

A MIXED-METHODS APPROACH TO THE EXPERIENCES OF NON-OFFENDING
PARENTS OF CHILDREN WHO HAVE EXPERIENCED SEXUAL ABUSE
PARTICIPATING IN CHILD PARENT RELATIONSHIP THERAPY (CPRT)

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When a child has been sexually abused, the non-offending parent and child may benefit from an intervention aimed at enhancing the parent child relationship. This mixed-methods study examined the process of child parent relationship therapy (CPRT) with non-offending parents of children who had been sexually abused. One purpose of the present study was to examine change in parent-child relationship, child behavior, and parent empathy of non-offending parents whose children have been sexually abused after participation in CPRT. A secondary purpose of this study was to explore subjective experiences of non-offending parents who participate in CPRT. Participants ($N = 8$) completed 11 weeks of CPRT in either Spanish speaking ($n = 4$) or English speaking ($n = 4$) groups. All participants completed pretest and posttest instruments including Child Behavior Checklist, Parenting Stress Index, and Measurement of Empathy in Adult-Child Interaction. Pretest and posttest means were reported but because of small sample size, only descriptive statistics are reported. Possible trends in pretest/posttest mean scores of the quantitative instruments are discussed. All participants also completed a post semi-structured interview to account for the experience of participants qualitatively. Analysis of the qualitative data revealed enhanced parent-child relationships, improved communication, greater acceptance, positive parental internal changes, positive behavioral changes in child, and positive changes in discipline.

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CHAPTER I

INTRODUCTION

In the United States, four children die as a result of physical abuse each day. Specifically in 2006, the state of Texas reported 227 children died as a result of physical abuse (DFPS 2006 Data Book). According to a recent report by the National Child Abuse and Neglect Data System (NCANDS), during 2006, 905,000 children were documented victims of maltreatment and nearly 3.6 million children received Child Protective Service (CPS) investigations or assessments. More specifically, reports indicated 64.1 % of victims experienced neglect, 16.0 % were physically abused, 8.8 % were sexually abused, 6.6 % were psychologically maltreated, and 2.2 % were medically neglected. Childhood sexual abuse is not a new phenomenon, nor is it confined to the U.S. The Violence Study by the World Health Organization (WHO) in 2002 estimated that 150 million girls and 73 million boys under the age of 18 years old were forced to have sex or experienced other forms of sexual violence. On the local level, a children's advocacy center may serve up to 2,500 abused children per year (as reported by Dallas County). Typically, more than half of child clients are under 9 years of age and are victims of sexual abuse. Perpetrators have powerful roles in children's lives such as; parents, guardians, teachers, coaches, priests, ministers, and relatives.

Since the 1970s, U. S. professionals have been concerned with detecting, reporting and educating the public about child abuse, especially child sexual abuse (Gil, 2006). Childhood sexual abuse can cause physical injury to the child and both short and long term emotional and psychological harm. Effects of childhood sexual abuse include developmental delay, depression, anxiety, propensity to re-victimization in adulthood,

and overt sexual behaviors (Gil, 1991; Gil, 2006; Van Fleet, 1994). Generally children who have experienced sexual abuse have also experienced severe damage to normal development and their overall well-being (Reyes & Asbrand, 2005). Feelings of vulnerability, insecurity, and shame may develop defenses such as hyper- vigilance or extreme compliance (Gil, 1991).

According to Gil (1991), children are unable to fully understand or explain the impact of abuse. Namka (1995) stated, "If the powerful feelings are not discharged after trauma, they are stored in the body and manifested as acting out behavior and other symptoms" (p. 85). Children traumatized by abuse need a trusted and safe place to express feelings and extra support through the process of coping (Oaklander, 1988). They have experienced the world as unsafe and perceive adults as mistrusting (Gil, 1991). According to Landreth (2002), children traumatized by sexual abuse can benefit from child-centered play therapy because of its developmental and healing properties. In child-centered play therapy, children receive support in a healthy relationship from a trusted adult and gain a safe place where they can express themselves freely without any judgments or shame. Through her report of case study outcomes, Gil (2006) also provided support for integrating non-directive and directive strategies in play therapy as a developmentally responsive and facilitative intervention for sexually abused children. Experts in the field emphasized that, when possible, any treatment of sexually abused children should involve parents (Costas & Landreth, 1999; Gil, 2006; Massat & Lundy, 1998).

Parents are the most important people in their child's life. As part of treatment, parents of children who have experienced abuse must learn ways of helping their

children feel accepted, valued, and empowered. Children may benefit when parents take an active role in helping their children cope after trauma. Coohy and O' Leary (2008) reported that children are affected by parental response to outcries of sexual abuse. Mothers who provide their children with more consistent maternal support improve their children's functioning (Coohy & O' Leary, 2008). A professional's role is to encourage and support the non-offending parent, as the parent encourages and supports the traumatized child. Rebuilding the parent-child relationship is crucial to the child's and parent's healing process. Parents typically need to acquire skills of acceptance and empathy, especially mothers who may lack positive childhood family experiences of their own.

Child parent relationship therapy (CPRT) is a filial therapy treatment based on child-centered play therapy principles for which research has shown to be effective in training parents to deal with their children's social, emotional, and behavioral problems (Landreth & Bratton, 2006). A review of literature revealed 34 outcome studies showing the effectiveness of CPRT in decreasing parent stress, decreasing children's externalizing behavioral problems, increasing parental acceptance, and increasing parental empathy (Landreth & Bratton, 2006). Recently a protocol treatment manual was developed for the CPRT model making the model easier to replicate in research (Bratton, Landreth, Kellum, & Blackard, 2006). Using a small group format, CPRT is presented to parents through didactic instructions, viewing video recordings of parent-child play sessions, supportive feedback, role-play, and group process, parents learn to convey acceptance, empathy, and encouragement to their child (Landreth & Bratton, 2006). In this supportive format, parents learn basic child-centered play therapy

principles to utilize with their children in a thirty minute weekly play session. The combination of didactic instruction and a support group format provides a dynamic process that sets CPRT training apart from other parent training programs, the majority of which are exclusively educational in nature (Landreth & Bratton, 2006). CPRT provides non-offending parents the skills to develop and consistently maintain a positive and healthy relationship with their children.

With abused populations of children, CPRT has been proven effective in reducing children's externalizing behavior problems and increasing parental empathy (Costas & Landreth, 1999, Smith & Landreth, 2003). Costas and Landreth (1999) conducted a controlled study and found that CPRT was effective in teaching the non-offending parent of children who experienced sexual abuse to become a constructive force for change in their children's' behaviors and attitudes. Researchers also reported a significant decrease in parent stress and increase in parental acceptance for their sexually abused children (Costas & Landreth, 1999). Smith and Landreth (2003) found children who resided in a domestic violence shelter or homeless shelter and whose parents participated in CPRT reported a significant increase in children's self-concepts, a decrease in overall child behavior problems, decrease in internalizing and externalizing child behavioral problems, and increase in parental empathic interactions compared to children in the control group.

Sexual abuse is a prevalent social problem as evidenced by an increase in outcries, especially from children, within the past decade. Treatment for children who have been sexually abused is imperative to help support children to express emotions and cognitions to heal from the trauma and prevent even more harmful long term

effects. Play therapy offers sexually abused children a safe place to explore their feelings and thoughts about the abuse (Gil, 1991). Non-offending parents also need a place to heal and feel supported. CPRT offers the non-offending parent a didactic instructional setting in a small support group format (Costas & Landreth, 1999).

Statement of Problem

Treatment for children who have been sexually abused is greatly needed. Limited research has supported the use of CPRT as a parent intervention for non-offending parents and their children who have experienced sexual abuse. The problem with which this research was concerned is the exploration of parent response to CPRT for non-offending parents whose children have been sexually abused. Specifically, this study was designed to collect quantitative data and qualitative analysis of parent participation in CPRT.

CHAPTER II

REVIEW OF RELATED LITERATURE

The review of literature concentrates on the following elements: (a) childhood disclosure of sexual abuse and the role of children's advocacy centers; (b) the effects on children's lives; (c) importance of the non-offending parent-child relationship; (d) non-play therapy interventions for childhood sexual abuse; (e) child-centered play therapy as an early intervention; (f) rationale for child parent relationship therapy (CPRT); and (g) rationale for using a qualitative approach with play therapy studies.

Childhood Disclosure of Sexual Abuse

Children who have been sexually abused have a choice of revealing abuse or keeping it secret. Children choose not to disclose for many reasons. Sexual abuse is more talked about today than 50 years ago and the rates of children's outcries have increased. Plummer (2006) collected a survey from 125 non-abusive mothers and analyzed using descriptive statistics. Plummer (2006) found that 41.6% of the mothers first learned about the sexual abuse from what the victimized child had told them and 15% learned from child behaviors (p. 1231). Almost half of the mothers reported sensing something was wrong with their children, however, other mothers reported having doubt the sexual abuse occurred. Plummer (2006) reported out of 125 mothers, 73.6% responded disclosure by their child decreased maternal doubt regarding whether the abuse occurred. Therefore, information disclosed to the parent from the child was the most frequent convincing evidence of the abuse. The children's behavior as an effect of the experienced sexual abuse was the second highest form of evidence that

decreased maternal doubt about the abuse. The third most significant evidence that decreased the maternal doubt about the abuse occurring with 60% of parent's responses was the child's emotions. Even after learning of the abuse, some mothers were in denial the abuse occurred. Plummer (2006) reported 78 mothers reported a total of 159 barriers to their belief in the abuse. The most common response was that "I would have/should have known" if the abuse was actually occurring (Plummer, 2006). To increase the percentage that the non-offending mother believes the child, Plummer recommended education, prevention awareness, and support all need to be immediate interventions available to the mother after discovering their children have been sexually abused.

Paine and Hansen (2002) completed a thorough synthesis of literature on self-disclosure of sexual abuse. They focused on characteristics of perpetrators and their relationships with children they abuse as well as the effects of the relationships on the child's disclosure of sexual abuse. The authors found perpetrators often know the child well, are in a position of authority and control over the child, and establish trusting relationships with the children (p. 277). The perpetrators often choose emotionally vulnerable children who may be seeking attention or affection as their victims (Paine & Hansen, 2002, p. 283). They concluded that a child might feel connected and close to a perpetrator which impacts the child's decision to conceal the sexual abuse. Paine and Hansen (2002) stated, "The dynamics of the abusive relationship and the insidious nature of the grooming process may lead victims to perceive themselves as willing participants in a 'relationship' with the offender" (p. 281).

Fear can be another reason children hesitate to disclose abuse. They may be afraid of hurting their parents emotionally or of the perpetrators hurting them physically (Paine & Hansen, 2002, p. 282). Children are told many lies by the perpetrators due to fear of the child telling an adult about the sexual abuse. Some children are threatened that if they tell, their family will be hurt or killed. Perpetrators also threaten children that they will be in trouble from other adults if they disclose abuse. Children can be deceived about the consequences and convinced that the perpetrator is acting rightfully.

Experts suggest when a child discloses information about abuse; the adult must take the information seriously, respect the feelings of the child, and report it immediately to Child Protective Services (Faller & Palusci, 2007). Childhood sexual abuse leaves the child feeling vulnerable, scared, and confused (Gil, 2006). Talking about the trauma in words can be just as scary, overwhelming, and confusing, especially if the child is not yet verbal. Kellogg (2002) stated, "The discrepancy in reported and estimated numbers suggests that child sexual abuse remains a significantly undetected and under reported problem" (p. 571). An additional concern is the number of sexually abused children who retract information to reestablish equilibrium in the family dynamic, and ease pain of the non-offenders (Paine & Hansen, 2002, p. 285). Kellogg (2002) reported intervention is effective in helping parents respond more appropriately to the abuse and to be more protective of their children, which allows children to have better prognosis for recovery (p. 581). Children must have open communication and trust to feel comfortable talking about personal experiences within their families.

Many children need the extra support of a therapeutic relationship to disclose sexual abuse. Jensen, Gulbrandsen, Mossige, Reichelt, and Tjersland (2005)

completed a qualitative study on children's perspectives, the context for disclosure by therapeutic sessions, and a follow up interview of 22 children. Jensen et al. (2005) found children were more willing to disclose sexual abuse if the therapist introduced the topic. The researchers also proposed that the child may know whether the adult they disclose sexual abuse to is ready to hear the outcry. Jensen et al. (2005) stated, "Disclosure may be facilitated if the confidant is psychologically prepared to hear about the children's experiences, without showing signs of despair, disgust or moral condemnation" (p. 1408). The child may not disclose if they perceive all interacting adults to be too emotionally vulnerable, judgmental, and non-accepting. The researchers found the child was more likely to disclose if opportunity to talk, purpose for speaking, and connection to what they were talking about emerged (Jensen et al., 2005, p. 1409).

Role of the Children's Advocacy Centers

The first children's advocacy center (CAC) began in 1984 by Alabama District Attorney Bud Cramer. Faller and Palusci (2007) stated, "The primary goal of the Children's Advocacy Center (CAC) was more successful prosecution of child sexual abuse, but it also had a humane goal, which was to conduct more child-friendly criminal investigations" (p. 1021). CACs' standards require a multidisciplinary team approach to treating childhood abuse including; law enforcement, child protective services, prosecution, mental health, medical-nurse examiners, victim advocacy, and forensic interviewers (Faller & Palusci, 2007). Typically, when a child outcries abuse and is referred to a CAC, the guardian or parent brings the child in to talk to a victim

assistance coordinator to help the parent and child understand the system. Children then tell their stories to a forensic interviewer, while other members of the multi-disciplinary team, including law enforcement, observe. This procedure for conducting forensic interviewing is a major contributor to the successful investigation and prosecution of crimes against children (Faller & Palusci, 2007). A careful, unbiased interview of each child is critical in determining if a crime has been committed and to the successful prosecution of perpetrators of these crimes. Perhaps the most important function that CACs serve for child victims and their families is offering counseling services to the child and his/her non-offending family.

Effects on Children's Lives

Effects on Emotional State

Feiring, Taska, and Lewis (1999) interviewed 169 children and adolescents within eight weeks after disclosure of sexual abuse. The authors studied how age at the time of the abuse discovery and gender of victim are related to psychological distress. They found adolescents compared to children reported higher level of depressive symptoms, negative reactions by others, and lower levels of self-esteem, social support, and sexual anxiety. Feiring et al. (1999) reported adolescents had higher levels of depression and were more vulnerable to numerous psychological problems specifically related to affect regulation and self-evaluation compared to children (p. 124). The authors also reported girls compared to boys had higher levels of intrusive thoughts, sexual anxiety, hyper arousal, personal vulnerability and perception of the world as a dangerous place (Feiring et al., 1999, p. 123). The authors implied that due to different

developmental stages at time of sexual abuse, children and adolescents need treatment interventions appropriate to their maturational level.

Gil (1991) explained that a child who has been abused has lost inner power and control. Gil (2006) also reported children who have been abused have two drives, stating, "The first drive is to master what is painful or confusing, restoring a sense of control and mastery; the second drive is to avoid painful emotions, thereby eluding attempts to engage in therapeutic work" (p. 8).

Effects on Behavior Performance and Academic Performance

Sexually abused children who suffer emotional disturbance or depression also tend to suffer from behavior or academic problems at school. Kinard (1999) assessed children school aged and their mothers at two points, one year apart. There were 165 children and mothers in the abused group and 169 non-abused children and mothers, with a total of 44 children confirmed as sexually abused. Kinard collected data and reviewed school records including; Child Behavior Checklist, Teacher Report Form, School Abstract Form, and Wide Range Achievement Test. Kinard (1999) found the lower achievement scores were likely due to the abuse. The mothers of these identified abused children lacked formal education and were unemployed, therefore, the child perceived less support from their mothers (p. 369). Kinard (1999) found childhood abuse is an added stress on mothers beyond socioeconomic status (p. 369). Kinard also found direct correlation between children's perceived support from their mothers and spelling and arithmetic achievement (p. 370).

Childhood sexual abuse has pervasive effects on children's lives, particularly their relationships with parents and teachers. Kinard (1999) implied if parents received treatment for their children who have been abused and increased their support, their child's cognitive abilities would improve as well as school performance (p. 371). Kinard (1999) stated, "Early interventions with abused children and their mothers may reduce the likelihood of academic as well as behavioral problems" (p. 372).

Importance of the Non-offending Parent-Child Relationship

Impact on the Non-Offending Parent

When children are sexually abused, it not only affects their lives, it affects their primary support system, particularly the non-offending parents. Mannarino, Cohen, Deblinger, and Steer (2007) administered the Beck Depression Inventory-II (BDI-II) to 164 biological mothers of children who had been sexually abused. The authors found 26% of these mothers scored indicative of clinical depression (Mannarino et al., 2007). Further they reported a statistically significant correlation between the BDI-II total score and mothers whose husbands or partners were the abusers, demonstrating higher depression scores among these mothers.

Massat and Lundy (1998) conducted a study with 104 non-offending parents and their sexually abused children and found, "Parents reported disruption of relationships, income loss, loss of jobs, and change of residence" (p. 376). The authors described the needs of non-offending parents after their children disclosed sexual abuse as important as the needs of the traumatized child due to level of parent trauma. Therefore,

therapeutic treatments that provide support for the non-offending parent to begin the healing process are crucial.

The non-offending parent-child relationship is important for children who have been sexually abused because of loss of trust in others, a loss of sense of security and safety, and violations of boundaries by perpetrators. Friedrich (1998) stated, "The parent-child relationship is critical for the successful development of all children" (p. 529). Lovett (1995) conducted an empirical analysis and interviewed 60 female children ages 7-12 years old and their non-offending mother within a few weeks of disclosure of sexual abuse. Lovett measured parental acceptance and parental rejection on a questionnaire and Child Behavior Checklist. She found perceived parental warmth was associated with children's perceived competency. Lovett also reported a correlation of higher violence abuse with less perceived competency by the child. Also, Lovett (1995) encouraged parent involvement in a child's healing process and improving treatment models by helping the mother to be a healer for her child (p. 736). The non-offending parent-child relationship is important for the child to feel safe, rebuild trust, and security in an adult relationship again.

A primary social support system characterized by compassion, acceptance and encouragement can help sexually abused children with the healing process. Hyman, Gold, and Cott (2003) completed a study on social support that moderates post traumatic stress disorder (PTSD) in survivors of sexual abuse. The authors administered the Interpersonal Support Evaluation List and the Impact of Events Scale to 172 adult females who had been sexually abused as children. Hyman et al. (2003) defined social support as "assistance provided to individuals who are coping with

stressful events” (p. 295). The authors found from regression analysis that social support significantly buffered PTSD development and the best social support identified was self-esteem support. Self-esteem support was identified as the most important variable in preventing PTSD development (Hyman et al., 2003). Therefore, providing the primary caregiver with information on how to support a sexually abused child may prevent the onset of PTSD.

Improving the Parent-Child Relationship by Educating Parents

Parental support, acceptance, and expectations have all been found to help or hinder a child’s recovery from sexual abuse. Kouyoumdjian, Perry, and Hansen (2005) completed a thorough literature review focusing on parental expectations of children’s recovery from sexual abuse. The authors highlighted the importance of parental support to foster the functioning and recovery of their children who have been sexually abused (p. 476). They further reported that negative stereotypes are often applied to children and adolescents who have been sexually abused, which in turn, affect adult interactions and expectations (Kouyoumdjian et al., 2005, p. 483). Adults in a child’s life, especially the non-offending parent or caregiver, must be educated on false negative stereotypes, expectance of recovery, and how to support and care for the child as a therapeutic agent.

However, most parents do not have access to appropriate educational resources to aid them in effectively responding to their child. Pullins and Jones (2006) investigated parental knowledge of symptoms associated with sexual abuse. Pullins and Jones (2006) asked 150 parents to fill out a project developed questionnaire that measured;

specific behaviors or knowledge, emotional symptoms, physical or medical symptoms, and behavior towards peers or adults. Pullins and Jones (2006) found parents were able to list one or two symptoms for each age group and each four developmental areas (p. 13). Parents were more likely to know behaviors that may be caused from other stressors than sexual abuse. They also found parents with higher socioeconomic status were more likely to list more symptoms. Therefore, education to lower socioeconomic status parents and education on symptoms of childhood sexual abuse to all parents is imperative. Parents that want to improve the parent-child relationship may need education on symptoms and expectations of recovery to provide nurturance and appropriate support.

Interventions for Childhood Sexual Abuse

Interventions specifically for survivors of sexual abuse are crucial. Cognitive-behavioral therapy (CBT) has been the most researched and reported intervention for this population (Cohen & Mannarino, 1996/1997/2000). Lev-Wiesel (2008) reviewed literature on childhood sexual abuse and discussed several different interventions and treatments. Of those discussed, Lev Wiesel (2008) reported there are four therapeutic goals for most which includes; symptom relief, de-stigmatization, increasing self-esteem through cognitive exercises, and prevention of future abuse (p. 3). Lev-Wiesel (2008) stated CBT is the most researched treatment for childhood sexual abuse and has been shown statistically significant in alleviating symptoms, building coping and social skills, and providing education for prevention.

Cohen and Mannarino (1996) randomly assigned 67 sexually abused preschool children, ages 3 to 6 years old, and their parents to either 12 sessions of cognitive-behavioral therapy adapted for sexually abused preschool children (CBT-SAP) or 12 sessions of nondirective supportive therapy (NST). The parents in the CBT-SAP were fully involved in the treatment and the model addressed specific parent and child issues. Parent issues addressed in the CBT-SAP included: appropriate emotional support to the child, ambivalence in belief of the child's abuse, ambivalent feelings toward the perpetrator, attributions regarding the abuse, feeling that the child is "damaged," providing appropriate emotional support to the child, legal issues and management of inappropriate behaviors (Cohen & Mannarino, 1996). Child issues addressed included: appropriate and inappropriate touches, safety education, assertiveness training, ambivalent feelings toward the perpetrator, attributions regarding the abuse, regressive and inappropriate behaviors, and fear and anxiety (Cohen & Mannarino, 1996). The NST model was designed to avoid addressing sexual abuse issues with children or parents. The child intervention appeared to utilize play therapy. For both parents and children, NST was designed to provide support, rapport, and encouraged expression of feelings by using reflective listening, empathy, clarification, support, and encouragement (Cohen & Mannarino, 1996).

The authors required parents to complete the Child Behavior Checklist, the Child Sexual Abuse Inventory and the Weekly Behavior Report to measure emotional and behavioral symptoms. A within-group comparison of pre- to post-treatment outcome measures showed that the CBT-SAP group was less symptomatic following treatment than the NST group. Repeated-measures analysis of variance was conducted to

evaluate Group X Time interaction. Statistically significant interaction in favor of CBT-SAP was found on two of the four CBCL broad-band factors, Total behavior problems and Internalizing behavior problems scales. A limitation to this study was a question regarding whether change was due to cognitive-behavioral therapy adapted for sexually abused pre-school children or solely the parent intervention, due to both children and parents receiving CBT-SAP simultaneously. The authors also asked parents to complete a Client Satisfaction Questionnaire and concluded that both groups of parents were equally satisfied with the treatment they received and that there was no difference in satisfaction between the groups (Cohen & Mannarino, 1996, p. 48). This study provided support to the significance of including parents in treatment for this population.

Cohen and Mannarino (1997) followed up with 43 of the 67 preschool children 6 to 12 months after the initial study in 1996. Parents were given the Child Behavior Checklist (CBCL), Child Sexual Abuse Inventory (CSBI), and Weekly Behavior Report (WBR) to measure symptoms. The authors ran repeated-measures analyses and found that CBT-SAP intervention was superior to NST for symptomatic improvement over time. However, they found no significant Group x time interaction on the CSBI. The authors reported that the study lends support toward therapy that directly discusses the abuse and has longer effectiveness at reducing symptoms than the therapy that does not address abuse issues directly or ever (Cohen & Mannarino, 1997, p.1235). The authors argued that parental involvement in the treatment is impactful in the CBT-SAP intervention and as effective as working with the child in reducing symptomatology (Cohen & Mannarino, 1997). The authors reported CBT-SAP was superior to NST at a

one year follow up from the initial study with preschool children who have been sexually abused and their non-offending parent.

Cohen and Mannarino (2000) randomly assigned 49 sexually abused children, ages 7-14 years of age, to either abuse-focused cognitive behavioral therapy or nondirective support therapy for 12 weeks. They concluded that addressing the child's sexual abuse related cognitions and including the non-offending parents in treatment significantly predicted treatment outcome (Cohen & Mannarino, 2000, p. 992). The authors reported a very large dropout rate and a high number of children acting out inappropriately led to non-conclusive results (Cohen & Mannarino, 2000, p. 992). The authors predicted problems with their study due to the children being older than in previous studies they completed with preschool aged children. Also, they reported that the children were more impacted by their own cognitions and perceptions of the abuse compared to younger children.

Cohen, Mannarino, Knudsen (2005) measured the improvement of 82 sexually abused children, ages 8-15 years old, in response to two treatments, trauma-focused cognitive-behavioral therapy (TF-CBT) and non-directive supportive therapy (NST). In a one year follow up, the authors found that the TF-CBT treatment intervention had significant effects on measures of depression, anxiety, and sexual problems. Among the 49 who completed the 6 and 12 months follow ups, the TF-CBT group had greater improvement, but not statistically significant, than the NST group on the Child Sexual Behavior Inventory. Cohen et al. (2005) concluded that TF-CBT is superior to NST due to having longer lasting effects of reducing symptoms associated with depression, anxiety, and sexual problems evidenced from the 6 month and 12 month follow up

improvement in mean differences. However, over time the authors noted most instruments demonstrated significant time effects and suggested children significantly improved over time in both groups.

PTSD is a frequent diagnosis for children traumatized by sexual abuse. King, Tonge, Mullen, Myerson, Heyne, Rollings, and Ollendick (2000) focused on cognitive behavioral therapy (CBT) for sexually abused children that meet criteria for PTSD. They proposed that CBT was effective due to the structured interventions focused on abuse related issues (p. 373). The author's model included coping skills training, social skills training, graded exposure, and education and prevention program. King et al. (2000) emphasized the parent involvement in intervention programs and stated, "However, the involvement of the non-offending parent or caretaker is usually essential for optimum therapeutic results" (p. 369). In family interventions, King et al. (2000) suggested development of family communication skills and behavior management skills used at home to help the child cope (p. 369).

Treatment for the child and non-offending parent begins the healing process and allows the child to start dealing with the trauma. Carr (2004) reviewed literature for treatment outcome of studies on PTSD and childhood sexual abuse survivors. Carr (2004) concluded programs that included psycho-education, skills training, safety skills training, behavioral parent training were most effective in alleviating PTSD, anxiety, depression, and adjustment problems (p. 236).

Play Therapy as an Early Intervention for Sexually Abused Children

Eliana Gil (1991) described the positive effects of an 8 year old named Sharlene

whose mother died of an overdose when she was 2 years old and since that age the biological father, a convicted felon, molested her and allowed various other men to sexually molest her while taking pornographic pictures. After 9 months of play therapy intervention, Sharlene's foster parents described her as, "happier, less sullen child, who made friends, joined the basketball team, and attended school more willingly" (p. 191). Also Gil (1991) stated, "She had nightmares and periods of staying in her room alone, but overall she seemed to have greater self-confidence and communicated more freely when she felt upset" (p. 191). Gil explained that a child who has been sexually abused can regain self-confidence and control over self through play therapy.

Child-Centered Play Therapy

Virginia Axline, a student of Carl Rogers, applied his non-directive approach to working with children and developed child-centered play therapy. Axline (1947/1969) stated, "Play therapy is based upon the fact that play is the child's natural medium of self-expression" (p. 9). The purpose of play therapy is to allow children the conditions and relationships needed to release their inner world in an expressive way that is appropriate for their cognitive and emotional development. Axline (1947/1969) stated, "Since play is his natural medium for self-expression, the child is given the opportunity to play out his accumulated feelings of tension, frustration, insecurity, aggression, fear, bewilderment, confusion" (p. 16).

From a child-centered play therapists' perspective, development of the therapeutic relationship is the means for therapeutic process. Self-directed play and the relationship are the vehicles of change, toys are the children's words and play is their

language (Landreth, 2002). According to Landreth (2002), the purpose of play and process of change occur within the child. Landreth (1993) stated, “The relationship that develops and the creative forces this relationship releases in the child generate the process of change and growth for the child” (p. 20). Therefore, the child through play in a safe environment awakens his or her inner ability to self- direct and self- evaluate (Moustakas, 1997). The purpose of play is for children to rediscover their inner wisdom and use their inner voices to deal with the unpredictable world around them.

The therapeutic relationship is crucial in child-centered play therapy and the therapist’s role is to communicate; “I am here,” “I hear you,” “I understand,” and “I care about you” (Landreth, 2002). The therapist has a non-judgmental and accepting way of being, trusts the child’s intrinsic motivation toward self-actualization, and more importantly understands the child’s perception of reality with respect (Landreth, 1993). Landreth (2002) stated, “Feeling in control is a powerful variable and helps children develop positive self-esteem” (p. 175). Play therapy provides a safe and secure environment for children.

Research on Child-Centered Play Therapy

According to Bratton, Ray, Rhine, and Jones (2005), a meta-analysis of 93 play therapy outcome studies supports play therapy as an effective intervention for children (ES = .8). Humanistic approaches, primarily child-centered and non-directive play therapy, were shown to have greater effect compared to non-humanistic, directive approaches, including behavioral therapies (Bratton et al., 2005). CCPT research has demonstrated increased self-esteem, decreased internalizing problem behaviors, and

decreased externalizing problem behaviors with many populations including child witnesses of domestic violence and sexual abuse (Costas & Landreth, 1999; Kot, Landreth, & Giordano, 1998; Tyndall-Lind, Landreth, Giordano, 2001; Bonner, Walker, Berliner, 1999; and Reyes & Asbrand, 2005).

Kot, Landreth, and Giordano (1998) measured the effectiveness of intensive CCPT with child witnesses of domestic violence who were residents in a domestic violence shelter with their mothers. The children were randomly assigned to either the control group or the experimental group. There were 11 children in the control group and 11 children in the experimental group that lived in the shelter for a minimum of 2 months. The children in the experimental group received 12, 45 minute sessions of individual CCPT in a period of 12 days to 3 weeks. The experimental group demonstrated significant improvement in self-concept, significant reduction in externalizing behavior problems, a significant reduction in total behavior problems, and significant increases in the play behaviors of physical proximity and play themes (Kot et al., 1998). Kot et al. (1998) concluded that CCPT was an effective treatment with children who witnessed domestic violence.

Tyndall-Lind, Landreth, and Giordano (2001) studied the effectiveness of intensive sibling group CCPT with child witnesses of domestic violence. Following Kot et al.'s research design, they compared a sibling group intervention to Kot et al.'s (1998) individual CCPT intervention and wait-list control group. Participants were recruited from the same locations as the Kot et al. study, following the same procedures, and selected to match participant demographics. As in Kot et al., children received 12 sessions over a period of 12 days to 3 weeks. Compared to the control group, children in both

individual and sibling CCPT demonstrated significant reductions in total behavior problems and externalizing behaviors. Children in the intensive sibling group play therapy demonstrated a reduction in internalizing behavior problems, aggression, anxiety, and depression (Tyndall-Lind et al., 2001). According to the researchers, intensive sibling group play therapy was found equally effective as intensive individual child-centered play therapy (Tyndall-Lind et al., 2001).

Bonner, Walker, and Berliner (1993, 1999) worked with children who were identified with sexual problem behaviors. Bonner and colleagues developed a 12-session, cognitive-behavioral group treatment intervention that was compared to 12-session group CCPT intervention. Parents in both treatment groups participated in structured collateral parent groups. Bonner et al. (1993) found statistically significant reductions in parent-reported sexual behaviors for children in both child-centered and cognitive-behavioral treatment groups. In a recent 10-year follow-up using the entire sample and public sector databases, the authors found children from both treatment groups were no more likely than individuals in the general population to perpetrate any sexual abuse or other sexual offenses as adolescents and young adults. The National Crime Victims Research and Treatment Center recognized and identified play therapy as a supported and acceptable treatment based on Bonner, Walker, and Berliner's (2000) study (Saunders, Berliner, & Hanson, 2004).

Scott, Burlingame, Starling, Porter, and Lilly (2003) studied child-centered play therapy with children who had been sexually abused and its effects on their mood, self-concept, and social competence. Of 26 cases of children ages 3 to 9 years old participating in 10 sessions, there was no statistically significant difference for parental

reports. However, children reported positive impact on their self-esteem, including increased feelings of competency over time. The authors utilized the reliable change index formula and reported 8 children clinically improved over time of treatment. The authors postulated a larger sample size and longer treatment period to remediate the traumatic effects of sexual abuse were likely needed.

Reyes and Asbrand (2005) conducted a longitudinal study assessing the effects of humanistic play therapy, primarily child-centered, as primary treatment by assessing the positive changes of the symptoms commonly associated with childhood sexual abuse (p. 31). For nine months, 18 participants, ages 8 to 16 years old, received 50-minute individual play therapy sessions one time per week. The Trauma Symptom Checklist for Children (TSCC) was administered at the first session and the session in the ninth month. Reyes and Asbrand (2005) found, "Specifically, symptoms of anxiety, depression, post-traumatic stress and sexual distress demonstrated the greatest statistically significant change evidenced by the effect scores" (p. 35- 36). Limitations the authors reported were attrition rate of 38%, small sample size, and short duration of study. The authors suggested longer treatment and more individualized treatment models with childhood sexual abuse may be helpful in the future. Reyes and Asbrand (2005) reported other contributing factors not measured in this study but that could have played a role in the results are circumstances of disclosure, family dynamics, disposition of the court case, change in family unit, or housing. The authors did not mention the involvement or interventions offered for the non-offending parent.

Child-Parent Relationship Therapy (CPRT)

Interventions that involve the non-offending parent are crucial for children who have experienced sexual abuse. CPRT, based on the principles of CCPT, has demonstrated a beneficial treatment effect on a variety of presenting issues in children and with varied populations of children and parents (Landreth & Bratton, 2006), including sexually abused children (Costas & Landreth, 1999).

History of CPRT

In the early 1960s, B. Guerney (1964) first wrote about an innovative idea for involving parents in children's therapy and called the approach, filial therapy. The goal of this new approach was to help children by improving the parent-child relationship. Guerney explained, "The technique uses parents as therapeutic agents with their own children" (p. 2). The parent learns to be a therapeutic agent through a didactic group process combined with training in CCPT skills to conduct play sessions with their children. Children's symptoms are released and expressed through play with their parents.

The goal of CPRT is to improve the parent-child relationship by strengthening their bond and healing the child's inner turmoil (Guerney, 1964). Guerney stated, "What we are training them to try to do during their session is to accept and understand their problems better" (p. 6). Change is viewed as occurring from the effect of the parent-child interaction. Fidler, Guerney, Andronico, and Guerney (1969) stated, "The children themselves are not seen in therapy; rather their parents are relied upon to effect changes with the support of the therapist and a group of other parents involved in the

same process” (p. 47). Parents are in control of providing therapeutic change for their child. According to B. Guerney (1969) the filial play sessions have three main objectives: 1) allowing the child to more clearly understand the parent’s feelings, attitudes, or behaviors toward him or her; 2) allowing the child to communicate thoughts, needs, and feelings to parents; 3) enhance the child’s self-respect, self-worth, and confidence.

Based on Guerney’s philosophy of filial therapy, Landreth (1991/2002) developed a more time limited and structured 10- session filial therapy model. The focus remained on strengthening the relationship between the child and parent. Landreth (2002) stated, “This relationship is viewed as the vehicle for the process of change. Therefore, the objective is to help the parent relate to the child in ways that will release the child’s inner directional, constructive, forward-moving, creative, self- healing power” (p. 370). CPRT was formalized by Landreth and Bratton (2006) with their text titled *Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model*. A treatment manual for the CPRT model was published by Bratton, Landreth, Kellum, and Blackard (2006). The manual provides a treatment protocol for each session, including the therapist’s notebook, study guide, and a parent notebook.

CPRT is a 10-session format of filial therapy in which a play therapist trains parents, typically in small group formats, to use child-centered principles with their children during weekly structured thirty-minute play sessions. The play therapist uses a variety of methods, including: instruction, role-playing, demonstration of play sessions, and supervision of parents’ play sessions to help parents. Parents learn reflective listening, recognition of children’s feelings, tracking responses, therapeutic limit setting,

and self-esteem building responses. Parents create an environment filled with nonjudgmental, understanding, and acceptance that enhances the parent-child relationship, thus facilitating personal growth and change for both child and parent (Landreth & Bratton, 2006).

Research in CPRT

CPRT has been thoroughly researched over the past 14 years and findings show strong support for its effectiveness as a treatment to alleviate children's mental health needs, reduce parental stress, and increase parental empathy toward their children. Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analysis investigating the overall treatment effect for play therapy and found a large treatment effect ($ES = .80$). They further analyzed the effect of studies involving parents using filial therapy methodology, the majority of which followed the CPRT protocol, and found an overall effect size of 1.15, compared to the calculated effect size for traditional play therapy involving child-only treatment ($ES = .72$). Landreth & Bratton (2006) conducted an analysis of only those filial studies that utilized the 10-session CPRT model and found an even larger treatment effect ($ES = 1.25$). These findings highlight the importance of parents and caregivers involvement in their child's healing process as a therapeutic agent.

CPRT has been researched in 34 controlled outcome studies examining its effect with a wide variety of presenting issues and populations. Findings supports the efficacy of CPRT for increasing parental acceptance, empathy, positive changes in family environment, and self-esteem; while decreasing parental stress and children's

behavioral problems (Landreth & Bratton, 2006; Rennie & Landreth, 2000). CPRT has also been researched and shown effective cross culturally with Native Americans (Glover & Landreth, 2000), immigrant Chinese (Chau & Landreth, 1997; Yeun, Landreth, & Baggerly, 2002; immigrant Koreans (Lee & Landreth, 2003; Koreans (Jang, 2000), and Israeli families(Kidron & Landreth, 2010). Recent studies have examined CPRT's effects with the growing population of low-income minority families, including African Americans (Sheely & Bratton, 2010) and immigrant Latinos (Ceballos & Bratton, 2010). CPRT has also been used successfully to help parents help their children recover from the aftermath of traumatic events such as witnessing domestic violence (Smith & Landreth, 2003), loss of parents through incarceration (Harris & Landreth, 1997; Landreth & Lobaugh, 1998) and hospitalization due to chronic illness (Tew, Landreth, Joiner, & Solt, 2002), and sexual abuse (Costas & Landreth, 1999).

CPRT has also been studied with children who witnessed family violence and at the time of the study resided in a domestic violence shelter. Smith and Landreth (2003) studied the effects of CPRT with 11 child witnesses of domestic violence and their parents compared to participants in two earlier studies with matched populations (Kot et al., 1998; Tyndall-Lind et al., 2001). The comparison groups consisted of individual CCPT and sibling group CCPT. Using procedure from the two earlier studies, Smith and Landreth conducted an intensive adaptation of the CPRT model over a period of three weeks. To fit the shelter's schedule they expanded the 10-session training protocol into 12 weeks. The authors indicated a statistically significant level of improved self-concept compared to the non-treatment comparison group. As assessed by blinded raters, mothers trained in CPRT showed an increase in their empathic interactions with their

children. Further, statistically significant findings revealed that mothers were effective in producing a comparable reduction in the problematic behaviors of their children compared to individual and sibling CCPT. The researchers concluded that mothers who have fled to a domestic violence shelter have the capability of becoming therapeutic agents in their children's life through CPRT treatment.

Harris and Landreth (1997) utilized CPRT with incarcerated mothers in a county jail. The incarcerated mothers were given special permission to be with their children of focus for 30-minute play sessions twice a week for a total of 5 weeks. Over a 1-year period, the researcher ran four CPRT groups of 4 to 10 mothers, twice a week for 2-hour sessions per week for 5 weeks. The authors indicated the results from the experimental group had a significantly lower mean total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than did the control parent group, which indicated an increase in empathic behavior (Harris & Landreth, 1997). Also, the experimental group attained a significantly higher mean total score for perceived acceptance of their children than the control group. The experimental group of mothers' perceived a significant reduction in the number of problems their children were experiencing (Harris & Landreth, 1997). The authors reported CPRT as an effective intervention for enhancing the parent-child relationship with incarcerated mothers and their children (Harris & Landreth, 1997).

Landreth and Lobaugh (1998) completed 10 weeks of CPRT with fathers incarcerated in a federal prison. They randomly assigned 32 men to the control group or the experimental group and their children ranged from 4 to 9 years old. The experimental group attended CPRT for one hour and a half per week for ten

consecutive weeks. Also the experimental group completed thirty-minute play sessions once per week in the prison. The control group visited their children with other family members in a large play area as usual. Landreth and Lobaugh (1998) found fathers in the experimental group scored significantly higher than the control group on the areas of acceptance, significantly lower for Total stress on the Parenting Stress Index (PSI), and significantly lower on the Parent Domain of the PSI compared to the control group (p. 161). Also, children of fathers in the experimental group had highly significant increases in their self-concept measured by Joseph Preschool and Primary Self Concept Scale. Landreth and Lobaugh (1998) stated, "Filial therapy can provide incarcerated parents with the skills necessary for healthy parent-child relationship" (p. 164). Children were able to bond with their incarcerated fathers, improve self-concepts, and develop stronger relationships with their fathers. CPRT is effective with different, confusing, overwhelming, and scary situations for children. Fathers incarcerated are separated from their families, removed from the home, and the children who visit the prison may feel scared, confused, and fearful.

Tew, Landreth, Joiner, and Solt (2002) studied CPRT with parents of children in a Children's Medical Center who were chronically ill. A total of 23 participants were divided into experimental group ($n=12$) and a control group ($n=11$). Results from analysis of covariance showed the experimental group scored significantly higher than parents in the control group on perceived acceptance measured by the PPAS, significantly lower on overall stress related to parenting on the PSI, and significantly lower on the child's behaviors measured by the CBCL (Tew et al., 2002, p. 90-93).

Costas and Landreth (1999) studied the effects of CPRT with 26 non-offending parents of children, between the ages of 5 to 9 years old, who had been sexually abused. Investigators assigned participants to the CPRT or wait list control group based on a convenience sampling method in which assignment was made based on geographic communities. The experimental group included 11 mothers, 2 fathers, and 1 grandmother. The control group consisted of 9 mothers and 3 fathers. The experimental group was divided into four smaller groups for treatment. Statistically significant between group differences results were found on parental acceptance, parental empathy, and parent-child stress. Specifically, results indicated that parents in the CPRT group reported a significant increase in their attitude of acceptance and a significant decrease in parent-child relationship stress. Further, objective raters blinded to the study reported that the CPRT group demonstrated statistically significant gains in their empathic interactions with their children compared to those assigned to the control group. The authors concluded that CPRT was effective in training parents to be a healing agent with their sexually abused child.

Costas and Landreth (1999) discussed considerations for applying CPRT with parents of children who have experienced sexual abuse. They recommended that practitioners and researchers allow more time for the emotional needs of this population of parents by slowing down the pace of the training and providing greater support. Allowing time before or after the CPRT session for parents who wish to attend and share more personal emotions and issues may be beneficial. Additional suggestions included researching the effects of a CPRT model that integrates an intensive support group to address unique needs and extending the training to 15 weeks. The authors'

also recommend further research could be done comparing the effectiveness of CPRT to other types of interventions commonly used with children who have been sexually abused.

The following two studies examined the effects of CPRT with low-income minority parents and children, a rapidly growing population of families in the U.S. Ceballos (2008) studied the effects of CPRT with 48 low income immigrant Latino parents and their children identified with clinical levels of behavioral problems. Participants were randomly assigned to CPRT or a wait list control condition. CPRT was modified to an 11 session model in response to cultural considerations. Results indicated that parents who participated in CPRT reported statistically significant decreases in children's externalizing and internalizing behavior problems as well as parent-child relationship stress compared to the control group over time. Large treatment effects were demonstrated for all dependent variables. Clinical significance of findings was demonstrated through 85% of children in the CPRT group moving from clinical to normal levels of behavioral concern and 62% of parents moving from clinical to normal levels of parent-child relationship stress. Findings were discussed in light of culturally relevant observations.

Sheely and Bratton (2010) studied CPRT with 23 low income African American parents and their children identified with clinical levels of behavioral concern. Participants were randomly assigned to CPRT or a wait list control condition. CPRT was modified to an 11 session model in response to cultural considerations. Results indicated that parents who participated in CPRT reported statistically significant decreases in child behavior problems and parent-child relationship stress compared to

the control group over time. CPRT demonstrated a large treatment effect on both dependent variables. The authors discussed cultural considerations for using CPRT with African American families.

Rationale for Using a Qualitative Approach with Play Therapy Studies

Qualitative analysis has been used in the counseling field to provide an in depth analysis of the process of counseling, client's issues and problems, and effectiveness of certain interventions. Corbin and Strauss (2008) reported qualitative analysis digs deeper and discovers themes underneath the surface material (p. 50). Associated with grounded theory in qualitative research, Corbin and Strauss (2008) stated, "It (qualitative research) presents description that embodies well-constructed theme's/ categories, development of context, and explanation of process or change over time" (p.50-51). Miles and Huberman (1984) who have been associated with phenomenological theory reported qualitative data is attractive and a source of well-grounded, rich description, and explanation of processes occurring in local contexts. Corbin and Strauss (2008) stated, "Being open to all possible meanings in data, as well as potential relationships between concepts, is very important early in analysis" (p. 53). Miles and Huberman (1984) stated, "We are interested in the idiosyncratic meanings people (including ourselves) develop, and we believe in the existence of lawful yet historically evolving relationships to be discovered in the social world" (p. 23).

Snow, Wolff, Hudspeth, and Etheridge (2009) reported qualitative research increases awareness of particular issues, provides a lens for viewing the researcher and participants in depth, and provides more understanding. Snow et al. (2009)

discussed the relevance of qualitative research in play therapy and provided critical considerations for case studies in play therapy. Glazer and Stein (2010) argued qualitative research is a natural extension of the therapeutic process and the basic conditions of genuineness, empathy, and positive regard. The authors reported the qualitative approach to research is particularly important to play therapists and how practitioners approach patients and the dialogue they have with them. The *International Journal of Play Therapy* has published numerous qualitative studies increasing the population of this method of research in play therapy (DeDomenico, 2002; Edwards, Ladner, & White, 2007; Glazer, 1998).

Foley, Higdon, and White (2006) interviewed and collected data on six parents who completed a modified CPRT model in 9 weeks with their preschool aged child. The authors used a qualitative method to provide the parents' evaluation of CPRT, with emphasis on specific components of the training, to contribute to CPRT research. Foley et al. (2006) found parenting stress decreased, stress due to personal awareness and efforts to apply the new skills appropriately increased, and intimacy in the relationship with the child increased. Foley et al. (2006) suggested future researchers need to include larger sample sizes, include participants from diverse backgrounds, and use interviewers who are not the trainers or co-leaders.

Edwards, Ladner, and White (2007) also completed a qualitative study on the effectiveness of CPRT with a Jamaican mother. The mother reported that the training helped her to increase parental empathy and awareness while strengthening the parent-child relationship (Edwards et al., 2007, p. 51). The implications cannot be generalized to all Jamaican mothers without further research, however, results indicated that CPRT

was effective in increasing parental empathy, decreasing stress, and increasing the parent-child relationship.

Garza, Kinsworthy, and Watts (2009) used a phenomenological approach to study CPRT with Hispanic parents. The authors asked a total of eight questions in their interview to examine the perceptions of the parents experience upon completing CPRT. Garza et al. interviewed a total of three participants and found all parents discussed changes in the child's behavior, changes in the parents towards their child, and changes in child-parent relationship including an increase in communication and warmth. The authors suggested CPRT resonates with the Hispanic culture in several respects: 1) value for children to show respect to their parents or *respecto*, 2) importance of a close-knit family system; and 3) the investment of time and shared stories with other Hispanic parents. Garza et al. concluded that the Hispanic parents in their study seemed to gain a more warm and cohesive relationship with their children and an increase in open communication. The authors cautioned that findings might have been influenced by researcher bias due to the co-leaders of the CPRT group also conducting the group interview.

Summary

Childhood sexual abuse is an epidemic impacting young children every day. Children are a minority and often do not speak out to the majority. Further, when children do speak, their outcries are often not heard nor reported. When a child chooses to disclose sexual abuse, adults must respond appropriately and supportively. Sexual abuse affects children emotionally, affects their academics, and impacts the parent-child

relationship. Effective interventions for mental health professionals to treat childhood sexual abuse are needed due to the rise of reported sexual abuse across the nation. CPRT has been found to increase parental acceptance, decrease stress related to parenting, decrease children's behavior problems, and increase empathic interaction between parent and child (Landreth & Bratton, 2006). More research on effective interventions for children who have suffered sexual abuse is needed. Research that examines the impact of abuse on children and their family dynamics and how those dimensions impact the suitability and effectiveness of an intervention would add to the understanding of the treatment needs of this population.

Purpose of the Study

This study focused on two main purposes of investigation. One purpose of the present study was to examine change in parent-child relationship, child behavior, and parent empathy of non-offending parents whose children have been sexually abused after participation in CPRT. A secondary purpose of this study was to explore subjective experiences of non-offending parents who participate in CPRT.

CHAPTER III

METHODS AND PROCEDURES

Research Questions and Assumptions

This study was a mixed-methods research design to investigate the experiences in child parent relationship therapy (CPRT; Landreth & Bratton, 2006) of non-offending parents of children who experienced sexual abuse. Interviews were conducted and data was collected from eight parents who participated in 11 sessions of CPRT. Using the CPRT curriculum, parents learned to use child-centered principles and procedures to conduct play sessions with their children in order to enhance the parent-child relationship. This study has incorporated quantitative data collection to examine participants change over time and qualitative analysis to report patterns and relationships to explore participants' experiences.

Smith (1984) discussed the controversy between quantitative and qualitative methods and reported mixing the two can be complementary to the problem at hand. Miles and Huberman (1984) reported a shift in researchers using both confirmatory and exploratory approaches simultaneously. Johnson and Onwuegbuzie (2004) stated, "Mixed methods research is formally defined here as the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study" (p. 17). Johnson and Onwuegbuzie (2004) reported collecting data using different strategies and mixing a mixture of data can result in complementary strengths and produce a product superior to monomethod studies. Benefits reported by Johnson and Onwuegbuzie (2004) include: 1) research today is complex and dynamic and many researchers need both

methods to complement one or the other; 2) more effective research; 3) research that closely resembles what is used in practice; 4) inclusion of induction (qualitative), deduction (quantitative), and abduction (relying on the best set of explanations for understanding one's results). Further benefits of using both methods include that researchers may enrich their results in ways that one form of data did not allow, can simultaneously generalize their results from a sample to a population and gain a deeper understanding of the phenomena of interest, and can test theoretical models and modify them based on participant feedback (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005). The goal of mixing data collection and analysis is to expand on the deeper meaning and understanding of the effectiveness of the interventions.

This mixed-methods study looked closely at eight non-offending parents of sexually abused children. Quantitative data was collected in the form of pre and post measurements. Semi-structured interviews provided qualitative data to explore themes and patterns from all participants. The qualitative data analysis consisted of three concurrent flows of activity: data reduction, data display, and conclusion drawing/verification. Discussed in this chapter are the following: research questions, definition of terms, participant selection, data collection procedures, instrumentations, details of treatment, and analyses of data.

The following research questions were addressed in this study:

1. Do non-offending parents of children who were sexually abused report improvement in child behavioral problems, parent-child relationship stress, and parental empathy after participation in CPRT?

2. What were the experiences of non-offending parents of children who were sexually abused regarding their participation and completion of CPRT?

Definition of Terms

For the purpose of this study, the following terms were operationally defined:

- *Child of focus*. Landreth and Bratton (2006) defined this term as: Parents are asked to select one child between the ages of 2 and 10 years that they will focus on during the 10-session training period (p.111). This child is typically referred to as the focus child or child of focus.

- *Child parent relationship therapy (CPRT)*. Landreth and Bratton (2006) defined this term 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)

- *Child sexual abuse (CSA)*. Children's advocacy centers (2008) define sexual abuse as sexual conduct harmful to a child's mental, emotional, or physical welfare, including conduct that constitutes the offense of indecency with a child, sexual assault, or aggravated sexual assault; failure to make a reasonable effort to prevent sexual conduct harmful to a child; compelling or encouraging the child to engage in sexual conduct; and causing, permitting, encouraging, engaging in, or allowing the

photographing, filming or depicting of the child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene or pornographic.

- *Empathy*. For the purpose of this study, empathy refers to parents' sensitivity to their children's current feelings and parents' ability to verbally communicate this understanding to the child. Empathy was operationally defined as the parents' Total scores on the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover et al., 1971).
- *Externalizing problem behaviors*. For the purpose of this study, externalizing problem behaviors is operationally defined as the overall score on the Externalizing Problems scale on the CBCL/1 ½-5 and CBCL/6-18. These behaviors for the CBCL/1 ½-5 includes: (a) Attention Problems, and (b) Aggressive Behavior. Externalizing Problems scale for CBCL/6-18 includes the following: (a) Rule Breaking Behavior, and (b) Aggressive Behavior (Achenbach & Rescorla, 2000).
- *Internalizing problem behaviors*. For the purpose of this study, internalizing problem behaviors is operationally defined as the overall score on the Internalizing Problems scale on the Child Behavior Check List (CBCL) /1 ½-5 and CBCL/6-18. These behaviors for CBCL/1 ½-5 include: (a) Emotional Reactive, (b) Anxious/Depressed, (c) Somatic Complaints, (d) Withdrawn (Achenbach & Rescorla, 2000). For the *CBCL/6-18* internalizing behaviors are as follows: (a) Anxious/Depressed, (b) Withdrawn/Depressed, and (c) Somatic Complaints (Achenbach & Rescorla, 2000).
- *Non-offending parent*. For the purpose of this study, a non-offending parent is operationally defined as a primary caregiver of the child that was not the perpetrator, or involved in the abuse of the child.

- *Parenting-child relationship stress.* For the purpose of this study, the Total score of the Parenting Stress Index (PSI) was used to measure overall parent-child relationship stress level (Abidin, 1995).
- *Parents.* For the purpose of this study, a parent is operationally defined as primary caregiver of the child, which may include biological parents, custodial, biological adult from the child's nuclear or extended family, custodial, non-biological parents and adopted parents.

Participants Selection

The sample for this study consisted of 8 non-offending parents seeking services from a local agency whose children disclosed sexual abuse. Participants were a sample of volunteer parents from a non-profit agency, a children's advocacy center (CAC) who serves clients that have been identified as abused and/or neglected. At this site, they reported serving nearly 2,500 abused children in 2008. More than half of CAC clients were under 9 years of age and 82% were victims of sexual abuse. In 2008, state officials investigated 18,000 cases of child abuse in the local county, confirming 5,4000 victims of severe sexual and physical abuse. This CAC houses nearly 60 trained professionals under one roof, including the police department's child abuse unit, a child protective services sex abuse unit, an assistant county district attorney, and 35 CAC staff members.

Human subjects approval from the University of North Texas Institutional Review Board was obtained prior to contacting potential participants. The clinical director at CAC was contacted to discuss potential benefits of providing CPRT with this population.

Permission was obtained from the director of clinical services and she provided referrals for the study based on the following criteria for participants:

1. Parents or guardians reported their child, between 3-12 years of age, experienced sexual abuse by someone other than themselves.
2. Non-offending parent or guardian had been referred or expressed interest in a parenting group.
3. Non-offending parent or guardian consented to participate in CPRT.

The clinical director identified a list of eligible parents who were referred to CAC and met criteria. She then contacted parents to let them know about the parenting groups in the study, the date and time of the first meeting, and my contact information. I did not conduct any extra measures of recruitment for this study above and beyond what recruitment measures were already in place for obtaining clients at the CAC. Child Protective Services and the local police department typically refer the majority of clients to counseling services at CAC. The CAC currently offers individual and group play therapy and an abbreviated model of CPRT to parents, and many parenting support groups. I was available to meet the parents in person on a designated day to go over the purpose of the study, explain an overview of the study, answer questions, and administer and collect informed consent from each participant. A Spanish-speaking therapist conducted the same informational recruiting meeting with the Spanish-speaking participants on a weekday evening. I clarified that other CAC counseling services were not impacted by the parent's participation or refusal of participation in this study. Parents who expressed interest in participating were given an informed consent form (Appendix A) and it was explained to each of them. Parents who did not meet the criteria to participate were allowed to attend the sessions of their choice and services were not denied to unqualified participants. These parents were offered the same

opportunity to participate in CPRT or other parenting groups as standard services of CAC. Parents who met criteria and completed an informed consent were asked to complete pre-testing instrumentation. Parents were offered a quiet setting to complete pretests and free child-care was offered for the children waiting. Parents were also asked to complete a 30-minute video recorded pre-play session with their child at CAC in one of their playrooms.

Participants who completed pre-testing data ($N = 12$) chose to participate in either English CPRT group ($n = 6$) or Spanish CPRT group ($n = 4$). The researcher offered CPRT in both Spanish and English to allow the parents to choose the group in which they felt most comfortable. Although twelve Spanish and English speaking participants consented to participate in CPRT, eight participants in total completed CPRT ($N = 8$). The Spanish CPRT group had four participants ($n = 4$). The English CPRT group had four participants at completion ($n = 4$). Interventions were conducted at the CAC for 11 weeks, 1.5-2 hours per week. Parents were divided into small groups in keeping with CPRT methodology (Bratton et al., 2006). Participants were compensated with money if they completed the entire 11 weeks of sessions, post tests, and semi-structured interview.

Individual Descriptions of Participants

In the following section each participant is described in detail.

Participant 1: Patty is a 23- year-old Hispanic female, speaks English primarily, and has 4-year-old and two year old biracial daughters. Patty works full time and raises her two daughters alone. Her 4-year-old daughter was at Patty's cousin's home when

her cousin's boyfriend allegedly sexually abused the girl by penetrating her vagina with his fingers. When her daughter disclosed to Patty, she was taken to a local hospital for an examination and referred to CAC. Her daughter received individual play therapy sessions for approximately one year with a counselor and was terminated. Patty was referred to CPRT. The four- year- old was Patty's child of focus and Patty completed the English CPRT.

Participant 2: Amanda is a 33-year-old Hispanic female whose primary language is English. She has two daughters, a 14-year-old and a 12-year-old. Amanda is divorced from her daughters' father. She is a single mother, works full time, and is completing undergraduate coursework. Amanda's 12-year-old daughter was at her father's when she was sexually abused by her father's brother. Amanda was referred to CAC by police and both of her daughters were concurrently in individual and group therapy sessions for a few months. Amanda was referred by her daughter's CAC therapist to CPRT and her child of focus was her 12-year-old. Amanda was in the English CPRT group.

Participant 3: Natalie is a 33-year-old African American female who speaks English and has one 9-year-old daughter and two sons ages 14 and 4. Natalie is divorced, a single mother of three, fully employed in technical support, and currently taking undergraduate classes at a local college. Natalie's 9-year-old daughter was sexually abused by Natalie's mother's boyfriend. Natalie was referred to CAC and her daughter was concurrently in individual play sessions beginning the same time as CPRT. Natalie was referred to CPRT by her daughter's therapist and her child of focus was her nine- year- old. Natalie was in the English CPRT group.

Participant 4: Katy is a 29-year-old African American woman whose primary language is English and has two children, a 6-year-old son and an 8-year-old daughter. Katy works full time, is enrolled in undergraduate classes, and is remarried. Katy has battled for custody of her two children with their father and he has alleged that her current husband sexually abused her 6-year-old girl. Katy was referred to CAC and her daughter was concurrently in individual play therapy sessions for the past few months. The CAC therapist referred Katy to CPRT and her child of focus was her 6-year-old daughter. Katy was in the English CPRT group.

Participant 5: Gloria is a 40-year-old Hispanic mother, speaks primarily Spanish and has a daughter who is 12 years old and older siblings. Gloria is separated from her spouse, employed full time, and a single mother. The 12-year-old experienced sexual abuse by Gloria's significant other and Gloria was referred to CAC. Gloria received two individual sessions prior to CPRT and her daughter received four individual sessions. Gloria's daughter was concurrently in individual play therapy sessions. Gloria was referred by the CAC therapist to CPRT. Gloria was in the Spanish CPRT group and her child of focus was her 12-year-old daughter.

Participant 6: Mary is a 28-year-old Hispanic mother who speaks Spanish and has an 11-year-old daughter. Mary is married and works full time. Mary's 11-year-old daughter experienced sexual abuse by her maternal uncle and was referred to CAC. Mary received 23 group support sessions and her daughter received 5 individual play sessions. Mary's daughter was concurrently in individual play therapy sessions. She was referred to CPRT when she completed support group. She was in the Spanish CPRT group and her child of focus was her 11-year-old daughter.

Participant 7: Sylvia is a 45-year-old Hispanic mother, speaks primarily Spanish, and has eleven children. Sylvia is separated and a single mother. Sylvia has a 12-year-old daughter who experienced sexual abuse by Sylvia's significant other and they were referred to CAC. Sylvia's daughter received group therapy sessions for four months prior to her mother starting CPRT and continued group therapy sessions concurrently. Sylvia had not received any services at CAC prior to CPRT. She was referred to Spanish CPRT group by her daughter's CAC therapist and her child of focus was her 12-year-old daughter.

Participant 8: Cathy is a 32-year-old Hispanic mother, speaks primarily Spanish, and has two daughters 9 and 3 years old. Cathy is separated and works full time. Cathy's 9-year-old daughter experienced sexual abuse by Cathy's friend and was referred to CAC. Cathy received support group sessions and her daughter received individual play therapy sessions for one year and was concurrently in individual play therapy. Cathy completed 5 months of parent support group prior to CPRT and was referred to CPRT by her CAC therapist. Cathy was in the Spanish CPRT group and her child of focus was her 9-year-old daughter.

Procedures and Instrumentation

Due to the nature of the research question, this study required a mixed-methods procedure. Quantitative and qualitative procedures were utilized to address research questions. The following section describes quantitative instruments and procedures of data collection. The second section addresses the qualitative semi-structured interviews and procedures.

Research Question 1: Do non-offending parents of children who were sexually abused report improvement in child behavioral problems, parent-child relationship stress, and parental empathy after participation in CPRT?

Quantitative Instrumentation

Child Behavior Checklist – Parent Version (CBCL). The Child Behavior Checklist (CBCL) instrument provides a measure of parents' view of the child's school and social competencies, behavior functioning, and problems. This instrument uses a Likert scale that gives respondents three possible answers (0) *not true*, (1) *sometimes true*, and (2) *very true* on a total of 99 items that describe children's different behaviors. The CBCL takes approximately 15 minutes to complete. The CBCL is composed of seven syndrome subscales. There are two versions of this instrument that fall into one of the two categories: 1) 1 ½- 5 year olds, and 2) 6-18 year olds.

The syndrome subscales are categorized into one of the following two categories: Internalizing Problems or Externalizing Problems. Achenbach and Rescorla (2000) defined Internalizing Problems as consisting of children's behavioral problems that are dealt with and expressed internally. The Internalizing Problems syndrome subscale for the 1 1/5-5 year old version include the following subscales: (1) Emotionally Reactive, (2) Anxious/Depressed (3) Somatic Complaints, and (4) Withdrawn. Achenbach and Rescorla (2000) defined Externalizing Problems as behaviors that affect children's relationships with others, in addition to other's expectations of children. The Externalizing Problems syndrome subscales for 1 ½-5 year old version include: (1) Attention Problems, and (2) Aggressive Behavior. Sleep Problems is an additional syndrome scale that is not included in either the Externalizing

Problems scale or the Internalizing Problems scale, but is included under the Total problem scale. A decrease in scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2000).

The Internalizing Problems scale for the 6-18 year old version consists of the following subscales: (1) Anxious/ Depressed, (2) Withdrawn/Depressed, and (3) Somatic Complaints. The Externalizing Problems Scale for the 6-18 year old version includes the following subscales: (1) Rule Breaking Behavior, and (2) Aggressive Behavior. Social Problems, Thought Problems, and Attention Problems are additional syndrome subscales that are not included in either the Externalizing Problems scale or the Internalizing Problems scale.

The CBCL results for both age versions provide scores for each syndrome subscale in addition to scores for the following domains: (1) Internalizing Problems scale, (2) Externalizing Problems scale, and (3) Total Problems. For both versions of the CBCL, a decrease in syndrome scores indicates improvement in the targeted behavior and for the 6-18 year old version an increase in competency scores indicates improvement in the targeted areas (Achenbach & Rescorla, 2000). Scores fall into one of the three ranges: normal, borderline, and clinical. The target child's scores are compared to a normed sample of children who are of the same age to determine if the child's behavior for a specific area is within one of the three ranges. Normal scores are reflective of areas not in need of attention or concern. Borderline scores reflect an area of concern but not immediate professional attention. Clinical scores indicate areas of clear need for intervention.

Achenbach and Rescorla (2000) reported internal consistency for the scales by calculated Cronbach's alpha. All show good internal consistency specifically: 1) Competence scores had alphas of .63 to .79; 2) Problem scales had alphas .78 to .97; and 3) DSM-scales had alphas .72 to .91. Test-retest reliability for the CBCL was high, with most correlations falling between .80 and .90 (Achenbach and Rescorla, 2000).

Spanish Version Child Behavior Checklist – Parent Version (CBCL). The normative population for the CBCL was based on a diverse sample, including children referred for clinical and special education services, and children enrolled in various preschool, prekindergarten, and childcare settings. Children were residents of the United States, Canada, Australia, and Jamaica. The mean score of the test-retest reliability for the CBCL is strong ($r = .85$). The test-retest reliability for each syndrome subscale of the CBCL is as follows: Emotionally Reactive ($r = .87$); Anxious/Depressed ($r = .68$); Somatic Complaints ($r = .84$); Withdrawn ($r = .80$); Sleep Problems ($r = .92$); Attention Problems ($r = .78$); Aggressive Behavior ($r = .87$); Internalizing Problems ($r = .90$); Externalizing Problems ($r = .87$); and Total Problems ($r = .90$). The content validity of the problem scales were strong, as was supported by research that determined that all, but two items, discriminated between referred and non-referred children. The criterion-related validity of the problem scales was also supported by the differentiation between referred and non-referred children (Achenbach & Rescorla, 2000).

Parenting Stress Index (PSI). The Parenting Stress Index (PSI; Abidin, 1995) measures the degree of stress a parent experiences in raising her/his child. The PSI is designed to identify parent-child systems that are under significant stress and at-risk for problematic parent and/or child behavior. The PSI can be used with parents of children

ranging from 1 month to 12 years. This instrument uses a Likert-type scale on a total of 120 items, which takes approximately 20 minutes to complete. The PSI is divided into three domains, the Child Domain, the Parent Domain, and Life Stress.

The Parent Domain measures parent's perceived competency, level of isolation, level of attachment to the child, parental health, restrictions imposed by parental role, depression, and relationship with spouse. The seven subscales on the Parent Domain indicate stress in the parent-child relationship and include the following: (1)

Competence: High scores on this subscale may be due to younger parents, parents who lack child development knowledge, and parents who do not find the role of parent as reinforcing as expected, (2) Isolation: High scores on this subscale indicate considerable stress due to the parents' perception of being socially isolate from their spouse, peers, relatives, and emotional support system, (3) Attachment: High scores on this subscale indicate the parent does not feel emotionally connected with the child or that the parent has difficulty understanding the child's feelings and/or needs accurately, (4) Health: High scores are suggestive of poor health that may be the result of either parenting stress or stress in the parent-child relationship, (5) Role Restriction: High scores on this suggest that the parents experience the parental role as restricting and in turn frustrates the parents to maintain their own identity, (6) Depression: High scores are indicative of the presence of depressive symptoms, (7) Spouse: Parents who earn high scores are those who lack emotional support of the other parent in the area of child care (Abidin,1995).

The Child Domain measures parent's perceptions towards level of child's distractibility and/or hyperactivity, child's ability to adapt/adjust to situations, level of

positive reinforcement parent experiences from the child, child's demandingness, child's mood, and parental acceptability of the child's characteristics. The Child Domain is representative of the following six scores according to Abidin (1995): (1)

Distractibility/Hyperactivity: High scores on this subscale appear to be associated with (a) children displaying behaviors associated with attention deficit disorder with hyperactivity, (b) parent lacking energy to keep up with a normal child, (c) older parents having difficulty adjusting, or (d) unreasonable parental expectations for development level, (2) Adaptability: High scores on this subscale are associated with the child's difficulty to adjust to change in their environment, (3) Reinforces Parent: High scores on this subscale indicate parent's lack of positive reinforcement as a result of parent-child interactions, (4) Demandingness: High scores indicate the parent experiences the child engaging in such behaviors as crying, physically hanging on to the parent, or frequently requesting help, (5) Mood: High scores are associated with the children who cry frequently and display minimal signs of happiness, (6) Acceptability: High scores on this indicate that the child possesses characteristics that do not match parental expectations for the child. PSI offers a Total Stress score that combines Child Domain and Parent Domain scores. Clinical scores are determined at or above the 85th percentile.

Score reliabilities, coefficient alpha, have ranged from .55 to .80 for both the Parent and Child Domain. Combined domain level reliability is reported at .89 and .93 for Parent and Child Domain scores. Total Stress score reliability was .95. Test-retest reliability was reported at .63 for Child Domain, .91 for Parent Domain, and .96 for Total Stress scores over one to three months (Abidin, 1995).

Parenting Stress Index – Spanish Version (PSI). The Parenting Stress Index (PSI) Spanish version is directly translated from the PSI English version. The norm sample for the PSI consisted of 2,633 mothers with an average age of 30.9 years. The participation of ethnic groups in this sample was as followed: 76% White, 11% African American, 10% Hispanic, and 2% Asian. The children of focus for this sample varied in age from 1 month to 12 years. Coefficients for test-retest reliability were obtained from four different studies. For Parent Domain, coefficients ranged between .69 and .91. For Child Domain, coefficients ranged between .55 and .82. For Total Stress score, coefficients ranged from .65 to .96. The instrument has been validated with diverse populations in the United States as well as in other countries. The Spanish version of the PSI has been validated in three different studies (Solis & Abidin, 1991). The instrument has also been validated with at-risk populations including battered women, negligent mothers, parental drug exposure, teenage parents, and families at-risk for parenting problems.

Measurement of Empathy in Adult-Child Interaction (MEACI). Measurement of Empathy in Adult-Child Interaction (MEACI) is a rating form adapted by Bratton (1993/1994) from a scale developed by Stover et al. (1971) to operationally define empathy as related to parent-child interactions. This direct observational scale measures three specific parental behaviors: (a) communication of acceptance; (b) allowing the child self-direction; and (c) involvement (Jones, Rhine, & Bratton, 2002, p.48). These three behaviors are identified as major aspects of empathy in adult-child interactions, and when combined, provide a total empathy score. Lower scores indicate higher levels of positive behavior in the subscales and total scores.

The Communication of Acceptance subscale measures the parent's verbal expression of acceptance-rejection of the child's feelings and behavior during spontaneous play sessions. The dimension of acceptance is viewed as a necessary condition for optimal development in the child's self-worth and a major element in the communication of empathy (Stover et al., 1971). The Allowing the Child Self-Direction subscale measures the verbal expression of acceptance and the behavioral willingness on the part of the parent to follow the child's lead rather than attempt to control the child's behavior (Stover et al., 1971). The Involvement subscale measures the parent's attention to and participation in the child's activity. Stover et al. (1971) found that parents who exhibited high levels of communication of acceptance and allowed their child self-direction also demonstrated high levels of involvement.

The MEACI is a 5-point bipolar scale used to rate the three dimensions of parental behavior every 3 minutes for six consecutive coding intervals. The scale ranges from a high rating of 1 to a low rating of 4. Each point on the scale is followed by typical responses obtained from coding of the direct observations of parent-child interactions. Considering the three subscales together as components of empathic behavior, the highest levels of empathy are evident when the parent is commenting frequently on the child's expression of feeling or behavior in a genuinely accepting manner; is clearly demonstrating that the child is fully permitted to engage in self-directed activity, and is attentive to the child's behavior. The lowest level of empathic communication is one in which the parent is verbally critical and rejecting of the feelings or behaviors of the child; demandingness and continually redirects the child's activity, and is self-involved, preoccupied, or shut off from the child.

Reliability coefficients were established for each of the three subscales in the development of the MEACI (Stover et al., 1971). After four training sessions for collaborative rating on a half hour play session, followed by discussions, six pairs of coders independently rated 7 to 10 parent- child play sessions of 20 minutes each. The average reliability correlation coefficient for the Communication of Acceptance subscale is strong ($r = .92$), the Child Self- Direction subscale had a median correlation coefficient ($r = .89$), and the Parental Involvement subscale had an average coefficient ($r = .89$) (Stover et al., 1971). Highly significant increases, at the .0005 level, between the pre-training and first post training play session were obtained on each subscale and for the total empathy. Construct validity had a significant increase at the .01 level, between the first and third post training play sessions, and demonstrated the scales are extremely sensitive measures of empathic behaviors. Concurrent validity established by a .85 correlation at the .005 level between the MEACI and a previously developed empathy measure for adult-child interaction (Guerney, Stover, & DeMerrit, 1968).

Several studies examining the impact of child parent relationship therapy (CPRT; Landreth & Bratton, 2006) have used the MEACI to measure adult-child empathy and have reported inter-rater reliability (Bratton & Landreth, 1995; Brown, 2003; Costas, 1999; Crane & Brown, 2003; Elling, 2003; Ferrel, 2004; Hess, 2004; Jang, 2000; Kidron, 2004; Lee & Landreth, 2003; Robinson, 2003; Smith & Landreth, 2004; Smith, 2002; and Yuen, 1997). Findings across studies and reported reliability coefficients in the following ranges: between .728 to 1.000 for Total Empathy; between .740 to 1.000 for Communication of Acceptance .88; between .453 to .999 for Allowing Self-Direction; and between .580 to 1.000 for Parent Involvement. In a more recent study, four raters

participated in a blind coding process to obtain inter-rater and intra-rater reliability on coding experimental (CPRT trained teachers) and control (Conscious Discipline trained teachers) from Morrison's (2006) study. Raters had no knowledge of study details or participants' group assignment (Bratton, personal communication, August 15, 2009). For inter-rater reliability, four raters rated six video segments of play session at pre-rating training until they achieved a pre-established acceptable level of reliability ($> .80$). Mid-point and post-rating reliability training sessions were held to ensure the established inter-rater reliability criteria was maintained. Intra-rater reliability was established at the end of the study by asking raters to score a video that they had previously rated to ensure rater's internal consistency ($r = .90$). Pearson Product Moment Correlation Coefficients were calculated to obtain the reliabilities on Total Empathy (.933), and its three subscales, Communication of Acceptance (.967), Allowing Self-Direction (.988), and Parental Involvement (1.00), which indicated a very high consistency of raters' ratings across time.

Quantitative Procedures

Once IRB approval and parental consent were obtained, the investigator administered the CBCL and PSI to parents prior to treatment. The investigator was present during all stages of data collection to ensure data integrity. Further, parents completed assessments in a controlled environment, free from distractions. Free childcare was offered at CAC during pretest, group sessions, and posttests including post interviews. The researcher offered parents the opportunity to complete documents by themselves or through "interview style" to accommodate for parents who may be

illiterate. During the initial assessment phase, the investigator met with parents to gather informed consents, CBCL, PSI, and also video record the parent and child playing together for MEACI scoring.

The CBCL and PSI were administered again immediately following treatment utilizing same procedures used at pretesting. The investigator video recorded the parent-child dyad in the CAC playrooms. Free childcare at CAC was offered while parents completed the post-CBCL and the post-PSI. Four blind raters were trained and supervised in rating procedures for MEACI to code pre and post video recordings for each parent-child dyad. Two of the raters were beginning doctoral students and two were advanced doctoral students. All raters had master's degrees in counseling and have taken at least one class in play therapy and one CPRT class at the local University. All raters specialized in play therapy and had clinical experience in play therapy and CPRT. The raters were blinded to the study, participants, and whether they were viewing pre or post video recordings. The researcher used Stemler's (2004) 70% benchmark and procedure for calculating and interpreting consensus estimates of interrater reliability (i.e. percentage agreement estimates). Percentage agreement scores were calculated through dividing the total number of agreements by the total number of observations and multiplying by 100. Agreements were defined as ratings that fell within one point of the mode or most frequently occurring rating. For the pre-rating training session, raters attained 100% agreement across all data. For the mid and end point rating sessions, raters achieved a 94% and 96% agreement, respectively. Hence, raters demonstrated a high level of interrater reliability throughout the rating period. Intrarater reliability is an estimate of how consistent a rater is with his or her own

ratings across time. Intrarater reliability was established by obtaining two separate ratings for a single video recorded play session. Previously scored video recordings were randomly selected by the researcher and re-assigned to the raters. To ensure independence of ratings, the second scoring of the selected video was conducted several weeks after the first scoring. Raters attained intra-rater reliability coefficients ranging from .977 to .998, indicating a high level of with-in rater consistency.

To ensure confidentiality, participants were assigned random code numbers for use in all data collection, analysis and interpretation. Participants were also given different names to ensure their individual identity remained confidential. Data was stored in a locked filing cabinet in a secure location.

Research Question 2: What were the experiences of non-offending parents of children who were sexually abused regarding their participation and completion of CPRT?

Qualitative Instrumentation

Semi-structured interviews were completed with all participants. A semi-structured qualitative interview was used to explore themes and patterns related to the experiences with non-offending parents of children who have been sexually abused and participated in CPRT. The researcher developed the interview questions in consultation with a faculty advisor who co-authored CPRT text and manual. Open-ended questions were asked to allow participants to elaborate on their personal experiences without restrictions, thus controlling for expectations and allowing for unexpected findings. Participants were asked to discuss changes in their child, themselves as a parent, and the parent-child relationship after completing the intervention. Also parents were asked to talk about their experience with the skills/ techniques; most helpful, least helpful,

easiest to use and most difficult to use. The parents were also asked to discuss aspects of the parenting group they found most helpful, least helpful, and suggestions. Specific interview questions can be found in Appendix B. A Hispanic Spanish-speaking master's level LPC and NCC who is Hispanic conducted the four Spanish interviews. The researcher is a Caucasian master's level LPC and also conducted the four English interviews. A hired Spanish translator translated the four Spanish participant's interviews directly word from Spanish to English. Through the use of qualitative interviews, I hoped for new insights relating to the experiences in CPRT with this population.

Qualitative Procedures

All participants were asked to schedule a 1-hour post interview with the Spanish-speaking licensed professional counselor (LPC) or English-speaking LPC who served as the researcher as well. All participants completed the qualitative interview and free childcare was offered as well as money for completion. Three trained coders reviewed the qualitative data for themes and patterns. All coders were advanced doctoral students in their third or fourth year and all had a master's in counseling. Two coders were LPC interns, completed several play therapy courses at the university and had clinical experience in child-centered play therapy and CPRT. The other trained coder was a LPC, completed one class in child-centered play therapy, and had clinical experience in play therapy but none in CPRT. The three coders received all transcripts and read all data. Themes were considered reliable when agreed upon by all three doctoral level coders at an acceptable mean agreement of 85% (Bakeman & Gottman,

1986), after which the researchers finalized the coding manual. The researcher conducted the last round of data analysis using the finalized coding manual. To ensure continued intercoder agreement, all three researchers independently coded all 8 interviews (100% of the data). Intercoder mean agreement was 91%, which fell in the acceptable range from 85% to 93% (Bakeman & Gottman, 1986).

Treatment Intervention

Parents of children assigned to the treatment intervention ($N = 8$) participated in CPRT training and supervision. CPRT facilitates the enhancement of the child-parent relationship by training parents to become therapeutic agents in their children's lives. Parents learn child-centered therapeutic play skills, such as, reflective listening, therapeutic limit setting, and building children's self-esteem, to use with their child in a 30-minute weekly play session (Landreth & Bratton, 2006). The curriculum content and procedures utilized during the training followed the published 10-session CPRT protocol (Bratton et al, 2006). The Spanish CPRT group was provided by a CAC bilingual Hispanic female counselor who held a master's degree in counseling, was a LPC and national board certified counselor. The CAC therapist had two graduate level play therapy courses and one CPRT graduate level course. The therapist had five years experience working with abused children utilizing child-centered play therapy and CPRT. The English CPRT group was provided by me, the researcher and an advanced doctoral student. I have completed 3 play therapy graduate courses, one group play therapy graduate course, and one CPRT graduate course. I have a master's of science

in counseling, and I am a LPC with 3 years of experience working with abused children. I completed two semesters of internship at children's advocacy centers.

The traditional 10-session CPRT training was modified to add one session at the beginning to accommodate the needs of non-offending parents. Non-offending parents often need to tell their story about their children's disclosure of sexual abuse. With this population it was also ethical and imperative to provide education regarding the child's abuse. Therefore, the first group session consisted of meeting, socializing, and allowing the parents to express their emotions regarding the trauma and victimization of their child. As needed, therapists facilitated a discussion of any parental concerns regarding protecting the child from further abuse, protecting the child from abusing others, and healthy versus unhealthy characteristics of a healthy family. Therapists provided parents with printed information provided by the CAC and ensured parents' feelings of concern and despair were adequately addressed. No additional modifications were made to the actual content and procedures presented in the 10-session CPRT sessions in the following weeks. Therapists were instructed to follow the protocol of the CPRT manual (Bratton et al., 2006), while remaining flexible and using their clinical judgment in order to best meet the needs of this population.

Consistent with CPRT methodology, parents met in small groups of 4 parents per group to facilitate small group interactions and conducted a minimum of 7 play sessions with their child during the last 7 weeks of CPRT. Parents had the choice to conduct play sessions in playrooms located at the CAC (investigator video recorded) or at their homes. All parents in Spanish and English CPRT were given a CPRT toy kit following the list of toys suggested by Landreth (2002) for parents who conducted play sessions

at the CAC, free childcare was provided. The English speaking CPRT therapist provided two additional make up group sessions due to absences for those parents who missed sessions and individual supervision of skills. The Spanish therapist had fewer absences and did not require two additional make up sessions for the entire group. The English and Spanish CPRT therapists ensured that parents who missed sessions had a make-up session by meeting with these parents at the end of the CPRT group.

Analyses of Data

Analysis of data was conducted according to quantitative and qualitative procedures based on the research questions. Each research question is listed below followed by the prescribed analysis for the data collected.

1. Do non-offending parents of children who were sexually abused report improvement in child behavioral problems, parent-child relationship stress, and parental empathy after participation in CPRT?

Quantitative data including pre and post test scores on the PSI, CBCL, and MEACI was collected to support and inform the research question associated with change measurement. Due to small sample size, data is preserved in description form. Means for the whole group as well as individual scores are provided.

2. What were the experiences of non-offending parents of children who were sexually abused regarding their participation and completion of CPRT?

Qualitative data analysis followed phenomenological procedures consisting of data collection, data entry and storage, segmenting, coding and developing category systems, identifying relationships such as themes, constructing diagrams, tables, and corroborating and validating results (Johnson & Christensen, 2004). Participants'

interviews were transcribed verbatim, translated from Spanish to English, typed in a word processor, and double-spaced. The interviews were translated into English by a hired professional translator who signed a confidentiality form to ensure confidentiality of the Spanish speaking participants. All interviews were transcribed verbatim from Spanish to English. The trained coders were asked to read all eight CPRT interviews. Miles and Huberman (1994) reported codes are labels for assigning units of meaning to the descriptive information collected. The trained coders utilized Huberman and Miles (1994) procedures including sketched ideas and notes written in the margins of each interview. Then the coders summarized field notes and compiled the thoughts and ideas written in the margins. Coders were asked to display data and work with the words making metaphors, incomplete ideas and thoughts into complete sentences or thorough statements. Coders identified codes line by line by reading and rereading all interviews several times. Coders worked to reduce information to eliminate ideas or thoughts, statements, and codes that were not agreed upon by the other coders. All coders were asked to count frequency of codes to gain an accurate perception of themes presented in interviews and gain insights into related categories to further gain depth of participant's experiences.

The coders met over a period of two months for theme analysis and each step of procedures is outlined in Table 1. I facilitated each of the three sessions. In the first session, the purpose of the study and goals of qualitative analysis were introduced. The coders were trained in Huberman and Miles (1994) procedures and given an example of the expectations of coding. The coders were then given all eight interviews and asked to read through all eight thoroughly without coding. Then the coders were asked to

individually re-read each interview to sketch ideas and write notes. The coders were asked to summarize field notes on all interviews. Coders were asked to review their field notes and work with words making metaphors, meanings, and identifying codes. The coders were asked to bring all their field notes and summaries to the second session. During the second session, all coders presented their summaries of field notes. All coders discussed, compared and contrasted their findings and specifically identified codes. As a group, coders reduced the information and discussed patterns and themes. The researcher established inter-coder agreement by independently analyzing the data presented. All coders came to a consensus and agreed upon nine themes, definitions of those themes, and support of statements (Table 13). When mean agreement was reached in the acceptable range of 85% to 90% (Bakeman & Gottman, 1986), the researcher finalized the coding manual. To avoid redundancy and address lack of support in the interviews, the coders utilized the list of themes from the finalized coding manual. Individually, coders were asked to re-read all eight interviews to reduce the information further and line by line identify statements related to themes. Coders assisted with enumeration to help communicate frequency of themes by noting how often they occurred through the interviews. In the third session, coders were asked to bring their list of themes and statements per interview. Each coder presented their identified statements for each theme by lines in the interviews. All coders were asked to utilize the finalized coding manual and re-read the interviews a final time to ensure emergence of any new themes or refine any existing themes. Coders provided their final list of agreed upon themes and statements and all field notes. To ensure continued

inter-coder agreement, all three researchers independently coded 100% of the data and the calculated final mean agreement was 91%.

Table 1

Qualitative Procedures Summary

Steps	Procedures
Step 1	Introduced coders to study, trained coders, and asked each coder to read all eight interviews.
Step 2	Coders re-read all interviews to sketch thoughts or ideas in the margins and write field notes on each interview.
Step 3	Each coder summarized their field notes and presented their findings using words rather than metaphors/thoughts line by line.
Step 4	As a group, coders discussed the display of data, themes that emerged throughout interviews and similar themes among coders for all eight interviews.
Step 5	Coders were asked to re-read all interviews individually to identify specific themes and codes line by line.
Step 6	Coders presented themes and discussed definitions related to those themes. Initial inter-coder agreement was calculated for all 3 coders and when reached 85%, the coding manual was finalized with the themes and definitions.
Step 7	The finalized coding manual was given to coders. Coders re-read all eight interviews to identify these themes line by line.
Step 8	Coders presented line by line their findings and eliminated information that was not agreed upon or consistent among coders. Coders counted frequency of identified themes and found consistency and inconsistencies line by line. Final coder agreement was reached at 91%.

To promote qualitative research validity, I used strategies including researcher-as-detective which means I developed an understanding of the qualitative data through careful consideration of potential causes and effects (Johnson & Christensen, 2004). Triangulation was utilized as a means of cross-checking information and conclusions through the use of multiple procedures or sources and when all are in agreement it is

called corroboration (Johnson & Christensen, 2004). I cross-checked all qualitative data and I ensured that the three coders also cross-checked all themes, definitions, and frequency of statements, thereby indicating corroboration. I ensured data triangulation through the inclusion of pre and post assessments and post interviews of each participant. Investigator triangulation in analyzing and interpreting data is the use of multiple researchers in collecting, analyzing, and interpreting the data and I was assisted in all these areas by three faculty supervisors familiar with qualitative analysis (Johnson & Christensen, 2004). I also reviewed all interpretations and conclusions with peers not interested or familiar with the field of study, which is peer review (Johnson & Christensen, 2004). Lastly, reflexivity involves self-awareness and critical self-reflection by the researcher on her potential biases that may affect the research conclusions (Johnson & Christensen, 2004). I kept thorough journals of each participant's group sessions and also video recorded every session to ensure there was no researcher bias. The qualitative analysis process and conclusions were all discussed with a supervising professor who assessed, suggested and agreed upon conclusions.

CHAPTER VI

RESULTS

This chapter presents the results of the qualitative and quantitative analyses for the research questions examined in this study. Included in this chapter is quantitative data on assessments completed by all eight participants. The first research question is addressed through the presentation of descriptive data including group means, subgroup means and individual results. The second research question was addressed through the revelation of patterns and themes related to the experiences of all eight participants. Themes as well as individual participant contribution to themes are presented.

Research Question 1: Do non-offending parents of children who were sexually abused report improvement in child behavioral problems, parent-child relationship stress, and parental empathy after participation in CPRT?

Participants completed Parenting Stress Index (PSI), Child Behavior Checklist (CBCL), and Measurement of Empathy in Adult-Child Interaction (MEACI) before and after Child Parent Relationship Therapy (CPRT). The instruments were scored and means were reported in Table 2 for all eight CPRT participants. All post test means indicate an improvement from pretest means. Table 2 results demonstrate that parents reported decreases in the PSI total, Parent Domain, and Child Domain indicating decrease in parent-child stress. Results also demonstrated decreases in child behavioral problems on CBCL Total, Internalizing problems, and Externalizing problems. Finally, means demonstrate an overall decrease in MEACI scores indicating improvements in parental empathy.

Table 2

Mean Scores for Parenting Stress Index, Child Behavior Checklist, and Measurement of Empathy in Adult-Child Interaction for all Child Parent Relationship Therapy Participants (N = 8)

	Pretest		Posttest		Mean Difference
	Means	SD	Means	SD	
PSI TOTAL	257	46.54	249.88	40.72	-7.12
Parent Domain	137.63	16.99	136.88	16.98	-0.75
Child Domain	119.37	31.25	113	26.28	-6.37
CBCL TOTAL	58.75	11.68	55.25	12.59	-3.5
Internalizing Problems	61.50	13.38	57.75	11.04	-3.75
Externalizing Problems	54.63	10.74	53.38	12.28	-1.25
MEACI	46.56	6.33	39.31	9.17	-7.25

Note. A decrease in mean scores means an improvement in CPRT participants.

Eight participants were divided into two CPRT groups based on their primary and preferred spoken language. The Spanish group had a total of 4 participants and the English group had a total of 4 participants who completed CPRT and all the assessments including the post interview. Table 3 presents the pretest and posttest means and standard deviations for the English speaking group ($n = 4$) and the Spanish speaking group ($n = 4$) on the Externalizing Problems, Internalizing Problems, and Total Problems scales of the Spanish and English version of the CBCL. Table 3 shows Spanish speaking participants and English participants all decreased on the report of Internalizing Problems, Externalizing Problems and Total Problems on the CBCL. Mean differences are greater for Spanish participants on Internalizing and Total Problems compared to the English speaking participants. English speaking participants had a greater mean difference on Externalizing Problems than Spanish participants. Figures

1-3 graphically represent mean differences on pretest and posttest among English and Spanish CPRT groups.

Table 3

Mean Scores on the Internalizing Problems, Externalizing Problems and Total Problems scales on the Spanish version of the Child Behavior Checklist (CBCL) and English Version of the Child Behavior Checklist (CBCL)

	English Participants $n = 4$				Spanish Participants $n = 4$			
	Pretest		Posttest		Pretest		Posttest	
	Mean	<i>SD</i>	Mean	<i>SD</i>	Mean	<i>SD</i>	Mean	<i>SD</i>
Internalizing Problems	51	6.27	50.75	9.03	72.00	9.20	64.75	8.50
Externalizing Problems	49.25	7.93	47.75	12.29	60.00	11.37	59.00	10.80
Total Problems	50.50	6.56	49.25	11.7	67.00	9.70	61.25	11.7

Note. A decreased in mean scores indicates an improvement in behavior.

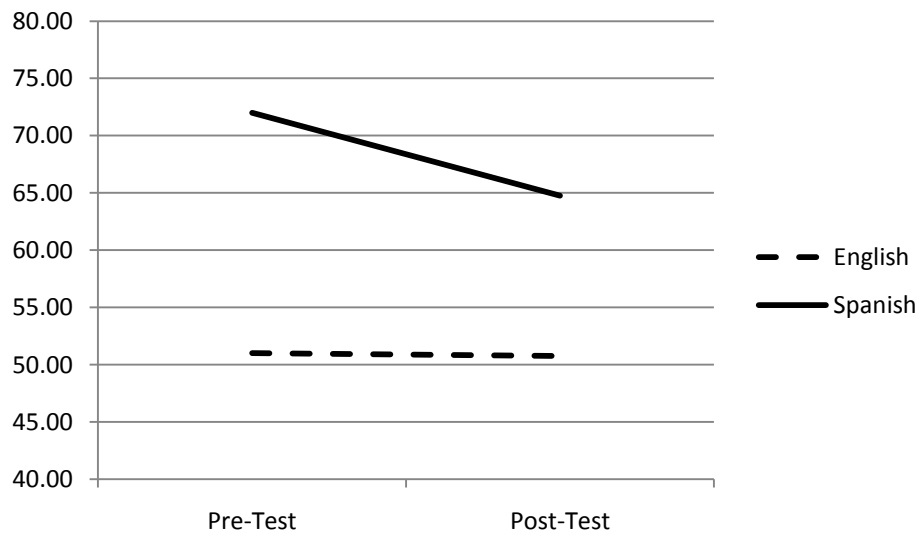


Figure 1. Child Behavior Checklist (CBCL) scores for Internalizing Problems.

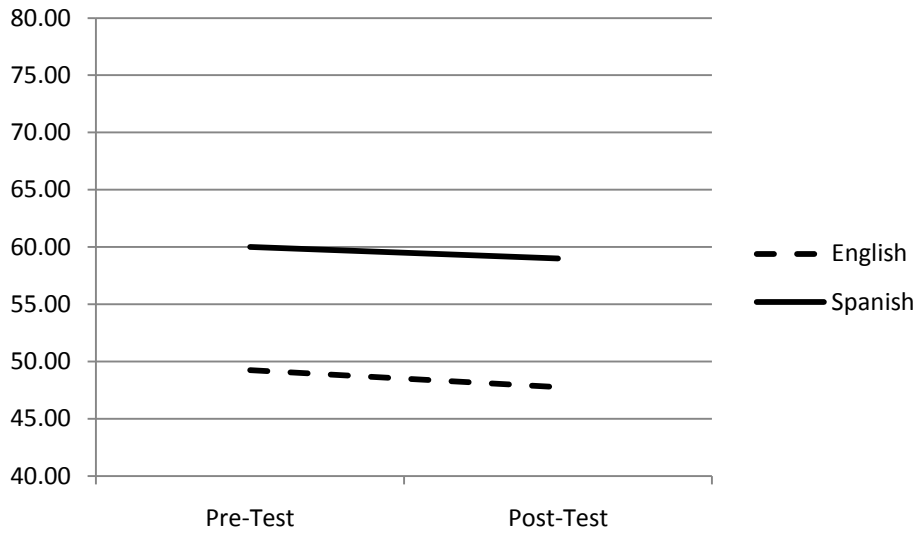


Figure 2. Child Behavior Checklist (CBCL) scores for Externalizing Problems.

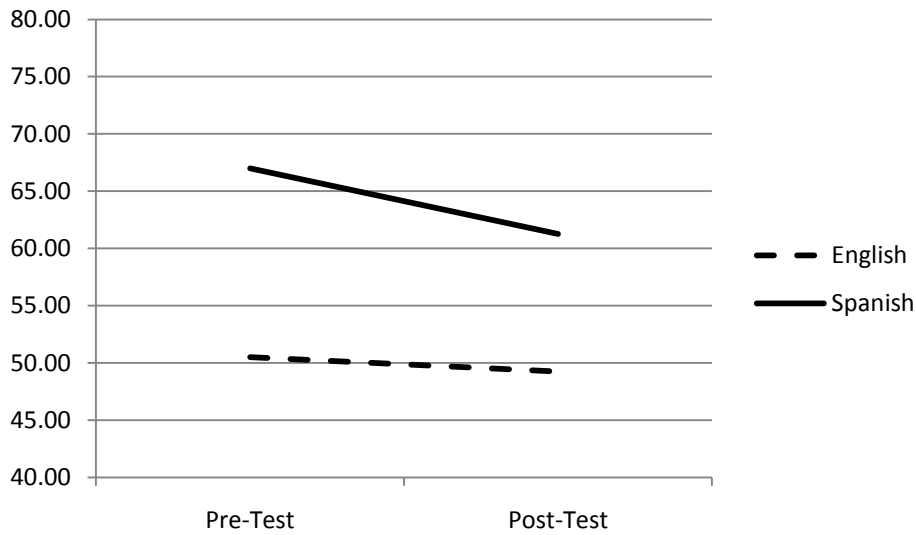


Figure 3. Child Behavior Checklist (CBCL) scores for Total Problems.

Table 4 presents the pretest and posttest means and standard deviations for the English and Spanish CPRT groups on the Child Domain, Parent Domain, and Total Stress of the Spanish and English version of the Parenting Stress Index (PSI). Table 4 presents English participants parent child stress increased on Child Domain, Parent Domain, and Total Stress. Table 4 shows Spanish participants parental stress

decreases on Child Domain, Parent Domain, and Total Stress on the PSI. Figures 4, 5, 6 graphically represent mean differences on pretests and posttests among English and Spanish CPRT groups.

Table 4

Mean Scores on the Child Domain, Parent Domain, and Total Stress on the Spanish and English Version of the Parenting Stress Index (PSI)

	English Participants <i>n</i> = 4				Spanish Participants <i>n</i> = 4			
	Pretest		Posttest		Pretest		Posttest	
	Mean	<i>SD</i>	Mean	<i>SD</i>	Mean	<i>SD</i>	Mean	<i>SD</i>
Child Domain	98.00	26.76	100.00	28.51	140.75	18.57	126.00	18.66
Parent Domain	128.25	15.52	130.75	13.28	147.00	14.10	143.00	19.92
Total Stress	226.25	38.92	230.75	41.63	287.75	31.90	269.00	41.63

Note. A decreased in mean scores indicates an improvement in perceived parent stress.

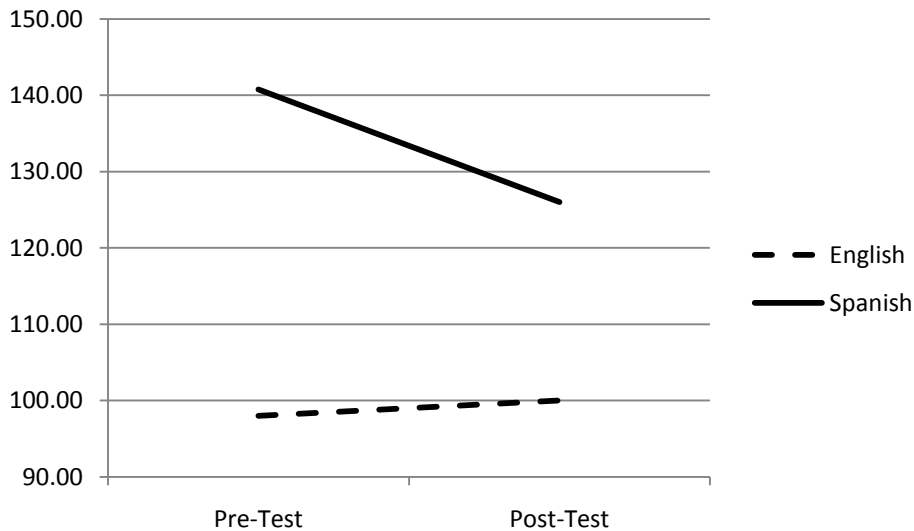


Figure 4. Parenting Stress Index (PSI) scores for Child Domain.

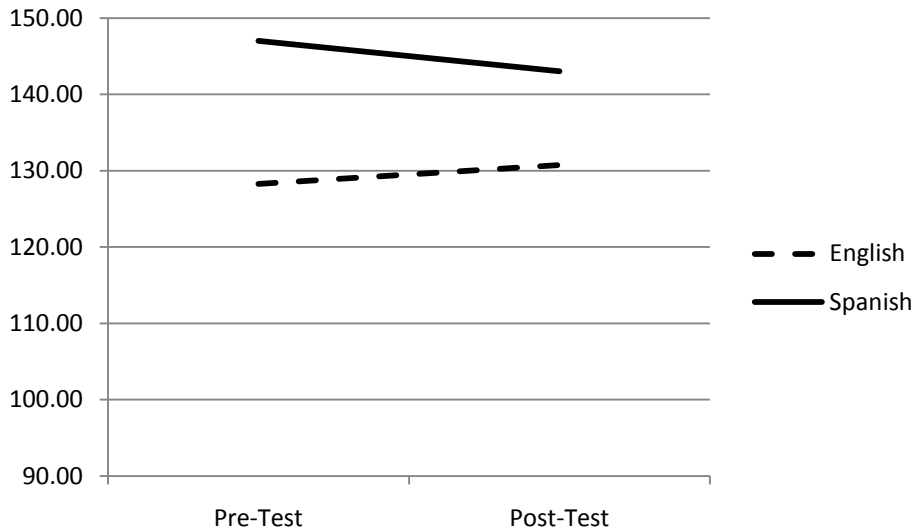


Figure 5. Parenting Stress Index (PSI) scores for Parent Domain.

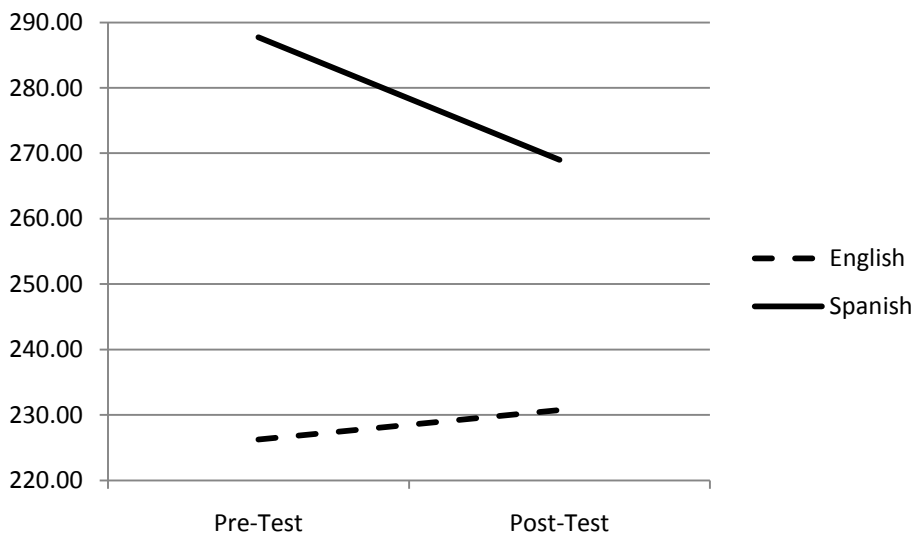


Figure 6. Parenting Stress Index (PSI) scores for Total Stress.

Table 5 presents the mean scores and standard deviations for the English and Spanish groups on the Measurement of Empathy in Adult-Child Interaction (MEACI). English and Spanish speaking participants demonstrated a decrease in parental empathy on MEACI indicating an improvement in parental empathy. English group demonstrated a notably larger decrease in mean scores compared to Spanish group.

Figure 7 graphically represents mean differences on pretests and posttests among English and Spanish CPRT groups.

Table 5

Mean Scores on the Measurement of Empathy in Adult-Child Interaction (MEACI)

	English Participants <i>n</i> = 4				Spanish Participants <i>n</i> = 4			
	Pretest		Posttest		Pretest		Posttest	
	Mean	<i>SD</i>	Mean	<i>SD</i>	Mean	<i>SD</i>	Mean	<i>SD</i>
MEACI	46.63	5.85	32.63	7.95	46.50	7.69	46.00	3.70

Note. A decrease in mean scores indicates an improvement in empathic adult-child interaction.

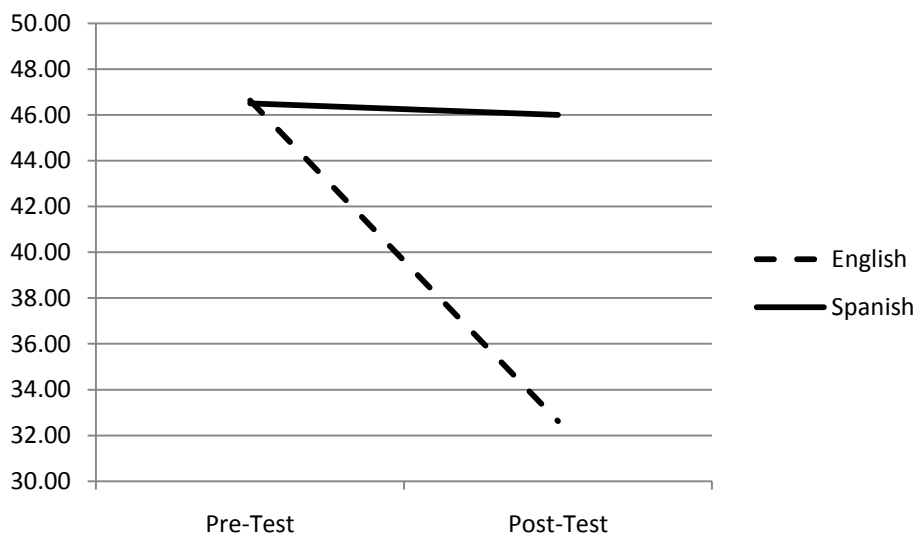


Figure 7. Measurement of Empathy in Adult-Child Interaction (MEACI) scores.

Individual Participants

In order to address the mean change for each participant, Tables 6-13 present the individual results on the CBCL, PSI, and MEACI for all participants.

Participant 1: Patty

Patty is a 23-year-old Hispanic female whose 4-year-old daughter was sexually abused by Patty's cousin's boyfriend. Patty participated in the English speaking CPRT group. From pretest to posttest, over the course of CPRT, Patty reported an increase in Total Stress and Parent Domain stress on the Parenting Stress Index (PSI), as well as increase on Total, Internalizing, and Externalizing Behavior scores on the Child Behavior Checklist (CBCL: see Table 6). She reported a decrease in Child Domain scores on the PSI, indicating experiencing less stress as related to child behavior characteristics. Quantitative behavioral data indicates that Patty's report of behavioral changes demonstrated an increase in problem behaviors and stress, except on the Child Domain. Concretely, this result can be interpreted as a worsening of behaviors during CPRT. However, Patty also demonstrated a decrease in MEACI scores from pretest to posttest indicating an increase in parental empathy toward her daughter.

Table 6

Participant 1 (Patty) Scores on the Parenting Stress Index (PSI), Child Behavior Checklist (CBCL), and the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Pretest	Posttest	Difference
PSI Total Stress	270	273	3
PSI Parent Domain	137	145	8
PSI Child Domain	133	128	-5
CBCL Total	45	62	17
Internalizing Behaviors	43	63	20
Externalizing Behaviors	44	60	16
MEACI	53	37.5	-15.5

Note. A negative difference in scores indicates an improvement.

Participant 2: Amanda

Amanda is a 33-year-old Hispanic female whose 12-year-old daughter was sexually abused by her paternal uncle. Amanda participated in the English speaking CPRT group and results of her data can be found in Table 7. Amanda reported no change from pretest to posttest on the PSI Total Stress and an increase on the Parent Domain, indicating experiencing more parenting stress related to parent characteristics. Amanda reported a decrease in Child Domain on the PSI, indicating experiencing less stress related to child behavior characteristics. She reported a decrease in Internalizing Behaviors scores and Externalizing Behaviors scores on the CBCL. Amanda demonstrated a decrease in scores on the MEACI indicating an increase in parental empathy. Amanda's scores demonstrated overall improvements in parenting stress and child behavioral characteristics.

Table 7

Participant 2 (Amanda) Scores on the Parenting Stress Index (PSI), Child Behavior Checklist (CBCL), and the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Pretest	Posttest	Difference
PSI Total Stress	196	196	0
PSI Parent Domain	111	118	7
PSI Child Domain	85	78	-7
CBCL Total	54	37	-17
Internalizing Behaviors	53	45	-8
Externalizing Behaviors	55	34	-21
MEACI	46	37.5	-8.5

Note. A negative difference in scores indicates an improvement.

Participant 3: Natalie

Natalie is a 33-year-old African American female whose 9-year-old daughter was

sexually abused by Natalie’s mother’s boyfriend. From pretest to posttest, over the course of CPRT, Natalie reported an increase in Total Stress on the PSI, as well as increase on Parent Domain and Child Domain on the PSI (See Table 8). Natalie reported a decrease in Internalizing Behaviors and CBCL Total on the CBCL. Natalie reported no change on Externalizing Behaviors on the CBCL. Natalie’s scores indicated increases in perceived stress on the PSI. Natalie’s scores on the MEACI, from pretest to posttest, decreased, indicating an increase in parental empathy.

Table 8

Participant 3 (Natalie) Scores on the Parenting Stress Index (PSI), Child Behavior Checklist (CBCL), and the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Pretest	Posttest	Difference
PSI Total Stress	191	194	3
PSI Parent Domain	120	121	1
PSI Child Domain	71	73	2
CBCL Total	45	42	-3
Internalizing Behaviors	50	43	-7
Externalizing Behaviors	41	41	0
MEACI	48.5	34	-14.5

Note. A negative difference in scores indicates an improvement.

Participant 4: Katy

Katy is a 29-year-old African American female whose 9-year-old daughter was perpetrated by her significant other. Katy participated in the English speaking CPRT group. Katy’s scores demonstrated an increase in Total Stress and Child Domain on the PSI (see Table 9). From pretest to posttest, Katy reported a decrease on the Parent Domain of the PSI, CBCL Total, Internalizing Behaviors on the CBCL, and Externalizing

Behaviors on the CBCL. Katy's scores on the MEACI decreased indicating increase in parental empathy.

Table 9

Participant 4 (Katy) Scores on the Parenting Stress Index (PSI), Child Behavior Checklist (CBCL), and the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Pretest	Posttest	Difference
PSI Total Stress	248	260	12
PSI Parent Domain	145	139	-6
PSI Child Domain	103	121	18
CBCL Total	58	56	-2
Internalizing Behaviors	58	52	-6
Externalizing Behaviors	57	56	-1
MEACI	39	21	-18

Note. A negative difference in scores indicates an improvement.

Participant 5: Gloria

Gloria is a 40-year-old Hispanic female in the Spanish speaking CPRT group whose 12-year-old daughter was sexually abused by Gloria's significant other. From pretest to posttest, over the course of CPRT, Gloria reported a decrease in Total Stress, Child Domain and Parent Domain on the PSI (see Table 10). Gloria's scores also decreased on the CBCL Total, Internalizing Behaviors, and Externalizing Behaviors on the CBCL. Although Gloria's scores improved on the PSI and CBCL, her scores did not improve on the MEACI.

Table 10

Participant 5 (Gloria) Scores on the Spanish Version of the Parenting Stress Index (PSI), Spanish Version of the Child Behavior Checklist (CBCL), and the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Pretest	Posttest	Difference
PSI Total Stress	285	240	-45
PSI Parent Domain	148	121	-27
PSI Child Domain	137	119	-18
CBCL Total	68	60	-8
Internalizing Behaviors	73	59	-14
Externalizing Behaviors	55	54	-1
MEACI	49.5	50.5	1

Note. A negative difference in scores indicates an improvement.

Participant 6: Mary

Mary is a 28-eight-year old Hispanic female in the Spanish speaking CPRT group whose 11-year-old daughter was sexually abused by her maternal uncle. From pretest to posttest, over the course of CPRT, Mary's scores decreased in Total Stress and Child Domain on the PSI, indicating experiencing less stress as related to child behavior characteristics (see Table 11). Mary's scores demonstrated decreases on CBCL Total and Internalizing Behaviors indicating positive behavioral changes. Mary's scores increased on Parent Domain on the PSI and Externalizing Behaviors on the CBCL. Mary's scores on the MEACI increased, indicating a lack of improvement in parental empathy during play sessions.

Table 11

Participant 6 (Mary) Scores on the Spanish Version of the Parenting Stress Index (PSI), Spanish Version of the Child Behavior Checklist (CBCL), and the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Pretest	Posttest	Difference
PSI Total Stress	306	298	-8
PSI Parent Domain	150	167	17
PSI Child Domain	156	131	-25
CBCL Total	73	65	-8
Internalizing Behaviors	84	73	-11
Externalizing Behaviors	65	74	9
MEACI	40.5	45.5	5

Note. A negative difference in scores indicates an improvement.

Participant 7: Sylvia

Sylvia is a 45-year-old Hispanic female whose 12-year-old daughter experienced sexual abuse by Sylvia's significant other. Sylvia participated in the Spanish speaking CPRT group. From pretest to posttest Sylvia's scores increased in Total Stress and Parent Domain on the PSI indicating experiencing more stress as related to parental role (see Table 12). Sylvia's scores decreased on the Child Domain, indicating experiencing less stress as related to child behavior characteristics. Sylvia's scores decreased on the CBCL Total and Internalizing Problems, but increased on Externalizing Behaviors. Sylvia demonstrated an increase in MEACI scores indicating a lack of improvement in empathic responses during her play sessions.

Table 12

Participant 7 (Sylvia) Scores on the Spanish Version of the Parenting Stress Index (PSI), Spanish Version of the Child Behavior Checklist (CBCL), and the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Pretest	Posttest	Difference
PSI Total Stress	244	239	-5
PSI Parent Domain	128	134	6
PSI Child Domain	116	105	-11
CBCL Total	53	46	-7
Internalizing Behaviors	62	56	-6
Externalizing Behaviors	47	49	2
MEACI	40	45.5	5.5

Note. A negative difference in scores indicates an improvement.

Participant 8: Cathy

Cathy is a 32-year-old Hispanic female who participated in the Spanish speaking CPRT group and whose 9-year-old daughter experienced sexual abuse by Cathy's friend. From pretest to posttest, Cathy's scores decreased on PSI Total Stress, Parent Domain, and Child Domain on the PSI, indicating a decrease in perceived stress (see Table 13). Cathy's scores on the CBCL Total scores did not change, however her scores on the Internalizing Behaviors and Externalizing Behaviors increased, indicating Cathy perceived an increase in problem behaviors. Cathy's scores on the MEACI decreased indicating an increase in parental empathy.

Table 13

Participant 8 (Cathy) Scores on the Spanish Version of the Parenting Stress Index (PSI), Spanish Version of the Child Behavior Checklist (CBCL), and the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Pretest	Posttest	Difference
PSI Total Stress	316	299	-17
PSI Parent Domain	162	150	-12
PSI Child Domain	154	149	-5
CBCL Total	74	74	0
Internalizing Behaviors	69	73	4
Externalizing Behaviors	73	74	1
MEACI	56	46.5	-9.5

Note. A negative difference in scores indicates an improvement.

Research Question 2: What were the experiences of non-offending parents of children who were sexually abused regarding their participation and completion of CPRT?

Through qualitative content analysis, 9 themes emerged among CPRT participants with regular frequency and saliency. Each theme included in the content analysis was referenced by a majority of respondents and often cited multiple times. Themes are listed in order of the amount of supporting evidence. The following themes were identified for CPRT participants: (a) Enhanced Parent-Child Relationship, (b) Internal Changes in Parent, (c) Changes in Child, (d) Improved Communication, (e) Changes in Discipline, (f) Universality, (g) Structure of Play Sessions, (h) Acceptance, and (i) Improvements to Model. For a list of definitions for each identified theme, see Table 14.

Table 14

Qualitative Themes and Definitions Derived from Content Analysis of Interviews for CPRT Participants (n = number of statements)

<i>n</i>	Theme	Definition
65	Enhanced Parent-Child Relationship	The parents' expression of a closer connection between themselves and child, better understanding of their child, and a significant increase of empathy for their child.
63	Internal Changes in Parent	The parents' perceptions of change within themselves that occurred as a result of CPRT such as, increased vulnerability, reduction of fear, increased awareness of feelings, patience with their child, and increased confidence in their parenting abilities.
54	Changes in Child	The parent's expression of their child's emotional or behavioral change since the sexual abuse occurred and the parent began CPRT.
49	Improved Communication	The parents' openness to become aware of their feelings, expresses their feelings to others, and reflect their child's thoughts and feelings.
36	Changes in Discipline	Parents expressed a change or difference in their parenting style, perception of discipline, and act of discipline with their child.
28	Universality	The parents' perception of group support and the feeling that they were not alone throughout the group process
22	Structure of Play Session	Parents' perception of difficulty with toys, playing, allowing child to be in charge, etc.
18	Acceptance	Parent expressed an increase in belief and approval of self, child, and others.
18	Improvements to Model	The parents' expression of needs including more group time, no or less homework, no or less reading, etc.

In the following section, each theme is defined and ordered by the frequency of supporting statements. Identified statements that support each theme are listed as quotes from participants.

Theme 1: Enhanced Parent-Child Relationship

Definition: The parents' expression of a closer connection between themselves and child, better understanding of their child, and a significant increase of empathy for their child.

The theme that emerged among CPRT participants reflected the very basic premise of CPRT, to enhance the parent- child relationship. All participants made reference to their relationship with their child improving:

. . . Like I don't want to, I want her to feel appreciated and I don't want to take her for granted, and she would ask me are we going to spend time together [30-minute play session] and I would say yes we are. . . Now we are definitely closer, now that I am here for her and we are going to get through it [sexual abuse].

Now it's like I do worry about our relationship and that's the only thing that is important, and she's like going through it [effects of sexual abuse], and if I wasn't there when it happened [sexual abuse], but I am there now. It's big changes like I said before it's the smallest things like she can be so happy and excited to tell me what she ate at lunch which has been really hard for her.

. . . I noticed they want to spend more time with me.

They are closer to me, and we talk more. I know that we still have a long way to go but I can tell that the change is closer to me.

She doesn't lie to me anymore. We don't fight as much and our fights are mother-daughter fights. I give her permission to tell me what she wants to say to me and I also apologize to her when I know I have done wrong.

She is closer to me. She has more confidence in me and we are like friends, we actually play like little girls . . . to know how to find the trust again which was the most difficult for me. How to get closer to her, coexist, and to be her friend, that was a challenge for me because she couldn't tolerate me but now I have her trust because she knows I'm here for her.

Theme 2: Internal Changes in Parent

Definition: The parents' perceptions of change within themselves that occurred as a result of CPRT such as, increased vulnerability, reduction of fear increased awareness of feelings, patience with their child, and increased confidence in their parenting abilities.

The theme that emerged was internal changes in parents and was answered mostly from Question 4: What changes do you notice in yourself and in your parenting of your child? Internal changes in parents:

. . . Instead of reacting I have to assess what's going on and then after that just consider their feelings and what's going on and what we're learning. . . I'm just less frustrated because at first it was like, you know, but now I get to understand them better so when I am frustrated, you know, I just take a different approach. I think about things more than I did before. Like one of my weaknesses was it was my way or no way and I think I learned that it works a little better if we [the mom and her 3 children] work together, let the kids have more of a say, with certain boundaries, what they can and can't do. That's the biggest thing that I have noticed. . . That, and I am very opinionated and a lot of times I think I don't allow my kids to express themselves, so me just shutting my mouth and allowing them to just express their feelings instead of me doing all the talking all the time, I really heard more.

I use to always, and I know this is going to sound bad, but I would always get frustrated and yell a lot and I know that's not good and, or I would be, like, when she would do something I would be, like, what's wrong with, you let me know or something like that, and now it's like I can talk to her, you know, I understand you're mad and it helps us because now it's like we have a bond. She knows I am there for her and she has an idea of me knowing what she is going through and, you know that lets her know it's ok for her to express her feelings with me. (Parent tearful)

. . . I know children don't have much experience and problem solving skills, and I feel like maybe before I expected too much or vice versa, maybe too little, but now I feel like I understand more from her side, what she is feeling. First, that I'm not so sad anymore. I don't feel sad in thinking about the past so much, instead I'm looking ahead in how to take my children and move them forward; give them better support, and to be more patient, something that I didn't have before. Also, learning how to listen and talk to them. Yes, I have changed a lot.

For me this group was very special, because I learned how to show my feelings for my daughter in a different way. The groups made me understand that I needed to spend more time with my daughter, and be closer to her. For example, playing with her, showing her more affection, eating with her and her siblings. Because the love of a mother is not just for them to know that I'm their mother, but also to demonstrate the love with actions. Letting them know that I love them, and that I'm a friend.

. . . That I can understand them better. When I was a little girl, my parents lived in another time and never understood me, and now when I look at my own children I feel that I can understand them. . . Also, I didn't use to hug or kiss them, but now I do, is a good feeling. . . I have learned to listen, enjoy, and love them more.

Many. My husband would say that I was an argumentative and distant person. As a mother, I have always loved them, but, I use to express my feelings differently. This group has showed me how to demonstrate my love for them. We play, go out, and have fun together, including my husband. I learned how to play with children.

. . . I have learned to have more confidence in myself. Before I use to cry a lot, but since I started therapy with my daughter, I can see things clearly. . . I learned to listen, give her time, and to set limits.

Theme 3: Changes in Child

Definition: The parent's expression of their child's emotional or behavioral change since the sexual abuse occurred and the parent began CPRT.

Overall the parents gave insight on how their children changed from the beginning of CPRT until completing the 11 weeks. The parents were also able to provide a lot of reflection upon their own changes. Another theme that emerged throughout the interviews was changes in child. Parents were asked to answer Question 3: What changes in your child, if any, have you noticed since you started the weekly play sessions? Parents reported mostly emotional changes, but also behavioral changes:

She's more, well, she talks a lot anyways, but she's more talkative and more open, and I think she realizes now that I am kind of, I am listening to her more and I respect her opinions and her feelings more, and I think in the beginning she maybe thought her opinions didn't matter, or maybe her thoughts didn't matter, which now I think she knows I am listening, and her thoughts and her opinions do matter.

. . . She is way different than in the beginning, she is nothing like she was in the beginning, she is like more talkative, she was talking before but, I think she knows she has more control over situations and she doesn't have to accept things that people give her, I'm referring to him [perpetrator]. It empowered her even more, she had it in the beginning, but now if someone tried to do something, she would not let it go unnoticed.

Well she likes it [weekly 30-minute play sessions] and she really does enjoy one on one mom time, and sometimes she likes it too much . . . she's been more independent, she's still kind of shy, but more around people she doesn't know. But you know, she talks more, plays more, interacts with kids more, and before she wasn't doing that, and that's something that was really very important, that I felt. . . Yeah, you know, she was more scared, you know, before she would sleep in her bed and I would sleep in my bed, but after this [sexual abuse] she was like, no I want to sleep with you, and it was like she wanted me to always protect her and always be with her, and for her to be independent was something big.

. . . I think with all that we have been going through she has gotten better with her school work, her grades are improving, and I think just her outlook on things. They are excited about it, and I just understand certain things about it, I get to talk better and understand why they do the things they do, and stuff like that.

. . . She has a friend now, because before she didn't have friends. . . yes, she is more sociable. She is happy now, and has increased her grades. She smiles more often, talks more, she plays with her siblings, and before she wasn't like that.

Now she has changed, because she looks forward to our playing sessions. . . I think now she feels more comfortable and confident being around me, before she was very shy. . . Yes, because she tells me everything that happens to her, what she feels when she is sad, but sometimes, she thinks a lot about the person that did the bad thing to her, [perpetrator who sexually abused her] but, is not that she is scared, is more like she worries about the person, because my daughter has a beautiful heart she doesn't hold a grudge against anybody.

. . . I noticed she is not so sad, because of what happened to her, [sexual abuse] she used to cry a lot, very sad, but now she plays with her siblings and laughs more.

The biggest change that I have noticed, is that she doesn't masturbate herself anymore. . . Sometimes she is very childish, but other times very mature. For me she has changed for the best.

Theme 4: Improved Communication

Definition: The parents' openness to become aware of their feelings, express their feelings to others, and reflect their child's thoughts and feelings.

Improved communication is another theme that emerged from CPRT participants. Parents were not directly asked about a change in their communication,

however throughout the interviews many participants responded communication was improved from CPRT:

Yes, because she tells me everything that happen to her, what she feels when she is sad. . . Before she didn't tell me anything, she will go into her room, but that has changed, now everything she does is with love. You could say that before (CPRT) I used to move them ahead in life, but I didn't dedicate quality time to them. For example, I could be there in the same room with them, but we didn't talk, nor have a conversation. Before, they used to ask me, "let's watch a movie together?" and I will tell them, "not now I am tired". We could be in the same room, but I will always fall asleep. Now that has changed because we talk and we spend time together.

Before I took the sessions with the group, I used to feel impotent, [powerless] because she used to cry a lot, after what happen to her [sexual abuse] and when she did told me something, I didn't know how to respond or tell her what was right or wrong. I really didn't know how to deal with it. But all this change because before the group I didn't know what to do. I didn't know how to calm her, so I will just cry with her, this problem destroy us. . . Now when I see her I feel prepared. If she asks a question I get very brave, I don't know where I get it from, and answer her with confidence.

Everything gave me good results because now I can understand her better and she talks to me more.

. . . I think she feels a lot more relaxed to talk to me, and she's gotten that time [30-minute weekly play sessions] and, she knows that it's just there for her and we just hang out.

I mean, I am not blaming myself by any means, but in the beginning, I was like what could I have done better as a parent, to, you know, to keep something like this [sexual abuse] from happening, so, you know, it was just for me to become a better parent all around, and she could feel more comfortable coming to me, and just be more open. . . Now she is more talkative.

Theme 5: Changes in Discipline

Definition: Parents expressed a change or different in their parenting style, perception of discipline, and act of discipline with their child.

Change in discipline was an interesting emerging theme. There was no direct question regarding a change, however, many participants reported they had a positive

change in discipline compared to how they discipline their child prior to CPRT. Changes in discipline were represented through the following statements:

I am slower to react, as far as parenting, I think I am doing better. . . The most helpful is giving them choices, I guess giving them that extra power so they can make their own decisions, and the consequences, I think that's very important.

The choices was easy and also the one where it's not praising but you encourage, yeah, encouragement that they can do things. And that's hard for me too, because I am always like oh your taking too long I will just do it for you, so that has worked out well because I allowed them to do things I normally wouldn't have, and then they did do it successfully I could say you did a really good job or whatever the case would be. It taught me patience. . . . I don't spend much time disciplining, because I am like you, have a choice. I love the choices, that is one thing that keeps sticking out in my head, you know you have a choice and if you don't do that then you have a consequence with the choice you make.

I feel like a better parent, I feel like I have more knowledge, I would want to pass that on to other parents that have little bitty kids that might not know that. You know I use to think that spanking was ok and now I know that's not ok and if it was a cycle in my family that's not something I would want to continue.

I liked giving her or making her choose, you know "you want this or that". I think that would be something to let her know she has a voice, and she a choice and with her being more independent it's better, because now she can be more outspoken, and before it was like someone would hit her and she wouldn't tell and now it's like someone will hit her and she will be like hey and go tell somebody now, and before she wouldn't, but now she will.

Before I used to scream a lot, but now I try to talk to her, and as a result I get more out of it. If she did something wrong I will discipline her, but not screaming [now]. I also teach my husband, because he can't come to the sessions because of work. He used to be an aggressive person. He would insult them and sometimes would spank them, but now he's different. This has helped us a lot. . . . To know how to dominate another way of disciplining them, and how to get their attention. My custom was to always scream and putting more severe punishments. Now I know that it was wrong to do that.

When we came to the sessions [CPRT] the therapist would give us a binder [CPRT Parent Notebook] and I would read about the discipline. Because I use to discipline my children, but the wrong way, I used to scream a lot. With that binder I learned a lot.

Interviewer: What changes have you noticed in yourself?

That I don't spank her as much. I do discipline her, but I don't spank her like I used to, I'm more patient now.

Theme 6: Universality

Definition: The parents' perception of group support and the feeling that they were not alone throughout the group process.

All participants reported group dynamics as being helpful and encouraging. Many group members reported just being in the group with other mothers who were going through similar difficulties and struggles with their child who had experienced sexual abuse as powerful in their healing. Universality is a significant theme in all participants interviews. There was not a specific question asked about universality, however all of the participants reported it as one of the most helpful aspects in CPRT:

The most thing that stood out for me, was the sharing and different people, and with different age groups. Just hearing that I think helped a lot. . . . Overall, I am feeling pretty good about you know, [parenting] I am learning more and I am seeing other parents that have gone through this, and I don't feel as alone, and I feel more empowered like I am not the only person [who has had a child experience sexual abuse]. So overall if I feel better about myself, maybe my family sees me like not as down, and I think that just carries over to work and everything.

I liked it [CPRT] because it's like you can just talk about anything, and it's like everyone lets you know their opinion, and its always something positive, and I am so use to being around so much negative.

. . . I liked the way we learned from each other, you know, everyone shared their experiences, and how they do in their session and stuff, and how we can improve on our stuff at home.

We all, to be honest, it seemed like we were all similar in some way or another, especially our situations you know; single parents, more than one child, and having to deal with that, [child's experience of sexual abuse] and in school and work full time. And I think we could relate, a lot to each other, because we were all in the same situation, I think that was the best part of the group. . . It makes you encouraged, because you know I am not the only one, they [other parents in the group] go through the same thing I go through keeps, you going, keeps you motivated.

When I realized that I was not the only person that was going through this. To know that there were more people. I used to look at them and ask myself, why are they smiling don't they feel what happened to them? That really helped me. At the beginning, with my problem [daughter experienced sexual abuse] I thought my world was crashing down, and I didn't want to live, and thought nobody was going to understand me, but I started coming here [CPRT at CAC] I'm so grateful to them [therapists].

Theme 7: Structure of Play Session

Definition: Parents' perception of difficulty with toys, playing, allowing the child to be in charge, etc.

The structure of the play sessions seemed harder for some due to age of the focus child, cultural background, or daily stressors. Other participants expressed difficulty in the allowing themselves to play with the child, the selection of toys, and finding a time and place for the weekly sessions. Participants also expressed difficulty allowing the child to be in the lead, which is an important principle in CPRT. Participants responded to no particular question when they expressed reflections on the structure of the play sessions:

The most difficult was being, you know sitting back, and like the play session letting them lead because I am use to you know ok you do this, this way and that that way you know, so I am used to that so that was the most difficult for me.

. . . Making time of course that was really hard for me and of course because I have three children and making time, and I work and I am in school.

.. . The toys were too infantile for her she told me, "These toys are for babies and I'm not a little girl". In the area of the toys it didn't work for us.

... When I play with my daughter, but not with toys we usually would color or do puzzles.

The toys, I didn't like to see her play it was complicated for me. . . . The playing sessions seem to me too infantile, for my 8-year-old daughter because I think she is too mature. . . . It was difficult for her, because she use to act like a spoil brat, but on the other hand it helps her in bringing her down to her age.

Let me tell you, that when we finish playing she tells me, “oh so little time” but that is what they taught me here [CAC] I need to share my time between my daughter and her siblings. She is learning to value the time we spend together. .

. . . When we finish playing she starts talking to her sister on how much she likes it, and you can tell that she is happy.

At the beginning, it was difficult to play with the children, because I had never done it before. It was strange to see myself as a mother [Spanish speaking] playing with the children, because I didn't see it as part of the role of a mother [due to Hispanic background]. But, it is incredible how a simple thing like playing with them, can have such a positive result.

Theme 8: Acceptance

Definition: Parent expressed an increase in belief and approval of self, child, and others.

Many parents expressed an increase of acceptance of themselves, their children or both. CPRT participants expressed an increase of acceptance:

And then I appreciate them more, even if it's just 30 minutes, because before I would play with them but it would be them, but now it's just me and her, [focus child] and with just me and her playing it's like it really helps.

Right now, I am like, if she is doing something she's good and proud of, then I am proud for her and I want to make sure she knows that I am proud of her. . . . My confidence is increasing just knowing that like I said some of the things I already did and I have to give myself little check marks for doing well, and some of the things I didn't know that I have learned I want to apply those and be better.

. . . I have never played with my children before. I never had time to play with them but today I do. I didn't know that I was going to see many things in my children while playing with them [30-minute weekly play sessions]. Making decisions and having confidence was something that we [parents] gain during these playing sessions. What I'm doing with my children, I never did with my older children, all I did was to go from work to the house. But, now I have a new opportunity to make right.

I see her [child of focus] more mature . . . I benefit the most on learning how to understand the children, so we can know them better, because since we [Hispanic culture] don't play with them, we don't have the same confidence.

Theme 9: Improvements to model

Definition: The parents' expression of needs including more group time, no or less homework, no or less reading, etc.

The final theme that emerged from the CPRT participant's interviews was suggestions or ways to improve the CPRT filial therapy model. Throughout the interviews parents expressed ways to improve the CPRT model for this population, the answers mostly correlated with the question, "Suggest ways to improve the training for the next group of parents". The following are participants' suggestions for improvement:

Less homework.

. . . If we had time to go over the sessions, I mean, I know our lessons are already a couple of hours, but there is only so much you can squeeze in that time session.

The videos were helpful, the homework probably was least helpful, because half of the time I didn't do it, well half of the time, I did and half of the time I didn't, because something always happened.

I think we started off with a decent size group [6 participants], I wish we had stayed with a decent size group, even though it shrunk a little bit [4 participants], it was still nice but I am glad it wasn't larger. I don't know if that would be intimidating if it was larger.

Giving them [future parents in CPRT] more time because when we find people that are really honest with us, then you start to be honest too. There was someone in the group that I didn't think was an honest person, and I had a hard time opening up my feelings, it was something that would stop me from expressing myself. The good part about expressing yourself, is that you could be honest but you have to feel comfortable in your environment. When you say what you feel you start knowing yourself.

. . . Yes, more time because I think it's not enough weeks.

Individual Participant Summary

Participant 1: Patty. Patty's statements in the qualitative semi-structured interview contributed to the following themes: enhancing her parent-child relationship,

changes in child, communication, acceptance, changes in discipline, internal changes in parent, universality, improvements to model, and structure of play session themes. Patty stated, "I used to always and I know this is going to sound bad but I would always get frustrated and yell a lot and I know that's not good and or I would like when she would do something I would be like what's wrong with you let me know or something like that and now it's like I can talk to her you know 'I understand your mad' and it helps us because now it's like we have a bond". Patty reported positive changes in the child's behavior from CPRT. She stated, "But you know she talks more, plays more, interacts with kids more and before she wasn't doing that and that's something that was really very important that I felt". Overall Patty expressed themes of behavioral changes seen of her daughter and within herself from CPRT. Patty stated, "And then I appreciate them more, even if it's just 30 minutes, because before it's like I would play with them but it would be them but now it's just me and her [child of focus] and with just me and her playing it's like it really helps". Her interview revealed CPRT improved her parenting skills, her empathy for the sexual abuse that occurred, and improved the parent-child relationship.

Participant 2: Amanda. Amanda expressed eight themes including enhance parent-child relationship, changes in child, internal changes, changes in discipline, acceptance, communication, improvement to model, and universality. Amanda's qualitative analysis did not reveal structure of play session themes. Amanda expressed a sense of oneness with her daughter who experienced sexual abuse and a closer relationship than before CPRT. Amanda stated, "I think we are just closer because we are going through this [effects of sexual abuse] together and overcoming this together. .

. . No, we are definitely closer now that I am here for her and we are going to get through it.” She expressed in the interview feeling better dealing with parenting stress than before CPRT, “Overall I am feeling pretty good about, you know, I am learning more and I am seeing other parents that have gone through this and I don’t feel as alone and I feel more empowered like I am not the only person. ” She also expressed feeling more confident from the skills learned in CPRT and less overwhelmed.

Participant 3: Natalie. Natalie expressed statements related to all identified themes including enhance parent-child relationship, changes in child, communication, internal changes, changes in discipline, universality, structure of play sessions, acceptance, and improvement to model. Natalie expressed a change in her perceived stress and the child’s behavior. She stated, “I think it’s gotten better and I’ve let them all know I am here and space it out better so that the time is managed better, I don’t spend much time disciplining because you know I am like you have a choice.” Regarding her daughter’s behavioral changes, she stated, “she talks a lot anyways but she’s more talkative and more open and I think she realizes now that I am kind of listening to her more and I respect her opinions and her feelings more and I think in the beginning she maybe thought her opinions didn’t matter or maybe her thoughts didn’t matter which now I think she knows I am listening and her thoughts and her opinions do matter”. Natalie reported many changes in their relationship and stated, “she loves it [30 minute weekly play session] because she didn’t have to share my time with the other two and it was just her, I think it makes her feel special the fact that I am taking my time out of my day and just sit and let her do what she wants to do”. Natalie reported CPRT improved

her parent-child relationship by helping her balance her time between her three children, work, and attending college.

Participant 4: Katy. Katy expressed statements under the following themes: enhance parent-child relationship, changes in child, internal changes, communication, changes in discipline, universality, improvement to model, acceptance, and structure of play sessions. Katy reported positive changes in stress and her daughter's behavioral characteristics. Katy stated, "They are excited about it and I just understand certain things about it, I get to talk better and why they do the things they do and stuff like that". Katy reported, "I just enjoyed being in group and the things learned and I don't know this is just new to me so, I mean you know this is just new and giving them the control and to just listen and I mean listen with everything you know with your heart and your eyes and just you know listen and observe and then really get down on that level and then you're like 'oh' that's why." She reported positive changes from completing CPRT.

Participant 5: Gloria. Gloria expressed many statements that supported enhanced parent-child relationship, changes in child, internal changes in parent, communication, acceptance, universality, improvement to model, and structure of play sessions. She expressed many changes in daughter and stated, "She smiles more often, talks more, she plays with her siblings and before she wasn't like that." Gloria reported communication improved and the trust in their relationship, "In that we talk more. Now they tell me about their day at school or simply a joke because before they couldn't". She also stated, "Spending more time with them [her children] because we could learn to know each other better. Now we have more confidence between us". Gloria stated, "Well, her [child of focus] relationships with my other daughters improved

and she is more open with my sisters. She is not upset anymore, her character has changed a lot". Gloria expressed a change from CPRT in herself and her daughter.

Participant 6: Mary. Mary expressed statements contributing to all themes except improvement to model. Mary reported perceived positive changes in her parent-child relationship, changes in child, discipline style, communication, structure of play sessions, universality, acceptance, and internal changes. Mary expressed, "For me this group was very special because I learned how to show my feelings for my daughter in a different way. The groups made me understand that I needed to spend more time with my daughter, and be closer to her, for example, playing with her, showing her more affection, eating with her and her siblings". She reported, "Before I use to scream a lot but now I try to talk to her and as a result I get more out of it". Mary also stated, "Before I took the sessions with the group I used to feel impotent, powerless, because she used to cry a lot [after sexual abuse] and when she did tell something I didn't know how to respond or tell her what was right or wrong. I really didn't know how to deal with it. But all this changed because before the group I didn't know what to do. I didn't know how to calm her do I will just cry with her, this problem really destroy us. Now when I see her I feel prepared. If she asks a question I get very brave, I don't know where I get it from, and answer her with confidence". Mary expressed CPRT helped her relationship with her daughter, "She is closer to me. She has more confidence in me and we are like friends, we actually play like little girls". Mary reported CPRT positively changed the way she communicated and disciplined for an enhanced relationship with her child.

Participant 7: Sylvia. Sylvia expressed many statements reflected in the following themes: enhanced relationship between parent and child, changes in child, internal

changes in parent, changes in discipline, communication, universality, structure of play sessions, and acceptance. Changes in the parent-child relationship were evident with Sylvia's statements including, "Many changes. For the better even the older ones that don't live with me anymore came to visit during December and they hug me. They were very detached from me but now we feel united, closer". She stated, "I noticed she is not so sad because of what happened to her, she used to cry a lot very sad but now she plays with her siblings and laughs more". Sylvia also reported changes within herself, "At the beginning of the problem [her daughter sexually abused] I will question myself about why I wasn't there so that I could defend her. How I didn't notice what was going on but as I started to come to the group I understand many things, I don't cry so much anymore I can see things clearly and I feel more love towards her". She reported changes in her discipline, "Yes, because before I used to scream at them and you can see the fear in their faces, but still they wouldn't listen. Now I talk to them and they pay more attention. I have a different attitude and my daughter has notice change in me". Sylvia stated, "I have learned to listen, enjoy, and to love them more. They have more confidence in me". She reported many positive changes with her parenting, relationship, and communication after completion of CPRT.

Participant 8: Cathy. Cathy expressed statements under all themes including enhance parent-child relationship, changes in child, changes in discipline, internal changes in parent, communication, universality, acceptance, structure of play sessions, and improvement to model. Cathy's interview demonstrated Cathy experienced positive internal changes in parenting and an improved parent-child relationship. Cathy expressed changes in child, enhanced parent-child relationship, and internal changes in

parent. Cathy reported, "Everything [learned in CPRT] gave me good results because now I can understand her better, and she talks to me more". She stated, "The biggest change that I have notice is that she doesn't masturbate herself anymore. . . for me she has changed for the best". Cathy expressed positive changes in her relationship. She stated, "She doesn't lie to me anymore. We don't fight as much but our fights are mother daughter fights. I give her permission to tell me what she wants to say to me and I also apologized to her when I know I have done wrong". Cathy reported changes internally in discipline and patients. She stated, "That I don't spank her so much. I do discipline her but I don't spank her like I used to. I'm more patient now." Regarding internal changes she also stated, "I have learned to have more confidence in myself. Before I used to cry a lot but since I started therapy with my daughter I can see things clearly". Her qualitative results indicated an improvement in her parent-child relationship and communication.

CHAPTER V

DISCUSSION

This study responds to the lack of empirically supported interventions for non-offending parents of children who have experienced sexual abuse. This study examines the experiences of non-offending parents. Child-parent relationship therapy (CPRT) is a filial therapy model based on child-centered play therapy principles for which research has shown to be effective in training parents to deal with their children's social, emotional, and behavioral problems (Landreth & Bratton, 2006). CPRT was provided as an intervention to teach non-offending parents skills to be therapeutic agents for their sexually abused children. Research on CPRT with non-offending parents of children who have been sexually abused is lacking and only one study has shown CPRT is effective with this population (Costas & Landreth, 1999).

The primary objective was to incorporate quantitative data from instruments with qualitative analysis of insights, experiences and themes among non-offending parents who participated in CPRT ($n = 8$). Quantitative results provided further information to support CPRT as an effective intervention with this population. Qualitative analysis allowed the perceptions of CPRT from the participants to be examined and displayed through themes.

Quantitative Summary

Overall all means on all instruments improved over time throughout CPRT. Greatest gains seemed to be on Measurement of Empathy in Adult-Child Interaction (MEACI) indicating most overall improvement in parental empathy. From pretest to

posttest, mean gains also seemed to occur among parental stress and behavioral characteristics indicated on Parenting Stress Index (PSI) and Child Behavior Checklist (CBCL).

In disaggregating the data, results indicated mean differences between English speaking participants and Spanish speaking participants. Spanish speaking participants at pretest were in the clinical ranges on CBCL and PSI, compared to the English speaking participants who were not in the clinical range at pretest. From pretest to posttest, English speaking participants had greater gains than Spanish speaking participants on MEACI, indicating increased parental empathy. English speaking participants had greater gains on Externalizing Problems on the CBCL compared to Spanish speaking participants. Spanish speaking participants had greater gains on Internalizing Problems and Total Problems on the CBCL exhibiting more positive behavioral characteristics. Among the Spanish speaking participants, greater gains appeared on the PSI indicating parents' perceived stress decreased related to their parenting roles, behaviors of children causing stress, and their total stress overall. However five participants out of eight actually had higher total stress than at pretest. The quantitative difference scores of three participants who improved greatly provided notable decreases that when averaged among all participants made overall scores lower. English speaking participants reported no decrease in parental stress as measured by the PSI. Quantitative data was collected specifically to provide data based on participants changes overtime from CPRT.

Qualitative Summary

Enhanced Parent-child Relationship

Non-offending parents of children who have been sexually abused may have difficulty understanding their children after the abuse and a possible disruption in the parent-child relationship (Gil, 1991; Lovett, 1999; Massat & Lundy, 1998). Experts in the field emphasized that, when possible, any treatment of sexually abused children should involve parents (Costas & Landreth, 1999; Gil, 2006; Massat & Lundy, 1998). A parent is often the most influential and significant person in a child's life. Coohy and O'Leary (2008) reported mothers who provided their children who recently outcried sexual abuse with more consistent maternal support improved their children's functioning. The quality of mother-child relationship can help mitigate the effects of childhood sexual abuse (Adams & Bukowski, 2007). CPRT effectively teaches the parent to be the therapeutic agent for their child.

A primary goal of CPRT is to enhance the parent-child relationship. The focus of CPRT is on the importance of the relationship between the parent and the child (Landreth & Bratton, 2006). The parent is the mechanism for therapeutic change in the child. Landreth and Bratton (2006) stated, "The overall aim 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). Costas and Landreth (1999) reported CPRT with non-offending parents of children who have been sexually abused was effective in decreasing parent's perceived stress in the parent-child relationships, decreasing parent's perceived child behaviors, and increasing parental acceptance.

All eight participants that completed interviews discussed and reported supporting statements that CPRT enhanced their relationships with their children. All parents qualitatively reported a positive change in their relationships from participating in 30-minute play sessions each week. One parent stated, "They are closer to me, and we talk more. I know that we still have a long way to go, but I can tell that the change is closer to me". Another parent reported, "She is closer to me. She has more confidence in me and we are like friends, we actually play like little girls". The qualitative analysis revealed all participants discussed an improvement in their relationship with the child of focus.

Internal Changes in Parent

Interventions with non-offending parents is imperative to help the parent respond to the child more appropriately, help the child cope with the trauma, and improve poor parenting skills that may be abusive such as yelling (Kellog, 2002; Paine & Hansen, 2002; and Hyman et al., 2003). Mannarino, et al. (2007) reported mothers of children who were sexually abused had high levels of depression after the outcry. Massat and Lundy (1998) stated, "Parents reported disruption of relationships, income loss, loss of jobs, and change of residence" (p. 376). Parents are internally affected by their children's abuse.

Parents may feel vulnerable, confused, and guilty if they perceive they could have protected their child from the abuse occurring. Plummer (2006) reported 78 out of 125 mothers reported 159 barriers to believing abuse occurred. Often these parents are in denial or feel ashamed about the abuse (Gil, 2006). This population of parents may

have difficulty seeing how focusing on themselves and completing an intervention with other parents such as CPRT is helpful. CPRT takes the focus off of changing the child behaviorally and focuses on changing the parent through increased parental efficacy (Landreth & Bratton, 2006). Landreth and Bratton (2006) stated, "How parents feel about themselves, their sense of adequacy as a person and a parent, significantly affects their interaction with their children and thus their children's development" (p.23). CPRT with non-offending parents can assist in internal changes that foster positive changes in the child.

All eight participants that completed CPRT reported positive changes in themselves after completing CPRT. Many parents reported an increase in confidence, patience, and understanding their children. One parent summarized it as, "Overall I am feeling pretty good about you know (parenting skills learned in CPRT) I am learning more and I am seeing other parents that have gone through this and I don't feel as alone and I feel more empowered like I am not the only person so overall if I feel better about myself then maybe my family sees me like not as down and I think that just carries over to work and everything". Another parent stated, "For me this group was very special because I learned how to show my feelings for my daughter in a different way". Many parents expressed similar feelings of empowerment, confidence, and increased knowledge about parenting that helps them help their hurting children traumatized by sexual abuse.

Changes in Child

Sexual abuse causes internal changes in the child's behavior (Gil, 1991).

According to Gil (1991), a child may experience psychological impact such as increased salience of sexual issues, confusion about sexual identity, confusion about sexual norms, confusion of sex with love and care getting or care giving, negative associations to sexual activities and arousal sensations, and aversion to sex or intimacy (p. 16). The child may also appear as anxious, tense, angry, or fearful especially if sexual topics are mentioned (Johnson, 1998). External behavioral changes may also occur after a child has experienced sexual abuse such as masturbation, decrease in academic performance, or aggressive behaviors (Johnson, 1998 and Feiring et al., 1999). Gil (1991) stated behavioral manifestations include precocious sexual activity, aggressive sexual behaviors, promiscuity, prostitution, and sexual dysfunctions (p. 16). Many changes occur psychologically, emotionally, and behaviorally within a child who has been sexually abused (Gil, 1991; Johnson, 1998; and Feiring et al., 1999). Kinard (1999) stated, "Early interventions with abused children and their mothers may reduce the likelihood of academic as well as behavioral problems" (p. 372).

In CPRT training, the emphasis is not on understanding the purpose of behavior, but rather the child, their emotional needs, and importance of relationship with the child (Landreth & Bratton, 2006). The nature of CPRT is to focus on the relationship with the child, rather than behavioral problems or emotional concerns. Parents create an environment filled with nonjudgmental understanding and acceptance that enhances the parent-child relationship, thus facilitating personal growth and change for the child (Landreth & Bratton, 2006). Non-offending parents were encouraged to focus on their children rather than their problems thereby helping parents appreciate children's positive qualities and encourage children's strengths.

All parents qualitatively reported positive changes in their children after completing the 11 weeks CPRT training and weekly 30-minute playtime. One parent reported, “I notice that she is not so sad because of what happened to her (sexual abuse), she used to cry a lot, very sad but now she plays with her siblings and laughs more”. Another parent stated, “The biggest change I have notice that she doesn’t masturbate herself anymore”. A parent described her daughter’s change as, “She’s more, well she talk a lot anyways but she’s more talkative and more open and I think she realizes now that I am kind of listening to her more and I respect her opinions and her feelings more. . .”.

Improved Communication

Children may benefit when parents initiate conversations, activities that encourage open communication, and quality time. Children who have been sexually abused especially benefit from parents who take an active role in helping them cope. Coohy and O’Leary (2008) discussed the importance of the maternal response and support when a child discloses sexual abuse. Many children feel threatened, silenced, and vulnerable disclosing sexual abuse (Paine and Hansen, 2002). Gil (2006) stated:

After disclosure, they may feel disloyal for mentioning the problem, or they may have to negotiate how to understand the listener’s reactions to what is said. A more general concern is that at times, people of all cultures may experience a sense of loss and control when they reveal secrets or discuss private worries and concerns. They may feel tricked, overexposed, resentful, and frightened, as if they’ve lost control of something indescribable. (p. 12)

A parent who has been trained to therapeutically respond to their child enables the child’s free expression of thoughts and feelings to cope with the trauma.

The goals of the CPRT play sessions according to Fidler, Guerney, Andronico, and Guerney (1969) were: (a) to help the child change his perceptions or misperceptions of the parent's feelings, attitudes and behavior; (b) to allow the child through the medium of play to communicate thoughts, needs, and feelings to his parents that he had previously kept from them and often his own awareness; and (c) to bring the child a greater feeling of self-respect, self-worth, and confidence (p. 50-51). Through implementing play sessions for 30-minutes a week, a child communicates to the parent through toys, metaphors and play, while the parent learns to respond empathically and genuinely. Parents learn reflective listening, recognition of children's feelings, tracking responses, therapeutic limit setting, and self-esteem building responses (Landreth & Bratton, 2006). With new skills of relating and communicating to the child, the parent improves the parent-child relationship and gains confidence in their parenting role.

Consistent with Guerney's model, CPRT encourages parents to focus on six objectives during the 30-minute playtime including 1) establish an atmosphere of consistency and predictability for the child, 2) understand and accept the child's world, 3) encourage the expression of the child's emotional world, 4) establish a feeling of freedom, 5) facilitate decision making by the child, and 6) provide the child with an opportunity to assume responsibility and to develop a feeling of control (Landreth & Bratton, 2006, p. 78). Throughout the interviews all parents expressed CPRT improved their communication with their child of focus. One parent expressed, "Yes, because she tells me everything that happen to her, what she feels when she is sad.. . Before she didn't tell me anything, she would go into her room, but that has changed, now

everything she does is with love”. Another Spanish speaking parent reported, “Everything gave me good results because now I can understand her better and she talks to me more”. Many parents reported allowing their child to be in control, take the lead and feel free during special playtimes enabled open communication during and after the playtimes.

Changes in Discipline

There are many studies that show a strong correlation between childhood sexual abuse and psychopathology (King et al., 2000; Molnar, Buka, & Kessler, 2001 and Spaccarelli & Fuchs, 1997). Children who have suffered sexual abuse need developmentally appropriate boundaries and discipline. CPRT teaches parents therapeutic limit setting using Landreth’s A-C-T and choice giving approaches (Landreth & Bratton, 2006). According to Landreth and Bratton (2006), A-C-T stands for Acknowledge the child’s feelings or desire, Communicate the limit, and Target acceptable alternatives (A-C-T). Acknowledge the child’s feeling or desire for example is, “Jack, you’re feeling very angry”. Communicate the limit provides a definitive boundary for the child. An example to communicate the limit is, “Your brother is not for hitting”. Target acceptable alternatives are used to provide an outlet to the child for expression within appropriate limits. For example, a target alternative statement may be, “You can hit the pillow instead”. Establishing consistent limits provides a predictable, safe environment, and sense of security (Landreth & Bratton, 2006, p. 226). Both approaches to limit-setting, giving choices and ACT limit setting, allow children to choose to stop and be in control of their own behavior and actions. Rather than hitting

the child or screaming to provide punishment, the child realizes there are natural, clear, and healthy consequences.

Many of the participants' interviews revealed their old approaches to discipline consisted of yelling, anger and aggression, spanking, and criticizing. In response to CPRT training, many of the parents reported a change in how they disciplined their children. Many reported less hitting, less yelling, and less aggression. An Spanish speaking parent stated, "That I don't spank her as much. I do discipline her but I don't spank her like I used to, I'm more patient now". Another parent reported, "Before I used to scream a lot but now I try to talk to her and as a result I get more out of it". Parents of sexually abused children benefit from being taught appropriate ways to discipline their children so the child's boundaries are respected.

Universality

Universality described by Yalom (2005) is a phenomena in the therapy group where the disconfirmation of a client's feelings of uniqueness is a powerful source of relief. Hearing other members disclose concerns similar to their own, clients report feeling more in touch with the world (p. 6). Yalom (2005) stated, "Some specialized groups composed of individuals for whom secrecy has been an especially important and isolating factor place a particularly great emphasis on universality" (p. 7). Due to the nature of sexual abuse, many parents keep their child's experience secret.

Landreth and Bratton (2006) characterized CPRT process by two key components: a didactic component and a group process component in the context of a safe, reassuring, supportive, nonthreatening environment that encourages parents to

express their feelings and thoughts about themselves, their children and their parenting. In the group setting, parents are able to hear other parents' struggles, stressors, and issues with their children and the abuse. Fidler et al. (1969) stated, "The children themselves are not seen in therapy; rather their parents are relied upon to effect changes with the support of the therapist and a group of other parents involved in the same process" (p. 47). CPRT parents are also able to see other parents' play sessions during feedback and supervision. Many parents appreciated seeing other parents who learned the same skills apply those skills with their children. They also appreciated observing how other children reacted to the use of parental CPRT skills in sessions.

CPRT parents reported not telling their sisters, mothers, co-workers, or friends that their children experienced sexual abuse. Parents also reported feeling relieved to hear someone else was going through the same problems as them. All parents that participated in CPRT reported being with other non-offending parents helped them feel less alone, more empowered to cope and help their child cope, and relieved to share their secrets about their child's abuse and their feelings. One parent stated, ". . . It (CPRT group) makes you encouraged because you know I am not the only one, they (other parents in the group) go through the same thing I go through, keeps you going, keeps you motivated". Another parent reported feeling, ". . . when I realized that I was not the only person that was going through this". Another parent stated, ". . . I am seeing other parents that have gone through this and I don't feel as alone and I feel more empowered like I am not the only person. . . ". Parents who have experienced their child's disclosure of sexual abuse can benefit from the group component of CPRT.

Structure of Play Session

According to Landreth and Bratton (2006) structuring means helping the child understand the nature of the play sessions both verbally and nonverbally (p. 79). The researcher furthered this concept to incorporate the participants' responses to include parent's response to the structure of play sessions including difficulty with the toys, being with the child while they played, and allowing the child to be in charge. Treatment that allows the parent to utilize their new child-centered skills in a supervised play session is seen to be the most effective for the child and parent (Bratton et al., 2005). The play session is essential for utilizing the skills taught in the group and building the parent-child relationship.

A few parents reported the toys selected for their special playtimes were too young for their children. Parents were given the suggestion by CPRT therapists to add more arts and crafts activities if their child experienced the selected toys as too young. Other parents reported feeling uncomfortable when they stayed with children as they played. Particularly one Spanish-speaking participant reported culturally she perceived the mother role to never be on the child's level and play with toys. Finally, a few mothers reported discomfort and awkwardness in allowing the child to lead and be in control for 30 minutes.

Acceptance

Acceptance of the child who has been sexually abused is crucial. Lovett (1995) encouraged parental acceptance and involvement in a child's healing process after sexual abuse. B. Guerney (1964) stated, "What we are training them to try to do during

their session is to accept and understand their problems better, and in the process avoid interpreting their behavior to them, avoid punitive action, etc.” (p.6). In CPRT, acceptance is conveyed by ‘being with’ attitude during 30-minute special playtimes. Landreth and Bratton (2006) stated, “Children who experience such an atmosphere of acceptance in their special play session with their parents learn that they can depend on others for support while developing their own sense of adequacy and independence” (p. 84). CPRT has proved to be effective at increasing parental acceptance (Costas & Landreth, 1999; Harris & Landreth, 1997; Landreth & Lobaugh, 1998; Tew et al., 2002). Costas and Landreth (1999) also reported acceptance was significantly improved after CPRT for non-offending parents.

All CPRT participants in this study except for one reported greater acceptance from completing the training. A parent stated, “I see her (child of focus) more mature. . . I benefit the most on learning how to understand the children so we can know them better, because since we (Hispanic culture) don’t play with them we don’t have the same confidence”. Another parent stated, “I feel like a better parent, I feel like I have more knowledge, I would want to pass that on to other parents that have little bitty kids that might not know that”. Acceptance was defined from these 8 participants statements as improved beliefs about themselves as a person/parent and increased approval for self, their child, and others. Non-offending parents need to convey acceptance to their children.

Improvement to Model

Landreth and Bratton (2006) encouraged modifications to the 10-week model

and supported the use of CPRT with different populations. Many of the participants responded with suggestions to change aspects of the model for this population. Some improvements suggested included extending the amount of weeks CPRT is offered, decreasing readings assigned, and decreasing homework. Due to many of the participants being single mothers, working full time, being mothers to multiple children, and attending college courses, the homework and readings were too difficult to complete with the additional stressors in these participants' lives. Many of the participants reported more group sessions would further help them feel connected to other non-offending parents going through similar problems and assist with learning skills at a slower pace. Many parents reported that more time to express feelings and thoughts and receive support would be helpful, instead of feeling rushed in 2-hours to receive support and learn new skills, supervise sessions, and cover all material. One parent suggested making the sessions longer than 2 hours.

Observations

Results of quantitative data indicated observational differences between Spanish and English participants from pretest to posttest. More specifically, compared to the English speaking participants, the Spanish speaking participants reported greater positive behavioral changes as demonstrated through scores on CBCL Total Problems, Externalizing Problems, and Internalizing Problems. Previous research supports that Hispanic participants in CPRT found the training to help their children become more respectful and obey them more frequently which was highly valued as 'respeto', a

frequent behavioral goal in the culture. (Ceballos, 2008; Garza & Bratton, 2005; Garza, Kinsworthy, & Watts, 2009).

The English speaking participants reported more stress and the Spanish speaking participants reported less stress on the PSI Total Stress index from pretest to posttest. Overall both groups had significant amounts of stress throughout CPRT. Many parents worked full time, operated as single parents, had multiple children, dealt with detective procedures and court hearings, attended college classes, and dealt with the emotional burden of their children's experiences of sexual abuse. Many parents experienced several stressors and some had to consistently interact with the perpetrator due to roles as significant others, cousins, or uncles. Many parents reported more external stressors after CPRT than in the beginning such as financial stress, family conflicts, stress from significant others, and educational stress. Overall, non-offending parents appeared to need extra support every week including phone calls, more time to process or express feelings in group, more time for questions and concerns, extra encouragement, and often more time after group to talk individually. This appeared to be specifically true for the Spanish speakers due to two parents reporting that more group sessions would be beneficial. Previous research supports that extra support is especially important for the Hispanic culture (Ceballos, 2008; Garza & Bratton, 2005; and Garza, Kinsworthy, & Watts, 2009).

Finally, the families' finances were a significant source of external stress for these parents. Income status was not obtainable, but most participants appeared to fall below the poverty line. Specifically, income was another characteristic that placed constraints on some participants' attendance and participation throughout CPRT

groups. Participants received free counseling services from CAC and many received additional resources upon requests. Many reported having difficulty with transportation, taking off of work, and receiving child-care payment from their ex-spouses.

The English speaking participants overall scored lower on the MEACI from pretest to posttest compared to Spanish speaking participants. The results indicated English speaking participants improved expressing empathy during adult-child interactions. One reason the English speaking participants may have improved more than the Spanish speaking group is the differential supervision of play sessions between English and Spanish groups. The Spanish speaking participants were asked to video record twice at CAC but the other play sessions were to be recorded at home. The English speaking participants were asked to record four at the CAC and the other play sessions were to be recorded at home. The English speaking group recorded and experienced supervision four times throughout the process of CPRT. Play session skills and competencies for the English group may have improved as a result of video recording more sessions than the Spanish group.

Another reason the skills on the MEACI may have improved for the English speaking participants is their comfort initially with conducting the 30-minute play sessions. Many of the Spanish speaking participants were reluctant or hesitant to begin the play sessions. One parent reported she felt culturally that her role as a mother was not to play with her children. The parent reported understanding the purpose of playing at the completion of CPRT and gained an enhanced relationship with her daughter. Spanish speaking participants may have been less comfortable initially to begin the play sessions than the English speaking participants and therefore scored higher on the

MEACI. This finding reinforces the suggestion that Spanish speaking participants may need more individual support to provide *personalismo* and more CPRT group sessions to emphasize *allocentrism* a value or need to form interpersonal relationships in groups that are nurturing and respectful (Ceballos, 2008).

Implications

Intervention

For future research with non-offending parents completing CPRT, I suggest extending the 10-week model to 15-weeks, concurring with suggestions from Costas and Landreth (1999). Adding five additional weeks at the beginning will allow the parents to tell their story of their children's abuse. This would allow for parents to slowly express feelings and thoughts that are uncomfortable or previously secret. Extra time would allow these particular parents who do not feel comfortable sharing during the first session to share in the following sessions, also allowing for parents to receive support and feel heard. As discussed before, the universality aspect for this population is significant. The five additional weeks before beginning CPRT allows for relationships to build between the group leader and participants, trust to be gained, and the bonds with other non-offending parents to be formed. Before beginning the teaching of new skills, the parents need support and time to cope with what has happened. The researcher experienced that these participants had several questions weekly regarding the court process, prosecution, specific sexual abuse behaviors, and emotional effects. Psychoeducation of sexual abuse effects, preventions, implications, and court hearing/prosecution process may need to be addressed before the parents begin

CPRT. Therefore, adding five weeks before beginning the 10-week filial therapy model may help the parent feel more open, comfortable, and ready to learn new skills, begin play sessions, and be supervised in front of the group. Costas and Landreth (1999), a study conducted with non-offending parents, similarly recommended the first four sessions be condensed into the first two weeks to begin the play sessions sooner. They also recommended five additional sessions are added for skill building and feedback, due to the uniqueness of these parents' experiences.

Furthermore, non-offending parents typically have many additional stressors in their lives beyond the children's experiences of sexual abuse. The researcher suggests altering the amount of homework and readings to provide the parent less stress outside CPRT group. I encourage CPRT group leaders to provide time during the group to complete any homework assignments or additional reading that was pertinent to learning the skills of CPRT. Feedback from many parents during the interviews included less homework and fewer assigned readings. Additionally, greater positive results on the MEACI scores from the English speaking participants indicating increased parental empathy than the Spanish speaking group. Additional supervision, recordings, and feedback given to the English participants may have contributed to their greater improvement of parental empathy. I suggest more one-on-one supervision and feedback for non-offending parents. This was consistent with Costas and Landreth (1999) findings. They reported finding it was difficult for parents to video record a play session on their own. Costas and Landreth (1999) also reported helping the parent record the play session was common in order for their participants to have a recorded session to share in CPRT group for feedback and supervision. The parent may benefit

most from the first video recording and feedback individually to prevent embarrassment, vulnerability, or feeling threatened initially in the group setting. Non-offending parents have several other stressors and appear to need as much one-on-one attention the leader can provide to learn the skills, feel comfortable to begin the play sessions, and utilize their skills with their children.

Research

Because there is a lack of empirically researched and validated interventions with non-offending parents whose children have experienced sexual abuse, future quantitative research with non-offending parents in CPRT would benefit the mental health population. Further research in CPRT may include a closer examination of Spanish speaking parents alone in CPRT who have sexually abused children. I found difficulty in recruiting parents who met criteria for the study and would suggest future researchers recruit from more than one site. To gain more insight of the non-offending parents' experiences, an interview before beginning CPRT would be helpful to make comparisons with the post interview. Also, if using instruments, multiple points of data collection may be useful if working with a smaller sample size in order to measure change effectively.

Limitations

Complications related to working with the special population of non-offending parents led to several limitations of this study. One limitation to this study was the sample size of participants. I was unable to recruit enough participants for quantitative

analysis, hence, the results are not generalizable. Results with such few participants ($N = 8$) pose a problem in making statements regarding all non-offending parents. Also, a limitation was the ability to keep the ideal amount of participants participating throughout the entire CPRT process. There were two participants who dropped out by the end of the intervention. Due to childhood sexual abuse being difficult to disclose for children and for adults to accept, the researcher found few participants willing to commit to CPRT for 11 weeks. Recruitment was low at CAC possibly due to busy parent's schedules, additional stressors in parents' lives, or parents emotionally not ready to cope and process the trauma their children have experienced. Non-offending parents may not be in a functional place to begin treatment after hearing the disclosure and may not be able to fully invest in CPRT. Due to CPRT teaching the non-offending parent to be the therapeutic agent, the parent must be emotionally available enough to learn through the didactic process and be with the child through the play sessions.

Another limitation was that all participants who completed CPRT ($N = 8$) only had one round of interviews. A lack of different time periods of qualitative data collection limits the qualitative analysis. I did not conduct an interview at pretest. The information to draw comparisons of interviews from pretest to posttest may have provided additional insight into the participants' experiences. I may have gained further insight into how the experience for participants fostered positive growth in self as a parent and positive changes for the child of focus. Another possible limitation was use of Spanish translation to analyze the qualitative interviews. I hired a Spanish translator to translate and transcribe all Spanish interviews. Meanings, cultural references, or words may have been lost in translation when translating from English to Spanish. Also the raters (two

Caucasian and one Asian) who coded the participants' interviews were unfamiliar with the Spanish language, affecting interpretations of sayings or meanings culturally. Although the professional translator attempted to transcribe for meaning, all coders read the interviews literally and may have missed cultural implications or references.

The Hawthorn effect is another limitation to this study because the parents in the CPRT groups may have perceived they should be doing better and therefore reported they did better. Additionally, a limitation was that all participants had a different number of previous sessions and different experiences of therapeutic interventions. Some participants were involved in support groups before beginning CPRT, some had individual sessions, and all had their children in individual or group play therapy. Therefore, the parent's change over time could be due to time, previous therapy, or their child's progression from separate interventions occurring simultaneously.

A final limitation was that parents in both groups did not record play sessions at home with the video cameras provided by me, as required by the CPRT protocol. I discussed with English speaking parents how crucial it was to complete the weekly play sessions and be consistent. Many parents reported extraneous stress was overwhelming and often the session was missed. Because parents were not following protocol, the researcher leading the English group asked parents to video record at CAC before or after CPRT group to ensure they completed their play sessions and they were recorded for feedback and supervision. Therefore, the English speaking participants completed three to four recordings at CAC and an additional one-on-one supervision of a play session. Parents in the Spanish group reported even less adherence to the protocol of recording sessions.

Conclusion

Although quantitative data was mixed, all 8 participants qualitatively reported CPRT was effective in helping them cope personally and as a parent with their children's sexual abuse. Qualitative analysis showed CPRT was a helpful and enriching experience for non-offending parents whose children have experienced sexual abuse. All participants reported CPRT improved their child-parent relationship, increased the communication, and changed the way they disciplined. Additionally, all participants reported positive changes internally regarding how they see themselves and how they perceive their parenting abilities and skills. Participants reported their children of focus demonstrated positive behavioral, psychological, and or emotional changes from completing CPRT. Finally, all parents reported being in a CPRT group helped them feel less alone, connected to other parents who experienced similar problems, and more empowered to heal and help their child cope with the trauma. Results of this study indicate that CPRT may be a valuable intervention for parents of sexually abused children, specifically in the building of a positive parent-child relationship.

APPENDIX A
PARENT CONSENT FORMS

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, risks, and benefits of the study and how it will be conducted.

Title of Study: Child Parent Relationship Training (CPRT) with Parents of Children who have been sexually abused

Principal Investigator: Brooke West, PhD candidate at University of North Texas (UNT) Department of Counseling and Higher Education. Co-Principle Investigator: Dr. Sue Bratton. Other key personnel: Dr. Ashley Lind, Senior Director of Clinical Services at Children's Advocacy Center.

Purpose of the Study: You are being asked to participate in a research study which involves measuring the effectiveness of a parent training model called Child Parent Relationship Training (CPRT). The goal of CPRT is to help parents build a stronger relationship with their children. A strong parent-child relationship is particularly important for children who have experienced sexual abuse. CPRT aims to help parents help minimize the impact of the abuse on their children by helping parents better understand their children's concerns and helping them learn developmentally appropriate responses that foster healthy social-emotional development. You will be randomly assigned to participate in CPRT the first 11 weeks.

Study Procedures: The entire project should take approximately **twenty-five hours**. You will meet **weekly** with a trainer for **two hours** in a group with other parents. During CPRT, you will also do **seven weekly** play sessions with your child at home. Each play session will be about **thirty minutes**. You will also be video recorded playing with your child to help you better understand your child's needs and to help you learn responses that can help your child feel closer to you, while facilitating your child's communication with you through play. Through play, children can more comfortably communicate their world, especially when they have experienced events outside of their cognitive understanding.

The eleven-week training will include the following:

Before the eleven-week training, you will be asked to answer some basic questions about yourselves, your child, and your relationship with your child. This will be done in written form using two standard assessment forms: the Parent Stress Index (PSI) and the Child Behavior Checklist (CBCL). The PSI asks questions about your level of parenting, and the CBCL asks questions about your child's behavior. Before beginning CPRT you will also be video recorded playing with your child for thirty minutes.

During the eleven-week CPRT training, you will learn skills that are designed to strengthen your relationship with your child, understand your child's needs, help you know how to respond to your child in difficult situations, and help your child feel understood and loved. Video and live demonstrations, live practice sessions, role-plays and group discussion will be used to help you apply CPRT skills. The weekly group sessions will be video recorded. You will also be video recorded playing with your child throughout the 10- week session to assist you in learning the CPRT skills. You have an opportunity to share a video of you and your child within the group for supervision of your skills and encouragement.

After the eleven-week training, you will be asked to complete a PSI and CBCL and participate in a final video recorded play session with your child.

Foreseeable Risks: There are no foreseeable significant risks to participating in this study. You might feel some discomfort discussing your family's experience with abuse or by hearing another parent's story or through sharing other personal information with the investigator or other parents. The investigator will attempt to minimize discomfort by ensuring that parents do not feel pressured to disclose information that would cause discomfort.

Benefits to the Subjects or Others: Potential benefits of being in this project may include a stronger parent-child relationship, increased confidence in parenting and reduced problem behaviors of your child. You may also benefit from being with other parents who are experiencing similar experiences with their child.

Procedures for Maintaining Confidentiality of Research Records: You will be assigned a code and only that code will be used on any stored information you provide, including pre and post video recordings. The confidentiality of your individual information will be maintained in any publications or presentations regarding this study. No one will view your group or play session recordings or look at your assessment responses other than the investigators/raters. Your pre and post video recordings and assessments will be kept for no more than three years beyond the end of data collection and will be destroyed by the researcher. All recordings and assessments will be securely locked in a secure location 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 *Brooke West* at telephone number or my faculty advisor *Dr. 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:

- The researcher, Brooke West, 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

Date

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

Tribunal de Examinadores de la Institución de La Universidad del
Norte de Texas (The University of North Texas)
Autorización de Aplicación para el Tratamiento

Antes de comprometerse a participar en este estudio investigativo, es importante que lea y entienda la explicación que sigue sobre el propósito, riesgos, y los beneficios del estudio y como se manejará.

El Título del Estudio: Entrenamiento de la Relación entre Padres e Hijos (ERPH) con padres o cuidadores de niños que han sido abusados sexualmente.

La Investigadora Principal: Brooke West, Candidata para el PhD de la Universidad del Norte de Texas (UNT) el Departamento de Consejería y Enseñanza Superior, Dr. Sue Bratton. Otra personal clave: La Doctora Ashley Lind, Directora Principal de los Servicios Clínicos en El Centro de la Defensa para los Niños de Dallas (Children's Advocacy Center).

El Propósito del Estudio: Pedimos a usted participar en un estudio investigativo que involucra medir la eficacia de un modelo de entrenar a los padres que se llama Entrenamiento de la Relación entre Padres e Hijos (ERPH). La meta de ERPH es ayudar a los padres construir una relación más fuerte con sus hijos. Una relación fuerte entre los padres e hijos es especialmente importante para los niños que han experimentado el abuso sexual. El ERPH intenta ayudar a los padres disminuir el impacto del abuso sobre sus hijos por ayudar a los padres mejor entender las preocupaciones de sus hijos; también los ayuda aprender respuestas apropiadas según el nivel de desarrollo de sus hijos que fomenta el desarrollo sano social y emocional. Tú serás asignado a participar en (ERPH) por 11 semanas, o in Amor y Lógica por 11 semanas. Si eres asignado en (Amor y Lógica) en el primer grupo, después de 11 semanas, tendrás la oportunidad de estar en (ERPH) y viceversa.

Procedimientos del Estudio: El proyecto entero debe de durar aproximadamente **veinticinco horas**. Usted necesitará juntarse con una entrenadora por **dos horas cada semana** en un grupo con otros padres. Durante el tiempo en ERPH usted hará **siete sesiones semanales** de jugar con su hijo en su casa. Cada sesión de jugar durará aproximadamente **treinta minutos**. También usted estará grabando por video su jugar con su hijo para ayudarle a entender mejor las necesidades de su hijo y ayudarle aprender respuestas que ayudan a su hijo sentirse más cerca de usted, mientras mejora la comunicación de su hijo con usted por medio de su jugar. Por medio de jugar, los niños pueden comunicar más cómodamente sobre su mundo, especialmente cuando han experimentado eventos fuera de su entendimiento y habilidad de conocer.

El entrenamiento de once semanas se incluirá lo siguiente:

Antes del entrenamiento de once semanas se preguntará a usted algunas preguntas básicas sobre si mismo, su hijo, y su relación con su hijo. Esto se hará en forma escrita usando dos formas de evaluación estándar: el Índice del Estrés de los Padres (IEP) y el Cuestionario sobre el Comportamiento de Niños (CCN). El IEP tiene preguntas sobre su habilidad para cuidar de los hijos, y el CCN tiene preguntas sobre el comportamiento de su hijo. Antes de comenzar el ERPH también se grabará a usted jugando con su hijo, por treinta minutos.

Durante del entrenamiento de once semanas para ERPH, usted aprenderá habilidades que son diseñadas para consolidar su relación con su hijo, entender las

necesidades de su hijo, ayudarle a saber cómo responder a su hijo en situaciones difíciles, y ayudar a su hijo sentirse amado y entendido. Demonstraciones por video y vivos, sesiones vivas de práctica, representación de papeles/ obras de situaciones reales y discusión en el grupo se usará para ayudarle a aplicar las habilidades del ERPH. Su identidad no se revelará y todos los videos se destruirán al final del proyecto.

Después del entrenamiento de once semanas, se pedirá a usted completar un IEP y un CCN y participar en una sesión grabado final de jugar con su hijo.

Riesgos Anticipados: No hay ningún riesgo anticipado sobre participar en este estudio. Es posible que usted se sienta alguna incomodidad en hablar de la experiencia de su familia con el abuso o en escuchar la historia de otro padre o por compartir otra información personal con la investigadora u otros padres. La investigadora intentará reducir al mínimo su incomodidad por asegurarse que los padres no se sienten apresurados compartir cualquier información que podría causar incomodidad.

Las Ventajas para los Participantes u Otros: Las ventajas de participar en este proyecto se pueden incluir una relación más fuerte entre el padre y el hijo, más confianza en su habilidad de cuidar de los hijos y menos comportamientos problemáticos de su hijo. También se puede beneficiar de estar con otros padres que están experimentando experiencias similares con sus hijos.

Los Procedimientos para Mantener la Confidencialidad de los Archivos del Estudio Investigativo: Le van a asignar un código a usted y solamente este código se usará en cualquier información archivada que usted provee; se incluyen los videos. La confidencialidad de su información individual se mantendrá en cualquier publicación o presentación sobre este estudio. Nadie va a ver las grabaciones de su grupo o sesiones de jugar, ver sus respuestas en las evaluaciones, o ver las grabaciones sus sesiones de jugar excepto la investigadora. Las grabaciones se guardarán no más que tres años después del fin de la colección de datos y entonces la investigadora se las destruirá. Todas las grabaciones y evaluaciones estarán cerradas con llave segura en un lugar seguro en Stoval Hall Cuarto 114 en la Universidad del Norte de Texas, Denton, TX.

Preguntas sobre el Estudio: Si tiene preguntas sobre el estudio, se puede contactar con Brooke West al número de teléfono o su consejera de la facultad Dr. Bratton al (940) 565-3864.

Reviso de la Protección de los Participantes: Este estudio investigativo será revisado y aprobado por el Tribunal de Examinadores de la Institución de La Universidad del Norte de Texas. Se puede contactar con el Tribunal de Examinadores de la Institución de UNT al (940) 565-3940 con cualquier pregunta que tenga sobre los derechos de los participantes del estudio.

Los Derechos de los Participantes: Su firma abajo indica que usted ha leído o alguien le ha leído todo lo de arriba y que usted confirme todo lo siguiente:

- La investigadora, Brooke West, le ha explicado el estudio a usted y ha contestado todas sus preguntas. Le han dicho a usted todas las ventajas posibles y los riesgos anticipados y o incomodidades del estudio.
- Usted entiende que no se requiere participar en este estudio, y si niega participar o si decide retirarse del estudio no resultará en ninguna sanción ni pérdida de derechos o ventajas. Los personales del estudio pueden escoger parar su participación en el estudio en cualquier momento.

- Usted entiende el propósito del estudio y como se realizará.
 - Usted entiende sus derechos como participante del estudio y usted consiente voluntariamente participar en este estudio.
 - Le dijeron a usted que va a recibir una copia de esta forma.
-

Nombre de la participante en letras de molde y firme

La fecha

Para la Investigadora Principal o la Nombrada:

Y certifico que he examinado el contenido de esta forma con el participante que firmó arriba. He explicado las ventajas posibles y los riesgos anticipados y o los incomodidades del estudio. Es mi opinión que el participante entendió la explicación.

Firma de la Investigadora Principal o la Nombrada

La fecha

APPENDIX B
SEMI-STRUCTURED INTERVIEW QUESTIONS

Semi Structured Interview Questions

1. When you heard about this group, how did you think this group would benefit you/your child? What were you hoping to learn or gain out of group?
2. What changes in your child, if any, have you noticed since you started weekly play sessions?
 - a. How many special playtimes have you had?
 - b. What was your child's response to the special play times?
3. What changes do you notice in yourself and in your parenting of your child?
4. What changes do you notice in your relationship with your child? Do you notice any difference in how you feel toward your child?
5. Describe your thoughts on the skills you learned in this group:
 - a. Most helpful:
 - b. Least helpful:
 - c. Easiest to use:
 - d. Most difficult to use:
6. Describe your impression of this group.
 - a. What did you like most/ find most helpful about the group?
 - b. What did you find least helpful about the group?
 - c. Suggest ways to improve training for next group of parents.
7. Other comments:

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