

CHILD PARENT RELATIONSHIP THERAPY: A PROGRAM EVALUATION

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For the past 40 years, one southwestern US university counseling program has sponsored two mental health training clinics in which master's and doctoral level students have learned to provide child parent relationship therapy (CPRT) services to community parents. In their training, students learn about the positive effects of CPRT, particularly on parental stress. To date, however, no program evaluation has been conducted at these clinics focusing specifically on parental stress outcomes after the completion of CPRT or to determine the demographics and characteristics of parents who pursue CPRT. The purpose of this study was to conduct such an evaluation of archival data spanning 7 years. Participants were 129 parents (70% female, 30% male; 80% Caucasian, 35% Hispanic/ Latino, 6% African American, and 4% Asian; 62% married, 9% separated, 16% divorced). Results from a *t*-test indicated a statistically significant decrease in self-reported parental stress, with a moderate effect size. Multiple regression revealed that women and those who attended with a co-parent reported greater stress reduction. This study confirmed the benefit of CPRT, provided by counselors-in-training, on reducing parental stress and indicated clientele for which and conditions in which those benefits might be optimized.

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## CHAPTER 1

### INTRODUCTION

There has been growing need for program evaluation in a wide array of organizations, foundations, and agencies that provide counseling services (Astramovich & Coker, 2007; Newcomer, Hatry, and Wholey, 2015). Program evaluation can help improve counseling services by giving program administrators a better understanding of the services being offered, determining how to further develop services, and identifying areas that require modification or change in order to better meet client needs (Kapp & Anderson, 2010). Although often overlooked as a concrete method of research, program evaluation requires a solid knowledge of research and observational methods, as well as thorough knowledge of research measurement, design, and analysis (Heppner, Wampold, Owen, Thompson, & Wang, 2016).

Goals of program evaluation include determining if the services provided are additive and helpful or instead, if they are harmful or ineffective, and to assess the effectiveness of a program with a particular group of clients (Heppner et al., 2016; Royse, Thyer, & Padgett, 2016). Program evaluation can reap great rewards such as gathering useful and helpful information, gaining a deeper understanding of the counseling services offered, and enhancing the offered programs (Kapp & Anderson, 2010).

The University of North Texas has two on-campus clinics that provide an array of counseling services to community members. One of the services offered is Child Parent Relationship Therapy (CPRT), a manualized protocol, that focuses on the importance of the parent-child relationship (Landreth & Bratton, 2006; Bratton, Landreth,

Kellam, and Blackard, 2006). An overriding goal of CPRT is to strengthen the parent-child relationship by increasing a parent's feelings of trust, warmth, and familial affection. CPRT offers parents the opportunity to improve their problem-solving strategies and family interactions. Parents learn how to help their child learn self responsibility and self-control, help build their child's self esteem, and learn how to respond empathically to their child's feelings (Landreth & Bratton, 2006). As well, parents learn skills that can help them better cope with any problems that may arise in the future (Bratton, Landreth, and Lin, 2010).

As a result of doing the play sessions, both the child and the parent have the opportunity for personal change and growth. Over 40 studies validate the effectiveness of CPRT (Bratton, Opiola, & Dafoe, 2015). Extensive studies have been done on CPRT, with outcomes indicating improvements in overall parent stress, parent-child relationship, child behavior, parenting skills, and parent personal growth (Landreth, Homeyer, Bratton, Kale, and Hilpl, 2000; Lin & Bratton, 2015).

### Statement of the Problem

Parental stress is on the rise and parents report higher levels of stress than non-parents (American Psychological Association, 2014). Meta-analytic studies have shown that CPRT is an effective modality when working with both parents and children (Bratton et al., 2015). Research has focused on the impact of CPRT on parents, such as parents being the therapeutic agents of change, and parents being more effective agents of change than trained professionals (Bratton & Landreth, 2010). However, no attention has been given solely to the impact of CPRT on parental stress. Whereas previous studies have researched CPRT effectiveness with diverse cultural groups and

across a variety of populations (Bratton & Landreth, 2010; Bratten et al., 2015), no research has specifically looked at the demographics of parents seeking CPRT services. The majority of prior studies have concentrated on the parent-child relationship, child behavior, or on parent levels of empathy (Bratton et al., 2015). Studies that have examined parental stress focused on stress in conjunction with other factors, such as child behavior.

For the past 40 years, one university counseling program has sponsored two mental health training clinics that both provide training to masters and doctoral level students (Tsai, 2009) and has offered CPRT services to community parents. In their CPRT training, university students learn about the successes of CPRT, particularly with parental stress. Yet, to date, no program evaluation has been conducted at these clinics focusing specifically on parental stress outcomes after the completion of CPRT. As well, no program evaluation has been conducted to determine the demographics and characteristics of parents who pursue CPRT services, and if upon completion of CPRT, if there are changes in the amount of parent-reported stress.

### Purpose of the Study

The purpose of this study was to conduct a program evaluation of two university-based counseling clinics with parents who sought CPRT services over a seven year time period. Archival data was examined to provide the characteristics of parents who came to the university clinics seeking CPRT services and to determine if parents who completed CPRT report changes in their levels of parental stress.

The researcher initially gathered demographic information from all of the parents who completed intakes at the two clinics. From that group of parents, a survey of a

smaller number was conducted in order to look more closely at parental stress. Finally, the researcher investigated if certain demographic characteristics made a difference in levels of parental stress. Additionally, the researcher attempted to determine if particular parental characteristics contributed to higher levels of parental stress.

### Significance of the Study

Program evaluation is necessary in order to ensure effective and quality counseling services (Chen, 2005). As a result of doing the program evaluation, the study provides feedback regarding the CPRT services that have been offered through the two university counseling clinics. The study results offer clinic administrators an explanation of what type of parents seek services and which parents are more likely to complete the ten-week modality. Broader implications of this study are ideas on how to better meet the needs of parents, particularly in how to retain them and what may cause parents to complete versus not complete CPRT.

Prior researchers have recommended further research to help strengthen CPRT's research rigor, in order to help support CPRT as evidence based (Bratton & Landreth, 2010). The current study adds to the body of research, in that it augments the intervention. The study results show that CPRT not only positively impacts child behavior and the parent-child relationship, but that it also reduces parental stress. Furthermore, study results provide a better understanding of the type of parents that seek CPRT services in a real life setting. This also adds to the teaching of the CPRT intervention, in that educators now have a more holistic explanation about the benefits of CPRT.

The study results further add to the counseling practice of leading CPRT groups. Practitioners are offered a deeper understanding about positive impacts of CPRT and a better understanding of parent outcomes and benefits. Furthermore, CPRT is a strengths-based modality that encourages practitioners to give weekly feedback to parents. The study results allow practitioners to provide parents with additional feedback, focusing on their stress reduction or improvements on their levels of stress.

### Conclusion

Program evaluation is a critical step when determining the effectiveness of services and interventions (Kapp & Anderson, 2010). The focus on service interventions is vital in connecting counseling research to counseling practice (Austin, 1998). Previous research indicates that CPRT is an effective modality (Bratton et al., 2010). As well, prior studies indicate that CPRT improves parental acceptance and unconditional love for their children (Costas & Landreth, 1999; Glover & Landreth, 2000; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Yuen, Landreth, & Baggerly, 2002) and parents expressed feeling improvement in their parenting skills and knowledge (Edwards, Sullivan, Meany-Walen, & Kantor, 2010; Kinsworthy & Garza, 2010; Taylor, Purswell, Lindo, Jayne, & Fernando, 2011). After completing CPRT, parents' overall stress decreased (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Kale & Landreth, 1999; Kidron & Landreth, 2010; Lee & Landreth, 2003; Ray, Bratton, & Brandt, 2010) and communication skills increased (Bavin-Hoffman, Jennings, & Landreth, 1996; Jang, 2000; Wickstrom, 2009).

There had not been an archival study at these clinics that focused solely on program evaluation. Although previous CPRT studies have looked at specific parent demographics, such as parents of a particular ethnic or religious background, no studies have looked at the broad demographics of parents seeking CPRT services. It was believed that an archival study of parents who sought services, and also completed CPRT, over the past seven years would allow administrators and researchers to have a better understanding of who was being serviced and to help learn about the full impact and benefit of CPRT on parental stress.

### Literature Review

The literature review synthesizes research from the areas of: a) program evaluation, b) evidence-based practice, c) parental stress, and d) filial therapy.

### *Program Evaluation*

#### *Definition of Program*

A program is an organized group of resources and activities that are utilized to reach certain goals (Newcomer et al., 2015; Royse et al., 2016). A further definition describes programs as a permanent procedure or organization created to meet clients' ongoing needs (Barker, 2014). Although programs can differ greatly in their scale (McDavid & Hawthorn, 2006), programs typically have certain characteristics, such as requiring staffing, maintaining a budget, having an identity, and having a service philosophy (Royse et al., 2016). Programs may be composed of a small set of activities in one particular agency or they can be broader, such as multiple levels of the government (Newcomer et al., 2015).

### *Definition of Program Evaluation*

Scientific research has three components: descriptive research, evaluative research, and explanatory studies (Royse et al., 2016). Descriptive research gives researchers a better understanding about the needs and characteristics of an agency's clients; evaluative research aims to discover if client needs and goals are being met; and explanatory studies are undertaken in order to determine the process through which an intervention works (Royse et al., 2016). Although sometimes questioned about being a valid method of research (Heppner et al., 2016), program evaluation fits under the category of research due to it being a process of "systematic procedures used in seeking facts or principles" (Barker, 2014, p. 365).

The American Educational Research Foundation (2016) stated that scientifically based research requires systematic, rigorous, and seeking objective information. Scientific studies require logical reasoning and planning, the use of design and instruments that offer reliable findings, and analysis and data that support the research findings (American Educational Research Foundation, 2016). Program evaluation fits well into this category and is best defined as

the application of systematic methods to address questions about program operations and results. It may include ongoing monitoring of a program as well as one-shot studies of program processes or program impact. The approaches used are based on social science methodologies and professional standards" (Newcomer et al., 2015, p. 8).

Today, program evaluation is considered a legitimate field where program evaluators have advanced training in research methods and are viewed as highly trained experts and specialists (Astramovich & Coker, 2007).

### *Purpose of Program Evaluations*

In order for counseling services to be fully successfully, program evaluation is necessary in order to assess, and ultimately improve, program planning, application, and effectiveness (Chen, 2005). Within the field of research, particularly in human services, there are three purposes: to objectively describe, to empirically evaluate, and to validly explain effectiveness. Descriptive research allows for better understanding of the needs and characteristics of clients; evaluative research determines if client needs or client goals are met; and explanatory research works to understand the underlying causes of client problems or how exactly interventions work (Royse et al., 2016).

The primary purpose of program evaluation is to determine the effectiveness of a program for a group of people (Heppner et al., 2016). Programs often are intentionally selected in order to help solve some existing problem (McDavid & Hawthorn, 2006; Royse et al., 2016). Additionally, researchers desire to know if a program's actual results are consisted with the expected outcomes (McDavid & Hawthorn, 2006). In performing a program evaluation, researchers often want to know certain things, such as: were clients helped, if the program made a difference, and how the program could be improved (Royse et al., 2016).

### *Process of Program Evaluation*

Program evaluation must be systematic, rigorous, and with the ultimate goal of gathering objective information (Royse et al., 2016). The steps for a successful



program evaluation include engaging the stakeholders in the process, assessing any political factors, choosing the evaluation design, collecting data, and reporting data (Kapp & Anderson, 2010). “An evaluator undertakes four phases of program evaluation, applicable at any stage of a program: (a) setting the boundaries of an evaluation, (b) selecting appropriate evaluation methods, (c) collecting and analyzing information, and (d) reporting the findings (Heppner et al., 2016, p. 527).

Initially, the evaluator learns about the program in great detail and spends time gathering background information and gaining a deeper understanding of the program’s mission and scope (Heppner et al., 2016; Newcomer et al., 2015). During this stage, the population of interest is determined, key evaluation questions are identified, and goals and objectives are set (Heppner et al., 2016; Newcomer et al., 2015). It is vital that objectives are not only theory-based, but that they are measureable and backed by research evidence (Heppner et al., 2016; Vera & Reese, 2000).

During the next stage, the program evaluator must choose the most appropriate evaluation methods (Heppner et al., 2016; Newcomer et al., 2015). The focus now becomes how the program evaluator will measure data and information about the program’s outcomes and effects (Heppner et al., 2016). This stage can be difficult and requires the program evaluator give great thought about the questions that are the most important and for which the answers are more desired (Newcomer et al., 2015).

If the first two steps of the process have been planned carefully, the collection process can be rather straightforward (Heppner et al., 2016). It is recommended that the planning for data collection be extensive, thus allowing for the most efficient collection of the most relevant data (Newcomer et al., 2015). Once all data has been

gathered, the data analysis process may begin (Heppner et al., 2016; Newcomer et al., 2015). Having a data analysis plan allows the program evaluator to work more effectively, thereby only gathering needed information and not spending time gathering data that does not add to the research study (Newcomer et al., 2015). The program evaluator then pulls all the compiled information together and actually evaluates the program. The interpretation of the evaluation is always completed by the program evaluator and is never left to the program administrators or stakeholders to determine (Heppner et al., 2016).

The final step in the process is reporting all evaluation findings (Heppner et al., 2016). Although it may appear to be the easiest of steps, it is crucial for the program evaluator to clearly share the positive and negative results of the program evaluation and that the strengths and limitations of the evaluation be addressed (Heppner et al., 2016; Newcomer et al., 2015). Once the report has been made, it is ultimately up to the program administrators to determine what to do with that information (Newcomer et al., 2015)

### *Ethics*

Practitioners have ethical responsibilities to evaluate their practices and have made an ethical commitment to ensuring their programs are successful (American Counseling Association, 2014). Ethical practitioners are accountable for the services they provide, and ideally should commit to program evaluation in order to ensure what is or is not working within their practice (Smith, 2010). As with practitioners, and in other areas of counseling, program evaluators are committed to maintain ethical standards (American Counseling Association, 2014; Kapp & Anderson, 2010).

The American Counseling Association (ACA) Code of Ethics (2014) lists a number of responsibilities for researchers. Such responsibilities include having informed consent from the clients, maintaining confidentiality, reporting research procedures and outcomes, and reporting errors and unfavorable results (American Counseling Association, 2014). Program evaluators should report the actual results found, and not allow program administrator's desired outcomes influence the findings (Bingham & Felbinger, 2002). Program evaluators have ethical responsibilities to clients, colleagues, practice settings, as professionals, to the profession, and ultimately to society (Kapp & Anderson, 2010). Due to ethical responsibilities that include the promotion of client well being, program evaluators ultimately have an ethical responsibility to determine if the programs and services being offered support and promote client well-being (Kapp & Anderson, 2010).

### *Multicultural Concerns*

The ACA Code of Ethics (2014) states that researchers are responsible for participants' emotional, physical, and social welfare. It is critical that program evaluation be culturally sensitive to the population of focus, which may require that the program evaluator give attention to cultural norms, beliefs, and practices of the population (Heppner et al., 2016). As well, program evaluators must identify any cultural insensitivities that may have occurred during the evaluation process and then determine ways to address those insensitivities (Kapp & Anderson, 2010).

### *Evidence-Based Practice*

The context whereby program evaluation is employed is crucial; the context includes broad components such as the overriding environment where the evaluation is

completed, as well as more specific details such as the timing during which the evaluation is planned (Newcomer et al., 2015) The term evidence-based practice has become more commonly used within various fields of research. Evidence-based practice is a process whereby practitioners look at the best research and, when determining how to best work with their clients, consider their area of expertise as well as their clients' attributes (Rubin & Bellamy, 2012). It is critical that researchers and counselors in practice engage in an evidence-based practice (Rubin & Bellamy, 2012). Additionally, evidence-based practice is accepted, expected, and addressed by state entities, professional organizations, the American Psychological Association (APA), and the American Counseling Association (ACA). The APA's Policy Statement on Evidence-Based Practice (2015) focuses on the areas of research, clinical expertise, client characteristics, and clinical practice. The ACA Code of Ethics (2014) further states that counselors utilize counseling practices that are based on sound research method methodologies.

In order to critically appraise any study, the internal validity, measurement validity, statistical conclusion validity, and external validity must be closely considered (Rubin & Bellamy, 2012). Internal validity refers to the relationship between variables and the likelihood the research outcomes occurred as a result of one variable upon the other (Johnson & Christensen, 2008; Rubin & Bellamy, 2012). Threats to internal validity include: history, any other events, other than the treatment, that may have caused the research outcomes; maturation, or changes that happened over the passage of time; statistical regression towards the mean, the changes that happen as a result of multiple testings, where subjects' scores move towards the mean; and

selectivity bias, when two groups are not actually comparable due to the chance that one group has a higher likelihood of moving towards the mean than another group (Rubin & Bellamy, 2012).

Even if researchers are stringent on controlling for threats to validity, measurement issues are always a concern. Measurement methods must be valid, reliable, and unbiased (Rubin & Bellamy, 2012). Additionally, the significance of the study must also be considered when reviewing research results. The evidence-based practitioner looks at three types of significance: clinical, real life significance that is not based on analyses, but rather how the outcomes apply in actual client application; practical, how much of a difference between groups can be contributed to the independent variable; and statistical, the probability the treatment effectiveness was due to chance (Johnson & Christensen, 2008; Rubin & Bellamy, 2012).

External validity is the extent that the research findings can be generalized beyond the research content and to the clients and settings of particular interest (Sue, 2003). When considering if research findings apply to one's area of practice, it is helpful to consider population validity, the degree that research results may be generalized from the specific study sample to the population where the sample was selected; personological variables, if there was an interaction of the personal characteristics of the research sample with the experimental treatment; and ecological validity, the amount that the experimental results can be generalized to a particular setting (Gall, Gall, & Borg, 2005).

## *Filial Therapy*

Although a rather new modality, filial therapy has been well researched over the course of its existence (Van Fleet, 2014). Throughout the years, filial therapy researchers have committed to investigating filial therapy's efficacy as a treatment modality (Bratton et al., 2015). Research has been conducted throughout the world, in a wide variety of settings, and with varying groups of parents (Van Fleet, 2014).

### *History*

Sigmund Freud was the first therapist to effectively work with a parent in a treatment of a child client. In 1900, Freud taught the child's father how to respond when playing with his 5-year-old son at home and later stated that the change in the boy's behavior was due, in large part, to the father's interactions with his child (Landreth & Bratton, 2006). Beginning in 1949, child psychologist Dorothy Baruch modeled home play sessions after Virginia Axline's (1947) play therapy sessions; Baruch highly recommended that parents engage in planned play sessions at home (Landreth & Bratton, 2006). Carl Rogers' daughter, Natalie Fuchs (1957) documented about her regularly held special play times at home with her own daughter, with much encouragement from her father (Landreth & Bratton, 2006).

Bernard and Louise Guerney developed a groundbreaking model of parent training in the mid-1960s (Landreth & Bratton, 2006). It was developed as an intervention to treat children who exhibited behavioral, social, and emotional problems (Guerney, 1964; Van Fleet, 2009). The modality was offered to parents as a way to communicate more effectively with their child, teach their child proper social behavior and habits, solve behavioral conflicts and problems, and to increase parental

confidence and self-esteem (Guerney, 1995). The Guerney's model was originally structured for small groups of parents to meet for an unspecified amount of time (Stover & Guerney, 1967) and was later revamped so that parents met for five or six months (Bratton & Landreth, 2006).

### *Child Parent Relationship Therapy*

Garry Landreth developed a filial model from the work of the Guerneys, however he structured and shortened the format to 10-sessions (Bratton et al., 2015). Landreth believed that play therapists should make parents their allies and “give their skills away to parents and teachers” (Bratton and Landreth, 2006, p. 8). Landreth and Bratton (2006) formalized the model; Bratton, Landreth, Kellum, and Blackard (2006) then manualized CPRT to ensure treatment integrity.

CPRT focuses on the importance of parent-child relationship (Landreth & Bratton, 2006), and targeted outcomes are improvements in both the child and the parent (Bratton et al., 2015). Goals of CPRT include strengthening the parent-child relationship; increasing the parent's feelings of trust, warmth, and familial affection; and improving problem-solving strategies and family interactions (Landreth & Bratton, 2006). Therapeutic goals for parents include understanding and accepting their child's emotional world, having more realistic attitudes of themselves and their child, learn more effective parenting skills, and recapture the joy in parenting (Bratton et al., 2006; Kraft & Landreth, 1998; Landreth & Bratton, 2006). With the CPRT model, both the parent and the child have an opportunity for personal change and growth (Bratton et al., 2010).

## *Outcomes*

Although there is a great deal of research on all of the outcomes of CPRT, this literature review focuses only on the parent outcomes. Of particular interest is how parents saw changes within themselves as a result of completing CPRT. A number of themes were seen in the parent outcomes: overall parental stress, parenting skills and practices, confidence, joy in parenting, parenting efficacy, self-esteem, competence in parenting role, understanding of child, partner relationships, partner communication, partner unity, co-parenting, parental acceptance, unconditional love, empathy and empathic behavior, and family functioning.

## *Subgroups*

Researchers have focused on a large number of different groups of parents in the CPRT studies. CPRT researchers have studied parents from different religious backgrounds. CPRT fundamentals were linked to biblical themes and references as a way to connect with parents who practice biblically-based parenting (Bornsheuer et al., 2012). Researchers were interested in conservative Christian parents' perceptions of CPRT (Bornsheuer-Boswell et al., 2013). The authors found that CPRT was an effective model for conservative Christians, although they suggested that some modifications could be made, including the integration of scripture and holding the sessions at the parents' church, in order to make parents feel more comfortable. Jewish Israeli parents were the subjects of focus in Kidron & Landreth's (2010) study. Although the study had several limitations, including varied assimilation level to Israeli culture, a nonrandom sample, and high attrition rates, the study still yielded positive



results in support of the CPRT modality with families who culturally have experienced prolonged trauma and stress.

CPRT studies were conducted with a wide variety of parents from different racial and ethnic backgrounds. Boyer's (2011) study addressed the unique needs and concerns of the First Nations People, a chronically undertreated community. Through her qualitative study, Boyer found that CPRT worked well in conjunction with, and alongside, the First Nations' core values. Glover and Landreth (2008) did a quantitative study with 14 Native American parents. Although attrition was high, the authors found that CPRT was effective in increasing desirable behaviors in children and enhancing parents' empathetic responses. The authors recommended changing the format to better meet cultural needs and expectations, such as longer training sessions with fewer total sessions, bringing food to establish a more social atmosphere, holding sessions on site at the reservation, and providing child care during the training sessions (Glover & Landreth, 2008).

Studies have focused on parental ethnicity, including parents who were Latino (Ceballos & Bratton, 2010; Garza, Kinsworthy, & Watts, 2009), African-American (Sheely & Bratton, 2010; Solis et al., 2004), Jamaican (Edwards, Ladner, & White, 2007), Sudanese (Lim & Ogawa, 2014), Iranian (Alivandi Vafa & Khaidzir, 2009), Korean (Jang, 2000; Lee & Landreth, 1998), and Chinese immigrants (Chau & Landreth, 1997; Yuen et al., 2002). Of particular interest was how CPRT impacted parents from these specific ethnicities. Furthermore, recommendations were made on how to best use CPRT and adaptations that could be made in order to meet the cultural needs of the different parent groups.

Further studies were conducted with parents with varying marital status, including single parents, couples, and divorced parents. Single parents were found to show significant improvements both in the way they interacted with their children and in their parenting abilities (Alivandi Vafa & Khaidzier, 2009; Bratton & Landreth, 1995; Harris & Landreth, 1997; Landreth & Lobaugh, 1998; Ray et al., 2000). After completing CPRT, couples reported improvements in both the parent-child relationship and also their partner relationships (Bavin-Hoffman et al., 1996). CPRT was found to help strengthen parent-child relationships that are often strained due to separation and divorce (Glazer & Kottman, 1994; Taylor et al., 2011).

CPRT studies have been done with different types of parents, to include grandparents, foster parents, adoptive parents, homeless parents, and parents with children who have chronic illnesses. Researchers were interested in how CPRT impacted parents who also struggled with other issues, such as not being the biological parents (Boyer, 2011; Capps, 2012; Ryan, 2007) and with outside issues such as being homeless or having a child with health problems (Kolos, Green, & Crenshaw, 2009; Glazer-Walderman, Zimmerman, Landreth, & Norton, 1992). Researchers found that all the parents experienced some improvement as a result of completing CPRT.

Additionally, CPRT researchers have worked with parents with different legal concerns, including incarcerated mothers, incarcerated father, nonoffending parents, and parents who have experienced family violence. Incarcerated mothers and fathers were found to connect more with their children and to strengthen their parent-child relationship, especially important when these parents are unable to interact with their children as frequently due to their incarceration (Harris & Landreth, 1997; Landreth &

Lobaugh, 1998). Several studies included parents who did not have legal concerns, but were impacted by their partner's law-breaking behaviors. Upon completion of CPRT, non-offending parents were able to be more empathic, better accept their child, and had lower stress (Costas & Landreth, 1999). Parents who were the victims of domestic violence and living in shelters were found to greatly decrease their levels of parenting stress due to the weekly play sessions with their child (Kinsworthy & Garza, 2010).

### *Consistent Outcomes*

Throughout the research studies, a number of themes have emerged. Two themes have been parental stress and parenting skills. Parents reported decreased parental stress, improved parenting skills and practices, increased joy in parenting, increase competence in parenting role, and increased parenting self-efficacy. The themes around relationships became evident, particularly with child and partner relationships. Parents reported improved understanding of their child, increased parental acceptance, increased unconditional love; improved partner relationships, partner unity, and co-parenting, and improved partner communication. Family functioning and personal growth were also themes that emerged. Parents reported improved family functioning, increased confidence, improved self-esteem, increased empathy and empathic behavior.

A great deal of research has been done on the topic of parental stress. Assessment results following CPRT training sessions show that parents' parental stress levels significantly decrease following filial therapy (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Kale & Landreth, 1999; Landreth & Lobaugh,

1998; Lee & Landreth, 2003; Lim & Ogawa, 2014; Kidron & Landreth, 2010; Ray et al., 2010; Yuen et al., 2002). Additionally, after completing CPRT, other studies found slightly lower decreases in overall parental stress (Alivanda Vafa & Khaidzir, 2009; Ceballos & Bratton, 2010; Glazer-Walderman et al., 1992; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Ray et al., 2000; Sheely & Bratton, 2010; Tew et al., 2002).

Several studies discovered that parents' parenting skills were increased as a result of doing filial therapy with their children. After completing CPRT, parents reported overall improvement in parenting skills (Johnson, Bruhn, & Winek, 1999; Kinsworthy, & Watts, 2009; Kolos et al., 2009; Rye, 2006; Wickstrom & Falke, 2013). Additionally, a qualitative case study showed that the parent of focus learned skills she was able to generalize to her overall style of parenting (Solis et al., 2004). A study of parents receiving services through a domestic violence advocacy center showed that parents were able to identify healthier parenting practices and that their parenting self esteem improved (Kinsworthy & Garza, 2010). In examining divorced parents, study results revealed that parents believed that they became more competent in their parenting role (Taylor et al., 2011). In the post-intervention interview, all of the parents in Edwards, Sullivan, Meany-Walen, and Kantor's (2010) study stated that their parenting skills and knowledge had improved.

One study found that parental joy increased as a result of CPRT (Boyer, 2011). The qualitative study of a First Nations grandfather, who had primary custody of his grandchild, found that CPRT greatly impacted the relationship between the grandfather and his grandson. Although one of the goals was for the grandfather to update his

parenting skills, he was surprised to find that he was able to enjoy parenting his grandson, after doing the weekly play sessions. The grandfather further stated that his joy also impacted his grandson, because he could feel the joy as well (Boyer, 2011).

In a mixed-methods study with divorced parents, parents reported feeling more competent in their role as parent (Taylor et al., 2011). Improvements were found in the child's behavior, parent-child relationship, and overall parental growth. In particular, parents reported becoming better parents due to learning new parenting skills. Group leaders noticed the improvements in both the parents actions and their perceptions (Taylor et al., 2011).

A phenomenological study helped researchers determine how CPRT resonated with Latino parents (Garza et al., 2009). Study results found that parents reported changes within themselves, their child, and the parent-child relationship. Furthermore, parents reported feeling more competent, being able to move away from unhealthy parenting methods, and wanting to share the learned knowledge with other Latino parents, as a way to help bring about cultural change (Garza et al., 2009).

As a result of completing CPRT, researchers learned that parents reported having a better understanding of their child. A phenomenological study with nine parents found that parents valued gaining a deeper awareness of what their children were thinking and feeling, but not expressing verbally. Through the play sessions, the parents reported that this deeper awareness allowed them to have stronger relationships with their children and to be more empathic (Wickstrom & Falke, 2013).

Following CPRT, parents were given assessments to determine their perceived acceptance of their child. Parents reported increased acceptance of their children

(Harris & Landreth, 1997; Kale & Landreth, 1999; Glover & Landreth, 2000; Yuen et al., 2002). In particular, several studies found that these parents reported a significant growth in their love for their child (Landreth & Lobaugh, 1998; Costas & Landreth, 1999; Lee & Landreth, 2003). As a result of learning new skills through CPRT, parents have reported feeling more confident when needing to handle stressful situations with their children (Foley et al., 2006).

Although not the direct subject CPRT studies, one of the research outcomes found has been increased unconditional love of the parent for their child. Two studies included parents whose children had suffered abuse or the loss of a parent due to incarceration (Costas & Landreth, 1999; Landreth & Lobaugh, 1998), while the third study was with immigrant parents raising first generation American children (Lee & Landreth, 2003). In all three studies overall parental stress decreased, but researchers were surprised to learn about parents' reports of increased unconditional love.

Another positive outcome resulting from CPRT has been improvements within partner relationships. Wickstrom's (2009) phenomenological study found that parents reported improvements within their marriages due to using some of the filial skills with their partner. As well, Jang (2000) found that mothers reported improved relationships. Noted as an unexpected dimension of change, researchers found that nearly all participants cited improvements within the marital relationship, regardless if the participant did CPRT alone or with their spouse (Wickstrom & Falke, 2013). Although Wickstrom (2009) found that parents recommended doing CPRT with their spouse in order to get the most benefit, parents still reported being able to co-parent more effectively as a result of learning the CPRT skills. A phenomenological study of 20

married couples found that parents, although not specifically asked, volunteered that they experienced increased partner unity following CPRT completion (Bavin-Hoffman et al., 1996).

When looking at improvements within partner relationships, several studies have cited partner communication improvements both during and following CPRT. Jang (2000) worked with Korean mothers and found that a number of the mothers reported improved relationships and communication with their husbands. In studying couples' perceptions of the CPRT process, a majority of the mothers and fathers reported improved interpersonal communication with their partners (Bavin-Hoffman et al., 1996). One participant in Wickstrom's (2009) study stated that she was better able to simply listen to her husband, rather than assuming what he was thinking. She further added that it improved their ability to communicate with one another.

Parents have reported changes within the family dynamics and how the family related as a result of CPRT. Through learning about CPRT and doing the play sessions, parents reported seeing family patterns, and allowing themselves to break some of the negative patterns (Wickstrom, 2009). As well, parents reported that CPRT allowed them to learn new and more effective ways to interact with their children and partners (Bavin-Hoffman et al., 1996; Garza et al., 2009; Wickstrom 2009). A later study found statistically significant improvements within family functioning, including increases in feelings both communicated by the parent and the child's acknowledgement of those feelings (Cornett & Bratton 2014).

One of the largest outcomes seen in parental personal growth resulting from CPRT is parents' increased confidence in themselves. Several studies cited parents

sharing how they felt after doing the play sessions with their child. Parents reported feeling more confident, something they struggled with upon beginning CPRT (Athanasious & Gunning, 1999; Foley, Higdon, & White, 2006). Additionally, CPRT leaders noticed changes in parental confidence, including appearing to feel better about themselves, improved appearance, and even smiling more (Garza et al., 2007; Glazer & Kottman, 1994; Kolos et al., 2009).

Self-esteem has been an area of improvement found in some of the more recent studies. Phenomenological studies have allowed researchers to inquire more specifically about self-esteem, as well allow for CPRT leader observations (Garza et al., 2007; Kinsworthy & Garza, 2010). Two studies found that parents not only reported feeling high levels of self-esteem as a result of the play sessions, but CPRT leaders noted the personal and affective changes during the weekly sessions.

As a result of having the filial play sessions a number of studies found a change in parent empathy and in the parents' empathic behavior. Studies found that parents' overall level of empathy increased (Bornsheuer-Boswell, et al., 2013; Edwards et al., 2007; Kinsworthy & Garza, 2010; Tew, Landreth, Joiner, & Solt, 2002;). One of CPRT's goals is teaching parents how to better understand their children (Landreth & Bratton, 2006). Studies throughout the years have found that parents increase their empathic behavior when interacting with their child. Parents increased empathic behavior during their observed play sessions (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Glover & Landreth, 2000; Harris & Landreth, 1997; Kidron & Landreth, 2010; Lee & Landreth, 2003; Smith & Landreth, 2003; Yuen et al., 2002). Although not directly cited as being the cause, parents did later report that they were



able to use the empathic behavior outside of the play sessions (Bavin-Hoffman et al., 1996; Garza, Kinsworthy, & Watts, 2009; Wickstrom 2009; Wickstrom & Falke, 2013).

### *Parental Stress*

Stress is defined as “a negative emotional experience accompanied by predictable biochemical, physiological, cognitive, and behavioural changes that are directed either towards altering the stressful event or accommodating to its effects” (Patnaik, 2014, p. 281; Baum, 1990). Parents who seek CPRT services often report feeling stress due to the parenting role (Bratton et al., 2015). Parents report increasing levels of stress (American Psychological Association, 2014) and studies have found that stress is additive (Rahe, 1974; Selye, 1974). Parents typically experience stress that is multifaceted (Cicchetti and Walker, 2001) indicating there is not one single cause of stress. As a result of stress, parents experience higher levels of anger and irritability, increased feelings of being overwhelmed, and impacts on their physical health and emotional well-being (American Psychological Association, 2014). Parents experiencing greater economic stress report greater parenting stress (Kotelchuck, 2006; Santiago, Etter, Wadsworth, and Raviv, 2012; Sturge-Apple, Suor, and Skibo, 2014; University of Minnesota, 2015). Additionally, parents report feeling they do not manage their stress levels effectively, and cited money, housing expenditures, and family responsibilities as the biggest stressors (American Psychological Association, 2014).

Although average stress levels have declined over the past few years, parents are reporting higher levels of stress compared to non-parents (APA, 2014). Stress causes both psychological and biological responses (Cicchetti & Walker, 2001). Chronic stress can lead to depression, high blood pressure, hypertension, and decrease

immune functioning (Berk, 2010; Patnaik, 2014). Reactions to stress can trigger stress responses and the body can become dysregulated (Berk, 2010; Cicchetti & Walker, 2001). The stress responses activate the entire body, to include the endocrine, autonomic, and immune systems, as well as cognitive, motor, emotional, and sensory functions (Cicchetti & Walker, 2001).

Evidence shows that parents experiencing higher levels of stress exhibit decreased functioning ability (Danforth, 2007). Parents respond to parenting stress in a variety of different manners (University of Minnesota, 2015). Parents often report maladaptive coping mechanisms such as denial, self-blame, self-medication through substance abuse, and avoidance (Carver, Scheier, and Weintraub, 1989; Friedman and Billick, 2014; Hastings, Kovshoff, Brown, Ward, Espinosa, & Remington, 2005; Lazarus 1993). With higher levels of parenting stress, there can be increases in problems with parenting behavior and parent-child interactions (Deater-Deckard, 1998; Steele, Steele, Danskin, Knafo, Nikitades, Dube, Bonuck, Meissner, & Murphy, 2016).

Parental stress is comprised of a number of components including parent characteristics, child characteristics, and situational variables, such as family context and life stress events (Abidin, 2012). Parent characteristics include depression, sense of competence, feeling restricted, parental attachment, spousal/partner relationship, parent health, and social support (Abidin, 2012). Child characteristics include adaptability, acceptability, demandingness, mood, hyperactivity/distractability, and reinforces parent (Abidin, 2012). Furthermore, these are important facets of the parent-child relationship (Abidin, 2012). Higher levels of parental stress within a child's first three years can be critical in the development of parent-child relationship (Abidin, 2012;

Bowlby, 1969; Deater-Deckard, 2004). Parents with high levels of stress often struggle to focus on their children's behavioral, social, and emotional needs (Landreth and Bratton, 2006; Bratton, et al., 2015). Additionally, stressed parents tend to more easily lose patience with their children (APA, 2014) and there can be a greater likelihood of child abuse or maltreatment (Steele et al., 2016; Whiteside-Mansell, Ayoub, McKelvey, Faldowski, Hart, & Shears, 2007).

### Summary of Literature

There is a rise in demand for systematic analysis of counseling programs (Newcomer et al., 2015). Program evaluation, and the focus on service interventions, is critical in the connection of research to the actual knowledge base, which is used by those practicing in the field of counseling (Austin, 1998). The primary goal of program evaluation is typically to gather information that can help improve services and program (Royse et al., 2016). However, other outcomes can result after doing a program evaluation, such as building a theory or adding to the research body (Royse et al., 2016).

Although overall results from the Bratton and colleagues (2010) meta-analysis indicate that CPRT is an effective modality, further studies are needed to help build the research body and to further support in its recognition as an evidence based treatment (Bratton & Landreth, 2010; Bratton et al., 2015). With parental stress on the rise (American Psychological Association, 2014) and with parents' stress being tied to specific roles, such as being a parent (Deater-Deckard, 2004), it is important to look more closely at CPRT in order to determine if CPRT may be an effective modality when working with parents citing higher levels of parental stress.

Prior CPRT research has looked at specific parent demographics, such as foster parents (Capps, 2012) or low-income parents (Sheely & Bratton, 2010), yet none of the research has looked at the comprehensive demographics of parents seeking CPRT services. As well, previous research has looked at the adaptability of CPRT to certain populations such as with Jamaican parents (Edwards et al., 2007) or incarcerated fathers (Landreth & Lobaugh, 1998), yet no studies have researched a location that does CPRT with generalized groups of parents from the community. As seen with the earlier research, typically outcome research is specified to a particular population. However, my proposed archival study, focusing on program evaluation, will offer a much broader focus than previous CPRT research. This study is the first to research CPRT in a natural setting lending to information about real-life practice. Research shows that parental stress is found across all cultures, income levels, and age levels (American Psychological Association, 2014). I believe there is a great deal to learn about stress, particularly parental stress. By evaluating a community program and focusing on both the demographics of parents who sought CPRT services, as well the levels of stress of those parents that completed CPRT, I hope to offer an overall, more generalized perspective.

## CHAPTER 2

### METHODS AND PROCEDURES

The purpose of this study was to conduct an analysis of archival data at a two university clinics in order to better understand the demographics of parents who sought Child Parent Relationship Therapy (CPRT) services, to determine the impact of CPRT on parental stress, and to see if certain demographic characteristics impacted parental stress. Two university counseling clinics located in the Southwestern region of the United States have been collecting data for the past seven years. Through gathering and reviewing the collected data, the researcher did a program evaluation of the two clinics and the CPRT services provided. This section includes the research questions, definition of terms, instrumentation, population and sample size, data collection, analysis of data, discussion, limitations of the study, and implications of the study.

#### Research Questions

This study analyzed archival data from two university counseling clinics in the Southwestern United States for the purpose of conducting a program evaluation. This study was designed to investigate the following questions:

1. What were the demographics of the parents who sought CPRT services?
2. Did parents who completed CPRT report improved Parent Domain scores of the PSI at completion?
3. Did parent gender and attending CPRT with co-parent predict difference scores from pre to post testing on the PSI Parent Domain following participation in CPRT?

## Definition of Terms

*Child parent relationship therapy (CPRT)* is defined as a 10-session, strengths-based, parent training model aimed at augmenting the parent-child relationship and help parents become better attuned to their child's needs and worldview through play. In CPRT, parents are viewed as the therapeutic agents of change (Bratton et al., 2015; Landreth & Bratton, 2006).

*Parent* is defined as the legal guardian of the child; the child's caregiver. In this study, "parent" is used to refer to any adult who has legal guardianship of the child, to include biological parents, grandparents, foster parents, adoptive parents, and step-parents.

*Parent domain* is defined as one of the two domains on the Parenting Stress Index, and measures characteristics of the parent that may be factoring into overall stress (Abidin, 2012). In this study, parental stress is operationalized as the parent domain score on the PSI. The parent domain is comprised of the following subscales (Abidin, 2012):

- *Competence* measures the degree to which the parent feels both capable and comfortable in the role of parent.
- *Isolation* measures the amount of parental social support.
- *Attachment* measures the parent's perceived closeness with the child as well as the parent's ability to both perceive and successfully respond to the child's needs; inherent investment in parenting role.
- *Health* measures how the parent's personal health impacts their overall parenting stress and their ability to parent.

- *Role restriction* measures the parent's perceived sense of limited freedom and constrained personality identity due to being a parent; assesses the negative impacts of parenting, including sacrifices, losses, and feelings of resentment.
- *Depression* measures the parent's affect, emotional availability to child, and physical and emotional energy.
- *Spouse* measures the parent's perceived emotional and physical support from their parenting partner; extent to which partner meets their parenting role.

*Parental Stress* is defined as "a function of certain salient child characteristics, parent characteristics, and situational variables that are directly related to the role of being a parent" (Abidin, 2012, p. 37).

### Participants

An archival data study was used to provide characteristics of parents who sought CPRT services, to determine the impact of CPRT intervention over two points of measure, pre-intervention and post-intervention, and to determine the impact of particular variables on parental stress. Seven years of data gathered from the Parenting Stress Index (PSI) and the Client Background Form was utilized. Parents were chosen who attended CPRT training at two university counseling clinics in the Southwestern United States. Each of the clinics serve approximately 150-200 clients per week and the clients range in age from 3 years old to the elderly (Tsai, 2009).

The two community clinics are training sites for counseling masters and doctoral students who are completing their clinical internships. These graduate students are required to complete a minimum of two courses in play therapy and most are concurrently enrolled in the CPRT course and receiving supervision while they are

leading CPRT groups. As well, the graduate students are under the supervision of play therapy faculty members while leading the CPRT groups. The clinics serve local community members and offer affordable services for adults, children, adolescents, families, and couples. Services are offered on a sliding scale in order to provide services to those community members who might not otherwise have the means to pay for counseling services.

Archival data was utilized for this study. Typical clinic procedures included the parents coming in for the initial intake meeting, undergoing CPRT training sessions, and completing weekly play sessions with their child. Inclusion Criteria for the study requires that the parent signed the informed consent form during their initial intake, and the parent must have completed pre-testing done prior to CPRT and post-testing done after the ninth or tenth session.

## Instruments

### *Parenting Stress Index*

This study utilized the Parenting Stress Index (PSI), an inventory that evaluates the stress within the parent-child system (Abidin, 2012). The PSI focuses on three areas of stress: parent characteristics, child characteristics, and demographic life stress. It assesses personal characteristics of the parent, parental perception of the child's characteristics, and the interaction between the parent and child. The PSI is used to identify issues of concern that may cause changes or problems in both parent's and child's behavior. The PSI is a 101-item inventory, plus includes a Life Stress Scale. There are 91 Likert scale questions, in which the parent answers *Strongly Agree*, *Agree*, *Not Sure*, *Disagree*, or *Strongly Disagree*. There are 10 specific response items,



numbered 1 through 4/5, and items 102-120 are the Life Stress Items, answered Yes or No (Abidin, 2012).

The PSI is comprised of two domains, child and parent, which are then combined to determine Total Stress. Scores less than 85% are considered within the normal range, whereas scores in the 85-90% are considered high and classified as borderline. Scores above 90% are considered clinically significant and are classified as clinical (Abidin, 2012). The Child Domain is composed of six subscales:

Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability. The six subscales are defined by Abidin as follows (2012, p. 17-18):

*Distractibility/Hyperactivity.* High scores on this subscale appear to be associated with a number of things including: children who display many of the behaviors associated with attention-deficit/hyperactivity disorder, the parent lacks the energy necessary to keep up with a normal child, older parents with a formerly stable life pattern experiencing difficulty adjusting to the child, or unreasonable parental expectations for mature, adult-like behavior.

*Adaptability.* High scores in this area are associated with characteristics that make the parenting task more difficult by virtue of the child's inability to adjust to changes in his or her physical or social environment.

*Reinforces Parent.* The parent who earns high scores on this subscale does not experience his or her child a choice of positive reinforcement.

*Demandingness.* High scores in this area are produced when the parent experiences the child as placing many demands on him or her, such as crying,

physically hanging on the parent, frequently requesting help, or exhibiting a high frequency of minor problems.

*Mood.* High scores in this area are associated with children whose affective functioning shows evidence of dysfunction, such as being unhappy or depressed, frequently crying, or do not shows signs of happiness.

*Acceptability.* High scores are produced in this area when the child possesses physical, intellectual, and emotional characteristics that do not match parental expectations.

The Parent Domain is composed of the seven subscales: Competence, Isolation, Attachment, Health, Role Restriction, Depression, and Spouse/Parenting Partner Relationship. The six subscales are defined by Abidin as follows (2012, p. 18-20):

*Competence.* High scores on this subscale may be produced by a number of factors, including: young parents of an only child, educational level of parent, parents who lack pretical child development knowledge, or parents who possess a limited range of child management skills.

*Isolation.* Parents who have high scores in this subscales are typically under considerable stress in terms of both the parenting role and their own psychic pain concerning issues of abandonment and rejection. They are socially isolated from their peers and relatives and others who might provide emotional support systems.

*Attachment.* A high score on this subscale suggests two possible sources of dysfunction: the parent may not feel a sense of emotional closeness to the child or the parent may have a real or perceived inability to observe and understand the child's feelings and/or needs accurately.

*Health.* High scores suggest deterioration in parental health that may be the result of either parenting stress or an additional, independent stress in the parent-child system.

*Role Restriction.* High scores on this subscale suggest that the parent experiences the parental role as restricting his or her freedom and frustrating his or her attempts to maintain self-identity.

*Depression.* High scores on this subscale suggest the presence of significant depression in the parent.

*Spouse/Parenting Partner Relationship.* Parents who earn high scores on this subscale lack the emotional and active support of the other parent in the area of child management and emotional support.

Reliability on the PSI child domain ranges from .78-.88 for the six subscales; reliability on the parent domain ranges from .79-.96 for the seven subscales. A high degree of internal consistency is exhibited with the reliability coefficients for the parent domain, child domain, and total stress scales being .96. The test-retest reliability is supported by four studies (Abidin, 2012). Reliability coefficients ranged from .78 to .88 on the child domain, .75 to .87 on the parent domain, and .96 to .98 on the total stress score (see Table 1) (Abidin, 2012). Defensive Responding is determined prior to interpreting scores. Defensive Responding scores of 24 or below indicate that the parent may have answered questions in a defensive manner and the researcher should be cautious when interpreting the results. The PSI has been validated through use in 250 studies, been translated into 40 different languages, and published with psychometric data and norms in seven different countries (Abidin, 2012). For the

purpose of this study, only the parent domain and parent domain subscales were analyzed.

Table 1 *Internal Consistency of Parenting Stress Indices and Subscales*

Domain/Subscale	No. of Items	Internal Consistency
<b>Child Domain</b>	47	.96
Distractibility/Hyperactivity	9	.78
Adaptability	11	.83
Reinforces Parent	6	.80
Demandingness	9	.84
Mood	5	.79
Acceptability	7	.88
<b>Parent Domain</b>	54	.96
Competence	13	.86
Isolation	6	.79
Attachment	7	.86
Health	5	.75
Role Restriction	7	.81
Depression	9	.87
Spouse/Parenting Partner	7	.86

The PSI is written so that parents with a fifth-grade reading level should be able to understand the items and instructions. Typically the assessment takes between 10-20 minutes to complete, although there is no time limit on the PSI (Abidin, 2012). The PSI has been found to be a multicultural assessment due to its use in studies in the United States as well as world-wide. Research utilizing the PSI has been done in English, Chinese, Portuguese, French Canadian, Finish, and Dutch. Studies have been done with a wide variety of parent and child concerns, including anxious parents, at-risk children, parent-child attachment disorders, children with ADHD, abused children, and single parent families (Abidin, 2012).

#### *Client Background Form*

In order to collect demographic information, the researcher gathered data from the client background form. Upon the initial intake at the counseling clinics, each client

is required to fill out an extensive background form. The form is created and established by the clinics; both clinics use the same six-page form. The background form requests in-depth information about the client including: name, address, emergency contact information, gender, ethnicity, previous or current mental health concerns, annual income, education level, household information, marital status, medical and/or psychological background, current concerns, and reasons for seeking counseling services. Of particular interest for this study is the demographic information about gender, ethnicity, education level, socio-economic status, and partner status.

#### Data Collection

The researcher obtained IRB approval through the University of North Texas. The researcher met with both of the clinic directors to explain her research design and gain formal approval to gather information from their clinics. All CPRT files were reviewed at both the university clinics to ensure that informed consent was received at the initial intake. The following information was collected: the background information, the PSI pre-test, completed at the parent's intake, and the PSI post-test, which was completed after the ninth or tenth CPRT session.

#### Data Analysis

The data analysis process included organizing, coding, and analyzing the data (Marshall & Rossman, 2006). Statistical Package for the Social Sciences for MacIntosh (SPSS, 2006) was used for data entry and analysis. Following data collection, all data was analyzed through different analyses for each of the specific research questions.

For Question 1, regarding the demographics of the parents who sought CPRT services, descriptive statistical data were computed, including the frequency, mean, and

standard deviation of participants' age and child's age as well as the frequency of participants' gender, ethnicity, annual income, education level, living arrangement, marital status, if CPRT was done with a co-parent, number of sessions attended by parents who did not complete CPRT, and reasons given for leaving CPRT.

For Question 2, regarding if parents who completed CPRT reported improved Parent Domain scores of the PSI at completion, a paired samples t-test was used to determine if parents reported lower scores on the Parent Domain after completion of CPRT. The dependent variable was parental stress and the two points of measure were pre-test, taken before starting CPRT, and post-test, taken after completion of CPRT.

Due to statistical significance being found in parents' reported levels of parental stress, a multiple regression was utilized for Question 3, regarding if certain variables predict different scores before pre and post testing on the PSI Parent Domain following participation in CPRT. The independent variables were parent gender and if the parent attended CPRT with co-parent, while the dependent variable was Parent Domain Score Difference. The Parent Domain Score Difference was computed as post-test score minus pre-test score of the Parent Domain.

## CHAPTER 3

### RESULTS AND DISCUSSION

#### Results

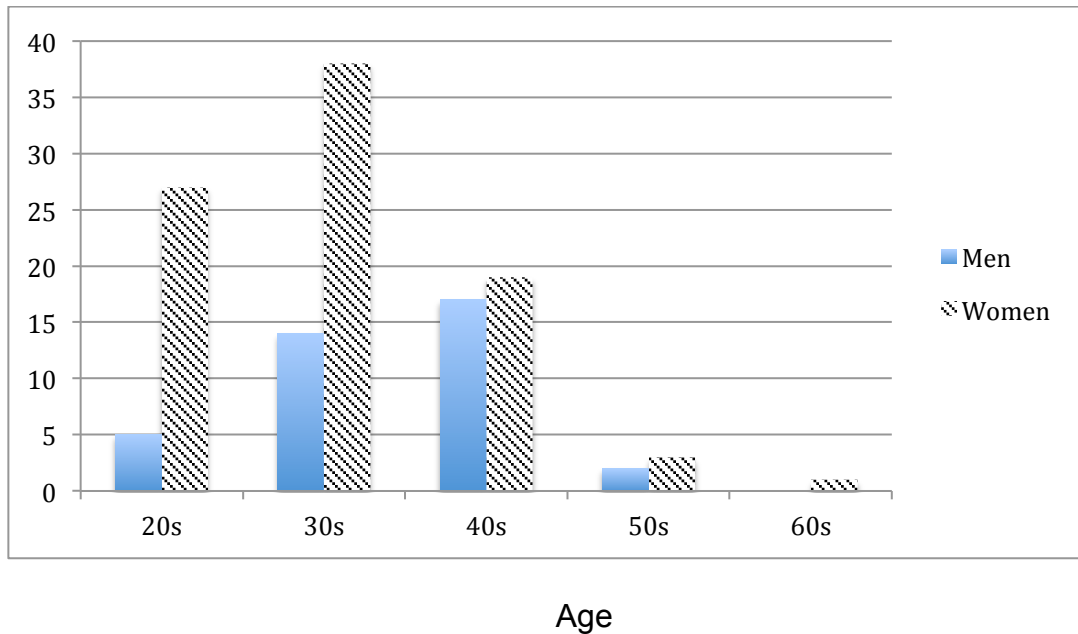
The results are reviewed in the order in which the research questions were presented. An alpha level of .05 was used, in order to limit a Type I error (Johnson & Christensen, 2008). Practical significance was reported through calculation of partial eta squared effect size (Kazdin, 1999). Clinical significance was reported through an individual look at each participant's scores to determine if parental stress decreased as a result of the intervention (Rubin & Bellemy, 2012).

#### *Research Question 1*

What are the demographics of the parents who seek Child Parent Relationship Therapy (CPRT) services? In order to answer Research Question 1, 129 participants were analyzed in this section.

#### *Gender and Age.*

Of the 129 participants, 39 (30.2%) were male and 90 (69.8%) were female. Ages ranged from 22 to 64, with a mean of 36 ( $M = 36.51$ ;  $SD = 7.787$ ) years old and a median of 36 years. Male participant ages were as follows: 20–29 years old ( $n = 5$ ; 12.9%), 30–39 years old ( $n = 14$ ; 36%), 40–49 years old ( $n = 17$ , 43.3%), 50–59 years old ( $n = 2$ ; 5.2%); Female participant ages were as follows: 20–29 years old ( $n = 28$ ; 30%), 30–39 years old ( $n = 38$ ; 42.3%), 40–49 years old ( $n = 19$ , 20.9%), 50–59 years old ( $n = 3$ ; 3.3%), 60–69 years old ( $n = 1$ ; 1.1%). Figure 1 presents the sample size of participants in each age group.

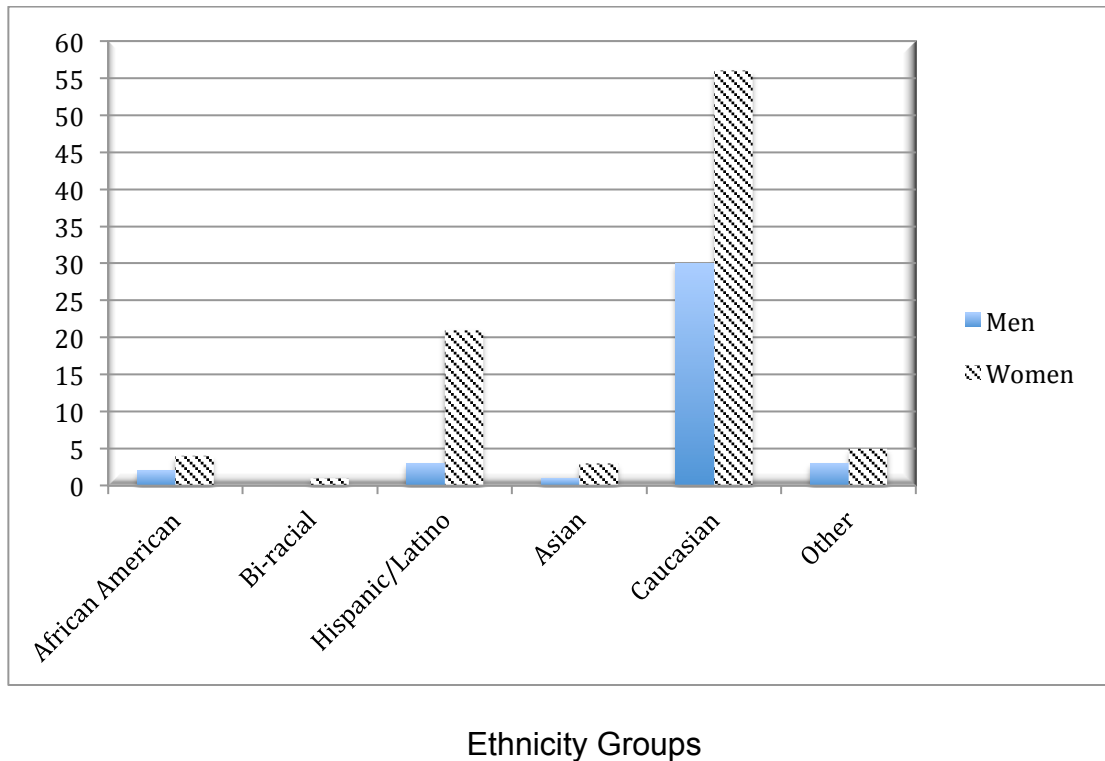


*Figure 1.* Sample size of participants in each age group.

### *Ethnicity*

Participants reported their ethnicity as: African American ( $n = 6$ ; 4.7%), bi-racial ( $n = 1$ ; 0.8%), Hispanic/Latino ( $n = 24$ ; 18.6%), Asian ( $n = 4$ ; 3.1%), Caucasian ( $n = 86$ ; 66.7%), and other ( $n = 8$ ; 6.2%). Male participant ethnicities were as follows: African American ( $n = 2$ ; 5.1%), Hispanic/Latino ( $n = 3$ ; 7.7%), Asian ( $n = 1$ ; 2.6%), Caucasian ( $n = 30$ ; 76.9%), and other ( $n = 3$ ; 7.7%). Female participant ethnicities were as follows: African American ( $n = 4$ ; 4.4%), bi-racial ( $n = 1$ ; 1.1%), Hispanic/Latino ( $n = 21$ ; 23.3%), Asian ( $n = 3$ ; 3.3%), Caucasian ( $n = 56$ ; 62.2%), and Other ( $n = 5$ ; 5.6%). Figure 2 presents the sample size of participants' ethnicity groups.

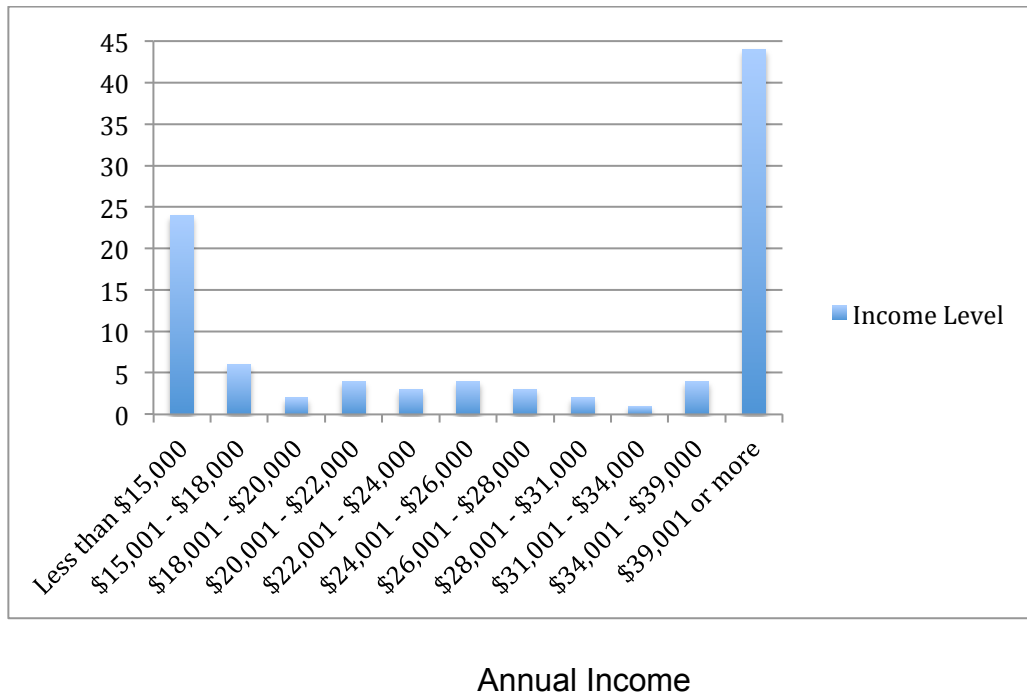




*Figure 2.* Sample size of participants' ethnicity groups.

#### *Annual Income*

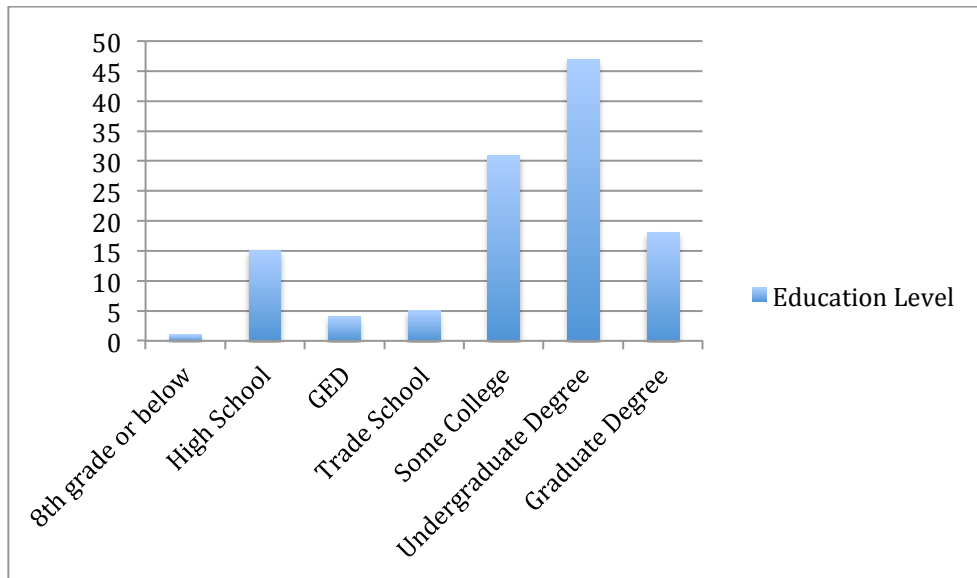
Annual income was reported as less than \$15,000 ( $n = 24$ ; 18.6%), \$15,001 – \$18,000 ( $n = 6$ ; 4.7%), \$18,001 – \$20,000 ( $n = 2$ ; 1.6%), \$20,001 – \$22,000 ( $n = 4$ ; 3.1%), \$22,001 – \$24,000 ( $n = 3$ ; 2.3%), \$24,001 – \$26,000 ( $n = 4$ ; 3.1%), \$26,001 – \$28,000 ( $n = 3$ ; 2.3%), \$28,001 – \$31,000 ( $n = 2$ ; 1.6%), \$31,001 – \$34,000 ( $n = 1$ ; 0.8%), \$34,001 – \$39,000 ( $n = 4$ ; 3.1%), \$39,001 or more ( $n = 44$ ; 34.1%), with missing data on 32. Participants' annual income is shown in Figure 3.



*Figure 3. Sample size of participant's annual income.*

#### *Education Level*

Education level was reported as 8<sup>th</sup> grade or below ( $n = 1$ ; 0.8%), High School ( $n = 15$ ; 11.6%), GED ( $n = 4$ ; 3.1%), Trade School ( $n = 5$ ; 3.9%), Some College ( $n = 31$ ; 24%), Undergraduate Degree ( $n = 47$ ; 36.4%), Graduate Degree ( $n = 18$ ; 14%), with missing data on 8. Figure 4 shows the participants' education level.

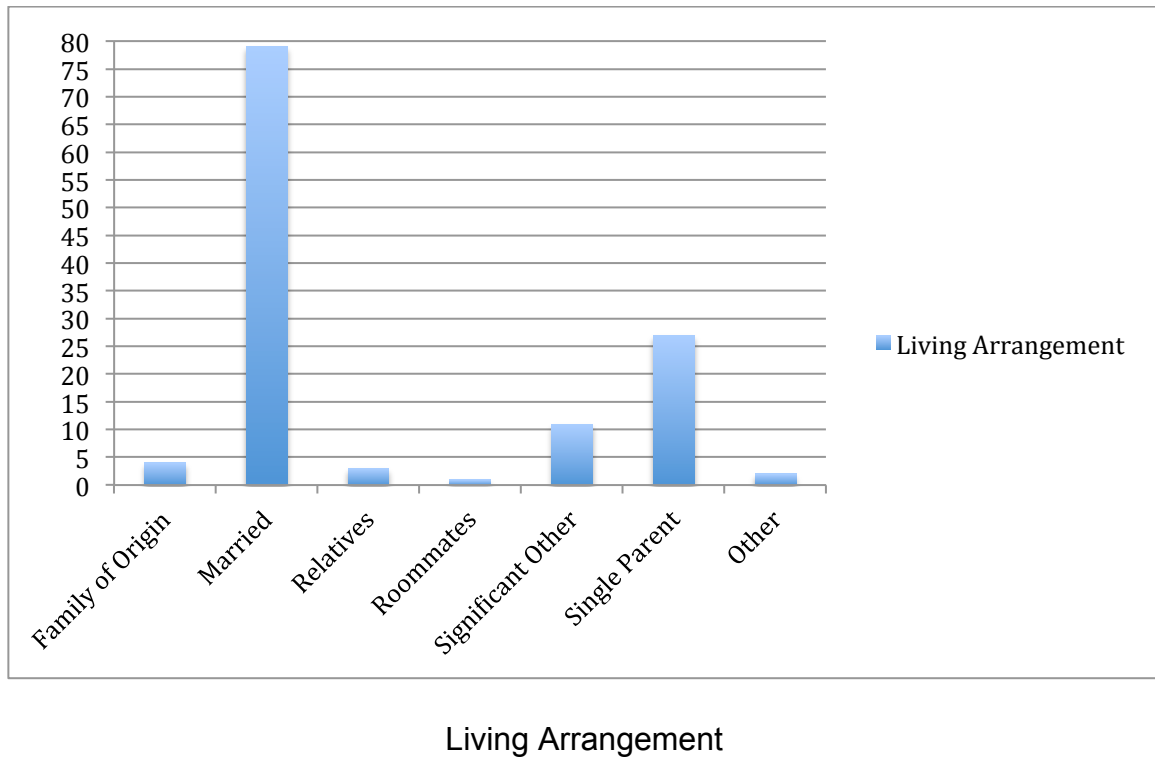


Education Level

*Figure 4. Participants' education level.*

#### *Living Arrangement*

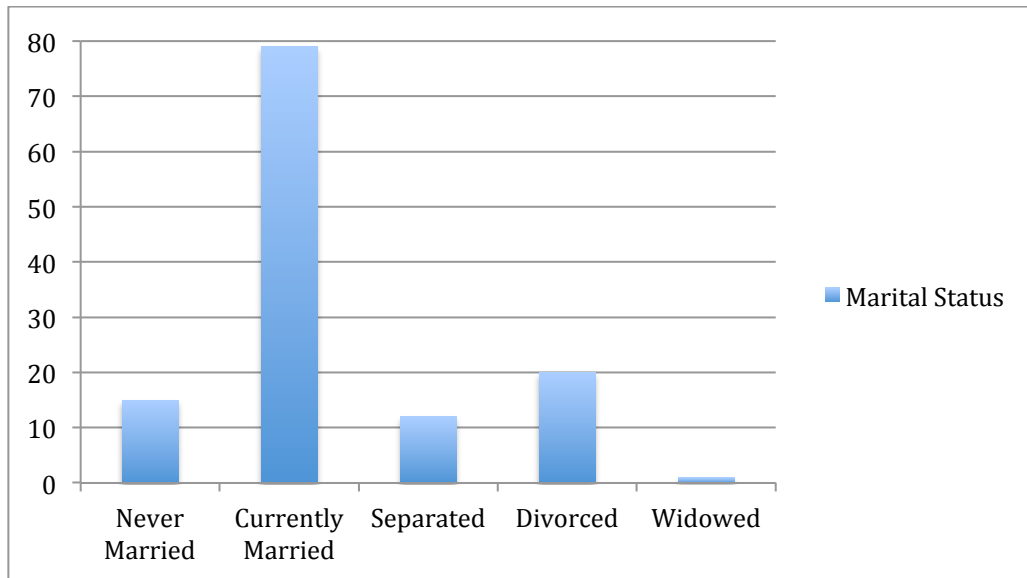
Participants' living arrangement were reported as follows: Family of Origin ( $n = 4$ ; 3.1%), Married ( $n = 79$ ; 61.2%), Relatives ( $n = 3$ ; 2.3%), Roommates ( $n = 1$ ; 0.8%), Significant Other ( $n = 11$ ; 8.5%), Single Parent ( $n = 27$ ; 20.9%), Other ( $n = 2$ ; 1.6%), with missing data on 2. Participants living arrangements are shown in Figure 5.



*Figure 5.* Participants' living arrangement.

#### *Marital Status*

Participants reported the following for their marital status: Never Married ( $n = 15$ ; 11.6%), Currently Married ( $n = 79$ ; 61.2%), Separated ( $n = 12$ ; 9.3%), Divorced ( $n = 20$ ; 15.5%), Widowed ( $n = 1$ ; 0.8%), with missing data on 2. Figure 6 presents participants' marital status.

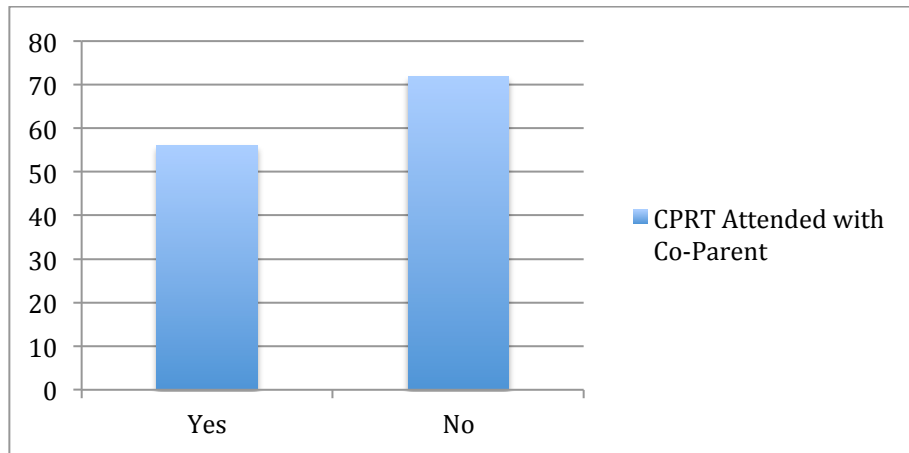


Marital Status

*Figure 6. Participant's marital status.*

#### *Attended CPRT with Co-parent*

Of the 129 participants, all but one reported whether they were doing CPRT with their co-parent. Of the 128 participants who reported, 56 participants (43.4%) reported doing the CPRT group with their co-parent, whereas 72 participants (55.8%) did the CPRT without their co-parent. Figure 7 presents the sample size of CPRT done with co-parent.

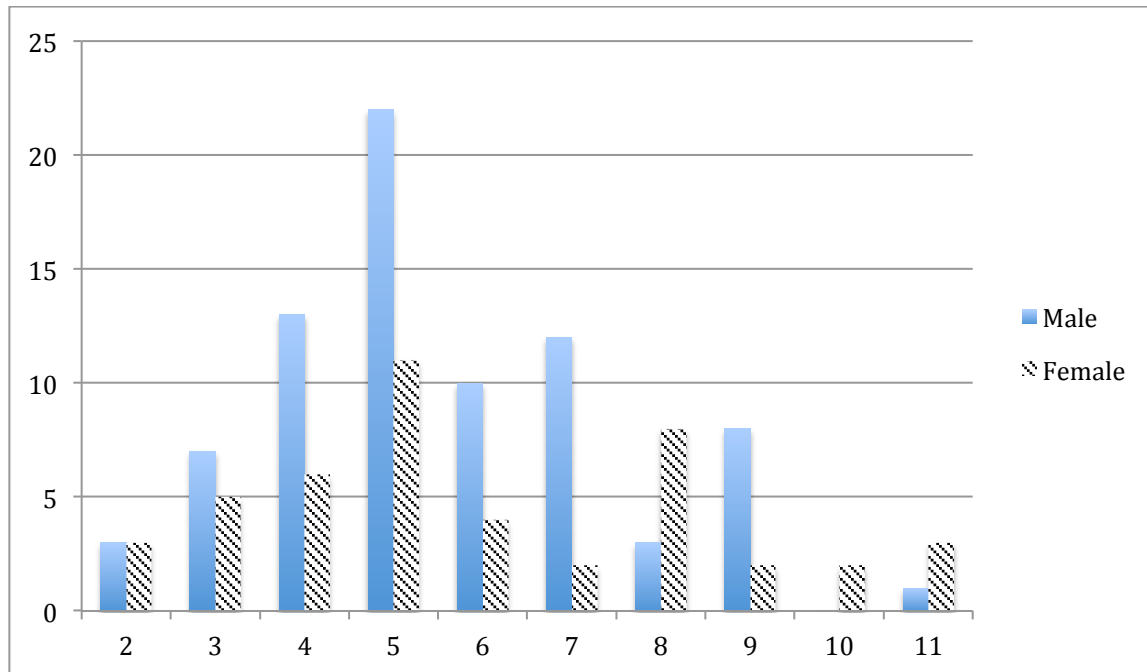


CPRT Attended with Co-Parent

*Figure 7.* Sample size of CPRT attended with co-parent.

#### *Child's Gender and Age*

Of the 129 participants, 125 reported their child's gender. 79 (61.2%) were male and 46 (35.7%) were female. Ages ranged from 2 to 11, with a mean of 5 ( $M = 5.67$ ;  $SD = 2.183$ ) years old and a median of 5 years. Male child ages were as follows: 2 years old ( $n = 3$ ; 3.8%), 3 years old ( $n = 7$ ; 8.9%), 4 years old ( $n = 13$ ; 16.5%), 5 years old ( $n = 22$ ; 27.8%), 6 years old ( $n = 10$ ; 12.7%), 7 years old ( $n = 12$ ; 15.2%), 8 years old ( $n = 3$ ; 3.8%), 9 years old ( $n = 8$ ; 10.1%), 11 years old ( $n = 1$ ; 1.3%). Female child ages were as follows: 2 years old ( $n = 3$ ; 6.5%), 3 years old ( $n = 5$ ; 10.9%), 4 years old ( $n = 6$ ; 13%), 5 years old ( $n = 11$ ; 23.9%), 6 years old ( $n = 4$ ; 8.7%), 7 years old ( $n = 2$ ; 4.3%), 8 years old ( $n = 8$ ; 17.4%), 9 years old ( $n = 2$ ; 4.3%), 10 years old ( $n = 2$ ; 4.3%), 11 years old ( $n = 3$ ; 6.5%). Figure 8 displays child's age.

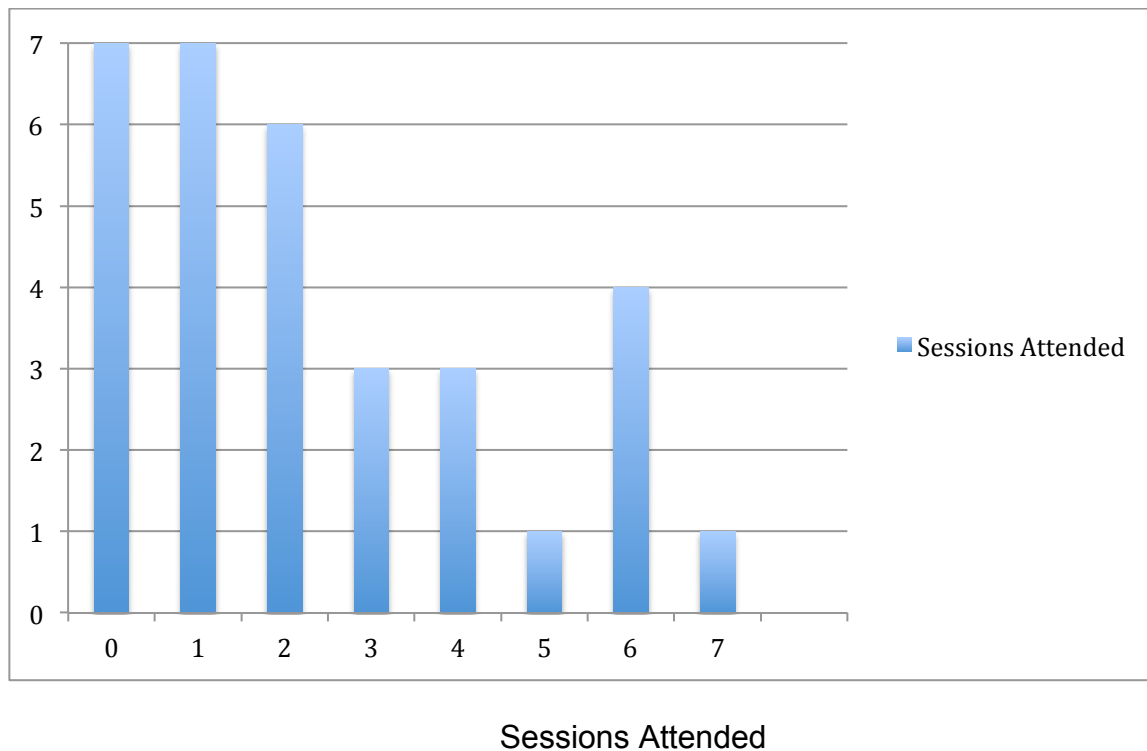


Child's Gender and

Age *Figure 8.* Child's gender and age.

#### *Parents who did not Complete CPRT*

Of the 129 total participants, 32 attended less than 10 sessions, therefore not completing CPRT. The attrition rate for this study was 25%. Sessions attended ranged from 0 to 7, with a mean of 2 ( $M = 2.37$ ;  $SD = 2.152$ ). Session attendance was as follows: 0 sessions – intake only ( $n = 7$ ; 21.9%), 1 session ( $n = 7$ ; 21.9%), 2 sessions ( $n = 6$ ; 18.8%), 3 sessions ( $n = 3$ ; 9.4%), 4 sessions ( $n = 3$ ; 9.4%), 5 sessions ( $n = 1$ ; 3.1%), 6 sessions ( $n = 4$ ; 12.5%), 7 sessions ( $n = 1$ ; 3.1%). Figure 9 displays sessions attended.

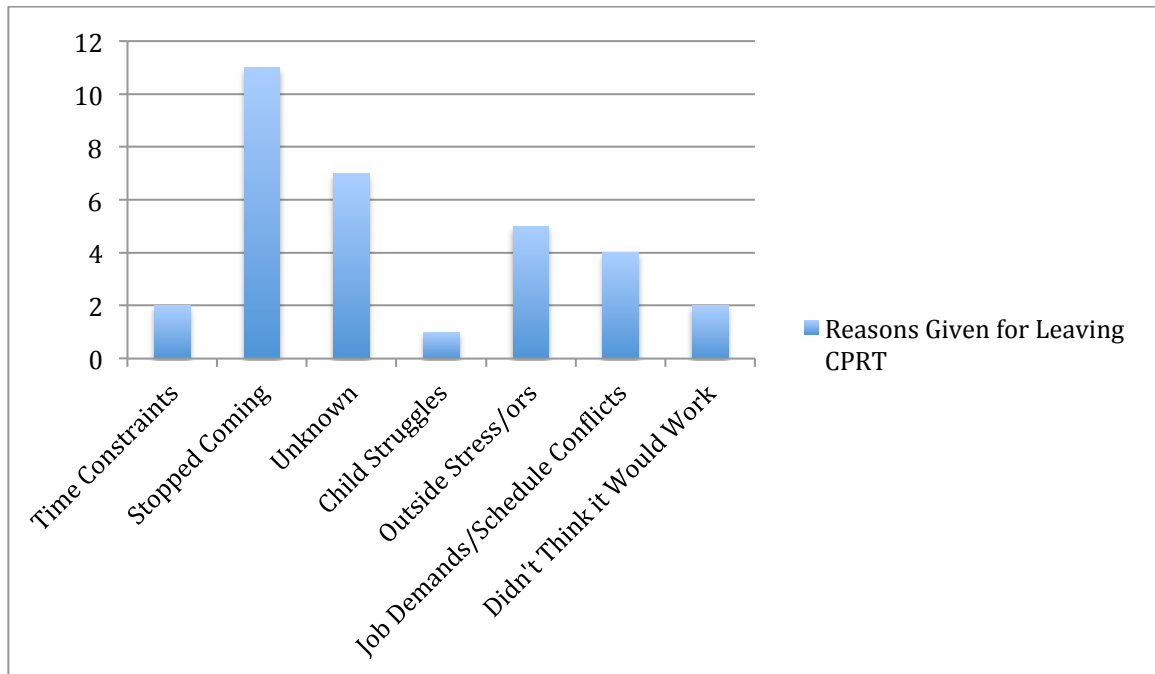


*Figure 9. Sessions attended by participants who did not complete CPRT.*

#### *Reasons Given for Leaving CPRT*

There were various reasons given for why the 32 participants did not complete CPRT. 2 (6.3%) of the participants stated time constraints, 11 (34.4%) participants stopped coming and gave no reason, 7 (21.9%) participants stopped coming for unknown reasons, 1 (3.1%) participant had a child who struggled when leaving the parent, 5 (15.6%) participants had outside stress or stressors, 4 (12.5%) participants had job demands or schedule conflict, and 2 (6.3%) participants did not think CPRT would work for their child. Figure 10 displays sessions attended.





Reasons Given for Leaving CPRT

Figure 10. Reasons given for leaving CPRT.

#### Research Question 2

Did parents who completed CPRT report improved Parent Domain scores of the PSI at completion? The pre- and post-test scores on the PSI were used to investigate levels of reported parental stress. Only the participants who completed a minimum of 9 sessions of CPRT and had pre- and post-test scores were analyzed in this section.

#### Paired Samples T-Test

A paired-samples t-test was conducted to evaluate the impact of the intervention on participants' reported levels of stress on the Parent Domain of the PSI. The t-test is a parametric test of statistical significance (Barrio Minton, 2015). The t-test is the most common way to compare the means of two populations (Good & Hardin, 2010) and is used to determine if the difference between the mean scores of two groups happened by chance or if it shows an actual difference between the two groups (Gall et al., 2005).

When performing t-tests there are a number of assumptions. It is assumed there is normality, in that the variable is normally distributed in the population; there is independence of the observations; and there is homogeneity of variances, in that the variances for each group are roughly similar (Barrio Minton, 2015).

Of the 129 total participants, 50 participants completed the PSI both prior to beginning CPRT and at the completion of CPRT. There was a statistically significant decrease in Parent Domain scores from pre-test ( $M = 53.45$ ,  $SD = 9.155$ ) to post-test ( $M = 51.70$ ,  $SD = 8.145$ ),  $t(49) = 2.040$ ,  $p < .05$  (two-tailed). The mean decrease in PD scores was 2.0 with a 95% confidence interval ranging from .030 to 3.970. The eta square statistic (.08) indicated a moderate effect size.

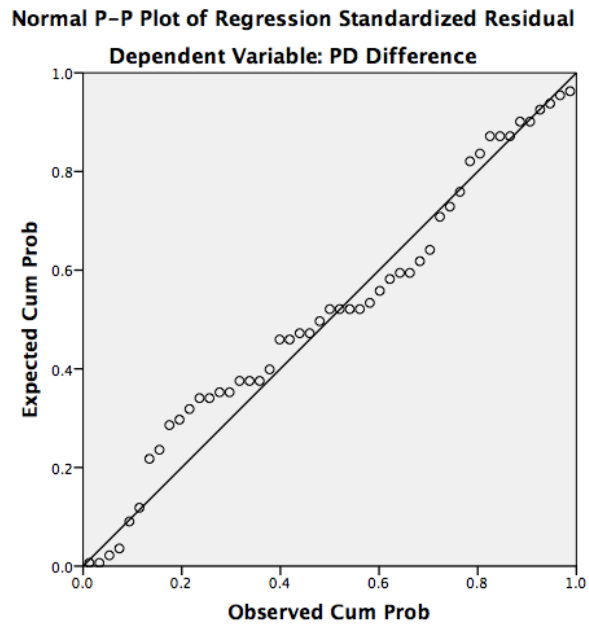
### *Research Question 3*

Did parent gender and attending CPRT with a co-parent predict difference scores from pre to post testing on the PSI Parent Domain following participation in CPRT? Multiple regression is the most commonly utilized multivariate statistic (Gall et al., 2005). The multiple regression design assesses the degree to which multiple variables predict another (Good & Hardin, 2010). Multiple regression is used when researchers desire to determine how scores on multiple measures for a group of individuals predict performance on an outcome (Gall et al., 2005). Tabachnick and Fidell (2006) suggest the rule of thumb of  $N \geq 50 + 8m$ , where  $m$  is the number of independent variables. Due to utilizing archival data, sample size did not meet this threshold. Because this was an exploratory study for evaluation purposes, I chose to use multiple regression to further explore data, although results are interpreted with caution. Parent gender and attending

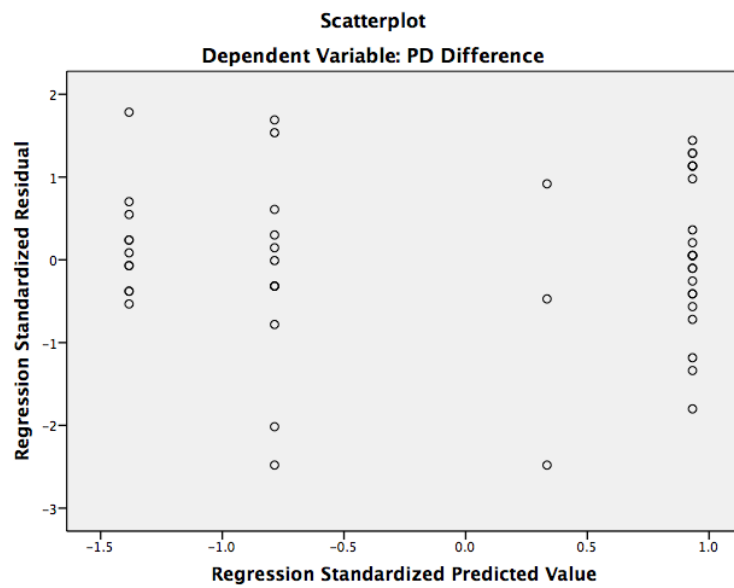
CPRT with co-parent were used as predictor variables, while Parent Domain Score Difference scores were used as the dependent variable.

When performing a random-effects model multiple regression, there are several assumptions. It is assumed that the sample size is generalizable, that multicollinearity exists and singularity occurs, there are no outliers (Pallant, 2013), the variables are multivariately normally distributed in the population, and there is independence of the observations (Barrio Minton, 2015). All assumptions were met, including generalizable sample size, the absence of multicollinearity and singularity, no outliers, and that the distribution of scores were normal, linear, and homoscedastic (Pallant, 2013).

As presented in Table 2, the sample sizes, means, and standard deviations were conducted for each predictor variable. There were more women ( $N = 36$ ) than men ( $N = 14$ ) who participated in CPRT. Men's post-test scores ( $M = 51.50$ ) increased by .50 upon completion of CPRT, whereas women reported lower levels of parental stress ( $M = 51.78$ ) with a decrease of 3.89 upon completion. Slightly more parents attended CPRT without their co-parent ( $N = 26$ ) than attended with co-parent ( $N = 23$ ). Those parents who attended without their co-parent reported lower levels of parental stress upon completion ( $M = 50.77$ ) with a 5.81 difference in pre and post-test scores. Parents who attended with their co-parent reported higher levels parental stress ( $M = 53.39$ ) upon completion with a 1.0 increase.



*Figure 11.* Normal plot of regression standardize residual.



*Figure 12.* Scatterplot of standardized residual and standardized predicated values.

Table 2

*Means and Standard Deviations of Pre-test and Post-test Scores for Predictor Variables*

Variable	<i>N</i>	<i>M</i>	<i>SD</i>
Pre-test PD Scores			
Male	14	51.00	7.854
Female	36	55.67	11.909
Attended with Co-Parent	23	52.39	8.675
Attended without Co-Parent	26	56.58	12.586
Post-test PD Scores			
Male	14	51.50	6.010
Female	36	51.78	8.913
Attended with Co-Parent	23	53.39	7.739
Attended without Co-Parent	26	50.77	8.071

As presented in Table 3, the results from the multiple regression analysis indicate a statistically significant prediction between the two predictor variables and Parent Domain Difference Scores.

Table 3

*Means, Standard Deviations, and Intercorrelations for Parent Domain Difference Scores and Predictor Variables*

Variable	<i>M</i>	<i>SD</i>	1	2
Parent Domain Score Difference	2.16	6.882	.243*	.377**
Predictor Variables				
1. Subject Gender	1.72	.454	---	.401**
2. Attended with Co-Parent	1.53	.504	.401**	---

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\* $p < .05$ . \*\* $p < .01$ .

Table 4 displays both predictor variable's multiple  $R$  ( $R$ ), coefficient of multiple determination ( $R^2$ ), adjusted  $R^2$  ( $R^2$ ), unstandardized coefficients ( $B$ ), standard error

unstandardized coefficients (*SE B*), standardized coefficients ( $\beta$ ), structure coefficients ( $r_s$ ), and squared structure coefficients ( $r_s^2$ ). The multiple regression analysis revealed a statistically significant prediction between the two predictors and Parent Domain Difference Scores with a moderate but practically meaningful  $R^2$  at 15%. Upon exploring contribution to variance explained, results revealed that attending CPRT with co-parent ( $\beta = 4.545$ ,  $r_s^2 = .933$ ) was the strongest predictor. Attending CPRT with co-parent could explain 93% of the 15% variance of the estimated decrease in parental stress. In addition, parent gender ( $\beta = 1.669$ ,  $r_s^2 = .388$ ) contributed to 39% of the variance explaining a meaningful amount of variance.

Table 4

*Regression Analysis Summary for Parent Gender and Attending with Co-Parent  
Predicting Parent Domain Difference Scores*

Variable	R	R <sup>2</sup>	Adj. R <sup>2</sup>	B	SE B	$\beta$	t	p	$r_s$	$r_s^2$
Parent Gender	.390	.152	.115	1.669	2.248	.110	.742	.462	.623	.388
Attending with Co-Parent				4.545	2.022	.333	2.247	.029	.966	.933

Note.  $R^2 = .152$  (N = 48,  $p < .005$ )

## Discussion

The purpose of this research was to conduct a program evaluation of two university-based counseling clinics with parents who sought CPRT services over a seven year time period. This discussion focuses on a) demographic factors, b) the effectiveness of CPRT on parental stress, and c) a correlational analysis of individual CPRT outcome prediction.

### *Demographic Factors*

The demographic factors discussed in this section specifically address the areas of ethnicity, annual income, parents who did not complete CPRT, and reasons given for not completing CPRT.

#### *Ethnicity*

United States census results found that within the Dallas-Fort Worth metroplex, 54% of the population identified as Caucasian, 27% Hispanic/Latino, 14% African American, and 5% Asian (Vision North Texas, 2009). Historically, people of color are less likely to seek out counseling services than Caucasians (Diller, 2011). Tsai (2009) found in her dissertation study that far less clients of color came to a university clinic seeking services than were represented in the local school district. As well, this study did not find a representative sample from the region where the clinics are located.

Of the 129 participants in this study, participants reported their ethnicity as: African American ( $n = 6$ ; 4.7%), bi-racial ( $n = 1$ ; 0.8%), Hispanic/Latino ( $n = 24$ ; 18.6%), Asian ( $n = 4$ ; 3.1%), Caucasian ( $n = 86$ ; 66.7%), and other ( $n = 8$ ; 6.2%). Male participant ethnicities were as follows: African American ( $n = 2$ ; 5.1%), Hispanic/Latino ( $n = 3$ ; 7.7%), Asian ( $n = 1$ ; 2.6%), Caucasian ( $n = 30$ ; 76.9%), and other ( $n = 3$ ; 7.7%). Female participant ethnicities were as follows: African American ( $n = 4$ ; 4.4%), bi-racial ( $n = 1$ ; 1.1%), Hispanic/Latino ( $n = 21$ ; 23.3%), Asian ( $n = 3$ ; 3.3%), Caucasian ( $n = 56$ ; 62.2%), and other ( $n = 5$ ; 5.6%). Results reveal a significantly higher number of Caucasians seeking CPRT services than African American and Hispanic/Latinos.

Many of the prior CPRT studies have been conducted with parents from a variety of racial and ethnic backgrounds. Previous studies have been done with parents who

were Native American/First Nations, Latinos (Boyer, 2001; Glover & Landreth, 2008), Hispanic/Latino (Ceballos & Bratton, 2010; Garza, Kinsworthy, & Watts, 2009), African-American (Sheely & Bratton, 2010; Solis et al., 2004), Jamaican (Edwards, Ladner, & White, 2007), Sudanese (Lim & Ogawa, 2014), Iranian (Alivandi Vafa & Khaidzir, 2009), Korean (Jang, 2000; Lee & Landreth, 1998), and Chinese immigrants (Chau & Landreth, 1997; Yuen et al., 2002). Research has found that there are often barriers to Hispanics receiving counseling services (Tsai, 2009) and African Americans historically not seeking out counseling services as frequently (Baggerly & Parker, 2005). Based on this study's findings, it is clear that people of color are underrepresented at these two university clinics. It is the researcher's recommendation that the clinics recruit and reach out to more parents who are Hispanic/Latino, African American, and Asian, thus making the CPRT more inclusive of parents of color. Perhaps working collaboratively with the local schools and community agencies would allow for reaching a more culturally diverse audience who may not be aware of CPRT. Furthermore, removing some of the barriers that may keep people of color from seeking services, such as offering CPRT in languages other than English and taking the time to explain CPRT to potential parents who may not fully trust counseling and the therapeutic process.

#### *Annual income*

U.S. census results found that the median income within the Dallas-Fort Worth metroplex was \$53,730 (Vision North Texas, 2009). Tsai's study of play therapy services at a university clinic (2009) found that that 31.4% of parents reported earning less than \$15,000, 17.8% reported earning \$15,000 - \$20,000, 19.2% reported earning \$20,001 - \$30,000, 14.3% reported earning \$30,001 - \$40,000, and 17.4% reported



earning over \$40,000. Of the 129 participants in this study, 97 reported annual income. Annual income was reported as less than \$15,000 ( $n = 24$ ; 18.6%), \$15,001 – \$18,000 ( $n = 6$ ; 4.7%), \$18,001 – \$20,000 ( $n = 2$ ; 1.6%), \$20,001 – \$22,000 ( $n = 4$ ; 3.1%), \$22,001 – \$24,000 ( $n = 3$ ; 2.3%), \$24,001 – \$26,000 ( $n = 4$ ; 3.1%), \$26,001 – \$28,000 ( $n = 3$ ; 2.3%), \$28,001 – \$31,000 ( $n = 2$ ; 1.6%), \$31,001 – \$34,000 ( $n = 1$ ; 0.8%), \$34,001 – \$39,000 ( $n = 4$ ; 3.1%), \$39,001 or more ( $n = 44$ ; 34.1%). Results reveal that the majority of parents fall either into the range of \$39,001 or more or less than \$15,000.

Whereas Tsai's (2009) results showed far more parents earning less than \$15,000 per year and the other areas being more equally distributed, this study found that parents tended to fall into the higher economic group of earning more than \$39,001 per year or in the lower end of earning less than \$15,000 per year. Comparatively, there were very few parents who fell into the middle earning areas. Of interest is why so few parents who sought CPRT services fell into these mid-earning ranges. Very little research can be found regarding specific income levels of clients who seek counseling, and much of research is conceptual rather than empirical (Hawley, Leibert, & Lane, 2014). However, many research studies have focused on clients who have either a lower socioeconomic status (SES) or a higher SES (Hawley et al., 2014). In moving forward at these two university clinics, therapists should be mindful of recruiting parents who represent all earning ranges and not just the lower and higher ends.

#### *Parents who did not complete CPRT*

Of particular interest were the parents who did not complete CPRT. Of the 129 total participants, 32 attended less than 10 sessions. There was 25% dropout rate, which is a particularly high attrition rate. Sessions attended ranged from 0 to 7, with a

mean of 2 ( $M = 2.37$ ;  $SD = 2.152$ ). Session attendance was as follows: 0 sessions – intake only ( $n = 7$ ; 21.9%), 1 session ( $n = 7$ ; 21.9%), 2 sessions ( $n = 6$ ; 18.8%), 3 sessions ( $n = 3$ ; 9.4%), 4 sessions ( $n = 3$ ; 9.4%), 5 sessions ( $n = 1$ ; 3.1%), 6 sessions ( $n = 4$ ; 12.5%), 7 sessions ( $n = 1$ ; 3.1%).

Discovered through this study was that 72% of the parents who did not complete CPRT stopped attending sessions by the fourth meeting. Over one-fifth of the parents attended the intake session, but never came to the group CPRT sessions. Almost 22% of the parents that began the CPRT group only attended one session and almost 19% of the parents attended two sessions. Almost 10% of the parents did not return after the third session. While it is unknown specifically why each parent left when they did, it is notable that parents are asked to start the home play therapy sessions with their child during week three and additionally, they are asked to record the sessions to show during the group meetings, so they may receive support and feedback. This may be part of the reason why parents choose to leave prior to the fourth session. Therapists may need to spend some time working with parents to help alleviate potential anxiety about taping themselves and showing the tapes to the group. While the concept of supervision of the play therapy sessions is discussed within the group format, perhaps more time needs to be allotted to working with parents' feelings about being taped and watched.

As well, the time constraints of a two-hour group each week for a total of ten weeks, along with the 30-minute play session outside of the group, may have contributed to the attrition rates. For parents who are already experiencing higher levels of stress, this may be an added factor to increasing their overall stress levels, thus

prompting them to leave the group. Although we are uncertain if the required hours per week or the number of weeks specifically contributed to attrition, of consideration is if the format of CPRT needs to be revised or adjusted in order to better meet parent needs, especially those who are already reporting high stress levels.

#### *Reasons given for leaving CPRT*

Several reasons were given regarding why the 32 participants did not complete CPRT. 2 (6.3%) of the participants stated time constraints, 11 (34.4%) participants stopped coming and gave no reason, 7 (21.9%) participants stopped coming for unknown reasons, 1 (3.1%) participant had a child who struggled when leaving the parent, 5 (15.6%) participants had outside stress or stressors, 4 (12.5%) participants had job demands or schedule conflict, and 2 (6.3%) participants did not think CPRT would work for their child.

Although it was helpful to know why parents did not complete CPRT, 25% left without any explanation – they either stopped coming or gave no reason for leaving. In the future, in order to better meet parent needs, it is recommended that the therapists do a more thorough job on following up with parents who decide to discontinue coming to CPRT sessions. One consideration about high attrition rates is that parents in the CPRT groups are presented with what they are not currently doing in their parent-child interactions. Although the CPRT format is strengths-based and focuses on the positive, parents may be internalizing the information and are self critical due to feeling they are not parenting well. This may be a reason why parents stop coming to the CPRT groups. Due to the unknown factors, there is no way to know if these parents might

have been willing to continue if the therapist had worked with them, offered additional support, or had adjusted the format of the CPRT sessions.

### *Effectiveness of CPRT on Parental Stress*

CPRT is known to be an effective modality for reducing parental stress. Prior studies have shown parents' parental stress levels significantly decrease following filial therapy (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Lim & Ogawa, 2014; Kidron & Landreth, 2010; Ray et al., 2010; Yuen et al., 2002).

Additionally, after completing CPRT, other studies found slightly lower decreases in overall parental stress (Alivanda Vafa & Khaidzir, 2009; Ceballos & Bratton, 2010; Glazer-Walderman et al., 1992; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Ray et al., 2000; Sheely & Bratton, 2010; Tew et al., 2002). In this study, 50 participants completed the PSI both prior to beginning CPRT and at the completion of CPRT. Results found there was a statistically significant decrease in Parent Domain scores from pre-test to post-test.

### *Correlational Analysis of Individual CPRT Outcome Prediction*

Due to finding statistical and practical significance on the t-test, the researcher explored the correlation between possible predictors and change scores using a multiple regression. According to simple correlations, the following variables were examined in relationship to change scores: parent age, annual income, education level, living arrangement, marital status, child's age, and child's gender. After review, there were only two variables that seemed to have a relationship with change scores and they were parent gender and if the parent attended CPRT with co-parent. The researcher

employed the use of the two variables as predictors to explore their relationship to the change scores. Parent gender and attending CPRT with co-parent variables were used as predictor variables, while Parent Domain Score Difference scores were used as the dependent variable.

Multiple regression analysis was conducted using the predictor variables of parent gender and attending CPRT with co-parent to examine the impact on parental stress. The variables that are normally considered to make a difference in counseling outcomes, such as parent age, annual income, education level, living arrangement, marital status, child's age, and child's gender were found to have little relationship to outcome in this study, thus the use of parent gender and attending CPRT with co-parent.

The multiple regression results determined a statistically significant prediction on Parent Domain Change Scores. Results from the prediction model demonstrated that parent gender was a moderate predictor on Parent Domain score reduction with it demonstrating 39% of the variance. Results from the prediction model revealed that attending CPRT with co-parent was the strongest predictor, with it explaining 93% of the variance of the estimated decrease in parental stress. Although both predictor variables were dichotomous variables, research supports the use of dichotomous variables in multiple regression (Pallant, 2013; Tabachnick & Fidell, 2006).

It appears that females benefitted more from CPRT, due to women report lower levels of parental stress after CPRT. It is possible that women make greater change after attending CPRT due to women feeling less alone, less distant, and more connected when working in therapy (Conner, 2000). These findings show there is a need to not

only recruit more men for the CPRT groups, but also for therapists to better serve the men who attend.

Parents who attend CPRT sessions without their co-parent reported a larger decrease in parental stress. Perhaps these parents felt less supported at home and found more support within the group setting. While there are no specific answers as to why parents who attended without their co-parents reported lower levels of parental stress, this is a significant finding that bears attention. Therapists working with co-parents who attend the groups, should be mindful of the dynamics that may be occurring with the co-parents and any additional stress that may occur as a result of attending together. Although these two variables contribute to change, there is still a great of variance that is unexplained, thus a need for further researcher on what specifically impacts change.

#### Limitations of the Study

Due to utilizing data from clinical archival files, there are a number of limitations for this study. The following are addressed for consideration when interpreting data analysis:

1. Although considered a reliable measure, the PSI was the only instrument used to assess parental levels of stress. Additionally, the PSI is a measure of self-report, thus there could be concerns with response bias or parents answering honestly.
2. Due to using convenience sampling, the sample was relatively small and the study had low power due to the lesser N. The researcher found that there were 129 CPRT files, however only 50 of them had pre- and post-data.

3. The study results may not be generalizable. All participants were from the Southwest region of the United States. Furthermore, these parents sought out counseling services, meaning that they might not be fully representative of those parents who chose not to seek counseling.
4. Although CPRT was conducted at university clinics, due to being an archival study, the researcher could not measure adherence to the CPRT protocol. Although all the counselors were trained in CPRT, and were under supervision, the researcher was unable to know specifically how the information was gathered and if the counselors adhered to clinic policies.
5. We must be cautious in interpreting the multiple regression results due to low power and the great amount of variance that was unexplained.
6. Program evaluations cannot be completed in the traditional ways of looking at statistical data.

### Implications

There are several clinical implications to this study. This study is significant in that it was the first study to look at CPRT through a program evaluation lens. Additionally, it was the first CPRT research done in a real-life setting and practice. No program evaluation had ever been completed solely on CPRT services offered through community clinics. Past research provided data on very specific populations who have participated in CPRT, yet this study offered information on a much wider clientele.

During this program evaluation, the researcher found a number of issues and concerns that will need to be addressed. There was a high attrition rate, with 25% of parents who started CPRT dropping out by the 7<sup>th</sup> session. Men were not well

represented in the CPRT group, nor did CPRT appear to be as effective with men. The current clinic background form design is not inclusive of parents who do not fit into the traditional biological mother and father roles, and the ethnicity section does not provide a comprehensive representation of parents. It would be helpful to know more specific information about parents who reported being bi-racial other. The clinics need to look at compliance procedures, especially in the administration of post-testing assessments. Of all the parents who attended CPRT, only 39% had pre and post data.

### Suggestions for Further Research

Based upon this study's results, several recommendations are listed for future research.

1. A longitudinal study recruiting more participants at these two university clinics is recommended. A larger sample size would increase the power of statistical measures.
2. Research to examine the premature termination factors in order to decrease the high rate of parents discontinuing CPRT.
3. Future program evaluations conducted at other university-based clinics is recommended in order to generalize findings from the current study.
4. A study focusing on the intake participants is suggested in order to better understand why parents seek CPRT services.
5. Research focusing on what specific variables impact change after CPRT.

### Conclusion

There is a great deal of research on parents who seek CPRT services. The purpose of this study was to conduct a program evaluation of two university-based



counseling clinics with parents who sought CPRT services over a seven year time period. Archival data was used to provide characteristics of parents who sought CPRT services, to determine the impact of CPRT intervention over two points of measure, pre-intervention and post-intervention, and to determine the impact of particular variables on parental stress.

Over 40 studies validate the effectiveness of CPRT (Bratton et al., 2015). In this study, demographic data was gathered on all 129 participants and results demonstrated statistically significant differences between pre and post tests scores on the Parent Domain of the PSI. Furthermore, when analyzing variables that impacted decreases in parental stress, gender and attending CPRT with co-parent were found to be significant, with gender contributing to 39% while attending CPRT with co-parent contributing 93%. In evaluating statistical, practical, and clinical significances, the main contribution of this study is the full exploration of parent characteristics and effectiveness of CPRT for parents who seek CPRT services.

## APPENDIX A

### CONFIRMATION OF RECEIPT OF PRIVACY NOTICE AND INFORMED CONSENT



University of North Texas  
Department of Counseling and Higher Education  
Counseling Program Clinical Services

**Confirmation of Receipt of Privacy Notice and Informed Consent**

By your signature below, you are indicating 1) that you have received a copy of the *Notice of Privacy and Informed Consent*; 2) that you voluntarily agree to receive mental health assessment and medical health care, treatment, or services, and that you authorize the clinic to provide such services as considered necessary and advisable; 3) that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may at any time stop such services received through the clinic; 4) that you have read and understand this statement and have had ample opportunity to ask questions about, and seek clarification of, anything unclear to you.

**Release for Liability and Hold Harmless Provisions:** By signing this document, you are releasing the clinic and holding the clinic harmless from any personal liability that arises from departure from your right of confidentiality.

By my signature, I verify the accuracy of *Notice of Privacy and Informed Consent* and acknowledge my commitment to conform to its specifications.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Counselor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

If the client is a minor, the legal guardian (managing conservator) must sign the statement below:

The UNT Counseling Program Clinical Services requires documentation of conservatorship/guardianship. If your conservatorship/guardianship is established by a divorce decree or custody document, you are required to furnish the clinic with a photocopy of the cause page (first page calling out the case), the page specifying conservator(s), and the signature page from the decree or document, before clinical services can begin.

With your signature below, you affirm that you are the legal guardian (managing conservator) of \_\_\_\_\_ (minor's name). With an understanding of the above requirements, you grant permission for your child to participate in counseling and release the counselor and the UNT Counseling Program Clinical Services from liability for same, as stated in the *Release from Liability and Hold Harmless* provisions above.

\_\_\_\_\_  
Managing Conservator's Signature

\_\_\_\_\_  
Date

## APPENDIX B

### NOTICE OF PRIVACY PRACTICE AND INFORMED CONSENT

*University of North Texas*

*Department of  
Counseling and Higher Education*

**Counseling Program  
Clinical Services**

**NOTICE OF  
PRIVACY PRACTICE  
AND  
INFORMED CONSENT**

THIS NOTICE DESCRIBES HOW  
PROTECTED HEALTH INFORMATION  
ABOUT YOU MAY BE USED AND  
DISCLOSED AND HOW YOU CAN GET  
ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

Welcome to the UNT Counseling Program Clinical Services (CPCS). The following notice is an introduction to your rights and responsibilities as a client at the clinic. The UNT CPCS serve dual functions: to provide counseling for the community and to aid in the professional development of counselors and supervisors. All counseling is facilitated by graduate students at the masters or doctoral level who are supervised by a counseling professor. Counseling sessions at the UNT CPCS are supervised and recorded.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice also serves to obtain your consent for clinical policies and procedures. Please review it carefully.

The UNT CPCS is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about the privacy practices at a UNT Counseling Clinic, please contact Dr. Dee Ray, (940) 565-2066.

Effective April 27, 2009:

**I. How We Protect Your Health Information**

We protect your health information by:

- ◆ Treating all of your health information that we collect as confidential.
- ◆ Stating confidentiality policies and practices in our clinic staff handbooks, as well as disciplinary measures for privacy violations.
- ◆ Restricting access to your health information only to those clinical staff that need to know your health information in order to provide our services to you.
- ◆ Maintaining physical, electronic, and procedural safeguards to comply with federal and state regulations guarding your health information.

**II. Conditions That Require Release of Health Information**

The UNT CPCS maintains records of client health information in a confidential file system. The client files remain the property of the UNT CPCS but the information belongs to you. The UNT CPCS protects the privacy of your health information.

**Uses and Disclosures Requiring Authorization**

The UNT CPCS may use or disclose mental health information outside treatment or healthcare operations when your appropriate authorization is obtained. An authorization is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the UNT CPCS are asked for your private information, we will obtain a written authorization from you before releasing this information. You may revoke such authorizations at any time provided each revocation is in writing.

**Uses And Disclosures With Neither Consent Nor Authorization**

The UNT CPCS may use or disclose your mental health information without your consent or authorization in the following circumstances:

- ◆ Abuse – If we have reason to believe that a minor child, elderly person, or person with a disability has been abused, abandoned, or neglected, the UNT CPCS must report this concern or observations related to these conditions or circumstances to the appropriate authorities.
- ◆ Health Oversight Activities – If the Texas State Board of Examiners of Professional Counselors is investigating a clinician that you have filed a formal complaint against, the clinic may be required to disclose protected health information regarding your case.
- ◆ Judicial and Administrative Proceedings as Required – If you are involved in a court proceeding and a court subpoenas information about the professional services provided you and/or the records thereof, we may be compelled to provide the information. Although courts have recognized a clinician-client privilege, there may be circumstances in which a court would order the clinic to disclose personal health or treatment information. The UNT CPCS will not release your information without attempting to notify you or your legally appointed representative.

- ◆ Professional Harm – If you disclose sexual contact with another mental health professional with whom you have had a professional relationship, we are required to report this violation to the licensing board. You have the right to anonymity in the filing of the report.
- ◆ Serious Threat To Health or Safety – If you communicate to clinic personnel an explicit threat of imminent serious physical harm to yourself or others and we believe you may act on that threat, we have a legal duty to take the appropriate measures, including disclosing information to the police. In both cases, we will disclose only what we feel is the minimal amount of information necessary.
- ◆ National Security – We may be required to disclose to military authorities the health information of armed forces personnel under certain circumstances. We may be required to disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may be required to disclose mental health information to a correctional institution or law enforcement official having lawful custody of protected mental health information of an inmate or client under certain circumstances.
- ◆ Research and Training: Because the UNT CPCS serves to train counselors, you agree that your assessment and therapy sessions will be recorded and may be observed for the purpose of student training, supervision and research. Recorded sessions may be used in class and/or conference presentations for educational purpose. In this case, personal identifying information is protected. Data contained in your file are available for archival research (i.e., reviews of records to describe clinical referrals, outcomes, and trends) as long as your identity cannot be linked to the data used. Any research conducted at the UNT CPCS is subject to an institutional review board that serves to safeguard your privacy and health.

### III. Client's Rights and Counselor's Duties

- ♦ Rights to Request Restrictions - You have the right to request additional restrictions on certain uses and disclosures of protected health information. The clinic may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.
- ♦ Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of mental health information by alternative means and at alternative locations. (For example, you may not want a family member to know you are being seen at the clinic. On your request, the clinic will send your information to another address.)
- ♦ Right to Inspect and Copy - You have the right to inspect or obtain a copy of your clinical records. A reasonable fee may be charged for copying. Access to your records may be limited or denied under certain circumstances, but in most cases, you have a right to request a review of that decision. On your request, we will discuss with you the details of the request and denial process.
- ♦ Right to Amend - You have the right to request in writing an amendment of your health information for as long as the mental health information records are maintained. The request must identify which information is incorrect and include an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial, which will be added to the information of the original request. If your original request is approved, we will make a reasonable effort to include the amended information in future disclosures. Amending a record does not mean that any portion of your health information will be deleted.
- ♦ Right to an Accounting - You generally have the right to receive an accounting of disclosures of mental health information. If your mental health information is disclosed for any reason other than

treatment or health operations, you have the right to an accounting for each disclosure of the previous five (5) years, but the request cannot include dates before April 14, 2003. The accounting will include the date, name of person, or entity, description of the information disclosed the reason for disclosure, and other applicable information. If more than one (1) accounting is requested in a twelve (12) month period, a reasonable fee may be charged.

- ♦ Electronic Information - The UNT CPCS does not allow the distribution of client information through electronic means. Requests for client mental health information are honored through phone and postal mail communication only.

### IV. UNT CPCS Duties:

- ♦ The UNT CPCS is required by law to maintain the privacy of mental health information and to provide you with a notice of legal duties and privacy practices.
- ♦ The clinic and university reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, the clinic is required to abide by the terms currently in effect.

### V. UNT CPCS Procedures:

- ♦ The clinic operates only during limited hours that do not include overnights, weekends, or university holidays and breaks. Counseling sessions are limited to pre-arranged times set between the counselor and client.
- ♦ The benefits you receive from counseling depend upon your attendance. Therefore, if you are absent three sessions in a row, your name will be placed at the end of the clinic's waiting list.
- ♦ Clinic hours are limited, Monday through Friday. If you wish to reach your counselor between sessions, you may leave messages with the clinic secretary who will contact your counselor.

- ♦ If you are in a life-threatening emergency, please call 911 or MHMR Crisis Line (800-762-0157).
- ♦ The clinic is not able to provide emergency services or psychiatric medications. Individuals who need substantial case management, ongoing medication adjustments, and/or emergency clinician access, are generally not appropriate for a training clinic. Such clients may be seen at the clinic when their situation is more stable.
- ♦ The clinic operates according to a fee schedule. You will be assigned a fee based on your financial situation and will be expected to pay for services at the end of each counseling session. If your fee represents a hardship for you, please notify your counselor who will work with you to possibly modify your fee. The counseling UNT CPCS do not file for reimbursement from health insurance companies.
- ♦ In case of secrets revealed during family or couple counseling, information will be kept confidential without another family member's knowledge (unless it involves one or more of the exceptions mentioned under the *Uses and Disclosure With Neither Consent Nor Authorization*). However, open communication is encouraged among family members and couples, and counseling will be terminated if secrets are judged to be detrimental to therapeutic progress. By signing this Informed Consent, clients involved in couple and family counseling consent for one file to be maintained for all joint sessions which any family/couple member may access or obtain copies of at any time.
- ♦ The clinic reserves the right to postpone or terminate counseling with you in any of the following circumstances: a) if you come to session under the influence of drugs or alcohol; b) if you do not comply with the medication recommendations of your psychiatrist or physician; c) if your counselor believes that you are not benefiting from counseling; d) if your counselor is impaired in providing competent counseling to you; e) if in couple counseling, your counselor learns that you are abusing your partner. In the case of group counseling, group entry may be denied to anyone considered inappropriate for the group or termination may be enacted for anyone whose behavior is considered detrimental to the group.

### Other Restrictions:

- ♦ The UNT CPCS must also conform to Federal Regulations (42CFR, Part 2) regarding the release of alcohol/drug treatment records and confidentiality standards related to such treatment.

### VI. Changes to this Notice

The UNT CPCS and the university reserve the right to change our privacy practices and terms of this notice at any time, as permitted by applicable law. We reserve the right to make the changes in our privacy practices and new terms of our notice effective for all mental health information that we maintain, including mental health information we created or received before we made the changes. Before we make such changes, we will update this notice and post the changes in the waiting room of the facility. You may request a copy of the notice at any time.

### VII. Questions and Complaints

For questions regarding this notice or our privacy practices, please contact the UNT CPCS Privacy Officer, Dr. Dee Ray.

If you are concerned that your privacy rights may have been violated, you may contact the person listed below to make a complaint. You may also make a written complaint to the U.S. Department of Health and Human Services whose address can be provided upon request.

If you choose to make a complaint with us or the Texas Department of Health and Human Services, we will not retaliate in any way.

Dee Ray, Ph.D., LPC, NCC, RPT-S  
Director, Child and Family Resource Clinic  
University of North Texas  
1155 Union Circle #310829  
Denton, TX 76203  
(940) 565-2066

APPENDIX C  
ADULT BACKGROUND INFORMATION FORM

University of North Texas  
Department of Counseling and Higher Education  
Counseling Program Clinical Services

## Adult Background Information

*Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you in your interview.*

Name: \_\_\_\_\_ First Visit Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_ (May call: Yes No Message: Yes No )

Work Phone: \_\_\_\_\_ (May call: Yes No Message: Yes No )

Home Address: \_\_\_\_\_  
Street City State Zip

Best time/place to contact you: \_\_\_\_\_ Occupation: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_  
Name: Last, First Relationship Phone

Gender: Male\_\_ Female\_\_ Date of Birth \_\_\_\_\_ Age\_\_ SS# \_\_\_\_\_

Ethnicity:

Africa American\_\_ Bi-racial\_\_ Hispanic/Latin\_\_  
Asian\_\_ Caucasian\_\_ Native American\_\_ Other \_\_\_\_\_

Are you currently in counseling elsewhere? Yes No (If yes, do not complete this form until you have met with your counselor)

Family members receiving services at this clinic Yes No (Name/Dates of service) \_\_\_\_\_  
\_\_\_\_\_

Are you seeking services because you are a victim of a crime? Yes No Did it result in legal action?  
Yes No

Are you currently on probation? Yes No

Have you ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No  
(If so, we will need your permission in order to communicate with that individual or agency)

Previous Mental Health Professional/Agency \_\_\_\_\_  
Name Address  
Phone \_\_\_\_\_ Dates of Service \_\_\_\_\_ (beginning - ending)

Have you ever been hospitalized for mental health concerns: Yes No

If yes please explain: \_\_\_\_\_

How were you referred to our clinic? (Check those that apply):

Counselor/Psychologist/Psychiatrist__		School personnel__
Court__	Minister__	Self__
DPRS__	Newspaper Ad__	UNT Community__
Flyer__	Physician__	Yellow Pages__
Friend or Co-Worker__	Relative__	Other__



Person responsible for financial arrangements with our clinic: \_\_\_\_\_  
Name: Last, First

Are you applying for sliding scale payments? Yes No

Gross Household Annual Income:

\_\_\_\_ Less than \$15,000 \_\_\_\_ 20,001 - 22,000 \_\_\_\_ 26,001 - 28,000 \_\_\_\_ 34,001 - 39,000  
\_\_\_\_ 15,001 - 18,000 \_\_\_\_ 22,001 - 24,000 \_\_\_\_ 28,001 - 31,000 \_\_\_\_ 39,001 -  
40,000  
\_\_\_\_ 18,001 - 20,000 \_\_\_\_ 24,001 - 26,000 \_\_\_\_ 31,001 - 34,000

Educational Level:

8th grade or below \_\_\_\_\_ Trade School \_\_\_\_\_ Master's Degree \_\_\_\_\_  
High School \_\_\_\_\_ Some College \_\_\_\_\_ Ph. D. Degree \_\_\_\_\_  
GED \_\_\_\_\_ College Graduate \_\_\_\_\_

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married \_\_\_\_\_

Married 1 \_\_\_\_\_ Separated 1 \_\_\_\_\_ Divorced 1 \_\_\_\_\_ Widowed 1 \_\_\_\_\_  
Married 2 \_\_\_\_\_ Separated 2 \_\_\_\_\_ Divorced 2 \_\_\_\_\_ Widowed 2 \_\_\_\_\_  
Married 3 \_\_\_\_\_ Separated 3 \_\_\_\_\_ Divorced 3 \_\_\_\_\_ Widowed 3 \_\_\_\_\_

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile Frustrating Friendly  
1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_

Are you currently involved in a custody dispute: Yes No (If yes, explain) \_\_\_\_\_

Current living arrangements:

Family of origin \_\_\_\_\_ Relatives \_\_\_\_\_ Single \_\_\_\_\_  
Married \_\_\_\_\_ Roommates(s) \_\_\_\_\_ Single parent w/children \_\_\_\_\_  
Married w/children \_\_\_\_\_ Significant other \_\_\_\_\_ Other \_\_\_\_\_

### Present Family

If married with children, list your family, beginning with the oldest member and include yourself.

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Family of Origin Primary Household (Family in which you resided the majority of your life)

List your family members, by household, beginning with the oldest member (include parents and self):

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Family of Origin Second Household (if applicable)

Name	Age	Gender	Relationship to you (include step, half, etc.)
_____	_____	_____	_____
_____	_____	_____	_____

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*Mother's Marital Status (indicate all that apply and duration of each, ex. 1965-1985):* Never married\_\_\_\_  
Married\_\_\_\_ Remarried\_\_\_\_ Divorced\_\_\_\_  
Separated\_\_\_\_ Widowed\_\_\_\_ Unknown\_\_\_\_  
Number of Marriages\_\_\_\_

*Father's Marital Status (indicate all that apply and duration of each, ex. 1965-1985):* Never married\_\_\_\_  
Married\_\_\_\_ Remarried\_\_\_\_ Divorced\_\_\_\_  
Separated\_\_\_\_ Widowed\_\_\_\_ Unknown\_\_\_\_  
Number of Marriages\_\_\_\_

\* **HEALTH** \*

*Primary Care Physician:* \_\_\_\_\_  
Name

Address \_\_\_\_\_ Phone \_\_\_\_\_

*Psychiatrist:* \_\_\_\_\_  
Name

Address \_\_\_\_\_ Phone \_\_\_\_\_

*Date of LAST complete physical:* \_\_\_\_\_

*Physical Disability:* Yes No (if yes, explain) \_\_\_\_\_

*Chronic Illness:* Yes No (if yes, explain) \_\_\_\_\_

*Terminal Illness :* Yes No (if yes, explain) \_\_\_\_\_

*Check the following items for a diagnosis or medication you are now receiving or have received:*

Diagnosis	Current	Past	Date of Diagnosis	Name of medication
Depression	_____	_____	_____	_____
ADHD	_____	_____	_____	_____
ADD	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____
Tics	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____
Addictions	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

*If you have been diagnosed, who gave the diagnosis?*

Counselor/Psychologist \_\_\_\_\_ Family Physician \_\_\_\_\_ Psychiatrist \_\_\_\_\_ School \_\_\_\_\_ Other \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

List other medication you are currently taking

Med. _____	Dosage _____
Med. _____	Dosage _____
Med. _____	Dosage _____

**\* CURRENT CONCERNS \***

**Indicate severity of up to 10 items (1-mild; 2-moderate; 3-severe) Circle the item that you see as the most significant issue**

- \_\_\_ Abuse (physical, emotional, sexual)
- \_\_\_ Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc.)
- \_\_\_ Career Dissatisfaction or decisions
- \_\_\_ Disturbing memories (past abuse, neglect or other traumatic experience)
- \_\_\_ Drug or alcohol use (both legal and illegal drugs)
- \_\_\_ Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
- \_\_\_ Family or Step-family relationship
- \_\_\_ Feeling angry or irritable
- \_\_\_ Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
- \_\_\_ Feeling guilty or shameful
- \_\_\_ Feeling sadness or depression or suicidal urges NOT related to grief
- \_\_\_ Feeling sadness or depression or suicidal urges related to grief
- \_\_\_ Health concerns (physical complaints and/or medical problems)
- \_\_\_ Illegal behaviors (repeated run-ins with the law, etc.)
- \_\_\_ Learning/Academic difficulties
- \_\_\_ Non-family relationship (roommates, friends, co-worker, boss, teacher, etc.)
- \_\_\_ Parent-Child relationship (discipline, adoption, single parent, etc.)
- \_\_\_ Personal Growth (no specific problem)
- \_\_\_ Religious or Spiritual concerns
- \_\_\_ Sexual functioning concerns
- \_\_\_ Sexual identity concern
- \_\_\_ Significant other/spouse relationship
- \_\_\_ Sleep problem (nightmares, sleeping too much or too little, etc.)
- \_\_\_ Speech problem (not talking, stuttering, etc.)
- \_\_\_ Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
- \_\_\_ Unusual experiences (loss of periods of time, sensing unreal things, etc.)
- \_\_\_ Other (explain \_\_\_\_\_)

**\*Remember to circle the most significant issue.**

When did you first become concerned about this issue? \_\_\_\_\_

How have you attempted before now to deal with this issue? \_\_\_\_\_

Other treatment you have received to address any of the concerns indicated above: None \_\_\_\_\_

Couples Counseling _____	Group counseling _____	Individual counseling _____
Family counseling _____	Hospitalization _____	Other _____

Anything else you think we need to know \_\_\_\_\_

What is the one thing I need to know to help you today? \_\_\_\_\_

**\* FAMILY HISTORY/EXPERIENCES \***

(For each of the following items that apply, write in your approximate age at the time it occurred):

Raised by:

Adoptive parent(s) _____	Institution _____	Relatives _____
Foster parents _____	Natural parents _____	Single natural parent _____
Grandparents _____	Natural and step-parent _____	Other _____

Stressors in the Family:

Chronic illness of family member _____	Death of significant person _____	Domestic Violence _____
Family member absent (explain) _____		
Family member's disability/major accident/illness _____		
Family member emotional problems (explain) _____		

Family member suicide (explain) \_\_\_\_\_  
 Financial problems \_\_\_\_\_ Moved a lot \_\_\_\_\_ Parents arguing frequently \_\_\_\_\_ Parents divorced \_\_\_\_\_  
 Other \_\_\_\_\_  
 History of learning, emotional, behavioral problems: Yes No  
 (If yes, please explain) \_\_\_\_\_

*History of alcohol/drug/substance abuse:* Yes No  
 (If yes, please explain) \_\_\_\_\_

*History of family violence:* Yes No  
 (If yes, please explain) \_\_\_\_\_

*History of criminal activity:* Yes No  
 (If yes, please explain) \_\_\_\_\_

*Abused* (check all that apply): Physically \_\_\_\_\_ Emotionally \_\_\_\_\_ Sexually \_\_\_\_\_  
*Neglected* (check all that apply): Physically \_\_\_\_\_ Emotionally \_\_\_\_\_

*School Problems* (check all that apply):  
 Academic problems \_\_\_\_\_ Discipline problems \_\_\_\_\_ Severely teased \_\_\_\_\_ Unpopular \_\_\_\_\_  
 Other \_\_\_\_\_

*Early Language/Speech Problems* (explain) \_\_\_\_\_

*Emotional Concerns:*

Appetite change _____	Heard voices _____	Suicidal thoughts _____
Emotional problems _____	Loss of energy or fatigue _____	Suicide attempts _____
Gained weight _____	Lost weight _____	Other _____

*Behavior Problems* (check all that apply):

Accident-prone _____	Aggressive Behavior (explain) _____		
Alcohol/drug use _____	Attention problems _____	Frequent arguments _____	Hyperactive _____
Impulsive _____	Loner _____	Misbehaved a lot _____	Ran away _____
Taken advantage of _____	Temper outbursts _____	Trouble with the law _____	Other _____

*Anxiety Symptoms* (indicate all that apply):

Irritable _____	Obsessive worrying _____	Physical symptoms (below) _____
Keyed up, on edge _____	Phobias _____	Other _____

*Health/Physical Problems* (check all that apply):

Asthma _____	Disability _____	Nervous stomach _____
Bedwetting _____	Dizziness _____	Neurological problems/exam _____
Bone/joint/muscle _____	Headache (kind) _____	PMS _____
Chest pain _____	Heart Palpitations _____	Serious overeating/undereating _____
Chronic illness _____	Hospitalization _____	Shortness of breath without exertion _____
Developmental delay(s) _____	Major accident _____	Sleep problem _____
Diarrhea _____	Major illness _____	Surgeries _____ Other _____

*Dissociative Symptoms* (check all that apply):

Amnesia of large parts of childhood after age 5 _____	Things of yours that are missing _____
Memories suddenly flashback _____	Trance-like episodes/lost track of time _____
Things appear but you don't know origin _____	Walk in sleep _____

*Trauma/Stressor* (check all that apply):

Child separated from parent (how long and when) \_\_\_\_\_  
Death of a pet \_\_\_\_\_ Death of a significant person \_\_\_\_\_ Incarcerated family member \_\_\_\_\_  
Medical \_\_\_\_\_ Natural Disaster \_\_\_\_\_ Sexual Assault \_\_\_\_\_  
Victim of trauma (unusual, terrifying experience) \_\_\_\_\_ Other \_\_\_\_\_

*Interpersonal Problems* (check all that apply):

Aggressive behavior (explain) \_\_\_\_\_  
Bullied \_\_\_\_\_ Taken advantage of \_\_\_\_\_  
Frequent arguments \_\_\_\_\_ Temper outbursts \_\_\_\_\_  
Loner \_\_\_\_\_ Other \_\_\_\_\_

*Specific to Adulthood* (check all that apply):

Abortion \_\_\_\_\_  
Changes in the last 12 months (getting married, becoming a parent, moves, change in employment, etc.) \_\_\_\_\_  
Parenting/Discipline problems \_\_\_\_\_ Placing child for adoption \_\_\_\_\_  
Sexual (explain) \_\_\_\_\_ problem \_\_\_\_\_

*Family of Origin Atmosphere* (circle the number that best describes how you viewed your family while you were growing up):

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

*Family of Origin Support System* (such as church, friends, relatives, school)

Hardly any support 1 2 3 4 5 Considerable support

*Family Atmosphere* (circle the number that best describes how you view your current family, if applicable):

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

*Family Support System* (such as church, friends, relatives, school)

Hardly any support 1 2 3 4 5 Considerable support

*Your current use of Computer, VCR, and Television* (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

## REFERENCES

- Abidin, R. R. (2012). *Parenting stress index* (4<sup>th</sup> ed.). Lutz, FL: PAR.
- Alivandi Vafa, M., & Khaidzir, I. (2009). Reaching out to single parent children through filial therapy. *US-China Education Review*, 6(2), 1-12.
- American Counseling Association (2014). ACA Code of Ethics. Alexandria, VA: Author.
- American Educational Research Foundation. (2016). *AERA offers definition of scientifically based research*. Retrieved from <http://www.aera.net/AboutAERA/KeyPrograms/EducationResearchandResearchPolicy/AERAOffersDefinitionsofScientificallyBasedRes/tabid/10877/Default.aspx>
- American Psychological Association. (2014). *Stress in America: Paying with our health*. Washington D. C.: Author.
- American Psychological Association. (2015). *Policy statement on evidence-based practice in psychology*. Retrieved from <http://www.apa.org/practice/guidelines/evidence-based-statement.aspx>
- Astramovich, R. L., & Coker, J. K. (2007). Program evaluation: The accountability bridge model for counselors. *Journal of Counseling & Development*, 85, 162-172.
- Athanasiou, M. S., & Gunning, M. P. (1999). Filial therapy: Effects on two children's behavior and mothers' stress. *Psychological Report*, 84(2), 587-590.
- Austin, D. M. (1998). *A report on progress in the development of research resources in social work*. Austin, TX: University of Texas School of Social Work.
- Axline, V. (1947). *Play therapy: The inner dynamics of childhood*. Cambridge, MA: Houghton Mifflin.

- Baggerly, J., & Parker, M. (2005). Child-centered group play therapy with African American boys at the elementary school level. *Journal of Counseling and Development, 83*, 387-396.
- Barker, R. (Ed.). (2014). *The social work dictionary* (6<sup>th</sup> ed.). Washington, DC: NASW Press.
- Barrio Minton, C. (2015, April). *Statistics Refresher*. Presentation in Research in Counseling course, University of North Texas.
- Baum, A. (1990). Stress, intrusive imagery and chronic distress. *Health Psychology, 9*, 653-675.
- Bavin-Hoffman, R., Jennings, G., & Landreth, G. (1996). Filial therapy: Parental perceptions of the process. *International Journal of Play Therapy, 5*(1), 45-58.
- Berk, L. E. (2010). *Development through the lifespan* (5<sup>th</sup> ed.). Boston: Allyn & Bacon.
- Bingham, R. D., & Felbinger, C. L. (2002). *Evaluation in practice: A methodological approach* (2<sup>nd</sup> ed.). New York, NY: Chatham House.
- Bornsheuer, J., Garza, Y., & Nichter, M. (2012). Biblically based parenting and child-parent relationship training: Common ground for helping religious clients. *Mental Health, Religion & Culture, 15*(1), 53-64.
- Bornsheuer-Boswell, J. N., Garza, Y., & Watts, R. E. (2013). Conservative Christian parents' perceptions of Child-Parent Relationship Therapy. *International Journal of Play Therapy, 22*(3), 143-158.
- Bowlby, J. (1969). *Attachment and loss*. New York: NY: Basic Books.
- Boyer, W. (2011). Using child parent relationship therapy (CPRT) with our First Nations People. *International Journal of Play Therapy, 20*(1), 38-49.



- Bratton, S., & Landreth, G. (1995). Filial therapy with single parents: Effects on parental acceptance, empathy, and stress. *International Journal of Play Therapy*, 4(1), 61-80.
- Bratton, S. C., Landreth, G., Kellum, T., & Blackard, S. (2006). *Child parent relationship therapy (CPRT) treatment manual: A ten session filial therapy model for training parents*. New York: Routledge.
- Bratton, S. C., Landreth, G. L. & Lin, Y. D. (2010). Child Parent Relationship Therapy: A review of controlled-outcome research. In J. N. Baggerly, D. C. Ray, & S. C. Bratton (Eds.), *Child-centered play therapy research: The evidence base for effective practice* (pp. 267-293). New Jersey: John Wiley & Sons.
- Bratton, S. C., Opiola, K., & Dafoe, E. (2015) Child-Parent Relationship Therapy: A 10-session filial therapy model. In D. A. Crenshaw & A. L. Stewart (Eds.), *Play therapy: A comprehensive guide to theory and practice* (pp. 129-140). New York: The Guilford Press.
- Capps, J. E. (2012). Strengthening foster parent-adolescent relationships through filial therapy. *The Family Journal: Counseling and Therapy for Couples and Families*, 20(4), 427-432.
- Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, 56(2), 267-283.
- Ceballos, P. L., & Bratton, S. C. (2010). Empowering Latino families: Effects of a

- culturally responsive intervention with low-income immigrant Latino parents on children's behaviors and parental stress. *Psychology in the Schools*, 47(8), 761-775.
- Chau, I. Y., & Landreth, G. L. (1997). Filial therapy with Chinese parents: Effects on parental empathic interactions, parental acceptance of child and parental stress. *International Journal of Play Therapy*, 6(2), 75-92.
- Chen, H. (2005). *Practical program evaluation: Assessing and improving planning, implementation, and effectiveness*. Thousand Oaks, CA: Sage.
- Cicchetti, D., & Walker, E. F. (2001). Stress and development: Biological and psychological consequences. *Development and Psychopathology*, 13(3), 413-418.
- Conner, M. G. (2000). Understanding the difference between men and women. Retrieved from <http://www.oregoncounseling.org/ArticlesPapers/Documents/DifferencesMenWomen.htm>
- Cornett, N., & Bratton, S. C. (2014). Examining the impact of child parent relationship therapy (CPRT) on family functioning. *Journal of Marital and Family Therapy*, 40(3), 302-318.
- Costas, M., & Landreth, G. (1999). Filial therapy with nonoffending parents of children who have been sexually abused. *International Journal of Play Therapy*, 8(1), 43-66.
- Danforth, J. S. (2007). Training with parents of children with comorbid Attention-

- Deficit/Hyperactivity Disorder and Oppositional Defiant Disorder. In J. M. Briesmeister & C. E. Schaefer (Eds.), *Handbook of parent training: Helping parents prevent and solve problem behaviors*. (pp.345-378). Danvers, MA: John Wiley & Sons, Inc.
- Deater-Deckard, K. (1998). Parenting stress and child adjustment: Some old hypotheses and new questions. *Clinical Psychology: Science and Practice*, 5, 314-332.
- Deater-Deckard, K. (2004). *Parenting stress*. New Haven, CT: Yale University.
- Diller, J. V. (2011). *Cultural diversity: A primer for the human services*. Belmont, CA: Brooks/Cole.
- Edwards, N. A., Ladner, J., & White, J. (2007). Perceived Effectiveness of filial therapy for a Jamaican mother: A qualitative case study. *International Journal of Play Therapy*, 16(1), 36-53.
- Edwards, N. A., Sullivan, J. M., Meany-Walen, K., & Kantor, K. R. (2010). Child Parent Relationship Training: Parents' perceptions of process and outcome. *International Journal of Play Therapy*, 19(3), 159-173.
- Foley, Y. C., Higdon, L., & White, J. F. (2006). A qualitative study of filial therapy: Parents' voices. *International Journal of Play Therapy*, 15(1), 37-64.
- Friedman, E. & Billick, S. B. (2014). Unintentional child neglect: Literature review and observational study. *Psychiatric Quarterly*, 86, 253-259.
- Fuchs, N. (1957). Play therapy at home. *Merrill-Palmer Quarterly*, 3, 89-95.
- Gall, J. P., Gall, M. D., & Borg, W. R. (2005). *Applying educational research: A practical guide*. Boston, MA: Pearson.

- Garza, Y., Kinsworthy, S., & Watts, R. E. Child-parent relationship training as experienced by Hispanic parents: A phenomenological study. *International Journal of Play Therapy*, 18(4), 217-228.
- Garza, Y., Watts, R. E., & Kinsworthy, S. (2007). Filial therapy: A process for developing strong parent-child relationships. *The Family Journal: Counseling and Therapy for Couples and Families*, 15(3), 277-281.
- Glazer, H. R., & Kottman, T. (1994). Filial therapy: Rebuilding the relationship between parents and children of divorce. *Journal of Humanistic Education & Development*, 33(1), 4-13.
- Glazer-Walderman, H. R., Zimmerman, J. E., Landreth, G. L., & Norton, D. (1992). Filial therapy: An intervention for parents of children with chronic illness. *International Journal of Play Therapy*, 1(1), 31-42.
- Glover, G. J., & Landreth, G. L. (2000). Filial therapy with Native Americans on the Flathead reservation. *International Journal of Play Therapy*, 9(2), 57-80.
- Good, P. I. & Hardin, J. W. (2010). *Common errors in statistics (and how to avoid them)*. Hoboken, NJ: John Wiley & Sons.
- Guerney, B. (1964). Filial therapy: Description and rationale. *Journal of Counseling Psychology*, 28(4), 304-310.
- Guerney, L. F. (1995). *Parenting: A skills training manual* (5<sup>th</sup> ed.). Maryland: Ideals.
- Harris, Z. L., & Landreth, G. L. (1997). Filial therapy with incarcerated mothers: A five week model. *International Journal of Play Therapy*, 6(2), 53-73.
- Hastings, R. P., Kovshoff, H., Brown, T., Ward, N. J., Espinosa, F. D., & Remington, B.

- (2005). Coping strategies in mothers and fathers of preschool and school-aged children with autism. *Autism: The International Journal of Research and Practice*, 9(4), 377-391.
- Hawley, L. D., Leibert, T. W., & Lane, J. A. (2014). The relationship between socioeconomic status and counseling outcomes. *Professional Counselor*, 4(4), 390-403.
- Heppner, P. P., Wampold, B. E., Owen, J., Thompson, M. N., & Wang, K. T. (2016). *Research design in counseling* (4<sup>th</sup> ed.). Boston, MA: Cengage Learning.
- Jang, M. (2000). Effectiveness of filial therapy for Korean parents. *International Journal of Play Therapy*, 9(2), 21-38.
- Johnson, B., & Christensen, L. (2008). *Educational research: Quantitative, qualitative, and mixed approaches*. Los Angeles: Sage.
- Johnson, L., Bruhn, R., & Winek, J. (1999). The use of child-centered play therapy and filial therapy with Head Start families: A brief report. *Journal of Marital & Family Therapy*, 25(2), 169-176.
- Kale, A. L., & Landreth, G. L. (1999). Filial therapy with parents of children experiencing learning difficulties. *International Journal of Play Therapy*, 8(2), 35-56.
- Kapp, S. A., & Anderson, G. R. (2010). *Agency-based program evaluation: Lessons from practice*. Thousand Oaks, CA: Sage.
- Kazdin, A. E. (1999). The meanings of and measurement of clinical significance. *Journal of Counseling and Clinical Psychology*, 67, 332-339.
- Kidron, M., & Landreth, G. (2010). Intensive Child Parent Relationship Therapy: With Israeli parents in Isreal. *International Journal of Play Therapy*, 19(2), 64-78.

- Kinsworth, S., & Garza, Y. (2010). Filial therapy with victims of family violence: a phenomenological study. *Journal of Family Violence, 25*, 423-429
- Kolos, A. C., Green, E. J., & Crenshaw, D. A. (2009). Conducting filial therapy with homeless parents. *American Journal of Orthopsychiatry, 79*(3), 366-374.
- Kotelchuck, M. (2006). Pregnancy risk assessment monitoring system (PRAMS): Possible new roles for a national MCH data system. *Public Health Reports, 121*(1), 6-10.
- Kraft, A., & Landreth, G. (1998). *Parents as therapeutic partners: Listening to your child's play*. New Jersey: Jason Aronson.
- Landreth, G. L., & Bratton, S. C. (2006). *Child Parent Relationship Therapy (CPRT): A 10-session filial therapy model*. New York: Routledge.
- Landreth, G., Homeyer, L., Bratton, S., Kale, A., & Hilpl, K. (Eds.). (2000). *The world of play therapy literature: A definitive guide to authors and subjects in the field* (3<sup>rd</sup> ed.). Denton: Center for Play Therapy.
- Landreth, G. L., & Lobaugh, A. F. (1998). Filial therapy with incarcerated fathers: Effects on parental acceptance of child, parental stress, and child adjustment. *Journal of Counseling & Development, 76*, 157-165.
- Lazarus, R. S. (1993). From psychological stress to the emotions: A history of changing outlooks. *Annual Review of Psychology, 44*(1), 1-22.
- Lee, M., & Landreth, G. L. (2003). Filial therapy with immigrant Korean parents in the United States. *International Journal of Play Therapy, 12*(2), 67-85.
- Lim, S., & Ogawa, Y. (2014). "Once I had kids, now I am raising kids": Child-parent

- relationship therapy (CPRT) with a Sudanese refugee family – a case study. *International Journal of Play Therapy*, 23(2), 70-89.
- Lin, Y. D., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy approaches. *Journal of Counseling and Development*, 93(1), 45-58.
- Marshall, C., & Rossman, G. (2006). *Designing qualitative research* (4<sup>th</sup> ed.). Thousand Oaks, CA: Sage.
- McDavid, J. C., & Hawthorn, L. R. L. (2006). *Program evaluation & performance measurement: An introduction to practice*. Thousand Oaks, CA: Sage.
- Newcomer, K. E., Hatry, H. P., & Wholey, J. S. (2015). *Handbook of practical program Evaluation* (4<sup>th</sup> ed.). New Jersey: John Wiley & Sons.
- Pallant, J. (2013). *SPSS survival manual: A step by step guide to data analysis using IBM SPSS*. New York, NY: McGraw-Hill.
- Patnaik, G. (2014). Life skill enhancement strategies to minimize stress. *Social Science International*, 30(2), 281-289.
- Rahe, R. H. (1974). The pathway between subject's recent life changes and their near future illness reports: Representation results and methodological issues. In B. S. Dohrenwend & B. P. Dohrenwend (Eds.). *Stressful life events* (p. 73-86). New York: Wiley.
- Ray, D., Bratton, S. C., & Brandt, M. A. (2010). Filial/family play therapy for single parents of young children attending community colleges. *Community College Journal of Research and Practice*, 24(6), 469-486.
- Rennie, R. & Landreth, G. (2000). Effects of filial therapy on parent and child behaviors. *International Journal of Play Therapy*, 9(2), 19-37.

- Royse, D., Thyer, B. A., & Padgett, D. K. (2016). *Program evaluation: An introduction to an evidence-based approach*. Boston, Massachusetts: Cengage Learning.
- Rubin, A., & Bellamy, J. (2012). *Practitioner's guide to using research for evidence-based practice*. Hoboken, NY: John Wiley & Sons.
- Ryan, V. (2007). Filial therapy: Helping children and new carers to form secure attachment relationships. *British Journal of Social Work*, 37, 643-657.
- Rye, N. (2006). Empowering the parent. *Therapy Today*, 17(7), 4-5.
- Santiago, C. D., Etter, E. M., Wadsworth, M. E., & Raviv, R. (2012). Predictors of responses to stress among families coping with poverty-related stress. *Anxiety, Stress & Coping*, 25(3), 239-258.
- Selye, H. (1974). *Stress without distress*. Philadelphia: J. P. Lippincott.
- Sheely, A., & Bratton, S. C. (2010). A strengths-based parenting intervention with low-income African-American families. *Professional School Counseling*, 13(3), 175-183.
- Smith, M. J. (2010). *Handbook of program evaluation for social work and health professionals*. New York, NY: Oxford University.
- Smith, N. & Landreth, G. (2003). Intensive filial therapy with child witnesses of domestic violence: A comparison with individual and sibling group play therapy. *International Journal of Play Therapy*, 12(1), 67-88.
- Solis, C. M., Meyers, J., & Varjas, K. M. (2004). A qualitative case study of the process and impact of filial therapy with an African American parent. *International Journal of Play Therapy*, 13(2), 99-118.
- Steele, H., Bate, J., Steele, M., Danskin, K., Knafo, H., Nikitades, A., Dube, S. R.,



- Bonuck, K., Meissner, P., & Murphy, A. (2016). Adverse childhood experiences, poverty, and parenting stress. *Canadian Journal of Behavioral Science, 48*(1), 32-38.
- Stover, L., & Guerney, B. G. (1967). The efficacy of training procedures for mothers in filial therapy. *Psychotherapy: Theory, Research, and Practice, 4*(3), 110-115.
- Sturge-Apple, M. L., Suor, J. H., & Skibo, M. A. (2014). Maternal child-centred attributions and hard discipline: The moderating role of maternal working memory across socioeconomic contexts. *Journal of Family Psychology, 28*(5), 645-664.
- Sue, S. (2003). Science, ethnicity, and bias: Where have we gone wrong? In A. E. Kazdin (Ed.), *Methodological issues and strategies in clinical research* (pp. 173-188). Washington, DC: American Psychological Association.
- Tabachnic, B. G., & Fidell, L. S. (2006). *Using multivariate statistics*. Boston, MA: Pearson.
- Taylor, D., Purswell, K., Lindo, N., Jayne, K., & Fernando, D. (2011). The impact of Child Parent Relationship Therapy on child behavior and parent-child relationships: An examination of parental divorce. *International Journal of Play Therapy, 20*(3), 124-137.
- Tew, K., Landreth, G. L., Joiner, K. D., & Solt, M. D. (2002). Filial therapy with parents of chronically ill children. *International Journal of Play Therapy, 11*(1), 79-100.
- Tsai, M. (2009). *Children in therapy: Evaluation of university-based play therapy clinical services*. University of North Texas, Texas.
- University of Minnesota. (2015). *Parents and stress: Understanding experiences, context and responses*. Minnesota: Regents of the University of Minnesota.

- Van Fleet, R. (2009). *Filial therapy: Strengthening parent-child relationships through play* (3<sup>rd</sup> ed). Sarasota, FL: Professional Resource Press.
- Vera, E. M., & Reese, L. E. (2000). Preventive interventions with school-age youth. In S. D. Brown, R. W. Lent, S. D. Brown, R. W. Lent (Eds.), *Handbook of counseling psychology* (3<sup>rd</sup> ed.) (pp. 411-434). Hoboken, NJ: John Wiley & Sons.
- Vision North Texas. (2009). *North Texas Now*. Retrieved from [http://www.visionnorthtexas.org/regionalchoices/RegChoices\\_NorthTexasNow\\_1.pdf](http://www.visionnorthtexas.org/regionalchoices/RegChoices_NorthTexasNow_1.pdf)
- Whiteside-Mansell, L., Ayoub, C., McKelvey, L., Faldowski, R. A., Hart, A., & Shears, J. (2007). Parenting stress of low-income parents of toddlers and pre-schoolers: Psychometric properties of a short form of the Parenting Stress Index. *Parenting: Science and Practice*, 7, 26-56.
- Wickstrom, A. (2009). The process of systemic change in filial therapy: A phenomenological study of parent experience. *Contemporary Family Therapy*, 31(1), 193-208.
- Wickstrom, A. C., & Falke, S. I. (2013). Parental perceptions of an advanced filial therapy model. *Contemporary Family Therapy*, 35, 161-175.
- Winek, J., Lambert-Shute, J., Johnson, L., Shaw, L., Krepps, J., & Wiley, K. (2003). Discovering the moments of movement in filial therapy: A single case qualitative study. *International Journal of Play Therapy*, 12(1), 89-104.
- Yuen, T., Landreth, G., & Baggerly, J. (2002). Filial therapy with immigrant Chinese families. *International Journal of Play Therapy*, 11(2), 63-90.