

SCHOOL BASED CHILD PARENT RELATIONSHIP THERAPY (CPRT) WITH LOW  
INCOME BLACK AMERICAN PARENTS: EFFECTS ON CHILDREN'S  
BEHAVIORS AND PARENT-CHILD RELATIONSHIP  
STRESS, A PILOT STUDY  
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This study examined the effectiveness of training low income Black American parents in child parent relationship therapy (CPRT). In response to the cultural values and challenges faced by low income Black American parents, the CPRT manual was adapted slightly for use with parents for this study. In this quasi-experimental design, 14 parents were assigned to the experimental group and 13 parents were assigned to the no treatment control group.

Six hypotheses were analyzed. Different analyses were conducted based on the hypotheses. A two-factor repeated measures analysis of variance and analysis of covariance were conducted to determine if the CPRT treatment and the no treatment control group performed differently across time according to pretest and posttest results of the Child Behavior Checklist – Parent Version (CBCL) and the Parenting Stress Index (PSI). Additionally, partial  $\eta^2$  was calculated to determine practical significance. Five hypotheses were retained at the .025 level of significance

Findings indicated that parents who participated in the CPRT training reported a statistically significant decrease in parent-child relationship stress. Specifically, parents assigned to the experimental group demonstrated a statistically significant decrease in Child Domain ( $p < .001$ ), Parent Domain ( $p < .001$ ), and Total Stress ( $p < .001$ ) of the PSI when compared to parents assigned to the no treatment control group. Similarly, results indicated that parents assigned to the experimental group reported statistically

significant improvements in Total Problems ( $p < .01$ ) and Externalizing Problems ( $p = .001$ ) of the CBCL, when compared to parents assigned to the no treatment control group. No statistical significant results were found on Internalizing Problems.

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I have waited long enough to make it to the end of this particular journey in my life. In light of this celebratory event, I have to take a moment to give many thanks to those who provided laughter, guidance, support, and love throughout this process.

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I wanted to save the best for last by dedicating this to my role model and hero – Mom, this one's for you.

## TABLE OF CONTENTS

	Page
ACKNOWLEDGEMENTS .....	iii
LIST OF TABLES .....	vi
Chapters	
1. INTRODUCTION .....	1
Statement of the Problem .....	3
Review of Related Literature .....	4
Rationale for Child Parent Relationship Therapy (CPRT) .....	19
Black American Values .....	34
Purpose of the Study .....	39
2. METHODS AND PROCEDURES .....	41
Definition of Terms .....	41
Research Hypotheses .....	43
Instrumentation .....	44
Participant Selection .....	49
Treatment .....	53
Data Collection .....	57
Analyses of Data .....	58
3. RESULTS AND DISCUSSION .....	61
Results .....	61
Discussion .....	67
Researcher's Observations .....	78
Limitations of the Study .....	83
Contributions and Strengths of the Study .....	85
Conclusion .....	87
Recommendations for Future Research .....	88
Appendices	
A. PARENT CONSENT .....	90

B. FAMILY BACKGROUND FORM.....	94
REFERENCES.....	97

## LIST OF TABLES

	Page
1. Demographic Information for Parents in the Experimental and Control Group...	53
2. Demographic Information for Children of Parents Assigned to the Experimental and Control Group .....	53
3. Mean Scores on Total Stress, Child Domain, and Parent Domain of the Parenting Stress Index.....	62
4. Mean Scores on Total, Externalizing, and Internalizing Problem Scales on the Child Behavior Checklist.....	65
5. Analysis of Covariance for Total Problems on CBCL .....	65
6. Analysis of Covariance for Externalizing Problems on CBCL.....	66
7. Analysis of Covariance for Internalizing Problems on CBCL .....	67



## CHAPTER 1

### INTRODUCTION

In September 2000, the Surgeon General's Conference on Children's Mental Health brought the nation's attention to the critical needs of mental health care services for children. A report (U.S. Public Health Service, 2000) was created as a result of this conference that described alarming statistics:

In the United States, one in ten children and adolescents suffer from mental illnesses severe enough to cause some level of impairment. Yet, in any given year, it is estimated that about one in five children receive mental health services. (p. 11)

This report addressed the overall goal of incorporating mental health as an essential component to healthy growth and child development, with an emphasis on more research supporting culturally and developmentally appropriate mental health services for minority children and their families. Furthermore, the report from the New Freedom Commission on Mental Health (2003) stressed the need to provide early mental health intervention in institutions with less stigma such as schools.

The need for action to address the socio-emotional development of young children may even be more critical for Black Americans. In 2002, Black Americans represented 13% (36 million) of the United States population, with 8.8 million consisting of Black American families (McKinnon, 2003). Black Americans accounted for approximately 23% of the population living in poverty within the United States in 2001, compared to 8% for Caucasians. Black American children under the age of 18 were three times more likely to live in poverty than Caucasian children. The disproportionate amount of Black American children increases for children aged six and below who represent 44% of the population living in poverty (Parham, White, & Ajamu, 1999).

Social and environmental forces, such as poverty, serve as a threat to the mental well being of Black American children and their future. The effects of poverty are extensive and place Black American children at-risk for academic failure and drop out, socio-emotional problems, and incarceration (Duncan, Brooks-Gunn, & Klebanov, 1994; Lamy, 2003; Fernandez, 2005; Nievar & Luster, 2006). In 2000, Cheeseman Day and Jamieson (2003) reported Black Americans ranking third in high school drop out rates. According to Harrison and Beck (2005), “blacks were nearly 5 times more likely than whites, nearly 3 times more likely than Hispanics, and over 8 times more likely than persons of other races to have been in jail” (p. 8).

In addition to the increased risk of poor academic, social, and emotional outcomes for Black American children living in poverty, negative outcomes extend to the familial environment. A lack of financial resources can result in high parental stress. Heightened stress coupled with poverty has been correlated with negative parenting styles (Bluestone & Tamis-LeMonda, 1999; Deater-Deckard & Dodge, 1997). In their examination of the negative outcomes of parental stress, Lempers, Clark-Lempers, and Simons (1989) stated that “parenting is likely to be less child-centered and nurturant and more rejecting, inconsistent, and parent-centered” (p. 35). The authors projected behavioral and emotional problems during adolescent years as a result of reduced parental nurturance and inconsistent parent discipline.

Parents serve as strong influences on children’s socio-emotional development and academic success (Jackson, Gyamfi, Brooks-Gunn, & Blake, 1998; Slater & Power, 1987). Positive outcomes of parental participation in parenting programs on children’s academic success, behavioral, and socio-emotional development include decrease in

child disruptive behaviors, increase in school adjustment, and higher academic achievement (Bernazzani, Cote, & Tremblay, 2001; Cann, Rogers, & Matthews, 2003; Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000; Veeing, Blampied, & France, 2003).

Historically, Black American families have underutilized mental health services in community settings and the review of literature shows that the counseling profession has been slow in addressing the unique needs of this population, particularly the needs of young children and their families (Baggerly & Parker, 2005; Glover, 2001; Ray, Bratton, Rhine, & Jones, 2001; Solis, Meyers, & Varjas, 2004). Reasons for Black Americans being underrepresented and underserved in mental health services include distrust of Caucasian service providers, misdiagnosis and overdiagnosis of mental disorders, and discrepancy of expectations between therapist and client (Boyd-Franklin, 1989; Grier & Cobbs, 1968; Parham & Parham, 2002; Parham et al., 1999; Solis et al., 2004; Sue, 1977). According to Parham et al. (1999), Black Americans utilize mental health services as a last resort. However, with people of color terminating therapy after one session twice as much as Caucasian clients (Sue, 1977), the utility of counseling services for Black Americans is difficult to establish. Sue proposed future research to examine more “responsive services....[that demonstrate a better] match or fit between ethnic background and treatment” (p. 624).

### Statement of the Problem

Although the outcome of parenting programs is encouraging, there is a dearth of literature examining the impact of parent education programs for low income, Black

American families (Gorman & Balter, 1997). According to Alvy (1994), most traditional parent education programs were designed for Caucasian, middle class parents who have, at minimum, obtained a high school diploma. Alvy suggested these traditional programs do not serve those who are non-White and living in poverty. Gorman and Balter (1997) identified only two quantitative published studies that examined culturally adapted parenting programs specifically for low income, African American families. Gorman and Balter defined culturally adapted programs as “incorporating, to a greater or lesser degree, the values and cultural traditions of the target population” (p. 343). Furthermore, two additional single case studies investigating the impact of filial therapy (a parenting program based upon child centered play therapy principles and skills) were identified: 1) one lower-middle class African American mother (Solis et al., 2004); and 2) one middle class, immigrant Jamaican mother (Edwards, Ladner, & White, 2007).

### Review of Related Literature

This review of related literature focuses on the following concepts: (1) parental influence on children’s well being, (2) rationale for early mental health intervention, (3) parenting styles, (4) Black American parenting styles, (5) importance of the parent and child relationship, (6) culturally adaptive parenting programs for Black Americans, and (7) rationale for utilizing child parent relationship therapy (CPRT) with Black American parents.

#### *Parental Influence on Children’s Behaviors and Social/Academic Success*

Parents serve as strong influences on children’s socio-emotional development

and academic success (Jackson et al., 1998; Slater & Power, 1987). In order to facilitate children's mental health, it is imperative for parents to be involved in their children's lives. Research has demonstrated the positive impact of parental involvement on children's academic achievement and enhancement of the parent-child relationship (Lamy, 2003; Parker, Boak, Griffin, Ripple, & Peay, 1999). Positive parenting strategies communicated to their children at an early age serves to mitigate potential cognitive and behavioral problems that will continue into adult life (Baggerly & Parker, 2005). In the absence of positive parenting strategies, children face the possibility of cognitive, social, and emotional difficulties.

Families living in poverty serve as a risk factor which may reduce parental effectiveness. There is a disproportionate amount of Black American families living in poverty. Based on data from a longitudinal study consisting of approximately 1,360 low income based families, Duncan, Brooks-Gunn, and Klebanov (1994) reported nearly 40% of African American families' income remained below poverty level for 5 out of the 6 years of the research study. The authors reported only 1 Caucasian in 20 fell below the poverty level in 5 of the 6 years. When compared to families who were above poverty level throughout the 6 year study, Duncan et al. (1994) reported that the children of families who remained below poverty level scored lower in IQ and scored higher in externalizing and internalizing behavior problems.

Additional risk factors associated with families living in poverty include increased use of negative parenting styles, such as corporal punishment, (Bluestone & Tamis-LeMonda, 1999; Deater-Deckard & Dodge, 1997; Evans, 2004; Larzelere, 2000; McLoyd, Jayaratne, Ceballo, & Borquez, 1994; Mitchell, 2005) and increased incidence

of parental depression (Albright & Tamis-LeMonda, 2002). In their study on the effects of low income depressed mothers, Albright and Tamis-LeMonda reported that mothers who were depressed communicated less warmth, less interaction, and less flexibility.

### *Rationale for Early Mental Health Intervention*

Black American children living in poverty are at risk for academic challenges and behavioral difficulty. Parenting intervention strategies in early childhood could substantially reduce negative child behavior outcomes (Garbarino, Dubrow, Kostelny, & Pardo, 1992; Slater & Power, 1987). Storch and Floyd (2005) stressed early intervention as being “critical to prevent negative developmental trajectories and outcomes” (p. 106). Other researchers also stressed the need for parenting intervention as early as the preschool level (Peth-Pierce, 2000; Randolph, Koblinsky, & Roberts, 1996).

The demand for early parenting intervention is warranted as disruptive behaviors, such as aggression, typically appears in early childhood and has a tendency to become resistant to change over time (Bernazzani et al., 2001; Tremblay, 2000). Hence, a young child demonstrating highly aggressive behaviors early in life will have a tendency to continue this negative behavior into adolescence and later into adulthood. Due to the stability of parenting behavior across the lifespan, Collins et al., (2000) postulated an accumulating effect of parenting practices that continue throughout childhood and adolescent years. Hence, it is strongly encouraged to provide parent interventions at the earliest possible age to facilitate children’s optimal growth and development.

## *Parenting Styles*

Baumrind (1967, 1971, 1978) described three distinct types of parenting: authoritarian, permissive, and authoritative. Each style consists of specific parenting characteristics related to the dimensions of nurturance and control. Authoritarian parenting consisted of characteristics that include punitive, demanding, and controlling behaviors. Authoritarian parents communicate a low degree of nurturance and warmth towards their children. The second type, permissive, characterized those parenting qualities that were lenient, nonpunitive, and nondemanding. Permissive parents tend to exhibit a high degree of nurturance and a low degree of parental control. The last type, authoritative parenting, was defined by behaviors that are collaborative, respectful, and firm. Authoritative parents have a tendency to use a high degree of control and warmth. In her examination of 134 parent-child relationships, Baumrind concluded that authoritative parents were most likely to facilitate competent, responsible, and independent children.

The parenting styles identified by Baumrind (1967, 1971, 1978) were generalized to families living in poverty. Martini, Root, and Jenkins (2004) found that low income mothers of various ethnic groups scored significantly higher on the authoritarian belief questionnaire compared to middle-income mothers. Additional studies that reported Black Americans as more authoritarian in parenting style and parental control compared to Caucasian parents also identified several cultural and environmental influences: low income, single parenting, high stress, low maternal age, high religiosity, and low neighborhood quality (Baumrind, 1972; Brody & Flor, 1998; Dearing, 2004; Durrett,

O'Bryant, & Pennebaker, 1975; Elder, Eccles, Ardelt, & Lord, 1995; Kelley, Power, & Wimbush, 1992).

Despite the extensive contribution of Baumrind's studies to the parenting literature and studies thereafter that applied her parenting styles to Black Americans, the universality of parenting styles remains an ongoing debate. For example, Whaley (2000) insisted that the result of Baumrind's study does not generalize to Black American families due to the fact that her participants consisted of middle to upper class Caucasian families. Instead, several researchers posited that parenting styles contribute to different child outcomes based upon their cultural background, such as socioeconomic status (Cohen, 2001; Dearing 2004; Deater-Deckard, Dodge, Bates, & Pettit, 1996; Sampson, 1992; Short, 2006). For example, strict parenting for low income Black Americans residing in potentially dangerous, low quality neighborhoods could serve as a form of protection and "tough love" in order to prevent children from engaging in high risk activities and to encourage independence (Bartz & Levine, 1978; Brody & Flor, 1998; Kelley et al., 1992; Young, 1974). This description fits one of the characteristics of "no nonsense parenting". Brody and Flor (1998) developed the term no nonsense parenting and compared their definition to Baumrind's parenting styles (1971) as "falling between authoritative and authoritarian styles" (p. 813). Brody and Flor highlighted the cultural value of high parenting control and high warmth:

In some cultural groups, children may perceive the high level of control associated with no nonsense parenting as harsh, and may consider it evidence of parental rejection. Among African Americans, however, the same parenting practice is construed as a sign of parental involvement and concern. (p. 813)



### *Black American Parenting Styles*

Black Americans identified as using an authoritarian style of parenting typically use physical punishment as a disciplinary measure. Goodman (1997) reported that Black American parents are more likely to use physical punishment. However, the use of physical punishment does not necessarily result in behavioral problems for Black American children. Whaley (2000) concluded from his literature review of physical discipline within Black American parents that none of the studies supported a positive correlation between spanking and disruptive behaviors as an outcome for Black American children.

In a longitudinal study examining the mediating effect of maternal support on spanking and behavioral problems in children, McLoyd and Smith (2002) indicated no relationship between spanking and behavioral problems among African Americans, Caucasians, and Hispanic children. Specifically, they concluded that mothers demonstrating high emotional support to their child reported a low level of child behavioral problems. Conversely, children with low level of maternal emotional support were reported to have a high level of behavioral problems. McLoyd and Smith further highlighted that children who were spanked coupled with high level of maternal emotional support did not demonstrate an increase in behavioral problems.

In his discussion of physical discipline, Whaley (2000) distinguished two distinct forms: parent-oriented and child-oriented. Child-oriented discipline stems from the goal of teaching children self respect and responsibility. Parent-oriented discipline stems from the goal of obeying parent authority. Whaley postulated that it is not the act of the discipline, but the intent behind the act that determines negative behavioral outcomes

for children. Based upon his review of literature of physical punishment outcomes with Black Americans, Whaley concluded that these studies have reported a negative association or no association between the use of physical punishment and disruptive behaviors in Black American children. Whaley speculated that Black American's previous and current exposure to oppression has shaped a unique role in the use of physical punishment in the Black American family. With a desire to protect children from racism and discrimination, Whaley proposed that physical discipline within Black American families is characterized as child-oriented and thus serves to increase the child's self control. Whaley explained "from an African American cultural perspective, the goal of spanking may be to use strong external controls to help children develop better self-control rather than external control being an end in itself"(p. 8). Furthermore, Whaley indicated that "a common saying in the Black community is 'I'd rather my child get a beating from me than from the police' (p. 8). Hence, Whaley and additional researchers (Baumrind, 1972; Kelley et al., 1992) implied that the Black American's perspective regarding the use of physical punishment serves as a means of surviving racial oppression and discrimination.

Dearing's (2004) study supported restrictive parenting (high parental control coupled with strong parental warmth and involvement) for Black American families residing in low income, high crime neighborhoods as an effective parenting strategy for children's academic performance and depressive symptoms. Specifically, his research results indicated "restrictive values were a protective factor in low-quality neighborhoods" (p. 570). However, the benefits of restrictive parenting decreased over time as indicated by similar outcomes for both Black American and Caucasian children

residing in low income, high crime neighborhoods. Thus, it seems that the effectiveness of restrictive parenting is limited and other parental practices must be integrated for Black American parents to continue the promotion of optimal mental health for their children. Refraining from condoning physical discipline within the Black American culture, Whaley (2000) challenged parenting programs to incorporate alternative forms of discipline “that are culturally compatible, such as response cost” (p. 10) in efforts to deter children from engaging in inappropriate behaviors. Response cost involves the removal of a desired object as a direct consequence of misbehavior (Fall, Holden, & Marquis, 2004).

### *Parent Education Programs*

Although there are several research studies pertaining to the effectiveness of parenting programs, there are few studies that focus on low income, Black American parents. In fact, the majority of parenting programs were developed and evaluated with Caucasian, middle-class, two-parent families (Alvy, 1994; Coard, Wallace, Stevenson, & Brotman, 2004; Dembo, Sweitzer, & Lauritzen, 1985; Gorman & Balter, 1997). In addition, Gorman and Balter (1997) criticized traditional parenting programs for being culturally insensitive and irrelevant for non-white, low income, one-parent household families. Socio-economic factors faced by families living in poverty lead to unique challenges and stressors that place undue hardship for parents and their children. With these challenges, parental involvement can be thwarted and thus place children at risk for behavioral problems and future academic success. Given the unique dimensions of families living in poverty, generalizing the effectiveness of the traditional Caucasian,

middle class, two parent household parenting programs onto low income, Black American children is questionable (Dembo et al., 1985; Gorman & Balter, 1997; Whaley, 2000).

The lack of overwhelming research support of traditional parenting programs for diverse populations challenges the generalization of these programs to the non-majority. Researchers agreed that cultural considerations must be accounted for to facilitate parent training effectiveness (Dearing, 2004; Gorman & Balter, 1997). Although in infancy, there is a growing interest in the research community to create parenting programs that respond to specific cultural values and beliefs.

In a literature review of the effectiveness of quantitative studies, four culturally sensitive parent education programs for Hispanics and one culturally sensitive parent education program for Black Americans, Gorman and Balter (1997) reported an overall weak support when compared meta-analytically to two previous literature critiques of traditional parent education programs (see Dembo et al., 1985; Medway, 1989). With limited quantitative studies, Gorman and Balter conducted a meta-analytic comparison of culturally sensitive parenting programs to traditional parenting programs, rather than comparing culturally sensitive parenting programs with other culturally sensitive parenting programs (p. 342). Notwithstanding, the authors reported a small effect size for parent ( $ES = 0.32$ ;  $SD = .20$ ) and children outcomes ( $ES = 0.19$ ;  $SD = .28$ ); results that were substantially smaller compared to traditional parenting programs. For parenting programs targeting Black Americans, the mean effect size was 0.21 for parent outcomes and 0.05 for children outcomes. Overall, the authors stated that parents seem to benefit more from the parenting program than their children. However, Gorman and

Balter postulated that the smaller effect size for culturally sensitive parenting programs compared to traditional programs could be attributed to methodological flaws (e.g., lack of randomization of subjects to treatment and control groups; lack of follow up data), rather than ineffective training procedures. Another rationale the authors indicated to explain the lack of effectiveness of culturally sensitive parenting programs compared to traditional parenting programs relates the computation of effect sizes for the latter programs. Gorman and Balter described their computation method of effect sizes included nonsignificant and significant findings for all measures and subscales scores when provided. The authors pinpointed that Medway's (1989) meta-analysis computation did not include "nonsignificant and insignificant findings" (p. 365) which might result in an inflated effect size. Other considerations that might influence research support for parenting programs for low income Black American parents include high attrition rate and lack of parent participation in follow up studies (Alvy, 1994).

### *Strong African American Families (SAAF) Parenting Program*

The strong African American families (SAAF) is a culturally responsive parenting program targeting low income, Black American parents living in the rural South with an 11 year old son or daughter (Brody et al., 2006). According to Brody et al., this program was designed to increase positive parent-child communication to serve as a mediator to their children engaging in high risk behaviors, such as drug and alcohol use and sexual activity. The program consisted of several components: positive parenting strategies based on high levels of control and nurturance, racial socialization practices (e.g.,

discussions regarding cultural pride, racism, and discrimination), safe sex discussions, and stringent rules on alcohol and drug use.

Brody et al.'s (2006) study consisted of 150 families assigned to the control group and 182 families in the experimental group. To prevent high attrition rates, participants were provided \$200 for completion of pre and post test assessments. Furthermore, free transportation and day care were provided to parents who participated in SAAF. During the seven sessions of the program, parents and children were separated for the first hour of each session to cover session content and then convened as a family for the second and final hour to practice newly learned skills. While separated, the children sessions focused on "the importance of caring family relationships and compliance with household rules, peer pressure and resistance efficacy strategies, and development of a positive racial identity" (Brody et al, 2006, p. 3). Black American group leaders, in teams of three, led an average of 20 parents per session using techniques that included didactic instruction, group discussion, and structured activities.

The parents of the experimental group demonstrated statistically significant gains ( $p < .01$ ) in regulated, communicative parenting as measured by the Racial Socialization Scale (Hughes & Johnson, 2001); The Parental Communication About Sex Scale (Gerrard, Gibbons, & Gano, 2003; Will et al., 2003), an involved-vigilant parenting assessment created by the authors (Brody et al., 2006); and a 2-item query focusing on clear communication to children related to alcohol use developed by Spoth, Redmond, and Shin (1998). The involved-vigilant parenting assessment consists of 19 items that examine the degree of frequency in which parents engage in "involvement, inductive

discipline, consistent rules and discipline, and monitoring” (Brody et al., p. 4). The 2-item inquiry related to clear communication of alcohol use examined the parent’s degree of veracity shared with their children about their thoughts of drugs and the lack of drug use for similarly aged children.

For children outcomes, Brody et al. (2006) utilized three parenting instruments to measure parenting behaviors: nurturant-involved parenting assessment created by the authors (Brody et al.), the Racial Socialization Scale, and a 4-item query examining general and specific household rules related to drug use that was developed by Spoth et al. (2001). In the parenting assessment, using a Likert-type scale, children rated their parents on the degree of nurturant-involved parenting. Initiation of risk behaviors was measured using previously used instruments created by Gibbons et al. (2003) and Wills et al. (2003). In this measurement, children respond whether or not they have ever consumed an alcoholic beverage or engaged in sexual intercourse. The children of the experimental group reported statistically significant gains ( $p < .05$ ) in parenting behaviors and statistically significant reduction ( $p < .05$ ) in the initiation of risk behaviors.

### *Effective Black Parenting Program (EBPP)*

In response to critics questioning the appropriateness of traditional parenting programs to culturally diverse populations, Alvy (1994) launched the culturally-adapted parent training project, a survey research project with the intended goal to develop program components to traditional parenting programs in order to address the needs of Black American families. His organization, the Center for Improvement of Child Caring

(CICC), in collaboration with community mental health experts, examined published research literature and interviewed low income, Black American parents and low income and high income Caucasian parents to provide support in making changes to the traditional parenting curriculum. Specifically, Alvy identified empirical support for differences in child-rearing practices between Caucasian and Black American parenting styles; in addition to specific values relevant to the Black American families: strong achievement orientation, use of relatives as major support network, and use of physical punishment for disciplinary measures. Furthermore, Alvy postulated the need for traditional parenting programs to incorporate “parenting themes that are relevant to the black experience” (p. 121) is critical. Such themes include the challenges of poverty, single-parenting, racism, and discrimination.

As a result of Alvy’s (1994) culturally-adapted parent training project, a new component was introduced within the traditional parenting program entitled the “Pyramid of Success for Black Children” (p. 130). This new component was infused throughout traditional parenting programs and as a result, the sessions were extended to account for the additional information provided to parents. The pyramid of success for black children incorporated several lessons related to facilitating high self-esteem, reinvesting in the Black American community, and teaching resistance to engaging in high-risk activities. The new culturally sensitive curriculum units reflecting the challenges of Black American parenting (e.g., physical discipline versus alternative discipline approaches, stress management, single parenting, promoting Black American pride) were also included to the traditional parenting program. The adaptations to a traditional cognitive-



behavioral parenting program eventually resulted in the creation of Alvy's (1994) effective Black parenting program (EBPP).

Alvy (1994) examined the effectiveness of the culturally-sensitive curriculum units infused with three traditional training programs. This study compared the results of 48 Black American parents with children enrolled in Head Start who participated in the culturally adapted program compared to Black American parents assigned to a control-comparison group in a previous study that examined the effectiveness of traditional parenting programs with this population group. Due to inconsistent attendance, analysis was based upon total amount of sessions attended. The low attendance group ( $n = 19$ ) was identified as parents who attended three to six parenting classes out of a total of 15. The high attendance group ( $n = 29$ ) attended seven sessions or more. The high attendance parents reported statistically significant improvements in the quality parent-child relationship as measured by Rohner's (1984) Parental-Acceptance-Rejection Questionnaire for Mothers. Although not statistically significant, the high attendance parents reported a decrease in the use of physical punishment and an increase in the amount of discussion related to what it means to be Black.

Additional studies were conducted to examine the effectiveness of EBPP (Myers et al., 1992) targeting low income, Black Americans with children enrolled in first and second grade. The two year study consisted of a quasi-experimental design on two cohorts totaling 109 parents assigned to the intervention and 64 parents assigned to the control group. The experimental group of cohort I demonstrated a statistically significant decrease in parental rejection and a statistically significant increase in the quality of family relationships. However, the results were mixed as the control group of cohort I

demonstrated a statistically significant increase in parental warmth, whereas the experimental group reported no changes. The experimental group for cohort II reported statistically significant reduction in parental rejection. However, the experimental group of cohort II reported no change in the quality of family relationships. Further results of cohort II indicated statistically significant decreases in the use of physical punishment for the experimental group when compared to the control group. Results from the 1 year follow up study indicated that previous positive changes were maintained in parents of cohort 1, but also reported parents' regression to the use of more hostile, aggressive parenting. Furthermore, results of the 1 year follow up data reported statistically significant increase in physical discipline for cohort I participants assigned to the experimental group. Hence, the authors concluded the need for booster sessions for parents to maintain the skills learned in training.

In Gorman and Balter's (1997) critical literature review of culturally responsive parenting programs, Alvy's (1994) EBPP was acknowledged for incorporating culturally relevant issues to the African American culture; however Gorman and Balter highlighted that these cultural adaptations are typically viewed as negative and limited components to this diverse population. For example, although issues such as single-parenting, drug use and abuse, domestic violence are pertinent to a subculture within the Black American culture, it is not prevalent for all Black Americans. In addition, Gorman and Balter raised suspicion regarding the effectiveness of EBPP's due to the lack of consistent outcomes in replication studies, in addition to methodological flaws that include inadequate description of participants and inadequate measurement instruments. Despite great efforts to meet the needs of low income, Black American

parents, the EBPP has yet to provide strong empirical support for its effectiveness with this population.

### Rationale for Child Parent Relationship Therapy (CPRT)

With the increased risk of poor academic, social, and emotional outcomes for Black American children living in poverty, parents can deter these outcomes with their strong influence on their children's socio-emotional development and academic success (Jackson et al., 1998; Slater & Power, 1987). With the need for empirical support for parenting programs designed for the needs of low income, Black American parents, one model, child parent relationship therapy, may serve to facilitate optimal mental health for Black American children and their families. With an emphasis on increasing parental sensitivity to the child's world by using the child's natural language of play, in child parent relationship therapy (CPRT; Landreth & Bratton, 2006) parents learn specific skills to enhance the parent-child relationship. Through didactic instruction and role play, parents learn skills such as tracking and reflective listening to communicate genuine interest, empathy, and understanding to their child. A history of the development of CPRT will focus on the following: 1) rationale for play in therapy; 2) child centered play therapy; 3) history of filial therapy and rationale for filial therapy; 4) description of CPRT and research support for CPRT; and 5) rationale for utilizing CPRT for low income, Black American families.

### *Rationale for Utilizing Play in Therapy*

Children under the age of eleven understand the world in concretes and have

difficulty comprehending abstractions (Schaefer & DiGeronimo, 2000). Lacking the capacity to understand ambiguities of language, traditional talk therapy places restrictions on children's ability to fully express themselves. In efforts to help children express a wide variety of emotions, thoughts, and experiences, Landreth (2002) indicated the need for therapists to utilize the child's natural language – play. Ginott (1961) agreed to the appropriateness of utilizing play in therapy, as he defined play as “the child's native tongue – his [*sic*] natural way of showing how he [*sic*] feels about himself and the significant persons and events in his [*sic*] life” (p. 126). Play grants children the ability to express themselves and their world in concrete form. In addition to using play in therapy as the appropriate medium of communication for children, Schaefer and DiGeronimo (2000) described play as facilitating cognitive growth within children by “stimulating [their] imagination, creativity, and problem solving abilities” (p. 127).

The developmental appropriateness of play therapy is not restricted to the child's cognitive dimension. Play therapy also enhances the child's emotional, social, and personal dimensions of growth. The playroom and therapeutic relationship serves as an excellent framework for exploring the child's emotional realm (Berk, 2003). Through unconditional acceptance conveyed by the therapist, the child is free to express a wide variety of emotions, including those that may seem embarrassing without fear of ridicule. Furthermore, play facilitates the child's ability to self regulate emotions (Berk, 2003) and to channel negative emotions in socially appropriate ways.

### *Child Centered Play Therapy*

With an emphasis on the therapeutic relationship in person centered therapy,

Carl Rogers's work served as the foundation of child centered play therapy. Landreth (2002) identified Virginia Axline as a major contributor to the development of the non-directive, child centered approach to play therapy through her expansion of Rogers's basic tenets to children. Although toys serve a tremendous role for child centered play therapists, the therapeutic relationship is of primary importance. As explained by Landreth (2002), the focus is on the child. Highlighting the importance of the relationship, Axline (1955) stated that the "child is given an opportunity to learn about himself [*sic*] in relation to the therapist. The therapist will convey to the child the security and opportunity to explore not only the room and the toys but himself [*sic*] in this experience and relationship" (p. 622). Moustakas (1959) and Landreth (2002) served as additional contributors to the child centered play therapy approach.

### *History of Filial Therapy*

In the early 1960s, Bernard Guerney created filial therapy in efforts to revamp the focus on preventive approaches with children and young adults, in addition to maximizing the roles of mental health professionals (Guerney, 1969). Louise Guerney joined her husband to further develop this approach and together have become the leading authorities on filial therapy. Filial therapy involves training a group of parents based upon child centered play therapy principles and skills in order to conduct play sessions with their own children. In groups of six to eight, parents are taught the child centered play therapy skills through didactic instruction, role play, modeling, at-home play sessions, and supervision. Sessions terminate when parents no longer need

assistance, which can range from six to eighteen months after the start of training (Guerney, Guerney, & Andronico, 1970).

### *Rationale for Filial Therapy*

With an emphasis on enhancing the quality of the parent-child relationship, in filial therapy parents are trained as the therapeutic change agents for their children, rather than the therapist. Guerney et al. (1970) stressed the greater significance of parents serving as therapeutic agents for their children rather than therapists due to the increased emotional bond between parent and child. Additional benefits for parents being trained in child centered play therapy skills include increased parenting knowledge and skill, and increased positive and appropriate interaction between parent and child (Gurney et al., 1970).

In contrast to other parenting programs, filial therapy reflects a strengths-based approach by utilizing the child's natural mode of communication, play, to facilitate parent's understanding of their child's world in order to promote positive child-parent relationships (Landreth & Bratton, 2006). Play allows the child to communicate symbolically a variety of emotions, thoughts, desires and personal experiences in the manner in which the child is most natural (Landreth, 2002). In filial therapy, parents are assigned to conduct home play sessions, which allow the child to take the lead and the parent to follow (Landreth & Bratton, 2006). During these play sessions, parents demonstrate "acceptance of the child and the child's decision within appropriate boundaries or limits" (Landreth & Bratton, 2006, p. 17) with no emphasis to correct the child's behavior. Hence, the primary focus of filial therapy is on the child, not the child's

problem (Landreth, 2002). With an emphasis on enhancing healthy parent-child relationships, filial therapy often results in positive behavior changes (Landreth, 2002).

Filial therapy utilizes the group format to train and supervise parents in child centered play therapy skills and principles (Landreth & Bratton, 2006). Based on Rogers's (1951) client centered therapy, Axline (1969) clarified these principles as applied to children, which were later expanded by Landreth (2002):

1. Children are not miniature adults, and the therapist does not respond to them as if they were.
2. Children are people. They are capable of experiencing deep emotional pain and joy.
3. Children are unique and worthy of respect. The therapist prizes the uniqueness of each child and respects the person the child as is.
4. Children are resilient. Children possess a tremendous capacity to overcome obstacles and circumstances in their lives.
5. Children have an inherent tendency toward growth and maturity. They possess an inner intuitive wisdom.
6. Children are capable of positive self-direction. They are capable of dealing with the world in creative ways.
7. Children's natural language is play, and this is the medium of self-expression with which they are most comfortable.
8. Children have a right to remain silent. The therapist respects a child's decision not to talk.
9. Children will take the therapeutic experience to where they need to be. The therapist does not attempt to determine when or how the child should play.
10. Children's growth cannot be speeded up. The therapist is patient with the child's developmental process. (p. 54)

The goals of filial therapy include helping parents "(a) understand and accept their child; (b) develop sensitivity to their child's feelings; (c) learn how to encourage their child's self-direction, self-responsibility, and self-reliance; (d) gain insight into themselves in relation to the child; (e) change their perception of their child; and (f) learn child centered play therapy principles and skills" (Landreth & Bratton, 2006, p. 12)

The therapeutic goals of filial therapy include helping children to “develop coping strategies and an increase in positive feelings of self worth and confidence” (Landreth & Bratton, 2006, p. 12). Additionally, filial therapy helps parents help their children to accept and respect themselves, develop a more positive self-concept, assume responsibility for themselves, and experience a feeling of self-control and self-direction (Landreth, 2002, pp. 90-92).

### *Child Parent Relationship Therapy Model (CPRT)*

Based on Guerney’s (1969) previous work, Landreth (1991, 2002) created a time limited model of filial therapy in response to parent attrition rates for filial trainings that exceeded 10 sessions. Landreth and Bratton (2006) formalized the 10-session filial therapy model within their textbook and termed the model child parent relationship therapy (CPRT). A treatment protocol, *Child Parent Relationship Therapy (CPRT) Treatment Manual: A 10-session Filial Therapy Model for Training Parents*, supplements the CPRT textbook (Bratton, Landreth, Kellum, & Blackard, 2006). The CPRT model utilizes lecture, discussion, role playing, group process, and supervision of conducted at-home play sessions. This model typically consists of a group of six to eight parents who meet two hours a week for 10 sessions total. The first three sessions focus on the goals, objectives, principles, and skills of child centered play therapy. With an emphasis on increasing parental sensitivity to the child’s world by using the child’s natural language of play, parents learn specific skills to enhance the parent-child relationship. Through didactic instruction and role play, parents learn skills such as tracking and reflective listening to communicate genuine interest, empathy, and



understanding to their child. Furthermore, parents are trained in discipline approaches that include limit setting and choice giving. It is with this discipline approach that parents learn to provide clear, firm limitations on inappropriate behavior in conjunction with logical consequences that enables the child to develop self-control. Typically, upon completion of the third session parents begin conducting weekly 30 minute at-home special play times using special play materials based on Landreth's (2002) category of toys. The remaining sessions emphasize the group process as parents volunteer to share a segment of their videotaped play session and receive supervision from the filial group facilitator and positive encouragement from fellow group members. To reinforce parents' skill acquisition, group facilitators utilize role playing and modeling. It is through this process that the primary objective of changing parent's perception of their child and of themselves in the child-parent relationship will occur (Bratton, Landreth, et al., 2006; Landreth, 2002; Landreth & Bratton, 2006).

### *Research Support for Filial Therapy*

Filial therapy has been utilized with diverse families with a variety of presenting issues (VanFleet, 2005). Landreth and Bratton (2006) identified CPRT as "one of the more well-researched treatment protocols in the field of child psychotherapy" (p. 457) with 33 studies involving over 800 subjects. In response to critics challenging the utility of play therapy, Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analysis of 93 controlled research studies to determine the efficacy of play therapy, in addition to conducting a separate analysis for filial studies. Results indicated that filial therapy conducted by a parent, teacher, or peer mentor demonstrated a large treatment effect

size ( $ES = 1.05$ ), whereas play therapy conducted by a mental health professional demonstrated a moderate treatment effect size ( $ES = .72$ ). In limiting the population to parents conducting play sessions with their child, the treatment effect size increased to 1.15. The authors noted that the favorable results of filial therapy with paraprofessionals (including parents) is due in part to close supervision and training by a mental health profession who utilized a treatment protocol, with the largest effect sizes being attributed to those studies who utilized the Guerney and Landreth model of filial therapy. Landreth and Bratton (2006) further analyzed the meta-analytic effects of CPRT studies and reported a large treatment effect size ( $ES = 1.30$ ) for parent only studies. The results of this meta-analysis clearly support training parents and other paraprofessionals through filial training programs. There is a plethora of literature that examines the effectiveness of filial training on specific populations. In efforts to extend the current literature of the effectiveness of filial therapy to Black American families, it is pertinent to examine previous studies examining the effectiveness of CPRT with various populations.

*Research Support for Traditional 10-Session Child Parent Relationship Therapy Model (CPRT) and Adapted Versions of CPRT*

The following studies have utilized Landreth's (1991) 10-session filial model with the overall goal of changing parent's perception of their children and of themselves within the child-parent relationship. Unless indicated otherwise, the following studies attended weekly 2-hour filial therapy training session for a total of 10 weeks and conducted weekly 30-minute special playtime with their children after the end of the third training session, for a total of seven playtime sessions. The following studies have

utilized a pretest, posttest control group design, unless otherwise specified.

Furthermore, statistical significance and significance are used synonymously throughout the examination of the following studies when reporting subject change due to treatment at the  $p < 0.025$  level or better.

Bratton and Landreth (1995) reported the first results utilizing Landreth's 10-session filial therapy training model in a study involving 43 single parents. The experimental group ( $n = 22$ ) demonstrated significant gains in their degree of acceptance and empathy toward their children, significant reduction in parental stress, and significant reduction in number of parent reported children problems.

In Landreth and Lobaugh's (1998) study, the CPRT model was implemented with incarcerated fathers utilizing child centered play therapy procedures with their selected child between 3 to 7 years of age. The authors reported significant results in all measures. Specifically, the experimental group ( $n = 16$ ) reported significant gains in parental acceptance and gains in children's self-concept when compared to the control group ( $n = 16$ ). Furthermore, the experimental group demonstrated statistically significant reduction in parental stress when compared to the control group.

Using the same population of incarcerated parents, Harris and Landreth (1997) adapted the CPRT model to accommodate for women's average length of stay in a county jail. Hence, the traditional 2-hour session per week model for a total of 10 weeks was condensed to 2-hour session biweekly for a total of 5 weeks. Compared to previous studies aforementioned, it is noteworthy to highlight that participant demographics for this study included a high percentage of Black American females (41%). Results of this study indicated the experimental group ( $n = 12$ ), compared to the control group ( $n = 10$ ),

demonstrated significant improvements in the following areas: parental empathy communicated to their children, parental acceptance communicated toward their children, and number of reported child behavior problems.

Similar results were reported for Costas and Landreth's (1999) CPRT study with non-offending parents of children who were sexually abused between 4 and 10 years of age. A total of 26 subjects completed the study with 14 subjects assigned to the experimental group and 12 assigned to the control group. The experimental group of parents reported statistically significant increases in parental acceptance and parental empathy when compared to the control group. In addition, the experimental group demonstrated significant reduction in the amount of reported parental stress.

N. Smith and Landreth (2003) examined the effectiveness of an adapted version of CPRT with parents whose children had witnessed domestic violence. In this study, the authors adapted the time frame of the traditional 2-hour weekly, 10-session model into 12, one and a half hour sessions over a two-week time frame. Additional adaptations to the model (e.g., length of training and play sessions) were made to adjust for the mother's "readiness and shelter demands on the mothers' time" (N. Smith & Landreth, 2003, p. 75). The authors reported significant improvement on all measures: parental stress, parental empathy, child behavior problems, and child self-concept. An additional adaptation of CPRT that involved 4 hour weekly sessions for a total of 4 weeks training time, yielded similar results (Ferrell, 2003).

In Tew, Landreth, Joiner, & Solt's (2002) study, the CRPT model was utilized with parents of chronically ill children. A total of 23 participants completed the study with 12 parents assigned to the experimental group and 11 parents assigned to the control

group. The parents assigned to the CPRT treatment group reported statistically significant decrease in parent stress and children behavioral problems. Furthermore, the parents assigned to the CPRT treatment group reported statistically significant increase in parental acceptance communicated to their children.

Kale and Landreth (1999) examined the effectiveness of CPRT with parents of children with learning difficulties. The parents assigned to the CPRT treatment intervention demonstrated statistically significant improvement in their degree of acceptance and empathy toward their children and significant reduction in parent stress. However, the parents assigned to the experimental group did not demonstrate statistically significant changes regarding their children's behavior problems compared to the no treatment control group.

In addition to examining the effectiveness of the CPRT model with parents, other studies have adapted this treatment intervention with teachers serving as change agents (Helker, 2006; Morrison, 2006; D. M. Smith & Landreth, 2004). Morrison (2006) examined the effectiveness of Child Teacher Relationship Training (CTRT) with Head Start teachers of preschool children identified with behavioral problems. In this study, teachers and their aides were randomly assigned to either the experimental or active control treatment. Results of this study indicated that the CTRT treatment group of children demonstrated statistically significant reductions in behavior problems. To support Morrison's findings, Helker (2006) conducted a follow up study to examine the effectiveness of CTRT. Helker reported a statistically significant decrease from pretest to posttest in Externalizing Problems of the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000) for children assigned to the experimental group when compared to

children assigned to the active control group. Furthermore, Helker indicated that students assigned to the experimental group did not demonstrate a statistically significant decrease in Internalizing Problems or Total Problems of the CBCL when compared to the active control group.

In D. M. Smith and Landreth's (2004) study, the CPRT model was utilized with teachers of deaf and hard of hearing preschool children. The experimental group of parents reported statistically significant improvement in teacher acceptance and empathy when compared to the no treatment control group. In addition, the experimental group demonstrated significant reduction in overall child behavior problems.

#### *Research Support for Traditional and Adapted Versions CPRT with Ethnically Diverse Populations*

The CPRT model has been used with several diverse ethnic population of parents that include Native Americans (Glover & Landreth, 2000), Koreans (Jang, 2000; Lee & Landreth, 2003), Chinese (Chau & Landreth, 1997; Yuen, Landreth, & Baggerly, 2002), and Israelis (Kidron, 2003). Glover and Landreth (2000) examined the effectiveness of CPRT for Native American parents living on the Flathead Reservation in the Midwestern region of the United States. A total of 21 parents completed the study, with 11 parents assigned to the experimental group and 10 parents assigned to the wait-control group. Results of the study indicated parents assigned to the experimental group demonstrated statistically significantly gains in empathic interactions with their children, in addition to statistically significant gains in children's positive play behaviors. Unlike previous studies involving ethnically diverse population of parents, Glover and

Landreth reported a lack of statistically significant changes with instruments measuring parental stress, parental acceptance, and children's self concept. The authors proposed the lack of significant results is due to a lack of cultural sensitivity within the measurement instruments.

Lee and Landreth (2003) utilized the CPRT model with immigrant Korean parents residing in a large metropolitan area. A total of 36 participants were randomly assigned to either the experimental group or wait-control group. Due to family crisis and scheduling conflicts, 32 participants completed the study, 17 in the experimental and 15 in the wait-control group. Parents in the experimental group demonstrated statistically significant increases in the areas of empathic parent-child interactions and acceptance. Parents in the experimental group also reported a statistically significant decline in parental stress when compared to the control group.

The effectiveness of CPRT was examined with 34 Chinese parents residing in the United States, 18 parents in the experimental group and 16 parents in the control group (Chau & Landreth, 1997). Similar to previous research findings with other ethnically diverse population of parents (Glover & Landreth, 2000; Lee & Landreth, 2003), Chinese parents assigned to the experimental group reported statistically significant gains in the areas of parental empathy and parental acceptance. Furthermore, the parents of the experimental group demonstrated a statistically significant decrease in parental stress. In an exploration of another subculture of the Chinese population, Yuen et al. (2002) determined the effectiveness of CPRT with immigrant Chinese parents living in Canada. Thirty-five parents were randomly assigned to either the experimental ( $n = 18$ ) or control group ( $n = 17$ ) Results indicated

support for CPRT with immigrant Chinese parents. Specifically, parents assigned to the experimental group reported statistically significant reduction in parental stress; the experimental group also reported statistically significant gains in empathic parent-child interactions and acceptance toward their children.

Kidron (2003) reduced the amount of the traditional 10-session CPRT model with 27 native Israeli families. The fourteen parents assigned to the experimental group received 9 filial training sessions over a 5-week span. The thirteen parents assigned to the control group received no treatment. Results of this study supported the use of a modified version of CPRT with Israeli parents. Specifically, parents of the experimental group reported statistically significant decreases in the areas of externalizing behavior problems and parental stress. Furthermore, parents of the experimental group demonstrated statistically significant gains in empathic behaviors toward their children.

Jang (2000) also modified the total amount of CPRT sessions in her study with native Korean parents. To adjust for time constraints shared by the 14 parents assigned to the experimental group, Jang reduced the standard 10-session filial model to 8-sessions over 4 weeks. Sixteen parents were assigned to the control group. Parents of the experimental group reported statistically significantly increase in empathic behaviors communicated to their level and statistically significant decrease in child behavioral problems.

In a qualitative study, Edwards et al. (2007) examined the perceived effectiveness of the VanFleet (2005) filial model with minor adaptations. The authors indicated positive changes as reported by the middle-class, immigrant Jamaican mother as a result of filial therapy training. Specifically, the parent reported increased empathic



behavior to her child, increased awareness of her child's needs, and a stronger connection with her child. However, the parent also reported resistance to the type of limit setting procedures and tracking responses taught in filial therapy training. Specifically, the parent reported limit setting involved too many steps. The mother also reported her unwillingness to give up spanking as a form of discipline, a parenting approach common to the Jamaican culture (Edwards et al., 2007).

Results of the studies mentioned earlier provide tremendous support to the effectiveness of CPRT with ethnically diverse population of parents. However, as to date, published research related to CPRT and Black Americans is minimal. There has been one published use of this parenting approach with one Black American parent. Solis et al. (2004) initiated research in this area by conducting a qualitative research inquiry in the effectiveness of filial therapy with one African American mother. Using Landreth's 10-week child centered model in addition to incorporating aspects of VanFleet's (2005) filial therapy training program, the authors examined the parent's reaction to the structure and content of filial therapy training. Specifically, the parent reported increased empathic behavior to her child, increased awareness of her child's needs, and a stronger connection with her child. Solis et al. (2004) indicated positive changes as reported by the parent as a result of filial therapy training. Specifically, the parent reported increased awareness of her parenting practices and increased awareness and sensitivity to the needs of her six-year-old son. The parent also reported the generalization of specific parenting techniques learned in training (e.g., setting limits, providing encouragement) to her daily interaction with her child. Similar to a previous study (Edwards et al., 2007), all dimensions of the training were not readily

accepted by the parent, as she indicated struggles maintaining a non-directive, permissive approach during home play sessions. For example, the parent expressed discomfort in the child's level of aggression that resulted in the parent taking the lead during the child's play sessions in efforts to minimize his aggressive play. Furthermore, when aggressive play subsided, the parent reported a desire to continue directing the play session when she was bored. The authors speculated the parents desire to take the lead during the play sessions as indicative of her difficulty of accepting the child's aggressive tendencies and her desires to correct misbehaviors. Furthermore, the parent reported difficulty in learning the specific play therapy skills due to its incompatibility to her own parenting approach. The parent reflected upon the discrepancy between the filial approach to parenting and her style of parenting:

I just wasn't raised that way. It was though because the way I was raised you really don't have a choice. I know that it's not the best way of parenting....My parents made all the choices for me. This is just an old mentality that has been passed down from my ancestors. I don't know if that is just black people but that is basically the way it is. (Solis et al., 2004, p. 108)

As a single working parent with three children, the parent also reported the time requirement for the filial training as a challenge. For example, the authors reported noncompliance with homework assignments throughout filial training (Solis et al., 2004).

### Black American Values

Historically, Black American families have underutilized mental health services in community settings and the review of literature shows that the counseling profession has been slow in addressing the unique needs of this population, particularly the needs

of young children and their families (Baggerly & Parker, 2005; Glover, 2001; Ray et al., 2001; Solis et al., 2004). Despite the dearth of literature exploring the effectiveness of CPRT with Black Americans, researchers (Bratton, Ray, et al., 2005; Ray et al., 2001) concluded the need for studies focusing on diverse populations. Baggerly and Parker (2005) specifically addressed the need to conduct filial training with Black American parents to promote their children's socio-emotional development. In examining Black American perspectives and values related to mental health services, family, and discipline, CPRT can serve as a promising intervention to mitigate stigma related to mental health services, in addition to promote values salient to Black American families.

#### *Perception towards Mental Health Services*

Black Americans tend to have a negative stigma towards mental illness and as a result, are less likely to seek treatment (Solis et al., 2004). Reasons for Black Americans being underrepresented and underserved in mental health services include distrust of Caucasian service providers; misdiagnosis and overdiagnosis of mental disorders; paraprofessionals providing services rather than psychiatrists, social workers, and other mental health professionals; and discrepancy of expectations between therapist and client (Parham & Parham, 2002; Parham et al., 1999; Sue, 1977). Furthermore, the report (U.S. Public Health Service, 2000) based on the Surgeon General's Conference on Children's Mental Health indicated that "African-American children...are least likely to receive [mental health] services and need to display more pathology to be referred for mental health services" (p. 23).

According to Parham et al. (1999) Black Americans utilize mental health services as a last resort. With Black American children identified as least likely to receive mental health services (U.S. Public Health Service, 2000) and Black Americans remaining distinguished by their high premature drop out rate from therapy, in addition to less positive treatment outcome reports (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), the utility of counseling services for Black Americans is difficult to establish. Instead, in times of struggle, many Black Americans obtain support from their families, both nuclear and extended (Boyd-Franklin, 2003; Drewes, 2005; Glover, 2001; Hines & Boyd-Franklin, 2005; Kerl, 2001; Parham & Parham, 2002; Parham et al., 1999).

#### Importance of Family

For Black Americans, the family unit is a pivotal source of support Boyd-Franklin, 2003; Drewes, 2005; Glover, 2001; Hines & Boyd-Franklin, 2005; Kerl, 2001; Parham & Parham, 2002; Parham et al., 1999). Parham et al. (1999) proposed the historical significance of family loyalty and interdependence within Black Americans today as a continuation of values derived from African slaves. In efforts to attain a form of psychological control and safety, slaves developed family interactions based on a community based approach, where cooperation and responsibility for others were paramount to psychological survival. Thus, in present day, many Black Americans continue to utilize their extended family “to share information, resources, and communal concerns” (p. 31). The sense of family for Black Americans extends beyond the family and into the community. According to Dearing (2004), stronger social networks exist within low income neighborhoods with a majority of the families being ethnic-minorities

when compared to similar neighborhoods composed of primarily Caucasian families (p. 558).

### *Discipline*

As discussed previously, Goodman (1997) reported that Black American parents are more likely to use physical punishment. Whaley (2000) speculated that Black American's previous and current exposure to oppression has shaped a unique role in the physical punishment in the Black American family. With a desire to protect children from racism and discrimination, Whaley proposed that physical discipline within Black American families are characterized as child-oriented and thus serves to increase the child's self control. Whaley explained "from an African American cultural perspective, the goal of spanking may be to use strong external controls to help children develop better self-control rather than external control being an end in itself" (p. 8). Hence, Whaley and additional researchers (Baumrind, 1972; Dearing, 2004; Kelley et al., 1992) implied that the Black American's use of high parental control serves as a means of surviving racial oppression.

Despite Whaley's (2000) research findings, additional research regarding physical punishment on Black American children indicate negative outcomes (Deater-Deckard, Dodge, Bates, & Pettit, 1996; Spieker, Larson, Lewis, Keller, & Gilchrist, 1999; Stormshak, Bierman, McMahon, & Lengua, 2000). For example, several studies (Deater-Deckard et al., 1996; Spieker et al., 1999; Stormshak et al., 2000) have reported positive correlation between physical punishment and negative child outcomes, such as oppositional behavior problems, aggressive behavior problems, and other

externalizing behavior problems. In light of conflicting research regarding outcomes of physical punishment for Black American children, alternative discipline strategies should be considered.

### *Rationale for Utilizing CPRT for Black American Parents*

Child parent relationship therapy seems to provide a sensitive approach to Black American's view on mental health. With an emphasis on enhancing the parent-child relationship, CPRT provides a pro-active, preventative approach, rather than a problem solving approach. Instead of the therapist serving as the expert, in CPRT the parent is empowered through learning filial skills to better understand their children's' needs. Thus, the power shifts from the mental health professional to the parent, which can lead to increased trust within the therapeutic process, in addition to increased parental confidence and capability. This pro-active approach to working with Black American parents can serve to alleviate feelings of being viewed as inferior (Kerl, 2001). Furthermore, Black American parents may be more responsive to the time limited model of CPRT, which may reduce early termination (Solis et al., 2004).

In addition to the CPRT training model's emphasis on the family, the value of extended family with Black Americans compliments the group format approach to CPRT. Within the group format, group cohesion develops as parents share their parenting struggles while learning new strategies to develop a closer bond with their children. The value of interdependence within many Black American communities is demonstrated in the CPRT format as parents provide encouragement and support for one another as they learn new parenting behaviors. Furthermore, the group format of

the CPRT model reflects similar support experienced in the broader community, such as church. In other words, Black American parents who participate in CPRT may convey to each other that we are in this together.

With an emphasis on parental control in Black American families, CPRT seems to fit with the parents' need to establish self-control within their children by providing strategies for setting firm limits and consequences. Furthermore, instead of placing value on social status, many Black Americans value family members for their "intrinsic worth" (Glover, 2001, p. 34). CPRT is based on the fundamental principle of acceptance of children as they are (Landreth & Bratton, 2006). During training, parents are taught to allow their children to lead the play session and to allow their child to just be. This perspective of children serves to compliment the Black American value of respecting others for who they are (Glover, 2001).

### Purpose of the Study

One of the primary objectives of the CPRT model is to enhance the parent-child relationship through communication of warmth, acceptance, and appropriate discipline (Landreth & Bratton, 2006). Positive parenting strategies may serve Black American parents living in poverty to increase their level of involvement in their children's lives and to reduce socio-emotional, behavioral, and academic difficulties among their children.

To contribute to existing literature, this pilot study focused on promoting early mental health of low income Black American children through parent training that responds to the cultural needs of Black American families. Specifically, this study examined the effectiveness of CPRT with low income, Black American parents of Head

Start, pre-kindergarten, and kindergarten children. Furthermore, this pilot study examined the effects CPRT has on reducing children's behavioral problems and reducing parent-child relationship stress.



## CHAPTER 2

### METHODS AND PROCEDURES

Using a quasi experimental-control group design, this pilot study utilized a sample from Head Start, pre-kindergarten, and kindergarten classrooms from two school districts located in the southwest region of the United States to investigate the effectiveness of child parent relationship therapy (CPRT; Landreth & Bratton, 2006) with low income Black American children experiencing behavioral problems. CPRT is a 10-session filial model that enhances the child-parent relationship by teaching parents child centered play therapy principles and skills in order to conduct play sessions with their children (Landreth & Bratton, 2006). In response to the call for mental health professionals to incorporate cultural values throughout the therapeutic relationship with clients (American Counseling Association, 2005), minor adjustments were made to the CPRT model to demonstrate ethical practice by responding to the cultural needs of low income Black American parents. In this chapter, key components related to the study are described: definition of terms, hypotheses, instrumentation, participant selection, treatment, data collection, and analyses of data.

#### Definition of Terms

The following terms have been operationally defined for this pilot study:

- Child parent relationship therapy (CPRT): A 10-session filial therapy model that trains parents in child centered play therapy principles and skills. CPRT utilizes lecture, discussion, role play, group process, and supervision of conducted at-home play sessions in efforts to teach parents how to become therapeutic agents in their

children's lives. Child centered play therapy principles and skills that are taught to parents include reflective listening, recognizing and responding to children's feelings, responding to children's efforts, therapeutic limit setting, and building children's self-esteem. After completion of the third session, parents conduct play sessions (30 minutes each week) with their children using a special kit of selected toys. Through skill acquisition and application of these skills, the parent learns how to create a nonjudgmental, empathic, permissive, and accepting environment that will facilitate personal growth and change for both parent and child (Landreth & Bratton, 2006).

- Child centered play therapy (CCPT): Landreth (2002) defined this term as

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

- Parents: Primary caregiver of the child, that may include biological parents, custodial, biological adult from the child's nuclear or extended family, custodial, non-biological parents and adopted parents.

- Black Americans: For the purposes of this study, Black Americans was operationally defined by the following characteristics: (1) parents identified self as Black, Black American, or African American; and (2) parent identified child as Black, Black American, or African American. For children with origins from more than one ethnic background, parents who identified their child as Black, Black American, or African American qualified for this study.

- Head Start program: Federally funded early childhood program for children aged 3 to 5 of economically disadvantaged families living at or below the poverty level

(Head Start Act, 1998). The goal of this program is to promote optimal social and cognitive development within children through the use of comprehensive services that include education, physical and mental health care, social services, and parent-community involvement.

- Low income: The United States Department of Health and Human Services Federal Register (2007) was used to determine poverty guidelines based on size of family unit, income, and geographical location. All participants in the study met this criterion.

- Parent-child relationship stress: Degree of reported parental stress based upon characteristics of both the child and the parent. For the purpose of this study, parent-child relationship stress was operationally defined as the Total Stress and two domains of the Parenting Stress Index (PSI; Abidin, 1995): Child Domain and Parent Domain.

### Research Hypotheses

The following research hypotheses were created for this study:

1. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on Total Stress of the Parenting Stress Index when compared to parents in the control group.
2. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Child Domain of the Parenting Stress Index when compared to parents in the control group.
3. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Parent Domain of the Parenting Stress Index when compared to parents in the control group.

4. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Total Problems scale of the Child Behavior Checklist when compared to parents in the control group.
5. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Externalizing Problems scale of the Child Behavior Checklist when compared to parents in the control group.
6. From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Internalizing Problems scale of the Child Behavior Checklist when compared to parents in the control group.

## Instrumentation

### *Parenting Stress Index*

The Parenting Stress Index (Abidin, 1995) is designed to identify parent-child systems that are under significant stress and at-risk for development of problematic parent and/or child behavior. The PSI includes a hand-scored answer sheet that consists of 120 Likert scale items and an eight-page item booklet. Parents who participated in this study completed the answer sheet based on questions from the item booklet, which takes approximately 20 minutes to complete. Parents' scores were graphed on a profile chart printed on the backside of the answer sheet. The PSI can be used with parents of children ranging from 1 month to 12 years. Clinical scores are determined at or above the 85th percentile. Abidin recognized three major sources of stress, which include child characteristics, parent characteristics, and situational life stress. Hence, the PSI reports in three domains including Child Domain, Parent Domain, and Life Stress. The Parent Domain and Child Domain are combined to present an overall Total Stress score.

The Child Domain score is representative of the following six subscales that indicate problematic child behaviors (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 to the child, or (d) unreasonable parental expectations for mature behavior.

2. Adaptability: High scores on this subscale are associated with the child's difficulty adjusting to changes in the child's 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 on this subscale indicate that the parent experiences the child engaging in such behaviors as crying, physically hanging on the parent, or frequently requesting help.

5. Mood: High scores on this subscale are associated with children who cry frequently and display minimal signs of happiness.

6. Acceptability: High scores on this subscale indicate that the child possesses characteristics that do not match parental expectations for the child.

The Parent Domain score is representative of the following seven subscales that indicate sources of stress in the parent-child relationship related to the parent's perception of their functioning as parents (Abidin, 1995):

1. Competence: High scores on this subscale may be produced by several factors that include young parents of a child, parents who lack practical child development knowledge, and parents who do not find the role of parent as reinforcing

as expected. High scores are also associated with a lack of acceptance and presence of criticism from the child's other parent.

2. Isolation: High scores on this subscale indicate considerable stress due to the parents' perception of being socially isolated from their spouse, peers, relatives, and emotional support systems.

3. Attachment: High scores on this subscale indicate that 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 subscale 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 in the parent.

7. Spouse: Parents who earn high scores on this subscale are those who lack emotional support of the other parent in the area of child care.

Abidin (1995) reported validity for PSI scores through multiple research studies conducted using the PSI in the areas of developmental issues, behavioral problems, disabilities and illnesses, at-risk studies, cross-cultural studies, parent characteristics, family transitions, marital relations, and correlational studies with other measures. 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, respectively. 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).

### *Child Behavior Checklist – Parent Version*

This instrument provides a measure of parents' view of the child's school and social competencies, behavior functioning, and problems. The Child Behavior Checklist – Parent Version (CBCL; Achenbach & Rescorla, 2000) provides three responses for 99 items that describe a variety of problem behaviors exhibited in children. Respondents indicate whether or not the child exhibits the particular behavior using the following ratings: 0 for *not true*; 1 for *somewhat or sometimes true*; and 2 for *very true or often true*. The CBCL includes several open-ended questions to allow respondents to report on an observed behavior not described in the questions. Approximate time to complete the assessment is 15 minutes. Parents who participated in the study completed the CBCL for their child. Parents completed one of the two age versions of this instrument, based upon the age of their child. The two versions of this instrument fall into one of two age categories: 1) 1½-5 year olds, and 2) 6-18 year olds. For each version, syndrome subscales are categorized into one of the following two scales: 1) Internalizing Problems, or 2) Externalizing Problems.

Achenbach and Rescorla (2000) defined Internalizing Problems as consisting of children's behavioral problems that are expressed internally. The Internalizing Problems scale for the 1½-5 year old version consists of the following subscales: 1) Emotionally Reactive, 2) Anxious/Depressed, 3) Somatic Complaints, and 4) Withdrawn.

Externalizing Problem consists of behaviors that affect children's relationships with others, in addition to others' expectations of children (Achenbach & Rescorla, 2000). The Externalizing Problems scale for the 1½-5 year old version includes the following subscales: 1) Attention Problems, and 2) Aggressive Behavior. Sleep Problems is an additional syndrome subscale of the 1½-5 year old version that is not included in either the Externalizing Problems scale or the Internalizing Problems scale.

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 of the 6-18 year old version 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 scale. The 6-18 year old version of the CBCL also provides scores for competency in the following areas: 1) Activities, 2) Social, and 3) School. For both versions of the CBCL, a decrease in syndrome scores indicates improvement in the targeted behavior (Achenbach & Rescorla, 2000). For the 6-18 year old version, an increase in competency scores indicates improvement in the targeted areas (Achenbach & Rescorla, 2000).

The normative population for the CBCL/1½ -5 was based on a diverse sample, including children referred for clinical and special education services, children enrolled



in various preschool, pre-kindergarten, and childcare settings. Children resided in 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 was strong, and was supported by research that determined that almost 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).

Furthermore, measurement equivalence of the CBCL/1½ -5 was supported when used with Black American parents of low income preschool children (Gross, Fogg, Young, Ridge, Cowell, Richardson, et al., 2006). Using a confirmatory factor analysis, Gross et al. (2006) indicated that “the Externalizing and Internalizing Scales of the CBCL/1½ -5 are largely equivalent across African American, Latino, and non-Latino White parent informants stratified by income” (p.320).

### Participant Selection

After obtaining human subjects approval from the University of North Texas Institutional Review Board (see Appendix A), as the researcher, I coordinated with administrators of Head Start programs and elementary schools in two school districts located within the southwest region of the United States to describe the study and to

determine optimal times to recruit participants. As a result, I recruited participants during school events such as registration, open house, and “Meet the Teacher” night. During these events, I provided an overview of the study, including potential benefits and selection criteria. Due to the limited attendance of these events, parents were also recruited during morning drop off and afternoon pick up times at participating schools through distribution of flyers. I also asked social workers, educational specialists, school counselors, and school psychologists from participating schools to assist in identifying participants by distributing flyers to Black American parents of students experiencing behavioral problems. Parents who were interested were able to return the flyer to the school to receive additional information.

Participating schools included two schools in District A (one Head Start school and one Title I elementary school) and one Head Start/Pre-kindergarten school in District B. All three schools were similar in demographics regarding Black American enrollment (22.7%, 14.8%, 18.6%, respectively). Parents of all participating children reported household income fell within the United States Department of Health and Human Services (2007) poverty guidelines, hence qualifying for free or reduced lunch.

#### *Parent Interview and Data Collection*

After parental consent was obtained, as the researcher, I interviewed parents who expressed interest to participate in the study. The following instruments and form were completed by interested parents:

- a. Family background – Information (see Appendix B)
- b. Child Behavior Checklist – Parent version

### c. Parenting Stress Index

Free childcare was provided for parents while they completed the aforementioned documents. After scoring the CBCL, I contacted parents to indicate if they qualified to participate in the study. Parents whose child scored at the borderline or clinical range in at least one scale or syndrome subscale of the CBCL qualified for the study and were contacted by the researcher to complete the PSI. Parents whose child did not score at the borderline or clinical range in at least one scale or syndrome subscale of the CBCL did not qualify for the study. I provided referrals for counseling services for those parents who did not qualify. Qualified parents received a stipend for completing the instruments.

### *Qualified Participants*

A total of 31 volunteer parents were recruited for this study that met the following criteria: (1) parent consented to participate in study; (2) parent identified self as Black, Black American, or African American; (3) parent identified child as Black, Black American, or African American; (4) parent reported household income fell within the United States Department of Health and Human Services (2007) poverty guidelines; (5) parent completed the PSI and CBCL, (6) child was scored in the borderline or clinical range for Internalizing Problems or Externalizing Problems, or one of the syndrome subscales on the CBCL, and (7) neither child nor parent planned to receive counseling services, including parent education programs, during the time of the study.

Qualified parents were assigned to groups through random assignment and available times indicated by parents at the initial parent interviews. According to random

assignment procedures, 16 parents were randomly assigned to the experimental group, while 15 parents were randomly assigned to the no treatment control group. Of the 16 parents assigned to the experimental group, 4 participants randomly drawn to the treatment group were unable to attend during the scheduled CPRT group time at their child's school due to work conflicts. Due to the scheduling conflict, 4 parents from the control group were randomly selected to participate in the treatment group while the 4 parents who reported work conflicts were assigned to the control group. The four parents who were unable to attend also identified themselves as single, working mothers, which might account for group differences in marital and employment status (see Table 1). Parents attended CPRT training at their child's school. Based on parents' schedule and location of their child's school, parents were divided into three groups (2 to 7 parents per group) in keeping with CPRT methodology (Bratton, Landreth, et al., 2006). In school District A, one group of seven parents was conducted at the Head Start site and one group of five parents was conducted at the Title I elementary school. In school District B, one group of two parents was conducted at the Head Start/Pre-kindergarten site. All groups were held during the evening, from 6:00 p.m.- 8:00 p.m. Free childcare and complimentary dinner was provided during the group meeting times.

Of the 16 parents assigned to the experimental group, 14 completed the study while 2 did not complete treatment due to relocation to another school district. Of the 15 parents assigned to the control group, 13 parents completed posttesting while 2 did not complete posttesting due to having disconnected phone numbers and relocation to another school district. Table 1 presents demographic information of the parents in the

experimental and control group. Table 2 presents demographic information on the children of parents assigned to the experimental and control group.

Table 1

*Demographic Information for Parents in the Experimental and Control Group*

		Experimental Group <i>n</i> = 14	Control Group <i>n</i> = 13
Gender	Males	1	2
	Females	13	11
Average Age		29.9 years	30.2 years
Average Level of Education		14.0 years	13.4 years
Employment Status	Currently Employed	8	11
	Currently Unemployed	6	2
	Marital Status		
	Single	8	10
	Married	6	3

Table 2

*Demographic Information for Children of Parents Assigned to the Experimental and Control Group*

		Experimental Group <i>n</i> = 14	Control Group <i>n</i> = 13
Gender	Males	7	9
	Females	7	4
Average Age		4.4 years	4.1 years

### Treatment

#### *Experimental Treatment Group*

Parents of children assigned to the experimental group (*n* = 14) completed

CPRT training and supervision. CPRT reflects a strengths-based approach by utilizing the child's natural mode of communication, play, to facilitate parent's understanding of their child's world in order to promote positive child-parent relationships (Landreth & Bratton, 2006). CPRT utilizes lecture, discussion, role play, group process, and supervision of conducted at-home play sessions using a special kit of selected toys in efforts to teach parents how to become therapeutic agents in their children's lives. Child centered play therapy principles and skills that are taught to parents include reflective listening, recognizing and responding to children's feelings, responding to children's efforts, therapeutic limit setting, and building children's self-esteem. Through skill acquisition and application of these skills, parents learn how to create a nonjudgmental, empathic, permissive, and accepting environment that will facilitate personal growth and change for both parent and child (Landreth & Bratton, 2006). Curriculum content and procedures utilized during training followed the CPRT 10-session manualized protocol (Bratton, Landreth, et al., 2006).

As discussed in Chapter 1, there is a call for counseling professionals to engage in a culturally proactive manner when working with clients. In response to the documented cultural needs of Black American parents and consistent with the need to apply clinical judgment with any counseling intervention the 10-session CPRT curriculum was delivered over 11 sessions. The extension of the CPRT curriculum was done in order to mitigate several barriers that serve as possible reasons for Black Americans' underutilization of mental health services: 1) lack of trust toward mental health service providers, and 2) early termination of therapy services (Boyd-Franklin, 1989; Grier & Cobbs, 1968; Parham & Parham, 2002; Parham et al., 1999; Solis et al.,

2004; Sue, 1977). Additional time was allotted for group facilitators to establish rapport and to gain trust from the parents in efforts to reduce stigma related to mental health services. Based on Connor's (2002) emphasis on the need to connect with Black American clients in order to decrease the likelihood for early termination, group facilitators granted more time for group members to ask questions in order to facilitate trust, veracity, and openness with group facilitators.

Extending the sessions over 11 meetings also ensured adequate coverage of the CPRT content to address Black American values related to discipline practices. Previous studies reported low income Black Americans as more authoritarian in parenting style and parental control compared to low income Caucasian parents (Baumrind, 1972; Brody & Flor, 1998; Dearing, 2004; Durrett et al., 1975; Elder et al., 1995; Goodman, 1997; Kelley et al., 1992). Black Americans utilizing a more authoritarian parenting style might have difficulty with CPRT's emphasis on a non-directive, permissive approach when applying child centered play therapy principles and skills. Based on previous research (Edwards et al., 2007; Solis et al., 2004) where authors reported parent resistance to several components of the filial training, extending the curriculum to 11 sessions granted additional time for parents to explore potential challenges in learning child centered play therapy skills, such as limit setting and choice giving.

Finally, extending the sessions across 11 meetings allotted extra time to address factors related to living in poverty such as high stress level, transportation and other scheduling difficulties which impacts tardiness and absences. Rather than seeking mental health services, in times of struggle Black Americans obtain support from their

families, both nuclear and extended (Boyd-Franklin, 2003; Drewes, 2005; Glover, 2001; Kerl, 2001; Hines & Boyd-Franklin, 2005; Parham & Parham, 2002; Parham et al., 1999). Due to the heavy reliance upon family and community members as a primary support system for Black Americans, extending the CPRT curriculum provided more opportunities for parents to connect and provide social support. On the few occasions where parents were absent for regularly scheduled meetings, as the researcher, I conducted individual make-up sessions.

The majority of the additional two hours of training was spent in the first session to establish rapport and to gain trust from the parents in efforts to reduce stigma related to mental health services. The remaining time allotted for adequate coverage of the CPRT content in light of tardiness and absences. No modifications were made to the actual content and procedures presented in the CPRT treatment manual (Bratton, Landreth, et al., 2006). Consistent with the CPRT protocol and procedures, parents of children assigned to the experimental group conducted seven weekly play sessions with their child during the last seven weeks of training. Parents were also provided the opportunity to conduct their play sessions at their child's school or at home. All parents chose to conduct their play sessions at home. Furthermore, to facilitate cultural sensitivity when working with low income families, toy kits and video equipment were loaned to parents in order to complete home play sessions.

Treatment was provided by the researcher and a master's level counselor, experienced in play therapy and trained in the CPRT treatment protocol. In order to assure adherence to the CPRT protocol, the researcher was supervised by Sue Bratton, PhD, LPC, RPT-S, co-author of the CPRT textbook and treatment manual, throughout



the study. The researcher was an advanced doctoral counseling student with five advanced doctoral level courses and supervision in play therapy. Furthermore, the researcher was a Licensed Professional Counselor and a National Certified Counselor.

### *No Treatment Control Group*

Parents of children assigned to the control group ( $n = 13$ ) received no treatment during the study. As the researcher, I contacted the parents assigned to the control group at the beginning of the study and explained their opportunity to receive CPRT during the second phase of parenting groups, which began after completion of the study.

### Data Collection

After parental consent was obtained, the CBCL was administered to screen children for participation. Parents of qualifying children also completed the PSI prior to treatment. PSI and CBCL were collected again upon completion of treatment. To ensure integrity of data collection, parents completed documents in a controlled environment, free from distractions. As the researcher, I was present during all data collection to answer questions and ensure consistency in data collection. Parents were provided the option of completing the documents by themselves or utilizing an interview format. The interview format consisted of the researcher reading the questions to the parent and marking the answers on the documents. This option was provided to allow parents with low reading ability to receive help without having to disclose their reading difficulty in order to ensure accuracy of parent responses. To ensure confidentiality, participants

were assigned random code numbers for use in all data collection. Data was stored in a locked filing cabinet in a secure location.

### Analyses of Data

Results obtained from the participants' pretest and posttest scores on the PSI and CBCL were analyzed in order to examine the effect of CPRT on childrens' behavior and parent-child relationship stress. To ensure accuracy, both pretest and posttest data were scored using computer software scoring for the CBCL, which requires verification of data by entering the data twice. The PSI was hand scored twice to ensure data accuracy.

Prior to conducting statistical analyses for both instruments, an analysis of outliers was performed. Wilcox (1998) cautioned researchers from removing all outliers prior to running statistical analysis without careful examination of each outlier. One outlier was identified on the PSI on posttest. However, upon further investigation, this case did not indicate an extreme life event or circumstance that would confound the results (R. Henson, personal communication, February 22, 2008). Furthermore, no other explanation, such as "error in recording, a miscalculation...or a similar type of circumstance" (Kutner, Nachtsheim, Neter, & Li, 2005, p. 108) served as justification to discard the outlier. In other words, there was no reason to believe that this outlier was not representative of the sample or a true score. Therefore, a total of 27 total cases were utilized for the PSI analyses.

Four cases were identified as outliers on the CBCL on pretest. Two of the four cases indicated an extreme life event that could confound the results, and as a result

were removed. The remaining 2 outliers did not indicate extraneous variables that would confound the results. As a result, only two cases were removed, resulting in 25 total cases for the analyses of the data for the CBCL.

### *Data Analysis for PSI*

A two factor (Time x Group) repeated measures analysis of variance (RM ANOVA) was utilized to statistically analyze the effects of group membership (experimental, control) and time (pretest, posttest) on the dependent measures of the Parenting Stress Index (PSI; Abidin, 1995). Dependent measures for PSI included Total Stress, Child Domain, and Parent Domain. Wilks' lambda was utilized to interpret results. One case was removed as an outlier. The PSI was analyzed to screen data for normality, homogeneity of variance, and sphericity. Assumptions of normality and homogeneity of variance was met for PSI. Sphericity was assumed because this study had only two points of measurement. Due to difficulty adhering to strict random assignment and visual inspection of the means that suggested inequality at pretest (see Table 3), one-way analysis of variance (ANOVA) was conducted to analyze the equality of groups at pretest scores and revealed no statistically significant differences for Total Stress and Child Domain scores. However, one-way ANOVA results on the Parent Domain revealed that the groups started out statistically different at pretest scores,  $F(1, 26) = 4.42, p < 0.05$ . Results for the Parent Domain are interpreted with caution. According to Hinkle, Wiersma, and Jurs (2003), random sampling is a technical term relating to the way the samples are selected. If other assumptions are met, which was true in this study, the impact on Type I error rate is minimal.

### *Data Analysis for CBCL*

Due to difficulty adhering to strict random assignment and visual inspection of the means that suggested inequality at pretest (see Table 4), one-way ANOVA was conducted to analyze the equality of groups at pretest scores and revealed statistically significant differences at pretest scores on all three dependent variables, Total Problems:  $F(1, 23) = 8.42, p < 0.01$ ; Externalizing Problems:  $F(1, 23) = 4.29, p = 0.05$ ; Internalizing Problems:  $F(1, 23) = 4.42, p < 0.05$ . Hence, one way between groups analysis of covariance (ANCOVA) was selected to analyze the effectiveness of CPRT on participants assigned to the experimental group when compared to participants assigned to the control group on the CBCL. Two cases were dropped as outliers. Preliminary checks were conducted to ensure that there was no violation of the assumptions of independence, normality, homogeneity of variance, linearity, homogeneity of regression of slopes, and reliable measurement of the covariate. All assumptions for a one way between groups ANCOVA for the CBCL were met.

To avoid Type I errors due to multiple hypotheses testing, a more conservative .025 alpha level was established as criterion for either accepting or rejecting all hypotheses (Armstrong & Henson, 2005). Partial  $\eta^2$  were also calculated in order to assess the magnitude of difference between the two groups and to better understand the practical significance of the findings (Kazdin, 1999). For the purpose of this study, partial  $\eta^2$  was calculated to assess the magnitude of the treatment effect. The following guidelines proposed by Cohen (1988) were used to interpret partial  $\eta^2$ : .01 = small, .06 = medium, and .14 = large. Effects were also interpreted in light of findings from other filial therapy studies.

## CHAPTER 3

### RESULTS AND DISCUSSION

The results of the analyses of data are presented in the order in which hypotheses were tested. Consultation with a qualified statistician was sought to ensure the validity and appropriateness of all statistical analyses.

#### Results

As discussed in Chapter 2, for Hypotheses 1-3, a two factor (Time x Group) repeated measures analysis of variance (RM ANOVA) was utilized to statistically analyze the effects of group membership (experimental, control) and time (pretest, posttest) on the dependent measures of the Parenting Stress Index (PSI; Abidin, 1995). Dependent measures for PSI included Total Stress, Child Domain, and Parent Domain. Wilks' lambda was utilized to interpret results. Assumptions were met for RM ANOVA, but due to mean differences on pretest Parent Domain,  $F(1, 26) = 4.42, p < 0.05$ , results for Parent Domain are interpreted with caution.

Due to preexisting mean differences at pretest scores, Total Problems:  $F(1, 23) = 8.42, p < 0.01$ ; Externalizing Problems:  $F(1, 23) = 4.29, p = 0.05$ ; Internalizing Problems:  $F(1, 23) = 4.42, p < 0.05$ , for Hypotheses 4-6, one way between groups analysis of covariance (ANCOVA) was selected to analyze the effectiveness of CPRT on participants assigned to the experimental group when compared to the no treatment control group on the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000). Dependent measures for CBCL included Total, Externalizing, and Internalizing

Problems scores. All assumptions for one way between groups ANCOVA for the CBCL were met.

The PSI and CBCL was administered prior to treatment and at the end of treatment. A reduction in scores on the PSI and CBCL indicated improvement in the targeted behavior. To avoid Type I errors due to multiple hypotheses testing, a more conservative .025 alpha level was established as criterion for either accepting or rejecting the hypothesis (Armstrong & Henson, 2005). Partial  $\eta^2$  were calculated in order to assess the magnitude of difference between the two groups and to better understand the practical significance of the findings (Kazdin, 1999). For the purpose of this study, partial  $\eta^2$  was calculated to assess the magnitude of the treatment effect. The following guidelines proposed by Cohen (1988) were used to interpret partial  $\eta^2$ : .01 = small, .06 = medium, and .14 = large.

### *Results for Hypotheses 1 to 3*

Table 3 presents the pretest and posttest means and standard deviations for the experimental and no treatment control group on Total Stress, Child Domain, and Parent Domain of the PSI.

Table 3

#### *Mean Scores on Total Stress, Child Domain, and Parent Domain of the Parenting Stress Index*

		Experimental Group n = 14		Control Group n = 13	
		Pretest	Posttest	Pretest	Posttest
Total Stress	Mean	272.93	208.43	239.77	257.69
	SD	46.70	37.73	43.75	65.34
Child Domain	Mean	121.29	92.71	112.62	123.00
	SD	20.86	20.45	21.31	29.12
Parent Domain	Mean	151.64	115.71	127.15	134.69
	SD	34.23	22.87	25.27	37.82

*Note:* A decrease in mean scores indicates a decrease in reported stress level.

### *Hypothesis 1*

From pretest to posttest, parents in the experimental group will report a statistically significant decrease on Total Stress of the PSI when compared to parents in the control group. Results of the two factor RM ANOVA of the dependent variable, Total Stress, revealed a statistically significant interaction effect of group membership (experimental/control) x time (pretest, posttest), Wilks' lambda = .50,  $F(1, 25) = 25.30, p < .001, \text{partial } \eta^2 = .50$ . These results indicate that the parents in the CPRT group reported a statistically significant decrease in Total Stress from pre- to posttreatment, when compared to the control group. On the basis of these results Hypothesis 1 was retained. Findings further indicated that the effects of the CPRT intervention on the experimental group compared to the control group was large (partial  $\eta^2 = .50$ ).

### *Hypothesis 2*

From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Child Domain of the PSI when compared to parents in the control group. Results of the two factor RM ANOVA of the dependent variable, Child Domain, revealed a statistically significant interaction effect of group membership (experimental/control) x time (pretest, posttest), Wilks' lambda = .53,  $F(1, 25) = 21.90, p < .001, \text{partial } \eta^2 = .47$ . These results indicate that the parents in the CPRT group reported a statistically significant decrease in Child Domain from pre- to posttreatment, when compared to the control group. On the basis of these results Hypothesis 2 was retained. Findings further indicated that the effects of the CPRT

intervention on the experimental group compared to the control group was large (partial  $\eta^2 = .47$ ).

### *Hypothesis 3*

From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Parent Domain of the PSI when compared to parents in the control group. Due to mean differences on pretest Parent Domain,  $F(1, 26) = 4.42, p = 0.05$ , results are interpreted with caution. Results of the two factor RM ANOVA of the dependent variable, Parent Domain, revealed a statistically significant interaction effect of group membership (experimental/control) x time (pretest, posttest), Wilks' lambda = .59,  $F(1, 25) = 17.05, p < .001$ , partial  $\eta^2 = 0.41$ . These results indicate that the parents in the CPRT group reported a statistically significant decrease in Parent Domain from pre- to posttreatment, when compared to the control group. On the basis of these results Hypothesis 3 was retained. Findings further indicated that the effects of the CPRT intervention on the experimental group compared to the control group was large (partial  $\eta^2 = .41$ ).

### *Results for Hypotheses 4 to 6*

Table 4 presents the pretest and posttest means and standard deviations for the experimental and no treatment control group on Total, Externalizing, and Internalizing Problem scales of the CBCL.



Table 4

*Mean Scores on Total, Externalizing, and Internalizing Problem scales on the Child Behavior Checklist*

		Experimental Group n = 14		Control Group n = 13	
		Pretest	Posttest	Pretest	Posttest
Total Behavior Problems	Mean	57.64	47.29	64.82	60.45
	SD	6.64	6.35	5.42	7.99
Externalizing Problems	Mean	57.21	48.36	64.36	60.09
	SD	7.67	5.42	9.60	6.63
Internalizing Problems	Mean	55.50	48.50	63.18	58.18
	SD	10.07	8.95	7.57	9.25

*Note:* A decrease in mean scores indicates an improvement in behavior.

*Hypothesis 4*

From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Total Problems scale of the CBCL when compared to parents in the control group. After adjusting for group mean differences at pretesting, results of ANCOVA of the dependent variable, Total Problems, indicate that parents in the CPRT group reported a statistically significant decrease in Total Problems from pre to posttreatment, when compared to the control group,  $F(1, 22) = 9.11, p < .01, \text{partial } \eta^2 = .29$ . On the basis of these results Hypothesis 4 was retained. Findings further indicated that the effects of the CPRT intervention on the experimental group compared to the control group was large (partial  $\eta^2 = .29$ ). Table 5 displays these results.

Table 5

*Analysis of Covariance for Total Problems on CBCL*

Source	df	SS	MS	F	p	$\eta^2$
Covariate (pretest)	1	325.68	325.68	8.55	<0.01	0.28
CPRT (group)	1	346.93	346.93	9.11	<0.01	0.29
Error	22	837.90	38.09			
Total	25	72669				

### *Hypothesis 5*

From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Externalizing Problems scale of the CBCL when compared to parents in the control group. After adjusting for group mean differences at pretesting, results of ANCOVA of the dependent variable, Externalizing Problems, indicate that parents in the CPRT group reported a statistically significant decrease in Externalizing Problems from pre to posttreatment, when compared to the control group,  $F(1, 22) = 16.14, p = .001, \text{partial } \eta^2 = .42$ . On the basis of these results Hypothesis 5 was retained. Findings further indicated that the effects of the CPRT intervention on the experimental group compared to the control group was large (partial  $\eta^2 = .42$ ). Table 6 displays these results.

Table 6

#### *Analysis of Covariance for Externalizing Problems on CBCL*

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	$\eta^2$
Covariate (pretest)	1	247.82	247.82	9.53	<0.01	0.30
CPRT (group)	1	419.88	419.88	16.14	.001	0.42
Error	22	572.31	26.01			
Total	25	73278				

### *Hypothesis 6*

From pretest to posttest, parents in the experimental group will report a statistically significant decrease on the Internalizing Problems scale of the CBCL when compared to parents in the control group. After adjusting for group mean differences at pretesting, results of ANCOVA of the dependent variable, Internalizing Problems,

results indicate that parents in the CPRT group did not report a statistically significant decrease in Internalizing Problems from pre to posttreatment, when compared to the control group,  $F(1, 22) = 2.39$ ,  $p = .14$ , partial  $\eta^2 = .10$ . On the basis of these results Hypothesis 6 is rejected. Findings further indicated that the effects of the CPRT intervention on the experimental group compared to the control group was medium (partial  $\eta^2 = .10$ ). Table 7 displays these results.

Table 7

*Analysis of Covariance for Internalizing Problems on CBCL*

Source	<i>df</i>	<i>SS</i>	<i>MS</i>	<i>F</i>	<i>p</i>	$\eta^2$
Covariate (pretest)	1	697.05	697.05	12.78	<0.01	0.37
CPRT (group)	1	130.11	130.11	2.39	0.14	0.10
Error	22	1200	54.55			
Total	25	72065				

### Discussion

This pilot study investigated the effectiveness of CPRT with low income Black American parents. Specifically, this study examined the effect of the CPRT treatment on reducing Black American children’s behavior problems and parent-child relationship stress. A total of 27 qualified parents completed the study. Of the six hypotheses, five were retained at the 0.025 level of significance. Partial  $\eta^2$  was also calculated to determine practical significance, or therapeutic value, of treatment findings (Kazdin, 1999). Thompson (2002) emphasized the importance of practical significance for counseling research and the need to report such findings. The discussion of treatment

results is organized as follows: (a) parenting stress outcomes and (b) child behavior outcomes.

### *Parenting Stress Outcomes for Child Domain*

The Child Domain represents sources of stress within the parent-child relationship that directly relates to problematic behaviors within the child (Abidin, 1995). Results of this study indicated that children whose parents participated in the CPRT treatment group reported a statistically significant improvement on the Child Domain of the PSI. Treatment effect for the CPRT intervention was large for Child Domain, demonstrating the practical significance of findings. Based on the mean scores from pretest to posttest Child Domain, the experimental group had a 28.58 point decrease in their mean score compared to a 10.38 point increase for the control group. These results are consistent with other CPRT controlled studies that showed a statistically significant reduction on scores for the Child Domain of the PSI (Chau, & Landreth, 1997; Kidron, 2003; Yuen et al., 2002). However, the results of this study were different from other filial therapy studies that reported no statistical significance in the reduction of stress as reported in the Child Domain of the PSI (Jang, 2000; Kale & Landreth, 1999; Landreth & Lobaugh, 1998).

Abidin, Jenkins, and McGaughey (1992) and Deater-Deckard (2005) suggested a cyclical relationship between child behavior problems and parent-child relationship stress. The Child Domain of the PSI is designed to assess the child's characteristics that contribute to stress in the parent-child relationship. Abidin (1995) indicated that high scores on the Child Domain warrant interventions to focus on the child's behavior. The

present study also found statistically significant decreases in children's externalizing and total problem behaviors as measured by the CBCL. It can be postulated that as the parent-child play sessions positively impacted children's behavior, parent-child relationship stress related to the child's behavior also improved. Furthermore, the CPRT curriculum emphasis on increasing parental empathy and normalizing parent concerns regarding their child's developmental level could have positively impacted parents' ability to accept their child; hence, resulting in the significant decrease on the Child Domain score. These findings support CPRT as a promising treatment to reduce parent-child relationship stress associated with child characteristics.

#### *Parenting Stress Outcomes for Parent Domain*

Parent Domain represents sources of stress within the parent-child relationship that is directly related to the parent's physical, emotional, and social functioning (Abidin, 1995). Results of this study indicated that children whose parents participated in the CPRT treatment group reported a statistically significant improvement on the Parent Domain of the PSI. Treatment effect for the CPRT intervention was large for Parent Domain, demonstrating the practical significance of findings. Based on the mean scores from pretest to posttest Parent Domain, the experimental group had a 35.93 point decrease in their mean score compared to a 7.54 point increase for the control group. These results are consistent with other CPRT controlled studies that showed a statistically significant reduction on scores for the Parent Domain of the PSI (Chau & Landreth, 1997; Kale, & Landreth, 1999; Kidron, 2003).

The CPRT supportive group format provides a safe environment for parents to share their struggles and challenges as parents. Allowing opportunities for parents to share their experiences seemed important and served to increase the level of acceptance and cohesion within the group. It can be postulated that as the level of acceptance between the group members increased, the more accepting they were of themselves. Furthermore, the CPRT curriculum provides skills to parents that can serve to increase their level of parental competence. Using a strength-based approach, CPRT focuses on enhancing the parent-child relationship. Hence, it is plausible to expect that as parents experience a closer relationship with their child, the more competent they will feel as parents. The statistical and practical significance of these findings support CPRT as a promising intervention to reduce parent-child relationship stress associated with parent characteristics.

#### *Parenting Stress Outcomes for Total Stress*

Total Stress of the PSI represents sources of stress within the parent-child relationship that relates to problematic behaviors within the child, parent, or a combination of both (Abidin, 1995). Results of this study indicated that children whose parents participated in the CPRT treatment group reported a statistically significant improvement on Total Stress of the PSI. Treatment effect for the CPRT intervention was large for Total Stress, demonstrating the practical significance of findings. Based on the mean scores from pretest to posttest Total Stress, the experimental group had a 64.50 point decrease in their mean score compared to a 17.92 point increase for the control group. These results were consistent with controlled filial studies that reported

statistically significant reduction in parent-child relationship stress (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Kale & Landreth, 1999; Kidron 2003; Landreth & Lobaugh 1998; Tew et al., 2002; Yuen et al., 2002).

Delivery of the CPRT curriculum within a group format seems a good fit with the values and preferences of Black Americans. These results with low income parents are particularly noteworthy in that living in poverty can result in high stress, which in turn has been correlated with negative parenting styles (Bluestone & Tamis-LeMonda, 1999; Deater-Deckard & Dodge, 1997). More emphasis on the supportive group format may have served as a factor in the reported improvement in parent-child relationship stress. In times of struggle, Black Americans tend to seek support from their families, both nuclear and extended (Boyd-Franklin, 2003; Drewes, 2005; Glover, 2001; Kerl, 2001; Hines & Boyd-Franklin, 2005; Parham & Parham, 2002; Parham et al., 1999). Within the CPRT approach, group cohesion develops as parents share their parenting struggles while learning new strategies to develop a closer bond with their children. The value of interdependence within Black American communities was demonstrated as parents provided encouragement and support for one another as they learned new parenting behaviors. Furthermore, the group format of the CPRT model reflects similar emotional support experienced in the broader community for Black American families, such as churches. It is plausible that as a result of feeling supported, parents' level of parent-child relationship stress was reduced. It can also be speculated that learning child centered play therapy skills led to an increase of parental competence and parental control, which in turn resulted in a decreased level of parent-child relationship stress. Another explanation for reduction in parent-child relationship stress could relate to the

reduction of child behavior problems. That is, a reduction in child behavior problems could attribute to the decreased level of parent-child relationship stress.

These results are noteworthy based on previous literature findings related to the negative effects of stress and poverty on parenting styles. For example, Lempers et al. (1989) stated that “parenting is likely to be less child centered and nurturant and more rejecting, inconsistent, and parent-centered” (p. 35). The authors further projected behavioral and emotional problems during adolescent years as a result of high stress experienced by parents. Thus, the findings for parent-child relationship stress for this study are promising due to the strong parental influence on children’s behavioral problems (Jackson et al., 1998; Slater & Power, 1987). Despite the small sample, the statistical and practical findings support the use of CPRT as a promising intervention for decreasing parent-child relationship stress.

#### *Child Behavior Outcomes for Externalizing Problems*

Externalizing behavior problems are difficulties that children express outwardly towards others. These behaviors include aggression, hyperactivity, and rule breaking (Achenbach & Rescorla, 2000). Results indicated that children whose parents participated in the CPRT treatment group reported a statistically significant improvement on the Externalizing Problems scale of the CBCL when compared to the children whose parents who were in the control group. Treatment effect for the CPRT intervention was large, demonstrating the practical significance of findings. Based on the mean scores from pretest to posttest, the experimental group had an 8.85 point decrease in their mean score compared to a 4.27 point decrease for the control group. These results



were consistent with controlled filial studies that reported statistically significant reduction in children's externalizing behavioral problems as a result of CPRT training conducted with parents and teachers (Kidron 2003; Morrison, 2006; N. Smith & Landreth, 2003; D. M. Smith & Landreth, 2004). In addition, findings from a meta-analysis examining the efficacy of play therapy, including filial and CPRT, reported similar treatment effects on children's externalizing behavioral problems (Bratton, Ray, et al., 2005).

Although the sample size was small, the use of a no treatment control group provides support that improvement in externalizing problems could be attributed to the CPRT treatment. Previous research suggested that parental participation in parenting programs resulted in decreased child externalizing behaviors (Bernazzani et al., 2001; Cann et al., 2003; Collins et al., 2000; Veeing et al., 2003). CPRT reflects a strengths-based parenting approach by utilizing the child's natural mode of communication, play, to facilitate parent's understanding of their child's world in order to promote positive child-parent relationships (Landreth & Bratton, 2006). Using child centered play therapy skills during the 30-minute home play session might have resulted in parents' increased ability to respond to their child's needs in a positive manner. Due the parent's heightened degree of sensitivity and understanding to their child's world, the child is now able to express self fully and as a result, may reduce the need to "act out" in order to satisfy needs.

Results of the CPRT intervention on externalizing behaviors demonstrates promise in light of current literature regarding the need for early parenting interventions to mitigate disruptive behaviors, such as aggression, which typically appears in early

childhood and has a tendency to become resistant to change (Bernazzani et al., 2001; Tremblay, 2000). In addition to externalizing problems being stable over time, Hinshaw (1992) also reported that these problems “carry a worse prognosis as well as resistance to most forms of intervention” (p. 127). Additional risk factors faced by children who experience externalizing problems include depression, drug abuse, juvenile delinquency, violence, and antisocial disorders (Webster-Stratton & Reid, 2003). Due to the stability of parenting behavior across the lifespan, Collins et al. (2000) postulated an accumulating effect of parenting practices that continue throughout childhood and adolescent years. Parenting programs provided to parents of young children, such as CPRT, serves as a promising treatment to mitigate externalizing behavior problems and to facilitate children’s optimal growth and development.

### *Child Behavior Outcomes for Internalizing Problems*

Internalizing behavior problems are difficulties that children express within themselves, rather than physically acting them out towards others. These behaviors include somatic complaints, anxiety, and depression (Achenbach & Rescorla, 2000). Based on the mean scores from pretest to posttest, the experimental group had a 7.00 point decrease in their mean score compared to a 5.00 point decrease for the control group. Despite the lack of statistically significant improvement in internalizing problems for children of parents who participated in CPRT, treatment effect for the intervention was medium, demonstrating practical significance of findings. These results were consistent with two controlled filial studies that reported a lack of statistical significance in reducing children’s internalizing behavioral problems as a result of CPRT training

conducted with teachers (Helker, 2006; Morrison, 2006). In addition, findings from a meta-analysis examining the efficacy of play therapy, including filial and CPRT, reported moderate to large treatment effects on children's internalizing behavioral problems (Bratton, Ray, et al., 2005).

In examining the lack of statistical significance, Internalizing Problems of the CBCL includes characteristics such as shyness and withdrawn which could also be associated with young children's adjustment to entering school for the first time. Hence, children in both groups may have demonstrated improvement in internalizing problems as the novelty of school lessened over time.

With an emphasis of increasing parents sensitivity and understanding of their child's feelings and needs, the lack of statistical significance may in part be explained to the parents increased level of sensitivity that has lead to accurate identification of internalizing problems. Morrison (2006) explained that the treatment effect on children's internalizing problems could have been a result of teacher's increased sensitivity and responsiveness to children. On the other hand, the lack of statistical significance may in part be explained to the parents' lack of sensitivity to subtle changes in their child's behaviors.

Despite small sample size, the moderate treatment effects on Internalizing Problems of children whose parents participated in CPRT, compared to no treatment control provides support for CPRT as a promising intervention for internalizing problems. Specifically, therapeutic goals of CPRT include helping children to "develop coping strategies and an increase in positive feelings of self worth and confidence" (Landreth & Bratton, 2006, p. 12). Additionally, CPRT helps parents help their children

to accept and respect themselves, develop a more positive self-concept, assume responsibility for themselves, and experience a feeling of self-control and self-direction. (Landreth, 2002, pp. 90-92). Hence, empowering the child could lessen the child's expression of internalizing symptoms. Results of the CPRT intervention on internalizing behaviors are also encouraging in light of current literature regarding at-risk factors associated with untreated internalizing problems for young children: 1) increased peer rejection (Keiley, Bates, Dodge, & Pettit, 2000) and 2) depression and substance use/abuse disorders (Kendell, Achenbrand, & Hudson, 2003).

#### *Child Behavior Outcomes for Total Problems*

Total Problems consists of a combination of externalizing and internalizing problems that children express. Additionally, Total Problems includes problems related to sleep for the 1½ -5 year old version of the CBCL (Achenbach & Rescorla, 2000). For the 6-18 year old version of the CBCL, Total Problems also include problems related to social interaction, negative self-talk, and attention.

Results indicated that children whose parents participated in the CPRT treatment group reported a statistically significant improvement on the Total Problems scale of the CBCL when compared to the children whose parents who were in the control group. Treatment effect for the CPRT intervention was large, demonstrating the practical significance of findings. Based on the mean scores from pretest to posttest, the experimental group had a 10.35 point decrease in their mean score compared to a 4.37 point decrease for the control group. These results were consistent with other controlled filial studies that reported statistically significant reduction in children's total behavior

problems a result of CPRT training conducted with parents and teachers (Bratton & Landreth, 1995; Kidron 2003; Lee & Landreth, 2003; Landreth & Lobaugh 1998; Morrison, 2006; D. M. Smith & Landreth, 2004; Tew et al., 2002). In addition, findings from a meta-analysis examining the efficacy of play therapy, including filial and CPRT, reported similar treatment effects on children's overall behavioral problems (Bratton, Ray, et al., 2005).

The statistical and practical significance of findings for CPRT's effects on total behavior problems are particularly noteworthy due to the fact that the majority of qualifying children displayed clinical to borderline levels of concern on multiple subscales of the CBCL. Achenbach & Rescorla (2000) reported that young children often present signs of comorbidity, making single diagnosis a difficult task. This view seems antithetical to the present movement in child psychotherapy research to focus on one specific diagnosis to determine the effects of a particular intervention on that diagnosis. The present study supports the idea that young children present with a broad range of behavioral concerns rather than a single diagnosis. Thus identifying culturally-responsive treatments, such as CPRT, that are responsive to young children's overall behavior problems is critical in addressing the crises in early mental health in this country (U.S. Public Health Service, 2000).

An additional noteworthy observation related to CPRT's effects on reducing overall child behavior problems is simultaneous decreases in parent-child relationship stress and child behavior problems experienced by the treatment group. Specifically, results of this study indicated that children whose parents participated in the CPRT treatment group reported a statistically significant improvement on parent-child

relationship stress and overall child behavior outcomes. The relationship between higher levels of parent-child relationship stress and higher levels of child behavior problems has been documented in the literature (Abidin et al., 1992; Deater-Deckard, 2005). It can be postulated that as parent-child play sessions positively impacted children's behavior, parent-child relationship stress related to children's behavior improved or vice versa. Despite the debate of identifying the interplay of parent influence on children and vice versa, the present results show that CPRT is a promising treatment to reduce child behavior problems and parent-child relationship stress.

#### Researcher's Observations

I observed two distinct, yet what appeared to be meaningful, phenomena in the delivery of CPRT to low income Black American parents: 1) importance of treatment provider-ethnicity match, and 2) importance of group support. During the participant recruitment process, I observed an increased interest in CPRT training once parents became aware that I too, was of similar ethnic background, and that I would be providing the CPRT treatment. Although utilizing flyers was a cost efficient means to inform potential participants of the study, several parents reported suspicion and upset due to the content of the flyer (e.g., advertising a parenting program exclusively for Black Americans). Several parents reported initial reactions of anger, as they reported their interpretation of the flyer was that Black American parents were inept parents compared to parents of other ethnicities. This observation supports the notion of the tendency for Black Americans to have a negative stigma towards mental illness and their decreased likelihood to seek treatment (Boyd-Franklin, 1989; Grier & Cobbs, 1968;

Parham & Parham, 2002; Parham et al., 1999; Solis et al., 2004; Sue, 1977). I observed that parents who contacted me by phone asked more questions about the purpose of the study and the rationale of selecting Black American parents when compared to those parents who met me in person. It seemed that the former group was more suspicious about the intention of the study. For the latter group, I observed these parents asking fewer questions about the purpose and rationale of the study, and more questions related to treatment logistics (e.g., schedule date and time for group meetings). For example, one parent who made initial contact via phone began the conversation by asking questions related to the rationale for the study and forthrightly inquired about my race. Once I shared that I was of similar ethnic background, the parent gave a sigh of relief and explained her relief knowing that I was not “white.” Such statements and observations appear to indicate that having a group facilitator of similar ethnic background served as a deciding factor for parents to decide whether or not to participate in the study. These observations emphasize the need for greater ethnic diversity among mental health professionals in an effort to reduce barriers for Black Americans who hold suspicious views of mental health services and mental health treatment providers

The importance of the supportive group setting appeared to be meaningful in the delivery of CPRT for low income Black American parents. The parent connections were particularly strong between those who shared similar experiences in their lives (e.g., living in poverty, being Black American) and did not have extended family to rely on for support. Furthermore, parents reflected upon the increased level of comfort due to the fact that others shared other similar experience. These similarities appeared to have

facilitated an extended sense of family, where parents seemed particularly open to share their struggles as parents and to provide support to one another. Allowing opportunities for parents to briefly share their experiences seemed important and served to increase the level of acceptance and cohesion within the group.

In efforts to evaluate the CPRT intervention, parents in the experimental group were asked to respond to the following questions:

- *What did you learn about yourself and/or your child as a result of CPRT?* The most often cited responses centered around parents reflecting upon the increased level of consistency in discipline, increased level of patience, reduced level of stress, and an increased ability to transfer newly learned child centered play therapy skills with other family members and friends. For example, one parent reflected an increased sense of flexibility in discipline:

Before this class, the form of discipline and how I raised my kids was spanking...I was just doing how I was raised. I was raised by my grandma. I felt like there was no other alternative besides time out and spanking...It [CPRT] gives you options.

Parents also reported that the reduction of stress also resulted in the reduction of the use of spanking as a form of discipline. During the last group meeting that occurred in mid December, one parent reported to the group how his daughter told him that it was before Thanksgiving when she remembered the last time she got spanked.

- *What was the most challenging skill you learned during this training experience?* Parents responded to this question in a variety of ways; however the majority of parents expressed initial hesitation and skepticism when learning the new skills. One parent explained, "Is this for real?" Another parent reported "I thought it was funny, but it



works.” In terms of a specific skill that was difficult to accept, several parents reflected upon difficulty in letting the child lead during scheduled play times. One parent explained this struggle when conducting the 30 minute play sessions:

Normally I wouldn't let him do whatever he likes, because as a parent I want to say, “You don't throw that”, “You don't hit that”, and “You're not going to do that”.

Another parent who defined herself as “controlling” reflected upon the difficulty of allowing the child to make choices in daily activities, such as allowing the child to decide what clothes to wear, because the parent had never allowed the child to do this before. Parent reports of difficulty in accepting certain dimensions of the training in this study were similar to challenges reported in previous studies that examined the effectiveness of filial therapy with a Jamaican mother (Edwards et al., 2007) and a Black American mother (Solis et al., 2004). An additional similarity to these previous studies relate to the parents reported ability to generalize skills into their daily parenting practices. For example, the parent who expressed difficulty in allowing her child to select what clothes to wear was able to generalize this skill to use with her older daughter by the end of CPRT training and reflected upon the rewards of choice giving:

I tell you when they realized that they made that choice, their reaction to me and my reaction to them was much different. Like before I was like “I'm going to tell you what to do and you're going to do it, if you don't you're going to get the consequences.” Now they know, “Well, if I choose to do it, it's my fault.”

- *What effect, if any, did it make to be in an all Black American group?* The majority of the parents reported that being in a group comprised of Black Americans was more comfortable and more relaxing. One parent elaborated about the feeling of comfort by explaining how “you see a reflection of you all around the room.” Several

parents also explained that the comfort was due to similar experiences shared by all group members, as explained by one parent:

Our families may have issues that could be considered like a hardship that we may not feel so comfortable sharing with other people that aren't in our ethnicity, but since we all have them, we're all poor....so that's one thing that's irrelevant. It's not an issue that we have to address or explain, it's just understood.

Another parent also commented about the value of shared experiences:

It makes a difference though...Remember how we talked about last week about the big red and all that? Like some people won't get that....it's a difference because it's comfortable, it's more comfortable.

Parents also commented on the level of comfort in having group facilitators of similar ethnic background. One parent stated, "We have confidence in ya'll [group facilitators]...and it's more comfortable." Another commented, "Ya'll know where we're coming from and we know where you're coming from." Another parent explained, "If you would have been white, it would have been a lot of questions. I don't think this many people would have stayed for this class." Another parent echoed this view:

Parenting from a white person rather than a black person is different because our parenting skills and raising our kids is very different, as far as how we discipline is very different. I don't think I would listen to her at all or even participated, just to be honest.

Based upon these observations, it seems to indicate that having group facilitators of similar ethnic background as the Black American parents provided a sense of safety to talk openly about parenting challenges, including spanking, and also to ask for assistance from the researcher on areas beyond the CPRT training.

Being viewed as Black American by the parents, as the researcher and one of the treatment providers, I observed the tendency for several parents to ask me to serve as an advocate for their child. Specifically, I was asked to attend parent-

teacher conferences, to serve as a resource to assist in the understanding of certain common childhood diagnoses (e.g., attention deficit disorder), and to provide referrals for medical physicians within the community. It can be proposed that the parents' perception of the researcher being Black American increased their sense of trust, increased their degree of openness, and increased their willingness to ask for assistance from the researcher. Hence, it seems as if the researcher was also viewed as a part of the parents' extended family, as they sought feedback and assistance from the researcher on areas beyond the CPRT training.

#### Limitations of the Study

While the results of this pilot study has broadened the literature regarding the effectiveness of CPRT with low income Black American parents, there are several limitations that served to confound results of this study and should be considered when interpreting results. Because this was a pilot study, the sample size was small. A larger sample size would increase statistical power, increase generalizability, and validate the results.

The real world setting of the study validates its applicability in school settings; however it also contributes to several limitations. Due to parents' scheduling conflicts, there was difficulty adhering to strict random assignment. As a result, several parental characteristics were not equally represented in both the experimental and no treatment control groups (e.g., gender, income, marital status). Hence, the potential influence of gender, income, and marital status on treatment outcome cannot be determined due to

the lack of controlling for these variables. Furthermore, although parents assigned to the experimental and control group reported that they did not receive counseling services during the course of treatment, it was impossible to control for all possible extraneous variables, including school support services for children that could have impacted the findings of this study.

Participating parents volunteered to be a part of the study. Hence, these parents that may have different motivating factors to participate in the treatment when compared to the general population. With the attrition rate of this study being approximately 1/6 of the original sample could have impacted the findings of this study. It can be speculated that those parents who dropped out of the study were less invested in participating in the training, compared to the parents who completed the training. In addition, participants were aware of their treatment group membership and the purpose of this research because they reviewed the informed consent for the study. The Hawthorne effect (Gay & Airsian, 2003) may have affected participants' perceptions. Furthermore, as the researcher, I also functioned as the group facilitator that provided treatment and as a result may have introduced a degree of researcher bias. For example, participants may have wanted to do well or look good on responses on behalf of the researcher.

Another limitation of this pilot study is the use of a no treatment control group. The statistical results of this study could have been the result of the use of an intervention, rather than the use of the CPRT curriculum and protocol. The use of a treatment comparison group would provide support to the present findings.

Another limitation was the use of only one report measure to examine the effects of CPRT on children's behaviors. The use of only one measurement restricts a broad

understanding of the impact of CPRT on children's behavior. Results of the CBCL might have reflected parental perception change of the child's behavior rather than true change due to the CPRT intervention. The use of multiple sources of measurement would add to the confidence of the present findings.

Finally, parents who participated in the CPRT treatment also served as a source for data collection. The use of participants as a source of data collection may have introduced a degree of bias. However, Abidin (1992) reported the use of parent self reports as "one important data source for both theory construction and clinical assessment" (p. 411).

#### Contributions and Strengths of the Study

Despite the limitations of generalizability of the results for this study due to small sample size and difficulty adhering to strict random assignment, this study has broadened the literature regarding the effectiveness of CPRT with ethnically diverse populations. One of the major contributions of the present study is that it appears to be the first to empirically examine the effects of CPRT with low income Black American families (Landreth & Bratton, 2006). In fact, an exhaustive review of the literature in the broader field of play therapy revealed no outcome studies with this targeted population.

Results from the present study are promising and provide support for further investigation with a larger sample size. These findings provide a rationale for mental health professionals who work with low income Black American families to utilize CPRT as a treatment modality to reduce parent-child relationship stress and to ameliorate child behavior problems. Furthermore, in light of current research (Bernazzani et al.,

2001; Hinshaw, 1992; Tremblay, 2000; Webster-Stratton & Reid, 2003) regarding the need to address externalizing problems in early childhood to prevent future costly and severe behavioral problems, CPRT serves as a promising intervention to facilitate low income Black American children's optimal growth and development.

Another strength of this study is that it serves as a catalyst to further investigate treatment outcomes on the basis of similar ethnic background for both therapist and client. As a result of this study, I observed the benefit of ethnic match of treatment providers and parent participants serving as a factor in parents' decision to participate and may have been a factor in preventing early termination. Previous research regarding ethnic match of client and therapist indicate conflicting results (Sue, 1998). Despite the lack of strong empirical support for differential outcomes on the basis of ethnic match between therapist and client, Sue, Fujino, Hu, Takeuchi, and Zane (1991) indicated for their study that "for all groups [Caucasian, Mexican American, Asian] except African Americans, ethnic match resulted in substantially lower odds of dropping out than for unmatched clients" (p. 536).

Sue (1998) proposed several limitations regarding studies examining ethnicity and treatment (e.g., lack of treatment studies, lack of randomization, lack of inclusion of Black American therapists, lack of control for social class); nevertheless Black Americans remain distinguished by their high premature drop out rate from therapy, in addition to less positive treatment outcome reports (Sue, Fujino, et al., 1991). These authors also identified low income as a predictor for early termination. Additional studies are warranted in the area of ethnic match for low income Black Americans to improve the delivery of mental health services for this population.

## Conclusion

The need for early intervention, with an emphasis on more research supporting culturally and developmentally appropriate mental health services for minority children and their families has been called upon to the mental health profession (U.S. Public Health Service, 2000). The New Freedom Commission on Mental Health (2003) echoed the call for early intervention, with an emphasis on providing such services in accessible, low-stigma settings such as schools. With almost a quarter of the Black American population living in poverty (McKinnon, 2003), the need for action to address the socio-emotional development of young children may even be more critical for Black Americans. Poverty serves as an additional threat to the mental well being of Black American children and their future. The effects of poverty are extensive and place Black American children at-risk for academic failure and drop out, socio-emotional problems, and incarceration (Duncan et al., 1994; Lamy, 2003; Fernandez, 2005; Nievar & Luster, 2006). Socio-economic factors faced by families living in poverty lead to unique challenges and stressors that place undue hardship for parents and their children. With these challenges, parental involvement can be thwarted and thus place children even more at risk for behavioral problems and future academic success. Identifying treatment that is responsive to these stressors, while providing effective parenting strategies is needed.

In order to facilitate children's mental health, it is imperative for parents to be involved in their children's lives. Research has demonstrated the positive impact of parental involvement on children's academic achievement and enhancement of the parent-child relationship (Lamy, 2003; Parker et al., 1999). Positive parenting strategies

communicated to their children at an early age serves to mitigate potential cognitive and behavioral problems that will continue into adult life (Baggerly & Parker, 2005). CPRT with low income Black American families serves as a promising intervention program that merges together the natural bond of the parent-child relationship and the child's natural mode of communication to enhance that relationship. Despite small sample size, this pilot study concluded that, as a result of participation in CPRT, Black American parents reported statistically significant decreases in their child's externalizing behavior problems, total behavioral problems, and parent-child relationship stress compared to parents who received no treatment.

The availability of a manualized treatment protocol for CPRT aids in treatment integrity and provides ease of replication for mental health professionals trained in this model. Providing this service within low-stigma settings with such as schools and utilizing treatment providers who are ethnically matched can serve to reduce barriers for Black Americans who hold suspicious views of mental health services and mental health treatment providers. Furthermore, providing additional support to low income Black American parents during CPRT training, such as free childcare and refreshments, as well loaning toy kits and video equipment to complete home play sessions also demonstrates responsiveness to the needs of this population.

### Recommendations for Future Research

Based upon the results of this pilot study, the following recommendations are offered:



1. Conduct a replication study using a larger sample size. A larger sample size would increase the power of the statistical measures.
2. Utilize an instrument that measures positive parenting based on Black American values.
3. In order to gain additional information related to the usefulness of CPRT with low income Black American parents, comparisons between CPRT protocol and other parenting programs designed for low income Black Americans should be made.
4. Utilize additional sources of measurement of children's behavior changes, such as teacher report and direct observations by trained professionals.
5. Conduct a follow up study of participants to determine long-term effects of CPRT.
6. Conduct a qualitative study to provide an in-depth understanding of the CPRT process and outcomes with low income Black American parents.
7. Utilize intracultural sensitivity through the use of treatment providers of similar ethnic background to lessen the stigma of mental health services for Black American parents.

APPENDIX A  
PARENT CONSENT

## RESEARCH CONSENT FORM

Subject Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Title of the study:** An Early Mental Health Intervention for At-Risk, Disadvantaged, Minority Primary-Age Children: Effects of Filial/Family Play Therapy Training on Children's Behavior and Academic Success.

**Principal Investigator:** Dr. Sue Bratton, Assistant Professor, Counseling Program, Director, Center for Play Therapy

Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks and discomforts of the study. It is important for you to understand that no guarantees or assurances can be made as to the results of this study.

Your participation is voluntary and you may choose to withdraw at any time during the study without penalty of any kind. Your signature indicates that you meet all of the requirements for participation and have decided to participate and you have been told that you will receive a signed copy of this consent form. Your decision whether or not to participate will not affect your child's standing in school. At the conclusion of this study, a summary of results will be made available to all interested parents and teachers.

**Purpose of the study and how long it will last:**

This project is designed to examine the effects of Child-Parent-Relationship Therapy (CPRT), also called filial therapy or family play therapy, in helping minority children attending elementary schools in Denton, Texas who are at-risk for not achieving school success. Providing school counseling services for minority children at the earliest possible age is critical in order to address problems early and help them achieve the most school success. Research shows that teaching parents to use CPRT skills with their children is highly effective in improving children's behavior problems and in reducing parenting stress. In addition, the purpose of the CPRT is to help parents learn ways to respond more appropriately to young children's behavior problems and create a more positive parent-child relationship. This study involves parents participating in training and supervision for 10-12 sessions (depending on the number of parents participating).

**Description of the study including the procedures to be used:**

If you choose to participate, you will be placed in either the Phase One CPRT treatment group or in the Phase Two CPRT group that will serve as the control group during the research study. Parents selected to participate in Phase Two will receive no training during Phase One, but will receive CPRT training in Phase Two. CPRT is a model that trains parents in skills of empathy, encouragement, limit setting and choice giving. These skills are designed to help parents effectively manage children's behavior and enhance the parent-child relationship. Parents selected for the CPRT treatment group will participate in training and supervision on a weekly basis for a total of 10-12 weeks. Participating parents will be asked to complete the Child Behavior Checklist (CBCL) two times, at the beginning and at the end of the training, to evaluate

the effects of parenting training on student behavior. The CBCL will take approximately 20 minutes to complete. In addition, parents will be provided a video camera to record their home play session with their child approximately two times during the training in order to provide parents with feedback. The researcher is also interested in interaction between parent and child specifically the parent's ability to communicate empathy and acceptance as well as execute the skills taught. Therefore, videotapes will be utilized to examine the effects of CPRT on the parent-child relationship. To examine the impact of CPRT in the classroom, the child's teacher of those parents who are participating in CPRT be asked to complete the Child Behavior Checklist (Caregiver-Teacher version- C-TRF) two times, at the beginning and end of the training, to evaluate the effects of parent training on student behavior. The C-TRF will take approximately 20 minutes to complete. Training and supervision will be provided by counseling professionals with advanced training in play therapy and the CPRT model. The Principal Investigator and Research Project Coordinators will ensure that all information will be kept confidential.

#### Child Parent Relationship Therapy (CPRT)

CPRT is a parent training model that has been shown to be highly effective in helping parents learn more effective ways of responding to their children's needs and more effective ways of disciplining their children. Parents attend a weekly group with other parents who are also interested in learning more effective parenting tools and are asked to practice the new skills they are learning with their child during a special 30-minute playtime each week. Research supports that this once-a-week format is highly successful in helping parents reduce child problems and improve their relationship with their child by helping parents create and maintain a positive home environment using positive discipline. CPRT has also been shown to help children be more successful at school by reducing behavior problems.

#### **Description of procedures/elements that may result in discomfort or inconvenience:**

There is no personal risk of discomfort directly involved with this study other than those associated with your normal daily activities. You may choose to withdraw at any time without penalty or prejudice.

#### **Description of the procedures/elements that are associated with foreseeable risks:**

There are no foreseeable risks involved with this study other than those associated with normal daily activities.

#### **Benefits to the subjects or others:**

The parent-child relationship is significant to the development of young children. Due to this significant relationship, parents have the potential to make a considerable difference in a child's development. Therefore, training parents to respond to children in a more encouraging and developmentally appropriate ways can benefit aspects of your child's development, including cognitive, behavioral, social and emotional.

#### **Confidentiality of research records:**

The information you provide when you answer the questionnaire will be kept confidential and will not be disclosed in any publication or discussion of this material. All data including assessments and video tapes will be assigned a code number and kept in a locked filing cabinet

in order to preserve confidentiality. Only the Principal Investigator and research assistants will review the video tapes. For research purposes, only the Principal Investigator and the Research Project Coordinators will have access to the list of participants' names and code numbers. At the end of this study the list of names will be destroyed.

The only exceptions to confidentiality are if the parent or legal guardian requests release information on C-TRF and/or CBCL results.

**Review for protection of participants:**

This research project has been reviewed and approved by the University of North Texas Institutional Review Board. Contact the UNT IRB at 940-565-3940 with any questions regarding your rights as a research subject.

**Research Subjects' Rights:**

I have read or have had read to me all of the above.

The Principal Investigator or Research Project Coordinators have explained the study to me and answered all of my questions. I have been told there are no foreseeable risks or discomfort directly involved with this study other than those associated with normal daily activities. I have also been informed of the possible benefits of participating in this study.

I understand that I do not have to take part in this study, and my refusal to participate or to withdraw will involve no penalty or loss of rights of benefits or legal recourse to which I am entitled. The study personnel may choose to stop my participation at any time.

In case there are problems or questions, I have been told that I am to call Dr. Sue Bratton at telephone number, (940) 565-3864.

I understand my rights as a research subject, and I voluntary consent to participate in this study. I understand what the study is about and why it is being done. I have been told that I will receive a signed copy of this consent form.

---

Signature of Subject

Date

**For the Investigator or Designee:**

I certify that I have reviewed the contents of this form with the person signing above, who, in my opinion, understood the explanation. I have explained the known benefits and risks of the research.

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Signature of the Principal Investigator or Research Project Coordinator

Date

APPENDIX B  
FAMILY BACKGROUND FORM

**FAMILY INFORMATION FORM**

Your name: \_\_\_\_\_ Your relationship to child: \_\_\_\_\_

How old are you? \_\_\_\_\_ What is your race? \_\_\_\_\_

Your child's name: \_\_\_\_\_ Child's race\*: \_\_\_\_\_

\*For biracial children, select **one** race you believe is most representative of your child.

School: \_\_\_\_\_ Teacher's name: \_\_\_\_\_

Contact number: \_\_\_\_\_ Best time to call you: \_\_\_\_\_

Available days and times to meet for the parenting group? \_\_\_\_\_

**BASIC INFORMATION**

Is your child receiving counseling now? No \_\_\_ Yes \_\_\_

Is your child receiving special education or other services? No \_\_\_ Yes \_\_\_

If yes, explain \_\_\_\_\_

Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? No \_\_\_ Yes \_\_\_

If yes, please provide the name and address of the previous mental health professional or agency: \_\_\_\_\_

Your child's current household (check one):

- \_\_\_ *Mother only* \_\_\_ *Father only* \_\_\_ *Natural Parents*
- \_\_\_ *Natural mother and stepfather* \_\_\_ *Natural father and stepmother*
- \_\_\_ *Blended family (both spouses with children from previous relationships)*
- \_\_\_ *Adoptive parents* \_\_\_ *Grandparents* \_\_\_ *Foster family*
- \_\_\_ *Other (specify \_\_\_\_\_)*

Including yourself and your child, how many children and adults live in your home?

\_\_\_\_\_

Are you currently involved in a custody dispute? No \_\_\_ Yes \_\_\_

If yes, explain \_\_\_\_\_

What is the highest grade you completed in school? (circle one)

- Grades 1 2 3 4 5 6 7 8
- High School 9 10 11 12 GED
- College 13 14 15 16 17+

Are you currently employed? Yes                      No  
If yes, what is your current job? \_\_\_\_\_

Gross Household Annual Income and Child Support Received (check one)  
\_\_\_\_ Less than \$15,000                      \_\_\_\_ 20,001 – 22,000                      \_\_\_\_ 28,001 – 30,000  
\_\_\_\_ 15,001 – 16,000                      \_\_\_\_ 22,001 – 24,000                      \_\_\_\_ 30,001 – 32,000  
\_\_\_\_ 16,001 – 18,000                      \_\_\_\_ 24,001 – 26,000                      \_\_\_\_ 32,001 – 34,000  
\_\_\_\_ 18,001 – 20,000                      \_\_\_\_ 26,001 – 28,000                      \_\_\_\_ 34,000+

Are you currently taking a parenting class?                      Yes \_\_\_\_ No \_\_\_\_

Any concerns you have about this child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there a diagnosis or medication that your child is now receiving or has received?  
\_\_\_\_\_

Anything else you would like to share about this child?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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