AN EXPLORATION STUDY OF THE RELATIONSHIP BETWEEN EFFECTIVENESS OF FILIAL THERAPY TRAINING GROUPS AND GROUP COHESION

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This study examined the relationship of group cohesion among heterogeneous and homogeneous groups on individual treatment outcome of child-parent relationship therapy (CPRT). CPRT is a filial therapy model that targets the parent-child relationship as a means for preventing or improving child and/or family problems. This study included 30 parents or caregivers from 9 groups which met for 10 sessions. Participants qualified for this study if their groups ended with at least 3 group members and 2 leaders, all pretest and posttest data on their child between the ages of 2-11 was completed, and if they attended at least 6 of the 10 sessions. Correlation coefficients, t-tests, and effect sizes were calculated.

Results demonstrated no statistically significant differences between pretests and posttests on the Child Behavior Checklist (CBCL) for all 30 participants; however, differences in measured effect ($\eta^2$) between children identified with borderline and clinical behavior problems and children with normal behavior problems suggest that CPRT is more effective among children who demonstrate significant behavior problems. Perceived and observed group cohesion measurements demonstrated no significant difference at the individual outcome level. This finding suggests that group cohesion may not be related to individual outcome. Although there was no significant relationship between group cohesion and individual outcome for this study, results of the group measurements regarding engagement and group cohesiveness, coupled with previous studies on CPRT effectiveness, suggest that CPRT should be utilized in homogeneous groups.
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF ILLUSTRATIONS</td>
<td>vi</td>
</tr>
</tbody>
</table>

Chapter

1. INTRODUCTION ................................................................. 1
   Statement of the Problem ........................................... 5
   Review of Related Literature .................................... 6
   Summary of Literature ............................................... 31
   Purpose of the Study ................................................. 32

2. METHODS AND PROCEDURES ............................................. 33
   Research Hypotheses ................................................. 33
   Definition of Terms ................................................ 34
   Instrumentation ...................................................... 36
   Participant Selection ............................................... 42
   Procedures ............................................................ 46
   Analysis of Data .................................................... 50

3. RESULTS AND DISCUSSION ............................................ 59
   Results ......................................................................... 59
   Discussion .................................................................... 69
   Limitations ................................................................... 93
   Research Implications .............................................. 97
   Recommendations for Future Research ......................... 98

APPENDIX .............................................................................. 100

   A. CONSENT FORM .................................................... 100
   B. CPRT PROTOCOL .................................................. 104

REFERENCES .......................................................................... 111
### LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Participants’ Presenting Concerns and Rationale for Participating in CPRT</td>
<td>43</td>
</tr>
<tr>
<td>2. Demographic Information for Filial Therapy Group Leaders and Co-leaders</td>
<td>44</td>
</tr>
<tr>
<td>3. Demographic Information for Participants in This Study</td>
<td>45</td>
</tr>
<tr>
<td>4. Demographic Information for Children in This Study</td>
<td>46</td>
</tr>
<tr>
<td>5. Participants’ Information at the Individual Level</td>
<td>54</td>
</tr>
<tr>
<td>6. Demographics, Presenting Concerns, and CBCL Results for Participants’ Child of Focus</td>
<td>56</td>
</tr>
<tr>
<td>7. Averaged Participants’ Information for a Group Total Score</td>
<td>58</td>
</tr>
<tr>
<td>8. Mean Scores on the Total Problems Scale of the Child Behavior Checklist (CBCL)</td>
<td>60</td>
</tr>
<tr>
<td>9. Participants’ Engaged Scores and Total Problems Outcome Scores</td>
<td>61</td>
</tr>
<tr>
<td>10. Participants’ CBCL Outcome Scores and Their Group’s Global Cohesiveness Scores</td>
<td>64</td>
</tr>
</tbody>
</table>
LIST OF ILLUSTRATIONS

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Correlation of GCQ-S Engaged Scores and CBCL Total Problems</td>
<td>62</td>
</tr>
<tr>
<td>Outcome Scores</td>
<td></td>
</tr>
<tr>
<td>2. Correlation of GCS-II Cohesiveness Scores and CBCL Total Problems</td>
<td>66</td>
</tr>
<tr>
<td>Outcome Scores</td>
<td></td>
</tr>
<tr>
<td>3. Correlation of GCQ-S Engaged Scores and GCS-II Cohesiveness Scores</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 1

INTRODUCTION

Raising a child is the most important responsibility that an adult can undertake. However, “few parents are prepared to deal with the challenges of child rearing as these challenges relate to the emotional needs of children” (White & Mullis, 1996, p. 47). Despite a widespread recognition of the importance of family relationships and the quality of family life on the psychological, physical, social and economic well-being of children, many parents receive little preparation for parenthood beyond their own personal experience of being parented. Parent education is of the utmost importance since today’s parents face very different challenges than those faced by their own parents. Today’s families are under a great deal of stress related to teenage or single parenting as well as transitions such as divorce, moving, or blending two families together (White & Mullis, 1996).

Data support the need for parenting programs because many parents may not have other resources for learning about child-rearing techniques (Conroy & Mayer, 1994). Providing parents with systematic child rearing techniques is a valuable contribution to the welfare of children. Researchers have shown that parent education can be effective in several important ways. Parent education provides an extension of treatment environments, ensures continuity of treatment, and assists parents in taking active roles in their children’s development (Stahmer & Gist, 2001). Parent education approaches have been shown to change attitudes toward family decision making, increase parenting skills, and affect parent-child communication and child learning (Conroy & Mayer, 1994).
All parents must learn to support and challenge their children’s development (Conroy & Mayer, 1994). Parents who want to help their children succeed and become productive adults face common challenges such as disciplining, fostering self-esteem, developing independence, developing responsibility, and improving communication. These issues can be addressed effectively in parent education groups. Practitioners typically choose group methods to teach parent education due to cost-effective measures. A review of the parent education literature indicates that the structured group format is the preferred method for providing parent training regardless of the theoretical approach being used. Case and Dalley (2006) stated, “Humans live in family and social groups and children cannot survive infancy without firstly a prime carer, usually a mother, but also a further supportive network for the mother whether it is nuclear family, extended family or state” (p. 195).

White and Mullis (1996) reported that psychoeducational groups are preferable to individual counseling for developing parenting skills. They noted that training parents in groups provides an economical method for reaching large numbers of people who can see that their problems relate to typical child rearing issues where reeducation is more appropriate than therapy. Moreover, some of the “curative factors” of psychotherapy groups discussed by Yalom (1985) are helpful elements in parent education groups (Conroy & Mayer, 1994). In the parent education group setting, universality occurs as individual parents learn that other parents have similar problems and feelings. In addition, the support of others instills hope, and parents benefit from sharing and learning strategies from other parents as well as the group leaders.

Moreover, a systematic review of the research on parent education groups indicates that the group-based models are more effective than individual program formats (Thomas,
Camiletti, Cava, Feldman, Underwood, & Wake, 1999; Barlow, 1999). The reviews of numerous studies demonstrate that a major component of parent training groups is the provision of social support. Researchers have shown that the social support component helps parents to decrease their feelings of stigma and isolation.

Filial therapy is a psychoeducational model based on client-centered, dynamic, behavioral, and family systems principles (VanFleet, 1994, 2005). Filial therapy offers significant possibilities for promoting the well-being of parents by equipping them with healthy parenting skills and providing emotional support. Filial therapy is unique in that it combines a group counseling format with didactic instruction. One parent stated, “I’ve taken so many classes in parenting...but I already see a real difference in filial training. I will experience it!” (Lahti, 1993, p. 48). This suggests that parents notice and value the unique aspects of filial therapy even in initial sessions of the training. Lahti concluded that the skillful balancing of the didactic element of filial therapy with a group process/therapy element may be the primary key to the manner in which filial therapy effectively facilitates change.

The majority of parenting programs are primarily educational in nature, teaching different types of parenting skills. However, in filial therapy, parents learn not only skills, but also, in the context of a safe, reassuring, supportive, nonthreatening environment, focus on self-exploration and enhancement of the parent-child relationship. Landreth and Bratton (2006) stated that the supportive format in a filial therapy, also termed Child Parent Relationship Therapy (CPRT), group “often resembles group therapy as the leader responds empathically to parents’ issues and emotional reactions related to their family or their role as parents” (p. 47).
In addition, they suggest that the supportive environment in their CPRT filial therapy model facilitates risk taking which leads to behavioral change.

The process or group therapy component of the CPRT filial model is unique and vital to the success of training parents to be effective therapeutic agents of change with their children. The group process component is essential because “parents often have strong reactions to their children and feelings about themselves and their family members that they need to process in order to be fully present and emotionally available to learn what is being taught in the CPRT training sessions” (Landreth & Bratton, 2006, p. 17). Moreover, allowing and encouraging parents to process their feelings and reactions about their children promotes the beginning of change in parents’ perceptions about their children. Landreth and Bratton stated that the effectiveness of filial therapy training is “dependent on parents actively processing personal issues related to themselves, their children, the play sessions, and their family” (p. 20).

Researchers have clearly shown that filial therapy works (Bratton, Ray, Rhine, & Jones, 2005), but there is no research on the variables that account for its level of effectiveness. Rennie and Landreth (2000) stated, “We still do not know about the process of filial therapy training” (p. 32). They encouraged further research into the specific dynamics of this approach to parent training. Glass (1986) argued that there is an apparent lack of breadth and depth in that the research studies fail to address the multiple facets of filial therapy.

Many researchers have speculated that the support and encouragement among parents in the group contributes to the decrease in pathological symptoms (e.g., parental stress). Although the research is plentiful regarding the effectiveness of filial therapy, there is a paucity of research in the current literature regarding the group process as a component of filial
therapy. Landreth and Bratton (2006) listed (a) “normalizing and generalizing individual parental concerns and fears to the group, (b) encouraging a parent to explore thoughts and feelings more fully, and (c) building group cohesion to encourage or teach members” as the facilitative group process components of the CPRT filial model (p. 51). The focus of this study was to lend information to filial therapy research regarding whether group cohesion is significantly related to positive outcome in the CPRT model of filial therapy.

Statement of the Problem

Filial therapy, a psychoeducational parent training model seeks to train parents, typically in a group setting, to develop better relationships with their children and improve child behavior problems through play therapy skills. There is an extensive amount of published literature regarding positive effects of filial therapy on behavioral problems, social adjustment, self-esteem, parent stress, parental acceptance, empathic interactions, and improved communication between parent and child. However, historically, research on filial therapy has only addressed its effectiveness (Landreth & Bratton, 2006). Currently, there is no cited research on the process variables that explain the treatment’s effectiveness. Group counseling experts (e.g., Yalom, 1995; MacKenzie, Dies, Coche, Rutan, & Stone, 1987; Ogrodniczuk & Piper, 2003; Castonguay, Pincus, Auras, & Hines, 1998; Hurley, 1989; Kivlough & Goldfine, 1991; Stokes, 1983; Marziali, Munroe-Blum, & McCleary, 1997; Taft, Murphy, King, Musser, & DeDeyn, 2003; Braaten, 1989; Budman, Soldz, Demby, Feldstein, Springer, & Davis, 1989) report that interpersonal process variables including group climate and interpersonal support between group members are significantly related to group outcome. Furthermore, filial literature postulates that group process is a therapeutic healing factor of filial therapy (Landreth & Bratton). Thus, there is a need to
investigate the relationship between process variables (group climate and group cohesiveness) and effectiveness of filial therapy.

Review of Related Literature

The review of literature concentrates on the following elements: (a) group process research; (b) support levels within parent education support groups; (c) effectiveness of filial therapy; and (d) group process dynamics in filial therapy.

Unique Aspects of Group Process/Therapy

Group process literature reports several unique aspects of and learning advantages for using a group approach. Among many valid reasons for using a group approach are the feeling of commonality, the experience of belonging, the chance to practice new behaviors, the opportunity for feedback, the opportunity for vicarious learning by listening to and observing others, the approximation to real-life encounters, and the pressure to uphold commitments (Jacobs, Masson, & Harvill, 2002). Through group process, group members enable both themselves and others (Johnson, in press).

Whitaker and Lieberman (1964) proposed that: (a) groups have a common underlying concern; (b) diverse events can be linked; (c) members act to reduce anxiety; (d) successful solutions are those that are shared by all members; and (e) solutions are either restrictive or enabling. The central themes are that process can describe what is happening, feared, and needed for both the individual and for the group as a whole, and whatever is happening in the group affects all members in some way. Moreover, much of what the group experiences as a whole takes place on an unconscious level and is manifested by each member in personally unique ways.
Fuhriman and Burlingame (1990) conducted a comparative analysis of individual and group process variables. They identified six factors as unique to group therapy situations. These therapeutic factors involved: (1) vicarious learning (client improvement in response to the observation of another group member’s experience); (2) role flexibility (client as both help seeker and help provider); (3) universality (group member’s realization that other members are struggling with similar problems); (4) altruism (client’s offering of support and encouragement to other group members); (5) family reenactment (resemblance of group to one’s family of origin); and (6) interpersonal learning (learning from interaction with other clients).

Fuhriman and Burlingame (1990) also addressed other learning experiences unique to group therapy, such as participating in a social microcosm. Similarly, Holmes and Kivlighan (2000) stated that the group environment is a representation of the outside environment for each of the individuals, but with greater safety and support. Fuhriman and Burlingame noted that the group setting allows clients opportunities to work therapeutically through transference. The group format also provides a forum for the giving and receiving of feedback and validation from people other than the therapist. Moreover, the client can experience role versatility in that he or she shifts between being a “help seeker” and a “help provider for other group members” (Fuhriman & Burlingame).

Holmes and Kivlighan’s (2000) study evaluated therapeutic processes in both group and individual treatment modalities. They expected a stronger endorsement of the relationship-climate component in group treatment because of the relational nature of the factors already established by Fuhriman and Burlingame (1990). Critical incident information obtained from twenty individual and twenty group clients was rated on four dimensions of session impact: (1)
emotional awareness-insight, (2) relationship-climate, (3) other-versus self-focus, and (4) problem definition-change using the Group Counseling Helpful Impacts Scale. Results indicated that there are, in fact, different factors reflecting different processes that occur in group versus individual treatments. Holmes and Kivlighan found that the components of relationship-climate and other-versus self-focus were more prominent in group, whereas emotional awareness-insight and problem definition-change were more central to the process of individual treatment. Because of the interactional and interpersonal nature of both the other-versus self-focus and relationship-climate components, it seems logical that these components would be more prominent in a treatment modality in which greater opportunity exists for interaction and relationship, as occurs in the group setting.

Holmes and Kivlighan’s (2000) finding of the importance of other-versus self-focus in group treatment is consistent with the hypotheses offered by Fuhriman and Burlingame (1990) that universality, altruism, and vicarious learning are unique to group treatment. They concluded that group therapy provides the basis for the development of many relationships for every group member, both between group members and with the group therapist(s). Thus, not only are member-therapist relationships important, but member-member relationships are also important. In addition, each group member may experience, through observation and participation, the therapy of other group members in addition to his or her own therapy. Furthermore, in a group setting, there are more people with whom one may learn, identify, disclose, and form significant therapeutic relationships. The supportive relationships created and maintained by group members working together toward similar goals can have substantial influence on clients’ views toward the group and its outcome (Holmes & Kivlighan).
**Group Climate/Cohesion**

A number of researchers have identified the relationships cultivated by the group setting as (a) group climate, (b) cohesion, (c) alliance, and (d) empathy, each of which has consistently been linked to client improvement and low drop-out rates (Burlingame, Fuhriman, & Johnson, 2001; Castonguay et al., 1998). Although containing subtle differences, these therapeutic relationships are closely interrelated (Burlingame, et al.). Group cohesion is defined as a sense of belonging in a group, while group climate is indicative of the group member’s perceptions of the group’s therapeutic environment.

Yalom (1995) argued that group cohesion is the group therapy analogue of the relationship in individual therapy. He noted that cohesiveness refers to “the condition of members feeling warmth and comfort in the group, feeling they belong, valuing the group and feeling, in turn, that they are valued and unconditionally accepted and supported by the other members” (p. 48). Moreover, Yalom described cohesiveness as the “necessary precondition for effective therapy” (p. 50). He postulated that the experience of being in a cohesive group enables group members to engage in the necessary self-disclosure and personal exploration that is the hallmark of effective therapy.

Furthermore, Yalom (1995) stated that cohesiveness is an agent of change in members’ lives through “the interrelation of group self-esteem and [personal] self-esteem” (p. 107). He argued that cohesiveness alters personal self-esteem through acceptance and empathy from the group. For Yalom, the group leader’s primary responsibility is the creation of a therapeutic group climate. Yalom stated, “If it is the group members who, in their interaction, set in motion the many therapeutic factors, then it is the group therapist’s task to create a culture maximally
conducive to effective group interaction” (pp. 109-110). Yalom’s writings suggest that the group members have a direct influence on member outcome whereas the group leader’s influence is indirect, acting through the creation of a therapeutic group climate, defined as a series of interactional dimensions.

*Group Outcome Research*

An important goal in group research has been to identify the factors and processes that give rise to increased levels of group performance. In the pursuit of this goal, researchers often focused on the social and motivational forces that exist between group members (Forsyth & Burnette, 2005). The theoretical belief is that these forces create a bond, or cohesion, among the members of the group, and that the stronger the bond, the greater the productivity of the group. Presumably, when cohesion is strong, the group is motivated to perform well and is better able to coordinate activities for successful performance.

The importance of group cohesiveness has been empirically supported in numerous studies (Budman, Soldz, Demby, Davis, & Merry, 1993; Hoberman, Lewinsohn, & Tilson, 1988; Hurley, 1989; Marziali et al., 1997; Yalom & Rand, 1966), and a number of authors have described cohesiveness as the group counterpart to the “therapeutic alliance” in the individual psychotherapy (Budman et al.; Marziali et al.). Researchers have found that there was a significant relationship between cohesiveness in therapy groups and client satisfaction (Shea & Seldacek, 1997), that cohesiveness was related to group therapy outcome (Soldz, Budman, Demby, & Feldstein, 1990), that perceived cohesiveness is related to less client dropout (Falloon, 1981), and that more successful groups were more cohesive (MacKenzie et al., 1987).
Marmarosh, Holtz, and Schottenbauer’s (2005) study included 102 participants, 54 from process groups and 48 from theme groups (i.e., grief/loss, women’s studies, trauma, relationship skill building, and family issues). Their study served to extend the theory that the group is powerful in its effects on the individual. They used both path analyses and regression analyses. The results of their study supported Yalom’s claim that group cohesiveness leads to group collective self-esteem, hope, and improved measures of well-being such as depression and self-esteem on both process groups and theme groups. In general, a higher level of cohesion has been related to better member outcome (Budman et al., 1989; Kapp, Gleser, & Brissenden, 1964; Roether & Peters, 1972; Weiss, 1972; Yalom, Houts, Zimerberg, & Rand, 1967). Studies of multidimensional aspects of group climate also show significant correlations between cohesion and group member outcome. For example, Mackenzie et al. (1987) studied 53 14-hour experiential training groups. They found that successful groups, when compared with less successful groups, were more cohesive and engaged and were less defended, superficial, conflicted, and avoiding.

Kivlighan and Tarrant (2001) studied group climate from 43 group leaders’ and 233 group members’ ratings and further noted that engaged and cohesive climates are associated with positive member outcome, whereas defended and conflicted climates are associated with negative member outcome. They reported that a group climate that was increasingly active and engaged was related to members seeing the group as more beneficial and encouraging of task-oriented roles and interactions (e.g., learning and practicing communication skills and anger management techniques). In addition, they reported that problem reduction was related to members engaging in these tasks. Furthermore, they found that a group climate that was
decreased in conflict and distance was related to members having a more positive relationship with the leader.

Kivlighan and Jauquet’s (1990) research addressed the relationship between group members’ approach to group sessions and group session climate. In their study, 36 members of six personal growth groups rated the group climate three times over a 13-week period. They found that high-quality goal setting, an important aspect of norm development in group therapy, was related to an engaged group climate. Kivlighan and Jauquet also found that group members increased their active involvement with the group when group leaders refrained from doing individual therapy in the group and actively set goals and norms while maintaining a warm and supportive environment.

Mayer (1998) conducted 195 interviews and received 550 responses to a questionnaire regarding group decision making. This researcher reported that participants believed decisions are most likely to be of high quality when group members participate fully in the process and the group climate is characterized by the presence of respectful behaviors and the absence of negative socioemotional behaviors. While participation has generally been associated with “acceptance” of a decision, research in ad hoc groups has indicated that the “quality” of decisions improves when information and solutions offered in the groups are analyzed by the group members (Mayer).

Ogrodniczuk and Piper (2003) studied 53 participants from interpretive therapy and 54 from supportive therapy. They theorized that group cohesiveness may provide members with encouragement to attempt to “get better” or with optimistic expectations for improvement. In essence, members from cohesive groups may participate more in group therapy and have
greater expectations that group therapy will help them achieve desired outcomes. Ogrodniczuk and Piper provided evidence that the common factor of group climate is indeed related to outcome of group psychotherapy. More specifically, their findings revealed that engagement was significantly related to favorable treatment outcome. The results of this study clearly showed that the group climate has an important relationship to therapeutic gain. These findings are consistent with the results of several previous studies (Braaten, 1989; Kivlighan & Lilly, 1997; Kivlighan & Tarrant, 2001).

Support Levels within Parent Education Groups

Smith, Cudaback, Goddard, and Myers-Walls (1994) advocated a shift to emotional support paradigms as the essential reference point for all parenting programs. They noted that while there are often practical needs for specific child-rearing information and advice, parents also need emotional support, something that more often comes from another parent than it does from an "expert" or a book. Smith et al. stated,

A professional can facilitate the establishment of the group and can be available as a resource person if they want specific educational programming, but the parents themselves can develop leadership skills and gain greater control over their lives and their stress by leading the group process and establishing its agenda. The premise of these programs is that official ‘experts’ are not the exclusive holders of knowledge. (p. 50)

Moreover, Smith et al. (1994) reported that many of these parenting groups were most effective when led by peers.
In recent years, considerable attention to the social context of parenting programs has increased.

This substantive shift reflects an interest in the interconnectedness of child, family, and community, and assumes that providing parents with social support in the form of helpful interpersonal relationships and material assistance (if needed) will enhance parent functioning and, ultimately, child development. (Powell, 1990, ¶ 12)

Smith et al. (1994) pointed out that in a group setting most parents are reassured by others that their child is normal and that they are normal. This support is imperative because parents have a need for normalcy. In addition, the group setting can further benefit parents by providing them with the opportunity to practice asking for help and offering help to other parents when needed.

Barlow’s (1999) systematic review of parent education programs included 16 studies and two follow-up studies that produced positive changes in parents’ perceptions of their child’s behavior. The review looked specifically at the type of parenting programs that produced the most positive results, and the author concluded that group-based parenting programs are more successful in the long-term in improving the behavior of children compared to methods that involve working with parents on an individual basis. In addition, Conroy and Mayer’s (1994) study reviewed 24 parents’ evaluations of three different parent education approaches. They found that the most frequent response to the question “What were the most helpful aspects of the course?” was “Discussion with other parents” (p. 65).

McBride (1990, 1991) utilized a discussion group format as one component in his caregiver education program for fathers because fathers have smaller structural and functional
support groups, yet they are as likely as mothers to turn to another individual for assistance with child rearing (Meyers, 1993). Participants in McBride’s (1990, 1991) study shared their feelings about their roles and responsibilities as fathers and discussed child discipline, sibling rivalry, and child development. Within the support group format, the men addressed themes such as emotional experiences and relationships with significant others. This group format fostered a supportive environment within the context of the parent education program and provided fathers with social support. Significant outcome differences were found between their treatment and control groups regarding parenting competence and responsibility. Treatment groups scored significantly better on both the Parenting Sense of Competence Scale (PSOC) and the Child-Care Task Checklist.

Parents enrolled in parent education programs often report that opportunities for social support are lacking in their communities and that additional support would reduce stress and increase their ability to focus on teaching techniques (Stahmer & Gist, 2001). Unfortunately, the type of support that would be most helpful is unclear. One possible mechanism of support for parents would be a facilitated information and support group in which parents could meet with other families in similar circumstances. This type of support may increase parents’ ability to focus on parent education, thereby increasing their use of techniques taught in parent education courses (Stahmer & Gist). However, there has been little research or clinical documentation demonstrating the effect a parent support program would have on the parents’ ability to successfully and consistently implement specific behavioral techniques with their children.
Stahmer and Gist’s (2001) study assessed the addition of a twelve-week parent education support group to an accelerated parent education program in 22 families with an autistic child under the age of five. They compared technique differences between parents assigned to “parent education content” and “parent information support group content” groups. Results of their study indicated that parents who participated in the parent information support group performed significantly better at demonstrating their skills for eliciting play and language with their children than parents who participated in the content only group. The majority of parents in the parent information support group reached criteria for skill mastery, defined as appropriate use of all of the pivotal response training (PRT) strategies, but the majority of those who did not participate in the support group did not reach criteria for skill mastery. These results indicated that parents who participated in a parent information support group along with a parent education program more often mastered the PRT techniques than parents who did not participate in a support group. Moreover, parents’ mastery of PRT techniques was associated with increased improvement in the children’s skills.

Stahmer and Gist (2001) listed a number of possible explanations for the success of parents who attended the support group, including: (a) the discussion of PRT among parents who participated in the support group helped them develop a better understanding of the techniques; (b) the support group may have served a respite function so parents were better able to focus on learning PRT techniques during the education session; (c) the additional support and reduced isolation increased their understanding of the importance of the education process; or (d) families may have learned about additional community resources or programs which they accessed during the course of training.
A major component of parent training groups and multiple family group interventions is the provision of social support in helping to reduce caregiver feelings of stigma and isolation. Research on family support groups documents that the provision of social support in groups affects the caregiver experience in four ways: (1) assists the caregiver to construct a self-identity as a “caregiver,” (2) promotes a sense of personal competence, (3) fosters the use of formal support groups, and (4) creates a community context within which to experience the caregiving role (O’Conner, 2002). O’Conner noted that these caregiver experiences in the group setting contribute to a sense of empowerment for the caregiver by helping caregivers view their experiences not as a personal issue but rather as a more collective experience.

Ruffolo, Kuhn, and Evans (2005) reported that parents who received family support services had increased access to information, improved problem-solving skills, and more positive views about parenting and their youth’s behavior. They noted that a family education and support group intervention designed to enhance knowledge of services and skills needed to negotiate the mental health system showed a significant positive effect on parents’ knowledge and self-efficacy even at one year post intervention. In addition, Ruffolo et al. noted that the families involved in the family psychoeducation approach were more likely to make and keep a first appointment at a mental health clinic. They also noted that two-thirds of the families in a study they reviewed reported attitudinal shifts, including more positive thinking about their youth, their family situation, and the mental health care system. Moreover, review of the literature on family psychoeducation approaches suggested that discussing strategies for addressing problematic behaviors was critical to the success of these parent training programs.
Although there are no standards for parent education group leaders, guidelines for effective group facilitators provide some indication of helpful leader traits. White and Mullis (1996) noted that the most effective leaders believe that people are able, friendly, worthy of respect, internally motivated, creative, trustworthy, dependable, and helpful. These beliefs about people encourage growth in group members. Moreover, they noted that effective group leader traits include using nontechnical language, providing a clear description of program goals, thoroughly explaining and demonstrating suggested interventions, and accepting participant differences in background and values. They urged leaders to share the values on which their parent education program is based with prospective group members so members can decide if they want to participate. White and Mullis also noted that it is the leaders’ responsibility to protect participants from being attacked or criticized by other group members. White and Mullis further argued that group parent education is not group therapy; therefore, leaders are obligated to make certain the participants remain focused on information sharing and learning skills and do not stray into interpreting their own or other participant’s behavior.

**Effectiveness of Filial Therapy**

Bernard Guerney viewed parents’ lack of parenting knowledge and skill as the cause for many children’s behavioral problems (Guerney, 1964). He saw a need for a more improved parent training program, and in the 1960s he developed filial therapy, in which parents are trained in basic child-centered play therapy skills to become therapeutic agents of change in their children’s lives (Guerney). Guerney viewed parents as the essential element of the filial therapy approach because they are typically the most significant people in a child’s life. He and his wife, Louise Guerney, trained parents to conduct weekly play sessions with their children at
a university clinic. Once the therapist believed the parents had become proficient in child-centered play therapy skills, they transitioned them to having their play sessions at home (Guerney).

As a result of this shift in therapy, where the parents were now the ones conducting play sessions, the Guerneys noticed that parents were feeling empowered and experiencing reduced feelings of guilt and helplessness (Landreth & Bratton, 2006). In addition, parents were learning more effective ways of interacting with their children and becoming less dependent on professionals for help. Moreover, through the parent’s shift in attitude, the Guerneys saw a greater potential for long-lasting change.

The filial training model offers unique aspects that set it apart from other parenting models. It includes didactic instruction, demonstrations, role-playing, at-home play sessions, and supervision. By utilizing play, the child’s natural mode of communication, filial therapy teaches parents to learn to look at things from the child’s perspective (Landreth & Bratton, 2006). Through training and supervision in the small group format, parents are able to see things from a new perspective. As a result of being able to see things from the child’s perspective, parents are better able to understand and relate to their children.

Originally, the Guerneys’ filial therapy group sessions consisted of six to eight parents for two hours a week, for approximately one year. They later adapted their model to span five to six months. To shorten the length of treatment, Landreth created a fifteen-week model and later a ten-week model (1991), now known as a ten-session model called Child Parent Relationship Therapy (Landreth & Bratton, 2006).
Extensive research has been conducted on filial therapy, using the Guernneys’ model (1964) and Landreth’s model (1991), now known as CPRT (2006). Landreth and Bratton (2006) noted that CPRT is one of the more well-researched treatment protocols in the field of child psychotherapy. The research validates the efficacy of filial therapy in various populations of parents and with various populations of children. A summary of the research findings is included in this section to demonstrate the effectiveness of filial therapy.

Many researchers have revealed that after parents have participated in filial therapy, their children have reduced pathological physical and behavioral symptoms, reduced levels of stress, increased academic performance, increased harmony in parent-child relationships, increased mirrored expressions of affection, more positive self-esteem, and improved psychosocial adjustment (Andronico & Blake, 1971; Boll, 1972; Ginsburg, Stutman, & Hummel, 1978; Glass, 1986; Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Payton, 1980; Sensue, 1981; Sywulak, 1977).

Filial therapy has been applied to many populations and has shown reliable, statistically significant changes in both parents and children. Research studies exploring the effectiveness of filial therapy, including but not limited to the CPRT model, have been implemented with single parents (Bratton & Landreth, 1995), incarcerated mothers (Harris & Landreth, 1997), incarcerated fathers (Landreth & Lobaugh, 1998), parents of different nationalities (Chau, 1996; Glover, 1996; Yuen, 1997), parents of mentally challenged children (Boll, 1972), parents of chronically ill children (Glazer-Waldman et al., 1992; Tew, 1997; VanFleet, 1992), parents of children demonstrating conduct problems (Clark, 1996), parents of children with learning disabilities (Kale & Landreth, 1999), parents of emotionally disturbed children (Sensue, 1981),
and nonoffending parents of sexually abused children (Costas & Landreth, 1999). Research instruments with these populations have assessed a variety of variables including: parental empathy, parental acceptance, parental stress, parental self-esteem, parental perception of positive changes in the family environment, parental perception of child adjustment, parental perception of child behavioral problems, child self-concept, and changes in child play behavior (Rennie & Landreth, 2000).

Filial therapy has improved mother’s behaviors in the areas of increased usage of reflective type statements, increased harmony with the child, enhanced self-concept, improved parental acceptance, improved child rearing attitudes, increased differentiation between parent and child, increased feelings of unconditional love for their children, and decreased directive type statements (Andronico, Fidler, Guerney, & Guerney, 1969; Glass, 1986; Glazer-Waldman et al., 1992; Ginsberg et al., 1978; Lebovitz, 1982; Payton, 1980; Sensue, 1981). One study of incarcerated fathers reported increased levels of acceptance, increased confidence and decreased levels of stress (Lobaugh, 1991).

Bratton and Landreth (1995) explored the effectiveness of filial therapy using a pretest-posttest, randomized control group design with 43 single parents and their children ages three to seven years. The 22 parents in the experimental group demonstrated significant increases in empathic behavior with their children. They demonstrated an increase in attending fully to the child, in following the child’s lead rather than attempting to control the child’s behavior, and in commenting on the child’s expression of feeling or behavior in a genuinely accepting manner. Moreover, single parents significantly increased their attitude of acceptance of their children.
The level of stress related to parenting decreased significantly, and the parents reported significantly fewer problems with their children’s behavior.

Landreth and Lobaugh (1998) demonstrated the effectiveness of filial therapy with incarcerated fathers. Significant improvements were found for all fathers regarding acceptance of their children and empathic behavior toward their children. All 16 of the fathers in the experimental group scored significantly higher than the 16 fathers in the control group on unconditional love for their children, acceptance of their children’s feelings, and their children’s rights to express those feelings. They also scored significantly higher on acceptance of their children’s unique makeup and recognition of their children’s needs for autonomy and independence. Results revealed that the level of parental stress had decreased after completing the filial therapy training. In addition, the fathers in the experimental group reported significant reductions in the number of child problem behaviors. Landreth and Lobaugh attributed these changes to the fathers’ learning of new parenting skills, along with an increased sense of competency as a parent and a more accepting view of their children. The assessment instrument administered to the children and the fathers’ self-reports showed highly significant increases in the children’s self-concepts.

The results of Costas and Landreth’s (1999) study demonstrated the effectiveness of filial therapy training with 26 nonoffending parents of children ages five to nine who had experienced sexual abuse. All 14 parents in the experimental group significantly demonstrated their ability to learn therapeutic skills. Results of this study are similar to the Landreth and Lobaugh (1998) study. The assessment instruments, along with the facilitator’s observations and the parents’ comments, revealed that parents reported a significant growth in
unconditional love for their children as well as an overall growth in acceptance of their children. Positive gains were also reported regarding their appreciation for their child’s unique make-up, acceptance of their child’s feelings and the right to express those feelings, and recognition of their child’s need for autonomy and independence. Parents also reported a decrease in stress related to parenting and to children’s behavior. Furthermore, they demonstrated significant increases in empathic behavior during observed play sessions with their children. These results were based on direct observation rather than self-report instruments. During the observations, it was noted that parents acquired increased skills in communicating acceptance, allowing the child self-direction, and being involved with the child during a special play session. These results confirmed that the parents not only became more accepting of their children but also learned how to communicate this acceptance. These results suggest that the CPRT model is an effective treatment for increasing empathy and involvement, allowing child self-direction, and communicating acceptance in parent-child interactions. Although parents reported fewer behavior problems, a decrease in their children’s anxiety, an increase in their children’s self-esteem, and a decrease in emotional disturbance, these results were not statistically significant at the .05 level. The researchers offered two possibilities to explain the lack of statistical significance: (1) more time might be needed with this population, and/or (2) the measuring instrument may not be sensitive to studies with few participants.

Tew (1997) examined the use of filial therapy with 23 parents of chronically ill children who were receiving or had received medical service from a children’s hospital. The results of her randomized, controlled pretest-posttest design showed that filial therapy decreased parenting stress and perceived child behavioral problems. Results also showed all twelve
parents in the experimental group increased their acceptance of their children. This study validated the earlier findings of Glazer-Waldman, Zimmerman, Landreth, and Norton’s (1992) study of five mothers with chronically ill children.

Chau and Landreth (1996) investigated the effectiveness of filial therapy with 34 immigrant Chinese parents in the United States. They noted that, due to cultural reasons, the parents in their study were more open to the concept of a parenting class (i.e., they were more comfortable with the didactic component of filial therapy as opposed to the counseling component). The 18 Chinese parents who received filial therapy training had significant changes in the areas of increased level of empathic interactions with their children, increased attitudes of acceptance toward their children, and reduction in their level of stress related to parenting. The parents also reported improved communication in their marriage. Yuen (1997) examined filial therapy with immigrant Chinese parents in Canada. He also found significantly increased levels of empathy and acceptance and decreased levels of parental stress and perceived child behavior problems from all 18 filial-trained parents.

Bratton, Ray, Rhine, and Jones (2005) used meta-analysis to investigate the overall treatment effect for 93 play therapy and filial therapy outcome studies. They reviewed both unpublished and published outcome studies. Their review of these studies revealed that when a professional therapist used play therapy, the result according to Cohen’s d was a medium-to-large effect size (ES = 0.72). When they reviewed studies that included parents, teachers, and mentees who used play therapy, the result was a very large effect size (ES = 1.05). Furthermore, their review of only parents revealed that when parents used play therapy with their child, the result was calculated to be an even larger effect size (ES = 1.15) than traditional play therapy.
with a professional or paraprofessional, and in fewer sessions. In all, filial therapy appears to be highly effective in helping change the relationship between the parent and child as well as the behavior of the child. In Landreth and Bratton (2006), the authors revealed that an analysis of both published and unpublished filial therapy outcome studies using CPRT methodology resulted in a very large treatment effect (ES = 1.25). This analysis included only filial therapy studies in which one of them had directly trained and supervised the researchers. These findings provide strong evidence for the overall efficacy of this model and for the importance of training with and adhering to a well-developed treatment protocol.

Results of the cited studies support the use of filial therapy as a unique and creative approach for increasing parental acceptance, self-esteem, and empathy; promoting positive changes in family environment; and improving the child’s adjustment and self-esteem while decreasing parental stress and the child’s behavioral problems. The research demonstrates that the CPRT model has preventive, educational, and clinical implications with numerous populations. It has also been shown effective in a variety of settings such as school, community centers, churches, prisons, hospitals, and mental health clinics.

Group Process Dynamics in Filial Therapy

Although parents do not attend filial therapy to receive group therapy, CPRT is founded on a belief that parents need to develop insight into their personal issues that interfere with relating to their children. Emotional wounds and issues related to participants’ own parents are often explored in the context of their interference with their role of relating to their children as therapeutic agents of change (Landreth & Bratton, 2006). The context in which these issues are explored is not related to personality issues that need to be corrected; rather these issues are
related to parents’ child rearing that may be hindering the parent-child relationship. This process of exploration into personal issues is known as the group therapy type component of filial therapy. Landreth and Bratton stated, “...the processing of personal issues facilitates the inner growth required to enable parents to incorporate the new skills and apply the new behaviors required” (p. 18-19).

Filial therapy combines the teaching component of CPRT with building group cohesiveness, especially in the first two or three training sessions (Landreth & Bratton, 2006). The skillful therapist accomplishes this by generalizing parent disclosures to help parents identify with each other. Asking questions such as “Does this sound familiar to anyone else?” or “Anyone else ever yell at your child?” and “What was that like for you?” helps to link parents. Hearing other parents’ experiences in the group setting also helps to break down barriers of defensiveness and isolation. It also encourages parents to reveal their own similar experiences, showing other group members that they are not alone in their feelings or experiences.

The filial therapist is not just a trainer of parent education. The therapist is active in facilitating interaction among parents and helping them to feel included in the group. One way the therapist encourages group interaction is by inviting parents to respond to each other’s questions. Encouraging parents to respond to each other not only increases interaction but also decreases parents’ dependence on the leader for solutions by inviting parents to contribute their own ideas (Landreth & Bratton, 2006). Thus, parents become more actively supportive and offer suggestions to each other in the filial therapy model. Furthermore, this interaction empowers parents to apply their newly learned skills and abilities and become a part of the solution in which all group members learn.
The limited number of qualitative studies provides contextual information that both supports and enriches the quantitative data regarding the value of the CPRT model. Qualitative studies by Bavin-Hoffman, Jennings, and Landreth (1996), Garwood (1999), and Lahti (1993) each demonstrated parents’ perceptions that the group format of filial therapy is prized.

Bavin-Hoffman et al. (1996) investigated parents’ perceptions of the filial therapy process. Their study examined audiotaped interviews of twenty married couples who had participated in filial therapy. Data revealed the recurring themes of improved communication and behavior. Parents reported increased positive interrelationship and unity, parental confidence, understanding of play, and acceptance of their children. The parents also made several recommendations to improve the filial therapy training classes. Twelve parents wanted refresher sessions. Eight would make no changes to the filial experience. Four parents recommended support groups to continue motivating parents to continue home play sessions. Three recommended more one-on-one training with the therapist. One parent wanted more in-depth information in training sessions and wanted a more homogenous group of parents. Although this study did not discuss the group process of filial therapy, it pointed out that parents recognize that the filial therapy model provides a support group.

Garwood (1999) examined aspects of filial therapy that parents of children with selective mutism found to be most helpful and aspects they viewed as less effective. Garwood used the Guerney’s model (1964). Although her filial therapy group contained five parents, only three chose to participate in her study. All three parents reported benefits derived from learning and utilizing the basic play therapy skills of structuring, limit setting, and reflective listening. All parents highly valued the group format as well. They cited advantages such as
group discussion regarding specific issues and the opportunity to talk with other parents of a child with selective mutism. All participants expressed beliefs that the group format was helpful in terms of supporting others and exchanging ideas. The parents also reported that observing the play sessions of others, as well as being observed by others, increased their active involvement and subsequent learning. They reported receiving useful suggestions and support from the other parents in the group. Thus, parents appeared to find value in the interactions with other parents. In addition, the therapist-researcher noted that when the parents were the primary observers of other parents during the parent-child play sessions, they took their mentor role seriously. Garwood reported that parents were insightful in their observations and supportive in their feedback to the other parents, sometimes even applauding one another for adhering to the limit setting process despite the resistance of the child. The researcher-therapist noted that parents were more diligent in applying the skills during the parent-child play sessions because they were being observed. She also noted that by watching others, parents improved their own skills and appeared to reduce their anxiety and feelings of scrutiny during their own sessions because they realized that others also made mistakes. This realization made through observing others probably reduced undue pressures parents may have been placing upon themselves. Moreover, Garwood noted that the group format appeared to allow for the use of humor during the therapy sessions, reporting frequent laughter during all sessions. She suggested that this use of humor increased the comfort level and bonding of the parent participants and the therapist.

Lahti (1993) used an ethnographic methodology with three parents to provide an intensive, in-depth examination of both the process and the interactive nature of filial therapy.
She posed two guiding questions to examine and describe the essential character and function of filial therapy: (1) “What is the nature of the filial therapy process and how is change facilitated?” and (2) “How is the parent/child relationship affected?” (p. 24). Lahti’s analysis revealed that the essential nature of the training process is focused on balancing a didactic component with a group counseling format. She found that the parents saw this model as most effective because it provided an atmosphere conducive to personal exploration along with teaching parenting skills. The parents listed the group counseling format, classes, educational information, method and techniques of teaching, play sessions, and enhanced confidence and increased personal power to be the beneficial and motivational components of filial therapy. The parents characterized the group counseling format as both beneficial and motivational because it provided a safe, non-threatening environment encouraging members to explore feelings, attitudes, and perceptions, not only about their children and about parenting but also about themselves. Parents reported that group members not only increased their personal power but also were able to help change their perceptions, attitudes, and behaviors. Lahti concluded that beneficial and motivational elements were interrelated. Perhaps one of the reasons certain elements were beneficial was related to their motivating qualities, or perhaps the motivating elements encouraged parents to help and be helped because they were perceived as beneficial.

Lahti (1993) noted that by the middle of the training sessions, the parents became no longer totally dependent on the group leaders for ideas and solutions. Rather, they began offering support, encouragement, and insight to one another. She attributed this increase in interaction to the safe, acceptant atmosphere and cohesiveness of the group, which removed
barriers toward change and encouraged parents to have confidence in themselves and their ideas. She also noted that the group members were “fondly ‘teasing’ one another as the leader had been doing with them earlier, lending an air of camaraderie to the group” (p. 56). This statement correlates with Garwood’s (1999) finding that the use of humor enhances the group.

Lahti’s (1993) research study offered further evidence of the benefit of the filial therapy group format and its motivating qualities. Parents indicated that the comfort, safety, and bonding of the group provided support and enhanced learning. In addition, being with others who have a common interest and who are going through similar struggles with their children seemed to relieve parents’ anxiety, facilitate their willingness to be helped, and motivate them to help their children. The parents also reported that the safe, nonjudgmental atmosphere of the group relieved them of the guilt they were experiencing in their parenting. Being in the group format, and listening to other parents and the group leader, gave the parents permission to view their behavior more realistically. The parents also reported the modeling of skills by the leader and other group members to be both beneficial and motivating. Parents described the group process as a positive growth experience. Lahti noted that one unexpected outcome was the parents’ reports on how they had improved all their relationships by employing the communication skills and the understanding, acceptance, and empathy they had acquired. One parent attributed his heightened sensitivity, understanding, and empathy in his relationships to the group process. This finding is similar to Bavin-Hoffman and colleague’s (1996) study, in which parents also reported that improvement occurred in other relationships, particularly their marriages.
The positive effect of the combination of the didactic element with group counseling appears to be a unique aspect of the nature of filial therapy and may be a key component to the manner in which it seems to facilitate change effectively. The advantages were discussed further by VanFleet (1994, 2005), who noted that the group format can increase parental support and facilitate learning through observation of others. She emphasized that parents, despite their different concerns, are able to relate well with each other because the experience of parenting has many common features. Furthermore, she noted that educational or occupational backgrounds are of no particular concern because all the parents are learning new skills at the same time, and parents that quickly master the skills can serve as additional role models for the others.

**Summary of Literature**

In summation, groups provide a number of advantages such as support and encouragement, the realization that others are similar and struggling with similar problems, and learning through hearing others’ experiences as well as from interpersonal interaction. The group environment is a representation of the outside environment for each of the individuals but with greater safety and support. Moreover, the supportive relationships created and maintained by group members in parent education groups working together toward similar goals can have substantial influence on clients’ views toward the group and outcome of the group experience. Both member-therapist and member-member relationships are important to the group process. Providing parent education through the CPRT filial group model is an appropriate modality for responding to the social-emotional needs of parents and children.
Results of the reviewed literature support the efficacy of filial therapy and the need to study variables of its effectiveness.

**Purpose of the Study**

The purpose of this study was to explore the relationship between outcome of filial therapy and group cohesion in the CPRT filial group model. Using self-report measures of total behavior problems of children and group climate, as well as observation of group cohesion, this investigation was designed to reveal the relationship between group process variables (engagement and cohesiveness) and the effectiveness of filial therapy.
CHAPTER 2

METHODS AND PROCEDURES

This study examined the relationship between outcome of filial therapy on children’s total behavior problems and group cohesion reported and observed in Child Parent Relationship Therapy (CPRT; Landreth & Bratton, 2006) training groups. Research questions, hypotheses, definition of terms, instrumentation, participant selection, procedures, and analysis of data are discussed in this chapter.

Research Questions

1. What is the relationship between parents’ and caregivers’ perceived levels of filial group cohesion and the effectiveness of filial therapy?
2. What is the relationship between objective raters’ observed levels of filial group cohesion and the effectiveness of filial therapy?

Research Hypotheses

The following research hypotheses were formulated in order to complete this study.

1. There will be a significant correlation between participants’ mean Engaged scale scores on the Group Climate Questionnaire-Short Form (GCQ-S; MacKenzie, 1983) and the difference scores between their pre and post Total Problems scale scores on the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001).
2. There will be a significant correlation between the objective raters’ mean or mode Global Cohesiveness scale scores on the Harvard Community Health Plan Group Cohesiveness Scale-Version II (GCS-II; Soldz, Bernstein, Rothberg, Budman, Demby, Feldstein, Springer, Keithly, Powers, & Davis, 1987) and participants’ difference scores
between their pre and post Total Problems scale scores on the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001).

Definition of Terms

For the purposes of this study the following terms have been operationally defined as indicated below.

*Filial therapy* is a parent training program in which parents are trained in basic child-centered play therapy skills (including reflective listening, therapeutic limit setting, self-esteem building, and encouraging responses) to become therapeutic agents in their children’s lives. Parents practice these skills in structured weekly play sessions with their children using a special kit of selected toys. They learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for both parent and child (Landreth & Bratton, 2006).

*Child Parent Relationship Therapy* (CPRT), developed by Landreth in the 1990s, is defined as a unique approach to filial therapy further refined by Landreth and Bratton (2006) that utilizes a 10-session group format of didactic instruction, demonstration play sessions, required 30-minute special play sessions with identified child, and supervision in a supportive atmosphere.

*Child-centered play therapy* is defined by Landreth (2002) as a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through
play, the child’s natural medium of communication, for optimal growth and development. (p. 16)

*Child of focus* is a child chosen by the parent with whom to conduct weekly, one-on-one special play sessions in order to practice CPRT skills. In most cases, the parent has identified that he/she desires help with his/her relationship with this child.

*Total behavior problems* are defined as the sum of scores on all the problem items of the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001). It includes affective problems, anxiety problems, attention problems, and/or aggressive behavior. For the purposes of this study, total behavior problems were operationally defined as the t-score on the Total Problems scale of the CBCL.

*The effectiveness of filial therapy* is defined as the level of positive change in the child as reported by parents following participation in CPRT. For the purposes of this study, difference scores between pre and post administration of the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001) were used to measure effectiveness. A positive difference/outcome score on the CBCL indicates an improvement in behavior.

*Perceived levels of filial group cohesion* is defined by individual group members’ perceptions that the group reflects a cohesive environment and facilitates the efforts of an individual to reach a particular goal. For the purposes of this study, the parents reported their perceived levels of cohesion using the Group Climate Questionnaire-Short Form (GCQ-S; MacKenzie, 1983).

*Objective rater* is defined as a well-trained, independent coder that observes session recordings to measure levels of filial group cohesion on a structured coding system such as the
Harvard Community Health Plan Group Cohesiveness Scale-Version II (GCS-II; Soldz et al., 1987). For the purposes of this study, the objective raters included three male doctoral level counseling students, each of whom had a master’s degree in counseling and at least two years of post master’s counseling experience.

*Observed levels of filial group cohesion* are defined by the connectedness of the group, demonstrated by working together toward a common therapeutic goal, constructive engagement around common themes, and an open, trusting attitude which allows members to share personal material. For the purposes of this study, the observed levels of group cohesion were observed using the *Harvard Community Health Plan Group Cohesiveness Scale-Version II* (GCS-II; Soldz et al., 1987).

**Instrumentation**

*Child Behavior Checklist* (CBCL; Achenbach and Rescorla, 2000, 2001). Two age-specific versions of the CBCL exist: CBCL for children ages one and a half to five (Achenbach & Rescorla, 2000) and CBCL for ages six to eighteen (Achenbach & Rescorla, 2001). The CBCL is designed to assess in a standardized format the behavioral problems and social competencies of children as reported by parents. It is one of the most widely-used measures in child psychology.

Comparability of the two versions can be used with no loss of differentiation on t-scores of internalizing, externalizing, and total problems scales (Achenbach & Rescorla, 2000).

The CBCL is composed of items that significantly differentiate clinically-referred from non-referred children. The items were factor analyzed to empirically identify the forms of psychopathology that actually occur in children. These items are presented in alphabetical order to reduce the bias that might occur as a result of informants' preconceived notions.
regarding the presence or absence or a particular disorder. The items on the CBCL can be completed in approximately 15 to 20 minutes. Test-retest reliability of the CBCL was established at .91 for Internalizing behavior problems scores and .92 for Externalizing behavior problems. The internal consistency of empirically based problem scales was supported by alpha coefficients of .78 to .97. Strong validity evidence for CBCL scores has been established through multiple studies conducted over the last 20 years (Achenbach & Rescorla, 2001).

The CBCL/1½-5/LDS is comprised of 99 problem items plus a description of problems, disabilities, what concerns parents most about their child, and the best things about the child. Syndrome scales include: Emotionally Reactive, Anxious/Depressed, Somatic Complaints, Withdrawn, Sleep Problems, Attention Problems, and Aggressive Behavior. It also includes Internalizing, Externalizing, and Total Problems scales. The DSM-oriented scales are: Affective Problems, Anxiety Problems, Pervasive Developmental Problems, Attention Deficit/Hyperactivity Problems, and Oppositional Defiant Problems. Raw scores on each scale can be computed to determine t-scores and percentiles. Furthermore, this version includes the Language Development Survey (LDS) for identifying language delays in children eighteen to thirty-five months.

The CBCL/6-18 obtains reports from parents, other close relatives, and/or guardians regarding children’s competencies and behavioral/emotional problems. Parents provide information for 20 competence items covering their child’s activities, social relations, and school performance. The CBCL/6-18 has 118 items that describe specific behavioral and emotional problems, plus two open-ended items for reporting additional problems. Parents rate their child for how true each item is now or within the past six months using the following
scale: 0 = not true (as far as you know); 1 = somewhat or sometimes true; 2 = very true or often true.

The CBCL/6-18 scoring profile provides raw scores, t-scores, and percentiles for three competence scales (Activities, Social, and School), Total Competence, eight cross-informant syndromes, and Internalizing, Externalizing, and Total Problems. The cross-informant syndromes scored are Aggressive Behavior; Anxious/Depressed; Attention Problems; Rule-Breaking Behavior; Social Problems; Somatic Complaints; Thought Problems; and Withdrawn/Depressed. The six DSM-oriented scales are: Affective Problems; Anxiety Problems; Somatic Problems; Attention Deficit/Hyperactivity Problems; Oppositional Defiant Problems; and Conduct Problems.

A reduction in scores between pre and post CBCL measures indicates an improvement in the child’s behavior. A t-score below 60 on the Total Problems scale indicates that parents’ or caregivers’ perceptions of their child’s behaviors are in the normal range indicating that the child’s behaviors are considered nonclinical when compared to other children of the same gender and age. A t-score of 60 or higher on the Total Problems scale indicates that parents’ or caregivers’ perceptions of their child’s behaviors are in the borderline or clinical range indicating that the child’s behaviors are clinical and considered significant when compared to other children of the same gender and age.

Group Climate Questionnaire–Short Form (GCQ-S; MacKenzie, 1983). The GCQ-S is the most commonly used group process instrument across a variety of settings in the group literature (Johnson et al., 2006). Johnson et al. noted that the instrument has been used in at least 46 group studies. MacKenzie (1983) defined the group climate as an environmental press,
a property or attribute of the group environment in terms of cohesion, resistance, and friction that facilitates or impedes the efforts of an individual to reach a particular goal (MacKenzie, 1983; MacKenzie & Tschuschke, 1993; Ogrodniczuk & Piper, 2003).

The GCQ-S is a self-report measure that assesses individual group member’s perceptions of the group’s therapeutic environment. The GCQ-S, a shortened version of an original 32-item questionnaire (MacKenzie, 1981), contains twelve items rated on a seven-point Likert scale. The scale ranges from 0 to 6: (0) not at all; (1) a little bit; (2) somewhat; (3) moderately; (4) quite a bit; (5) a great deal; and (6) extremely. The GCQ-S represents behavioral descriptions of group climate in clear, simple language, requiring little interpretation. It takes approximately five to ten minutes to complete.

A factor analysis of these items resulted in the development of three scales: (1) Engaged, (2) Conflict, and (3) Avoiding. The Engaged scale reflects cohesion and self-disclosure among the members and also reflects group members’ attempts to understand the meaning of their behavior (MacKenzie, 1983). This scale describes constructive therapeutic work, including a positive working atmosphere (item 1), cognitive understanding (item 2), group cohesion (item 4), confrontation (item 8), and self-disclosure (item 11). A high score on this scale indicates a positive working atmosphere where members are involved in the group and are able to interact freely with one another. In addition, challenge and confrontation on the Engaged scale have been linked to promoting social learning (MacKenzie, 1983; Kivlighan & Tarrant, 2001).

The Conflict scale measures interpersonal anger (item 6), distancing (item 7), distrust (item 10), and tension (item 12). A high score on this scale indicates an atmosphere where members confront one another in an aggressive manner, distrust each other, and withdraw
from each other. The Avoiding scale measures how much group members avoid responsibility for their change process, such as avoiding issues between members (item 3), depending on the group leader(s) (item 5), and engaging in high social monitoring (item 9). A high score on this scale suggests that members are reluctant to take responsibility for examining their problems, are superficial in their discussions, and are highly influenced by the group norms for behavior.

Construct validity of the GCQ-S has been tested extensively, with demonstrated links to outcome and process (Johnson, in press; Kivlighan & Goldfine, 1991; MacKenzie et al., 1987). Ratings on the GCQ-S have been found to differentiate different types of group therapy, group therapies of varying duration, and different client samples. Variations in GCQ-S ratings during treatment have found to be consistent with developmental group therapy theory and related to therapeutic gain. Kivlighan and Goldfine (1991) reported alpha coefficients of .94 for the Engaged scale, .88 for the Conflict scale, and .92 for the Avoiding scale. A recent review (Johnson) concluded that high Engaged scores generally predict positive outcomes at both group and individual levels, that Conflict appears to predict negative outcomes at the group level and has had mixed outcomes at the individual level, and that Avoiding is less consistently associated with outcome.

*Harvard Community Health Plan Group Cohesiveness Scale-Version II* (GCS-II; Soldz et al., 1987). The GCS-II is intended to measure group cohesiveness, a construct that has frequently been cited as critical to the successful functioning of therapy groups. The authors of the GCS-II believe that a moderate amount of cohesiveness is a prerequisite for the successful functioning of any interactional therapy group. They believe that group cohesiveness is a necessary prerequisite for beneficial therapeutic outcome.
The GCS-II views cohesiveness as an observable characteristic of group functioning, which can therefore be rated by non-participant observers (and perhaps participant observers, such as the therapist(s) as well). It was designed for use with 30-minute segments of 90-minute group psychotherapy sessions. Trial and error revealed that videotaped segments are far superior to audiotaped segments (Soldz et al., 1987).

The GCS-II consists of one global scale and five subscales. The global scale measures cohesiveness as a whole. Soldz et al. (1987) stated that the global cohesiveness scale is defined by “group connectedness, demonstrated by working together toward a common therapeutic goal, constructive engagement around common themes, and openness to sharing personal material” (p. 2). Key components of cohesiveness are further specified in the GCS-II subscales as group processes of: (1) trust, (2) focus, (3) interest/involvement facilitative behavior, and (4) bonding. Each scale ranges from Level 1 (very slight) to Level 9 (very strong). A score of four is the highest rating for groups that demonstrate no therapeutic work but considerable engagement between group members. A score of 5 and above requires high level of connectedness and therapeutic work.

There are five steps suggested for training, including: (1) familiarization; (2) discussion of the subscales and anchor point descriptors; (3) discussion and practice of techniques; (4) reliability testing; and (5) periodic review. These steps can be accomplished with or without the aid of a previously trained rater because a beginning rater can become familiar with the material on the scale from the manual and the scale itself. The GCS-II manual includes overall rating instructions, specific subscale rating instructions, and additional notes and rules. The definition of each subscale is meant to serve as a guide for inference when observed behavior
does not clearly match scale-level descriptors. For this study, reliability and validity were established through interrater training and established intraclass correlation coefficients, which ranged from .80 to 1.00 at pre, mid, and post levels.

Participant Selection

The majority of CPRT groups were marketed to parents and caregivers through counselor recommendations and clinic advertisements, including brochures that were disseminated in local schools. Through advertising, these parents and caregivers contacted the counseling training facility on a university campus and were placed in a group according to convenience of scheduling. Both the filial therapy group leaders and group members were matched according to convenience of scheduling. These group leaders called their assigned group members to schedule intakes.

For the other CPRT groups, group leaders were asked to recruit parents and caregivers to participate in their CPRT groups. Because all of these groups were conducted to fulfill a class requirement, some groups contained acquaintances of the leader(s). More specifically, two groups began and ended with acquaintances of a CPRT group leader(s). These participants were clearly told that their experience would simply be a psychoeducational group, not a therapy group.

During CPRT intakes or at the beginning of treatment, the research investigator solicited participants for this study. Participants consisted of parents and primary caregivers. The majority of participants identified concerns regarding one of their children between the ages of two and eleven years old. Nearly 57% of the participants reported aggressive behavior or attention problems as their primary concern for their child of focus. Table 1 on the next page
gives a complete list of participants’ presenting concerns and rationales for why they chose to participate in CPRT.

Table 1

*Participants’ Presenting Concerns and Rationale for Participating in CPRT*

<table>
<thead>
<tr>
<th>Concern</th>
<th>Males</th>
<th>Females</th>
<th>Average Age of Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggressive Behavior, n = 10</td>
<td>9</td>
<td>1</td>
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</tr>
<tr>
<td>Attention Problems, n = 7</td>
<td>6</td>
<td>1</td>
<td>5.00</td>
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<tr>
<td>Anxious Feelings, n = 4</td>
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<td>2</td>
<td>8.25</td>
</tr>
<tr>
<td>Low Self-Esteem, n = 4</td>
<td>2</td>
<td>2</td>
<td>8.25</td>
</tr>
<tr>
<td>Depressed Feelings, n = 4</td>
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<td>1</td>
<td>7.25</td>
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<tr>
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<td>1</td>
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</tr>
<tr>
<td>Developmental Concerns, n = 3</td>
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</tr>
<tr>
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<td>1</td>
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<td>Academic Difficulties, n = 1</td>
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<tr>
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<td>1</td>
<td>0</td>
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</table>

Due to high dropout rates, community mobility, and lack of completed paperwork, nine out of twenty-two CPRT groups led between February 2007 and May 2008 met the selection criterion to participate in this study. These nine groups from the southwestern United States finished with at least three group members, at least two of whom completed pretest and posttest data, and all of whom attended at least six out of ten sessions. Data were obtained from thirty out of thirty-seven participants from these groups. Six groups met at a counseling training facility serving community mental health clients and located on a university campus. This particular facility served residents from local and surrounding counties on a sliding scale fee, paying a very low weekly fee. Typical clients could be classified as low socio-economic
status with low educational levels. The remaining three groups were held free of charge and met at a local community center, childcare facility, and group leader’s residence.

The filial therapy group leaders and co-leaders who conducted the CPRT groups included seventeen females and one male. Seventeen of them were enrolled in Filial Therapy for the semester in which their groups were conducted. Filial Therapy is a weekly three hour class that requires students to conduct filial therapy groups. Only one of the group leaders in this study was an experienced filial therapist. Fifteen of the leaders were master’s level students who had completed Introduction to Play, Basic Counseling Skills, and Advanced Counseling Skills classes and were at the practice level of their accredited counseling program. Three of the leaders were doctoral level students, all of whom have a master’s degree in counseling and at least two years of post master’s counseling experience. All of them received weekly supervision from experienced filial therapists throughout the CPRT process. Table 2 addresses the demographics and education level of the filial therapy group leaders in this study.

<table>
<thead>
<tr>
<th>Table 2</th>
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<tr>
<td><strong>Demographic Information for Filial Therapy Group Leaders and Co-leaders</strong></td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Master’s level students</td>
</tr>
<tr>
<td>Doctoral level students</td>
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<tr>
<td><strong>Gender</strong></td>
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</tr>
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<td>Male</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
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<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Hispanic</td>
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</tbody>
</table>
Of the thirty CPRT group participants, twenty-two were females and eight were males. Their ethnicity was reported as follows: Caucasian \((n = 23)\), African American \((n = 5)\), Asian \((n = 1)\), and Hispanic \((n = 1)\). Ages ranged from 24 to 53 years, with a mean of approximately 37 years old \((M = 37.13; SD = 8.14)\) and a median of 35 years. The majority of the sample \((87\%)\) was 29 years old or older. Marital status was reported as twelve married, eleven divorced, and seven single. Relationship to the child was reported as twenty-four biological parents, three adoptive parents, two grandparents, and one boyfriend of a parent. Table 3 addresses the demographics of the participants in this study.

Table 3

<table>
<thead>
<tr>
<th>Demographic Information for Participants in This Study</th>
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</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Female</td>
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<tr>
<td>Male</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
</tr>
<tr>
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</tr>
<tr>
<td>African American</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>Average</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Divorced</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td><strong>Relationship to Child</strong></td>
</tr>
<tr>
<td>Biological Parent</td>
</tr>
<tr>
<td>Adoptive Parent</td>
</tr>
<tr>
<td>Grandparent</td>
</tr>
<tr>
<td>Boyfriend of a Parent</td>
</tr>
</tbody>
</table>

Each participant reported the ethnicity of their child of focus as follows: Caucasian \((n = 21)\), African American \((n = 4)\), Asian \((n = 1)\), and other \((n = 4)\). Of the thirty children, twenty-
one were males and nine were females. The children’s ages ranged from two to eleven, with a mean of almost six years ($M = 5.70; SD = 2.39$) and a median of five years. The majority of children (90%) were nine years old or younger. Of note, one of the children was the same child of focus for two participants; thus, his demographics are listed twice. Table 4 addresses the demographics of each participant’s child of focus in this study.

Table 4

<table>
<thead>
<tr>
<th>Demographic Information for Children in This Study</th>
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<tbody>
<tr>
<td>Gender</td>
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<tr>
<td>Male</td>
<td>21</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
</tr>
<tr>
<td>Age</td>
<td>$M$</td>
</tr>
<tr>
<td>Average</td>
<td>5.70 years</td>
</tr>
<tr>
<td>Ethnicity</td>
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</tr>
<tr>
<td>Caucasian</td>
<td>21</td>
</tr>
<tr>
<td>African American</td>
<td>4</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
</tr>
</tbody>
</table>

Procedures

After obtaining approval from the Institutional Review Board for Human Subjects Research, participants were recruited either at their initial intake or at the beginning of their participation in CPRT. All participants signed a consent form explaining the nature of the research study by the examiner. Once parents and caregivers signed the consent forms, the investigator collected their Adult Background Information form, Child/Adolescent Background Information forms, and Child Behavior Checklist (CBCL) pre assessment scores (administered and collected by the filial therapy group leaders) to measure the level of behavioral and relational problems between the parent and child of focus.
Parents and caregivers participated in a ten-session CPRT model of filial therapy. Throughout this process, the filial therapy group leaders participated in weekly supervision with experienced therapists. See Appendix B for an overview of the CPRT protocol. The protocol includes educating parents and caregivers in the areas of communication skills and limit setting with children, along with facilitation of group interpersonal dynamics. The CPRT protocol is provided in Bratton, Landreth, Kellam, and Blackard (2006).

The CPRT protocol suggests that therapists conduct initial parent interviews/intakes prior to the first filial group to screen parents for appropriateness for CPRT training, to begin to develop rapport with parents, and to briefly explain what CPRT is and how it can help strengthen the parent-child relationship and alleviate child and/or family difficulties (Landreth & Bratton, 2006). Additionally, groups begin with some informal sharing to allow parents to check in with the group. Groups often end with a motivational poem, short story, or rule of thumb. Throughout the treatment manual, therapists are told to “Encourage, Support, and Connect!” (Bratton et al., 2006).

The Group Climate Questionnaire Short Form (GCQ-S), a self-report survey most commonly used in the group literature for assessing individual group member’s perceptions of the group’s therapeutic environment, was administered by either the research investigator or by the CPRT group leader(s) to each attending group member at the end of sessions eight, nine, and ten. Because of its strong reliability and validity among the current research, only the Engaged scale of the GCQ-S was used to analyze group members’ perceived levels of group cohesion. The Conflict and Avoiding scales were not analyzed because researchers have reported no effect or mixed results on outcome (Ogrodiczuk & Piper, 2003; Sehring & Engel,
1998; MacKenzie et al., 1987; Phipps & Zastowny, 1988; Braaten, 1989; Tschuscheke & Greene, 2002). Moreover, the Engaged scale alone appeared to complement the Global Cohesiveness scale. The Engaged scale reflects the importance of group members and a sense of closeness between them. It identifies the positive working atmosphere, and details a sense of constructive interpersonal investigation. Kivlihan and Goldfine (1991) reported an alpha coefficient of .94 for the Engaged scale.

In addition, at the end of their participation in CPRT, parents and caregivers completed a post treatment CBCL. Furthermore, participants were knowledgeable that all their filial sessions were recorded for educational purposes and for the purpose of this study. Three video recordings from each CPRT group were collected from the filial therapy group leaders. Budman et al. (1987) found that the end cohesion level predicted outcome, but not in the first six sessions. Thus, for eight of the groups, video recordings of sessions eight, nine, and ten were collected. For one of the groups, video recordings of sessions seven, eight, and nine were collected because one of the filial therapy group leaders was absent for session ten, thus that session would not have been a good representation of their typical group cohesion.

The research investigator edited the collected video recordings to consecutive 30-minute segments per the instructions of the GCS-II manual. For the purpose of rating group cohesion, guidelines were set for choosing which 30-minutes to rate. The guidelines were set to include segments that demonstrated most extensive group interaction in 30-minutes. The segments were edited to encompass when all the attending group members were present, and when paperwork and/or video watching in the group setting were both minimal. Each segment was put on a separate dvd, coded with a number so that only the research investigator would
know the session number and, if necessary, how to obtain more information on the group or its members. One of the group’s video recordings were unable to be rated because the GCS-II manual stated that the entire group needs to be observed in order to receive an accurate rating. In all three of this group’s video recordings, one of the group members and both leaders could not be viewed. Thus, only 27 sessions were rated.

Session recordings were reviewed by trained objective raters, who were in a doctoral program in counseling. Each rater had a master’s degree in counseling and at least two years of post master’s counseling experience. The objective raters were trained by the research investigator. Raters participated in a four hour training on the GCS-II manual, including practice rating video recordings. After the training, the raters scored two additional practice segments to establish pre interrater reliability. The Global Cohesiveness scale on the GCS-II was analyzed as the observed group measure for group cohesion because its rating best captures the overall cohesiveness of the group. It reflects group connectedness demonstrated by working together as a unit, constructive engagement around common themes, and openness to sharing personal material. The intraclass correlation coefficient was .80 on the Global Cohesiveness scale indicating that the three raters established 80% agreement on how they were rating cohesion. The manual stated that a minimum of .70 is needed.

Because the raters had obtained an acceptable intraclass correlation coefficient after their training, Urbaniak and Plous’s (2008) Research Randomizer form v4.0 was used to randomly assign the session recordings. The raters scored each session on the level of group cohesiveness using the Harvard Community Health Plan Group Cohesiveness Scale Version II (GCS-II; Soldz et al., 1987). After each rater scored three segments independently, the raters
met again as a group to practice and discuss how they were rating the segments for this project. They were asked to rate two more segments to determine mid-point interrater reliability. The intraclass correlation coefficient was 1.00 indicating that all three rated the same for these two segments. The raters continued to rate their remaining assigned segments. Afterward, each rater was given two more segments to rate to determine post interrater reliability. The final intraclass correlation coefficient was .83 indicating that they established 83% agreement on how they rated group cohesion. Averaging the ratings of sessions eight, nine, and ten for each group allowed for further examination if a group session score appeared off from its other session scores. Raters’ objective and subjective comments were analyzed to gain additional knowledge regarding some CPRT groups.

Upon completion of collecting data, the investigator coded instruments and session recordings with participants’ and/or groups’ matched code. To protect participant confidentiality, names were deleted from any instrumentation or databases; names and corresponding codes were kept in one file only accessible by the investigator. All other materials were kept in a locked cabinet at the counseling training facility.

Analysis of Data

SPSS was utilized to analyze data. To ensure accuracy, pretest and posttest data were scored using computer scoring software for the CBCL, which requires all data to be entered twice for verification. Prior to testing the hypotheses of this study, results obtained from the pretest and posttest measurements on the CBCL were analyzed to examine the effectiveness of CPRT filial therapy training groups on children’s total behavior problems. A paired sample t-test was applied to determine whether there was a significant difference between parents’ and
caregivers’ pre and post scores on the Total Problems Scale of the CBCL. A reduction in scores on the CBCL indicated improvement in behavior. Due to the small sample size and lack of a control/comparison group, eta-squared effect sizes were also calculated to determine the practical significance of the results.

The mean of participants’ self-reported engaged scores on the GCQ-S was analyzed and used for reporting parents’ and caregivers’ perceived levels of group cohesion. Appropriate statistics were reviewed for reporting observed ratings. The mean, or arithmetic average, takes into account the values of each case in a data set. It is a weighted average, whereas the mode, also termed the probability average, is the most frequent value in a data set (Schutt, 2006). The mode provides the answer to what is most common. It is the value that is most likely to be sampled. Thus, when the issue is what the most probable value is, the mode is the most appropriate statistic (Schutt, 2006). Where the mean has problems with representativeness, mode focuses on the most common numbers and gives less or no attention to less frequently-occurring numbers.

Both modes and arithmetic means were used to determine an average observed cohesiveness group score. The mode was used as the average when two of the three scores for a group equaled the same number and the third score only varied by one or two points. The mean was used when the groups’ scores varied for all three sessions or by more than two points. Determining an average this way is based on the notion that groups that scored the same for two of the three sessions were likely to remain fairly consistent across the ten sessions and should be viewed that way; whereas the other groups that varied in scores may not have been consistent across ten sessions and the lowest and highest values should be taken
into account. The mean was used to obtain an average score for four groups. The mode was used for four groups as well.

The mean was used on the groups that had varied scores, most often because the group members’ attendance varied for all three sessions. The mode was used when only one score varied greatly because that session was dissimilar from their typical sessions. For example, session nine varied greatly for three groups and session eight for one group in particular, all because someone was either present for that session but not for the other two, or someone was not present for that session but had been for the others. The scores indicated that group cohesion may have varied based on who attended. For one group in particular, the score for both sessions eight and ten was 6, but for session nine they received a 5 demonstrating an atypical rating. Their sessions eight and ten contained at least five members, while only two members attended session nine. The mode for these groups should be a more accurate average because the mode score represents what was most common for these groups.

The mean or mode observed group ratings for sessions eight, nine, and ten ranged from 4 (slight to moderate) to 6 (moderate to strong) on the Global Cohesiveness scale. Because the mean or mode was the same for some of the groups, the objective raters’ comments were analyzed to indicate which groups may have been more cohesive when comparing those to others with the same scores. Based on subjective comments, the highest rated group on the GCS-II was also the highest rated group on the GCQ-S lending validity to the group cohesiveness outcome.

Furthermore, to determine the relationship between group cohesion and CPRT outcome, Pearson product-moment correlation analyses were performed. The alpha .05 level
of statistical significance was established as the criterion for either accepting or rejecting a hypothesis. In addition, because of the exploratory nature of this study, post hoc analyses were performed to investigate intricate details within the data.

Tables 5, 6, and 7 are provided at the end of this chapter for easy access and reference to data that was reported in this study. In chapter 3, I discuss further data contained in these tables.
Table 5
Participants’ Information at the Individual Level

<table>
<thead>
<tr>
<th>Participant</th>
<th>Group</th>
<th>GCQ-S Engaged Self-report, 0-6 scale</th>
<th>GCS-II Observed Cohesion, 1-9 scale</th>
<th>CBCL Total Problems Outcome</th>
<th>Attendance</th>
<th>Gender</th>
<th>Ethnicity</th>
<th>Age</th>
<th>Marital Status</th>
<th>Child of Focus</th>
<th>Gender</th>
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(table continues)
Table 5 (continued)

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<td>AA</td>
<td>39</td>
<td>S</td>
<td>M</td>
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</table>

Note. A positive CBCL outcome score indicates that the parent or caregiver reported an improvement in the child’s behavior after participating in CPRT. A negative CBCL outcome score indicates that the parents’ or caregivers’ perceptions of their child’s behavior worsened between the beginning and end of their participation in CPRT. For Gender, F = Female; M = Male. For Ethnicity, C = Caucasian; H = Hispanic; AA = African American; A = Asian. For Marital Status, M = Married; S = Single; D = Divorced.

*aAttendance unknown for this group.

*bThis group’s video recordings could not be rated.
<table>
<thead>
<tr>
<th>Participants’ Child of Focus</th>
<th>Gender</th>
<th>Age</th>
<th>CBCL Outcome</th>
<th>Clinical/Nonclinical</th>
<th>Parents’ Presenting Concerns</th>
<th>Change Between Pre &amp; Post</th>
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<td>3</td>
<td>1</td>
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<td>Aggression</td>
<td>Improved</td>
</tr>
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<td>F</td>
<td>5</td>
<td>27</td>
<td>C</td>
<td>Aggression; Relationship</td>
<td>Improved</td>
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<td>M</td>
<td>8</td>
<td>8</td>
<td>C</td>
<td>Self-esteem; Depressed feelings</td>
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</tr>
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<td>M</td>
<td>2</td>
<td>1</td>
<td>N</td>
<td>Aggression</td>
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</tr>
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<td>5</td>
<td>3</td>
<td>N</td>
<td>Attention</td>
<td>Improved</td>
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<td>9</td>
<td>8</td>
<td>C</td>
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<td>C</td>
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<td>Improved</td>
</tr>
<tr>
<td>17</td>
<td>M</td>
<td>9</td>
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<td>C</td>
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<td>Worse</td>
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<td>5</td>
<td>13</td>
<td>N</td>
<td>Anxious; Depressed feelings</td>
<td>Improved</td>
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<td>19</td>
<td>M</td>
<td>5</td>
<td>3</td>
<td>C</td>
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<td>Improved</td>
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<td>N</td>
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<td>7</td>
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<td>C</td>
<td>Aggression; Attention</td>
<td>Worse</td>
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Table 6 (continued)

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<td>N</td>
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<td>6</td>
<td>13</td>
<td>N</td>
<td>Attention</td>
<td>Improved</td>
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Note. Clinical (C) means that the child’s CBCL Total Problems score was in the borderline/clinical range. Nonclinical (N) means that the child’s score was in the normal range. The N to C means that the child’s score was in the nonclinical range on the pretest and in the clinical range on the posttest.

aThe child of focus was the same child for both participants.
Table 7
Averaged Participants’ Information for a Group Total Score

<table>
<thead>
<tr>
<th>Group</th>
<th>Group Members</th>
<th>Members’ Data Missing</th>
<th>GCQ-S Engaged Self-reports</th>
<th>GCS-II Observed Group Cohesion</th>
<th>CBCL Group Outcome</th>
<th>Average Attendance</th>
<th>Male Dropouts</th>
<th>Female Dropouts</th>
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<tr>
<td>1</td>
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<td>3</td>
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<td>2</td>
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<td>7.33</td>
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<td>8.17</td>
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<td>.33</td>
<td>8.33</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. Members’ Data Missing means that those group members’ data could not be included in the study because either they were absent more than four times or because they did not complete all the necessary paperwork. CBCL group outcome score is the mean outcome for group participants’ perceptions of their children’s behavior after CPRT treatment. A positive score specifies that the group’s average indicated a positive improvement in their children’s averaged behavior outcome after CPRT.

The dash indicates that this group’s video recordings could not be rated.
CHAPTER 3
RESULTS AND DISCUSSION

This chapter presents the results, discussion, and limitations of this study, as well as research implications and recommendations for future research. The results of the data are presented in the order of which hypotheses were tested. Consultation with a qualified statistician was used to ensure the validity and appropriateness of all statistical analyses. All tables related to data are reported in Tables 1-10. A list of tables is on page v.

Results

CPRT Outcome

A paired sample t-test analysis was computed to determine whether there was a statistically significant difference between parents’ and caregivers’ pre and post scores on the Total Problems scale of the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001). Statistical significance was not established ($t(29) = 1.31, p = .20, \eta^2 = .06$). Due to a lack of control/comparison group, an eta-squared effect size was calculated to explain the practical significance of parents’ and caregivers’ perceptions of their children’s behavior problems between the beginning and end of treatment in Child-Parent Relationship Therapy. According to Cohen’s (1988) guidelines, the calculated eta-squared indicates that CPRT demonstrated a medium effect on child behavioral changes as reported by parents and caregivers on the CBCL. However, a two point decrease within a normal range on the CBCL may not represent clinical significance. Table 8 on the following page reports participants’ mean scores on the Total Problems scale of the Child Behavior Checklist before and after treatment in CPRT.
Table 8

Mean Scores on the Total Problems Scale of the Child Behavior Checklist (CBCL)

<table>
<thead>
<tr>
<th>Total Behavior Problems, n = 30</th>
<th>Pretest</th>
<th>Posttest</th>
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<tr>
<td>Mean</td>
<td>57.23</td>
<td>55.07</td>
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<tr>
<td>Standard Deviation</td>
<td>11.74</td>
<td>11.30</td>
</tr>
</tbody>
</table>

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

Hypothesis 1

Hypothesis 1 stated that there will be a significant correlation between participants’ mean Engaged scale scores on the Group Climate Questionnaire-Short Form (GCQ-S; MacKenzie, 1983) and the difference scores between their pre and post Total Problems scale scores on the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001).

The engaged score reflects the importance of group members and a sense of closeness between them. It also identifies the positive working atmosphere, and details a sense of constructive interpersonal investigation. The scale on the GCQ-S ranges from 0 to 6: (0) not at all; (1) a little bit; (2) somewhat; (3) moderately; (4) quite a bit; (5) a great deal; and (6) extremely. The CBCL outcome score reflects parents’ and caregivers’ perceptions of their children’s total behavior problems between the beginning and end of their participation in CPRT. A positive CBCL outcome score indicates an improvement in the child’s total behavior problems after CPRT treatment.

Table 9 on the following page reports participants’ mean Engaged scores and their outcome scores on the Total Problems scale of the CBCL. Participants’ mean ratings from sessions eight, nine, and ten on the GCQ-S indicate that the groups were engaged. Their scores ranged from 2.40 to 5.14 (M = 4.05, SD = .80) indicating that participants thought their groups exhibited “somewhat” to “a great deal” level of engagement and positive working alliance.
Moreover, 63% of the participants scored four or above indicating that they believed their groups established “quite a bit” or higher level of engagement and positive working alliance.

Table 9
Participants’ Engaged Scores and Total Problems Outcome Scores

<table>
<thead>
<tr>
<th>Participant</th>
<th>Group</th>
<th>Engaged Score</th>
<th>CBCL Outcome Score</th>
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</thead>
<tbody>
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<td>1</td>
<td>1</td>
<td>4.60</td>
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Note. Engaged scale ranges from 0 to 6. A positive CBCL outcome score indicates an improvement in the child’s total behavior problems after CPRT treatment.
Results of the Pearson product-moment correlation coefficient analysis with the participants’ mean scores \( n = 30 \) on the Engaged scale of the GCQ-S and their difference scores between the pre and post on the Total Problems scale of the CBCL did not reveal a statistically significant correlation, \( r(29) = .23, p = .23 \). These findings indicate that the results of parents’ and caregivers’ perceptions of their children’s behavior problems between the beginning and end of participation in CPRT are not statistically correlated to their perceived levels of engagement within their groups. In other words, parents’ and caregivers’ perceptions of the working atmosphere, sense of constructive interpersonal investigation, the importance of the group for members, and a sense of closeness between them had little or no association with the outcome of their scores on the Total Problems scale of the CBCL. On the basis of these results, Hypothesis 1 was rejected.

Figure 1 graphically displays the correlation between parents’ and caregivers’ mean Engaged scale scores on the GCQ-S and the difference between their pre and post scores on the Total Problems scale of the Child Behavior Checklist (CBCL).
Hypothesis 2

Hypothesis 2 stated that there will be a significant correlation between the objective raters’ mean or mode Global Cohesiveness scale scores on the Harvard Community Health Plan Group Cohesiveness Scale-Version II (GCS-II; Soldz et al., 1987) and participants’ difference scores between their pre and post Total Problems scale scores on the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2000, 2001).

The Global Cohesiveness score reflects group connectedness demonstrated by working together as a unit, constructive engagement around common themes, and openness to sharing personal material. The scale on the GCS-II ranges from 1 (very slight) to 9 (very strong). The CBCL outcome score reflects participants’ difference scores regarding their perceptions of their child’s total behavior problems between the beginning and end of treatment in CPRT. A decrease in score indicates that the child’s behavior improved.

Table 10 on the following page reports participants’ outcome scores on the Total Problems scale of the CBCL and their group’s Global Cohesiveness score on the GCS-II. The groups’ ratings on the Global Cohesiveness scale ranged from 4 to 6 ($M = 5.04$, $SD = .76$). Three groups were given a rating of 5 and two groups received a 6 indicating that five of the seven groups rated demonstrated high levels of connectedness and therapeutic work. The two groups that were rated a 4 demonstrated considerable engagement between the group members, but no therapeutic work. In the GCS-II manual, therapeutic work is classified as involving identification of a problem, elaboration of how the problem manifests itself, exploration of causes, reasons for the problem (external or internal), making connections between problem areas, and interpersonal learning through feedback between members or between therapist
and a member (Soldz et al., 1987). The raters’ scores suggest that all the groups rated displayed some positive degree of connectedness.

Table 10

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*Note.* The Global Cohesiveness scale ranges from 1 to 9. A positive CBCL outcome score indicates an improvement in the child’s behavior between the beginning and end of treatment in CPRT.

*aThe dashes indicate that this group’s video recordings could not be rated.*
Results of the Pearson product-moment correlation analysis with the observers’ mean or mode scores ($n = 27$) on the Global Cohesiveness scale of the GCS-II and the difference scores between the pre and post Total Problems scale scores on the CBCL did not reveal a statistically significant correlation, $r(26) = .13, p = .51$. These findings indicate that the results of parents’ and caregivers’ perceptions of their children’s behavior problems between the beginning and end of their participation in CPRT are not statistically correlated to the observed levels of cohesiveness within their groups. In other words, the observed overall level of cohesiveness had little or no association with the outcome of the parents’ or caregivers’ scores on the Total Problems scale of the CBCL. On the basis of these results, Hypothesis 2 was rejected.

Figure 2 on the following page graphically displays the correlation between the observers’ mean or mode scores on the Global Cohesiveness scale of the GCS-II and the difference scores between parents’ and caregivers’ pre and post Total Problems scale scores on the CBCL. Table 5 at the end of chapter 2 lists participants’ GCS-II self-report scores, their GCQ-S observed scores, their CBCL outcome scores, attendance, gender, ethnicity, age, marital status, child’s gender, and child’s age.
Figure 2. Correlation of GCS-II Cohesiveness Scores and CBCL Total Problems Outcome Scores.

Group Cohesion Measurements

Results of the Pearson product-moment correlation analysis on the participants’ GCQ-S Engaged scores and the raters’ GCS-II Global Cohesiveness scale scores revealed a statistically significant correlation, $r(26) = .53, p = .01$. This finding suggests that participants’ perceived levels of group cohesion and raters’ observed levels of group cohesion are related. The self-report and observation measurements appear to complement each other regarding group cohesion. Figure 3 on the following page graphically displays the correlation between participants’ GCQ-S Engaged scores and raters’ GCS-II Global Cohesiveness scores.
Figure 3. Correlation of GCQ-S Engaged Scores and GCS-II Cohesiveness Scores.

Post Hoc Analyses

Due to the exploratory nature of this study, several post hoc analyses were performed to investigate intricate details within the data. Because no statistical significance was found between the beginning and end of treatment in CPRT, separate paired sample t-tests were performed for those children who scored in the normal range \( n = 18 \) and for those who scored in the borderline or clinical range \( n = 12 \) on the CBCL. The results revealed no statistically significant difference between either group; however, the difference between these two groups in terms of effect sizes was striking. Results revealed a negligible effect size for those that scored in the normal range \( t(17) = .18, p = .86, \eta^2 < .01 \), but a large effect size for those that scored in the borderline or clinical range \( t(11) = 2.04, p = .07, \eta^2 = .27 \). Moreover, the mean difference T-score of those in the normal range was .39, and the mean difference T-score of those in the borderline or clinical range was 4.83, indicating a difference between the two groups; and thus, a sizable variation among the participants in this study (see Table 6 in chapter)
2). These results suggest that CPRT is an effective filial treatment model for children who score in the borderline or clinical range on the CBCL. It is important to note these results came from small sample sizes, so the results must be interpreted with caution. Research with larger sample sizes is certainly recommended.

T-test and correlation analyses were further used to investigate whether participants’ demographics and/or attendance was significant to the CPRT treatment outcome or group cohesion measurements. Although, there were not many significant findings, there was a significant relationship between participants’ gender and their scores on the Engaged scale of the GCQ-S, \( t(28) = 2.42, p = .02, \eta^2 = .17 \). Females reported higher levels of group cohesion than males, even when they participated in the same group. Moreover, attendance did not appear to be related to outcome or engagement, but a significant correlation was found between participant’s age and attendance, \( r(27) = .43, p = .02 \).

Furthermore, data regarding the nine groups was analyzed because group researchers encourage group instruments to be reviewed at the group level rather than the individual level, and because participants’ individual scores on the CBCL varied greatly making it too difficult to compare the group members’ outcomes within each group, or to other participants in this study. Results of the Pearson product-moment correlation analysis between the groups’ mean self-report scores of group cohesion on the GCQ-S and their mean group outcome on the CBCL revealed a significant correlation, \( r(8) = .70, p = .04 \). This finding suggests that outcome at the group level may be related to group cohesion. There was no significant relationship between the group outcome on the CBCL and the observed group cohesion on the GCS-II, \( r(8) = .35, p = .40 \), likely because so many of the groups scored alike.
Discussion

This research was conducted to assess the impact that group cohesion has on the outcome of Child-Parent Relationship Therapy groups. Group members \((n = 30)\) who met the criteria to be considered for this study participated in at least six sessions of CPRT and completed pretest and posttest data on their child of focus. Treatment outcome was measured through participants’ ratings of their children’s total behavior problems. The treatment effect of CPRT, for this study, yielded no statistical difference between the pretest and posttest data. Eta-squared was calculated to determine the practical significance of the treatment findings. Although the calculated eta-squared showed a moderate effect on the behavior of children whose parents or primary caregivers participated in CPRT, a two point decrease on the Total Problems scale between the beginning and end of treatment may not represent clinical significance.

Group cohesion was measured through participants’ self-reports of group engagement and objective raters observed levels of filial group cohesiveness. Data was collected regarding sessions eight, nine, and ten because, according to group research findings, group cohesion increases over time. In addition, the investigator was trying to obtain information with the least amount of interruption of the filial therapy process.

For this study, statistical analyses revealed that group cohesion had little or no relationship to parents’ and caregivers’ difference scores between their pretest and posttest results on the Total Problems scale of the Child Behavior Checklist (CBCL). Thus, the two hypotheses were rejected because results of correlations were not significant. Group cohesion did not appear to be related to participants’ individual outcomes.
Discussion of results is organized as follows: (1) CPRT outcome, (2) self-reports of group cohesion, (3) observed ratings of group cohesion, (4) group cohesion and group outcome, (5) homogeneous versus heterogeneous groups, (6) high cohesion groups versus low cohesion groups, (7) attendance, (8) selection process, and (9) dropout rates.

**CPRT Outcome**

In a meta-analysis of twenty-two studies coded as parent filial therapy interventions, Bratton et al. (2005) revealed that parent filial therapy groups had a large treatment effect. In determining effectiveness for this study, I chose to use one composite score from the CBCL. The Total Problems scale seemed most logical because it entails children’s total behavior problems, including internalizing and externalizing behaviors, giving a better description of children’s overall behaviors.

Although, this particular study did not reveal a statistically significant difference between parents’ and caregivers’ perceptions of their children’s behavior problems between the beginning and end of treatment in CPRT, 63% of the participants (19/30) saw an improvement in their child’s total behavior problems after participating in CPRT (see Table 6). These results suggest that CPRT is helpful in making a difference in children’s behaviors, as already recognized in the results of previous research on the effectiveness of CPRT. Several explanations may help to clarify why this study did not reveal statistical significance or a large treatment effect size, as has often been found in other CPRT filial studies.

This particular study is unique from other filial studies in several ways. Not only is this study the first to examine the group support aspect of filial, it is also the first heterogeneous filial therapy study. In other words, these participants were not selected based on a specific
population criterion (e.g., single parents or Korean parents) nor did their children meet a
problem-specific criterion (e.g., child witnesses of domestic violence, chronically ill children, or
children who scored in the borderline or clinical range on the CBCL). The participants in this
study were recruited by clinic flyers; community advertisements; word of mouth; and by
acquaintances of filial therapy leaders. The only selection criterion for this study was that
participants had to complete pretest and posttest data, attend six out of the ten group sessions,
and attend a group that terminated with at least three group members and both leaders. Thus,
children with and without behavioral problems were examined in this study, which is atypical of
other filial research. In fact, 60% of the children in this study scored in the normal range on the
Total Problems scale on the CBCL indicating that parents’ and caregivers’ perceptions of their
children’s behaviors were normal compared to children of the same gender and age.

Moreover, an analysis examining the relationship between CPRT outcome and children
who scored nonclinical versus clinical on the CBCL was conducted. The results revealed that
children who scored in the normal range on the Total Problems scale demonstrated a negligible
effect size after participating in the CPRT filial therapy training groups. However, those who
scored in the borderline or clinical range demonstrated a large effect size suggesting that CPRT
may be most effective for children who score in the borderline or clinical range on the CBCL. It
is important to note these results came from small sample sizes, so the results must be
interpreted with caution. Research with larger sample sizes is certainly recommended.

Furthermore, the high percentage of participants whose children scored in the normal
range, yet who reported concern for their children’s behaviors, might suggest that parents and
caregivers are unaware of children’s developmental stages and what is considered normal
behavior for their children’s ages. It also suggests that a wider variety of parents and caregivers are seeking better ways of parenting, possibly because they desire a more positive parent-child relationship, or because they are feeling overwhelmed and need help dealing with their children’s behaviors.

*Self-reports of Group Cohesion*

Although the results of the participants’ self-reports revealed no statistical correlation with their individual outcomes, there were some findings which merit further discussion. Table 5 lists participants’ scores on the self-report GCQ-S, their GCS-II observed scores, their CBCL outcome scores, their CPRT attendance, gender, ethnicity, age, marital status, child’s gender, and child’s age. There was a significant relationship between participants’ gender and their scores on the Engaged scale of the GCQ-S, $t(28) = 2.42, p = .02, \eta^2 = .17$. On the 0-6 scale, females’ mean scores were .74 points higher than male participants. When looking at the groups that contained both females and male(s), females’ scores were on average .88 points higher than males from the same group. However, for the all male group, two of their three group members’ scores were higher than two of the other groups with both females and male(s) suggesting that male participants may feel more engaged and benefit most from being in groups with other males. Further research is needed to investigate gender and cohesion in CPRT groups.

Participants’ mean engaged scores ranged from 2.4 to 5.14, with 63% scoring four or above indicating that they thought their groups exhibited “quite a bit” or higher level of positive working alliance. The majority of high scores suggests that individuals responded positively to a socially-oriented psychoeducational counseling experience. Moreover, the mean
group scores ranged from 2.82 to 4.8 indicating that the least engaged group reported a “somewhat” to “moderately” positive working alliance in the group, and the most engaged group reported “quite a bit” to “a great deal.”

Only four participants scored below three on the scale, two of whom were in the same group suggesting that they did not believe their group had much cohesion, perhaps because their group was the least homogeneous. Their group differed greatly by presenting concerns, gender, relationship to their child, marital status, and occupation. These differences might have made it difficult for them to relate to one another and account for their perceived levels of group cohesion. The third individual who scored below a three on the GCQ-S was the only divorced parent in her group. This factor likely created other differences between this mother and the other two mothers in the group. In addition, the fourth individual who scored below a three was also from one of the least homogeneous groups. More specifically, this individual was significantly different from the other two group members who appeared to relate better to one another. This particular group member was thirteen to fifteen years older than the other two group members, he had been divorced and remarried, he had a higher level of education and SES, his child of focus was three years older than the other two members’ children, his child of focus was the only one in this group who scored in the normal range on the CBCL pretest, and his rationale for participating in CPRT was not regarding behavioral concerns, rather it was to learn new parenting skills. His low score compared to his group members’ high scores suggested that perhaps he did not feel as engaged as the other members.
**Observed Ratings of Group Cohesion**

The top four rated groups on the GCQ-S were also among the top four rated groups on the GCS-II. Based on subjective comments, the highest rated group on the GCS-II was also the highest rated group on the GCQ-S lending validity to the group cohesiveness outcome. The objective raters’ comments stated that the group members appeared bonded and cohesive. They also noted that this leader was facilitative throughout and encouraged members to discuss personal examples.

In addition, one of the objective rater’s comments mentioned that the group being conducted at the group leader’s home seemed to have the best chemistry. It was suggested that the reason might have been because being at a home provided a more familiar and comfortable atmosphere. This group was comprised of the leader’s sister, sister-in-law, a friend of the co-leader, and an unknown individual who was recommended for the group. These relationships may have influenced the group cohesion as well. However, at the beginning of the process, two of the group members did not know the other two members, nor did they know one of the leaders, suggesting that perhaps the environment may have played a more significant role. Further research is needed to explore the relationship between group cohesion and filial therapy group settings.

The other two groups that were rated among the top four in terms of cohesiveness were described as having good dynamics, seemed very bonded, and demonstrated observable affect. Comments regarding the lowest rated group suggested that the group leaders did a nice job of attending to the educational components of filial therapy as well as the needs of a process group; however, the group did not appear to be bonded. Comments regarding two of
the other groups with lower scores revealed that the group leaders seemed to lack warmth and empathy, yet their scores were boosted by the many attempts at exploring underlying causes and feelings. The objective raters’ comments suggested that group cohesion was lower for those groups whose leaders seemed to lack warmth and empathy ($n = 2$); however, their comments regarding the lowest rated group suggest that group leaders can do a good job of bridging the teaching and counseling components of filial therapy, but for some groups this aspect cannot change how well the group members bond to one another, which seems to further support the idea that homogeneous groups may be most effective. The group that scored the lowest on the GCQ-S could not be rated on the GCS-II, because their videotapes only showed one or two group members, and the raters noted that without seeing the group members and leaders the tapes could not be rated accurately.

Moreover, the GCQ-S and the GCS-II were correlated at the .01 level, which is consistent with the finding that the four groups rated highest on the GCQ-S were also among the top four groups on the GCS-II. Furthermore, only two groups ended with lower observed cohesiveness ratings consistent with previous research findings that cohesiveness typically increases over time (MacKenzie et al., 1987). To note, both of the groups whose cohesiveness scores were lower at the end of CPRT contained at least one group member who had not been there for the previous session, suggesting the departure and return of group members may have a negative effect on group cohesion. The same appeared to be true of other groups regarding session nine.

According to Berg et al. (1998), every group member has formulated preferences for how he or she prefers all other participants to be and to act, and when the preferences do not correspond with reality, there may be an increase in group resistance. Absenteeism or
inconsistent attendance of some group members might have been a cause for resentment by others who were more committed or better able to attend all sessions, and who expected the same from other group members. In other words, the difference between group members’ preferences (e.g., for more commitment or better attendance from all group members) and reality (some members were absent or demonstrated inconsistent attendance) may have had a negative effect on group cohesion. Further research with a larger sample size is needed to examine absenteeism and group cohesion in CPRT groups.

**Group Cohesion and Group Outcome**

Improvement in children’s total behavior problems did not seem to have a relationship with group cohesion at the individual outcome level. Group research has previously revealed mixed results when analyzing group instruments at the individual level (Johnson, in press). Although the initial plan was to look at group outcome rather than individual outcome, I was unable to do so because of the limited number of groups ($n = 9$). In addition, four of the nine groups did not include their entire group members’ data; thus, some self-report measures on group engagement and outcome were unable to be determined for those groups.

I would have preferred to analyze the data using the groups’ overall averaged engaged scores on the GCQ-S and their averaged outcome scores on the CBCL because the participants’ individual scores on the CBCL varied greatly making it too difficult to compare the group members’ outcomes within each group, or to other participants in this study. However, because the research encourages these instruments to be reviewed at the group level rather than the individual level, I decided to analyze the data with only nine groups and found a significant correlation between the mean group self-report scores of group cohesion on the GCQ-S and the
mean group outcome on the CBCL. This finding suggests that outcome at the group level may be related to group cohesion. In other words, when group members’ scores are considered collectively, the more cohesive the group the better the outcome of CPRT. It is important again to note the small sample size \((n = 9)\) and that these results should be considered with caution (see Table 7).

There was no significant relationship between the group outcome on the CBCL and the observed group cohesion on the GCS-II, likely because so many of the groups scored alike. The ratings ranged from 4 to 6, with three groups all having a rating of 5, two with ratings of 4, and two with ratings of 6. However, a closer examination seems to support the idea that both perceived and observed levels of group cohesion may be related to group outcome, because three out of four of the groups who scored highest on the self-report measure and on the observed ratings also had the highest group outcome (see Table 7).

**Homogeneous Versus Heterogeneous**

“Homogeneous groups jell more quickly, become more cohesive, offer more immediate support to group members, are better attended, have less conflict and provide more rapid relief of symptoms” (Yalom & Leszcz, 2005, p. 272). Results from Perrone and Sedlacek’s (2000) study on six homogeneous and four heterogeneous counseling groups revealed that group cohesiveness and client satisfaction were significantly higher in homogeneous groups, consistent with previous research (Connelly & Piper, 1989; Marziali et al., 1997). These researchers often attribute these significant findings to social identity theory and Yalom’s notions, which suggest that connection with similar others, in terms of external characteristics
(age, ethnicity) or internal ones (values, attitudes), promotes positive feelings about the self and the group in which one is a member (Tajfel & Turner, 1986; Yalom & Leszcz, 2005).

Perrone and Sedlacek (2000) suggested that homogeneity with regard to both gender and ethnicity, and homogeneity of the presenting problem appear to offer a positive experience for group members. They were unable to determine which influential homogeneous characteristic is most important, but MacKenzie (1990) recommended that short-term groups, regardless of theoretical orientation, be homogeneous around a common presenting complaint. Perrone and Sedlacek’s finding that homogenous groups were more cohesive and led to more client satisfaction than heterogeneous counseling groups suggests that counselors should consider increased use of homogenous groups rather than heterogeneous counseling groups for some clients. Moreover, research from six internet support groups found that the more homogeneous groups were more attracted and committed to their groups. These groups also demonstrated significantly greater positive change than the heterogeneous groups (Lieberman, Wizlenberg, Golant, Di Minno, 2005).

The results on group cohesion for this study emphasize the need for CPRT to be conducted in homogeneous groups. This suggestion is further supported by the effectiveness difference between other CPRT homogeneous studies and this heterogeneous study which included a wide variety of children with nonclinical and clinical behavioral problems and a wide variety of parents and caregivers with different reasons for participating in CPRT. The group cohesion outcome measures from this study suggest that participants feel more supported in homogeneous groups, whether by parent factors (e.g., gender, ethnicity, age, occupation, marital status, etc.) or by child factors (gender, age, behavior problems, etc.). Because these
groups were mainly heterogeneous due to the fact that participants were placed together primarily based on which day or time was best for them to attend, this study was unable to determine whether there is a stronger relationship between groups formed on the basis of children’s ages, behavior problems, or parent factors. Previous research suggests that researchers inquire as to what participants view as most important to their identity and try to match groups accordingly in order to provide the most group support and satisfaction possible. Further studies are needed to address how to homogeneously group them (e.g., by gender/ethnicity, by single parents, divorced parents, adoptive parents, housewives, grandparents by age, employed mothers, employed fathers, or by children’s developmental ages and/or problems).

It is important that all group counselors be sensitive and knowledgeable about gender and multicultural issues, especially when leading homogenous groups based on gender or ethnicity. Furthermore, it is recommended that if filial therapists wish to lead groups based on homogeneity of presenting problem (e.g., developmentally delayed), they first gain knowledge and counseling experience related specifically to that problem.

*High Cohesion Groups Versus Low Cohesion Groups*

The highest rated groups on both the self-report and observed group cohesion measurements were also among the most homogeneous. The group with the highest average on both the GCQ-S and the GCS-II was led by a Caucasian male doctoral student and co-led by an Asian female international Master’s student. Their group members were homogeneous regarding gender and ethnicity, and the majority appeared homogeneous regarding presenting concerns. The group consisted of six female Caucasian members ranging in age from twenty-six
to forty-eight years old. Three of the group members were married mothers, one married step-grandmother, and two single mothers. Furthermore, three of the members listed their occupation as stay-at-home mothers, and the other three included a real estate agent, massage therapist, and a temp agency worker. Their children of focus ranged in age from two and a half to five years old. Two group members listed their reason for participating in CPRT as wanting to improve their relationship with their child of focus, and four listed their reason as concern for their child’s aggressive behaviors. Only three of these members completed the pretest and posttest CBCL; thus, only three were able to participate in this study. All three participants were biological mothers, all considered themselves stay-at-home mothers, and all were concerned with their child’s aggressive behaviors. Moreover, two of the three children were three year olds who scored in the normal range on the CBCL. These findings may suggest multiple implications, including but not limited to, the notion that group leaders do not need to be homogeneous to the group, or there are some advantages to having a male leader.

Some researchers suggest that there may be a difference among groups based on the therapist’s gender. Greene, Morrison, and Tischler (1981) suggested that male leaders are seen as significantly more potent, active, instrumental, and insightful. Thune, Manderscheid, and Sillegeld (1981) suggested that gender was a determinant of status rather than professional experience or affiliation. Their findings suggest that the group led by the male leader in this study may have resulted in better outcomes because the group inferred thoughts about the group, CPRT therapy, and the positive working alliance as a result of being led by a male. Interestingly, one of the objective rater’s comments regarding this group noted that the group
was focused and bonded on topics such as discussing absent husbands. More research should be done comparing groups led by male leaders versus female leaders.

Moreover, one of the other more cohesive groups was homogeneous by participants’ gender, age, ethnicity, and relationship to their child. These findings support previous research that homogeneity by gender and ethnicity, and by presenting problems yields benefits at both the individual and group levels. The two groups just discussed were in the top three groups that demonstrated the greatest group improvement in their children’s total behavior problems.

Furthermore, two out of three of the groups which scored the lowest on the group cohesion measurements also scored among the two lowest group outcomes. These groups were least homogeneous. Their participants’ varied greatly by children’s behavioral concerns, participants’ ages, and by children’s ages. The age difference for the participants spanned up to 15 and 16 years. For one of these groups, the age difference for the participants’ child of focus varied by eight years, demonstrating a very large difference in the children’s developmental stages, and thus likely a large gap in the group members’ individual needs being met.

Furthermore, the lifestyles of individuals within these two groups varied greatly. For one of these groups, one mother had no prior experience with children while the other two had older children. In the other group, members consisted of a homosexual, adoptive father in his thirties with a seven year old male, a married grandfather in his thirties with a seven year old female, and a married grandfather in his fifties with a ten year old male. The grandfather in his fifties had a mean engaged score of 2.8 suggesting that he might not have felt connected to the other members. Perhaps, he would have benefited more from being in a group with others with whom he could relate better.
Furthermore, the group that was unable to be rated on the GCS-II but that had the lowest engaged scores on the GCQ-S appeared to be homogeneous by ethnicity and age. This group was led by two female master’s students, one African American, the other Caucasian. The group consisted of three single African American parents, ranging from thirty to thirty-nine years old, all of whom knew the African American leader prior to the start of this group, but none of whom knew one another or the Caucasian co-leader. This group was not homogeneous by presenting concerns. One parent was a single adoptive father concerned with his eight year old son’s attention problems. The single biological mother was concerned with her five year old daughter’s self-confidence. The divorced biological father was concerned with his three year old son’s speech impediment and his living situation with his mother. Although this group appeared homogenous by ethnicity and age, this group was not homogenous by gender or by presenting concerns. The findings of this group warrant further research regarding group leader’s friends participating in their CPRT groups. The research investigator of this study warns that this factor may create a negative outcome based on the different role the friend must play. The high dropout rates of the leader’s friends from this study, and the low engagement scores, and low outcome scores of this group seem to support this notion.

Attendance

The mean attendance for participants in this study was 8.4 sessions. Of note, the least attended sessions were four, five, six, and nine. Seven of the twenty-eight participants missed each of these sessions. Attendance for two participants was unknown. Further research is needed to investigate predictors of attendance. This research investigator believes there may be a relationship between attendance and parents’ and caregivers’ anxiety regarding the need
to show their recorded at-home play sessions to the group. Perhaps some participants decide not to attend for fear of embarrassment.

Interestingly, only one parent missed session seven, making it the most attended session in this study. Although the CPRT manual lists session seven as reviewing self-esteem building responses, some group leaders chose to review choice-giving, while others focused on encouragement versus praise. Thus, we cannot infer that high attendance was necessarily related to learning self-esteem building responses.

One explanation for poor attendance for session nine is that it may be related to participants’ fear of or disappointment in preparing for termination. Perhaps participants were trying to protect themselves from emotional feelings related to discussing session ten as their final session, or perhaps they decided not to attend because they did not want to complete the final paperwork. Many parents and caregivers complained about the paperwork. Further research is needed regarding attendance rates, especially in relation to participants’ showing their play session videotapes and filling out post data.

The day and time of year may also be a factor that influences attendance. The only group to have zero participants drop out also had the most absentees, indicating that Saturdays in the summer time may not be the best time to hold CPRT groups. This group reported traveling and moving as the top reasons for missing some sessions, suggesting other seasons may be better times to conduct CPRT groups.

In short, attendance for this study did not appear to be related to engagement or outcome. Rather, attendance appeared to be related to participant’s age, \( r(27) = .43, p = .02 \). Participants age thirty-six and above \( (n = 16) \) missed no more than two sessions (see Table 5).
Selection Process

Previous researchers have suggested that there is a strong correlation between member selection criteria and successful group experiences. Yalom (1975) stated that “the fate of a therapy group and its members is to a large extent determined before the first group session” (p. 19). Thus, when therapists are able to identify suitable participants, they are more likely to prevent negative effects that are associated with failures and causalities for both group members and leaders (Piper & McCallum, 1994). This approach stresses the importance of member selection to the success of group process and outcome. I believe this concept should apply to CPRT groups as well, because CPRT is considered both psychoeducational and group process oriented.

Berg, Landreth, and Fall (1998) suggested assessing group members’ intrapersonal awareness, self-concept, and interpersonal strengths and weaknesses prior to placing them in group therapy. Member selection should involve assessing whether particular individuals should be included or excluded from participating in CPRT or from participating in particular CPRT groups. Therapists might need to refer some interested parents being considered for group membership to individual CPRT or counseling, or their children to individual or group play therapy, or to suggest other resources such as parenting books specific to both their parenting needs and their children’s needs. It might also be helpful to refer children with academic difficulties to a testing center, where the child can participate in a full battery of assessments to help determine problem areas and to receive suggestions on how to improve or cope with these academic difficulties.

Piper and McCallum (1994) agree that the goals of therapy groups are strong
determinants of participant selection criteria. Thus, it is important for therapists to be clear with participants about the didactic approach of CPRT prior to the start of the first session. The selection criteria should follow in a manner consistent with the CPRT didactic approach.

Participants that are not likely to share the CPRT objectives and are unable or unwilling to participate in the required interpersonal process, educational learning process, and skill practice process should typically be excluded from participating. Therapists should make other recommendations for these individuals. Researchers suggest that this preparation process is likely to increase attendance, retention, and certain types of therapy processes. In addition, this preparation process has been linked to lower anxiety, lower disappointment, and lower dissatisfaction for clients.

Thus, one suggestion to increase attendance and participation would be to discuss and/or assess the following with participants prior to their first filial therapy session: (1) CPRT beliefs/theoretical model; (2) goals of CPRT; (3) learning objectives of CPRT; (4) therapist’s techniques (e.g., use of role play, expressive arts, handouts, homework assignments, etc.); (5) strategy for selecting the group (e.g., homogeneous regarding presenting concern, homogeneous regarding child’s age, etc.); (6) structural aspects of the group (e.g., group size, gender, two hour sessions, ten sessions, etc.); (7) participant’s motivation for treatment; (8) participant’s expectations of gain from therapy; (9) participant’s interpersonal problems; (10) participant’s commitment to changing interpersonal problems; (11) participant’s commitment to changing parent-child relationship; (12) participant’s willingness to learn and practice new skills; (13) participant’s willingness to be of help to others; and (14) participant’s willingness to be helped by others.
Although I have listed many things for therapists to discuss with individuals seeking CPRT, this discussion does not have to be time consuming. Therapists can ask participants simple questions to obtain information, such as: (1) What has motivated you to seek our help? (2) What are your expectations? (3) Are you experiencing any difficulties right now that may be affecting you, your child, and your parenting? (4) How willing are you to work on improving problems that may be affecting you, your child, and/or your parenting? and (5) Are you willing to learn and to practice new skills on your own through videotaped, at-home play sessions and in the group setting through role play and supervision of your videotapes?

In short, it is recommended that the therapist give prospective group members a handout or brochure to help them review and discuss the beliefs, goals, and learning objectives of CPRT. This process should help therapists to understand participants’ expectations of CPRT, and help participants to understand better what is expected of them in order to achieve a positive outcome.

CPRT training groups often accept all individuals that seek participation in parent education programs. Referring clients to CPRT for student training purposes may not, however, reflect a consideration of the needs of the client. Two leaders from this study revealed that they would have recommended individual counseling for one of their group members, and individual play therapy for the children; however, they stated they did not do so because they were encouraged to create a large group size in case some members dropped out. This suggests that when filial therapy group leaders are being evaluated, they do not feel comfortable making individual recommendations unless those recommendations have first been proposed by their mentors. There may need to be more emphasis in training on how to carefully select CPRT
participants in order to increase attention, retention, and positive outcomes for both clients and therapists. Of note, those individuals whose group leaders wanted to recommended individual counseling showed no positive outcome on the CBCL further suggesting the need for better CPRT selection criteria.

**Dropout Rates**

Due to lack of post data and large dropout rates, I was able to collect useable data from only nine out of twenty-two groups that were led from February 2007 to May 2008. Because there was such a high dropout rate, I chose to review this aspect as well. In this study, engagement did not appear to be related to group dropout rates. This finding is supported by McCallum, Piper, Ogrodncizuk, and Joyce’s (2002) research. Further research is needed to determine causative factors related to dropout rates in CPRT.

In the nine groups that were selected for this study, there was a thirty percent dropout rate. These groups originally began with a total of 53 participants, 14 males and 39 females. They ended ten sessions later with 37 participants, 9 males and 28 females. Thus, 16 participants dropped out of the CPRT groups, 28% of females (n = 11) and 36% of males (n = 5). However, it should be noted that one group managed to retain 100% of its male members. The group began with Caucasian females (n = 2) and males (n = 3), but ended with only males suggesting that perhaps males will remain in CPRT if the majority of their group members are males. This notion supports the idea that CPRT should be undertaken with more homogeneous groups.

Moreover, it appeared that most of the participants who dropped out did so before session four, or prior to the start of having their first play session with their child of focus. Most
of the group leaders in this study did not ask the participants to begin their at-home play
sessions until after session four. VanFleet (1994, 2005) suggested that filial therapists must
trust that their participants are capable of learning the necessary skills to conduct child-
centered play sessions with their children. Although the CPRT manual suggests parents begin
their at-home play sessions after session three, parents and caregivers often do not appear to
be ready to conduct a successful session, so therapists use their clinical judgment to postpone
that assignment in order to help lower parents’ and caregivers’ anxiety and prepare them more,
thus setting them up for success and not failure.

Social anxiety likely occurs because of the evaluation situation involved in
demonstrating one’s skills through role play and showing videotaped at-home play sessions in
front of leaders and group members. A review of group leaders’ filial session summary notes for
participants suggests that parents and caregivers may have high anxiety regarding review and
feedback of their videotaped play sessions. For example, the files contained statements such as,
“Client was concerned about videotaping her play session;” “Client seemed overly concerned
about doing play sessions and being in front of others;” and “Client forgot to bring tape.” In
addition, some notes suggested that parents and caregivers were absent on the day they were
supposed to show their videotape.

Berg, Landreth, and Fall (1998) hypothesized that individuals show resistance because of
fear of failure, fear of being judged by others, and/or because they lack courage to apply new
knowledge in the real world. An analysis regarding the role anxiety about video reviews might
have played in this study could not be done because group leaders’ note taking greatly differed.
Some leaders’ notes discussed personal factors relevant to participants (e.g., their concerns,
excitement, etc.), while others only discussed what the group did each session (e.g., reviewed session eight material, practiced limit-setting skills, watched Choices, Cookies & Kids video, etc.). Improved and consistent note taking might improve the ability to investigate the role play sessions may have on CPRT.

Some explanations given as to why participants dropped out of this study include: (1) One mother dropped out after session four, because she reported having difficulty with scheduling and not being able to find a babysitter for her child. Of note, babysitting services were available free of charge at the clinic where her group met.; (2) One of the grandfathers dropped out after session two. He sought help on how to get his granddaughter to understand that her mom was gone and not coming back. Perhaps he may have benefited more from recommendations of books to read with her that described what it means when someone dies.; (3) One mom asked the child’s father not to return to their group after they got into an argument.; (4) One mother was in the middle of a messy custody dispute that was taking up too much of her time and energy, so she decided the timing was not right, and she sought individual counseling for herself and play therapy for her daughter (something her filial therapy group leaders initially wanted to recommend).; (5) One grandmother had surgery after session six and never returned.; (6) Another step-grandmother traveled for work and was unable to attend after session seven. Those who dropped out, but who knew their group leaders (n = 4), failed to discuss with them their reasons for no longer participating. Six other participants failed to make contact or give reasons as to why they did not return. Thus, no explanation was offered for ten of the sixteen who dropped.
Interestingly, the only group to remain intact throughout the ten sessions was led at the group leader’s residence, which may suggest the need for a more familial or relaxing atmosphere. Being held at the leader’s home likely helped her anxiety to remain low, which may have helped lower others’ anxieties as well. However, another possibility for this group’s high retention rate may be the fact that two of the group members were family of the leader and one was a friend of the co-leader; thus, they may have already felt comfortable being among family or a friend. Further research is needed to investigate participants’ levels of anxiety or comfort and dropout rates.

Another possibility for the high level of retention in this group may be related to the fact that the friend and family members were motivated to participate because they knew the leaders’ grades depended on their ability to run a group that trained parents to use CPRT skills. In other words, the group members may have felt more obligated toward helping the leaders. It is unsure whether their motivation was mainly to help the leaders or to reduce their child’s behavior problems. These children all scored in the normal range on the CBCL, suggesting that none of their children’s behaviors were significantly problematic.

In contrast, two of the other groups contained friends of the leaders, but four of the seven friends dropped out of CPRT, suggesting that friends may be better suited for a different CPRT group. In other words, it may be best not to have filial therapy leaders’ friends participate in their CPRT group, because the leader is no longer in the friend role, but rather in the teacher and evaluator role. Some individuals may have a difficult time with this change or experience.

There appears to be only one study that examines the characteristics of those who drop out of filial therapy programs. Topham’s (2003) dissertation study examined the relationship
between select participant characteristics (e.g. socioeconomic status, parent ethnic background, severity of parent symptoms and distress, severity of child behavior problems, and parent acceptance of child emotion) and the number of sessions attended in a filial therapy program, which he adapted from Van Fleet (1994) and Bernard and Louise Guerney (1987). His filial therapy program consisted of ten sessions conducted in an individual format with predominantly single parents. The researcher noted that 48% of the participants in his study terminated prior to completion, not including the nine that dropped out after attending the assessment sessions, but prior to the start of treatment. More specifically, 30% dropped out prior to session five. Of note, in his study parents began conducting their at-home play sessions after session five. Topham’s dropout findings coupled with the findings of this study may suggest that parents and caregivers may prefer a more didactic, discussion format rather than practice format. Further research is needed to explore this notion.

Topham's findings from his study indicated that parents who experience higher levels of distress, and parents who have children with more severe behavioral problems, are less likely to continue in the filial therapy treatment program. He suggested a need to adapt the program to better fit the needs of parents with children with severe behavioral problems and for parents with higher symptoms and distress. He suggested that restructuring the program for these parents, where they learn effective limit setting and how to apply the skills to problem areas with their child early in treatment, may help parents to perceive the program as more applicable to their needs. Thus they may experience quicker change and develop more confidence in the filial therapy treatment program.
Topham also suggested addressing parent expectations at the beginning of treatment and setting achievable goals with parents throughout the process to help them see improvement at each step of the program. Furthermore, he recommended that the filial program have more flexibility early in the treatment program to provide parents with opportunities to discuss personal issues that may be sources of distress (e.g., other family problems, social relationships, occupational problems, etc.). He thought this flexibility may help alleviate parent distress and strengthen the therapist-parent relationship, thus increasing the likelihood that parents remain in filial therapy treatment. He stated the need for research comparing filial programs with and without these adaptations in order to identify whether they improve retention.

Topham’s dropout rate (9 out of 36) after parents attended the assessment stage of therapy may suggest that the therapist did a fairly good job of explaining the goals, yet the program did not seem to fit some parents’ expectations or needs; therefore, they chose not to continue treatment. Perhaps they might have felt overwhelmed by all the paperwork or felt that the therapist did not seem like a good fit. His 48% dropout rate after participants started treatment, however, suggests there may be more to it. The fact that 30% of his participants dropped out prior to the start of conducting their at-home play sessions, suggests further research is needed to investigate whether the cost and effort parents are expected to put into creating their filial toy kits and/or the need for videotaped at-home play sessions is related to participant dropout.

There are many factors to consider with regard to investigating dropout rates. Obtaining data from those who have dropped out may help us to understand why people often drop out,
and help us to find a way to prevent it. In addition, with this knowledge, we may be able to improve the CPRT outcome for parents, children, and groups.

Limitations of the Study

One of the most significant limitations to the present study is the small sample size. With a sample size of only thirty participants there may not have been enough power in the analyses to detect effectiveness or significant relationships between group cohesion and individual outcome. Furthermore, the small sample size of only nine groups limited the possible analyses that could be used to test the relationship between group cohesion and group outcome. A larger sample size would make it possible to extend beyond the relationship between group cohesion and individual outcome to a more sophisticated investigation of the influence group cohesion has on group outcome, which may be predictive of other factors influencing outcome (e.g., learning of CPRT skills, number of at-home play sessions held, parents’ symptoms, etc.). Data from this study offers some support to the need for CPRT to be employed in homogeneous groups; however, a much larger sample size would be required to test this hypothesis.

In addition, the generalization of the results may be restricted. The participants in this study were primarily Caucasian females. Further research is needed to test the generality of these findings with parents and caregivers of other ethnic backgrounds, and across different treatment settings, because the majority of these CPRT groups were led at a university clinic, which may also restrict the generalizability of the results.

Furthermore, the use of filial therapy training groups in this study is an important limitation. Ninety-four percent of the group leaders were conducting their first CPRT groups,
and their skill level may be a significant limitation. In addition, because leaders were instructed to conduct CPRT groups as part of their class requirement, some leaders had to recruit their own members. Due to their recruitment, some group members in this study were acquaintances of leaders which may represent another significant limitation because their groups were not considered therapy groups.

Another important limitation in the present study is the fact that some participants’ data \( (n = 7) \) was not included due to lack of completed pretest and posttest measures. Without inclusion of this data, any conclusion regarding the relationship between outcome and group cohesion is limited because data from these participants may have created different results regarding the outcome of CPRT and the relationship between outcome and group cohesion. In addition, a limitation exists regarding the consistency and integrity of data collection because measurements were collected by different individuals (leader(s) and/or research investigator).

Furthermore, absenteeism may have been a limitation in determining group cohesion. Some group members were absent during the final three sessions; thus, the level of cohesion may have been different for these sessions. The research investigator tried to control for this limitation by obtaining an overall perceived group cohesion average from the final three sessions.

Moreover, obtaining an average from only the final three sessions may not have been an accurate representation of group cohesion; however, time constraints, cost effectiveness, minimal treatment interference, and research findings from Budman et al. (1987) were factored into the decision. The research investigator noted differences in ratings on the observed level of group cohesion, which may have been related to absenteeism or to interrater reliability. Thus,
either mean or mode averages were utilized for the purpose of demonstrating a cohesiveness average that was hopefully representative of the groups’ typical sessions.

It is difficult to attribute outcome in children’s total behavior problems to CPRT. Taking posttests typically after only two or three months (after the ten CPRT sessions) may not allow enough time to accurately measure the outcome results of CPRT on children’s total behavior problems. The CBCL asks for participants to describe their child’s behavior “now” or “within the past six months”. In the present study, it was impossible to determine whether parents’ and caregivers’ ratings of their child’s behavior was regarding “within the past six months” or “now”. If parents or caregivers filled out their posttests regarding their child’s behavior “within the past six months” then their posttests may not have been accurate in determining effectiveness of CPRT or accurate in determining their individual outcome.

Furthermore, the CBCL ratings are only a three point scale, which vary significantly. In addition, this instrument does not have a deception scale or a way to determine whether participants are responding defensively. Outside factors may have occurred which influenced outcome (e.g., death of a friend, loss of job, concurrent therapy, etc). Also, participants’ perceptions of their child’s behavior problems may have been altered by the CPRT treatment, which encourages parents and caregivers to focus on their children’s feelings rather than behavior. In other words, their altered perceptions may have influenced their CBCL ratings more than the child’s true change in behavior. Another possible limitation is that the data for measuring outcome of children’s total behavior problems was reported only by the parent or caregiver who participated in CPRT. Relying solely on the participants’ information may have
affected the validity of the data. Utilizing other sources of data (e.g., teachers, child, significant others) would strengthen future research regarding CPRT outcome.

The outcome may also be limited to the participants’ abilities to learn and genuinely utilize the CPRT skills at home with their children. Furthermore, some participants may have conducted more at-home play sessions and spent more time practicing their skills, and this may have affected their outcome. Additionally, for the majority of those leading the CPRT groups, it this was their first filial therapy experience, so lack of experienced therapists may have been a confounding factor.

Raters’ biases may also be a limitation. Of note, all three objective raters were males, and were acquaintances of the male who led one of the CPRT groups. Interrater reliability was analyzed in order to determine whether the raters were agreeing on the observed level of cohesion for the male leader’s group. The interrater reliability for the two raters who scored this group was high 100% indicating that they were agreeing on how they were rating this group.

Another limitation may exist regarding the rated video segments. The two hour video recordings were edited down to thirty minute segments. The segments varied as to when their thirty minutes began and ended in relation to the actual two hours spent in session. Due to the focus on group cohesion, the videos were edited to avoid rating segments where the groups were watching at-home play sessions or filling out paperwork. In addition, due to tardiness some groups started a little later in their two hour time slot; thus, to ensure accuracy of group cohesion their segments were edited to begin when all group members for that session were present.
Videotapes from one of the groups could not be rated due to the fact that only one or two members could be seen in their videos. An accurate score on the GCS-II cannot be obtained without seeing the nonverbals of everyone in the group. Thus, without their ratings, it was not possible to determine how their observed level of cohesion might compare to other groups or how it might have affected their outcome.

Research Implications

Despite limitations, the present study makes a unique contribution to the filial therapy literature. Previous filial therapy research has primarily focused on effectiveness of treatment, leaving many questions about the predictors of outcome unanswered. This study provides some suggestions regarding CPRT filial groups. Although no significant difference was found on the CBCL regarding children’s total behavior problems between the beginning and end of participation in CPRT, post hoc analyses revealed that CPRT may be more effective for parents and caregivers whose children score in the borderline or clinical range on the CBCL.

In addition, this study provides some suggestions regarding the group aspect in CPRT filial groups. There were no significant findings regarding the relationship between participants’ individual outcome in CPRT, measured by parents’ and caregivers’ reports on their children’s total behavior problems, and the levels of group cohesion, measured by both participants’ reports of engagement and observed ratings of cohesiveness. Because this investigation appears to be the only filial therapy study to include heterogeneous groups, the findings suggest the need for CPRT to be conducted in homogenous groups, either by parents’ and caregivers’ gender and ethnicity or by their presenting concerns.
Homogeneous groups in this study appeared to provide the most group support for parents and caregivers. This result relates to group researchers findings that homogenous groups provide more therapeutic gains, including a more immediate source of identification and understanding, a clearer sense of group purpose, and increased cohesiveness, as well as a shortened period of treatment, less resistance, fewer cliques, better attendance, and quicker symptomatic relief (Yalom, 1995; MacKenzie et al., 1987; Ogrodniczuk & Piper, 2003; Castonguay et al., 1998; Marziali et al., 1997; Taft et al., 2003; Budman et al., 1989; Braaten, 1989; Stokes, 1983).

Recommendations for Further Research

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

1. Conduct a replication study with experienced filial therapists using a larger sample size. A larger sample size would increase the power of the statistical measure.

2. Conduct a study to investigate the relationship between group cohesion in CPRT groups and parents’ and caregivers’ outcome (e.g., stress, self-concept, depression, child acceptance, competence as a parent, learning of CPRT skills, etc.).

3. Conduct a controlled, randomized comparison study regarding effectiveness of CPRT used in individual format to group format.

4. Conduct a comparison study regarding group cohesion and outcome of CPRT in homogeneous groups to heterogeneous groups.

5. Conduct a comparison study regarding outcome and cohesion with participants from homogenous groups by gender and ethnicity to groups homogeneous by presenting concerns.
6. Conduct a controlled, randomized comparison study regarding outcome and group cohesion in groups led by male leaders to groups led by females.

7. Conduct a comparison study of experienced CPRT therapists and CPRT therapists in training to examine the impact therapists’ training and skill might have on participants’ outcome.

8. Conduct a correlational study examining the relationship between group cohesion across all sessions and dropout rates.

9. Explore the impact showing videotapes in group might have on dropout rate.

10. Conduct a correlational study examining the relationship between group cohesion, participants’ learning of CPRT skills, and outcome of CPRT.

11. Conduct a correlational study examining the relationship between leaders’ teaching styles, group cohesion, and outcome of CPRT.
APPENDIX A

PARENT AND CAREGIVER CONSENT FORM
Before agreeing to your participation in this research study, it is important that you read and understand the following explanation of the purpose and benefits of the study and how it will be conducted.

Title of Study: Relationships between Process and Effectiveness Variables of Filial Parent Education Groups

Principal Investigator: Dr. Dee Ray, director of the Child and Family Resource Clinic at the University of North Texas (UNT). Co-investigator, Kelly Reed, is a counselor at the clinic.

Purpose of the Study:

You are being asked to participate in a research study that involves measuring the level of support and its relationship to the effectiveness of filial therapy. Filial therapy, known here as Child Parent Relationship Therapy, is an approach used by play therapists to train parents to be therapeutic agents with their own children. Parents are taught basic child-centered play therapy principles and skills, including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem, and structuring required weekly play sessions with their children using selected toys.

Study Procedures:

As a part of the study, you will be asked to:

1. Before and after you participate in 10 filial sessions, fill out the Child Behavior Checklist and the Parenting Stress Index to assess the level of behavioral concerns for your child of focus and the stress you experience related to your child’s behaviors. These assessments will take you approximately one hour to fill out.
2. Participate in the 10-week filial model known as Child Parent Relationship Therapy.
3. In the final three sessions of the filial group, you will be asked to complete the Group Climate Questionnaire-Short Form, a short self-report survey. This form will take approximately 5-10 minutes to complete.
4. Also, the final three video recorded sessions will be rated by trained objective raters using the Group Cohesiveness Scale-Version II, an observation rating instrument. These videotapes will be coded without a name on them.
Foreseeable Risks:

There are no significant personal risks directly involved in this study. Participation by you and your child is completely voluntary. You and your child may withdraw at any time during the course of the study. However, you might experience some discomfort, which may include one or more of the following:

1. Anything that is said and done during the filial counseling sessions is considered confidential, meaning that the therapist will not reveal anything that happens in the session to another individual. However, if you disclose abuse, neglect, exploitation or intent to harm another person, the therapist is required by law to report it to the appropriate authority.
2. Because filial therapy is a counseling method, you will be expressing emotions that could be strong. The therapist will help you talk through these emotions and will stop therapy if any harmful effects upon you are noted. Harmful effects would include inability to maintain self-control or being in a distraught state of mind.

Benefits to the Subjects or Others:

We expect the project to benefit you and your child by possibly improving self-esteem, behavioral difficulties, emotional difficulties, parent support, social interaction and skills. The results of this study are expected to provide filial therapists and parent training educators across the nation with knowledge that helps them improve parent training so that it is most effective.

Procedures for Maintaining Confidentiality of Research Records:

All information will be kept confidential in a locked cabinet in the Child and Family Resource Clinic. Names of parents and children will not be disclosed in any publication or discussion of this material. Information obtained from the instruments will be recorded with a code number. Only the research team will have a list of the participant’s names. The filial sessions will be videotaped. At the end of this study, the videotapes may possibly be shown in professional presentations for educational purposes. Identity information such as name, place of living, and other specific information will not be revealed when videotapes are shown in educational settings.

Questions about the Study

If you have any questions about the study, you may contact Kelly Reed, Counselor at the Child and Family Resource Clinic, 940-565-2066 or mrs.reed@tcu.edu, and Dr. Dee Ray, Director of the Child and Family Resource Clinic at (940) 565-2066 or dray@coe.unt.edu.
Review for the Protection of Participants:

This research study has been reviewed and approved by the UNT Institutional Review Board. The UNT IRB can be contacted at (940) 565-3940 with any questions regarding your rights as a research subject.

Research Participants’ Rights:

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

- Mrs. Kelly Reed has explained the study to you and answered all of your questions. You have been told the possible benefits and the potential risks and/or discomforts of the study.
- You understand that you do not have to take part in this study, and your refusal to participate or your decision to withdraw from the study will involve no penalty or loss of rights or benefits.
- You understand why the study is being conducted and how it will be performed.
- You understand your rights as a research participant and you voluntarily consent to your participation in this study.
- You have been told you will receive a copy of this form.

_________________________________
Printed Name of Parent or Guardian

__________________________    _________________
Signature of Parent or Guardian              Date

For the Principal Investigator or Designee:

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

__________________________    _________________
Signature of Principal Investigator or Designee              Date
APPENDIX B

CPRT PROTOCOL
The majority of the following information has been extracted from the CPRT training manual by Bratton et al. (2006). Some information may have also come from the my personal training with Bratton.

Session One A

Therapists distribute nametags and pass out parent notebooks created from the CPRT treatment manual. Therapists then allow approximately 15 minutes for the group members to introduce themselves and say why they are attending the group. This informal sharing time helps parents to feel supported and connected before introducing the training content. The therapists then begin with a review of what CPRT training is and how it can be helpful. This information provides an overview of what the ten-session training model involves and stresses the importance of having play sessions and strengthening the parent-child relationship. The essential concepts, also known as “rules of thumb” for session one of CPRT are: (1) “Focus on the donut, not the hole!” (In other words, focus on the relationship, not the problem.); (2) “Be a thermostat, not a thermometer” (Learn to respond/reflect rather than react.); and (3) “What’s most important may not be what you do, but what you do after what you did!” (We all make mistakes, but we can recover. It is how we handle our mistakes that makes the difference.) (Bratton et al., p. 5). This session focuses on teaching parents how to use reflective responding to communicate to their child that they understand the child’s behaviors, thoughts, needs/wishes, and feelings without asking questions. The treatment manual provides an in-class practice worksheet and a homework worksheet to apply the skills being taught during session one.
Session Two

Therapists begin by asking each parent about their week. Next, they review the homework that was assigned in session one. The group then discusses the handout *Basic Principles of Play Sessions*. Through these principles, parents learn how important it is to follow the child’s lead (i.e. “The parent’s toes should follow his/her nose.”), empathize with the child, communicate understanding to the child, and to be clear and firm about limit setting. During this session, therapists review the *Toy Checklist for Play Sessions* handout. Therapists typically show toys and give rationales for some toys parents may have reservations about (i.e. the dart gun and baby bottle). Therapists often role-play and/or demonstrate basic play session skills and allow parents time to process their experiences. Homework is assigned which includes collecting toys and deciding on a time and place for their play sessions. Parents are encouraged to pick a time and place with the least distractions. The rule of thumb, “You can’t give away that which you don’t possess,” is stressed during this time.

Session Three

Therapists refer parents to the *Play Session Do’s and Don’ts* handout. In addition to discussing the do’s and don’ts, the therapists provide examples through demonstration and/or role-play. For example, the therapists might demonstrate how to let the child lead and how to set limits. The don’ts list is comprised of statements like “Don’t criticize any behavior” and “Don’t praise the child.” During session three, preferably, therapists will do a live demonstration of play session do’s with a child; however, due to the need to protect confidentiality, it may not be possible to do a live demo when other clients are being seen. Most often, parents are shown a video clip of a play session. Later, the parents are asked to
work with a partner to practice using the skills they saw during the demo/video session.

Therapists practice methods of starting and ending a session with parents. In addition, therapists hold a discussion on how to explain special play time to children. Therapists briefly discuss the *Play Session Procedures Checklist* handout and arrange for one or two parents to bring a videotape of their play session with their identified child the following session. Assigned homework is to review the information on the handouts and prepare for holding play sessions before the next session.

*Session Four*

The protocol stresses more linking among the group members (i.e., “Seize opportunities to forge connections between parents with similar struggles”) (Bratton et al., 2006, p. 27).

During this session, the parents share their experiences of conducting their first play sessions. After the informal sharing process, the group reviews the parent’s play session and provides positive feedback/supervision. The therapists are to facilitate and encourage parents to share what it was like to be videotaped knowing that the group would be watching the session. The goal is to model focusing on the parent’s strengths; thus, the videotape is to be played until the therapist can point out a strength. The therapists can suggest one thing the parent might do differently. The group then shifts to focus on the *Limit Setting: A-C-T Before It’s Too Late* handout and practice worksheet. The therapists can show a video clip on limit setting if they so desire. If not, they can role-play limit setting in front of the parents, and then ask the parents to team up and practice using their limit setting skills. The rules of thumb for session four are noted as “During play sessions, limits are not needed until they are needed!” and “When a child is drowning, don’t try to teach her to swim” (Bratton et al., p. 29). The therapists and parents
then arrange who will present their play session video next time. The homework is for the parents to complete the *Limit Setting: A-C-T Practice Worksheet* and review handouts.

Session Five

Parents report on their play sessions. Therapists encourage and support parents and facilitate connecting among group members. Therapists also model skills by reflecting parents’ feelings. Then, they watch parents’ videotaped play sessions, review the A-C-T limit setting method, demonstrate play session skills focusing on skills the parents report as most difficult, and assign homework to review the handouts and prepare for at-home play sessions.

Session Six

Parents report on their play sessions usually with a focus on limit setting attempts. One or two parents’ videotaped play sessions are shown, and therapists continue to encourage and facilitate peer feedback. *The Choice-Giving 101: Teaching Responsibility & Decision-Making* handout is discussed. Therapists usually show Dr. Landreth’s *Choices, Cookies & Kids* video and role-play/demonstrate how to give choices. Homework is assigned for parents to review the handouts *Choice-Giving 101, Advanced Choice-Giving: Providing Choices as Consequences*, and *Common Problems in Play Sessions*. They are asked to practice giving at least one kind of choice to their child before the next session, thus allowing the child to feel empowered.

Session Seven

Parents review homework and report on play sessions. The group watches one or two videotaped play sessions and provides positive feedback by pointing out the parent’s play session do’s. The therapists introduce the *Esteem-Building Responses* handout and discuss the rule of thumb, “Never do for a child that which he can do for himself” (Bratton et al., 2006, p.
The therapists then demonstrate self-esteem building responses and responses that return responsibility by watching a live play session with a child, video clip, or role-play. Parents are then asked to work with a partner to practice these skills through role-play. Homework includes reviewing handouts and writing a special letter to their child. Some therapists prefer to have the parents write the letters during the session and address the envelopes so they can mail them, because most children love getting mail that is especially for them.

Session Eight

Parents report on play sessions and learned skills, generalizing them to outside of play sessions as well. Videotaped play sessions are reviewed, and the group is introduced to the Encouragement vs. Praise handout. The rule of thumb is “Encourage the effort rather than praise the product” (Bratton et al., 2006, p. 70). Therapists discuss the importance of encouraging the child and fostering internal motivation rather than external motivation, and then demonstrate responses. After viewing the demonstration, parents role-play. Homework includes reviewing handouts.

Session Nine

Parents report on giving encouragement responses during and outside their play sessions. The group watches parents’ videotaped play sessions, continuing to provide feedback referring to the Play Session Do’s and Don’ts poster/handout. The group typically reviews learned skills and the use of them outside of the play sessions (e.g., reflecting feelings, limit setting, choice-giving, esteem building, and encouragement). Homework is to review handouts and notice the use of skills outside the play sessions.
Session Ten

Parents report on homework and watch one or two parents’ videotaped play sessions, with a focus on growth and change in both parent and child. Therapists introduce the Rules of Thumb & Other Things to Remember handout that focuses on what they have learned from this training. The therapists then ask parents to share what have been their most important learnings from this process, and to discuss how each perceives their child now as compared to ten sessions ago. Therapists reflect groups’ positive changes. Therapists then emphasize the importance of continuing play sessions and provide some recommended reading. Therapists schedule additional professional help for parents and/or children needing such help. The group then receives a Certificate of Completion for making a difference in their child’s life.
REFERENCES


Landreth, G. L. (1994). *Cookies, Choices & Kids: A creative approach to discipline* [video]. (Available from the Center for Play Therapy, University of North Texas, P. O. Box 311337, Denton, TX 76203-1337).


