FILIAL THERAPY AND THE FAMILY: EXAMINING THE IMPACT OF CHILD PARENT RELATIONSHIP THERAPY (CPRT) ON FAMILY FUNCTIONING

Nicholas A. Cornett, M.S.

Dissertation Prepared for the Degree of

DOCTOR OF PHILOSOPHY

UNIVERSITY OF NORTH TEXAS

May 2012

APPROVED:

Sue Bratton, Major Professor
Natalya Lindo, Committee Member
Jan Holden, Committee Member and Chair of the Department of Counseling and Higher Education
Jerry Thomas, Dean of the College of Education
James D. Meernik, Acting Dean of the Toulouse Graduate School
Cornett, Nicholas A. *Filial therapy and the family: Examining the impact of child parent relationship therapy (CPRT) on family functioning*. Doctor of Philosophy (Counseling), May 2012, 201 pp., 15 tables, 32 illustrations, references, 302 titles.

Research has indicated that filial therapy, an approach in which parents conduct play sessions with their young children, has strong effects on the participating parents and children. As a result, some have speculated that filial therapy improves the family system; however, minimal research exists to support this claim. Using a single-case, time-series design, I examined the impact of child parent relationship therapy (CPRT), a filial therapy approach, on the functioning of 8 diverse families (two-parent, biological children = 4; two-parent, adopted children = 3; single-parent, biological children = 1). 15 parents and 17 children (male = 15, female = 17) participated in the study. All but 1 parent was Caucasian. The children were more ethnically diverse (Caucasian = 5, Hispanic/Caucasian = 5, Hispanic = 3, Asian = 2). Parents’ ages ranged from 29 to 49 and children’s from 2 to 13. Results from simulation modeling analyses (SMA) indicated that 6 of 7 families experienced a statistically significant improvement in their targeted areas of family functioning, and the average effect size was moderate. Results from self-reported measures indicated that 7 families experienced notable improvements in family satisfaction, 4 in cohesion, 3 in communication, and 1 in flexibility. Data from an observational measure rated by independent assessors also indicated improvements pre- to post-intervention: 5 families in flexibility, 4 families in cohesion, and 4 families in communication. All families reported improved functioning in post-intervention interviews. The results support that the benefits of filial therapy may indeed extend to the family system.
ACKNOWLEDGEMENTS

Although this work bears my name, it truly reflects the relentless support and effort of so many. First and foremost, I thank God, who has bestowed His blessings over my life time and time again. This season of my life was no different, and His sustenance and provision was readily evident: To Him be the glory. I also want to express my undying gratitude to my family: to my wife, Kim, whose life has and continues to be an ever-present source of encouragement and support; to my newborn daughter, Evie, whose impending arrival during the course of this research gave me all the initiative I needed to ensure its completion; to my parents, Alex and Teresa, whose sacrificial love and devotion has given me the most convincing evidence of the amazing influence that parents have on their children; and to my siblings, Callan, Kara, and Colleen, who contributed to making the joys of family life something that I often dwell on, desire, and want to help others experience. I am so very grateful for my friends as well who have often encouraged me and prayed for me as I have taken this journey.

I also want to acknowledge all the wonderful people at the University of North Texas who have given their care and support to me over the past three years: to my fellow doctoral students from my cohort, who contributed so much to my personal and professional growth; to my professors, whose personal investment in my education has given me a desire to do the same for others; and to my clients, who always seem to give me more than I am ever able to give in return. In particular, I thank Dr. Sue Bratton, my major professor. Her passion for and belief in using parents as therapeutic agents in the lives of their children was infectious. I also am indebted to Dr. Garry Landreth, who first showed me the joys of entering into the world of children through play. Finally, I want to express my gratitude for the families who gave so much of themselves in making this research study a reality.
TABLE OF CONTENTS

ACKNOWLEDGEMENTS ........................................................................................................... iii

LIST OF TABLES .......................................................................................................................... v

LIST OF FIGURES ....................................................................................................................... vi

FILIAL THERAPY AND THE FAMILY: EXAMINING THE IMPACT OF CHILD PARENT
RELATIONSHIP THERAPY (CPRT) ON FAMILY FUNCTIONING ........................................ 1

   Introduction ................................................................................................................................. 1

   Methods ....................................................................................................................................... 4

   Results ....................................................................................................................................... 19

   Discussion ................................................................................................................................. 22

   References ................................................................................................................................. 31

Appendices

   A. EXPANDED LITERATURE REVIEW ................................................................................. 38

   B. DETAILED METHODOLOGY ......................................................................................... 90

   C. UNABRIDGED RESULTS ............................................................................................ 111

   D. EXPANDED DISCUSSION .......................................................................................... 162

   E. ADDITIONAL MATERIALS .......................................................................................... 172

COMPREHENSIVE REFERENCE LIST .................................................................................. 182
# LIST OF TABLES

1. Results on Daily Ratings of Targeted Areas of Family Functioning .......................... 29
2. Results on the FACES IV, FCS, FSS, and CRS ............................................................... 30
3. Demographics of Parents in the Research Study (n = 15) ........................................... 104
4. Demographics of Children in the Research Study (n = 17) ........................................... 102
5. Demographics of Families in the Research Study (n = 8) ............................................ 102
6. Peasley Family: Family Cohesion, Flexibility, Communication, and Satisfaction ....... 117
8. Gilster Family: Family Cohesion, Flexibility, Communication, and Satisfaction ........ 130
10. Keith Family: Family Cohesion, Flexibility, Communication, and Satisfaction ......... 140
11. Jacobs Family: Family Cohesion, Flexibility, Communication, and Satisfaction ....... 145
12. Brooks Family: Family Cohesion, Flexibility, Communication, and Satisfaction ....... 152
13. Portela Family: Family Cohesion, Flexibility, Communication, and Satisfaction ....... 155
14. Results on Daily Ratings of Targeted Areas of Family Functioning ........................... 157
15. Results on the FACES IV, FCS, FSS, and CRS ............................................................... 159
LIST OF FIGURES

1. From baseline to treatment, Stephen’s ratings of the number of instances in which family members communicated feelings. .............................................................. 113
2. From baseline to treatment, Heather’s ratings of the number of instances in which family members communicated feelings............................................................ 114
3. From baseline to treatment, Stephen’s ratings of the number of instances in which family members acknowledged the feelings of another family member. ....................... 114
4. From baseline to treatment, Heather’s ratings of the number of instances in which family members acknowledged the feelings of another family member. ....................... 115
5. From baseline to treatment, Stephen’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.” ....... 115
6. From baseline to treatment, Heather’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.” ....... 116
7. From baseline to treatment, Patrick’s ratings of the number of instances in which family members communicated feelings.............................................................. 120
8. From baseline to treatment, Sophia’s ratings of the number of instances in which family members communicated feelings.............................................................. 120
9. From baseline to treatment, Patrick’s ratings of the number of instances in which family members acknowledged feelings.............................................................. 121
10. From baseline to treatment, Sophia’s ratings of the number of instances in which family members acknowledged feelings.............................................................. 121
11. From baseline to treatment, Patrick’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.” ....... 122
12. From baseline to treatment, Sophia’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.” ....... 123
13. From baseline to treatment, Jeffery’s ratings of the number of instances in which family members communicated feelings.............................................................. 127
14. From baseline to treatment, Nicole’s ratings of the number of instances in which family members communicated feelings.............................................................. 127
15. From baseline to treatment, Jeffery’s ratings of the number of instances in which family members acknowledged feelings.............................................................. 128
16. From baseline to treatment, Nicole’s ratings of the number of instances in which family members acknowledged feelings.............................................................. 128
17. From baseline to treatment, Jeffery’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.” ....... 129
18. From baseline to treatment, Nicole’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.” ........... 129
19. From baseline to treatment, Danielle’s ratings of the number of times a child did not comply with a parental directive................................................................. 134
20. From baseline to treatment, Danielle’s degree of agreement with the statement: “Family members are often able to utilize and respond to discipline successfully.” ............... 134
21. From baseline to treatment, Jane’s ratings of the number of times a child did not comply with a parental directive........................................................................... 138
22. From baseline to treatment, Jane’s degree of agreement with the statement: “Family members are often able to utilize and respond to discipline successfully.” ............... 139
23. From baseline to treatment, Warren’s ratings of the number of times a child did not comply with a parental directive........................................................................... 143
24. From baseline to treatment, Gwen’s ratings of the number of times a child did not comply with a parental directive........................................................................... 143
25. From baseline to treatment, Warren’s degree of agreement with the statement: “Family members are often able to utilize and respond to discipline successfully.” ............... 144
26. From baseline to treatment, Gwen’s degree of agreement with the statement: “Family members are often able to utilize and respond to discipline successfully.” ............... 144
27. From baseline to treatment, Harry’s ratings of the number of times a family member criticized another family member................................................................. 148
28. From baseline to treatment, Kathryn’s ratings of the number of times a family member criticized another family member................................................................. 149
29. From baseline to treatment, Harry’s ratings of the number of times a family member encouraged another family member................................................................. 149
30. From baseline to treatment, Kathryn’s ratings of the number of times a family member encouraged another family member................................................................. 150
31. From baseline to treatment, Harry’s degree of agreement with the statement: “Family members often encourage one another.” ......................................................... 150
32. From baseline to treatment, Kathryn’s degree of agreement with the statement: “Family members often encourage one another.” ......................................................... 151
FILIAL THERAPY AND THE FAMILY: EXAMINING THE IMPACT OF CHILD PARENT RELATIONSHIP THERAPY (CPRT) ON FAMILY FUNCTIONING

Introduction

The Call for Family-Centered Intervention

How a family functions has significant implications for the health of its members—to their betterment or detriment. Across helping professions, practitioners are increasingly emphasizing the need for and the importance of family-centered assessment and treatment, particularly for caregivers and young children (Perry, 2007; Pritchett et al., 2010; Reeves & Anthony, 2009; Reinherz et al., 2008; Tomlin & Viehweg, 2003; Wallander, Dekker, & Koot, 2006). Researchers have found that caregivers desire family-centered treatment (Sax, 2007) and that their involvement in the mental health treatment of children is associated with better outcomes (Richards, Bowers, Lazicki, Krall, & Jacobs, 2007). Researchers have also demonstrated the importance of family functioning to the health of infants and toddlers (Brackbill, White, Wilson, & Kitch, 1990; Herring et al., 2006; Keren, Dollberg, Koster, Danino, & Feldman, 2010), young children (Bastiaansen, Koot, & Ferdinand, 2005; Wallander et al., 2006), adolescents (Crane, Ngai, Larson, & Hafen, 2005; Reigstad, Jørgensen, Sund, & Wichstrøm, 2006), and adults (Kessler et al., 2010; Paradis et al., 2011).

In accordance with this research evidence, governmental (U.S. Public Health Service, 2000) and professional organizations have underscored the importance of developing, researching, and utilizing family-centered treatment approaches (AAMFT, 2001, 6.8; ACA, 2005, A.1.d.; APA, 2002, 10.02, 2005, p. 2; CACREP, 2009, II.G.5.e.; NASW, 2008, preamble). Currently, though, there appears to be a lack of practitioners who are using such interventions, especially with families who have young children. Family therapists and play therapists are two groups of professionals in particular who have frequent contact with families. Several studies in
play therapy reveal that play therapists often encounter family issues (Kranz, Kottman, & Lund, 1998; Ryan, Gomory, & Lacasse, 2002; Tsai & Ray, 2011), and family therapists often encounter families who are experiencing issues with their young children (Doherty & Simmons, 1996; Hines, 1996). Interestingly, practitioners and researchers within both specialty areas have voiced concerns regarding the lack of inclusive family treatment (Botkin, 2000; Gil, 1994; Green, 1994; Haslam & Harris, 2011; Hutton, 2004; Johnson & Thomas, 1999; Korner & Brown, 1990; Miller & McLeod, 2001; Raimondi & Walters, 2004; Sori & Sprenkle, 2004; Zilbach, 1986).

Filial Therapy as an Intervention for Families

Some practitioners have pointed to filial therapy as a viable treatment option for working more holistically with families and their young children. Filial therapy, first introduced by Guerney (1964), is an approach in which parents learn the basic principles and skills of child-centered play therapy and apply them through having play sessions with their young children. The aim of filial therapy is to utilize parents as therapeutic agents in the lives of their children (Guerney, 1964; Landreth & Bratton, 2006). One of the most popular models of filial therapy, child parent relationship therapy (CPRT), is a 10-session model of filial therapy developed by Landreth and Bratton (2006). Research has supported the overall effectiveness of CPRT in promoting changes in the parents and children who participate in treatment (Bratton, Ray, Rhine, & Jones, 2005). Replicated findings have indicated notable improvements in parental acceptance and expressions of empathy as well as decreased child behavior problems and decreased stress in the parent-child relationship (see Bratton, Landreth, and Lin, 2010).

Proponents of filial therapy, based on such research as well as theoretical and anecdotal evidence, have contended that filial therapy effectively changes the family (Gil, 1994; Guerney
& Guerney, 1987; Hutton, 2004; Johnson, 1995; Johnson, Bruhn, Winek, Krepps, & Wiley, 1999; Kellam, 2001). However, investigators have conducted very little research to evaluate this contention. Qualitative studies conducted by Bavin-Hoffman, Jennings, and Landreth (1996), Lahti (1992), and Wickstrom (2009) have resulted in findings that are suggestive of potential changes occurring in the family as a whole. In interviews with 20 married couples who participated in CPRT, Bavin-Hoffman et al. (1996) found that participants reported improved family interpersonal communication skills, specifically improved parent-child communication and improved partner communication. In addition, these couples reported increased marital unity and indicated that their families valued CPRT. Lahti’s (1992) ethnographic study of three CPRT-trained parents also found reports of closer marital relationships. Using a sample of eight parents trained in CPRT, Wickstrom (2009) found “four relational shifts” as a result of treatment, which included “improved parent-child relationships, improved marital relationships, improved sibling functioning, and improved family-of-origin relationships” (p. 199). Only one filial therapy study, conducted by Glass (1986), incorporated a quantitative measure of family functioning. She found that filial-trained parents reported statistically significant increases in their perceptions of expressed conflict in the family. Glass examined several other variables related to family functioning in this study; however, the relatively small sample size and low power interfered with the ability to draw appropriate conclusions using conventional tests of statistical significance.

Purpose of the Study

Given (1) previous research indicating the importance of family functioning, (2) the call for investigating and utilizing family-centered approaches, and (3) the current gap in the professional literature and research related to filial therapy, the purpose of this study is to
examine the impact of filial therapy on family functioning. The following research question was
the focal point of this study: What impact does filial therapy, specifically CPRT, have on family
functioning?

Methods

In conducting this study, I employed a single-case, time-series design (Borckardt et al.,
2008; Lundervold & Belwood, 2000; Ray, Barrio Minton, Schottelkorb, & Brown, 2010;
Sharpley, 2007). A single-case design allowed for experimental rigor without the noted
difficulties in conducting large-scaled studies (Borckardt et al., 2008).

Instrumentation

Individualized Ratings Forms

The primary instrumentation utilized in this study consisted of individualized rating
forms that I created for families, using guidelines offered by Borckardt et al. (2008), in order for
them to track a targeted area of family functioning. Prior to the intervention, I collaborated with
parents to identify a target area of family functioning that they believed needed improvement
(e.g., emotional responsiveness, discipline, conflict, communication, etc.). Once identified, I
created forms consisting of three ratings that the parents would use to assess the target area on a
daily basis. Of the three ratings, two consisted of rating actual behaviors, and one consisted of
rating one’s perception of the family’s functioning related to the target area. To promote the
fidelity of data collection, I ensured that the parents understood the constructs that they were
rating, instructed them on the importance of rating on a daily basis, and helped participants come
up with a routine for completing the ratings. I also contacted participants using their preferred
mode of communication (e.g., phone or email) throughout the first week to provide a reminder
and to be available for any questions. I instructed participants not to complete the ratings for
days in which they had limited or no contact with their family due to work travel so that this circumstantial factor would not act as a confounding variable. Participants began completing these ratings the day of or the day after pretesting, which provided 7-8 baseline observations prior to treatment, fulfilling the minimum of 5-7 ratings recommended by Borckardt et al. (2008). Participants then completed the ratings on a daily basis throughout treatment, thus resulting in 76-77 treatment observations.

Three families targeted emotional responsiveness as the area of family functioning that needed improvement and completed the following ratings: (1) number of instances in which family members communicate their feelings; (2) number of instances in which a family member acknowledges the feelings of another family member; and (3) degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members often express their feelings and are sensitive to the feelings of others.” Three families targeted discipline and completed these ratings: (1) number of instances in which a parent provides a directive, limit, or consequence for behavior; (2) number of instances in which a child complies with a directive, limit, or consequence set by a parent; and (3) degree of agreement with the statement: “Family members often utilize and respond to discipline successfully.” On the discipline ratings, I subtracted the number of directives complied with by a child from the number provided by a parent, which resulted in the number of times a child did not comply with a parental directive. This served as the indicator of the degree of improvement in the family’s discipline. One family targeted encouragement and completed ratings of the following: (1) number of instances in which a family member criticizes another family member; (2) number of instances in which a family member praises or encourages another family member; and (3) degree of agreement with the statement: “Family members often encourage one another.”
Formal Outcome Measures of Family Functioning

I utilized instruments developed by David Olson and his colleagues to measure family functioning according to the circumplex model of marital and family systems. Olson, Sprenkle, and Russell (1979) first presented the circumplex model, and Olson (2000) and Olson and Gorall (2003) provided more recent overviews. According to Olson and Gorall (2003), the model provides a “relational diagnosis” by assessing a family’s “relational system” according to three dimensions: cohesion, flexibility, and communication (p. 515). Olson (2011) provided the most updated definitions of these constructs. Cohesion is “the emotional bonding that couple and family members have toward one another” (p. 65). Family flexibility refers to “the quality and expression of leadership and organization, role relationship, and relationship rules and negotiations” (p. 65). Finally, family communication is “the positive communication skills utilized in the couple or family system” and is “a facilitating dimension that helps families alter their levels of cohesion and flexibility” (p. 65).

The main hypothesis of the circumplex model is as follows: “Balanced levels of cohesion and flexibility are most conducive to healthy family functioning. Conversely, unbalanced levels of cohesion and flexibility (very low or very high levels) are associated with problematic family functioning” (Olson, 2011, p. 65). The model contains five levels of flexibility: inflexible, somewhat flexible, flexible, very flexible, and overly flexible. The three middle levels represent the balanced dimension, and the first and last levels are the unbalanced dimensions. Similarly, the model contains five levels of cohesion: disconnected, somewhat connected, connected, very connected, and overly connected. Thus, the circumplex model posits a curvilinear relationship between a family’s degree of cohesion and flexibility and healthy functioning. Olson and Gorall (2003) reported that more than 250 studies have supported this hypothesis.
A second main hypothesis in the circumplex model is that positive communication skills enable families to change their levels of cohesion and flexibility. Olson and Gorall (2003) cited a study of 21,501 married couples that provided support for the relationship amongst these constructs.

*Family Adaptability and Cohesion Evaluation Scale (FACES IV)*

The FACES IV (Olson et al., 2006), one of the most widely used family assessments, is a 42-item self-report instrument used to assess family cohesion and flexibility. An extensive review conducted by Kouneski (2000) revealed that researchers have used a version of FACES in more than 1,200 published articles and dissertations.

Olson (2011) reported results from a validation study of FACES IV on a sample of 469 individuals. An exploratory factor analysis of the items in FACES IV supported four unbalanced factors (Disconnected, Overly Connected, Inflexible, and Overly Flexible) and two balanced factors (Balanced Cohesion and Balanced Flexibility). A confirmatory factor analysis revealed “an acceptable or well-fitted model” (p. 68). Cronbach’s alpha internal consistency analyses of the scales revealed very good reliability: Overly Connected $\alpha = .77$, Balanced Cohesion $\alpha = .89$,Disconnected $\alpha = .87$, Overly Flexible $\alpha = .86$, Balanced Flexibility $\alpha = .84$, and Inflexible $\alpha = .82$. Large positive correlations ($r = .89$ to $r = .99$) existed between the balanced scales and three other measures of family functioning, providing support for concurrent validity. Using all the scales, FACES IV was able to discriminate groupings of problem and non-problem families with a predictive accuracy averaging 92%, providing support for discriminant validity.

*Family Communication Scale (FCS)*

The FCS is a 10-item self-report instrument based on the 20-item Parent-Adolescent Communication (PAC) scale developed by Barnes and Olson (1985). In the interests of creating
a shorter scale, 10 items from the Open Family Communication subscale became the Family Communication Scale. The norming sample consisted of 2,465 individuals. The items are on a 5-point, Likert scale, and individuals rate the degree to which they perceive they agree with the item as being true for their family. The following is an example item: “Family members can calmly discuss problems with each other.” Based on this sample, researchers standardized the instrument and developed the following categories for interpretation: very high (86th-99th percentiles), high (70th-83rd percentiles), moderate (50th-65th percentiles), low (24th-44th percentiles), and very low (10th-20th percentiles). The internal consistency reliability of the scale was $\alpha = .90$, and the test-retest reliability was $r = .86$.

**Family Satisfaction Scale (FSS)**

The FSS, developed by Olson and Wilson (1982), is a 10-item self-report instrument. According to Olson (2011), the FCS assesses “the level of satisfaction family members have with their families’ functioning,” specifically their cohesion, flexibility, and communication. The scale was first used in a study of 1,000 families (Olson, 2006). Results from this study revealed that family satisfaction accounted for roughly half of the variance in ratings of quality of life. Individuals rate the items on a 5-point, Likert scale, indicating the degree to which they are satisfied with various aspects of their family. For example, the following is an item from this scale: “[How satisfied are you with] The degree of closeness between family members.” The FSS was normed using a sample of 2,465 individuals. Olson reported the following as cutoff scores for interpretive purposes: very high (86th-99th percentiles), high (61st-85th percentiles), moderate (36th-60th percentiles), low (21st-35th percentiles), and very low (10 to 20th percentiles). The alpha reliability of the scale was .92, and the test-retest reliability was $r = .85$ for the norming sample.
Clinical Rating Scale (CRS)

The CRS is an observational instrument developed by Olson (2003) and his colleagues to assess family cohesion, family flexibility, and family communication using a semi-structured interview, a family interaction task, or both. The CRS, like the FACES IV, offers an assessment of family functioning according to the circumplex model. Within family cohesion, raters scored families on a 10-point scale that categorizes families as disconnected, somewhat connected, connected, very connected, or overly connected. Within family flexibility, raters assess families on a 10-point scale that categorizes families as inflexible, somewhat flexible, flexible, very flexible, or overly flexible. For family communication, raters scored families on a 6-point scale that categorizes their communication as low, moderate, or high.

Two studies involving factor analyses of the CRS support the construct validity of the instrument (Lee, Jager, Whiting, & Kwantes, 2000; Thomas & Olson, 1993). Researchers have found the CRS to discriminate between problem and non-problem families (Thomas & Olson, 1993) and to support the curvilinearity hypothesis of the circumplex model (Thomas & Olson, 1994; Thomas & Ozechowski, 2000). Exploratory and confirmatory factor analyses have indicated that the CRS measures the three constructs it purports to measure (Thomas & Lewis, 1999). Lee et al. (2000) reported acceptable to good internal consistency values ranging from $\alpha = .78$ to $.89$ for the three variables. Thomas and Olson (1993) reported excellent internal consistency values of $\alpha = .95$ to $.97$. Thomas and Olson also reported that the two raters in their study achieved excellent interrater reliability, with percentage agreement within one point ranging from 91.1% to 97.4% for the three constructs.
Participants

To recruit participants, I used convenience sampling and two primary resources in the community where I conducted the study. The first resource was a group of waitlisted parents who expressed interest in receiving CPRT at the university-based, community counseling clinic at which the interventions for this study took place. The second resource was an organization providing extensive support and training to foster and adoptive parents.

Families had to meet the following criteria: (1) had at least one parent interested in CPRT, at least 18 years old, and able to speak and read in English; (2) had at least one child between the ages of 2-10, with identified behavioral or emotional concerns and normal cognitive ability, who would serve as the child of focus for the parent participating in CPRT; (3) had at least one additional family member other than the parent or child participating in CPRT who was willing to participate in pretest and posttest family assessments; and (4) demonstrated clinical appropriateness for participation in CPRT (Landreth & Bratton, 2006) and the research study as determined through completion of the intake and informed consent process.

Ten families consented to participate. Two families dropped out during the course of the study: one prior to the intervention due to transportation issues and one after the second CPRT session due to a family emergency. An examination of the available data revealed that the families who dropped out did not differ notably from those who completed the study. A total of 8 families, consisting of 15 parents and 17 children, participated in the research study in its entirety. Of the 15 parents, 13 participated in CPRT. The parents participating in the study were predominantly Caucasian (n = 14); however, the children were more ethnically diverse (Caucasian = 5, Hispanic/Caucasian = 5, Hispanic = 3, Asian = 2). In general, the parents were highly educated, with 11 having at least a bachelor’s degree. Regarding relationship status, most
were in their first marriage ($n = 10$), one parent was single (divorced), and the remaining parents were in second marriages. Gender was roughly equal in representation amongst parents (male = 7, female = 8) and children (male = 8, female = 9). Parents’ ages ranged from 29 to 49, and children’s ages ranged from 2 to 13. The families were diverse in structure (two parents, biological children = 3; two parents, adopted children = 3; two parents, stepfamily, biological children = 1; one parent, biological children = 1). Level of income differed notably amongst families ($80-100k = 4, $60-80k = 1, $10-20k = 1, <$10k = 1, Not reported = 1). In the following descriptions, pseudonyms are used to protect participants’ identities.

**Peasley Family**

The Peasley family consists of 3 members: father, Stephen (49); mother, Heather (45); and son, Anthony (8½). Stephen and Heather, who are Caucasian, adopted Anthony, who is Asian, internationally roughly 1½ years prior to the study. Stephen attended 6 out of the 10 CPRT sessions and conducted only 3 of the 7 possible play sessions. Heather attended 9 CPRT sessions and conducted 4 play sessions.

**Romm Family**

The Romm family consists of 6 members: father, Patrick (41); mother, Sophia (29); 2 daughters, Candace (10) and Vanessa (5); and 2 sons, Parker (9) and Clayton (4). Sophia is Hispanic, and Patrick is Caucasian. Vanessa and Clayton are the parents’ biological children. Candace and Parker are children from Sophia’s first marriage and are Hispanic. Patrick and Sophia participated in CPRT. Patrick attended 6 out of the 10 CPRT sessions and conducted 4 of the 7 play sessions with Parker. Sophia attended 9 CPRT sessions and conducted all 7 play sessions with Candace.
Gilster Family

The Gilster family has 4 members: father, Jeffery (36); mother, Nicole (35); and 2 daughters, Callie (5½) and Chelsea (4). All family members are Caucasian. Callie is Jeffery and Nicole’s biological child, and they adopted Chelsea when she was 2 years old. Nicole attended 8 of the 10 CPRT sessions and conducted 6 out of 7 play sessions with Chelsea.

Roe Family

The Roe family has 4 members: father, Kurtis (45); mother, Danielle (47); son, Isaac (7); and daughter, Madeline, (5). All family members are Caucasian, and Isaac and Madeline are the parents’ biological children. During the course of the study, Isaac and Madeline received individual play therapy services, and Danielle received individual counseling services. Danielle attended 9 CPRT sessions and conducted all 7 play sessions with Madeline.

Keith Family

The Keith family consists of 4 members: mother, Jane (42); son, Jared (12); and 2 daughters, Lindy (10) and Meagan (7). Jared, Lindy, and Meagan are Jane’s biological children. Jane is Caucasian, and her children are Caucasian and Hispanic. Jane attended 8 CPRT sessions and conducted 5 of the 7 play sessions.

Jacobs Family

The Jacobs family has 4 members: father, Warren (35); mother, Gwen (36); and 2 daughters, Kimberly (3½) and Elizabeth (21 months). Kimberly and Elizabeth are the parents’ biological children, and all family members are Caucasian. Warren attended only 5 CPRT sessions and conducted 5 play sessions. Gwen attended 7 CPRT sessions and conducted 4 play sessions. Both parents conducted play sessions with Kimberly.
Brooks Family

The Brooks family consists of 4 members: father, Harry (46); mother, Kathryn (43); and 2 sons, Miles, (8) and Robert (6). Harry and Kathryn, who are Caucasian, adopted Miles, who is Hispanic, and Robert, who is Asian, internationally. Miles and Robert received individual play therapy services during the study. Harry and Kathryn participated in CPRT. Harry did his play sessions with Miles and Kathryn with Robert. Harry attended 9 out of the 10 CPRT sessions and conducted 6 of the 7 possible play sessions. Kathryn attended 7 CPRT sessions and conducted 4 play sessions.

Portela Family

The Portela family has 3 members: father, Kyle (35); mother, Carol (33); and son, Cliff (6). Cliff is the biological son of Kyle and Carol. All family members are Caucasian. Kyle and Carol participated in CPRT and conducted at-home play sessions with Cliff. Kyle attended 6 out of the 10 CPRT sessions and conducted 4 of the 7 play sessions. Carol attended 8 CPRT sessions and conducted 5 play sessions.

Treatment

I assigned the 13 CPRT participants into 1 of 2 groups in order to meet the recommended number of 6-8 parents per group (Landreth & Bratton, 2006). Both groups met for 2-hour sessions for 10 weeks, and the groups took place at a university-based, community counseling clinic.

I facilitated the sessions, along with a co-leader, according to the protocol outlined in the CPRT manual (Bratton et al., 2006). My co-leaders and I received formal training and supervision in child-centered play therapy and in CPRT protocol. The goal of CPRT is to strengthen the child-parent relationship through teaching parents how to conduct at-home play
sessions with their children (Landreth & Bratton, 2006). CPRT involves two primary components: (1) a didactic component, which revolves around teaching the basic play session attitudes, procedures, and skills; and (2) a group process component, which consists of facilitating an environment of warmth, support, and feedback amongst the parents (Landreth & Bratton, 2006).

In Session 1, parents describe their child of focus and report the primary issues they are experiencing with this child. The parents learn the skill of reflective responding. Session 2 consists of parents learning basic concepts and skills related to facilitating their play sessions. Parents also start collecting the toys for the play sessions from a defined list. In Session 3, parents role-play the basic skills in preparation for their weekly 30-minute play sessions, which begin after this session and continue throughout the remaining seven sessions. Beginning in Session 4, time is spent processing and supervising parents’ play sessions. One to two parents per week share a video recording of their most recent play session so that group leaders and group members can provide supportive and constructive feedback. This supervision time is continued throughout CPRT, with each parent ideally showing a video at least once. In Session 4, parents also learn the skill of limit setting. Session 5 provides time to review the skills already covered, to role-play, and to process play sessions in greater depth. In Sessions 6, 7, 8, and 9 parents learn the skills of choice giving, esteem-building responses, encouragement, and advanced limit setting. Session 10 consists of helping parents to generalize the skills they learned and to process the changes they have noticed in themselves and in their children.

In order to assess for treatment integrity, I recorded video of all the group sessions. One of the authors of the CPRT protocol evaluated a random selection of these sessions and determined that the sessions adequately reflected CPRT.
Data Collection

Using single-case research guidelines provided by Borckardt et al. (2008), I collected data on target behaviors related to family functioning in conjunction with pretest-posttest data on more formal outcome measures (FACES IV, FCS, FSS, and CRS). To protect the confidentiality of participants, I assigned codes to all data collected.

Data collection occurred in three phases: (1) pre-intervention, (2) during the intervention, and (3) post-intervention. For the pre-intervention phase, I arranged a 1½-hour session with each family that took place 1 week prior to the intervention. I first reviewed the informed consent for CPRT and the study. After obtaining consent, I conducted a 30-minute play activity with each family in which they created a scene to represent a typical day in their family using a sandtray and a variety of figurines. The goal of the activity was to generate interaction between family members, using a developmentally-sensitive task relevant to all family members, to provide additional data for the raters to utilize in completing the CRS. After the play activity, I allowed the children to leave and conducted a 30-minute, semi-structured interview with the parents using the questions provided in the CRS manual. Afterwards, the parents completed the self-report family measures related to family functioning (FACES IV, FCS, and FSS). The researcher provided an environment free of distractions for the parents to complete these measures in order to promote the fidelity of the data and limit the bias that might otherwise occur if they completed these in the presence of other family members. Research team members were available to address any questions or concerns.

After the family activity and the interview, I collaborated with parents to identify a target area of family functioning that they believed needed improvement. I created individualized
rating forms as indicated in the instrumentation section. I collected rating forms on a weekly basis during each CPRT session.

The post-intervention phase involved families returning 1 week after the final session to complete the family play activity, semi-structured interview, and formal outcome measures. I utilized raters to complete the CRS based on video recordings of the family play activity and semi-structured interviews. The raters were two doctoral-level counseling students with advanced training and experience in child-centered play therapy, CPRT, and observational assessments. I facilitated an 8-hour training with the raters, which included practice ratings. I instructed raters to complete the CRS based on the family interaction task and then to utilize the semi-structured interview to further inform their ratings. To evaluate interrater reliability, I calculated the percentage of agreement on global ratings of cohesion, flexibility, and communication that were within 1 point of each other. This approach to calculating interrater reliability is common (Stemler, 2004), and a previous study using the CRS utilized this method (Thomas & Olson, 1993). Based on the three practice ratings completed during the training, the raters demonstrated excellent interrater reliability, achieving 100% agreement on all ratings. I randomly assigned the recordings to the raters, and the order in which the raters were to watch the recordings, in order to blind them to whether the recording was pre- or post-intervention. The raters completed all ratings within 1 week of the training. After completing their ratings, the raters completed an additional assessment of their interrater reliability using another practice rating, and they again achieved 100% agreement.

Data Analysis

When analyzing single subject data, researchers have tended to rely on either visual or statistical methods, and there is considerable debate regarding which method is more valid (Gast,
2010; Morgan & Morgan, 2009; Nugent, 2010). After reviewing the literature on approaches to analyzing single-case data, it became clear that there were strengths and limitations to visual and statistical analyses. I elected to rely on statistical methods for the following reasons: (1) as noted by Campbell and Herzinger (2010), there can be significant limitations involved in visual analysis, such as low reliability, susceptibility to Type 1 error, and a lack of universal decision rules; (2) the strengths of statistical analyses appeared more attractive for this study, namely the ability to identify small effects, to better control for variability in the data, to provide greater objectivity, and to quantify the magnitude of change (Campbell & Herzinger, 2010); (3) the use of statistical methods allows for greater ease in consolidating and comparing results between participants within a study and across studies; (4) my own background involved more training in the utilization of approaches based on statistical inference as opposed to visual methods; and (5) I designed this study in accordance with guidelines outlined by Borckardt et al. (2008), which incorporated the use of a specific statistical approach to analyzing data.

I conducted time-series statistical analyses on each rating using a computer software program called Simulation Modeling Analysis 9.9.28 (SMA; Borckardt, 2006), which can be downloaded for free (http://clinicalresearcher.org/software.htm). I elected to exclude from further analysis any ratings that contained less than 75% of completed data. One advantage of SMA is that it accounts for autocorrelation that is present in the data as part of the analysis, a noted issue in single-case research for which a limited number of analytical approaches take into account (Campbell & Herzinger, 2010; Nugent, 2010). Autocorrelation reflects the degree of dependence between observations: that “the value of one observation depends (at least in part) on the value of one or more of the immediately preceding observations” (Borckardt et al., 2008, p. 82). Single-case, time-series data tends to have more dependence across observations for two
reasons: (1) the same individual is completing the observations; and (2) the observations often occur in proximity to one another, and observations that are more closely rated in time are more likely to be closely related in value. Many conventional statistical methods rely on the assumption that observations are independent, and, if used with data that has high autocorrelation, researchers risk greater chances of making a Type I error. In addition to accounting for autocorrelation, SMA has a distinct advantage in being able to analyze short data streams, which are present in this study in the relatively small number of baseline ratings. Borckardt et al. (2008) recommended that other statistical methods be used with larger data streams (> 29 ratings per phase), a condition that I met for treatment phase data but not for baseline phase data. I completed the steps of time-series analysis as outlined by Borckardt et al. (2008). SMA calculates a Pearson $r$ value between the data collected during the baseline and treatment phases. SMA then analyzes the statistical significance of this $r$ value by comparing it to a random distribution of 5,000 $r$ values generated by the program that have the same number of phase ratings and degree of autocorrelation. This allows for determining the likelihood of obtaining such a value by chance.

I also analyzed additional quantitative data provided by the FACES IV, FCS, FSS, and CRS. Scores from these measures served as additional evidence for evaluating the impact of CPRT on family functioning. From the FACES IV, I utilized the ratio scores on cohesion and flexibility, which Olson (2011) recommended for research purposes. These scores reflect the ratio of balanced levels to unbalanced levels of cohesion and flexibility. For example, the cohesion ratio equals families’ scores on the Balanced Cohesion subscale over their average scores on the Overly Connected and Disconnected subscales. I used the mean and standard deviation of these ratio scores from the norming sample in order to analyze the results from these
measures. For the FCS and FSS, I used the percentile scores and the associated category from their norming samples. Finally, for the CRS, I used the scores and associated category from the global ratings.

The above measures allowed me to assess the results for statistical and clinical significance (Thompson, 2002). To assess practical significance, I calculated the percent of data exceeding the median (PEM; Ma, 2006). This method involves calculating the percentage of data points in the treatment phase that indicate an improvement above the median of the data points in the baseline phase. If the treatment phase data mirrors the baseline phase data, then one would expect that 50% of the data would be above the baseline median and 50% would be below the baseline median. As the PEM increases above 50%, it provides an indication of a change in the data from baseline to treatment. I utilized the following interpretive guidelines provided by Scruggs and Mastropieri (1998), as recommended by Ma (2006): 50% or less indicates no effect, 50-70% indicates a questionable effect, 70-90% indicates a moderate effect, and 90% and above indicates a strong effect. By calculating an average PEM across all participants, I obtained an indication of the overall effect. I also examined the effect size within the context of previous research (Thompson, 2006).

Results

Although it is typical to report results of a single-case study according to each participant, space limitations necessitate examining the results collectively. I first report the results on the targeted areas of family functioning and then move towards examining the collective results on the more formal outcome measures.
Targeted Areas of Family Functioning

Table 1 presents the results of the statistical analyses on the targeted areas of family functioning. Both parents from Portela family and the father from the Roe family did not meet the criteria of completing at least 75% of their ratings, thereby excluding their ratings from further analysis. Looking at the results collectively, 6 of the 7 families experienced at least one statistically significant improvement related to their targeted area of family functioning. In addition, average PEM effect sizes were either moderate or strong for 5 of the 7 families. Interestingly, the Gilster family was the only one in which the raters differed consistently, with the father’s ratings revealing no significant differences and the mother’s indicating all significant differences. This result is also intriguing given that he was the only parent in the study who completed the targeted area ratings and did not participate in CPRT. Across all families, the average PEM was 72%, which is indicative of a moderate effect (Scruggs & Mastropieri, 1998).

Family Cohesion, Flexibility, Communication, and Satisfaction

All eight families completed pre- and post-intervention data for the formal measures (FACES IV, FCS, FSS) as well as the family play activities and semi-structured interviews for the raters to complete the observational measure (CRS). Table 2 reflects the data compiled on these measures.

The pre-intervention data reflected that, in general, families were functioning at healthy levels prior to the intervention. FACES IV data revealed that no families fell below 1 standard deviation of the average cohesion and flexibility ratios for the norming sample. Data from the FCS also indicated that most of the parents perceived their families as having positive family communication prior to the intervention, with data from 11 of the 15 parents resulting in families scoring as moderate or above. In addition, on the FSS, 9 of the 15 parents obtained a score on
family satisfaction that was moderate or above. Data from the observational measure of family functioning (CRS) revealed that only one family scored in an unbalanced range on cohesion and only 1 scored low on communication.

Despite the generally healthy levels observed in family functioning prior to intervention, post-intervention data revealed notable changes in many of the families. On the cohesion dimension for the FACES IV, data from at least one parent in 4 of the 8 families reflected notable to substantive increases in balanced cohesion from pretest to posttest. Specifically, data from two parents reflected approximately ½ standard deviation improvements in their families’ balanced cohesion (Peasley: Mom, Brooks: Dad), two parents reflected improvements of roughly 1 standard deviation (Jacobs: Mom, Gilster: Dad), and one reflected an improvement of 1½ standard deviations (Jacobs: Dad). Data from one parent reflected a ½ standard deviation decrease in balanced cohesion from pretest to posttest (Gilster: Mom). Data from the post-intervention observations also revealed notable increases in balanced cohesion for 4 of the 8 families. Specifically, two families shifted from very connected to connected (Roe and Brooks), one family shifted from overly connected to very connected (Keith), and one family shifted from somewhat connected to connected (Portela). Two families shifted to less balanced levels of cohesion, with one family moving from connected to very connected (Romm) and one from connected to overly connected (Peasley).

Data from only one family on the FACES IV reflected a notable increase in their balanced flexibility from pretest to posttest (Jacobs: Dad), which was an increase of a ½ standard deviation. Two families reflected notable to moderate decreases in balanced flexibility. One parent’s data reflected roughly ½ standard deviation decrease in balanced flexibility (Romm: Mom) and another a decrease of roughly 1 standard deviation (Gilster: Dad). Data from the
observational measure, however, reflected notable improvements in balanced flexibility for 5 of the 8 families. Specifically, 4 families moved from somewhat flexible to flexible (Keith, Jacobs, Romm, and Portela) and one from very flexible to flexible (Roe). Data from one family reflected a shift towards a more unbalanced level of flexibility, moving from flexible to overly flexible (Peasley).

Regarding communication, data from at least one parent in 3 of the 8 families on the FCS reflected notable increases in the quality of communication: one from low to moderate (Keith: Mom), one from moderate to high (Gilster: Dad), and one from high to very high (Brooks: Mom). Data from one parent reflected a categorical decrease, from low to very low (Portela: Mom). Data from the observational measure reflected notable improvements in communication for 4 of the 8 families. Specifically, three families shifted from moderate to high (Roe, Keith, and Romm), and one family shifted from low to moderate (Portela). One family (Peasley) reflected a notable decrease in communication, moving from moderate to low.

Concerning family satisfaction, data from at least one parent in 7 of the 8 families on the FSS reflected notable to moderate increases in their level of family satisfaction: two from very low to low (Keith: Mom, Portela: Dad), two from low to moderate (Romm: Dad, Gilster: Dad), one from moderate to high (Peasley: Dad), one from moderate to very high (Brooks: Mom), and one from high to very high (Jacobs: Mom). No data reflected noteworthy decreases in family satisfaction.

Discussion

All eight families involved in the study appeared to experience some impact in their family functioning. Nearly all families experienced statistically significant improvements pertaining to the targeted areas of family functioning, and the average effect was moderate.
Interpreting this effect size in light of previous research (Thompson, 2006) is complicated by the fact that there are numerous effect size measures in single-case research, and these various effect size measures do not appear to yield similar interpretations (Parker et al., 2005). As a result, I examined the literature for previous studies in which researchers utilized the PEM effect size. No other research studies related to the field of counseling or filial therapy incorporated the PEM effect size.

Because I utilized a single-case design and a different measure of effect size, it is difficult to know whether the interpretations of the effect in this study can be accurately compared to the previous research in CPRT. Researchers conducting previous studies using CPRT have often used randomized control group designs, have incorporated conventional parametric statistical analyses, and have examined the effect on parent and child functioning. Given this limitation, it is important to interpret the comparisons tentatively. Based on the review of research completed by Bratton et al. (2010), CPRT appears to have a strong effect when looking at outcome measures related to child functioning, parent functioning, and the parent-child relationship. Thus, the moderate effect size in this study indicates that the impact that CPRT has on family functioning is substantive but notably less than the impact on the participating parent and child. This greater effect on participating parents and children makes sense given the primary emphasis of CPRT is strengthening the parent-child relationship (Landreth & Bratton, 2006).

The results from the self-reported and observational measures based on the circumplex model also suggested that many families experienced practically significant changes in their cohesion, flexibility, communication, and satisfaction despite the fact that many exhibited functioning that appeared healthy prior to the intervention. Interestingly, the families that appeared to improve in an area based on the results from the observational measure (CRS) did
not often align with the results from the self-report measures (FACES IV, FCS, and FSS). Olson and Gorall (2003) noted that previous research suggests that the CRS more accurately measures families according to the circumplex model than the FACES IV. The fact that more families exhibited improvements when looking at the CRS data only further affirms the practical significance of the results.

Another observation from the CRS data revolved around the Peasley family, who exhibited significant deterioration across all variables. It is important to note that as I was facilitating the posttest play activity, it became clear that Anthony, the child, was more agitated than prior times that I had observed him. When the activity ended, Stephen and Heather acknowledged that that they took away privileges due to misbehavior just prior to coming to the clinic. This situational factor appeared to contribute to poorer interactions that were not representative of the family’s typical functioning.

**Implications for Practice**

Given that this is the only study of its kind, I caution others to interpret the results tentatively. The following are tentative implications for practice:

1. The results of provide initial support for the theoretical claims (Gil, 1994; Guerney & Guerney, 1987; Hutton, 2004; Johnson, 1995; Johnson et al., 1999; Kellam, 2001) and results of qualitative studies (Bavin-Hoffman et al., 1996; Lahti, 1992; Wickstrom, 2009) suggesting that filial therapy impacts the family system. Although the primary aim of filial therapy is to improve the parent-child relationship, it appears the impact of filial therapy may extend to some degree to the family as a whole.

2. The results also provide greater confidence in filial therapy as a developmentally-relevant intervention for working conjointly with parents and children. The lack of conjoint treatment of
parents and young children may reflect the difficulty in reconciling the developmental 
preferences of talk for adults and play for children. In filial therapy, practitioners can integrate 
parents and children using their preferred mode of communication.

3. The results give credence to the recommendations of involving families into treatment, 
especially families with young children. As results from this study and previous research in filial 
therapy have suggested, parents are capable of realizing therapeutic benefits with their children 
(Bratton et al., 2005; Lin, 2011). Finding ways of working alongside families is not simply a 
theoretical preference but a best-practice imperative that is finding increasing support in the 
research literature.

4. Although the results suggest families receiving filial therapy do seem to experience 
positive changes in their family functioning, it is difficult to know whether the same may be true 
for families that exhibit poorer functioning. Given that many of the families in this study 
appeared to be healthy, based on self-report and observational measures, it would be 
inappropriate to conclude that filial therapy would be an effective intervention for all families. 
In fact, proponents of filial therapy have acknowledged that not all parents and children are 
viable candidates for filial therapy (Bratton et al., 2005; Landreth & Bratton, 2006).

5. Although CPRT is a time-limited approach, the number of sessions and the degree of 
parental involvement can be a significant commitment for many families. The fact that all 
parents missed one CPRT session or more and all but two missed at least one play session attests 
to the “real world” difficulties of incorporating families into treatment. Despite this noteworthy 
lack of treatment adherence, the families were able to experience therapeutic benefits. This 
supports the potency of CPRT as well as its generalizability to the realities of everyday clinical 
practice.
6. For those interested in utilizing filial therapy, experts recommend first receiving training in play therapy (Landreth & Bratton, 2006). The Association for Play Therapy’s website includes a searchable directory of approved centers of play therapy and universities that provide such training (http://www.a4pt.org/university.cfm). For example, the University of North Texas and its Center for Play offer semester-long courses as well as intensive trainings in child-centered play therapy and CPRT (http://cpt.unt.edu).

Limitations and Recommendations for Future Research

One of the limitations of this study was sampling. Convenience sampling, a small sample size, and a lack of a defined population were present in this study, thereby affecting the internal and external validity of the results. The high number of two-parent families, coupled with the fact that most of these families had both parents participate in CPRT, was unique to this study and limits the generalizability of the results. Studies utilizing a randomized control group design with more families and targeted populations would help in increasing the ability to attribute effects to the intervention and in generalizing the results. Results from this study justify the greater resources and expenses involved in completing such future research. In addition, comparing CPRT with alternative treatments would help in better understanding the comparative effect of CPRT on family functioning compares.

Another limitation relates to instrumentation. Ideally, this research study would have included multiple measures of family functioning, based on a variety of models of family health, in order to decrease measurement error. Although the individualized rating forms provided another means for assessing family functioning that was not associated with a particular model, the bulk of the instrumentation reflected the circumplex model. The individualized rating forms also were a limitation. Despite being developed according to guidelines (Borckardt et al., 2008),
the rating forms had no established reliability or validity and were developed for the purposes of this study. In addition, with this instrument, unlike the more formal measures that parents completed in a controlled environment, I could not control for the conditions under which parents completed the daily ratings. Another limitation was that most of the data was self-reported, which may have biased the results. The observational measure, however, helped in counteracting this limitation, and in this study, provided unique information beyond what the self-reported data suggested. To address these limitations, future research could include different measures and constructs of family functioning than those used in this study and use more observation-based measures.

Another set of limitations in this current study relates to the design. There were a relatively small number of baseline phase ratings when compared to treatment phase ratings. Although a short baseline phase can be common in single-case research (Nugent, 2010), future research in this area could improve by extending the baseline phase. A longer baseline would likely improve measurement accuracy. Also, having a longer baseline might provide a better indication of the degree to which parents daily tracking may have impacted their family’s functioning. Another limitation was the lack of follow up, which makes it difficult to know how the families may have been impacted over time.

Poor attendance and a relative lack of treatment adherence amongst participants was another limitation. In this study, I made no attempts to cover missed material with parents. Although this perhaps increased the generalizability of the results to everyday practice, it remains unclear how greater treatment adherence on the part of the parents would have impacted the results. Future research could entail a more stringent protocol for making up missed sessions in order to ensure a more complete delivery of the intervention.
A final limitation of this study was my heavy involvement in carrying out the intervention and research, which may have introduced experimenter bias. My training and belief in the value of filial therapy may have influenced how I administered the treatment and research activities. Another consideration is that I have additional training in family therapy, which may have impacted the way I conducted CPRT even when adhering to protocol. Although I put mechanisms in place to limit the impact of bias, I may have exerted some unique influence over the results.

Conclusion

An ever-growing number of researchers have found strong support for the therapeutic benefits of filial therapy (Bratton et al., 2010). That the parents and children involved in filial therapy often experience remarkable changes in themselves and in their relationships with one another is not surprising given the primary aim of this approach. After all, filial therapists assume that strengthening the parent-child relationship will have therapeutic benefits. What is perhaps more surprising is the suggestion that the benefits of filial therapy do not end with the participating parents and children but extend to the family as a whole.

Prior to this study, the claim of filial therapy’s impact on the family was largely a theoretical assumption advocated strongly by its proponents but lacking research-based support. Although more research is undoubtedly necessary, and will likely come given the growing popularity of filial therapy, the results of this study suggest that the impact of filial therapy on the family is more than just a theoretical ideal. Filial therapy’s impact on the family appears to be a therapeutic reality.
### Table 1

**Results on Daily Ratings of Targeted Areas of Family Functioning**

<table>
<thead>
<tr>
<th>Family</th>
<th>Target Area</th>
<th>Source</th>
<th>Baseline M [95% CI]</th>
<th>Treatment M [95% CI]</th>
<th>r</th>
<th>p</th>
<th>Avg. PEM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Emotional Responsiveness</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peasley</td>
<td># of feelings communicated</td>
<td>D</td>
<td>1.5 [0.88, 2.13]</td>
<td>4.11 [3.78, 4.44]</td>
<td>.53</td>
<td>.007**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.5 [1.75, 3.38]</td>
<td>4.11 [3.57, 4.28]</td>
<td>.25</td>
<td>.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td># of feelings acknowledged</td>
<td>D</td>
<td>1.38 [0.63, 2.13]</td>
<td>4.27 [3.9, 4.65]</td>
<td>.53</td>
<td>.01**</td>
<td>91% Strong</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2 [1.5, 2.5]</td>
<td>3.3 [3.05, 3.54]</td>
<td>.34</td>
<td>.047*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>D</td>
<td>7 [6.38, 7.75]</td>
<td>10.07 [9.74, 10.38]</td>
<td>.632</td>
<td>.004**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>6.13 [4.75, 7.75]</td>
<td>9.9 [9.19, 10.64]</td>
<td>.365</td>
<td>.035*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td># of feelings acknowledged</td>
<td>D</td>
<td>1.13 [.38, 1.88]</td>
<td>1.82 [1.57, 2.09]</td>
<td>.194</td>
<td>.135</td>
<td>73% Moderate</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>5.88 [2.63, 11]</td>
<td>5.76 [5.24, 6.27]</td>
<td>-.012</td>
<td>.938</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gilster</td>
<td># of feelings acknowledged</td>
<td>D</td>
<td>2.14 [1.57, 2.71]</td>
<td>2.33 [2.04, 2.64]</td>
<td>.045</td>
<td>.764</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.57 [1.86, 3.29]</td>
<td>3.78 [3.55, 4.03]</td>
<td>.328</td>
<td>.032*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>D</td>
<td>1.13 [1.1, 1.71]</td>
<td>1.54 [1.36, 1.72]</td>
<td>.094</td>
<td>.460</td>
<td>60% Mild</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>8 [6.29, 9.57]</td>
<td>7.3 [6.71, 7.9]</td>
<td>-.08</td>
<td>.585</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roe</td>
<td># not complied</td>
<td>M</td>
<td>4.5 [2.88, 6.38]</td>
<td>2.13 [1.77, 2.52]</td>
<td>-.378</td>
<td>.013*</td>
<td>93% Strong</td>
</tr>
<tr>
<td>Keith</td>
<td># not complied</td>
<td>M</td>
<td>2.25 [0.5, 4.25]</td>
<td>0.45 [0.21, 0.75]</td>
<td>-.352</td>
<td>.002**</td>
<td>86% Moderate</td>
</tr>
<tr>
<td>Jacobs</td>
<td># not complied</td>
<td>D</td>
<td>0.5 [0, 0.75]</td>
<td>0.3 [0.14, 0.47]</td>
<td>.021</td>
<td>.876</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>1.75 [0.75, 2.88]</td>
<td>3.53 [2.82, 4.3]</td>
<td>.16</td>
<td>.241</td>
<td>20% None</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>10.86 [10.14, 11.43]</td>
<td>10.08 [9.4, 10.72]</td>
<td>-.077</td>
<td>.537</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brooks</td>
<td># of criticisms</td>
<td>D</td>
<td>3.86 [3, 4.57]</td>
<td>2.16 [1.9, 2.41]</td>
<td>-.412</td>
<td>.002**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>4.38 [3, 5.75]</td>
<td>1.99 [1.79, 2.2]</td>
<td>-.555</td>
<td>&lt;.001***</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>5.38 [4.88, 5.75]</td>
<td>9.45 [8.55, 10.36]</td>
<td>.302</td>
<td>.113</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* CI = confidence intervals; D = Dad; M = Mom.

* = p < .05. ** = p ≤ .01. *** = p ≤ .001.
### Table 2

Results on the FACES IV, FCS, FSS, and CRS

<table>
<thead>
<tr>
<th>Family</th>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Peasley</td>
<td>D</td>
<td>3.33</td>
<td>3.58</td>
<td>1.76</td>
<td>1.71</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.57</td>
<td>2.95*</td>
<td>1.75</td>
<td>1.58</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6,C</td>
<td>9,OC††</td>
<td>5,F</td>
<td>9,OF††</td>
</tr>
<tr>
<td>Romm</td>
<td>D</td>
<td>2.40</td>
<td>2.23</td>
<td>1.57</td>
<td>1.59</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>1.74</td>
<td>1.63</td>
<td>2.06</td>
<td>1.71†</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6,C</td>
<td>7,VC†</td>
<td>4,SR</td>
<td>4,SF</td>
</tr>
<tr>
<td>Gilster</td>
<td>D</td>
<td>1.94</td>
<td>2.80**</td>
<td>2.00</td>
<td>1.47††</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>3.04</td>
<td>2.64†</td>
<td>1.72</td>
<td>1.76</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>7,VC</td>
<td>7,VC</td>
<td>4,SF</td>
<td>4,SR</td>
</tr>
<tr>
<td>Roe</td>
<td>D</td>
<td>2.48</td>
<td>2.58</td>
<td>1.87</td>
<td>1.80</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.38</td>
<td>2.48</td>
<td>1.65</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>7,VC</td>
<td>6,C*</td>
<td>8,VF</td>
<td>6,F*</td>
</tr>
<tr>
<td>Keith</td>
<td>M</td>
<td>1.74</td>
<td>1.93</td>
<td>1.10</td>
<td>1.18</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>9,OC</td>
<td>7,VC*</td>
<td>4,SR</td>
<td>5,F*</td>
</tr>
<tr>
<td>Jacobs</td>
<td>D</td>
<td>2.69</td>
<td>4.12***</td>
<td>2.64</td>
<td>3.00*</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.70</td>
<td>3.58**</td>
<td>2.07</td>
<td>2.22</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6.5,VC</td>
<td>7,VC</td>
<td>3.5,SR</td>
<td>5,F*</td>
</tr>
<tr>
<td>Brooks</td>
<td>D</td>
<td>2.64</td>
<td>3.04*</td>
<td>1.54</td>
<td>1.57</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>4.38</td>
<td>4.12</td>
<td>2.07</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6.5,VC</td>
<td>5.5,C*</td>
<td>6,F</td>
<td>6,F</td>
</tr>
<tr>
<td>Portela</td>
<td>D</td>
<td>1.75</td>
<td>1.52</td>
<td>1.22</td>
<td>1.26</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.07</td>
<td>2.00</td>
<td>1.30</td>
<td>1.30</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>4,SC</td>
<td>5,C*</td>
<td>3,SR</td>
<td>5,F*</td>
</tr>
</tbody>
</table>

**Note.** * ≈ ½ SD or one-level improvement; ** ≈ 1 SD or two-level improvement; *** ≈ 1½ SD or three-level improvement; † ≈ ½ SD or one-level deterioration; †† ≈ 1 SD or two-level deterioration. D = Dad; M = Mother; R = Rater; SC = somewhat connected; C = connected; VC = very connected; OC = overly connected; SF = somewhat flexible; F = flexible; VF = very flexible; OF = overly flexible; VL = very low; L = low; Mo = moderate; H = high; VH = very high.
References


APPENDIX A

EXPANDED LITERATURE REVIEW
Introduction

Families are cultures in their own right, and although most people would affirm that families have significant influence on their members, few do so with a comprehensive understanding and appreciation of the breadth and depth of its influence and inner workings.

A family is far more than a collection of individuals sharing a specific physical and psychological space. While families occur in a diversity of forms and complexities in today’s rapidly changing society, and represent a multiplicity of cultural heritages, each may be considered a natural, sustained social system with properties all its own—one that has evolved a set of rules, is replete with assigned and ascribed roles for its members, has an organized power structure, has developed intricate overt and covert forms of communication, and has elaborated ways of negotiating and problem solving that permit various tasks to be performed effectively. The relationship between members of this microculture is deep and multilayered, and is based largely on a shared history, shared internalized perceptions and assumptions about the world, and a shared sense of purpose. Within such a system, individuals are tied to one another by powerful, durable, reciprocal, multigenerational emotional attachments and loyalties that may fluctuate in intensity and psychological distances between members over time, but nevertheless persist over the lifetime of the family. (Goldenberg & Goldenberg, 2008, p. 1)

What occurs in this microculture of families has significant implications for the health of its members: to their betterment or detriment. Perhaps no one recognizes this truth more than those working with young children. Across helping professions, practitioners are increasingly emphasizing the need and the importance of family-centered assessment and treatment, particularly for caregivers and young children (Perry, 2007; Pritchett et al., 2010; Reeves & Anthony, 2009; Reinherz, Giaconia, Paradis, Novero, & Kerrigan, 2008; Tomlin & Viehweg, 2003; Wallander, Dekker, & Koot, 2006). The importance of family-centered treatment is buttressed by researchers who suggest caregiver involvement in the mental health treatment of children results in better outcomes (Richards, Bowers, Lazicki, Krall, & Jacobs, 2007).

Recommendations regarding the importance of using family-centered approaches have come not only from practitioners within helping professions but also from significant organizations and associations that seek to improve the mental, emotional, behavioral, and
relational health of society. For instance, the U.S. Public Health Service (2000) published a national action agenda based on the Surgeon General’s Conference on Children’s Mental Health that underscored the importance of family-centered treatment to the mental health of children. They highlighted the need for “integrating family, child, and youth-centered mental health systems into all systems that serve children and youth” as well as the need for “engaging families…in the development of all mental healthcare planning” (p. 3). A related emphasis in this action agenda was for the continued development, dissemination, and implementation of “scientifically-proven prevention and treatment services” (p. 4) in which researchers, among many things: (1) examine the context of the family, (2) develop and test innovative interventions, and (3) utilize and research “prevention and treatment interventions that are organized to support families, and that consider children and their caregivers as a basic unit” (p. 7). Because of these significant identified needs, the writers of this national agenda also called for the mobilization of helping professionals to be frontline providers of scientifically-supported, family-centered treatment approaches.

Professional organizations have also emphasized the importance of family-centered approaches. The ethical code of the American Counseling Association (2005) clearly advocates for the consideration of involving the support network of clients, such as the family members, in their treatment (A.1.d.). The standards of the Council for Accreditation of Counseling and Related Educational Programs (2009) also references the importance of training counselors in “a systems perspective that provides an understanding of the family” as well as promoting their understanding of “major models of family and related interventions” (II.G.5.e., p. 12). A similar emphasis on involving and attending to the family and social context in the provision of therapeutic services is evident in ethical codes for other professional associations, such as the
American Association for Marriage and Family Therapy (AAMFT, 2001, 6.8), the American Psychological Association (APA, 2010, 10.02), and the National Association of Social Workers (NASW, 2008, preamble). In addition, APA’s (2005) policy statement on evidence-based practice reinforces the importance of considering patient characteristics, such as “familial factors,” in the delivery of therapeutic services. Furthermore, the APA policy includes the contention that “some effective treatments involve interventions directed towards others in the patient’s environment, such as parents, teachers, and caregivers” (p. 2).

Although families likely differ in their motivation to seek treatment, some members undoubtedly recognize the influence they have in the lives of their fellow members and desire to find ways to optimize their influence. Research conducted by Sax (2007) reveals that parents of children with mental health concerns appear to be seeking family-centered systems of care that provide effective helping strategies, entail meaningful parental involvement, and enhance support amongst parents. However, as Perry (2007) noted, few systematic treatment methods exist that comprehensively address the diverse treatment needs of families.

Because family therapists and play therapists are two groups of professionals in particular who have frequent contact with families, they are ideal candidates as frontline providers of family-centered approaches. Several studies in play therapy reveal that play therapists often encounter family issues (Kranz, Kottman, & Lund, 1998; Ryan, Gomory, & Lacasse, 2002; Tsai & Ray, 2011), and family therapists often encounter families who are experiencing significant problems with their young children (Doherty & Simmons, 1996; Hines, 1996). However, practitioners and researchers within both specialty areas have voiced concerns regarding the lack of inclusive family treatment for parents and young children (Botkin, 2000; Gil, 1994; Green, 1994; Haslam & Harris, 2011; Hutton, 2004; Johnson & Thomas, 1999;
Correspondingly, family therapists have long recognized the lack of inclusion of children in family therapy. Ackerman (1970) challenged family therapists to find meaningful ways to involve children in family therapy. Alongside Ackerman, other influential family therapists, such as Salvador Minuchin (1974), Jay Haley (1973), and Virginia Satir (1983), encouraged the use of approaches that involved children in meaningful ways. Carl Whitaker (Keith & Whitaker, 1981) also advocated strongly for the relevant inclusion of children and adults in family therapy, particularly referencing the importance of play as a mechanism for such integration. Family therapists even compiled a special issue on including children in family therapy (Zilbach, 1989). However, a decade after that special issue, Ruble (1999) noted that most family therapists have not answered affirmatively to the challenge of Ackerman and these early family therapists to include young children in family therapy. In a review of family therapy sessions with young children, Cederborg (1997) concluded: “young children seem to have the participant status of nonpersons, in that they do not occupy much of the discourse space or much interactional time with the adults but are monitored to positions of side-participants” (p. 37). A thorough review of the literature provided no indication that this state of affairs has changed since Cederborg’s (1997) and Ruble’s (1999) conclusions.

In order to address the issue of providing conjoint treatment, several family therapists and play therapists have advocated for the integration of methods from their respective fields (Botkin, 2000; Haslam & Harris, 2011; Levant & Haffey, 1980; Villaneuve & LaRoche, 1993). For instance, several family therapists have advocated for the use of activities, games, and play as techniques within family sessions (Arad, 2004; Berger & Brooks, 2000; Dumont, 2008; Early,
1994; Resnick, 1976; Rotter & Bush, 2000; Schachter, 1978; Shi, 2003; Staton & Lucey, 2004; Swank, 2008; Wolfe & Collins-Wolfe, 1983). Other family therapists have advocated for the viability of specific family therapy approaches for integrating children through the use of play (McLuckie, 2005; Nims & Duba, 2011; Wittenborn, Faber, Harvey, & Thomas, 2006). Play therapists have also advocated for the use of play-based techniques to use in isolated sessions as a way to incorporate family members (Baggerly & Exum, 2008; DeOrnellas, Kottman, & Millican, 1997; Green & Connolly, 2009; Harvey, 2008; Hill, 2006; Lantz & Raiz, 2003; Weir, 2007). Other play therapists have described more holistic approaches to integrating play and family therapy, such as family play therapy (Botkin, 2000; Busby & Lufkin, 1992; Gil, 1994).

Survey research suggests that play therapists and family therapists believe in the importance of involving parents and children in treatment (Haslam & Harris, 2011; Phillips & Landreth, 1998; Sori & Sprenkle, 2004). Despite the efforts of some professionals to integrate family therapy and play therapy, a notable contingent of family therapists and play therapists continue to view their approaches as distinct methods (Haslam & Harris, 2011; Sori, Dernier, & Wesolowski, 2006). Family therapists, in particular, appear to be less interested in integrating play therapy into their approaches (Cooklin, 2001; Raimondi & Walters, 2004) whereas play therapists, in general, appear to be more interested in this type of integration (Haslam & Harris, 2011). Discomfort with conjoint family work and lack of training in ways to integrate play therapy and family therapy are noted issues in surveys of play therapists (Haslam & Harris, 2011) and family therapists (Johnson & Thomas, 1999). As Miller and McLeod (2001) indicated, with regard to practitioners working with children and families within the fields of play therapy and family therapy, it has been apparent that “what the literature and theory define and what happens practically is often divergent” (p. 376).
Several practitioners have proposed that a treatment method known as filial therapy, with its direct involvement of caregivers and children in treatment, is a solution that family therapists and play therapists can have in common in order to work effectively with the entire family system (Gil, 1994; Guerney & Guerney, 1987; Hutton, 2004; Johnson, 1995; Johnson, Bruhn, Winek, Krepps, & Wiley, 1999; Kellam, 2001). Family therapists may find this approach more amenable to their current methods because filial therapy involves training parents to work with their own children as opposed to therapists directly incorporating children. Play therapists may also find filial therapy as a more comfortable treatment option as it draws directly from their training as play therapists. A major limitation of filial therapy, however, is that investigators have conducted little research regarding how and to what degree filial therapy impacts families. Without this research, family therapists and play therapists may continue in their reluctance to utilize conjoint approaches with parents and young children given that the arguments in support of filial therapy as a family intervention are theoretical as opposed to research-based.

Statement of the Problem

The call from professional associations and government organizations is abundantly clear: The research and utilization of family-centered mental health interventions are of paramount importance. It is also clear that, despite having frequent contact with families, play therapists and family therapists do not seem to be providing the degree of family involvement in their services that one might expect. Interestingly, family therapists and play therapists have noted this problem within their fields but have not made significant gains in addressing this issue. Some have cited the integration of play and family therapy, as seen in filial therapy, as being a common solution. Research to date, however, has provided little information regarding
the impact that filial therapy may have as a family intervention, thus giving family therapists and play therapists minimal evidence in considering whether to use this approach.

**Purpose of the Study**

In light of these noted issues, the purpose of the study is to examine the impact of child parent relationship therapy (CPRT), a filial therapy approach, on family functioning.

**Review of Related Literature**

The review of related literature includes the following: (a) theoretical importance of family functioning, (b) research concerning family functioning, (c) the circumplex model of marital and family systems, (d) overview of child-centered play therapy, (e) the history and development of filial therapy, (e) theoretical arguments for the impact of filial therapy on family functioning, and (f) outcome research in filial therapy.

**Theoretical Importance of Family Functioning**

Family functioning, as defined in this study, refers to the characteristic nature and patterns of relating among family members. According to Goldenberg and Goldenberg (2008), these interactional patterns are reflective of a “family’s *structure* (how it arranges, organizes, and maintains itself at a particular cross section of time) and to its *processes* (the way it evolves, adapts, or changes over time)” (p. 403). To varying degrees, counseling theorists have included references to the importance of family functioning in relation to the overall health of families and the mental health of individuals. As a result, there is a plethora of theoretical conceptualizations regarding the interface of family dynamics and mental health. Although an extensive presentation of theoretical conceptualizations of family functioning is beyond the scope of this review, it is important to note the theoretical importance of family functioning within various approaches to mental health intervention. To this end, I provide an overview of the theoretical
importance of family functioning within the most influential approaches to individual counseling and family therapy.

Most, if not all, of the founders and developers of influential, individually-oriented theoretical models of counseling have included, to varying degrees, either implicit or explicit references to the importance of family functioning. In their overview of these major theoretical models, Fall, Holden, and Marquis (2010) described how each model incorporates attention to the familial environment. For instance, for Sigmund Freud (1949), mental health was, in part, reflective of patients’ early experiences in being able to satisfy their innate drives as an infant and child. Neo-Freudians, most notably Alfred Adler (1956), Karen Horney (1950), and Harry Stack Sullivan (1968), substantially expanded the importance of family functioning as a basis for understanding individual personality development and mental health. Carl Rogers (1961) emphasized the importance of how the regard expressed by influential caretakers influences the development of self-concept and psychological congruence. Cognitive- and behaviorally-based approaches, through concepts such as social learning theory and reinforcement, also give credence to the importance of the family environment in the development of cognitions and behaviors. In Ken Wilber’s (2000) integral approach, systems, including family systems, comprise 1 of 4 quadrant perspectives he considered essential to a complete understanding of any phenomenon. Although perhaps to a lesser degree than the ones already mentioned, theoreticians ascribing to other prominent models, such as existential, Gestalt, and constructivist approaches, also reference the importance of the family environment (Fall et al., 2010). Despite having individuals as their predominant focus of conceptualizations and interventions, it is evident that each of these major theoretical models of counseling has included at least some attention to how family functioning may bear on individual development.
The advent of the family therapy movement, which reflected the simultaneous contributions of a variety of individuals, contributed greatly to the development of theoretical conceptualizations of family functioning and corresponding family-based interventions. Early family therapists made families, as opposed to individuals, the predominant unit of focus for conceptualization and intervention (Goldenberg & Goldenberg, 2008; Nichols, 2009; Winek, 2010). Goldenberg and Goldenberg (2008) captured this change in focus:

> Without negating the significance of individual internal processes and intrapsychic dynamics, today’s broader view of human problems focuses on the family context in which the individual behavior currently occurs…While bearing in mind the often complex ways in which individual behavior contributes to that interaction, such an interpersonal perspective—as opposed to an intrapsychic one—regards all behavior as part of a sequence of ongoing, interactional, recursive, or recurring events…the family relational view directs the clinician’s attention externally to *transaction patterns* currently taking place within the family. (p. 13)

The greater attention of early family systems therapists on interpersonal, family functioning truly represented a paradigm shift from traditional theoretical conceptualizations that attended to family functioning only as it related to intrapersonal, individual functioning (Goldenberg & Goldenberg, 2008). This new paradigm included a set of common assumptions and beliefs informed largely by concepts from general systems theory (von Bertalanffy, 1968; Hanson, 1995) and cybernetics (Weiner, 1948). From this common set of assumptions and concepts, early family therapists developed their own unique conceptualizations of family functioning that informed how they intervened with families. These included intergenerational (Boszormenyi-Nagy, 1987; Bowen, 1978), experiential (Satir, 1983; Whitaker & Bumberry, 1988), strategic (Boscolo, Cecchin, Hoffman, & Penn, 1987; Haley, 1976; Watzlawick, Weakland, & Fisch, 1974), structural (Minuchin, 1974), and postmodern approaches, such as solution-focused (de Shazer, 1985), narrative (White & Epston, 1990), and collaborative therapies (Anderson, 1997).
As evidenced in this brief overview, the most influential theorists and their guiding theories have included at least some attention to the influence of the family environment. The family therapy movement led to proliferation of conceptualizations regarding family systems that guided subsequent interventions. It was through this latter movement of family therapy that the theoretical importance of the family truly blossomed.

*Research on Family Functioning*

What these theorists have speculated concerning the importance of family functioning, researchers have attempted to confirm. Researchers conducting investigations of family functioning have supported the notion that what occurs in families may have implications for the health of its members. An overview of this research on family functioning is telling of its significance. I categorize and review the research as follows: (a) studies that reflect the general importance of family functioning, (b) studies that reflect the interconnectedness of family functioning and the mental health of infants, young children, adolescents, and their parents, and (c) studies that demonstrate the impact of family-based interventions on the family functioning of families with young children.

Before presenting this review of the research, it is important to note that much of the research to date on family functioning has been correlational in nature. As a result of using this design, researchers are able to examine the relationship between family functioning and a variety of variables; however, researchers are not able to determine whether family functioning shares a causal relationship with any of these variables. This is a noteworthy limitation as it is plausible that another outside factor not accounted for, such as genetics, may help to explain the relationship between the variables. Thus, it is important to use caution when making interpretations and conclusions based on the results of these studies.
General Importance of Family Functioning

A considerable amount of research underscores the importance of overall family functioning. For instance, using a sample of 276 mothers, Boger, Tompson, Briggs-Gowan, Pavlis, and Carter (2008) found that family expressiveness was a significant predictor of expressed emotion (EE), and the authors cited numerous studies indicating that lower EE relates to greater mental health outcomes for adults and children. Peisah, Brodaty, Luscombe, and Anstey (2005), using a sample of 94 children whose parents had been identified as depressed 25 years prior, found significant relationships between child characteristics, parent illness, and family relationship variables, indicating “systemic interactions between parental illness, child psychopathology, and family relationships” (p. 97). For instance, the researchers found that when using the parents’ scores on a parental overprotection subscale, they were able to classify which children had clinical diagnoses with 66% accuracy. The implications of such research findings are potentially even more important when considering that Klever (2009) found significant associations between individuals’ current family functioning and their family-of-origin functioning. Klever (2009) speculated that this finding indicates that patterns of family functioning may have intergenerational stability.

Importance of Family Functioning for Children, Adolescents, and Adults

This substantive relationship between family functioning and wellbeing appears to hold true across the lifespan. Researchers investigating the relationship between family functioning and the mental health of infants have found that what occurs between infants and their family members, particularly in their interactions with their parents, shares significant relationships with variables related to children’s mental health, so much so that Infant Mental Health (IMH) has become an important area of clinical focus and practice (Tomlin & Viehweg, 2003). For
instance, Brackbill, White, Wilson, and Kitch (1990) found that they could accurately classify the disposition of roughly 75% of infants in their sample of 90 infants based on scores from an assessment of their families’ dynamics. In a comparison study of clinic-referred infants ($n = 38$) to a matched control group ($n = 34$), Keren, Dollberg, Koster, Danino, and Feldman (2010) found significant associations between referral status and family functioning, maternal intrusiveness, and maternal psychopathology. Herring et al. (2006) discovered significant relationships between family functioning, parental functioning, and the behavior and emotional functioning of 123 toddlers experiencing pervasive developmental disorders or developmental delays. The discovery of such problematic relationships between family, parent, and child functioning has led practitioners to propose diagnostic frameworks for infants and toddlers that include aspects of family functioning (Evangelista & McLellan, 2004). Even family medicine practitioners have recommended assessing parent-child interaction and family functioning as a part of children’s wellness checkups (Talen, Stephens, Marik, & Buchholz, 2007).

Researchers have also found a notable relationship between family functioning and the health of young children. Pavuluri, Luk, Clarkson, and McGee (1995) found that poor family functioning, maternal mental health, and parental separation accounted for a significant amount of variance in the behavior disorders of a sample of 320 preschool children. Hill and Bush (2001) found a significant relationship between parenting and family interaction patterns and symptoms of anxiety and conduct problems in a sample of 103 kindergarteners and their mothers. In a study on the relationship between a variety of variables and the adjustment of children to divorce ($n = 81$), Ellwood and Stolberg (1993) found that variables related to family competence accounted for a significant amount of variance (21%) in children’s adjustment. In addition, these researchers found a significant relationship between higher levels of family
functioning and lower levels of parental hostility and rejecting behaviors. Family functioning and stressful life events shared significant relationships with quality of life ratings in a sample of 252 children with psychiatric disorders (Bastiaansen, Koot, & Ferdinand, 2005). In a study of 234 kindergarten children and their parents, Sturge-Apple, Davies, and Cummings (2010) found three typologies of families (cohesive, enmeshed, and disengaged), and these family types had differential and meaningful associations with the presence of problematic adjustment to school. A cross-sectional study of 145 children and adolescents conducted by Wynne, Cole, and Perkins (1987) found that parental psychopathology and family variables accounted for 27% of the variance in school functioning. Wallander et al. (2006) found in a sample of 968 children with intellectual disability that family risk factors accounted for 7% of the variance in problem behaviors.

Researchers have also found significant relationships between adolescent functioning and family functioning. Using data collected from 335 families with adolescents over a period of four years, Rueter and Conger (1995) found that families characterized by warmth and hostility progressed in these patterns over time. Reigstad, Jørgensen, Sund, and Wichstrøm (2006) found that poor family functioning was 1 of 4 significant factors in their study that differentiated adolescents who had received mental health services ($n = 76$) from those who had received more intensive mental health services ($n = 129$). Reinherz et al. (2008) found that family factors in mid-adolescence (i.e., feeling valued in family, family cohesion, and family social support) predicted functioning in late-adolescence in a sample of 370 adolescents. Sagrestano, Paikoff, Holmbeck, and Fendrich (2003) found in their longitudinal study of depression in 302 African-American inner-city adolescents and their parents that as family functioning changed, there were changes in the depression levels of the adolescents and parents. Using a sample of 429 Chinese
adolescents and their parents, Shek (1997) found that there was roughly 50% shared variance between scores on family functioning variables and adolescent adjustment variables. Another study conducted using a sample of Chinese adolescents and parents ($n = 41$) found that family functioning shared roughly 40% of the variance with adolescent depression (Crane, Ngai, Larson, & Hafen, 2005). Tamplin, Goodyer, and Herbert (1998) found that families of adolescents with major depressive disorder ($n = 61$) had significantly more problematic family functioning than a control sample from the community ($n = 34$). Ghanizadeh and Shams (2007) found significant differences in family functioning when comparing matched samples of children and adolescents with ADHD ($n = 49$) to those without a diagnosis ($n = 51$).

The relationship of family functioning to indicators of health in adults is also evident. Many of the findings from research studies already cited reinforce this notion. Researchers have consistently found that early childhood experiences in one’s family environment share significant relationships to the mental health of adults (Scott, Varghese, & McGrath, 2010). In an international study of 51,495 adults, researchers found that the experience of childhood adversities (e.g. parental psychopathology, child abuse, neglect) more strongly predicted adult mental health disorders than any other variable examined in the study, accounting for nearly 30% of the variance in adult mental health disorders (Kessler et al., 2010). A longitudinal study of 353 adolescents conducted by Paradis et al. (2011) found that the risk for experiencing a current mental disorder as an adult was reduced by nearly half for those who felt highly valued by their families as adolescents and by roughly 40% for those who felt they were able to confide in a family member as adolescents. In a study of 75 parents of young children with behavioral or emotional concerns, Scheel and Rieckmann (1998) found that family functioning accounted for 38% of the variance in parental self-efficacy and 24% of the variance in parental empowerment.
Impact of Interventions on the Family Functioning of Families with Young Children

Few researchers have conducted rigorous experimental designs on the impact that family-based interventions may have on family functioning, especially with families of young children. Such experimental designs provide greater control and, thus, greater confidence in evaluating the potential causal relationship between variables. Although limited in number, researchers investigating the impact of interventions on family functioning with families of young children have obtained positive results. Hoagwood (2005) conducted an extensive review of studies reported since 1980 in order to examine the impact of family-centered interventions on families with young children. Based on the 41 studies that met criteria for inclusion in the study, Hoagwood concluded that one commonly-found outcome of these family-based interventions was improved family interactions. In addition, Hoagwood found that many studies that utilized interventions incorporating education and support resulted in positive outcomes. Although adults with mental illnesses and infants served as the primary population of focus, Hoagwood speculated that such interventions with families of young children would have similar outcomes.

In addition, several researchers have found that psychoeducational parenting groups have a positive impact on family functioning. For instance, Berge, Law, Johnson, and Wells (2010) examined the effect of a 12-week psychoeducational parenting group in a sample of 35 parents and found that participants reported statistically significant improvements with moderate effects in child behavior, couple functioning, and family functioning. Lochman’s (2000) review of research on several parent and family skills training programs revealed consistent improvements in child behavior, parenting strategies, and family functioning. Rhodes (1995) conducted a study of 92 participants who completed a parent education program and found a statistically significant increase in family adaptability following the intervention.
Summary of Research on Family Functioning

Research on the impact of interventions on family functioning provides greater credence to the notion that family functioning can improve as a result of treatment. If family functioning is indeed changeable, as the intervention studies suggest, then it is plausible that improvement in family functioning may promote wellbeing given the positive relationships between these variables as indicated by results from the correlational studies cited earlier.

Although the research on family functioning is growing, more research is needed regarding the impact that interventions may have on family functioning. In particular, there is a need to examine the impact of family-based interventions on family functioning. The available research suggests that educational parenting groups may impact family functioning, yet additional research is needed in order to replicate and extend these findings with other populations, especially with families who have young children.

Circumplex Model of Marital and Family Systems

The importance of family functioning, as seen in theory and research, provides even stronger support for the necessity of formally assessing family functioning and using interventions that seek to promote healthy family functioning. One important step for researchers and practitioners is finding a model for conceptualizing and assessing family functioning that includes formal measures. Although the influential family therapists alluded to earlier provided a diverse range of conceptualizations of family functioning, many of these theoretical approaches lacked standards or concepts concerning what constituted healthy family functioning (Becvar & Becvar, 1982; Wilcoxon, 1985). In addition, these models have lacked the inclusion of formal instruments that researchers and practitioners can utilize to measure family functioning according to their conceptualizations. The circumplex model of marital and
family systems, however, is a theoretical model of healthy and unhealthy family functioning that conceptualizes family functioning according to a family systems lens and contains corresponding measurement devices. As a result, this model will serve as the major framework for the conceptualization and assessment of family functioning in this current study. What follows is an overview of the major theoretical constructs of this model and the research that supports it.

Olson, Sprenkle, and Russell (1979) first presented the circumplex model, and Olson (2000) and Olson and Gorall (2003) provided more recent overviews. Olson and Gorall (2003) indicated that the primary purpose of the circumplex model is to provide a “relational diagnosis” by assessing a family’s “relational system” according to three dimensions: cohesion, flexibility, and communication (p. 515). After reviewing the literature, Olson and Gorall (2003) reported that the original developers found over 50 concepts related to marital and family dynamics, and their conceptual clustering of these concepts led to the three dimensions. Olson (2011) provided the most updated definitions of these constructs. Cohesion is “the emotional bonding that couple and family members have toward one another” (p. 65). Family flexibility refers to “the quality and expression of leadership and organization, role relationship, and relationship rules and negotiations” (p. 65). Finally, family communication is “the positive communication skills utilized in the couple or family system” and is “a facilitating dimension that helps families alter their levels of cohesion and flexibility” (p. 65). More specifically, Olson and Barnes (2006) defined family communication “as the act of making information, ideas, thoughts and feelings known among members of a family unit” (p. 1).

The main hypothesis of the circumplex model is as follows: “Balanced levels of cohesion and flexibility are most conducive to healthy family functioning. Conversely, unbalanced levels of cohesion and flexibility (very low or very high levels) are associated with problematic family
functioning” (Olson, 2011, p. 65). Olson and Gorall (2003) indicated that healthy family systems generally operate within the balanced ranges of cohesion and flexibility as opposed to the extreme ranges, except when family expectations or cultural norms support the unbalanced patterns of relating. The model contains five levels of flexibility: inflexible, somewhat flexible, flexible, very flexible, and overly flexible. The three middle levels represent the balanced dimension, and the first and last levels are the unbalanced dimensions. Similarly, the model contains five levels of cohesion: disconnected, somewhat connected, connected, very connected, and overly connected. Thus, the circumplex model posits a curvilinear relationship between a family’s degree of cohesion and flexibility and healthy functioning. Olson and Gorall (2003) reported that more than 250 studies, most of them comparing families experiencing problems with nonclinical families, have supported this hypothesis.

A second main hypothesis in the circumplex model is that positive communication skills will enable families to change their levels of cohesion and flexibility. Olson and Gorall (2003) cited a study of 21,501 married couples that provided support for the relationship amongst these constructs, revealing that most happy marriages scored as balanced on cohesion and flexibility and had very good communication.

According to Olson and Gorall (2003), comprehensive family assessment is multimethod, multiperson, multitrait, and multisystem. Multimethod assessment gathers information from within and outside of the family with the recognition that these sources of information are valuable and may indicate differences. Multiperson assessment gathers information from as many individual family members as possible with the recognition that family members likely differ in their perceptions of their families. Multitrait assessment gathers information on a variety of constructs with the assumption that multiple variables are important to family health.
Multisystem assessment gathers information that acknowledges the variety of important subsystems in the family, such as the couple subsystem or parent-child subsystem. The measures Olson and his colleagues developed in relation to the circumplex model attempt to help researchers and practitioners to incorporate these characteristics of quality family assessment. Accordingly, the bulk of the instrumentation in this study reflects the circumplex model.

Overview of Child-Centered Play Therapy

As alluded to earlier, a number of proponents of filial therapy have advocated for the applicability of this approach as a method of family therapy through which practitioners can impact the family system (Gil, 1994; Guerney & Guerney, 1987; Hutton, 2004; Johnson, 1995; Johnson et al., 1999; Kellam, 2001). However, before I review these theoretical contentions, a thorough review and description of filial therapy is necessary. An accurate understanding of the nature and process of filial therapy first necessitates an understanding of its status as an outgrowth of child-centered play therapy (CCPT), an approach based on the person-centered theory of Carl Rogers (1942, 1951).

According to Rogers (1986),

the person-centered approach…is primarily a way of being that finds its expression in attitudes and behaviors that create a growth-producing climate. It is a basic philosophy rather than simply a technique or a method. When this philosophy is lived, it helps the person expand the development of his or her own capacities. When it is lived, it also stimulates constructive change in others. It empowers the individual, and when this personal power is sensed, experience shows that it tends to be used for personal and social transformation. (p. 199)

In a similar manner to what Rogers described above, child-centered play therapists attempt to create a growth-producing environment for children through a manner of being that prompts children’s inherent capacities for growth and transformation. In other words, what occurs between the play therapist and children in this rich relationship provides the impetus for what
comes forth from within the children. This process is identical conceptually and theoretically to what a person-centered therapist aims to do with their adult clients.

However, given the developmental differences between adults and children, child-centered play therapists use the medium of play as opposed to talk as the primary context for forming and exercising this growth-producing relationship. Child-centered play therapists see play as a naturally enjoyable and therapeutic medium for children. Perhaps more importantly, “play gives concrete form and expression to children’s inner worlds…The therapist uses play with children because play is children’s symbolic language of self-expression” (Landreth, 2002, p. 12). As a result of this perspective, child-centered play therapists firmly believe that “toys are used like words by children, and play is their language” (Landreth, 2002, p. 16). Combining person-centered concepts with this perspective of play, Landreth (2002) offered the following as a definition for play therapy:

Play therapy is defined as a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child’s medium of communication, for optimal growth and development. (p. 16)

Virginia Axline (1947), a student and eventual colleague of Rogers, was one of the forerunners in taking person-centered principles and concepts and applying them in the context of play therapy with children. She provided a classic list of eight principles of play therapy, which Landreth (2002) revised and extended, that elucidate how child-centered play therapists exercise their perspectives in the actual context of play sessions:

1. The therapist is genuinely interested in the child and develops a warm, caring relationship. 2. The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way. 3. The therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express self completely. 4. The therapist is always sensitive to the child’s feelings and gently
reflects those feelings in such a manner that the child develops self-understanding. (5) The therapist believes deeply in the child’s capacity to act responsibly, unwaveringly respects the child’s ability to solve personal problems and allows the child to do so. (6) The therapist trusts the child’s inner direction, allows the child to lead in all areas of the relationship, and resists any urge to direct the child’s play or conversation. (7) The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry things along. (8) The therapist establishes only those therapeutic limits that help the child accept personal and appropriate relationship responsibility. (pp. 84-85)

These “lived” principles of child-centered play therapists simultaneously act as reflections of and contributors to that pivotal relational environment that serves as the antecedent to growth. This same relational process that serves as the foundation for child-centered play therapy carries over as filial therapists work with parents towards living out the same way of being with their children.

Research on CCPT has supported its effectiveness (Baggerly, Ray, & Bratton, 2010). Bratton, Ray, Rhine, and Jones (2005) conducted an extensive meta-analysis of outcome research in play therapy and found that play therapy has a large overall treatment effect ($d = 0.8$). When examining those studies in which researchers utilized humanistic, nondirective play therapy, such as CCPT, the treatment effect was even greater ($d = .92$). More specific analyses of CCPT have also resulted in positive outcomes. Tsai (2009) found that children receiving CCPT experienced statistically significant decreases in child behavior problems and in parent-child relationship stress, with moderate to large treatment effects. Using a sample of 22 children in a domestic violence shelter, Kot, Landreth, and Giordano (1998) found that children receiving intensive CCPT experienced significant increases in self-concept and significant decreases in externalizing and total behavior problems. Baggerly and Jenkins (2009) found CCPT to be effective in improving outcomes for a sample of 36 children who were homeless. Researchers have also achieved positive results using CCPT in school settings in decreasing teacher-child relationship stress (Ray, Henson, Schottelkorb, Brown, & Muro, 2008), ADHD symptoms
(Schottelkorb & Ray, 2009), behavior problems (Garza & Bratton, 2005; Ray, Blanco, Sullivan, & Holliman, 2009), and in improving academic achievement (Blanco & Ray, 2011). Other researchers have achieved positive outcomes with child-centered group play therapy in addressing diverse presenting concerns, such as the suicide risk and anxiety of Chinese earthquake victims (Shen, 2002); the receptive and expressive language skills of young children with speech difficulties (Danger & Landreth, 2005); and the self-esteem, anxiety, and depression of homeless youth (Baggerly, 2004).

History and Development of Filial Therapy and Child Parent Relationship Therapy

Given the effectiveness of CCPT, perhaps it is no surprise that its practitioners sought to expand its influence through exploring alternative applications of its principles and methods. One of these applications of CCPT is filial therapy. Bernard Guerney (1964) formally introduced filial therapy in his landmark article, “Filial therapy: Description and rationale.” In this article, he provided an overview of the filial therapy approach. The objective of filial therapy is to use “parents as therapeutic agents with their own children” (p. 304), maximizing what Guerney assumed to be the inherent therapeutic power of the parent-child relationship. Guerney offered the following as a definition of filial therapy:

Filial therapy involves the training of parents of young children (in groups of six to eight) to conduct play sessions with their own children in a very specific way. After training, parents continue to meet weekly with the therapist to discuss results, conclusions, and inferences about their children and themselves. (p. 305)

The “very specific way” in which Guerney trained parents to conduct play sessions with their children was analogous to nondirective or child-centered play therapy. Guerney (1964) communicated the child-centered nature of filial therapy in describing the goals of parent-child play sessions:

(1) The encouragement of complete determination of the activities of the child by the
child, within certain specified, definite limits…(2) The development of empathic understanding on the part of the parent as to the basic needs and feelings the child is trying to communicate and express through his play. (3) The immediate communication back to the child that these needs and feelings are understood, and that he as an individual is fully accepted, whatever his feelings or thoughts may be. (4) The need of the child to learn to see and accept responsibility for his actions. This is represented in the sessions by an understanding, but completely firm, enforcement of the “limits.” (pp. 305-306)

Guerney further described filial therapy training as a combination of instruction, demonstration play sessions, and role-playing, as well as group processing of the attitudes and feelings of parents. Although Guerney was the first to offer a systematic description and process for conducting filial therapy, he cited several influential antecedents that informed its development. The first was Baruch’s (1949) contention that play sessions between parents and their children could foster healthy parent-child relationships. Shortly thereafter, Freud (1954) described the impressive therapeutic results a father achieved in conducting treatment with his son, noting that no other person aside from the boy’s parent could have had such an effect. Another precursor to filial therapy came from Fuch (1957), the daughter of Carl Rogers, who, at the recommendation of her father, started conducting play sessions at home with her daughter after encountering difficulties with toilet training. Finally, Moustakas (1959), an influential figure in the development of nondirective play therapy, recommended that parents of well-adjusted children could conduct play sessions with their children as a way to build stronger parent-child relationships. Guerney formalized and expanded these initial ideas into a coherent methodology and added to it a radical belief that this approach was not only for the well-adjusted parent and child but also for parents and children encountering significant emotional and behavioral difficulties.

After providing this initial description and rationale for this innovative approach, Guerney continued to work on developing filial therapy with his wife, Louise Guerney. In 1966,
the Guerneys secured funding from the National Institute of Mental Health (NIMH) to conduct research on their approach. Several other colleagues joined them in their efforts, including Michael Andronico, Lillian Stover, and Jay Fidler (L. Guerney, 2000). Their early research on the approach yielded promising results. In the first study on filial therapy, Stover and B. Guerney (1967) assessed the ability of their sample of 28 mothers to assume a reflective and empathic role with their children and to utilize child-centered play therapy skills. After just four play sessions, the researchers found that the mothers showed an increase in reflective statements and a decrease in directive statements in play sessions with their children; however, the control group showed no changes in reflective and directive statements. In addition, the children of filial-trained parents showed increased nonverbal aggression and verbalized negative feelings, a finding that child-centered play therapists would conceptualize as a positive result early on as it indicates that children are feeling comfortable and free to express themselves. Stover and Guerney made the following conclusion based on these results:

The question of whether parents can learn to modify their pattern of interaction with their own emotionally disturbed children in the direction of the role behavior of client-centered therapists has been answered affirmatively. Also, in some significant aspects of their behavior in the play situation, children respond quickly to this change in mother's behavior. (p. 115)

Subsequently, B. Guerney and Stover (1971) conducted a more extensive study of filial therapy using 71 mothers of children referred to their clinic for behavioral and emotional problems to assess further whether parents could assume a therapeutic role and achieve therapeutic results. A high number of these mothers, roughly 75%, completed the treatment, which was impressive considering that the treatment lasted roughly a year. Using the 51 mother-child dyads that completed filial therapy, the researchers found that all children demonstrated improved social adjustment and decreased behavior problems, and 18 of the children showed
statistically significant gains. By the end of treatment, the children experienced a 66% reduction in symptoms according to behavior checklists. Results from observation measures of play sessions showed that the children exhibited decreased aggression and increased leadership, and the mothers demonstrated significant improvement in their ability to respond empathically to their children. A later study by Oxman (1971) further highlighted the positive results experienced by these mothers and their children. Oxman compared the results from the Guerney and Stover sample with a matched sample of 77 mother-child pairs serving as a no-treatment control group, which revealed that children in the treatment group demonstrated statistically significant improvement in their behavior. Oxman utilized an additional measure that assessed how close the behavior of the children approximated the behavior their parents considered as representative of their “ideal child” and found that children in filial therapy made greater gains on this measure than the control group.

Early research conducted by students trained by the Guerneys continued to demonstrate positive results. Sywulak (1977) conducted a study of 32 filial-trained parents, in which the parents served as their own control group, and found statistically significant improvements in parental acceptance and children’s adjustment as measured by problem checklists. Significant gains in parental acceptance occurred within two months of treatment. In addition, Sywulak reported that parents indicated improved parent-child relationships as a result of filial therapy, specifying greater closeness, warmth, openness, positivity, and less tension. Parents also indicated perceiving themselves as more self-aware, patient, self-confident, and better at communicating.

Sensué (1981) conducted a follow-up study of the parents trained in the Sywulak study and added a comparison group of parents of children not referred for treatment to serve as a
normative sample. Sensué found that the gains in child adjustment and parental acceptance of the filial-trained parents were statistically significant at six months and three years after treatment when compared to pretreatment scores. In addition, when comparing the results to the normative sample, Sensué found that the filial-trained parents showed higher levels of parental acceptance.

Other researchers aside from the Guerneys and their colleagues also began conducting studies on filial therapy that yielded positive results. Boll (1972), using a sample of 21 mothers of children with mental retardation, found that mothers who participated in a filial therapy group reported statistically significant gains in the social adjustment of their children when compared to a no-treatment control group. In a research study involving 22 mothers and their children, Payton (1980) found that parents trained in filial therapy reported statistically significant improvement in their children’s personality adjustment and maternal child rearing attitudes when compared to the control group. In a sample of 32 parents participating in filial therapy, Dematatis (1981) also found statistically significant improvements in measures of child adjustment, parental acceptance, and allowing the self-direction of the child. Lebovitz (1982) compared a group of filial-trained mothers to a group of mothers conducting supervised play sessions with their children. The researcher found that children participating in play sessions with their filial-trained parents showed decreases in behavior problems such as aggression, withdrawal, and dependence. This decrease in problems was greater than a sample of other children in their classroom and a sample of children who participated in supervised play sessions with parents that did not receive filial therapy instruction or training. In addition, on observational measures, parents completing filial therapy showed significantly greater acceptance of their children’s feelings, greater involvement, and allowed their children more
self-direction. Interestingly, a study by Eardley (1978) of a didactic-only version of filial therapy did not achieve the same positive results as these earlier studies that included the group processing component.

In light of the promising gains established through their personal experiences and their research, the Guerneys and their colleagues published several early articles advocating for the use and applicability of filial therapy (Andronico & B. Guerney, 1967; Andronico, Fidler, Guerney, & Guerney, 1967; B. Guerney, 1969; B. Guerney, 1976; Guerney, Guerney, & Andronico, 1966; Guerney, Guerney, & Stover, 1972; B. Guerney, Stover, & Andronico, 1967). Despite the extensive research and publications, few utilized the approach outside of those trained by the Guerneys and colleagues, and outside interest seemed to dwindle as the helping professions turned to more behaviorally-based interventions in the 1970s (L. Guerney, 2000). L. Guerney (2000) indicated that during this time, their team worked on refining their approach by condensing its length to around five to six months. In addition, those they had trained started utilizing, modifying, and extending the filial therapy approach in university and community settings.

Two of these individuals in particular, Barry Ginsberg (1976, 1984, 1989, 1997, 2002, 2003; Ginsberg, Stutman, & Hummel, 1978) and Risë VanFleet (1992, 2000, 2003, 2005, 2006, 2009a, 2009b, 2011a, 2011b; Topham & VanFleet, 2011; VanFleet & Guerney, 2003; VanFleet, Ryan, & Smith, 2005; VanFleet & Topham, 2011), continued to utilize and to write extensively about filial therapy. Despite going through this period of relative stagnation, L. Guerney (2000) noted that several child-centered play therapists in academia helped in maintaining and advocating for the utility of child-centered approaches. One of these influential individuals Guerney cited was Garry Landreth, whose work during this time contributed to the development
of child-centered play therapy. Perhaps of more importance to filial therapy was the fact that Landreth would later develop his own model of filial therapy that would contribute to the advancement of this treatment method.

In his book on his approach, Landreth and co-author Sue Bratton (2006) described the process of developing his filial therapy model. After encountering the work of the Guerneys, Landreth started exploring using filial therapy, indicating that the approach matched his passions for child-centered play therapy, group therapy, and teaching. One of the primary difficulties that Landreth had with the approach, however, was its length. First, he believed that people had a greater potential to accomplish change than the original timeframe of the Guerneys approach. In addition, he found that parents had difficulty sustaining their commitment to treatment. Landreth started experimenting with condensing sessions and eventually found success with a 10-session model. After a period of successfully using, refining, and supervising the approach in local private practices, Landreth began to utilize and teach his approach at the University of North Texas where he was a professor.

Over two decades later, Landreth, Bratton, and colleagues published the book and manual for the model, which they called child parent relationship therapy (CPRT; Bratton, Landreth, Kellam, & Blackard, 2006, Landreth & Bratton, 2006). In a similar manner to the Guerneys’ model, Landreth and Bratton conceptualized CPRT as an outgrowth of child-centered play therapy, primarily formatted the approach to use with groups of parents, concentrated on the development of the parent-child relationship, and utilized a combination of didactic instruction and dynamic group processing in training parents.

Landreth and Bratton (2006) offered the following as a definition:

In the CPRT model, filial therapy is defined as a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children
through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children’s feelings, therapeutic limit setting, building children’s self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent. (p. 11)

As did Guerney (1964) in his seminal work, Landreth and Bratton also outlined goals for parent-child sessions, in which parents

(1) understand and accept their child; (2) develop sensitivity to their child’s feelings; (3) learn how to encourage their child’s self-direction, self-responsibility, and self-reliance; (4) gain insight into self in relation to the child; (5) change their perception of their child; and (6) learn child-centered play therapy principles and skills. (p. 12)

Despite its condensed timeframe, extensive research on CPRT has reinforced the ability of filial therapists to induce dramatic changes in children and parents using this approach (Bratton, Landreth, & Lin, 2010). L. Guerney (2000) credited the work of Landreth and his colleagues in developing and researching CPRT as being a highly influential factor in the proliferation of filial therapy.

Theoretical Arguments for the Impact of Filial Therapy on Family Functioning

In addition to contending that filial therapy impacts parents and children through the parent-child relationship, proponents of filial therapy have contended that filial therapy addresses and effectively changes family functioning. In his first publication on filial therapy, B. Guerney (1964) clearly communicated that one of the primary reasons for using filial therapy is to utilize the power of family functioning, particularly the parent-child relationship, to change problematic family functioning. For instance, Guerney offered the following contentions regarding family functioning and filial therapy: (1) that “the primary source of maladjustment [of children] can presumably be traced directly or indirectly to interpersonal relationships, past and present, within
the family, and to the patterns of deprivation, conflict, and defense that these relationships have engendered” (p. 307); (2) that filial therapy involves “working with the parent toward changing the network of family relationships that support and reinforce the child's maladjustment” (p. 307); and (3) that filial therapy has the effect of facilitating “the parent’s ability to change negative patterns of interaction with the child” (p. 308). These contentions make it evident that the originators of filial therapy, from the very beginning, believed that family functioning was not only a contributor to problems but also an object and mechanism of change in the filial therapy process.

This theoretical assumption that filial therapy involves and changes family functioning continued to be evident in early publications on the approach. Stover and B. Guerney (1967) argued that one of main advantages of filial therapy was the “avoidance of the problems that otherwise could be aroused when the parent does not develop appropriate new responses to new behavioral patterns of the child” (p. 110). Stover and Guerney reiterated that the primary contention in filial therapy was that family functioning was simultaneously the problem, the mechanism of change, and the object of change: “The question is whether parents of emotionally disturbed children can develop behaviors that will contribute to the solution of interpersonal problems that the parents presumably helped create” (p. 110). Guerney, Guerney, and Stover (1972) also strongly reinforced this assumption of the integral nature of family functioning to problem formation and problem resolution in filial therapy:

if certain general favorable patterns of interaction between parent and child had existed throughout their relationship, a serious psychogenic problem would not now exist. But it [filial therapy] also assumes that whatever happened in the past, the most efficient way to remedy the difficulty is to strive to create a favorable set of circumstances in family relationships at the present time. (p. 276)

Another indication of the pervasive connection between filial therapy and family
functioning was evident in the fact that those within and outside of filial therapy viewed the approach as a form of family therapy. For instance, within five years of the original article by Guerney, Huff (1969), a family practitioner, cited filial therapy as a family therapy model because of its focus being on the “family unit” and the modification of family relationships (p. 22). Those most intimately involved with developing filial therapy also perceived their model as a form of family therapy. In reviewing the historical development of filial therapy, L. Guerney (2000) indicated that they initially called the approach “filial therapy” and that this is the most widely used term in referring to this treatment method. However, Guerney stated that early on in the development of filial therapy, they started using the term “filial family therapy” as they felt this latter term provided a more accurate description of the approach (p. 4). In continuation of this emphasis on the family-centered nature of their approach, they eventually named their particular model of filial therapy as child relationship enhancement family therapy (CREFT) (Guerney, 2000), which they continue to use to refer to their approach along with filial family therapy (National Institute of Relationship Enhancement, n.d., para. 2).

In later publications, the founders of filial therapy advocated for the theoretical connections between filial therapy and family therapy, contending that filial therapy does indeed change the family system. For example, in an article on the integration of child therapy and family therapy, Guerney and Guerney (1987) argued that an optimal approach “promotes change in the family system. By ‘system’ we refer to patterns of verbal and nonverbal interpersonal interactions among family members” (p. 611). They argued filial therapy provides such an environment for family change in which “intrapsychic, individual changes and the systemic changes are synergistic: each type of positive change being both the cause and the result of change in the other, and each type of change mutually eliciting and strengthening the other” (p.
In another publication, Guerney and Guerney (1988) contended that the focus of filial therapy is “not on the individual as such, but on improving the individuals’ relationships with others,” working to change “the system as a whole; that is, on attaining the sought-after skillful patterns of interaction” (p. 56). Similar to many traditional family therapy approaches, the founders of filial therapy acknowledged that change in the family system was the objective of the therapeutic process regardless of whether there was one family member or multiple family members participating (Guerney & Guerney, 1988).

Following the lead of their predecessors, Ginsberg and VanFleet have also repeatedly emphasized the relationship between filial therapy and family change and the nature of filial therapy as a form of family therapy. Ginsberg (1976), in his first publication on filial therapy, noted how filial therapists shared the perspective of early family therapists in viewing children merely as the “identified patient” and addressing “the problem residing in the larger context of the family” (p. 48), which he further articulated as “the pathological functioning and balance which is etiological to the problems the child is encountering” (p. 50). In a later work, Ginsberg (1989) pointed to the similarities between filial therapy and traditional family therapy models as a way of highlighting the family-centered nature of filial therapy. The heavy emphasis on creating family change is also evident in Ginsberg’s (1997) list of the family objectives of filial therapy, which are to help families to: (1) “feel more secure and comfortable with each other”; (2) “have better relationships with each other”; (3) “trust, accept, respect, and be open to others”; (4) “be more intimate with each other”; (5) “be more independent while acknowledging the importance of the family relationships”; (6) “reduce stress and conflicts”; and (7) “shift the family’s interactional system to one that is more positive, functional, and proactive” (p. 68).
VanFleet (2005, 2011a; Topham & VanFleet, 2011) also noted the family-centered nature of filial therapy, describing the approach as “an empowering form of family therapy that seeks to help the family system attain higher levels of functioning” (2005, p. 3). In order to accomplish this overall objective of higher family functioning, VanFleet (2005) contended that filial therapy changes family dynamics through accomplishing goals such as promoting “an open, cohesive family climate,” developing “positive interactions between parents and their children,” and increasing “families’ communication, coping, and problem-solving skills” (p. 4). VanFleet (2011a) succinctly summarized her perspective on the relationship between filial therapy and family change: “It [filial therapy] empowers children, parents, and families. It changes children. It changes parents. It changes the family” (p. 16). VanFleet (2011a) also highlighted the similarities between filial therapy and family systems approaches, asserting that filial therapy focuses on the relationship “between each parent and the child and among all the family members” (p. 18). She indicated that by affecting change in an individual or dyadic relationship, filial therapy affects the family as a whole.

Landreth and Bratton have also alluded to the impact that filial therapy has on family functioning, although with less frequency than those directly trained by the Guerneys. In a similar manner to VanFleet (2005) and Ginsberg (1997), Landreth and Bratton (2006) provided descriptions of the family change that occurs through filial therapy, noting that the primary objective of CPRT “is to enhance and strengthen the parent-child relationship through improved family interactions and problem-solving strategies and through increased feelings of familial affection, warmth, and trust” (p. 11). Although their views on the impact of filial therapy on the family are not as frequent in their writings, Landreth and Bratton have provided comments that would indicate that they believe filial therapy can influence the family. For instance, in an
interview with Watts and Broaddus (2002), Landreth stated that “filial therapy possibly holds the
greatest promise for changing the world by strengthening families” (p. 378). In the preface to
their book, Landreth and Bratton (2006) offered a similar comment: “This book is about
changing the mental health structure of families, communities, and ultimately society, by
changing the nature of relationships in families through a process of helping parents become
therapeutic agents in their children’s lives” (p. vii). Bratton et al. (2005) indicated that “common
sense would dictate that working with each component of a child’s system would increase the
positive outcome of therapy,” contending that filial therapy “provides the additional benefit of
serving to prevent future problems by impacting the family system” (p. 386).

In addition to these primary founders and developers of filial therapy, other proponents of
filial therapy have also provided extensive theoretical arguments for the impact of filial therapy
on family functioning, focusing particularly on the commonalities between filial therapy and
family systems approaches. For instance, Johnson et al. (1999) provided six arguments for filial
therapy that coincide with traditional family therapy principles: (1) “Filial therapy requires
family involvement”; (2) “filial therapy takes the focus off the child as the IP [identified
patient]”; (3) “filial therapy often leads to the parents’ seeing their role in the problem”; (4)
“filial therapy enhances parental leadership, strengthening the generational boundary between
parents and children”; (5) “filial therapy increases differentiated relating and reduces
polarizations between parents and children”; (6) “filial therapy highlights unhelpful systemic
sequences” (pp. 172-173).

Kellam (2001) also contended that filial therapy successfully involves and changes the
family system. The author argued, “Like family systems therapists…filial therapists
conceptualize the presenting problem as a manifestation of the patterns of relating within the
family” (p. 65). According to Kellam, filial therapy achieves family change through allowing the filial therapist to observe “enactments of the family’s conflicts” and work with interactions, through providing opportunities to deal with “resistance to structural change,” through encouraging the family to define appropriate hierarchy and boundaries, and through opportunities presented during the filial therapy process to work through “intergenerational patterns” (p. 65).

In a similar manner to Guerney and Guerney (1987), Hutton (2004) also argued for the effectiveness of filial therapy as a bridge between child therapy and family therapy and contended that filial therapy changes the family system. The author stated that filial therapy, in working conjointly with parents and children, could meet “the intrapsychic needs of young children and the systemic demands of the family” (p. 268). According to Hutton,

“shifting the balance” of power both between family members and from therapist to parent through the process of filial therapy ensures that therapeutic change can continue to occur beyond the therapist’s play room and be of long-term benefit to all the family members involved. (p. 269)

As evidenced in this review of the literature, filial therapists have consistently offered arguments for the impact of filial therapy on family functioning. These arguments have come from filial therapy’s founders, major developers, and more current users. Although the approach most immediately involves the participating parents and children, it is clear that many filial therapists believe that the benefits of this approach extend beyond the participating members to the family as a whole.

Outcome Research in Filial Therapy

Since its inception and development by the Guerneys and their colleagues, numerous researchers have conducted studies examining the effectiveness of filial therapy on a variety of outcome measures. Results from these studies provide opportunities to evaluate whether filial
therapy accomplishes the kinds of changes that its proponents conceptualized as occurring. The following is a review of the outcome research in filial therapy according to the following categories: (a) the general effectiveness of filial therapy, (b) the effect of filial therapy on individual family members, (c) the effect of filial therapy on the parent-child relationship, and (d) the effect of filial therapy on family functioning. In order to provide a thorough analysis, I have included quantitative and qualitative results as well as results from studies using small and large numbers of participants. In addition, I have separated the results based on the particular filial therapy model the researchers utilized in their studies.

**General Effectiveness of Filial Therapy**

Results on the effectiveness of filial therapy have consistently demonstrated the viability of this treatment approach. Perhaps one of the most impressive research conclusions on filial therapy came from a meta-analysis conducted by Bratton et al. (2005) of 93 controlled outcome research studies investigating play therapy and filial therapy. Using Cohen’s (1988) $d$ to interpret effect sizes (.20 = small, .50 = medium, .80 = large), the researchers found that studies using parents as treatment providers through filial therapy demonstrated a large overall treatment effect ($d = 1.15$). Interestingly, play therapy provided by a mental health professional resulted in a moderate treatment effect ($d = .72$). Further analysis conducted by Bratton et al. revealed that the difference between these effect sizes was statistically significant ($p < .01$). The researchers offered the following conclusion in light of these results:

Certainly, this research strongly supports the adoption of filial therapy as an effective therapeutic modality in working with children…a therapy model that not only can be greatly effective in a relatively short amount of time but also provides the additional benefit of serving to prevent future problems by impacting the family system. (p. 386)

Examining the data collected in the Bratton et al. (2005) meta-analysis, Bratton et al. (2010) reported that studies using CPRT methodology resulted in an even larger treatment effect ($d =$
1.30). This result is impressive when considering that parents only conduct seven play sessions with their children during the course of the training. A more recent meta-analysis conducted by Lin (2011) replicated the finding that parents trained in filial therapy, on average, achieved larger treatment effects than professionals conducting individual play therapy and group play therapy.

Other findings from research studies have supported the ability of parents to be competent treatment providers for their children. In a study comparing the change in observed empathic behaviors of 21 parents who received training in CPRT to 13 graduate students enrolled in a play therapy course, Elling (2003) found no significant differences between the skill levels of these groups in being able to communicate acceptance and allow the children to self-direct the sessions. Smith and Landreth (2003) found that filial therapy conducted by parents was as effective in reducing problematic behaviors in children as intensive play therapy and intensive sibling group therapy conducted by professionals.

In addition, research thus far has supported the effectiveness of filial therapy in maintaining changes over time. Guerney (1975) reported the results of a longitudinal study of 42 mothers who completed filial therapy and found that 76% of these participants reported continued improvement in their children 1 to 3 years after treatment, and 86% reported maintained improvements. Sensué (1981) conducted a follow-up study of parents trained in filial therapy and found that parents continued to show positive gains in parental acceptance and perceptions of their children’s adjustment six months and three years after training when compared to a normative sample.

Researchers have also supported the effectiveness of filial therapy with a variety of populations that represent various cultures, family structures, and presenting concerns. Regarding culture, researchers have successfully utilized filial therapy with Hispanic parents
Filial therapists have also demonstrated the effectiveness of filial therapy in a variety of
formats. Although researchers conducting investigations of the effectiveness of filial therapy often have utilized the 10-week CPRT model, as noted earlier, a large body of studies has also supported the effectiveness of filial therapy based on the methodology of the Gureneys and their colleagues. In addition, several of the research studies noted above used a condensed version of CPRT and achieved positive results (Harris & Landreth, 1997; Jang, 2000; Kidron & Landreth, 2010; Smith & Landreth, 2003; Walker, 2002). Ferrell (2003) conducted a more formal investigation of the effect of delivering CPRT in a condensed form over four days of training. When comparing this format to traditional CPRT, the researcher found no significant differences between the groups on parent-child relationship stress, parental acceptance, empathic responses, and child behavior problems, thus providing support for the comparable effectiveness of the traditional and condensed formats.

**Effect of Filial Therapy on Individual Family Members**

Most of the outcome research in filial therapy has focused on its effects on the parents and children participating in filial therapy. What follows is a review of the research on the effects of filial therapy on participating family members.

**Effects on Participating Children**

One well-researched area concerning filial therapy is its effect on the children who participated in play sessions with their filial-trained parents. Improved child adjustment, as measured by decreased problematic behaviors, was a consistent finding in the earliest filial studies (Dematatis, 1981; L. Guerney & Stover, 1971; Lebovitz, 1982; Oxman 1971; Swyulak, 1977), and Sensué (1981) found that the children maintained these improved behaviors over time. An added benefit is that many of the studies conducted by the Guerneys and their colleagues, as well as most conducted by those outside their team, utilized some of the same
instrumentation, thus allowing greater ease in comparing and replicating findings. In addition to the studies investigating child adjustment, researchers conducting early studies of children in filial therapy also reported improved social adjustment (Boll, 1972), personality adjustment (Payton, 1980), and behavior that more closely approximated what their parents considered as representative of an “ideal child” (Oxman, 1971).

Other researchers conducting studies using CREFT have also found improvements related to children. Johnson-Clark (1996) conducted a rigorous study of 52 mother-child pairs using a different measure of child behavior problems and also found statistically significant improvements in child behavior when comparing the treatment group to a play-only group and a no-treatment control group. In a study of using CREFT with two families of children with selective mutism, Garwood (1999) found that parents described their children as more adaptable, more autonomous, and less selectively mute. A case study of using CREFT with a four-year old child and her parents revealed decreased temper tantrums and greater control of emotions (Packer, 1990).

Outcome research regarding the effects of CPRT on participating children has also often revealed positive changes. In addition, researchers also have often used the same instrumentation. The two main instruments utilized by these researchers to measure child behavior problems have been the Filial Problem Checklist (FPC; Horner, 1974) and the Child Behavior Checklist (CBC), which comes in two versions depending on the age of the child (Achenbach & Rescorla, 2000, 2001). The FPC is a self-report instrument completed by parents indicating the presence and severity of 108 problematic child behaviors. The CBC is a self-report measure of child behavior problems completed by parents that yields results regarding whether the child is demonstrating clinically concerning behavior problems. Multiple controlled
outcome research studies have demonstrated that parents trained in CPRT reported statistically significant decreases in child behavior problems, as measured by either the FPC or CBC (Bratton & Landreth, 1995; Carnes-Holt, 2010; Ceballos & Bratton, 2010; Grskovic & Goetze, 2008; Harris & Landreth, 1997; Jang, 2000; Kidron & Landreth, 2010; Sheely-Moore & Bratton, 2010; Smith & Landreth, 2003; Tew et al., 2002; Villarreal, 2008; Yuen et al., 2002). Although notably less in number, some researchers have not observed statistically significant improvement in behavior (Beckloff, 1997; Costas & Landreth, 1999; Ferrell, 2003; Kale & Landreth, 1999; Kellam, 2003; Ray, 2003). However, when taking a holistic view of the research conducted thus far, the general trend supports the notion that filial therapy has a positive impact on the behavior of children. Researchers have also examined the effect of CPRT on the self-concept of children, with findings from two studies indicating a statistically significant improvement (Landreth & Lobaugh, 1998; Yuen et al., 2002) and two others indicating no statistically significant improvement (Costas & Landreth, 1999; Glover & Landreth, 2000).

Several researchers have also reported noteworthy findings using qualitative examinations regarding changes in children. Several qualitatively-based research studies, each involving multiple parents, have found that CPRT-trained parents reported improved child behavior (Bavin-Hoffman et al., 1996; Edwards, Sullivan, Meany-Walen, and Kantor, 2010; Garza et al., 2009; West, 2010). In an extensive ethnographic study of CPRT using three parents and their children, Lahti (1992) found that the reported changes in the children were increased responsibility for their behavior, improved communication, decreased aggressive and withdrawn behaviors, and increased happiness. Two separate qualitative studies of individual parents who completed CPRT found reports of improved self-confidence in the children (Edwards et al., 2007; Solis et al., 2004). Steen (2005), using a collection of case studies of filial therapy with
seven parents who had a child with a life-threatening illness, found that parents reported that their children were more confident, more cooperative in the hospital, more communicative with parents and staff regarding medical issues, and more communicative with parents regarding personal feelings and concerns. In a qualitative study of six mothers, Foley, Higdon, and White (2006) found that parents reported that their children displayed more empathy and cooperation, used some of the same play therapy skills and attitudes that parents were using in play sessions, and were more responsible and self-directed.

*Effects on Participating Parents*

Many researchers investigating the effect of filial therapy on participating children also included outcome measures aimed at measuring potential changes in participating parents. Researchers conducting investigations on the effect of filial therapy on parents have frequently included one or both of the following: the Porter Parental Acceptance Scale (PPAS) (Porter, 1954), a self-report measure of a parent’s acceptance of a child, and the Measurement of Empathy in Adult-Child Interactions (MEACI) (Stover, Guerney, & O’Connell, 1971), an observation instrument that assesses the ability of parents to demonstrate empathic behaviors towards their children. The coded behaviors of the MEACI are communication of acceptance, allowing self-direction of the child, parental involvement, and total empathy.

Early filial therapy research revealed statistically significant improvements in parental acceptance (Swyulak, 1977; Dematatis, 1981) that parents maintained over time (Sensué, 1981). In addition, early researchers repeatedly found statistically significant improvements in one or more of the empathic behaviors of parents trained in filial therapy (Dematatis, 1981; Guerney & Stover, 1971; Lebovitz, 1982). Utilizing another parent outcome measure, Payton (1980) found statistically significant improvement in maternal child-rearing attitudes in a sample of 22
mothers. Informal reports collected by Swyulak (1977) indicated that parents perceived themselves as more self-aware, patient, self-confident, and better at communicating as a result of training in filial therapy. Packer (1990) found in her intensive case study that the parents reported perceiving themselves as having and being able to use parenting skills to promote positive changes in their child’s behavior.

More recent studies conducted by researchers using CREFT have also found changes related to parents. For instance, Johnson-Clark (1996) found that filial-trained parents reported statistically significant decreases in parental rejection from pretest to posttest, a finding stable at a 2-month follow-up testing. In an intensive case study of two families, Garwood (1999) found that parents reported a number of changes in themselves, such as feeling more empathic and firmer in limit-setting, as well as increased parental competence and nurturance and decreased parenting stress.

Researchers conducting studies of the effects of CPRT on parents have found similar results, replicating these findings in numerous studies. Multiple controlled outcome research studies have revealed that parents trained in CPRT reported statistically significant increases in parental acceptance as measured by the PPAS (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Ferrell, 2003; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Ray, 2003; Sparks, 2010; Tew et al., 2002; Yuen et al., 2002). Only one controlled outcome study on CPRT did not find a statistically significant improvement in parental acceptance (Beckloff, 1997). In addition, CPRT researchers have found statistically significant increases in the empathic responses of parents as measured by the MEACI (Bratton & Landreth, 1995; Carnes-Holt, 2010; Chau & Landreth, 1997; Costas & Landreth, 1999; Ferrell, 2003; Glover & Landreth, 2000; Harris & Landreth 1997; Jang, 2000;
Kidron & Landreth, 2010; Lee & Landreth, 2003; Smith & Landreth, 2003; Sparks, 2010; Yuen et al., 2002). Using other parent outcome measures, Grskovic and Goetze (2008) found that parents reported statistically significant improvements in displaying a positive attention parenting style compared to a control group of parents receiving another intervention.

Researchers conducting qualitative investigations of changes in parents as a result of CPRT have further highlighted the personal changes parents have experienced. The most frequently occurring finding based on parents’ reports across qualitative studies was an increased awareness of the feelings or needs of their children (Edwards et al., 2007; Foley et al., 2006; Kinsworthy & Garza, 2010; Lahti, 1992; Solis et al., 2004; Wickstrom, 2009). Another common finding was increased parental confidence or competence (Foley et al., 2006; Garza et al., 2009; Grskovic & Goetze, 2008; Lahti, 1992; West, 2010; Wickstrom, 2009). Several researchers have reported that parents indicated improved parenting knowledge, skills, or styles (Edwards et al., 2010; Kinsworthy & Garza, 2010; Solis et al., 2004; West, 2010). Researchers have also reported findings of increased parental empathy (Grskovic & Goetze, 2008; Kinsworthy & Garza, 2010; Wickstrom, 2009) and increased acceptance of their children (Grskovic & Goetze, 2008; West, 2010; Wickstrom, 2009). Other replicated findings were feeling less responsible for and controlling of the behavior of their children (Kinsworthy & Garza, 2010; Lahti, 1992; Wickstrom, 2009), increased feelings of support (Foley et al., 2006; Kinsworthy & Garza, 2010), and increased understanding of their children (Foley et al., 2006; Grskovic & Goetze, 2008). Isolated results included increased self-awareness, patience, and resourcefulness (Foley et al., 2006); changed expectations of children, decreased reactivity, and decreased rescuing behaviors (Wickstrom, 2009); increased vulnerability (West, 2010); more realistic expectations
of self (Kinsworthy & Garza, 2010); and decreased feelings of frustration related to parenting (Garza et al., 2009).

**Effects on the Parent-Child Relationship**

It seems reasonable to assume that the extensive changes reported in parents and children in filial therapy both reflect and contribute to changes in these parent-child relationships. Researchers have specifically examined the effect of filial therapy on the parent-child relationship, primarily through qualitative analyses of information gathered during and after treatment. Although early research studies did not include formal assessments of the parent-child relationship, Sywulak (1977) reported that parents in her study indicated improved parent-child relationships as a result of filial therapy, specifying greater closeness, warmth, openness, positivity, and less tension. Garwood’s (1999) in-depth case study of two families found that parents reported closer parent-child relationships. Based on their case study with a single mother, Vafa and Ismail (2009) also observed improvements in the parent-child relationship, and reports from the mother corroborated that she also perceived changes in the relationship.

Several researchers studying the effect of CPRT on the parent-child relationship have utilized a quantitative outcome measure of the parent-child relationship, the Parenting Stress Index (PSI) (Abidin, 1995). The PSI evaluates the degree of stress in the parent-child relationship with the knowledge that stressful child-parent relationships may be at risk for developing problematic parent or child behaviors (Abidin, 1995). Most researchers conducting controlled outcome research studies of CPRT have found statistically significant decreases in parent-child relationship stress (Bratton & Landreth, 1995; Carnes-Holt, 2010; Ceballos & Bratton, 2010; Chau & Landreth, 1997; Costas & Landreth, 1999; Kale & Landreth, 1999; Kidron & Landreth, 2010; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Sheely & Bratton,
2010; Tew et al., 2002; Yuen et al., 2002). A smaller number of researchers have not observed statistically significant reductions (Ferrell, 2003; Glover & Landreth, 2000; Kellam, 2003; Ray, 2003; Sparks, 2010).

All researchers performing qualitative analyses involving CPRT have noted that parents reported improved parent-child relationships (Bavin-Hoffman et al., 1996; Edwards et al., 2007; Edwards et al., 2010; Foley et al., 2006; Garza et al., 2009; Kinsworthy & Garza, 2010; Lahti, 1992; Sangganjanavanich et al., 2010; Solis et al., 2004; West, 2010; Wickstrom, 2009). One of the most common findings in qualitative studies was improved parent-child communication (Bavin-Hoffman et al., 1996; Garza et al., 2009; Lahti, 1992; Solis et al., 2004; West, 2010). In addition, multiple researchers found that parents reported increased closeness (Edwards et al., 2007; Kellam, 2003; West, 2010). Isolated results included increased enjoyment (Foley et al., 2006), increased warmth (Garza et al., 2009), more collaboration between parent and child (Foley et al., 2006), less friction (Lahti, 1992), and increased respect for the parent-child relationship (Kinsworthy & Garza, 2010).

Winek et al. (2003) conducted a unique observational study of the process of parent-child interactions in filial play sessions with the objective of identifying interactive behaviors on part of the parent and the child that appeared to inhibit or facilitate the therapeutic process. Researchers identified the following parental behaviors as being facilitative of the filial therapy process: setting limits, accepting, encouraging, redirecting, narrating, joining in fantasy play, and self-awareness. Conversely, researchers identified the following parental behaviors as being inhibitive: anticipating child’s next behavior, undermining/contradicting, directiveness, threatening, non-enforcement of limits, insulting, guilting, interpreting behavior/feelings, and insulting self. In terms of the behaviors of the child, researchers identified the following as being
facilitative: asking for help, being independent, following rules, learning, awareness of competency, expressing emotions, engaging in fantasy play, and exploring. Inhibitive behaviors were being oppositional and not following rules. In addition, the researchers identified conditions not attributable to either the parent or child that also appeared to benefit the process, such as initiating affecting/intimacy, connection, and calming. Although these researchers did not study outcomes of filial therapy, their findings support that there do appear to be important interactional dynamics elicited through filial play sessions that have therapeutic implications.

Effects on Family Functioning

The substantial amounts of research regarding the effects of filial therapy on individuals and parent-child relationships make sense given the conceptual importance of these domains within this treatment approach. Given the substantial emphases on family functioning, one would expect that this too would be an object of much research attention within filial therapy. However, investigators have conducted little research to date regarding the effect of filial therapy on family functioning.

Qualitative studies conducted by Bavin-Hoffman et al. (1996), Lahti (1992), and Wickstrom (2009) have resulted in findings that are suggestive of potential changes occurring in the family as a whole. In interviews with 20 married couples who participated in CPRT, Bavin-Hoffman et al. (1996) found that participants reported improved family interpersonal communication skills, specifically improved parent-child communication and improved partner communication. In addition, these couples reported increased marital unity and indicated that their families valued the filial therapy experience. Lahti’s (1992) ethnographic study of three CPRT-trained parents also found reports of closer marital relationships. Using a sample of eight parents trained in CPRT, Wickstrom (2009) found that parents identified “four relational shifts”
as a result of treatment, which included “improved parent-child relationships, improved marital relationships, improved sibling functioning, and improved family-of-origin relationships” (p. 199).

Only one filial therapy study, conducted by Glass (1986), has incorporated a quantitative measure of family functioning. The sample in the Glass (1986) study consisted of 47 individuals comprising an experimental group ($n = 15$ parents, $n = 9$ children) and a control group ($n = 12$ parents, $n = 11$ children). To measure the impact of filial therapy on the family environment, Glass utilized the Madanes Family Hierarchy Test (MFHT) (Madanes, Dukes, & Harbin, 1980), the Family Environment Scale (FES) short form (Moos, 1974), and the Children’s Version of the Family Environment Scales (CVFES) (Pinos, Simons, and Slavinowski, 1984). As described by Glass, the MFHT attempts to measure family hierarchy and closeness between family members. Children and adults completed the assessment, in which they first choose which family configuration out of four pictured best represents their family’s hierarchy. Then, with movable figures, they adjust the physical proximity between figures to represent the closeness between family members. According to Glass, the FES short form is a 40-item instrument containing subscales that reflect a family’s interpersonal relations, perceived growth for individual members, and family organization. The CVFES is a 30-item pictorial version of the FES in which children choose which picture is the most like their family.

Each of these measures contains problematic elements. For instance, Glass reported that the MFHT was in an experimental stage and cited researchers conducting two studies prior to hers that utilized this test. Neither of these studies appeared to use it as a pretest-posttest measure of within-group differences over time but rather used it to discriminate between families at one time. In addition, no standardization of this instrument existed, which made the task of
determining a noteworthy finding much more difficult. The FES did not have any reported validity and minimal support for its reliability. The CVFES also had little established validity or reliability, and the sample used for standardization of the instrument was relatively small and lacked representativeness.

These issues regarding instrumentation warrant consideration when considering the results and conclusions of this study. For instance, one of the findings that Glass (1986) reported was that filial therapy may be able to improve closeness between family members without altering hierarchy. The basis for this finding was that the experimental group participants had a quarter-inch difference in closeness of the moveable figures at posttesting when compared to the control group on the MFHT. However, a lack of standardization makes it difficult to generate conclusions regarding this result. Another consideration is the execution of the data analysis within the study. Glass conducted tests of statistical significance on the FES and CVFES, finding one statistically significant result on the Conflict subscale of the FES. Although commonly performed, using tests of statistical significance with such a small number of participants is inadvisable due to low statistical power. Glass (1986) appeared to recognize the limitations in her study and offered several corrective recommendations for future research, such as a replication of this study with more subjects; the use of different measures of family dynamics, including those completed by outside raters; the use of alternative treatment control groups; and gathering information from family members who did not participate in filial therapy.

*State of Filial Therapy Outcome Research*

Researchers investigating filial therapy have found strong results that support its general effectiveness. In particular, these researchers have discovered strong empirical support for the effects of filial therapy on participating children and parents. Parent-child relationships also
appear to undergo significant changes as evidenced primarily by a substantive body of qualitative research. These findings provide support for the theoretical contentions that parents can serve as therapeutic agents in the lives of their children, that parents and children experience positive changes in filial therapy, and that changes in the parent-child relationship might serve as an initiator of that growth. However, there is a clear gap when considering the large quantity of theoretical arguments on the impact of filial therapy on family functioning and the minimal research conducted to evaluate these important contentions. In addition, research in this area would align with the strong evidence that supports the importance of considering family functioning and the utilization of effective, family-centered treatment methods.

Summary of Review of Related Literature

Individuals producing theory and research, within filial therapy and beyond, reinforce the importance of family functioning and the need to research and develop interventions that may promote healthy family functioning. For instance, all of the prominent founders and developers of theoretical approaches to counseling and family therapy, to varying degrees, have attended to the potential influence that families have on individual wellbeing. In support of these theoretical emphases on families, researchers examining the relationship between family functioning and wellbeing have found significant associations between healthy family functioning and the health of infants, young children, adolescents, and adults. In addition, researchers conducting a more limited number of experimental studies have found that family functioning may improve through group interventions with parents. Taken as a whole, the research evidence, although limited, suggests that family functioning may be changeable and that changes in family functioning may promote the wellbeing of family members.
Proponents of filial therapy, citing researchers who have investigated the therapeutic benefits of their approach, have contended that filial therapy can promote healthy changes in family functioning. However, there is very limited research evidence available in order to evaluate these contentions as researchers have focused their examinations on the parents and children receiving treatment as opposed to the families as a whole. If filial therapy does impact family functioning in a positive manner, then governmental and professional organizations; play therapists, family therapists, and other providers of professional therapeutic services; and seekers of family-based services may have an approach that warrants consideration as a therapeutic intervention for families. Thus, given the current state of research regarding family functioning and filial therapy and the importance of researching family-based services, I aim to investigate the impact CPRT has on family functioning.
APPENDIX B

DETAILED METHODOLOGY
In this study of the impact of filial therapy on family functioning, I employed a single-case, time-series design (Borckardt et al., 2008; Lundervold & Belwood, 2000; Ray, Barrio Minton, Schottelkorb, & Brown, 2010; Sharpley, 2007). According to Lundervold and Belwood (2000), “single-case experimental design is a methodology in which information on a single individual or several individuals is obtained concurrently” and is especially fitting for use in “practice settings” (p. 93). Single-case design allows for experimental rigor without the noted difficulties in conducting large-scaled studies (Borckardt et al., 2008).

A sample of parents in the southwestern United States participated in child parent relationship therapy (CPRT), a 10-session filial therapy model developed by Landreth and Bratton (2006). The developers of CPRT have manualized the approach (Bratton et al., 2006). In this section, I review the following as it relates to this study: research question, definition of terms, instrumentation, participant selection, details of treatment, data collection, and data analysis.

Research Question

The following research question was the focal point of this study: What is the impact of CPRT on family functioning? Within this overall research question, I examined the impact of CPRT on: (1) target behaviors related to family functioning that the researcher and participants jointly identified in the intake; (2) family cohesion and family flexibility as measured by scores on the Family Adaptability and Cohesion Evaluation Scales (FACES IV; Olson, Gorall, & Tiesel, 2006); (3) family communication as measured by the Family Communication Scale (FCS; Olson & Barnes, 2006); (4) family satisfaction as measured by the Family Satisfaction Scale (FSS; Olson, 2006); and (5) family cohesion, family flexibility, and family communication as measured by the Clinical Rating Scale (CRS; Olson, 2003).
Definition of Terms

The following is a list of important concepts and their operational definitions according to this research study:

Family functioning. Family functioning, as defined in this study, refers to the characteristic nature and patterns of relating among family members that reflect family structure and processes (Goldenberg & Goldenberg, 2008). For the purposes of this study, I operationally define family functioning as scores on the target family behaviors, FACES IV, FCS, FSS, and CRS.

Family cohesion. Family cohesion is “the emotional bonding that couple and family members have toward one another” (Olson, 2011, p. 65). Scores on the FACES IV and CRS serve as the operational definitions of family cohesion.

Family flexibility. Family flexibility refers to “the quality and expression of leadership and organization, role relationship, and relationship rules and negotiations” (Olson, 2011, p. 65). Scores on the FACES IV and CRS serve as the operational definitions of family flexibility.

Family communication. Family communication is “the positive communication skills utilized in the couple or family system” and is “a facilitating dimension that helps families alter their levels of cohesion and flexibility” (Olson, 2011, p. 65). More specifically, Olson and Barnes (2006) defined family communication “as the act of making information, ideas, thoughts and feelings known among members of a family unit” (p. 1). Scores on the FCS and CRS serve as the operational definitions of family communication.

Family satisfaction. Family satisfaction is “the degree to which family members feel happy and fulfilled with each other” (Olson, 2006, p. 1). Scores on the FSS serve as the operational definition of this construct.
*Child parent relationship therapy (CPRT).* Landreth and Bratton (2006) defined filial therapy in CPRT as

a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children’s feelings, therapeutic limit setting, building children’s self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent. (p. 11)

*Parent.* For the purposes of this study, a parent is any primary caregiver of the child, which may include biological parents, custodial parents, or adoptive parents.

*Family.* For the purposes of this study, a family is at least two individuals, one who is an adult and another who is a child, who reside in the same household. The adult assumes the primary role of caretaking, and the child sees the adult as being a primary caretaker.

*Child of focus.* A child of focus is a child between the ages of 2-10 whom parents participating in CPRT selected as the individual with whom they conducted play sessions.

Instrumentation

*Individualized Ratings Forms*

The primary instrumentation utilized in this study consisted of individualized rating forms that I created for families, using guidelines offered by Borckardt et al. (2008), in order for them to track a targeted area of family functioning. Prior to the intervention, I collaborated with parents to identify a target area of family functioning that they believed needed improvement (e.g., emotional responsiveness, discipline, conflict, communication, etc.). Once identified, I created forms consisting of three ratings that the parents would use to assess the target area on a daily basis. Of the three ratings, two consisted of rating actual behaviors, and one consisted of
rating one’s perception of the family’s functioning related to the target area. To promote the fidelity of data collection, I ensured that the parents understood the constructs that they were rating, instructed them on the importance of rating on a daily basis, and helped participants come up with a routine for completing the ratings. I also contacted participants using their preferred mode of communication (e.g., phone or email) throughout the first week to provide a reminder and to be available for any questions. I instructed participants not to complete the ratings for days in which they had limited or no contact with their family so that this circumstantial factor would not act as a confounding variable. Participants began completing these ratings the day of or the day after pretesting, which provided 7-8 baseline observations prior to treatment, fulfilling the minimum of 5-7 ratings recommended by Borckardt et al. (2008). Participants then completed the ratings on a daily basis throughout treatment, thus resulting in 76-77 treatment observations.

Three families targeted emotional responsiveness as the area of family functioning that needed improvement and completed the following ratings: (1) number of instances in which family members communicate their feelings; (2) number of instances in which a family member acknowledges the feelings of another family member; and (3) degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members often express their feelings and are sensitive to the feelings of others.” Three families targeted discipline and completed these ratings: (1) number of instances in which a parent provides a directive, limit, or consequence for behavior; (2) number of instances in which a child complies with a directive, limit, or consequence set by a parent; and (3) degree of agreement with the statement: “Family members often utilize and respond to discipline successfully.” On the discipline ratings, I subtracted the number of directives complied with by a child from the
number provided by a parent, which resulted in the number of times a child did not comply with a parental directive. This served as the indicator of the degree of improvement in the family’s discipline. One family targeted encouragement and completed ratings of the following: (1) number of instances in which a family member criticizes another family member; (2) number of instances in which a family member praises or encourages another family member; and (3) degree of agreement with the statement: “Family members often encourage one another.” One family, who targeted conflict, did not meet the criteria of completing at least 75% of their ratings.

*Formal Measures of Family Functioning*

I utilized the following instruments developed by Olson and his colleagues to measure constructs according to the circumplex model of marital and family systems: (1) the Family Adaptability and Cohesion Evaluation Scales (FACES IV), (2) the Family Communication Scale (FCS), (3) the Family Satisfaction Scale (FSS), and (4) the Clinical Rating Scale (CRS). The first three measures are self-reported measures delivered within a single instrument in order to provide a comprehensive assessment of the family. The final measure, the CRS, is an observational measure completed by clinicians.

*Family Adaptability and Cohesion Evaluation Scale (FACES IV)*

The FACES IV (Olson et al., 2006) is a 42-item self-report instrument used to assess the overall health of families according to the dimensions of cohesion and flexibility. Family members over 12 years can complete the instrument. The FACES is one of the most widely used family assessments. An extensive review conducted by Kouneski (2000) revealed that researchers have used a version of FACES in more than 1,200 published articles and dissertations.
Research on the initial versions of FACES revealed that the items did not adequately capture the curvilinear relationship posited in the circumplex model. Specifically, the initial versions lacked items tapping into the unbalanced levels (high/low cohesion and high/low flexibility). A research study by Tiesel (1994) successfully addressed this issue of developing items that tapped into the extreme levels of cohesion and flexibility. The FACES IV combined these new items with items from previous versions of FACES that adequately measured the balanced areas of cohesion and flexibility.

Olson (2011) reported results from a validation study of FACES IV on a sample of 469 individuals. Results from an exploratory factor analysis of the items in FACES IV supported four unbalanced factors (Disconnected, Overly Connected, Inflexible, and Overly Flexible) and two balanced factors (Balanced Cohesion and Balanced Flexibility). A confirmatory factor analysis revealed “an acceptable or well-fitted model” (p. 68). Cronbach’s alpha internal consistency analyses of the scales revealed very good reliability: Overly Connected $\alpha = .77$, Balanced Cohesion $\alpha = .89$, Disconnected $\alpha = .87$, Overly Flexible $\alpha = .86$, Balanced Flexibility $\alpha = .84$, and Inflexible $\alpha = .82$. Large positive correlations ($r = .89$ to $r = .99$) existed between the balanced scales and three other measures of family functioning, providing support for concurrent validity. Using all the scales, FACES IV was able to discriminate groupings of problem and non-problem families with a predictive accuracy averaging 92%, providing support for discriminant validity.

*Family Communication Scale (FCS)*

The FCS is a 10-item self-report instrument based on the 20-item Parent-Adolescent Communication (PAC) scale originally developed by Barnes and Olson (1985). Olson and Barnes (2006) reported that in developing the PAC, they created a 35-item pool and pilot tested
these items on a sample of 433 individuals. Factor analysis led to the deletion of 15 items and confirmed that these items reflected a two-factor solution: Open Family Communication and Problems in Family Communication. According to Olson and Barnes, over 60 published studies have utilized the PAC. Olson and Barnes reported that reviews of the research revealed that Open Family Communication subscale had more predictive validity than the Problems in Family Communication subscale. Open Family Communication measured “the degree to which family members feel unconstrained and satisfied with the communication in their family (p. 3).

In the interests of creating a shorter scale, the 10 items from the Open Family Communication scale became the Family Communication Scale. Data gathered from 2,465 individuals served as the norming sample for this scale. The items are on a 5-point, Likert scale, and individuals rate the degree to which they perceive they agree with the item as being true for their family. The following is an example item: “Family members can calmly discuss problems with each other.” Based on this sample, researchers standardized the instrument and developed the following categories for interpretation based on raw scores: very high (86th-99th percentiles), high (70th-83rd percentiles), moderate (50th-65th percentiles), low (24th-44th percentiles), and very low (10th-20th percentiles). Very low family communication reflects that “family members have many concerns about the quality of their family communication,” and very high family communication reflects that “family members feel very positive about the quality and quantity of their family communication” (Olson & Barnes, 2006, p. 4). The internal consistency reliability of the scale was $\alpha = .90$, and the test-retest reliability was $r = .86$.

*Family Satisfaction Scale (FSS)*

The FSS, developed originally by Olson and Wilson (1982), is a 10-item self-report instrument. According to Olson (2011), the FCS assesses “the level of satisfaction family
members have with their families’ functioning,” specifically their cohesion, flexibility, and communication. Olson (2006) reported that the scale was first used in a study of 1,000 families, which served as the original norming sample. Results from this study revealed that family satisfaction accounted for roughly half of the variance in ratings of quality of life. Since this initial study, researchers have utilized the FCS with diverse families and a variety of family issues (Olson, 2006).

Individuals rate the items on a 5-point, Likert scale, indicating the degree to which they are satisfied with various aspects of their family. For example, the following is an item from this scale: “[How satisfied are you with] The degree of closeness between family members.” Olson (2006) reported renorming the FSS using a sample of 2,465 individuals. Olson reported the following as cutoff scores for interpretive purposes: very high (86th-99th percentiles), high (61st-85th percentiles), moderate (36th-60th percentiles), low (21st-35th percentiles), and very low (10th-20th percentiles). Very low scores reflect that “family members are very dissatisfied and are concerned about their family,” and very high scores reflect that “family members are very satisfied and really enjoy most aspects of their family” (Olson, 2006, p. 5). The alpha reliability of the scale was .92, and the test-retest reliability was $r = .85$ for the norming sample.  

Clinical Rating Scale (CRS)  

The CRS is an observational instrument developed by Olson (2003) and his colleagues to assess family cohesion, family flexibility, and family communication using a semi-structured interview, a family interaction task, or both. The CRS, like the FACES IV, offers an assessment of family functioning according to the circumplex model. Within family cohesion, raters scored families according to the following subscales: balance of separateness-togetherness in the family, marital closeness, family closeness, family loyalty, participation in activities as a family, and the
degree of independence of family members. The ratings for cohesion are on a 10-point scale, with every 2 points representing 1 of 5 categories: disconnected, somewhat connected, connected, very connected, and overly connected. Within family flexibility, raters assess families according to how they manage leadership, discipline, negotiation, roles, rules, and how open families are to change. The ratings for flexibility are on a 10-point scale, with every 2 points representing 1 of 5 categories: inflexible, somewhat flexible, flexible, very flexible, and overly flexible. For family communication, raters scored families according to their listening skills, speaking skills, self-disclosure of feelings, clarity, staying on topic, and respect and regard. The ratings for communication are on a 6-point scale, with every 2 points representing 1 of 3 categories: low, moderate, and high. Each of the three main constructs of cohesion, flexibility, and communication also has a separate global rating.

Two studies in which researchers conducted factor analyses of the CRS support the construct validity of the instrument (Lee, Jager, Whiting, & Kwantes, 2000; Thomas & Olson, 1993). Researchers have found the CRS to discriminate between problem and non-problem families (Thomas & Olson, 1993) and to support the curvilinearity hypothesis of the circumplex model (Thomas & Olson, 1994; Thomas & Ozechowski, 2000). Exploratory and confirmatory factor analyses have provided support that the CRS measures the three constructs it purports to measure (Thomas & Lewis, 1999). In using the CRS with graduate student raters in a clinic setting, Lee et al. (2000) reported that exploratory factor analysis revealed the same factor structure as found by Thomas and Olson (1993). Lee et al. reported acceptable to good internal consistency values ranging from $\alpha = .78$ to $\alpha = .89$ for the three variables. Thomas and Olson (1993) reported excellent internal consistency values of $\alpha = .95$ to $\alpha = .97$. These researchers also found
good interrater reliability for the instrument, with percentage agreement within 1 point ranging from 91.1% to 97.4% for cohesion, flexibility, and communication.

Participants

Before recruiting participants, I obtained approval for the study from the University of North Texas Institutional Review Board. To recruit participants, I used a combination of convenience sampling using two primary resources in the community in which I conducted the study. The first resource was a group of waitlisted parents who expressed interest in receiving CPRT at a university-based, community counseling clinic. The second resource was an organization in the region that provides extensive support and training to foster and adoptive parents and their families. I contacted the director of this organization to discuss the research study and to solicit help in recruiting potential parents. I sent a description of CPRT and the research study, along with my contact information, for dissemination to their contact list. I contacted parents who expressed interest in order to discuss the nature of CPRT and the research study in order to determine if they were still interested in participating and if they met the necessary criteria for participation. I referred those who did not meet criteria to another filial therapy group that was not affiliated with this research study.

The participants had to meet the following criteria in order to participate in the study and in CPRT: (1) had at least one parent interested in participating in CPRT, at least 18 years old, and able to speak and read in English; (2) had at least one child between the ages of 2-10, with identified behavioral or emotional concerns and normal cognitive ability, who would serve as the child of focus for the parent participating in CPRT; (3) had at least one additional family member other than the parent or child participating in CPRT who was willing to participate in pretest and posttest family assessments; and (4) demonstrated clinical appropriateness for participation in
CPRT (Landreth & Bratton, 2006) and the research study as determined through completion of the intake and informed consent process.

18 parents and 23 children, representing 10 families, consented to participate in the research study. Of the 18 parents involved in the study, 16 also consented to participate in CPRT. A family of one parent and three children dropped out after the parent was unable to attend the first CPRT session. A second family of two parents and three children dropped out after the second session due to an unexpected family emergency. A total of 8 families, consisting of 15 parents and 17 children, participated in the research study in its entirety.

Table 3 presents demographic information on the parents involved in the study, and Table 4 presents demographic information on the children involved in the study. Table 5 presents demographic information on the families.

Table 3

<table>
<thead>
<tr>
<th>Demographics of Parents in the Research Study (n = 15)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Male 7</td>
</tr>
<tr>
<td>Female 8</td>
</tr>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>29-35 6</td>
</tr>
<tr>
<td>36-42 3</td>
</tr>
<tr>
<td>43-49 6</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
</tr>
<tr>
<td>Caucasian 14</td>
</tr>
<tr>
<td>Hispanic 1</td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Completed high school 1</td>
</tr>
<tr>
<td>Some college 3</td>
</tr>
<tr>
<td>Completed college 8</td>
</tr>
<tr>
<td>Advanced degree 3</td>
</tr>
<tr>
<td><strong>Relationship status</strong></td>
</tr>
<tr>
<td>Single, divorced 1</td>
</tr>
<tr>
<td>Married, first marriage 10</td>
</tr>
<tr>
<td>Married, not first marriage 4</td>
</tr>
</tbody>
</table>
Table 4

**Demographics of Children in the Research Study (n = 17)**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-5</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>6-9</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>10-13</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>2-5</th>
<th>6-9</th>
<th>10-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>8</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Caucasian</th>
<th>Hispanic</th>
<th>Asian</th>
<th>Hispanic/Caucasian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 5

**Demographics of Families in the Research Study (n = 8)**

<table>
<thead>
<tr>
<th>Family structure</th>
<th>Two parents, biological</th>
<th>Two parents, stepfamily</th>
<th>Two parents, adopted</th>
<th>One parent, biological</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of children</th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Family income</th>
<th>Not reported</th>
<th>&lt;$10,000</th>
<th>$10,000-20,000</th>
<th>$60,000-80,000</th>
<th>$80,000-100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
Treatment

I assigned the 13 CPRT participants into 1 of 2 groups in order to meet the recommended number of 6-8 parents per group (Landreth & Bratton, 2006). Both groups met for 2-hour sessions for 10 weeks, and the groups took place at university-based, community counseling clinic.

I conducted the sessions, along with a co-leader, according to the protocol outlined in the CPRT manual (Bratton et al., 2006). My co-leaders and I received formal training and supervision in child-centered play therapy and in CPRT protocol. Although a complete description of the treatment is beyond the scope of this review, I present a brief synopsis of the treatment provided. The goal of CPRT is to strengthen the child-parent relationship through teaching parents how to conduct at-home play sessions with their children (Landreth & Bratton, 2006). CPRT involves two primary components: (1) a didactic component, which revolves around teaching the basic play session attitudes, procedures, and skills; and (2) a group process component, which consists of facilitating an environment of warmth, support, and feedback amongst the parents in the group (Landreth & Bratton, 2006).

In Session 1, parents describe their child of focus and report the primary issues they are experiencing with this child. The parents also learn the skill of reflective responding, which consists of being keen raters of their child so that they can understand their child and communicate this understanding. Session 2 consists of parents learning basic concepts and skills related to facilitating their play sessions with their child of focus. Parents also start collecting the necessary toys for the play sessions from a defined list provided in their parent notebook. In Session 3, parents spend a significant amount of time role-playing the basic skills in preparation for their weekly 30-minute play sessions, which begin after this session and continue throughout
the remaining seven sessions. Beginning in Session 4, time is spent processing and supervising parents’ play sessions. One to two parents per week share a video recording of their most recent play session so that the group leaders and group members can provide supportive and constructive feedback. This supervision time is continued throughout CPRT, with each parent ideally showing a video at least once. In Session 4, parents also learn the skill of limit setting. Session 5 provides time to review the skills already covered, to role-play, and to process play sessions in greater depth. In Sessions 6, 7, 8, and 9 parents learn the skills of choice giving, esteem-building responses, encouragement, and advanced limit setting. Session 10 consists of helping parents to generalize the skills they learned and to process the changes they have noticed in themselves and in their children.

In order to assess for treatment integrity, I recorded video of all the group sessions. One of the authors of the CPRT protocol evaluated a random selection of these sessions and determined that the sessions adequately reflected CPRT.

Data Collection

Using single-case research guidelines provided by Borckardt et al. (2008), I collected data on target behaviors related to family functioning in conjunction with pretest and posttest data on more formal outcome measures (FACES IV, FCS, FSS, and CRS). To protect the confidentiality of participants, I assigned codes to all data collected.

Data collection occurred in three phases: (1) pre-intervention, (2) during intervention, and (3) post-intervention. For the pre-intervention phase, I arranged a 1½-hour session with each family that took place 1 week prior to the intervention. I first reviewed the informed consent for CPRT and the study (see Appendix E for the informed consent documents for this study). After obtaining consent, I conducted a 30-minute play activity with each family in which they created
a scene to represent a typical day in their family using a sandtray and a variety of figurines (see Appendix E for the protocol for this activity). The goal of the activity was to generate interaction between family members, using a developmentally-sensitive task relevant to all family members, to provide additional data for the raters to utilize in completing the CRS. After the play activity, I allowed the children to leave and conducted a 30-minute, semi-structured interview with the parents using the questions provided in the CRS manual. Afterwards, the parents completed the self-report family measures related to family functioning (FACES IV, FCS, and FSS). These measures, which participants completed at the intake session and at the follow-up session, assess family cohesion, family flexibility, family communication, and family satisfaction. The researcher provided an environment free of distractions for the parents to complete these measures in order to promote the fidelity of the data and limit the bias that might otherwise occur if they completed these in the presence of other family members. Research team members were available to address any questions or concerns participants had.

After the family activity and the interview, I worked in collaboration with parents to identify a target area of family functioning that they believed needed improvement. I created individualized rating forms as indicated in the instrumentation section. I collected rating forms on a weekly basis during each CPRT session.

The post-intervention phase involved families returning 1 week after the final session of CPRT to complete the family play activity, semi-structured interview, and formal outcome measures. The parents also responded to the following interview questions regarding the impact CPRT may have had on their family functioning: “Has CPRT impacted the way your family functions? If so, how does your family function differently as a result of CPRT?” Individuals
other than myself administered these questions in order to limit the influence of bias and social desirability.

I also utilized raters to complete the CRS based on video recordings of the family play activity and interview completed pre- and post-intervention. The raters were two doctoral-level counseling students with advanced training and experience in child-centered play therapy, CPRT, and observational assessments. I facilitated an 8-hour training with the raters. Prior to the training, I sent the raters an article that provided an overview of the circumplex model, the theoretical background of the CRS (Olson & Gorall, 2003). On the day of the training, I reviewed the circumplex model, provided descriptions of the theoretical constructs, reviewed the CRS rating scale, and introduced the raters to the nature of the family play activity and semi-structured interview. We then watched a recording of an example from a family who eventually dropped out from the study, stopping the recording periodically in order to note what we had observed in their family interaction. The raters then completed the CRS and compared their ratings, discussing any differences. Afterwards, the raters completed the CRS based on recordings of the pre- and post-intervention family play activity and semi-structured interview from a family who participated in the study. I instructed raters to complete the CRS based on the family interaction task and then to utilize the semi-structured interview to further inform their ratings.

To evaluate interrater reliability, I calculated the percentage of agreement on global ratings that were within 1 point of each other on cohesion, flexibility, and communication. This approach to calculating interrater reliability is common (Stemler, 2004), and a previous study using the CRS utilized this method (Thomas & Olson, 1993). Based on the three practice ratings completed during the training, the raters demonstrated excellent interrater reliability, achieving
100% agreement on all ratings. I randomly assigned the recordings to the raters, and the order in which the raters were to watch the recordings, in order to blind them to whether the recording was pre- or post-intervention. The raters completed all ratings within 1 week of the training. After completing their ratings, the raters completed an additional assessment of their interrater reliability using another practice rating, and they again achieved 100% agreement.

Analysis of Data

When analyzing single subject data, researchers have tended to rely on either visual or statistical methods, and there is considerable debate and controversy regarding which method is more valid (Gast, 2010; Morgan & Morgan, 2009; Nugent, 2010). After reviewing the literature on approaches to analyzing single-case data, it became clear that there were strengths and limitations to visual and statistical analyses. I elected to rely on statistical methods for the following reasons: (1) as noted by Campbell and Herzinger (2010), there can be significant limitations involved in visual analysis, such as low reliability, susceptibility to Type 1 error, and a lack of universal decision rules; (2) the strengths of statistical analyses appeared more attractive for this study, namely the ability to identify small effects, to better control for variability in the data, to provide greater objectivity, and to quantify the magnitude of change (Campbell & Herzinger, 2010); (3) the use of statistical methods allows for greater ease in consolidating and comparing results between participants within a study and across studies; (4) my own background involved more training in the utilization of approaches based on statistical inference as opposed to visual methods; and (5) I designed this study in accordance with guidelines outlined by Borckardt et al. (2008), which incorporated the use of a specific statistical approach to analyzing data.
I conducted time-series statistical analyses on each rating using a computer software program called Simulation Modeling Analysis 9.9.28 (SMA; Borckardt, 2006), which can be downloaded for free (http://clinicalresearcher.org/software.htm). I elected to exclude from further analysis any ratings that contained less than 75% of completed data. One advantage of SMA is that it accounts for autocorrelation that is present in the data as part of the analysis, a noted issue in single-case research for which a limited number of analytical approaches take into account (Campbell & Herzinger, 2010; Nugent, 2010). Autocorrelation reflects the degree of dependence between observations: that “the value of one observation depends (at least in part) on the value of one or more of the immediately preceding observations” (Borckardt et al., 2008, p. 82). Single-case, time-series data tend to have more dependence across observations for two reasons: (1) the same individual is completing the observations; and (2) the observations often occur in proximity to one another, and observations that are more closely rated in time are more likely to be closely related in value. Many conventional statistical methods rely on the assumption that observations are independent, and, if used with data that has high autocorrelation, researchers risk greater chances of making a Type I error. In addition to accounting for autocorrelation, SMA has a distinct advantage in being able to analyze short data streams, which are present in this study in the relatively small number of baseline ratings. Borckardt et al. (2008) recommended that other statistical methods be used with larger data streams (>29 ratings per phase), a condition that I met for treatment phase data but not for baseline phase data. I completed the steps of time-series analysis as outlined by Borckardt et al. (2008). SMA calculates a Pearson $r$ value between the data collected during the baseline and treatment phases. SMA then analyzes the statistical significance of this $r$ value by comparing it to a random distribution of 5,000 $r$ values generated by the program that have the same number
of phase ratings and degree of autocorrelation. This allows for determining the likelihood of obtaining such a value by chance.

I also analyzed additional quantitative data provided by the FACES IV, FCS, FSS, and CRS. Scores from these measures served as additional evidence for evaluating the impact of CPRT on family functioning. From the FACES IV, I utilized the ratio scores on cohesion and flexibility, which Olson (2011) recommended for research purposes. These scores reflect the ratio of balanced levels to the unbalanced levels of cohesion and flexibility. For example, the cohesion ratio equals families’ scores on the Balanced Cohesion subscale over their average scores on the Overly Connected and Disconnected subscales. I used the mean and standard deviation of these ratio scores from the norming sample in order to analyze the results from these measures. For the FCS and FSS, I used the percentile scores and the interpretation from their norming samples. Finally, for the CRS, I used the scores and the interpretation from the global ratings.

The above measures allowed me to assess the results for statistical, practical, and clinical significance (Thompson, 2002). The results of the time-series analysis on the target behaviors provided data to measure whether there was statistically significant improvement in the mean values of the ratings from the baseline phase to the treatment phase. I assess practical significance through calculating an effect size statistic on the data that is appropriate for single subject research, the percent of data exceeding the median (PEM; Ma, 2006). This method involves calculating the percentage of data points in the treatment phase that indicate an improvement above the median of the data points in the baseline phase. If the treatment phase data mirrors the baseline phase data, one would expect that 50% of the data would be above the baseline median and 50% would be below the baseline median. As the PEM increases above
50%, it provides an indication of a change in the data from baseline to treatment. I utilized the following interpretive guidelines provided by Scruggs and Mastropieri (1998), as recommended by Ma (2006): 50% or less indicates no effect, 50-70% indicates a questionable effect, 70-90% indicates a moderate effect, and 90% and above indicates a strong effect. By calculating an average PEM across all participants, I obtained an indication of the overall effect. I also examined the effect size within the context of previous research (Thompson, 2006; Trusty, Thompson, & Petrocelli, 2004; Vacha-Haase & Thompson, 2004). Because the FACES IV, FCS, and FSS are standardized measures and the CRS is a clinician-rated instrument, I assessed clinical significance through examining the potential therapeutic improvement indicated by these measures. I also utilized the responses provided by participants in the post-intervention interviews as indicators of practical and clinical significance.
APPENDIX C

UNABRIDGED RESULTS
Because the population of focus for this study is families and the nature of the study’s design is single-case, I first present the results according to each family. After presenting the results on each family, I provide an overall analysis of the results across families. In the following descriptions, pseudonyms are used to protect participants’ identities.

The Peasley Family

The Peasley family consists of 3 members: father, Stephen (49); mother, Heather (45); and son, Anthony (8½). Stephen and Heather, both Caucasian, adopted Anthony, who is Asian, internationally. He is their first and only child, and they adopted him roughly 1½ years prior to the study. No one in the Peasley family received therapeutic services at the time of the study.

Stephen indicated that Anthony’s issues seem to be related to a fear of abandonment. He said that Anthony’s behavior seems to worsen whenever he is away from the home for an extended amount of time due to work travel. He noted that Anthony often will get “testy” right before he leaves for travel and that it takes several days after he returns from his trips for Anthony’s behavior to return to normal. Heather said that Anthony will have “meltdowns” and “tantrums” and that they want to work on helping him express his feelings.

Stephen and Heather targeted emotional responsiveness as an area of family functioning that needed improvement. Heather reported that they had already been working on acknowledging and responding to Anthony’s feelings more after being encouraged to do so through previous training they received on parenting adopted children. Stephen and Heather completed the following ratings of emotional responsiveness throughout the study: (1) number of instances in which family members communicate their feelings; (2) number of instances in which a family member acknowledges the feelings of another family member; and (3) degree of
agreement (on a 13-point scale from *strongly disagree* to *strongly agree*) with the statement:

“Family members often express their feelings and are sensitive to the feelings of others.”

Stephen and Heather participated in CPRT and each of them conducted at-home play
sessions with Anthony. Stephen attended 6 out of the 10 CPRT sessions and conducted only 3 of
the 7 possible play sessions. Heather attended 9 CPRT sessions and conducted 4 play sessions.
Stephen and Heather noted having difficulty conducting their play sessions due to having to
move to a new house during CPRT.

*Targeted Area: Emotional Responsiveness*

Stephen completed 85% of the data for the first two ratings and 79% of the data for the
third rating. Heather completed 100% of the data for the first two ratings and 99% for the third rating. Based on Stephen’s data, the Peasley family exhibited a statistically significant increase
in the average number of communicated feelings from baseline to treatment, Baseline \(M = 1.5\),
95% CI [0.88, 2.13], Treatment \(M = 4.11\) [3.78, 4.44], \(r = .53, p = .007\). Heather’s data also
indicated an increase in the average number of communicated feelings, but this increase was not
statistically significant, Baseline \(M = 2.5\) [1.75, 3.38], Treatment \(M = 4.11\) [3.57, 4.28], \(r = .25, p = .08\). Figure 1 and Figure 2 represent Stephen’s and Heather’s ratings, respectively.

![Figure 1](image)

*Figure 1.* From baseline to treatment, Stephen’s ratings of the number of instances in which family members communicated feelings.
Based on Stephen’s data, the Peasley family exhibited a statistically significant increase in the average number of acknowledged feelings from baseline to treatment, Baseline $M = 1.38$, 95% CI [0.63, 2.13], Treatment $M = 4.27$ [3.9, 4.65], $r = .53$, $p = .01$. Heather’s data also indicated an increase in the average number of acknowledged feelings that was statistically significant, Baseline $M = 2$ [1.5, 2.5], Treatment $M = 3.3$ [3.05, 3.54], $r = .34$, $p = .047$. Figure 3 and Figure 4 represent Stephen’s and Heather’s ratings, respectively.

**Figure 2.** From baseline to treatment, Heather’s ratings of the number of instances in which family members communicated feelings.

**Figure 3.** From baseline to treatment, Stephen’s ratings of the number of instances in which family members acknowledged the feelings of another family member.
Figure 4. From baseline to treatment, Heather’s ratings of the number of instances in which family members acknowledged the feelings of another family member.

Data collected from Stephen also indicated a statistically significant increase, from baseline to treatment, in his average level of agreement with the notion that family members often express their feelings and are sensitive to the feelings of others, Baseline $M = 7$, 95% CI [6.38, 7.75], Treatment $M = 10.07$ [9.74, 10.38], $r = .632$, $p = .004$. Heather’s data also indicated a statistically significant increase in her average degree of agreement, Baseline $M = 8.75$ [8.13, 9.25], Treatment $M = 10.59$ [10.35, 10.81], $r = .484$, $p < .001$. Figure 5 and Figure 6 represent Stephen’s and Heather’s ratings, respectively.

Figure 5. From baseline to treatment, Stephen’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.”
Figure 6. From baseline to treatment, Heather’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.”

Looking at the results of the ratings collectively, the emotional responsiveness in the Peasley family appeared to increase substantively from baseline to treatment. Stephen and Heather’s data reflected increases between the baseline and treatment phases across all ratings, with 5 of the 6 reflecting statistically significant increases. The average percentage of data in the treatment phases that exceeded the median of the baseline phases (PEM) was 91%, which reinforces that the results are also practically significant. A PEM of 91% is indicative of a strong effect (Scruggs & Mastropieri, 1998).

Family Cohesion, Flexibility, Communication, and Satisfaction

Stephen and Heather completed the self-report measures of family functioning (FACES IV, FCS, and FSS). The Peasley family also participated in the play activity and family interviews, which I video recorded and a trained rater used to complete the observational measure of family functioning (CRS). Table 6 presents the data from these measures.
Table 6

Peasley Family: Family Cohesion, Flexibility, Communication, and Satisfaction

<table>
<thead>
<tr>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Δ SD</td>
<td>Pre</td>
</tr>
<tr>
<td>Stephen</td>
<td>3.33</td>
<td>3.58</td>
<td>0.27</td>
<td>1.76</td>
</tr>
<tr>
<td>Heather</td>
<td>2.57</td>
<td>2.95</td>
<td>0.41*</td>
<td>1.75</td>
</tr>
<tr>
<td>Rater</td>
<td>6, C 9, OC††</td>
<td>5, F 9, OF††</td>
<td>3, M 2, L†</td>
<td></td>
</tr>
</tbody>
</table>

Note. * ≈ ½ SD or one-level improvement; † ≈ ½ SD or one-level deterioration; †† ≈ 1 SD or two-level deterioration; Δ SD = change in SD from pretest to posttest; C = connected; OC = overly connected; F = flexible; VF = very flexible; OF = overly flexible; L = low; M = moderate; and H = high.

Even prior to the intervention, the data reflected that the family was functioning at a healthy level. The data from the self-report measures revealed that their balanced cohesion and balanced flexibility ratios were higher than the average for the norming sample, their family communication was high, and their family satisfaction levels ranged from moderate to high. The data from the observational assessment of the family also indicated healthy functioning, with the family scoring as connected, flexible, and exhibiting communication that was moderate.

In examining the results of the self-report measures, Stephen’s data reflected an increase in balanced cohesion from pretest to posttest; however, this increase was minimal when comparing it to the data from the norming sample. Heather’s data reflected a more notable increase in balanced cohesion, with roughly a ½ standard deviation improvement from pretest to posttest. Neither Stephen’s nor Heather’s data reflected any notable changes in balanced flexibility from pretest to posttest when compared to data from the norming sample. In addition, on family communication, Stephen’s and Heather’s data remained relatively stable from pretest to posttest, revealing no substantive changes. On family satisfaction, however, Stephen’s data reflected a notable increase from moderate to high.

When looking at the results from the observational measure, the data reflected a substantial deterioration in cohesion and flexibility as well as a notable deterioration in
communication from pretest to posttest. On cohesion, the family shifted from connected to overly connected. The family made a similar shift in flexibility, moving from flexible to overly flexible. Regarding communication, the family dropped from moderate to low. It is important to note that as I was facilitating the posttest activity, it became clear that Anthony was noticeably more agitated than prior times that I had observed him. When the activity ended, his parents acknowledged that his agitation was due to them taking away privileges for his misbehavior just prior to coming to the clinic. This situational factor appeared to contribute to poorer interactions that were not representative of the family’s typical functioning.

*Parent Feedback*

In response to the question of whether CPRT impacted their family functioning, Stephen and Heather indicated that the intervention helped improve their family interactions. Stephen stated, “The whole family dynamic has improved.” Specifically, they noted that their family has improved in their ability to identify, communicate, and acknowledge their feelings. They indicated seeing this increase in emotional responsiveness in their marriage as well as noticing that Anthony has communicated his feelings at times since they started CPRT. In addition, Heather noted that the skills of choice giving, limit setting, and encouragement in particular influenced their family.

*The Romm Family*

The Romm family consists of 6 members: father, Patrick (41); mother, Sophia (29); two daughters, Candace (10) and Vanessa (5); and two sons, Parker (9) and Clayton (4). Sophia is Hispanic, and Patrick is Caucasian. Vanessa and Clayton are the parents’ biological children. Candace and Parker are children from Sophia’s first marriage and are Hispanic. During the course of the study, none of the family members received other therapeutic services.
Sophia reported having the most concerns about Parker. She indicated that he is self-conscious and struggles with low self-esteem. She reported that he has difficulty expressing his emotions and that he often cries or has outbursts of anger. Sophia also said that she is somewhat concerned about Candace and her upcoming transition to middle school. She indicated being concerned about the social pressure that Candace may experience and wanted to focus on building a relationship with her that encouraged open communication.

Patrick and Sophia targeted emotional responsiveness as an area of family functioning that needed improvement. They completed the following ratings related to emotional responsiveness throughout the study: (1) number of instances in which family members communicate their feelings; (2) number of instances in which a family member acknowledges the feelings of another family member; and (3) degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members often express their feelings and are sensitive to the feelings of others.”

Patrick and Sophia participated in CPRT. Patrick conducted his play sessions with Parker, and Sophia had her play sessions with Candace. Patrick attended 6 out of the 10 CPRT sessions and conducted 4 of the 7 play sessions. Sophia attended 9 CPRT sessions and conducted all 7 play sessions.

Targeted Area: Emotional Responsiveness

Patrick completed 89% of the data across all three ratings, and Sophia completed 89%, 88%, and 86%. Based on Patrick’s data, the Romm family exhibited an increase in the average number of communicated feelings from baseline to treatment, but this increase was not statistically significant, Baseline $M = 3.88$, 95% CI [2.38, 5.88], Treatment $M = 5.64$ [5.16, 6.15], $r = .245$, $p = .111$. Sophia’s data also reflected an increase, and this increase was
statistically significant, Baseline $M = 6.13$ [4.75, 7.75], Treatment $M = 9.9$ [9.19, 10.64], $r = .365$, $p = .035$. Figure 7 and Figure 8 represent Patrick’s and Sophia’s ratings, respectively.

**Figure 7.** From baseline to treatment, Patrick’s ratings of the number of instances in which family members communicated feelings.

**Figure 8.** From baseline to treatment, Sophia’s ratings of the number of instances in which family members communicated feelings.

Based on Patrick’s data, the Romm family exhibited no statistically significant increase in the average number of acknowledged feelings from baseline to treatment, Baseline $M = 1.13$, 95% CI [0.38, 1.88], Treatment $M = 1.82$ [1.57, 2.09], $r = .194$, $p = .135$. Sophia’s data also
indicated no statistically significant increases in the average number of acknowledged feelings, baseline \( M = 5.88 \ [2.63, 11] \), Treatment \( M = 5.76 \ [5.24, 6.27] \), \( r = -0.012, p = .938 \). Figure 9 and Figure 10 represent Patrick’s and Sophia’s ratings, respectively.

*Figure 9.* From baseline to treatment, Patrick’s ratings of the number of instances in which family members acknowledged feelings.

*Figure 10.* From baseline to treatment, Sophia’s ratings of the number of instances in which family members acknowledged feelings.

As evidenced in Figure 10, Sophia’s baseline phase ratings contained an extreme outlier that skewed the baseline mean. After dropping the outlier, there was an increase in the average
number of acknowledged feelings from baseline to treatment, but it was still not statistically significant, Baseline \( M = 3.43 \ [2.29, 4.71] \), Treatment \( M = 5.76 \ [5.24, 6.29] \), \( r = .313, p = .09 \).

Data collected from Patrick indicated no statistically significant change in his average level of agreement with the notion that family members often express their feelings and are sensitive to the feelings of others, Baseline \( M = 10.38, 95\% \ CI [9.75, 11] \), Treatment \( M = 8.94 [8.39, 9.48] \), \( r = -.196, p = .173 \). Sophia’s data also indicated no statistically significant improvement in her average degree of agreement, Baseline \( M = 9.75 [8.5, 11] \), Treatment \( M = 10.58 [10.31, 10.82] \), \( r = .215, p = .102 \). Figure 11 and Figure 12 represent Patrick’s and Sophia’s ratings, respectively.

![Figure 11](image)

**Figure 11.** From baseline to treatment, Patrick’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.”
Looking at the results of the ratings collectively, the emotional responsiveness in the Romm family appeared to somewhat improve from baseline to treatment. Patrick and Sophia’s data reflected increases between the baseline and treatment phases across 5 of the 6 ratings; however, only one rating reflected a statistically significant improvement. The average percentage of data in the treatment phases that exceeded the median of the baseline phases (PEM) was 73%, which supports that the data reflected at least some change from baseline to treatment. A PEM of 73% is indicative of a moderate effect (Scruggs & Mastropieri, 1998).

*Family Cohesion, Flexibility, Communication, and Satisfaction*

Patrick and Sophia completed the self-report measures of family functioning (FACES IV, FCS, and FSS). The Romm family also participated in the family play activities and semi-structured interviews, which I video recorded and a trained rater used to complete the observational measure of family functioning (CRS). Table 7 presents the data from these measures.

*Figure 12.* From baseline to treatment, Sophia’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.”
Table 7

Romm Family: Family Cohesion, Flexibility, Communication, and Satisfaction

<table>
<thead>
<tr>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Δ SD</td>
<td>Pre</td>
</tr>
<tr>
<td>Patrick</td>
<td>2.40</td>
<td>2.23</td>
<td>-0.18</td>
<td>1.57</td>
</tr>
<tr>
<td>Sophia</td>
<td>1.80</td>
<td>1.63</td>
<td>-0.19</td>
<td>2.06</td>
</tr>
<tr>
<td>Rater</td>
<td>6, C</td>
<td>7, VC†</td>
<td>4, SF</td>
<td>5, F*</td>
</tr>
</tbody>
</table>

* ≈ ½ SD or one-level improvement; † ≈ ½ SD or one-level deterioration; Δ SD = change in SD from pretest to posttest; C = connected; VC = very connected; F = flexible; M = moderate; H = high; and VH = very high.

Prior to the intervention, the data reflected that the family had some concerning aspects in their family functioning. The data from the self-report measures revealed that their balanced cohesion ratios were near average and their balanced flexibility ratios were near to slightly higher than the averages of the norming sample. However, their family communication and family satisfaction ranged from low to moderate. The data from the observational assessment of the family indicated healthy functioning, with the family scoring as connected, somewhat flexible, and exhibiting communication that was moderate.

In examining the results of the self-report measures, Patrick’s and Sophia’s data reflected decreases in balanced cohesion from pretest to posttest; however, these decreases were minimal when compared to data from the norming sample. Regarding balanced flexibility, Patrick’s data reflected essentially no changes from pretest to posttest, but Sophia’s data reflected a notable decrease in balanced flexibility of roughly a ½ standard deviation. On family communication, data from both parents reflected no noteworthy changes, with Patrick’s data staying constant at low and Sophia’s at moderate. Sophia’s data also reflected no noteworthy changes in satisfaction, which remained moderate from pretest to posttest. Patrick’s data reflected a notable increase in family satisfaction, which shifted from low to moderate.
When looking at the results from the observational measures, the data reflected notable improvements in balanced flexibility and communication from pretest to posttest. On flexibility, the family shifted from somewhat flexible to flexible. The family made a similar shift in communication, moving from moderate to high. On cohesion, however, the family moved from connected to very connected. Although this functioning is still within normal limits, it is considered to be a shift towards becoming less balanced. Overall, the observational measure reflects noteworthy improvements in family functioning whereas the self-report measures reflected little to no improvements.

Parent Feedback

In response to the question of whether CPRT impacted their family functioning, Patrick and Sophia indicated that the intervention improved their family interactions. Specifically, they noted an increased peacefulness in the interactions between family members. Patrick noted, “It [CPRT] has added a different dynamic to the way we confront situations…it takes some of the pressure off.” They noted that the skills they learned have led to “slowing [the family] down when it comes to moment” as opposed to things “escalating.” Sophia referenced a time recently when one of their children used the skill of choice giving with a sibling. Sophia also noted that CPRT has helped them to recognize the importance of making it a priority to give individual attention to the children.

The Gilster Family

The Gilster family has 4 members: father, Jeffery (36); mother, Nicole (35); and two daughters, Callie (5½) and Chelsea (4). All family members are Caucasian. Callie is Jeffery and Nicole’s biological child, and they adopted Chelsea when she was 2 years old. During the course of the study, none of the family members received other therapeutic services.
Nicole indicated having the most concerns about Chelsea. She described Chelsea as being very emotional. She reported that Chelsea often seems fearful, anxious, and sensitive, especially when they question her or discipline her. Nicole also indicated that Chelsea has had difficulties related to eating and that she often will want to gorge or hoard food.

Jeffery and Nicole targeted emotional responsiveness as an area of family functioning that needed improvement. They completed the following ratings related to emotional responsiveness throughout the study: (1) number of instances in which family members communicate their feelings; (2) number of instances in which a family member acknowledges the feelings of another family member; and (3) degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members often express their feelings and are sensitive to the feelings of others.”

Nicole participated in CPRT, conducting her at-home play sessions with Chelsea. Nicole attended 8 of the 10 CPRT sessions and conducted 6 out of 7 play sessions.

Targeted Area: Emotional Responsiveness

Jeffery and Nicole completed 92% of the data across all three ratings. Based on Jeffery’s data, the Gilster family exhibited no statistically significant increase in the average number of communicated feelings from baseline to treatment, Baseline $M = 2.14$, $95\%$ CI [1.57, 2.71], Treatment $M = 2.33$ [2.04, 2.64], $r = .045$, $p = .764$. Nicole’s data, however, reflected an increase, and this increase was statistically significant, Baseline $M = 2.57$ [1.86, 3.29], Treatment $M = 3.78$ [3.55, 4.03], $r = .328$, $p = .032$. Figure 13 and Figure 14 represent Jeffery’s and Nicole’s ratings, respectively.
Figure 13. From baseline to treatment, Jeffery’s ratings of the number of instances in which family members communicated feelings.

Figure 14. From baseline to treatment, Nicole’s ratings of the number of instances in which family members communicated feelings.

Based on Jeffery’s data, the Gilster family exhibited no statistically significant increase in the average number of acknowledged feelings from baseline to treatment, Baseline $M = 1.29$, 95% CI [1, 1.71], Treatment $M = 1.54$ [1.36, 1.72], $r = .094$, $p = .460$. Sophia’s data, however, indicated a statistically significant increase in the average number of acknowledged feelings,
Baseline $M = 1.43$ [1.14, 1.86], Treatment $M = 2.91$ [2.64, 3.19], $r = .358$, $p = .01$. Figure 15 and Figure 16 represent Jeffery’s and Nicole’s ratings, respectively.

**Figure 15.** From baseline to treatment, Jeffery’s ratings of the number of instances in which family members acknowledged feelings.

**Figure 16.** From baseline to treatment, Nicole’s ratings of the number of instances in which family members acknowledged feelings.

Data collected from Jeffery indicated no statistically significant change in his average level of agreement with the notion that family members often express their feelings and are sensitive to the feelings of others, Baseline $M = 8$, 95% CI [6.29, 9.57], Treatment $M = 7.3$ [6.71, 7.91].
Nicole’s data, however, indicated a statistically significant improvement in her average degree of agreement with the notion that family members often express their feelings and are sensitive to the feelings of others, Baseline $M = 7.86 \ [6.86, 8.71]$, Treatment $M = 10.51 \ [10.13, 10.87]$, $r = .448, p = .001$. Figure 17 and Figure 18 represent Jeffery’s and Nicole’s ratings, respectively.

**Figure 17.** From baseline to treatment, Jeffery’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.”

**Figure 18.** From baseline to treatment, Nicole’s degree of agreement with the statement: “Family members often express their feelings and are sensitive to the feelings of others.”
Looking at the results of the ratings collectively, whether or not the emotional responsiveness in the Gilster family improved from baseline to treatment appeared conflicting based on the source of the data. Interestingly, Nicole’s ratings reflected statistically significant improvement across all three ratings, but Jeffery’s ratings did not reflect the same. The average percentage of data in the treatment phases that exceeded the median of the baseline phases (PEM) was 60% for Nicole’s and Jeffery’s ratings. A PEM of 60% is indicative of a mild or questionable effect (Scruggs & Mastropieri, 1998). The PEM values for their data alone was 78% for Nicole’s ratings, indicating a moderate effect, and 43% for Jeffery’s, indicating no effect.

*Family Cohesion, Flexibility, Communication, and Satisfaction*

Jeffery and Nicole completed the self-report measures of family functioning (FACES IV, FCS, and FSS). The Gilster family also participated in the family play activities and semi-structured interviews, which I video recorded and a trained rater used to complete the observational measure of family functioning (CRS). Table 8 presents the data from these measures.

Table 8

*Gilster Family: Family Cohesion, Flexibility, Communication, and Satisfaction*

<table>
<thead>
<tr>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Δ SD</td>
<td>Pre</td>
</tr>
<tr>
<td>Jeffery</td>
<td>1.94</td>
<td>2.80</td>
<td>0.94**</td>
<td>2.00</td>
</tr>
<tr>
<td>Nicole</td>
<td>3.04</td>
<td>2.64</td>
<td>-0.44†</td>
<td>1.72</td>
</tr>
<tr>
<td>Rater</td>
<td>7,VC</td>
<td>7,VC</td>
<td>4,SF</td>
<td>4,SF</td>
</tr>
</tbody>
</table>

*Note.* * ≈ ½ SD or one-level improvement; ** ≈ 1 SD or two-level improvement; † ≈ ½ SD or one-level deterioration; †† ≈ 1 SD or two-level deterioration; Δ SD = change in SD from pretest to posttest; VC = very connected; SF = somewhat flexible; L = low; M = moderate; and H = high.
Even prior to the intervention, the data reflected that the family was functioning at a healthy level. The data from the self-report measures revealed that their balanced cohesion and balanced flexibility ratios were near the averages of the norming sample. In addition, their family communication was moderate. Their family satisfaction level, however, ranged from low to moderate. The data from the observational assessment of the family also indicated healthy functioning, with the family scoring as very connected, somewhat flexible, and exhibiting communication that was moderate.

In examining the results of the self-report measures, Jeffery’s data reflected a substantive increase of roughly 1 standard deviation in balanced cohesion from pretest to posttest; conversely, Nicole’s data reflected a notable decrease in balanced cohesion of roughly a ½ standard deviation. Regarding balanced flexibility, Jeffery’s data reflected a notable decrease of roughly 1 standard deviation. Nicole’s data reflected essentially no changes from pretest to posttest. On family communication, Jeffery’s data reflected a notable shift from moderate to high. Nicole’s data, however, reflected relatively no changes in communication, remaining at the moderate level. A similar pattern emerged on family satisfaction, with Jeffery’s data reflecting a slight shift from low to moderate. Nicole’s data reflected relatively no change from pretest to posttest, with the level of satisfaction remaining at moderate.

When looking at the results from the observational measures, the data reflected no notable changes in balanced cohesion, balanced flexibility, and communication from pretest to posttest. On flexibility, the family remained somewhat flexible. On cohesion, the family continued to exhibit signs of being very connected. Finally, on communication, the family remained at a moderate level. Thus, the self-report measures, exclusively from Jeffery’s data,
were suggestive of changes in family functioning; however, the observational measure reflected no apparent changes.

**Parent Feedback**

In response to the question of whether CPRT impacted their family functioning, Jeffery and Nicole indicated that the intervention improved their family interactions. However, Nicole emphasized that CPRT did not have as strong as an impact that she imagined that it could have if her and Jeffery would have been able to attend together. She noted that it was difficult attempting to relay information to Jeffery, especially without an understanding of the “context” of the information. Nicole indicated that CPRT helped in bringing an enhanced focus amongst family members regarding the importance of family relationships as well as bringing to the “forefront of [their] minds better ways of communicating, better ways of disciplining…better ways of interacting.”

**The Roe Family**

The Roe family has 4 members: father, Kurtis (45); mother, Danielle (47); son, Isaac (7); and daughter, Madeline, (5). Isaac and Madeline are the parents’ biological children, and all family members are Caucasian. During the course of the study, Isaac and Madeline received individual play therapy services, and Danielle received individual counseling services.

Danielle indicated that Isaac had been diagnosed with Asperger’s syndrome. She noted that “he can be really hard to handle” and that he had been experiencing issues with separation anxiety. She indicated that she and Kurtis have spent a significant amount of time and energy focusing on him and his issues. As a result, Danielle reported that Madeline had “been pushed aside” and that her and Kurtis had given her less attention. Danielle indicated that Madeline was going to be her child of focus. She said that when the family is experiencing difficulty due to
Isaac’s behavior, Madeline “tries to make things better.” She said that Madeline “dissolves” when they attempt to discipline her. Danielle also indicated that Madeline has struggled with selective mutism, often only speaking when at home.

In light of the issues they were experiencing, Kurtis and Danielle targeted discipline as an area of family functioning that needed improvement. Danielle completed the following ratings related to discipline throughout the study: (1) number of instances in which a parent provides a directive, limit, or consequence for behavior; (2) number of instances in which a child complies with a directive, limit, or consequence set by a parent; and (3) degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members often utilize and respond to discipline successfully.” Kurtis did not follow through with completing the ratings.

Danielle participated in CPRT and conducted at-home play sessions with Madeline. Danielle attended 9 out of the 10 CPRT sessions and conducted all 7 play sessions.

Targeted Area: Discipline

Danielle completed 99% of the data for the first two ratings and 94% of the data for the third rating. Because the first two rating items directly related to one another, I subtracted the number of directives, limits, and consequences complied with by a child from the number of directives, limits, and consequences provided by a parent, which resulted in the number of times a child did not comply with a parental directive. This number served as the indicator of the degree of improvement in the family’s discipline. Based on Danielle’s data, the Roe family exhibited a statistically significant decrease in the average number of instances of noncompliance from baseline to treatment, Baseline $M = 4.5$, 95% CI [2.88, 6.38], Treatment $M = 2.13$ [1.77, 2.52], $r = -.378$, $p = .013$. Figure 19 represents Danielle’s compiled discipline rating.
Data collected from Danielle also indicated a statistically significant increase, from baseline to treatment, in her average level of agreement with the notion that family members are able to utilize and respond to discipline successfully, Baseline $M = 6.29$, 95% CI [4, 8.86], Treatment $M = 9.62$ [9.25, 9.94], $r = .479$, $p = .007$. Figure 20 represents Danielle’s ratings on this item.

Figure 20. From baseline to treatment, Danielle’s ratings on the number of times a child did not comply with a parental directive.

Data collected from Danielle also indicated a statistically significant increase, from baseline to treatment, in her average level of agreement with the notion that family members are able to utilize and respond to discipline successfully, Baseline $M = 6.29$, 95% CI [4, 8.86], Treatment $M = 9.62$ [9.25, 9.94], $r = .479$, $p = .007$. Figure 20 represents Danielle’s ratings on this item.

Figure 20. From baseline to treatment, Danielle’s degree of agreement with the statement: “Family members are often able to utilize and respond to discipline successfully.”
Examining the results of the ratings collectively, the discipline in the Roe family appeared to improve substantively from baseline to treatment. The data reflected statistically significant improvement between the baseline and treatment phases across all ratings. The average percentage of data in the treatment phases that represented an improvement over the median of the baseline phases (PEM) was 93%, which reinforces that the results are also practically significant. A PEM of 93% is indicative of a strong effect (Scruggs & Mastropieri, 1998).

*Family Cohesion, Flexibility, Communication, and Satisfaction*

Kurtis and Danielle completed the self-report measures of family functioning (FACES IV, FCS, and FSS). The Roe family also participated in the family play activities and semi-structured interviews, which I video recorded and a trained rater used to complete the observational measure of family functioning (CRS). Table 9 presents the data from these measures.

Table 9

<table>
<thead>
<tr>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Δ SD</td>
<td>Pre</td>
</tr>
<tr>
<td>Kurtis</td>
<td>2.48</td>
<td>2.58</td>
<td>0.11</td>
<td>1.87</td>
</tr>
<tr>
<td>Danielle</td>
<td>2.38</td>
<td>2.48</td>
<td>0.10</td>
<td>1.65</td>
</tr>
<tr>
<td>Rater</td>
<td>7, VC</td>
<td>6, C*</td>
<td>8, VF</td>
<td>4, M</td>
</tr>
</tbody>
</table>

*Note. *≈ ½ SD or one-level improvement; Δ SD = change in SD from pretest to posttest; C = connected; VC = very connected; F = flexible; VF = very flexible; L = low; M = moderate; and H = high.*

Even prior to the intervention, the data reflected that the family was functioning at a healthy level. The data from the self-report measures revealed that their balanced cohesion and balanced flexibility ratios were near the average for the norming sample, and their family communication was high. Their family satisfaction levels, however, ranged from low to
moderate. The data from the observational assessment of the family also indicated functioning that was within healthy parameters, with the family scoring as very connected, very flexible, and exhibiting communication that was moderate.

In examining the results of the self-report measures, Kurtis’s and Danielle’s data reflected increases in balanced cohesion from pretest to posttest; however, these increases were minimal when comparing it to the data from the norming sample. In addition, neither Kurtis’s nor Danielle’s data reflected any notable changes in balanced flexibility from pretest to posttest when compared to data from the norming sample. On family communication and family satisfaction, Kurtis’s and Danielle’s data remained relatively stable from pretest to posttest, revealing no substantive changes.

When looking at the results from the observational measure, however, the data reflected a notable improvement in balanced cohesion, balanced flexibility, and communication from pretest to posttest. On cohesion, the family shifted from very connected to connected, reflecting more balance in their cohesion. The family made a similar shift in flexibility, moving from very flexible to flexible. Regarding communication, the family improved from moderate to high. Thus, the data from the observational measure indicated improvements in family cohesion, flexibility, and communication whereas the self-report measures did not reflect similar improvements.

Parent Feedback

In response to the question of whether CPRT impacted their family functioning, Kurtis and Danielle indicated that the intervention improved their family interactions. Kurtis noted improvements amongst family members in their abilities to communicate and to set boundaries. Danielle acknowledged that CPRT “made a huge difference.” They agreed that the intervention
has had the greatest impact in terms of decreasing tension. Danielle noted, “We’re all more relaxed…we are not walking on eggshells waiting for the next conflict to explode.” In addition, they noted increased collaboration amongst family members. As an example, Danielle referenced a time when the children were able to negotiate their own conflict without the parents having to intervene. Danielle acknowledged that family members are taking “more of a shared responsibility for us all to get along.”

The Keith Family

The Keith family consists of 4 members: mother, Jane (42); son, Jared (12); and two daughters, Lindy (10) and Meagan (7). Jared, Lindy, and Meagan are her biological children. Jane is Caucasian, and her children are Caucasian and Hispanic. During the course of the study, none of the family members received other therapeutic services.

Jane indicated that their family had been experiencing a series of significant transitions. Roughly a year prior to the study, her and her children moved to the United States from Mexico, where her children had been born and raised. Shortly after their move, she divorced her husband, who was also the father of her children. Her and her children had been living with her mother and stepfather for the past year. Jane chose Meagan as her child of focus for CPRT. She described Meagan as a “typical…baby of the family. She’s the happiest kid you know until you tell her, ‘No’ and then it’s like, ‘Watch out.’”

Jane targeted discipline as an area of family functioning that needed improvement. She completed the following ratings related to discipline throughout the study: (1) number of instances in which a parent provides a directive, limit, or consequence for behavior; (2) number of instances in which a child complies with a directive, limit, or consequence set by a parent; and
degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members often utilize and respond to discipline successfully.”

Jane participated in CPRT and conducted at-home play sessions with Meagan. Jane attended 8 out of the 10 CPRT sessions and conducted 5 of the 7 at-home play sessions.

**Targeted Area: Discipline**

Jane completed 100% of the data for the first two ratings and 94% of the data for the third rating. Because the first two rating items directly related to one another, I subtracted the number of directives, limits, and consequences complied with by a child from the number of directives, limits, and consequences provided by a parent, which resulted in the number of times a child did not comply with a parental directive. This number served as the indicator of the degree of improvement in the family’s discipline. Based on Jane’s data, the Keith family exhibited a statistically significant decrease in the average number of instances of noncompliance from baseline to treatment, Baseline $M = 2.25$, 95% CI [0.5, 4.25], Treatment $M = 0.45$ [0.21, 0.75], $r = -.352$, $p = .002$. Figure 21 represents Jane’s compiled discipline rating.

![Figure 21](image-url)

*Figure 21.* From baseline to treatment, Jane’s ratings of the number of times a child did not comply with a parental directive.
Data collected from Jane also indicated a statistically significant increase, from baseline to treatment, in her average level of agreement with the notion that family members are able to utilize and respond to discipline successfully, Baseline $M = 5.25$, 95% CI [4.25, 6.5], Treatment $M = 8.85$ [8.49, 9.15], $r = .605$, $p < .001$. Figure 22 represents Jane’s ratings on this item.

![Figure 22](image_url)

*Figure 22. From baseline to treatment, Jane’s degree of agreement with the statement: “Family members are often able to utilize and respond to discipline successfully.”*

Examining the results of the ratings collectively, the discipline in the Keith family appeared to improve substantively from baseline to treatment. The data reflected statistically significant improvement between the baseline and treatment phases across all ratings. The average percentage of data in the treatment phases that represented an improvement over the median of the baseline phases (PEM) was 86%, which reinforces that the results are also practically significant. A PEM of 86% is indicative of a moderate effect (Scruggs & Mastropieri, 1998).

**Family Cohesion, Flexibility, Communication, and Satisfaction**

Jane completed the self-report measures of family functioning (FACES IV, FCS, and FSS). The Keith family also participated in the family play activities and semi-structured
interviews, which I video recorded and a trained rater used to complete the observational measure of family functioning (CRS). Table 10 presents the data from these measures.

Table 10

*Keith Family: Family Cohesion, Flexibility, Communication, and Satisfaction*

<table>
<thead>
<tr>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Δ SD</td>
<td>Pre</td>
</tr>
<tr>
<td>Jane</td>
<td>1.74</td>
<td>1.93</td>
<td>0.21</td>
<td>1.10</td>
</tr>
<tr>
<td>Rater</td>
<td>9, OC</td>
<td>7, VC*</td>
<td>4, SF</td>
<td>5, F*</td>
</tr>
</tbody>
</table>

*Note. * ≈ ½ SD or one-level improvement; Δ SD = change in SD from pretest to posttest; OC = overly connected; VC = very connected; SF = somewhat flexible; F = flexible; VL = very low; L = low; M = moderate; and H = high.*

Prior to the intervention, the data reflected that the family was functioning at a somewhat unhealthy level. The data from the self-report measures revealed that their balanced cohesion and balanced flexibility ratios were nearly 1 standard deviation below the average for the norming sample, their family communication was low, and their family satisfaction was very low. The data from the observational assessment of the family also indicated functioning that showed signs of unhealthy family functioning, with the family scoring as overly connected, somewhat flexible, and exhibiting communication that was moderate.

In examining the results of the self-report measures, Jane’s data reflected increases in balanced cohesion and balanced flexibility from pretest to posttest; however, these increases were minimal when comparing it to the data from the norming sample. Concerning family communication, the data reflected improvements from pretest to posttest, as the family moved from low to moderate communication. Family satisfaction also improved from very low to low, although this level of family satisfaction may still be cause for concern.

When looking at the results from the observational measure, the data reflected a more notable improvement in balanced cohesion, balanced flexibility, and communication from pretest
to posttest. On cohesion, the family shifted from overly connected to very connected, reflecting more balance in their cohesion. The family made a similar shift in flexibility, moving from overly flexible to very flexible. Regarding communication, the family improved from moderate to high. Thus, the data from the observational measure indicated improvements in family cohesion, flexibility, and communication whereas the self-report measures only indicated noteworthy change in communication and satisfaction.

*Parent Feedback*

In response to the question of whether CPRT impacted their family functioning, Jane indicated that the intervention improved their family interactions. Jane noted that CPRT “definitely had an impact on the family as a whole” as a result of the “change in [her]…the way [she] handled situations.” She noted that CPRT was a “wake-up call” that cued her in to focusing on how the children “needed individual attention.” Jane indicated that family members were more independent, that there had been an improvement in discipline, and that there was an overall increase in happiness in the family. Jane noted that the children are “playing more together” and that there seems to be more laughter in their family.

The Jacobs Family

The Jacobs family has 4 members: father, Warren (35); mother, Gwen (36); and two daughters, Kimberly (3½) and Elizabeth (21 months). Kimberly and Elizabeth are the parents’ biological children, and all family members are Caucasian. During the course of the study, none of the family members received other therapeutic services.

Gwen indicated that their family had been experiencing significant transitions. She reported that Elizabeth had just recently had casts removed from her legs after having hip surgery. Gwen noted that Elizabeth has required a significant amount of attention and care
during that time and that this change in their family has seemed to influence Kimberly. Gwen described Kimberly as a strong-willed child who “craves attention.” She indicated that they experience the most difficulty with Kimberly when it comes to bedtime. In addition, Gwen said that they recently fostered a child and that Kimberly and Elizabeth had a difficult time adjusting to this child’s presence and subsequent absence.

Warren and Gwen targeted discipline as an area of family functioning that needed improvement. They completed the following ratings related to discipline throughout the study: (1) number of instances in which a parent provides a directive, limit, or consequence for behavior; (2) number of instances in which a child complies with a directive, limit, or consequence set by a parent; and (3) degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members often utilize and respond to discipline successfully.”

Warren and Gwen participated in CPRT and conducted at-home play sessions with Kimberly. Warren attended only 5 out of the 10 CPRT sessions and conducted 5 of the 7 at-home play sessions. Gwen attended 7 CPRT sessions and conducted 4 play sessions.

**Targeted Area: Discipline**

Warren completed 100% of the data for the first two ratings and 89% of the data for the third rating. Gwen completed 100% of the data for the first two ratings and 98% of the data for the third rating. Because the first two rating items directly related to one another, I subtracted the number of directives, limits, and consequences complied with by a child from the number of directives, limits, and consequences provided by a parent, which resulted in the number of times a child did not comply with a parental directive. This number served as the indicator of the degree of improvement in the family’s discipline. Based on Warren’s data, the Jacobs family
exhibited no statistically significant decrease in the average number of instances of noncompliance from baseline to treatment, Baseline $M = 0.5$, 95% CI [0, 0.75], Treatment $M = 0.3$ [0.14, 0.47], $r = .021$, $p = .876$. Gwen’s data also suggested that there was no statistically significant difference, Baseline $M = 1.75$ [0.75, 2.88], Treatment $M = 3.53$ [2.82, 4.3], $r = .16$, $p = .241$. In fact, Gwen’s data suggested an average increase in instances of noncompliance from baseline to treatment. During later group sessions, Gwen referenced that Kimberly’s increase in noncompliance revolved around her not wanting to go to bed at night. Figure 23 and Figure 24 represent Warren’s and Gwen’s compiled discipline ratings, respectively.

![Figure 23](image1)

**Figure 23.** From baseline to treatment, Warren’s ratings of the number of times a child did not comply with a parental directive.

![Figure 24](image2)

**Figure 24.** From baseline to treatment, Gwen’s ratings of the number of times a child did not comply with a parental directive.

Data collected from Warren also indicated no statistically significant increase, from baseline to treatment, in his average level of agreement with the notion that family members are
able to utilize and respond to discipline successfully, Baseline $M = 11$, 95% CI $[11, 11]$, Treatment $M = 10.97 [10.9, 11]$, $r = -.056$, $p = .596$. Gwen’s data also indicated no statistically significant improvement from baseline to treatment, Baseline $M = 10.86 [10.14, 11.43]$, Treatment $M = 10.08 [9.4, 10.72]$, $r = -.077$, $p = .537$. As evidenced by their high baseline means, Warren and Gwen’s data indicated that, even prior to treatment, they agreed that family members were able to utilize and respond to discipline successfully. Figure 25 and Figure 26 represent Warren’s and Gwen’s ratings on this item.

Figure 25. From baseline to treatment, Warren’s degree of agreement with the statement: “Family members are often able to utilize and respond to discipline successfully.”

Figure 26. From baseline to treatment, Gwen’s degree of agreement with the statement: “Family members are often able to utilize and respond to discipline successfully.”
Examining the results of the ratings collectively, the discipline in the Jacobs family did not improve from baseline to treatment. The data reflected no statistically significant improvement between the baseline and treatment phases across all ratings. The average percentage of data in the treatment phases that represented an improvement over the median of the baseline phases (PEM) was only 20%. A PEM of 20% is indicative of no effect (Scruggs & Mastropieri, 1998).

Family Cohesion, Flexibility, Communication, and Satisfaction

Warren and Gwen completed the self-report measures of family functioning (FACES IV, FCS, and FSS). The Jacobs family also participated in the play activity and family interviews, which I video recorded and trained raters used to complete the observational measure of family functioning (CRS). Two raters scored the Brooks family as part of assessing interrater reliability; thus, I used the average of their ratings. Table 11 presents the data from these measures.

Table 11

<table>
<thead>
<tr>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Δ SD</td>
<td>Pre</td>
</tr>
<tr>
<td>Warren</td>
<td>2.69</td>
<td>4.12</td>
<td>1.55***</td>
<td>2.64</td>
</tr>
<tr>
<td>Gwen</td>
<td>2.70</td>
<td>3.58</td>
<td>0.96**</td>
<td>2.07</td>
</tr>
<tr>
<td>Raters</td>
<td>6.5,VC</td>
<td>7,VC</td>
<td>3.5,SF</td>
<td>5,F*</td>
</tr>
</tbody>
</table>

Note. * ≈ ½ SD or one-level improvement; ** ≈ 1 SD or two-level improvement; *** ≈ 1½ SD or three-level improvement; Δ SD = change in SD from pretest to posttest; VC = very connected; SF = somewhat flexible; F = flexible; M = moderate; H = high; and VH = very high.

Prior to the intervention, the data reflected that the family was functioning at a healthy level. The data from the self-report measures revealed that their balanced cohesion and balanced flexibility ratios were slightly above the average for the norming sample, their family
communication was very high, and their family satisfaction ranged from high to very high. The data from the observational assessment of the family also indicated functioning that exhibited healthy family functioning, with the family scoring as very connected, somewhat flexible, and exhibiting communication that was moderate.

In examining the results of the self-report measures, Warren’s and Gwen’s data reflected substantive increases in balanced cohesion from pretest to posttest, with Warren’s reflecting an increase of roughly $1\frac{1}{2}$ standard deviations and Gwen’s an increase of roughly 1 standard deviation. Concerning family flexibility, the data also reflected improvements from pretest to posttest, although Warren’s data reflected a more noteworthy increase than Gwen’s when comparing their data to the norming sample. Warren’s data reflected an increase of roughly a $\frac{1}{2}$ standard deviation. On family communication, the Jacobs family remained at very high from pretest to posttest. Family satisfaction also remained stable for Warren’s data, at very high, but increased for Gwen’s moving from high to very high.

When looking at the results from the observational measure, the data also reflected improvements in balanced flexibility and communication from pretest to posttest. On cohesion, the family remained very connected. The family made a shift in flexibility, moving from somewhat flexible to flexible. Regarding communication, the family showed improvement, but this improvement remained within the moderate range.

Parent Feedback

In response to the question of whether CPRT impacted their family functioning, Warren and Gwen indicated that the intervention improved their family interactions. Gwen noted an increase in playing together amongst family members: “We play more together, which was surprising…we thought we played a lot to begin with. The girls seek us out to play more…not
just being there. They’re wanting us to participate in what they do.” Gwen also indicated that family members seem to be “more aware of each other…more in-tune.” She acknowledged that family members are closer to one another despite the fact that they already considered themselves to be a very close family prior to CPRT. Gwen referenced the value of the play sessions in particular, noting, “If we miss the play sessions, we see it…the parenting breaks down. Their [the children’s] behavior completely changes.”

The Brooks Family

The Brooks family consists of 4 members: father, Harry (46); mother, Kathryn (43); and two sons, Miles, (8) and Robert (6). Harry and Kathryn, who are Caucasian, adopted Miles, who is Hispanic, and Robert, who is Asian, when they were infants. They adopted the children internationally. Miles and Robert received individual play therapy services during the study.

Harry indicated that Miles has experienced significant difficulties revolving around social anxiety, mostly related to school. He indicated that Miles has increasingly withdrawn from others, including him and Kathryn, and that Miles’s issues tended to take up a significant amount of their attention and energy. Kathryn described Robert as being happy and that he has tended to present fewer issues than Miles. She said that Robert is sensitive to whether he is receiving the same degree of attention as Miles and that he tends to speak up when he thinks that he is being treated unfairly. Kathryn noted that Robert has also displayed some shyness and social awkwardness but wondered if these behaviors were a reflection of what he has seen modeled to him by his older brother.

Harry and Kathryn targeted encouragement as an area of family functioning that needed improvement. They completed the following ratings related to encouragement throughout the study: (1) number of instances in which a family member criticizes another family member; (2)
number of instances in which a family member praises or encourages another family member; and (3) degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members often encourage one another.”

Harry and Kathryn participated in CPRT and each of them conducted at-home play sessions. Harry had his play sessions with Miles, and Kathryn had them with Robert. Harry attended 9 out of the 10 CPRT sessions and conducted 6 of the 7 possible play sessions. Kathryn attended 7 CPRT sessions and conducted 4 play sessions.

Targeted Area: Encouragement

Harry completed 93% of the data for the first two ratings and 90% of the data for the third rating. Kathryn completed 100% of the data for the first two ratings and 98% of the data for the third rating. Based on Harry’s data, the Brooks family exhibited a statistically significant decrease in the average number of criticisms from baseline to treatment, Baseline $M = 3.86$, 95% CI $[3, 4.57]$, Treatment $M = 2.16$ $[1.9, 2.41]$, $r = -.412$, $p = .002$. Kathryn’s data also indicated a statistically significant decrease in the average number of criticisms, Baseline $M = 4.38$ $[3, 5.75]$, Treatment $M = 1.99$ $[1.79, 2.2]$, $r = -.555$, $p < .001$. Figure 27 and Figure 28 represent Harry’s and Kathryn’s ratings, respectively.

![Figure 27. From baseline to treatment, Harry’s ratings of the number of times a family member criticized another family member.](image)
Figure 28. From baseline to treatment, Kathryn’s ratings of the number of times a family member criticized another family member.

Based on Harry’s data, the Brooks family exhibited no statistically significant improvement in the average number of instances of encouragement from baseline to treatment, Baseline $M = 8.43$, 95% CI [5.71, 11], Treatment $M = 8.71$ [8.09, 9.4], $r = .028$, $p = .846$.

Kathryn’s data, however, indicated a statistically significant increase in the average number of instances of encouragement, Baseline $M = 5.38$ [4.88, 5.75], Treatment $M = 9.45$ [8.55, 10.36], $r = .302$, $p = .113$. Figure 29 and Figure 30 represent Harry’s and Kathryn’s ratings, respectively.

Figure 29. From baseline to treatment, Harry’s ratings of the number of times a family member encouraged another family member.
Figure 30. From baseline to treatment, Kathryn’s ratings of the number of times a family member encouraged another family member.

Data collected from Harry indicated a statistically significant increase, from baseline to treatment, in his average level of agreement with the notion that family members often encourage one another, Baseline $M = 9.75$, 95% CI [8.25, 10.88], Treatment $M = 11.91$ [11.7, 12.09], $r = .555$, $p < .001$. Kathryn’s data also indicated a statistically significant improvement from baseline to treatment, Baseline $M = 8.25$ [7, 9.75], Treatment $M = 11.68$ [11.49, 11.88], $r = .703$, $p < .001$. Figure 31 and Figure 32 represent Harry’s and Kathryn’s ratings on this item.

Figure 31. From baseline to treatment, Harry’s degree of agreement with the statement: “Family members often encourage one another.”
Examining the results of the ratings collectively, the encouragement in the Brooks family appeared to improve substantively from baseline to treatment. The data reflected statistically significant improvements between the baseline and treatment phases in 5 of the 6 ratings. The average percentage of data in the treatment phases that represented an improvement over the median of the baseline phases (PEM) was 84%, which reinforces that the results are also practically significant. A PEM of 84% is indicative of a moderate effect (Scruggs & Mastropieri, 1998).

Family Cohesion, Flexibility, Communication, and Satisfaction

Harry and Kathryn completed the self-report measures of family functioning (FACES IV, FCS, and FSS). The Brooks family also participated in the play activity and family interviews, which I video recorded and trained raters used to complete the observational measure of family functioning (CRS). Two raters scored the Brooks family as part of assessing interrater reliability; thus, I used the average of their ratings. Table 12 presents the data from these measures.
Table 12

*Brooks Family: Family Cohesion, Flexibility, Communication, and Satisfaction*

<table>
<thead>
<tr>
<th>Source</th>
<th>Cohesion Pre</th>
<th>Cohesion Post</th>
<th>Δ SD</th>
<th>Flexibility Pre</th>
<th>Flexibility Post</th>
<th>Δ SD</th>
<th>Communication Pre</th>
<th>Communication Post</th>
<th>Δ SD</th>
<th>Satisfaction Pre</th>
<th>Satisfaction Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harry</td>
<td>2.64</td>
<td>3.04</td>
<td>0.44*</td>
<td>1.54</td>
<td>1.57</td>
<td>0.04</td>
<td>74,H</td>
<td>74,H</td>
<td>0.04</td>
<td>51,M</td>
<td>58,M</td>
</tr>
<tr>
<td>Kathryn</td>
<td>4.38</td>
<td>4.12</td>
<td>-0.28</td>
<td>2.07</td>
<td>2.00</td>
<td>-0.10</td>
<td>83,H</td>
<td>97,VH*</td>
<td>1.00</td>
<td>58,M</td>
<td>87,VH**</td>
</tr>
<tr>
<td>Raters</td>
<td>6.5, VC</td>
<td>5.5, C*</td>
<td></td>
<td>6, F</td>
<td>6, F</td>
<td></td>
<td>5, H</td>
<td>5, H</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* *≈ ½ SD* or one-level improvement; **≈ 1 SD* or two-level improvement; Δ SD = change in SD from pretest to posttest; C = connected; VC = very connected; F = flexible; M = moderate; H = high; and VH = very high.

Even prior to the intervention, the data reflected that the family was functioning at a healthy level. The data from the self-report measures revealed that their balanced cohesion and balanced flexibility ratios were average to above average when compared to the norming sample, their family communication was high, and their family satisfaction level was moderate. The data from the observational assessment of the family also indicated functioning that was within healthy parameters, with the family scoring as very connected, flexible, and exhibiting communication that was high.

In examining the results of the self-report measures, Harry’s data reflected a notable increase in balanced cohesion, roughly a ½ standard deviation improvement, from pretest to posttest. Kathryn’s data reflected a decrease in cohesion, although this decrease was minimal when compared to data from the norming sample. Neither Harry’s nor Kathryn’s data reflected any notable changes in balanced flexibility from pretest to posttest when compared to data from the norming sample. On family communication and family satisfaction, Harry’s data remained relatively stable from pretest to posttest, revealing no substantive changes. Kathryn’s data, however, reflected increases in communication, from high to very high, and in satisfaction, from moderate to very high.
When looking at the results from the observational measures, the data reflected a notable improvement in balanced cohesion from pretest to posttest. On cohesion, the family shifted from very connected to connected. On the flexibility and communication variables, the family’s already healthy functioning remained stable from pretest to posttest, with the family scoring as flexible and high in communication in all ratings. Thus, the changes indicated by the observational measure appeared similar to what the data from the self-report measures revealed.

**Parent Feedback**

In response to the question of whether CPRT impacted their family functioning, Harry and Kathryn indicated that the intervention improved their family interactions. Harry noted “lower stress and more connecting” amongst family members and increased family bonding. In addition, he noted an increased ability in being able to respond to the children’s needs. They indicated that all family members have improved in their ability to respond to one another and referenced that the “children respond better to each other” as well. Harry also noted an increased recognition of the impact that their responses as parents have on the responses of their children.

The Portela Family

The Portela family has 3 members: father, Kyle (35); mother, Carol (33); and son, Cliff (6). Cliff is the biological son of Kyle and Carol. All family members are Caucasian. During the course of the study, none of the family members received other therapeutic services.

Kyle indicated that their family had been experiencing difficulty due to issues of control and characterized their problems as being reflective of a “family dynamic.” He indicated that he and Carol differed in their styles of communication and parenting, and these differences contributed to conflict. He reported that Cliff has noticed their differences and has used manipulation as a way of getting what he has wanted. He also characterized Cliff as being
Kyle and Carol disagreed at first on the area of family functioning that needed the most improvement, with Kyle noting discipline and Carol noting negotiation. After further discussion, Kyle and Carol targeted negotiation as the area of family functioning that they believed needed improvement. They completed the following ratings related to negotiation throughout the study: (1) number of instances of conflict between two or more family members; (2) number of instances in which family members successfully manage or resolve conflict; and (3) degree of agreement (on a 13-point scale from strongly disagree to strongly agree) with the statement: “Family members are often able to manage or resolve conflict appropriately.”

Kyle and Carol participated in CPRT and conducted at-home play sessions with Cliff. Kyle attended 6 out of the 10 CPRT sessions and conducted 4 of the 7 play sessions. Carol attended 8 CPRT sessions and conducted 5 play sessions.

**Targeted Area: Negotiation**

Kyle completed 32%, 26%, and 15% of the data for the three target area ratings, and Carol completed 67% of the data for each of the three ratings. Because the percentage of completed data fell below 75% for all rating items, I excluded this data from further analysis.

**Family Cohesion, Flexibility, Communication, and Satisfaction**

Kyle and Carol completed the self-report measures of family functioning (FACES IV, FCS, and FSS). The Portela family also participated in the play activity and family interviews, which I video recorded and a trained rater used to complete the observational measure of family functioning (CRS). Table 13 presents the data from these measures.

Prior to the intervention, the data reflected that the family had some concerning aspects in their family functioning. The data from the self-report measures revealed that their balanced
cohesion and balanced flexibility ratios were just slightly below the averages of the norming sample but still within normal limits, their family communication was low, and their family satisfaction level was very low.

Table 13

Portela Family: Family Cohesion, Flexibility, Communication, and Satisfaction

<table>
<thead>
<tr>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Δ SD</td>
<td>Pre</td>
</tr>
<tr>
<td>Kyle</td>
<td>1.75</td>
<td>1.52</td>
<td>-0.26</td>
<td>1.22</td>
</tr>
<tr>
<td>Carol</td>
<td>2.07</td>
<td>2.00</td>
<td>-0.08</td>
<td>1.30</td>
</tr>
<tr>
<td>Rater</td>
<td>4, SC</td>
<td>5, C*</td>
<td>3, SF</td>
<td>5, F*</td>
</tr>
</tbody>
</table>

Note. * ≈ ½ SD or one-level improvement; † ≈ ½ SD or one-level deterioration; Δ SD = change in SD from pretest to posttest; C = connected; SC = somewhat connected; F = flexible; SF = somewhat flexible; VL = very low; L = low; and M = moderate.

In examining the results of the self-report measures, Kyle’s and Carol’s data reflected decreases in balanced cohesion from pretest to posttest; however, these decreases were minimal when compared to data from the norming sample. Regarding balanced flexibility, Kyle’s and Carol’s data reflected essentially no changes from pretest to posttest. On family communication, Kyle’s data reflected no noteworthy changes in communication, which remained low from pretest to posttest. Carol’s data, however, reflected a notable decrease from low to very low. Carol’s data also reflected no substantive changes in family satisfaction, which remained very low. Kyle’s data reflected a notable increase in family satisfaction, from very low to low, although this level of satisfaction still warrants concern.

When looking at the results from the observational measures, the data reflected more improvements than the data from the self-report measures indicated. Examining the data from the observational measure revealed notable improvements in balanced cohesion, balanced flexibility, and communication from pretest to posttest. On cohesion, the family shifted from
somewhat connected to connected. The family made a similar shift in flexibility, moving from somewhat flexible to flexible. On communication, the family shifted from low to moderate. Thus, the observational measure reflects noteworthy improvements in family functioning whereas the self-report measures reflected minor to no improvements.

Parent Feedback

In response to the question of whether CPRT impacted their family functioning, Kyle and Carol indicated that the intervention helped improve their family interactions. Kyle stated, “It [CPRT] has had a significant impact on the practical, day-to-day dynamics that were leading, quite frankly, to a diminished quality of life.” Carol also indicated that it was “enormously helpful.” Specifically, they noted that it increased the unity in their relationship, allowing them to “get on the same page” in parenting. In addition, they indicated that CPRT helped in giving them “something to focus on” during a time in which they “had a lot going on in [their] family.” Kyle and Carol shared that they were working through issues in their marriage that happened to arise during the course of CPRT and that they expected that CPRT would have an even greater impact once they navigated these issues as a couple.

Summary and Synthesis of Results

In order to provide a summary and synthesis of results across all families, I provide an overall analysis of the findings according to each main category of data: (1) the targeted areas of family functioning, and (2) family cohesion, flexibility, communication, and satisfaction.

Targeted Areas of Family Functioning

Table 14 presents the results of the time-series statistical analyses conducted on all of the daily ratings completed by the families.
### Table 14

**Results on Daily Ratings of Targeted Areas of Family Functioning**

<table>
<thead>
<tr>
<th>Family</th>
<th>Target Area</th>
<th>Source</th>
<th>Baseline ( M ) [95% CI]</th>
<th>Treatment ( M ) [95% CI]</th>
<th>( r )</th>
<th>( p )</th>
<th>Avg. PEM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emotional Responsiveness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td># of feelings</td>
<td>D</td>
<td>1.5 [0.88, 2.13]</td>
<td>4.11 [3.78, 4.44]</td>
<td>.53</td>
<td>.007**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>communicated</td>
<td>M</td>
<td>2.5 [1.75, 3.38]</td>
<td>4.11 [3.57, 4.28]</td>
<td>.25</td>
<td>.08</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of feelings</td>
<td>D</td>
<td>1.38 [0.63, 2.13]</td>
<td>4.27 [3.9, 4.65]</td>
<td>.53</td>
<td>.01**</td>
<td>91%,</td>
</tr>
<tr>
<td></td>
<td>acknowledged</td>
<td>M</td>
<td>2 [1.5, 2.5]</td>
<td>3.3 [3.05, 3.54]</td>
<td>.34</td>
<td>.047*</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>D</td>
<td>7 [6.38, 7.75]</td>
<td>10.07 [9.74, 10.38]</td>
<td>.632</td>
<td>.004**</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>8.75 [8.13, 9.25]</td>
<td>10.59 [10.35, 10.81]</td>
<td>.484</td>
<td>&lt;.001***</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of feelings</td>
<td>D</td>
<td>3.88 [2.38, 5.88]</td>
<td>5.64 [5.16, 6.15]</td>
<td>.245</td>
<td>.111</td>
<td></td>
</tr>
<tr>
<td></td>
<td>communicated</td>
<td>M</td>
<td>6.13 [4.75, 7.75]</td>
<td>9.9 [9.19, 10.64]</td>
<td>.365</td>
<td>.035*</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of feelings</td>
<td>D</td>
<td>1.13 [0.38, 1.88]</td>
<td>1.82 [1.57, 2.09]</td>
<td>.194</td>
<td>.135</td>
<td>73%,</td>
</tr>
<tr>
<td></td>
<td>acknowledged</td>
<td>M</td>
<td>5.88 [2.63, 11]</td>
<td>5.76 [5.24, 6.27]</td>
<td>-.012</td>
<td>.938</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>D</td>
<td>10.38 [9.75, 11]</td>
<td>8.94 [8.39, 9.48]</td>
<td>-.196</td>
<td>.173</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>9.75 [9.5, 11]</td>
<td>10.58 [10.31, 10.82]</td>
<td>.215</td>
<td>.102</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of feelings</td>
<td>D</td>
<td>2.14 [1.57, 2.71]</td>
<td>2.33 [2.04, 2.64]</td>
<td>.045</td>
<td>.764</td>
<td></td>
</tr>
<tr>
<td></td>
<td>communicated</td>
<td>M</td>
<td>2.57 [1.86, 3.29]</td>
<td>3.78 [3.55, 4.03]</td>
<td>.328</td>
<td>.032*</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of feelings</td>
<td>D</td>
<td>1.29 [1, 1.71]</td>
<td>1.54 [1.36, 1.72]</td>
<td>.094</td>
<td>.460</td>
<td>60%,</td>
</tr>
<tr>
<td></td>
<td>acknowledged</td>
<td>M</td>
<td>1.43 [1.14, 1.86]</td>
<td>2.91 [2.64, 3.19]</td>
<td>.358</td>
<td>.01**</td>
<td>Mild</td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>D</td>
<td>8 [6.29, 9.57]</td>
<td>7.3 [6.71, 7.9]</td>
<td>-.08</td>
<td>.585</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>7.86 [6.86, 8.71]</td>
<td>10.51 [10.13, 10.87]</td>
<td>.448</td>
<td>.001***</td>
<td></td>
</tr>
<tr>
<td></td>
<td># not complied</td>
<td>M</td>
<td>4.5 [2.88, 6.38]</td>
<td>2.13 [1.77, 2.52]</td>
<td>-.378</td>
<td>.013*</td>
<td>93%,</td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>M</td>
<td>6.29 [4, 8.86]</td>
<td>9.62 [9.25, 9.94]</td>
<td>.479</td>
<td>.007**</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td># not complied</td>
<td>M</td>
<td>2.25 [0.5, 4.25]</td>
<td>0.45 [0.21, 0.75]</td>
<td>-.352</td>
<td>.002**</td>
<td>86%,</td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>M</td>
<td>5.25 [4.25, 6.5]</td>
<td>8.85 [8.49, 9.15]</td>
<td>.605</td>
<td>&lt;.001***</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td># not complied</td>
<td>D</td>
<td>0.5 [0, 0.75]</td>
<td>0.3 [0.14, 0.47]</td>
<td>.021</td>
<td>.876</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>M</td>
<td>1.75 [0.75, 2.88]</td>
<td>3.53 [2.82, 4.3]</td>
<td>.16</td>
<td>.241</td>
<td>20%,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D</td>
<td>11 [11, 11]</td>
<td>10.97 [10.9, 11]</td>
<td>-.056</td>
<td>.596</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>10.86 [10.14, 11.43]</td>
<td>10.08 [9.4, 10.72]</td>
<td>.077</td>
<td>.537</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of criticisms</td>
<td>D</td>
<td>3.86 [3, 4.57]</td>
<td>2.16 [1.9, 2.41]</td>
<td>-.412</td>
<td>.002**</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brooks</td>
<td>M</td>
<td>4.38 [3, 5.75]</td>
<td>1.99 [1.79, 2.2]</td>
<td>-.555</td>
<td>&lt;.001***</td>
<td></td>
</tr>
<tr>
<td></td>
<td># of encourage</td>
<td>D</td>
<td>8.43 [5.71, 11]</td>
<td>8.71 [8.09, 9.4]</td>
<td>.028</td>
<td>.846</td>
<td>84%,</td>
</tr>
<tr>
<td></td>
<td>Brooks</td>
<td>M</td>
<td>5.38 [4.88, 5.75]</td>
<td>9.45 [8.55, 10.36]</td>
<td>.302</td>
<td>.113</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Agreement</td>
<td>D</td>
<td>9.75 [8.25, 10.88]</td>
<td>11.91 [11.7, 12.09]</td>
<td>.555</td>
<td>&lt;.001***</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>8.25 [7, 9.75]</td>
<td>11.68 [11.49, 11.88]</td>
<td>.703</td>
<td>&lt;.001***</td>
<td></td>
</tr>
</tbody>
</table>

*Note. CI = confidence intervals; D = Dad; M = Mom.

* = \( p < .05 \). ** = \( p \le .01 \). *** = \( p \le .001 \).
Looking at the results collectively, 6 of the 7 families experienced at least one statistically significant improvement related to their targeted area of family functioning. In addition, average PEM effect sizes were either moderate or strong for 5 of the 7 families. Interestingly, the Gilster family was the only one in which the parents differed consistently, with the father’s ratings revealing no significant differences and the mother’s indicating all significant differences. This result is also intriguing given that he was the only parent in the study who completed the targeted area ratings and did not participate in CPRT. Across all families, the average PEM was 72%, which is indicative of a moderate effect (Scruggs & Mastropieri, 1998).

*Family Cohesion, Flexibility, Communication, and Satisfaction*

All eight families completed pre- and post-intervention data for the formal measures (FACES IV, FCS, FSS) as well as the family play activities and semi-structured interviews for raters to complete the observational measure (CRS). Table 15 reflects the data compiled on these measures.

The pre-intervention data reflected that, in general, families were functioning at healthy levels prior to the intervention. FACES IV data revealed that no families fell below 1 standard deviation of the average cohesion and flexibility ratios for the norming sample. Data from the FCS also indicated that most of the parents perceived their families as having positive family communication prior to the intervention, with data from 11 of the 15 parents resulting in families scoring as moderate or above. In addition, on the FSS, 9 of the 15 parents obtained a score on family satisfaction that was moderate or above. Data from the observational measure of family functioning (CRS) revealed that only one family scored in an unbalanced range on cohesion and only one scored low on communication.
Table 15

Results on the FACES IV, FCS, FSS, and CRS

<table>
<thead>
<tr>
<th>Family</th>
<th>Source</th>
<th>Cohesion</th>
<th>Flexibility</th>
<th>Communication</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peasley</td>
<td>D</td>
<td>3.33</td>
<td>3.58</td>
<td>1.76</td>
<td>1.71</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.57</td>
<td>2.95*</td>
<td>1.75</td>
<td>1.58</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6.2C</td>
<td>9.OC††</td>
<td>5.3F†</td>
<td>9.0F††</td>
</tr>
<tr>
<td>Romm</td>
<td>D</td>
<td>2.40</td>
<td>2.23</td>
<td>1.57</td>
<td>1.59</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>1.74</td>
<td>1.63</td>
<td>2.06</td>
<td>1.71†</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6.2C</td>
<td>7.0C†</td>
<td>4.0F†</td>
<td>4.0F†</td>
</tr>
<tr>
<td>Gilster</td>
<td>D</td>
<td>1.94</td>
<td>2.80**</td>
<td>2.00</td>
<td>1.47††</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>3.04</td>
<td>2.64†</td>
<td>1.72</td>
<td>1.65</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>7.0C</td>
<td>7.0C†</td>
<td>4.0F†</td>
<td>4.0F†</td>
</tr>
<tr>
<td>Roe</td>
<td>D</td>
<td>2.48</td>
<td>2.58</td>
<td>1.87</td>
<td>1.80</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.38</td>
<td>2.48</td>
<td>1.65</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>7.0C</td>
<td>6,0C*</td>
<td>8.0F†</td>
<td>6,0F*</td>
</tr>
<tr>
<td>Keith</td>
<td>M</td>
<td>1.74</td>
<td>1.93</td>
<td>1.10</td>
<td>1.18</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>9.0C</td>
<td>7.0C*</td>
<td>4,0F†</td>
<td>5,0F*</td>
</tr>
<tr>
<td>Jacobs</td>
<td>D</td>
<td>2.69</td>
<td>4.12***</td>
<td>2.64</td>
<td>3.00†</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.70</td>
<td>3.58**</td>
<td>2.07</td>
<td>2.22</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6.5,VC</td>
<td>7.0C</td>
<td>3.5,0F</td>
<td>5,0F*</td>
</tr>
<tr>
<td>Brooks</td>
<td>D</td>
<td>2.64</td>
<td>3.04*</td>
<td>1.54</td>
<td>1.57</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>4.38</td>
<td>4.12</td>
<td>2.07</td>
<td>2.00</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>6.5,VC</td>
<td>5.5,0C*</td>
<td>6,0F</td>
<td>6,0F</td>
</tr>
<tr>
<td>Portela</td>
<td>D</td>
<td>1.75</td>
<td>1.52</td>
<td>1.22</td>
<td>1.26</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>2.07</td>
<td>2.00</td>
<td>1.30</td>
<td>1.30</td>
</tr>
<tr>
<td></td>
<td>R</td>
<td>4.0C</td>
<td>5,0C*</td>
<td>3,0F†</td>
<td>5,0F*</td>
</tr>
</tbody>
</table>

Note. * ≈ ½ SD or one-level improvement; ** ≈ 1 SD or two-level improvement; *** ≈ 1½ SD or three-level improvement; † ≈ ½ SD or one-level deterioration; †† ≈ 1 SD or two-level deterioration. D = Dad; M = Mother; R = Rater; SC = somewhat connected; C = connected; VC = very connected; OC = overly connected; SF = somewhat flexible; F = flexible; VF = very flexible; OF = overly flexible; VL = very low; L = low; MR =moderate; H = high; and VH = very high.

Despite the generally healthy levels observed in family functioning prior to intervention, post-intervention data revealed notable changes in many of the families. On the cohesion dimension for the FACES IV, data from at least one parent in 4 of the 8 families reflected notable to substantive increases in balanced cohesion from pretest to posttest. Specifically, data from two parents reflected approximately ½ standard deviation improvements in their families’ balanced cohesion (Peasley: Mom, Brooks: Dad), two parents reflected improvements of roughly 1 standard deviation (Jacobs: Mom, Gilster: Dad), and one reflected an improvement of 1½
standard deviations (Jacobs: Dad). Data from one parent reflected a \(\frac{1}{2}\) standard deviation decrease in balanced cohesion from pretest to posttest (Gilster: Mom). Data from the post-intervention observations also revealed notable increases in balanced cohesion for 4 of the 8 families. Specifically, two families shifted from very connected to connected (Roe and Brooks), one family shifted from overly connected to very connected (Keith), and one family shifted from somewhat connected to connected (Portela). Two families shifted to less balanced levels of cohesion, with one family moving from connected to very connected (Romm) and another from connected to overly connected (Peasley).

Data from only one family on the FACES IV reflected a notable increase in their balanced flexibility from pretest to posttest (Jacobs: Dad), which was an increase of a \(\frac{1}{2}\) standard deviation. Two families reflected notable to moderate decreases in balanced flexibility. One parent’s data reflected roughly \(\frac{1}{2}\) standard deviation decrease in balanced flexibility (Romm: Mom) and another a decrease of roughly 1 standard deviation (Gilster: Dad). Data from the observational measure, however, reflected notable improvements in balanced flexibility for 5 of the 8 families. Specifically, four families moved from somewhat flexible to flexible (Keith, Jacobs, Romm, and Portela) and one from very flexible to flexible (Roe). Data from one family reflected a shift towards a more unbalanced level of flexibility, moving from flexible to overly flexible (Peasley).

Regarding communication, data from at least one parent in 3 of the 8 families on the FCS reflected notable increases in the quality of communication: one from low to moderate (Keith: Mom), another from moderate to high (Gilster: Dad), and another from high to very high (Brooks: Mom). Data from one parent reflected a categorical decrease, from low to very low (Portela: Mom). Data from the observational measure reflected notable improvements in
communication for 4 of the 8 families. Specifically, three families shifted from moderate to high (Roe, Keith, and Romm), and one family shifted from low to moderate (Portela). One family (Peasley) reflected a notable decrease in communication, moving from moderate to low.

Concerning family satisfaction, data from at least one parent in 7 of the 8 families on the FSS reflected notable to moderate increases in their level of family satisfaction: two from very low to low (Keith: Mom, Portela: Dad), two from low to moderate (Romm: Dad, Gilster: Dad), one from moderate to high (Peasley: Dad), one from moderate to very high (Brooks: Mom), and one from high to very high (Jacobs: Mom). No data reflected noteworthy decreases in family satisfaction.
APPENDIX D

EXPANDED DISCUSSION
In the following section, I: (1) review the results and their significance (Thompson, 2002); (2) review the implication of the results with regards to practice; and (3) provide an overview of the limitations of this current study and recommendations for future research.

Review of the Results and Significance

All eight families involved in the study appeared to experience some positive impact in their family functioning. Nearly all families experienced statistically significant improvements pertaining to the targeted areas of family functioning, and the average effect was moderate. Interpreting this effect size in light of previous research (Thompson, 2006) is complicated by the fact that there are numerous effect size measures in single-case research, and these various effect size measures do not appear to yield similar interpretations (Parker et al., 2005). As a result, I examined the literature for previous studies in which researchers utilized the PEM effect size. No other research studies related to the field of counseling or filial therapy incorporated the PEM effect size.

Because I utilized a single-case design and a different measure of effect size, it is difficult to know whether the interpretations of the effect in this study can be accurately compared to the previous research in CPRT. Researchers conducting previous studies using CPRT have often used randomized control group designs, have incorporated conventional parametric statistical analyses, and have examined the effect on parent and child functioning. Given this limitation, it is important to interpret the comparisons tentatively. Based on the review of research completed by Bratton et al. (2010), CPRT appears to have a strong effect when looking at outcome measures related to child functioning, parent functioning, and the parent-child relationship. Thus, the moderate effect size in this study indicates that the impact that CPRT has on family functioning is substantive but notably less than the impact on the participating parent and child.
This greater effect on participating parents and children makes sense given the primary emphasis of CPRT is strengthening the parent-child relationship (Landreth & Bratton, 2006).

The results from the self-reported and observational measures based on the circumplex model also suggested that many families experienced practically significant changes in their cohesion, flexibility, communication, and satisfaction despite the fact that many exhibited functioning that appeared healthy prior to the intervention. Interestingly, the families that appeared to improve in an area based on the results from the observational measure (CRS) did not often align with the results from the self-report measures (FACES IV, FCS, and FSS). Olson and Gorall (2003) noted that previous research suggests that the CRS more accurately measures families according to the circumplex model than the FACES IV. The fact that more families exhibited improvements when looking at the CRS data only further affirms the practical significance of the results.

Finally, the responses of parents during the post-intervention interviews, which individuals other than myself conducted, also provided support for the practical significance of the impact of CPRT on family functioning. All parents confirmed that CPRT did have a positive impact on the way their family functioned beyond changes in individual family members and noted specific ways in which their family interacted differently as a result. Parents from five families noted examples of family members generalizing CPRT attitudes and skills in their interactions with one another. Five families also noted changes related to increased connection amongst family members. Three families indicated changes related to increased emotional responsiveness, and three families reported noting improvements related to communication. Finally, two families noted decreased tension, two reported increased playfulness, and two indicated improved discipline in their families as a result of CPRT.
Implications for Practice

Given that this study is the only one of its kind, I caution others to interpret the results tentatively. With that in mind, the results provide some initial support for the theoretical claims that filial therapy positively impacts the family system (Gil, 1994; Guerney & Guerney, 1987; Hutton, 2004; Johnson, 1995; Johnson et al., 1999; Kellam, 2001). In addition, the results of this quantitatively-based study also corroborate what qualitative researchers have reported regarding the influence that filial therapy may have on family functioning (Bavin-Hoffman et al., 1996; Lahti, 1992; Wickstrom, 2009). Thus, although the primary aim of filial therapy is to improve the parent-child relationship, it appears the impact of filial therapy may extend to the family as a whole. The notion that families experienced benefits in their functioning after only 10 sessions is also remarkable, especially given that the initial portion of CPRT involves encouraging parents to not attempt to generalize the skills beyond their play sessions with their child of focus (Bratton et al., 2006).

The results also provide greater confidence in filial therapy as a potential intervention for family therapists and play therapists to utilize in addressing issues in families with young children. As noted previously, there appears to be a lack of family therapists and play therapists who are involving families in treatment, and this issue seems to reflect the training that these practitioners receive (Haslam & Harris, 2011; Johnson & Thomas, 1999). It makes sense that family therapists, primarily trained in talk-based methods, would likely find that integrating young children through the medium of talk is less comfortable for them than it is for parents. Similarly, it makes sense that play therapists, primarily trained in play-based methods, would likely find that integrating parents through the medium of play is less comfortable for them than it is for children. Thus, the lack of conjoint treatment of parents and young children may reflect
the difficulty in reconciling these developmental differences. In filial therapy, practitioners have an approach in which the delivery of the intervention occurs primarily through talk with the parents during group sessions and primarily through play with the children during play sessions. As a result, the intervention includes parents and young children but primarily through means that are developmentally appropriate to each.

In addition, the results give additional credence to the recommendations from governmental organizations, professional organizations, and practitioners across helping professions of the value of involving families into treatment, especially families with young children. The results support that family functioning can improve within the context of an approach that involves parents and children. Counseling practitioners should note that finding ways of working alongside families is not simply a theoretical preference but a best-practice imperative that is finding increasing support in the research literature. As the results of this study and previous research in filial therapy have indicated, parents are capable of realizing therapeutic benefits with their children (Bratton et al., 2005; Lin, 2011).

Although the results suggest families receiving filial therapy do seem to experience positive changes in their family functioning, it is difficult to know whether the same may be true for families that exhibit poorer functioning. Given that many of the families in this study appeared to be healthy, based on self-report and observational measures, it would be inappropriate to conclude that filial therapy would be an effective intervention for all families. In fact, proponents of filial therapy have acknowledged that not all parents and children are viable candidates for filial therapy (Bratton et al., 2005; Landreth & Bratton, 2006).

Although CPRT is a time-limited approach, the number of sessions and the degree of parental involvement can be a significant commitment for many families. The fact that all
parents missed one CPRT session or more and all but two missed at least one play session attests to the “real world” difficulties of incorporating families into treatment. Despite this noteworthy lack of treatment adherence, the families were able to experience therapeutic benefits. This supports the potency of CPRT as well as its generalizability to the realities of everyday clinical practice.

For those interested in utilizing filial therapy, experts recommend first receiving training in play therapy (Landreth & Bratton, 2006). Training in play therapy undoubtedly improves the filial therapist’s ability to teach, support, and supervise parents in conducting their plays sessions with their children. The Association for Play Therapy’s website includes a searchable directory of approved centers of play therapy and universities that provide such training (http://www.a4pt.org/university.cfm). For example, the University of North Texas and its Center for Play offer semester-long courses as well as intensive trainings in child-centered play therapy and CPRT (http://cpt.unt.edu).

Limitations and Recommendations for Future Research

One of the limitations of this study was sampling. Convenience sampling, a small sample size, and a lack of a defined population were present, thereby affecting the internal and external validity of the results. The high number of two-parent families, coupled with the fact that most of these families had both parents participate in CPRT, was unique to this study and limits the generalizability of the results. Although employing a single-case design helped in providing mechanisms for adding control to the research study, it is difficult to make substantive conclusions based on the results of a single study given the lack of research. Studies utilizing a randomized control group design with more families and targeted populations would help in increasing the ability to attribute effects to the intervention and in generalizing the results.
Results from this study justify the greater resources and expenses involved in completing such future research. In addition, comparing the effect of CPRT on family functioning with alternative treatments, such as individual play therapy, other evidence-based parent-child approaches, filial family therapy, or family play therapy, would also help in better understanding whether CPRT’s effect on family functioning is greater than what other approaches might achieve.

Another limitation relates to instrumentation. Ideally, this research study would have included multiple measures of family functioning, based on a variety of models of family health, in order to decrease measurement error. Although the individualized rating forms did provide another means for assessing family functioning that was not associated with a particular model, the bulk of the instrumentation reflected the circumplex model. To address these limitations, future research could include different measures and constructs of family functioning than those used in this study and use more observation-based measures.

Another limitation relates to instrumentation. Ideally, this research study would have included multiple formal research instruments measuring family functioning, based on a variety of theoretical and research-based models of family health, in order to decrease the potential impact of measurement error. Although the individualized ratings of the target family behaviors did provide another means for assessing family functioning that was not associated with a particular theoretical model, the bulk of the instrumentation reflected the circumplex model. The individualized rating forms also were a limitation. Despite being developed according to guidelines (Borckardt et al., 2008), the rating forms had no established reliability or validity and were developed for the purposes of this study. In addition, with this instrument, unlike the more formal measures that parents completed in a controlled environment, I could not control for the
conditions under which parents completed the daily ratings. Another limitation was that most of the data was self-reported, which may have biased the results. The observational measure, however, helped in counteracting this limitation, and in this study, provided unique information beyond what the self-reported data suggested. Not having a self-report measure of family functioning included for children was another limitation related to instrumentation. The inclusion of an observational assessment of family functioning was an attempt to address these limitations of relying on self-report measures and the lack of a measure that accounts for the perspective of young children. To address these limitations, future research could include different measures and constructs of family functioning, use more observation-based measures, and find ways to incorporate the perspective of children more heavily. In addition, a research study using multiple measures of family functioning and structural equation modeling could provide a more holistic measurement of families in addition to providing the means to account for error.

Another set of limitations relates to the design. This study was limited in that there were a relatively small number of baseline phase ratings when compared to treatment phase ratings. Although a short baseline phase is common in single-case design (Nugent, 2010), future research could improve by extending the baseline phase rating. The higher variability in the confidence intervals surrounding the means of the baseline phase data when compared to the treatment phase data demonstrates the benefits in terms of accuracy of having more ratings. Also, having a longer baseline might provide a better indication of the degree to which parents tracking their functioning may have impacted their family’s interactions even without the intervention. Another limitation was the lack of follow up, which makes it difficult to know how the families may have been impacted over time. It is unclear whether families maintained their
improvements, worsened, or perhaps realized greater improvements beyond the intervention. Future research should include collecting data on participants beyond the conclusion of the intervention. Not having a mechanism of control for the formal outcome measures utilized in this study was also a limitation as it was less clear whether the changes in family functioning observed in these measures was a reflection of the intervention.

Poor attendance and a relative lack of treatment adherence amongst participants was another limitation. In this study, I made no attempts to cover missed material with parents. Although this perhaps increased the generalizability of the results to everyday practice, it remains unclear how greater treatment adherence on the part of the parents would have impacted the results. Future research could entail a more stringent protocol for making up missed sessions in order to ensure a more complete delivery of the intervention.

A final limitation of this study was my heavy involvement in carrying out the intervention and research, which may have introduced experimenter bias. I facilitated the process of identifying targeted areas of family functioning, co-led the CPRT groups, and facilitated the family play activities and semi-structured interviews that were part of the data collection process. My training and belief in the value of filial therapy may have influenced how I administered the treatment and research activities. Another consideration is that I have additional training in family therapy, which may have impacted the way I conducted CPRT even when adhering to protocol. Although I put mechanisms in place to limit the impact of bias, such as using outside raters for the CRS, having treatment integrity assessed, and other individuals to complete the post-intervention interviews, it is possible that I may have exerted some unique influence over the results of the study.
Conclusion

An ever-growing number of researchers have found strong support for the therapeutic benefits of filial therapy (Bratton et al., 2010). That the parents and children involved in filial therapy often experience remarkable changes in themselves and in their relationships with one another is perhaps not surprising given the primary aim of this approach. After all, filial therapists assume that strengthening the parent-child relationship will have therapeutic benefits. What is perhaps more surprising is the suggestion that the benefits of filial therapy do not end with the participating parents and children but extend to the family as a whole.

Prior to this study, the claim of filial therapy’s impact on the family was largely a theoretical assumption advocated by its proponents but lacking research-based support. Although more research is undoubtedly necessary, and will likely come given the success of filial therapy, the results of this study suggest that the impact of filial therapy on the family is more than just a theoretical ideal. Filial therapy’s impact on the family appears to be a therapeutic reality.
APPENDIX E

ADDITIONAL MATERIALS
University of North Texas Institutional Review Board

Informed Consent Form

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

**Title of Study:** Filial Therapy and the Family: Examining the Impact of Child Parent Relationship Therapy (CPRT) on Family Functioning

**Investigator:** Dr. Sue Bratton, Professor at the University of North Texas (UNT) Department of Counseling and higher Education, is the investigator for this research study and can be contacted at (940) 565-3864.

**Research Assistant:** Nick Cornett, PhD student at the University of North Texas (UNT) Department of Counseling and higher Education, is the research assistant.

**Purpose of the Study:** We are asking you to participate in a research study of how a parent training model (Child Parent Relationship Training; CPRT) may impact the way your family works. The goal of CPRT is to help parents build a stronger relationship with their children. CPRT helps parents connect with their children by understanding their children’s concerns and responding in such a way that helps them grow.

**Study Procedures:** The study will begin with a 45-minute family play activity. All family members who agree to be a part of the research study will be a part of this activity. We will record this activity on video, and it will help us to better understand how your family works. All family members who are at least 12 years old will then complete an assessment called FACES IV that asks about how people view their family’s closeness, structure, communication, and satisfaction.

If you take part in CPRT, you will attend 10 meetings, once a week, as part of a group with other parents. These sessions will last two hours each, and we will record them on video. As part of CPRT, you will complete seven play sessions at home with your child. Each play session will last 30 minutes. We will ask you to record these sessions on video. The play sessions allow you to practice the skills you are learning. These skills help you to build your relationship with your child, understand your child’s needs, know how to respond to your child in difficult situations, and help your child feel loved. We will also use example play sessions, role-plays, and group discussion to help you apply the skills. During the 10 weeks of the training, you will rate how the family is doing every day using a short form that we will give you. Adult family members who do not take part in CPRT may also choose to rate the family.

After CPRT, all family members who agree to be a part of the study will do another 45-minute family play activity. We will video record these sessions. All family members who completed the FACES IV at the first session will do it again.

The time it will take to be a part of this study will be different for each person. The parents who participate in the CPRT will spend about 27 ½ hours on this project. Family members who do not participate in CPRT will spend about 2 hours on this project.
Foreseeable Risks: The potential risks in this study are minimal. You may become more aware of concerns you have about yourself or your family. If you experience discomfort, we will refer you to places that provide counseling.

Benefits to the Subjects or Others: You may benefit from being more aware of how your family works. Having the time to play as a family may also benefit you. People who participate in CPRT tend to experience a decrease in child behavior problems and decreased stress, increased acceptance, and increased empathy in parenting. Results from this study may help counselors and clients to see how CPRT may impact families.

Procedures for Maintaining Confidentiality of Research Records: To protect your privacy, we will put a code to take the place of your name on all information that you provide, including the recordings. We will also keep your information private in any presentations or writings on this study. No one will view your private information except for the researchers. We will keep the recordings for no more than two years, and then we will destroy them. We will lock all recordings and assessments in Stovall Hall Room 114 at the University of North Texas, Denton, TX.

Questions about the Study: If you have any questions about the study, you may contact Dr. Sue Bratton at (940) 565-3864.

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

Research Participants’ Rights:

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

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

Signature of Participant ___ Date

For the Principal Investigator or Designee:

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

Signature of Principal Investigator or Designee ___ Date
Title of Study: Filial Therapy and the Family: Examining the Impact of Child Parent Relationship Therapy (CPRT) on Family Functioning

Investigator: Dr. Sue Bratton, Professor at the University of North Texas (UNT) Department of Counseling and higher Education, is the principal investigator and advisor for this research study and can be contacted at (940) 565-3864.

Research Assistant: Nick Cornett, PhD candidate at the University of North Texas (UNT) Department of Counseling and higher Education, is the research assistant.

Purpose of the Study: We are asking you to participate in a research study of how a parent training model (Child Parent Relationship Training; CPRT) may impact the way your family works. The goal of CPRT is to help parents build a stronger relationship with their children. CPRT helps parents connect with their children by understanding their children’s concerns and responding in such a way that helps them grow.

Study Procedures: We are asking your child to participate in two 45-minute family play activities with other family members who agree to be a part of the study. We will video record these sessions.

For children who are at least 12 years old, we are asking them to complete an assessment called FACES IV. This assessment asks about how they view their family’s closeness, structure, communication, and satisfaction. This assessment will be completed a total of two times. Children 12 or older will spend about 2 hours on this project. Children under 12 will spend about 1 ½ hours.

Foreseeable Risks: The potential risks involved in this study are minimal. Children may become more aware of concerns they have about themselves or their families. If your child experiences discomfort, we will refer you to places that provide counseling.

Benefits to the Subjects or Others: Children may benefit from being more aware of how their family works. Having the time to play as a family during the activity may also benefit them. Results from this study may help counselors and clients to see how CPRT may impact families.

Procedures for Maintaining Confidentiality of Research Records: To protect their privacy, we will put a code to take the place of the name of your child on all information that you provide, including the recordings. We will also keep their information private in any presentations or writings on this study. No one will view their private information except for the researchers. We will keep the recordings for no more than two years, and then we will destroy them.
them. We will lock all recordings and assessments in Stovall Hall Room 114 at the University of North Texas, Denton, TX.

Questions about the Study: If you have any questions about the study, you may contact Dr. Sue Bratton at (940) 565-3864.

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

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

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

________________________________
Printed Name of Parent or Guardian

________________________________                                            ____________
Signature of Parent or Guardian                                     Date

For the Principal Investigator or Designee: I certify that I have reviewed the contents of this form with the parent or guardian signing above. I have explained the possible benefits and the potential risks and/or discomforts of the study. It is my opinion that the parent or guardian understood the explanation.

______________________________________                                 ___________
Signature of Principal Investigator or Designee                     Date
Child Assent Form

We are asking you to be part of a research project. We are from the University of North Texas Department of Counseling. In this project, you will do two play activities with your family. Each play activity will last 45 minutes. These will help us get to know your family better. We will record these on video. If you are 12-years-old or older, we also will ask you to fill out a form. This form asks about how you view your family. There are no right or wrong answers. You will complete the form two times. It should take about 15 minutes each time.

If you want to be part of this project, know that you can choose not to be a part of it at any time.

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

__________________________________________________________________________
Printed Name of Child

__________________________________________________________________________
Signature of Child                                Date

__________________________________________________________________________
Signature of Principal Investigator                Date
Family Play Activity for CRS

(Exact wording determined by the developmental level of children in the family)

- “I’d like you to work together as a family to make a ‘scene’ in the sandtray using any of the objects on the shelves (pointing to the sandtray and then to the objects). I’d like you to imagine that the title of your ‘scene’ is ‘A typical day in the Martinez family.’ I’d like you to start by choosing at least one object to represent each person in your family (it is okay if each of you chooses a figure to represent each person in your family). Then add as many other objects as you want to complete your ‘scene.’ When everyone is finished, I will ask you to tell me about your ‘scene’ so that I can better understand what your family is like. At the end, Maria and Miguel, you will go back to the waiting area and play some games while I go over some paperwork with Mom and Dad.

- Observe family interactions during the activity, paying particular attention to the following:
  - As family members participate in the activity, how separate or together are they?
  - How emotionally close do the parents seem?
  - How emotionally close do the family members seem?
  - To what degree, if any, does the family moderate itself or its responses or each other in order to maintain loyalty? For instance, do some family members seem tentative or seem to be “holding back” how they truly feel or perceive things?
  - To what degree do family members participate in the activity in isolation or in conjunction with one another?
  - How independent (or dependent) do the family members seem as they participate in the activity?
  - How do the parents seem to manage leadership during the activity? Does one of them take charge? Both? Neither?
  - How does the family seem to handle discipline during the activity? Does the family seem too strict or too lenient?
  - To what degree, if any, do family members negotiate or discuss things with one another as they complete the activity?
  - What roles do family members take during the activity? Do these roles change or remain the same? Do these roles seem rigid or flexible?
  - Do family members state any rules regarding each other’s behavior during the activity? Are these rules rigid? Nonexistent? How do family members respond to the “rules” of the activity?
  - This is likely a new activity for many families and may indicate how open they are to change as a family. How does the family appear to respond to the activity? To what degree does the family appear to tolerate changes?

- First, conduct processing of activity with the entire family, paying particular attention to gathering information from the children. Stay within the representational world created by the family: “Tell me about what you made.” “I noticed that ….”

- Dismiss children and conduct semi-structured interview with parents using protocol in the CRS manual
Family Rating Sheet

Instructions: Complete ratings every night before you go to bed. Please bring each completed weekly form to Nick when you come to the sessions. If you have any questions, please ask.

Sunday
Number of instances in which family members communicate their feelings: _______
Number of instances in which a family member acknowledges the feelings of another family member: _______
Family members often express their feelings and are sensitive to the feelings of others (circle an “X”).

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Uncertain</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Comments:_____________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Monday
Number of instances in which family members communicate their feelings: _______
Number of instances in which a family member acknowledges the feelings of another family member: _______
Family members often express their feelings and are sensitive to the feelings of others (circle an “X”).

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Uncertain</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Comments:_____________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Tuesday
Number of instances in which family members communicate their feelings: _______
Number of instances in which a family member acknowledges the feelings of another family member: _______
Family members often express their feelings and are sensitive to the feelings of others (circle an “X”).

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Uncertain</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Comments:_____________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
### Wednesday
Number of instances in which family members communicate their feelings: _______
Number of instances in which a family member acknowledges the feelings of another family member: _______
Family members often express their feelings and are sensitive to the feelings of others (circle an “X”).

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Uncertain</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Comments: ____________________________________________________________
____________________________________________________________________
____________________________________________________________________

### Thursday
Number of instances in which family members communicate their feelings: _______
Number of instances in which a family member acknowledges the feelings of another family member: _______
Family members often express their feelings and are sensitive to the feelings of others (circle an “X”).

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Uncertain</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Comments: ____________________________________________________________
____________________________________________________________________
____________________________________________________________________

### Friday
Number of instances in which family members communicate their feelings: _______
Number of instances in which a family member acknowledges the feelings of another family member: _______
Family members often express their feelings and are sensitive to the feelings of others (circle an “X”).

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Uncertain</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Comments: ____________________________________________________________
____________________________________________________________________
____________________________________________________________________

### Saturday
Number of instances in which family members communicate their feelings: _______
Number of instances in which a family member acknowledges the feelings of another family member: _______
Family members often express their feelings and are sensitive to the feelings of others (circle an “X”).

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Uncertain</th>
<th>Somewhat Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Comments: ____________________________________________________________
____________________________________________________________________
____________________________________________________________________
COMPREHENSIVE REFERENCE LIST


183


