157-171.

Mahler, M. S. (1975). On human symbiosis and the vicissitudes of individuation. *Journal of American Psychoanalytic Association, 23,* 740-763.

Mash, E. J. & Barkley, R. A. (Eds.) (2007). *Assessment of childhood disorders* (4th ed.). New York: Guilford.

McClure, E. B. & Pine, D. S. (2006). Social anxiety and emotion regulation: A model for developmental psychopathology perspectives on anxiety disorders. In D. Cicchetti and D. Cohen (Eds.) *Developmental psychopathology* (2nd ed., Vol. 3: Risk, disorder, and adaptation, pp. 470-502). Hoboken, NJ: Wiley.

McNally, R. J. (2007). Mechanisms of exposure therapy: How neuroscience can improve psychological treatments for anxiety disorders. *Clinical Psychology Review, 27,* 750-759.

Milos, M., & Reiss, S. (1982). Effects of three play conditions on separation anxiety in young children. *Journal of Consulting and Clinical Psychology, 50,* 389-395.

Moustakas, C. (1953). *Children in play therapy.* New York: McGraw Hill.

Muris, P., Merchelbach, H., Gadet, B., & Moulaert, V. (2000). Fears, worries, and scary dreams in 4- to 12-year-old children: Their content, developmental pattern, and origins. *Journal of Clinical Child Psychology, 29,* 43-52.

Nauta, M.H., Scholing, A., Rapee, R.M., Abbott, M., Spence, S.H., Waters, A. (2004). A parent-report measure of children's anxiety: Psychometric properties and comparison with child-report in a clinic and normal sample. *Behaviour Research and Therapy, 42,* 813–839.

Nestler, E. J., Hyman, S. E., & Malenka, R. C. (2009). *Molecular neuropharmacology: A foundation for clinical neuroscience* (2nd ed.). McGraw Hill: New York.

Noël, V.A. & Francis, S.E. (2011). A meta-analytic review of the role of child anxiety sensitivity in child anxiety. *Journal of Abnormal Child Psychology 39,* 721-733.

O'Neil, K. A., Podell, J. L., Benjamin, C. L., & Kendall, P. C. (2010). Comorbid depressive disorders in anxiety-disordered youth: Demographic, clinical, and family characteristics. *Child Psychiatry and Human Development, 41,* 330-341.

Parker, A. J., Hamlin, G. P., Coleman, C. J., & Fitzpatrick, L. A. (2003). Dehyrdation in stressed ruminants may be the result of a cortisol-induced diuresis. *Journal of Animal Science,* 81(2), 512-519.

Piche, G., Bergeron, l., Cyr, M., & Berthiaume, C. (2011) Maternal lifetime depressive/anxiety disorders and children's internalizing symptoms: The importance of family context. *Journal of the Canadian Academy of Child & Adolescence Psychiatry, 20*(3), 176- 185.

Play. (2009). In *The American heritage dictionary of the English language* (4th ed.). Retrieved from http://www.thefreedictionary.com/play.

Porto, P. R., Oliveira, L., Mari, J., Volchan, E., Figueira, I., & Ventura, P. (2009). Does cognitive behavioral therapy change the brain? A systematic review of neuroimaging in anxiety disorders. *The Journal of Neuropsychiatry and Clinical Neurosciences, 21,* 114-125.

Rachman, S. (1977). The conditioning theory of fear acquisition: A critical examination. *Behaviour Research and Therapy, 15,* 375-387.

Rae, W., Worchel, R., Upchurch, J., Sanner, J., & Dainiel, C. (1989). The psychosocial impact of play on hospitalized children. *Journal of Pediatric Psychology, 14,* 617-627

Reiss, S., Peterson, R. A., Gursky, D. M., & McNally, R. J. (1986). Anxiety sensitivity, anxiety frequency and the predictions of fearfulness. *Behaviour Research and Therapy, 24*, 1–8.

Research Unit on Pediatric Psychopharmacology. (2001). Fluvoxamine for the treatment of anxiety disorders in children and adolescents: The Research Unit on Pediatric Psychopharmacology Anxiety Study Group. *New England Journal of Medicine, 344*(17), 1279-1285.

Reynolds, C. R., & Kamphaus, R. W. (2004). Behavior Assessment System for Children (2nd ed.). Circle Pines, MN: American Guidance Service

Reynolds, C. R., & Richmond, B. O. (2008). Revised Children's Manifest Anxiety Scale (2nd ed.). USA: Western Psychological Services.

Rounsaville, B. J., Carroll, K. M., & Onken, L. S. (2001). A stage model of behavioral therapies research: Getting started and moving from stage I. *Clinical Psychology Science and Practice, 8,* 133-142.

Russ, S. W. (1995). Play psychotherapy research: State of the science. In T. Ollendick & R. Prinz (Eds.), *Advances in clinical child psychology* (pp. 365-391). New York: Plenum.

Russ, S. W. (2004). *Play in child development and psychotherapy: Toward empirically supported practice.* Mahwah, NJ: Lawrence Erlbaum Associates.

Schniering, C.A., Hudson, J.L., Rapee, R.M. (2000). Issues in the diagnosis and assessment of anxiety disorders in children and adolescents. *Clinical Psychology Review, 20*, 453–478

Silverman, W. K., & Albano, A. M. (1996). *The Anxiety Disorders Interview Schedule for DSM-IV – Child and Parent Versions.* San Antonio, TX: Graywind.

Southam-Gerow, M. A. & Chorpita, B. F. (2007). Anxiety in children and adolescents. In E. J. Mash & R. A. Barkley (Eds.) *Assessment of childhood disorders* (4th ed., pp. 347-397). Guilford: New York.

Taylor, S., Cox, B. J., & Asmundson, G. J. G. (2009). Anxiety disorders: Panic and phobias. In P. Blaney and T. Millon (Eds.) *The Oxford textbook of psychopathology,* (2nd ed., pp. 119-145). New York: Oxford University Press.

Vervoort, L., Wolters, L. H., Hogendoorn, S. M., de Haan, E., Boer, F., & Prins, P. J. M. (2010). Gray's behavioral inhibition system and clinically anxious and non-anxious children and adolescents. *Personality and Individual Differences, 48,* 629-633.

Waelder, R. (1933). Psychoanalytic theory of play. *Psychoanalytic Quarterly, 2,* 208-224.

Wampold, B. E. (2001). *The great psychotherapy debate.* Mahwah, NJ: Erlbaum.

Warren, S. (2003). Narrative Emotion Coding System (NEC). In R. N. Emde, D. P. Wolf, & D. Oppenheim (Eds.), *Reveling the inner worlds of young children: The MacArthur Story Stem Battery and parent-child narratives* (pp. 92-105). New York: Oxford University Press.

Warren, S. L., Emde, R. N., & Sroufe, L. A. (2000). Internal representations: Predicting anxiety from children's play narratives. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 100-107.

Watson D. & Pennebaker J. W. (1989). Health complaints, stress, and distress: Exploring the central role of negative affectivity. *Psychological Review, 96,* 234–54.

Weiss, D. D., & Last, C. G. (2001). Developmental variations in the prevalence and manifestation of anxiety disorders. In: M. W. Vasey, & M. R. Dadds (Eds.), *The developmental psychopathology of anxiety* (1st ed.., pp. 27–42). Oxford: Oxford University Press.

Weisz, J. R., Donenberg, G. R., Han, S. S., & Weiss, B. (1995). Bridging the gap between laboratory and clinic in child and adolescent psychotherapy. *Journal of Consulting and Clinical Psychology, 63,* 688-701.

Weisz, J. R., & Kazdin, A. E. (2010). *Evidence-based psychotherapies for children and adolescents.* New York: Guilford.

Weisz, J., & Weiss, B. (1993). *Effects of psychotherapy with children and adolescents.* Newbury Park, CA: Sage.

Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, CA: Stanford University Press.

Woo Sik, C., & Pardeck, J. T. (1995). Factors associated with premature termination of psychotherapy by children. *Adolescence, 30*(119), 717.

Wood, J.J., Piacentini, J.C., Bergman, R.L., McCracken, J., Barrios, V. (2002). Concurrent validity of the anxiety disorders section of the Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Versions. *Journal of Clinical Child Psychology, 31,* 335–342.

Yerkes R. M. & Dodson J. D. (1908). The relation of strength of stimulus to rapidity of habit-formation. *Journal of Comparative Neurology and Psychology, 18,* 459–482.

Zatz, S., & Chassin, L. (1985). Cognitions of test-anxious children under naturalistic test-taking conditions. *Journal of Consulting and Clinical Psychology, 53*(3), 393-401.