

Child Parent Relationship Therapy: Exploring Parents' Perceptions of Intervention, Process, and Effectiveness

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Abstract

Child Parent Relationship Therapy (CPRT) is a group consultation model designed to increase parental empathy, improve confidence in parenting ability, enhance parent-child relationship quality and reduce children's problem behaviors. The current study took place in a Head Start school and employed a mixed method approach to examine the effectiveness of CPRT with parents of preschool children at risk for school failure. Responses on the Parenting Stress Index (PSI) and the Child Behavior Checklist (CBCL) as well as comments made throughout the post-intervention interviews indicated that all of the parents in this study found the CPRT intervention to be an effective and useful treatment. Results showed clinical improvements in several subscales of PSI and CBCL. In addition, qualitative analyses revealed that all participants reported reduced parental stress, improved parent-child relationships, and reduced child behavioral problems.

Keywords: Child Parent Relationship Therapy, filial therapy, parenting stress, child behavior, Head Start, at-risk students

1. Introduction

Parenting is a complex and challenging process. Even parents who possess a strong support network experience the demands that come with raising children. This pressure is exacerbated for parents in underserved communities who may lack financial resources and support services. Regardless of the specific circumstances, a breakdown in the family structure and deterioration of parent-child relationships may be unintended consequences of the socio-economic stressors faced by underserved families (Cooper, McLanahan, Meadows, & Brooks-Gunn, 2009). The rising cost of living, the prevalence of single-income homes, below average wages, and extended work hours are just a few of the obstacles faced by parents in underserved communities (Page & Stevens, 2004). Even with government sponsored programs such as 'welfare-to-work', parents may have to travel long distances in order to earn a living wage. This further reduces the time they can spend with their children or participate in informal parenting support networks (Bruckman & Blanton, 2003). The school system is a convenient way for service providers to make contact with parents in underserved communities (Weist, Ambrose, & Lewis, 2006).

However, services offered at schools are largely tailored to meet the needs of students receiving special education (Weist et al., 2006), or they are focused on students who demonstrates significant externalizing problems (e.g. delinquency and aggressive behavior; Achenbach & Rescorla, 2000; George, Harrower, & Knoster, 2003). As a result, school personal may overlook students who primarily exhibit internalizing problems (e.g. anxiety and depression; Achenbach & Rescorla, 2000; Einsenberg et al., 2001), focusing instead on overt 'acting out' behaviors (George et al., 2003). To better meet the needs of all students, school-based programs also need to involve students who may be struggling emotionally but demonstrate few substantial behavioral problems. At risk students are largely from low-income homes and typically demonstrate low academic potential, high absenteeism, disciplinary problems and low self-esteem (Donnelly, 1987). Additionally, these students are often from family environments that are high in conflict and aggression, and low in emotional support (Turner, Powell, Langhinrichsen-Rohling, & Carson, 2009). Thus, to provide more effective services, mental health professionals should focus on prevention and intervention programs that emphasize parent education and parent involvement in school activities.

1.1 Head Start and Parent Education

The Head Start Program is a preventative model that provides comprehensive educational services for young children from underserved populations (Head Start Bureau, 1998). Head Start Programs encourage parents to actively participate in their children's school activities while also providing parental support in the form of parenting skills training and child development education. Research on parent education and training groups suggests they are effective in reducing parental isolation, depression and stress, as well as increasing social support and parental competence (Keller & McDade, 2000; Ruffolo, Kuhn, & Evans, 2005; Whipple & Wilson, 1996). In a meta-analysis of preventative programs for parents, those programs that contained high levels of participation, utilized an empowerment/strength approach, and included a component of social support, demonstrated higher effect sizes than programs lacking these components (MacLeod & Nelson, 2000). This finding underlines the importance of developing parent education programs emphasizing group participation and social support in addition to enhancing parenting skills and the parent-child relationship.

1.2 Child Parent Relationship Therapy

Child-Parent Relationship Therapy (CPRT; Landreth & Bratton, 2006) is a comprehensive parent education program that is largely compatible with the goals of Head Start, which includes developing a supportive learning environment for both parents and children (Head Start Bureau, 1998). Through active group participation, CPRT provides parents a strength-based approach in a support group format. Moreover, because it is a time-limited model that requires only ten-weeks of participation and places relatively few additional demands on parents, it is an ideal model for families in underserved communities that may be experiencing considerable strain on financial and logistical resources. CPRT is an empirically validated parent education program that has been researched across various populations and settings (e.g. Athanasiou & Gunning, 1999; Costas & Landreth, 1999; Glover & Landreth, 2000; Kale & Landreth, 1999; Kidron & Landreth, 2010; Lee & Landreth, 2003; Tew, Landreth, Joiner, & Solt, 2002; Walker, 2008). The findings of these studies include increased parental acceptance and empathy (Costas & Landreth, 1999; Glover & Landreth, 2000; Kidron & Landreth, 2010; Lee & Landreth, 2003; Tew et al., 2002) reduced parenting stress (Kale & Landreth, 1999; Kidron & Landreth, 2010; Lee & Landreth, 2003; Tew et al., 2002; Walker, 2008) and decreased problem behaviors of children (Athanasiou & Gunning, 1999; Tew et al., 2002).

CPRT is typically offered in a group setting in which the participants meet once per week for 10 consecutive weeks (Landreth & Bratton, 2006). The group format facilitates a supportive environment that decreases the social isolation commonly experienced by parents of children with significant emotional and behavioral problems (Cairney et al., 2003). Landreth and Bratton (2006) recommend that each group consist of 6-8 parents. During the ten-week program, parents are expected to complete preparatory work, short homework assignments, and 30-minute weekly home play sessions. These requirements help to improve the parent-child relationship and increase parental understanding, competence and acceptance (Landreth & Bratton). The CPRT classes require few materials and can be held in the school during flexible hours, thereby meeting the Head Start requirement for parental involvement in school-based activities (Head Start Bureau, 1998). An important goal of CPRT is to help parents make small changes aimed at improving the parent-child relationship. This relationship-based angle helps to offset the tendency to focus solely on children's problem behaviors.

1.3 Purpose of the Study

The purpose of the current study was to examine the effectiveness of CPRT with parents of academically at-risk preschool children from a Head Start school. The goals of the CPRT intervention were to encourage parental empathy, develop greater confidence in parenting ability, and enhance the parent-child relationship. We also explored parents' perceptions of the process and outcome of CPRT, including its impact on the parent, child, parent-child relationship, and child's academic progress.

1.4 Research Questions

The current study addressed the following guiding research questions: (1) What are the effects of CPRT on parenting stress, and children's internalizing and externalizing behaviors? (2) What are parents' perceptions of the process and outcome of CPRT? (3) What are parents' perceptions of the impact of CPRT on the parent, child, parent-child relationship, and child's academic progress?

1.5 Research Design

To date, researchers conducting CPRT have primarily utilized quantitative data collection to evaluate the effectiveness of the model. Relatively few CPRT studies have employed qualitative methods (i.e. Bavin-Hoffman, Jennings, & Landreth, 1996; Edwards, Sullivan, Meany-Walen, & Kantor, 2010; Foley, Higdon, & White, 2006), and none have examined this consultation model in a Head Start school. According to Huberman and Miles (1994), qualitative data helps to explain and provide alternate interpretations to quantitative results. A mixed methods approach therefore allows for richer data collection and deeper understanding of the focus of the study (Powell, Mihalas, Onwuegbuzie, Suldo, & Daley, 2008). Consistent with this perspective, the current study utilized a mixed methods approach. Data collection included conducting semi-structured post-intervention interviews as well as administering standardized assessments to parent participants.

2. Methodology

2.1 Setting and Participants

The intervention site was a school for young children (ages 3 to 5 years) in the Southern United States, which houses a Head Start program. Using purposeful sampling, we recruited from this school 6 parents and their children to participate in a Child Parent Relationship Therapy (CPRT). According to Patton (2002), purposeful sampling involves selecting participants based on a fundamental feature of the study. We specifically targeted parents of children who were at risk for school failure. The participants consisted of five women and one man between the ages of 28 - 44. Four of the six parents held bachelor's degrees and two parents held high school diplomas. The group included one Hispanic, one Afro-Caribbean, and four White participants.

2.2 Research Team

The research team included the first author and two advanced Ph.D. Counseling students. The first author is an Assistant Professor at a large suburban university in the Southern United States. All three researchers have specialized training in play therapy, CPRT, and school-based interventions.

2.3 Child Parent Relationship Therapy Intervention

2.3.1 Group Leaders

An advanced Ph.D. student in Counselor Education (one of the co-authors) and an advanced master's level student in Counseling with specialized training in play therapy and CPRT led the CPRT group. The first author directly supervised the group leaders.

2.3.2 Weekly Group Meetings

The parent participants met with the group leaders for 2 hours each week over 10 weeks. Following the CPRT protocol (Landreth & Bratton, 2006), the group leaders provided instruction on the techniques of child-centered play therapy and its application to the home-setting. The CPRT content included didactic instruction, skill demonstration, direct supervision, group feedback, and sharing of personal experiences. The 10-week training included reflective responding, play session skills, limit-setting, supervision, choice-giving, self-esteem building responses, encouragement vs. praise, and generalizing skills. For a detailed description of CPRT content and training procedures, see Landreth and Bratton (2006) and Bratton, Landreth, Kellam, & Blackard (2006).

2.3.3 Play Sessions and Direct Supervision

Beginning in week three, a major part of CPRT involves the participants practicing the CPRT principles and skills during 30-minute home play sessions. Consistent with training protocol, the participants chose a child of focus for the training period and conduct seven weekly 30-minute play sessions at home. They also video-recorded at least one play session to receive group feedback and direct supervision. The participants viewed the video-recorded playtimes during CPRT group sessions to receive direct supervision from the group leaders and other group members (Landreth & Bratton, 2006).

2.4 Data Sources

The current study employed three primary data sources: the Parenting Stress Index (PSI), the Child Behavior Check List (CBCL), and an in-depth interview with each parent participant. Each parent completed the PSI and CBCL prior to beginning CPRT and after completing CPRT. Each parent also participated in an individual post-intervention interview upon the conclusion of CPRT.

2.4.1 Parenting Stress Index

The Parenting Stress Index (PSI; Abidin, 1995) is a 120-item instrument designed for parents of children ages 1 month to 12 years. The PSI evaluates the parent-child relationship and is based on the theory that the total stress a parent experiences is a result of particular parent and child characteristics, and circumstances directly associated with the parental role. The PSI is divided into the child domain and the parent domain. The child domain consists of 6 subscales that describe the parent's perceptions of child characteristics. These include: *distractibility/hyperactivity*, *adaptability*, *reinforces parent*, *demandingness*, *mood*, and *acceptability*. The parent domain includes 7 sub-scales reflecting the parent's perception of him/herself. The subscales on this domain include: *competence*, *isolation*, *attachment*, *health*, *role restriction*, *depression*, and *spouse (partner)*. The *life stress* score gives an overall indication of the degree of stress experienced outside of the parent-child dyad that is largely out of the parent's control.

2.4.2 Child Behavior Check List

The Child Behavior Checklist 1.5-5 (CBCL; Achenbach & Rescorla, 2000) consists of 99 items that describe parents' perceptions of specific behavioral and emotional problems, as well as adaptive child behavior. The CBCL consists of 6 cross-informant syndromes: *emotionally reactive*, *anxious/depressed*, *somatic complaints*, *withdrawn*, *attention problems*, and *aggressive behavior*. The instrument also includes three primary scales (*internalizing*, *externalizing*, *total problems*) and a *sleep problems* syndrome.

2.4.3 Post-Intervention Interview

We conducted a post-intervention interview with each participant. Each interview lasted approximately one hour and examined parents' perceptions of changes in them, their child, and their relationship with their child. The interview also explored parents' views of the process and outcome of CPRT, including whether parents intended to continue using the CPRT skills after the training period was complete.

2.5 Trustworthiness

According to Patton (2002), trustworthiness reflects the strength, integrity and overall quality of a study. The strategies we used to ensure trustworthiness included: (a) prolonged engagement, in which the second author functioned as a liaison between the research university and the intervention school and had extensive (1 year) contact with parents and school personnel at the intervention site. The prolonged engagement allowed her to access the cultural context and enabled her to build rapport with key gatekeepers and parent participants (Nastasi, Moore, & Varjas, 2004); (b) triangulation, by which the second author, who also functioned as CPRT group leader, compared interview data with her own observations of the parent's video-taped home play sessions; (c) audit trail, which involved a careful record of all aspects of data collection, reduction and analysis (Guba & Lincoln, 2005), including interview protocols informed consent forms, and the coding manual; (d) thick description, which delineated the research context, participants, training protocol and research procedures with sufficient detail to allow for replication of the research study.

2.6 Qualitative Data Analysis Strategy

We analyzed the post-intervention interviews using an adaptation of Mile and Huberman's (1994) data analysis approach.

We employed an inductive-deductive method (e.g., Varjas, Nastasi, Moore & Jayasena, 2005) in which the initial stages utilized *open coding* (Corbin & Strauss, 2008) and the latter stages involved testing and confirming codes developed during the inductive process (Patton, 2002).

2.6.1 Margin Notes

We independently analyzed a subset of the data (three of the interviews). This involved sketching ideas and writing marginal notes on the interview transcripts (Miles & Huberman, 1994). As we examined the data, we recorded our reactions to the material.

2.6.2 Summarizing Marginal Notes

During weekly data analysis meetings, we compared marginal notes, discussed reflections, and developed a summary sheet (Miles & Huberman, 1994). This summary sheet included those ideas that were common to all three authors.

2.6.3 Making Metaphors

This is a preliminary step in the development of codes and involves *playing with words* (Creswell, 2007). In this stage, we examined the summary sheet and coined key phrases. We developed these terms from our own understanding of the focus of the study, research questions, and training and interview protocols.

2.6.4 Code Development

We compared and contrasted the key phrases, placed them in categories and developed category headings. We then further reduced the information (Creswell, 2007) by collapsing some of the categories, revising category headings and developing a preliminary coding manual (Huberman & Miles, 1994).

2.6.5 Initial Coding

To establish inter-coder agreement (e.g., Marques & McCall, 2005) we each independently analyzed the same data subset (three of the interviews) using the preliminary coding manual. During weekly data analysis meetings, we discussed results, including points of agreement and discrepant coding. This practice continued until we reached a mean agreement of 85% on all coding categories (Bakeman & Gottman, 1986). We then finalized the coding manual.

2.6.6 Final Coding

We conducted a final round of data analysis using the finalized coding manual. To guarantee continued intercoder agreement, we independently coded all 6 interviews. The weekly data analysis meetings facilitated continued discussion of discrepant coding and coder drift (Marques & McCall, 2005). Intercoder agreement ranged from 90% to 98% throughout the final coding period.

3. Findings

The current study employed a mixed methods approach to examine the effectiveness of Child Parent Relationship Therapy (CPRT) with parents of children at risk for school failure. In terms of quantitative data, clinical findings were observable on the Parenting Stress Index (PSI; Abidin, 1983) and the Child Behavior Checklist (CBCL; Achenbach & Edlebrock, 1983). According to Henson (2006), clinical findings more accurately reflect the results for small groups, as they emphasize the impact of the intervention on individuals. Thus, in this study, we used clinical findings to emphasize the impact of CPRT on the individuals to describe the findings more accurately. We used quantitative data obtained from pre- and post-tests for the CBCL and PSI to report the clinical findings. We will discuss the findings from both the qualitative analysis and clinical findings within the framework of the research questions.

3.1 Research Question One

The first research question investigated the effects of CPRT on parenting stress, and children's internalizing and externalizing behaviors. The data sources used to answer research question one included the Parenting Stress Index (PSI) and the Child Behavior Check List (CBCL). We looked at parents' pre-and post-intervention responses on the PSI to examine the impact of CPRT on parenting stress and the parent-child relationship. On the PSI, a decrease from the clinical range to normal range on a particular domain indicates a decrease in parenting stress in that domain. According to the results, parents reported a decrease from the clinical range to normal range on several subscales. Two parents reported a decrease from clinical to normal range on the social problems subscale within the child domain.

Two parents reported a decrease from the clinical to normal range on the isolation subscale within the parent domain. Two parents reported a decrease from the clinical range to the normal range on the spouse subscale within the parent domain. One parent reported a decrease from the clinical to normal range for each of the following subscales: demandingness, acceptability, depression, and total stress. Three parents reported a decrease from the clinical to normal range on overall parent stress. However, one parent reported an increase from normal range to clinical range in the adaptability, competence, depression, and spouse subscales, in addition to overall parent domain and total stress scores.

We also looked at clinical findings from the CBCL to examine the effects of CPRT on the child's externalizing and internalizing behaviors. The pre- and post-test scores of 5 parents were examined as one parent did not complete the CBCL post-test. Among the syndrome subscales, the following subscales revealed a decrease from borderline range to normal range: withdrawn/social problems for two parents, rule-breaking behavior for one parent, and aggressive behavior for one parent. Additionally, one parent indicated a decrease from clinical range to normal range on the attention problems subscale. For the DSM-oriented scales, one parent indicated a decrease from clinical range to normal range on the affective problems subscale, while another parent indicated a decrease from clinical range to normal range on the attention deficit hyperactivity subscale. According to one parent's report, the oppositional defiant problems/conduct problems subscale decreased from borderline to normal range. In the competence scales, social competence subscale decreased from borderline to normal range for one parent. The scores of two parents on total problems subscale decreased to the normal range after CPRT. In addition, the scores of one parent in externalizing problems subscale decreased from clinical to normal range. In contrast with the clinical improvements mentioned above, one parent reported an increase from normal to clinical range in anxiety problems and pervasive/somatic problems subscales.

3.2 Research Questions Two and Three

The second research question examined parents' perceptions of the process and outcome of CPRT. This question referred to the degree of acceptability of the intervention, including its appropriateness for the parent participants (Kazdin, 2000). The third research question examined parents' perceptions of changes in themselves, their child, the parent-child relationship, and the behavior and academic progress of their child. The data source used to answer research questions two and three was the post-intervention interview held with each participant. Data analysis revealed eight major categories related to research questions two and three: *Child-parent relationship, child dynamics, participant dynamics, training structure, CPRT knowledge and skills, group dynamic, generalizability, and sustainability.*

3.2.1 Child-Parent Relationship (CPR)

CPR referred to the relationship between the parents and their child-of-focus. This included specific interactions between the parent and child or a deliberate effort to spend time together outside of the required special play times. CPR was also coded when parents described their perceptions, attitudes, and feelings regarding their child and their relationship with their child. This included references to perceived changes in the child-parent relationship. During the post-intervention interview, all parents stated that their relationship with their child of focus had improved as a result of CPRT. One parent noted increased mutual understanding and a closer parent-child bond. "I think we both got a better understanding [of each other]. I got a better understanding of him especially. I think it has helped me understand, especially with the [CPRT] that he loves his [special] time, so I think it has brought us closer together." Another parent made a similar comment and also emphasized the importance of one on one time between parent and child. "I think I've become more understanding of [him] because we've been working together more and we're spending more quality time together so I'm more understanding of him and his behavior now. [I see the importance of] spending more quality time together and [giving] him the undivided attention that he really requires."

3.2.2 Child Dynamics

Child dynamics related to parents' descriptions of their child's behavior outside of the special play times. This included all references to social, emotional, cognitive, and academic components. This code also applied whenever parents referred to specific changes in their child's behavior. During the post-intervention interview, all parents described the positive impact that CPRT had on their child's behavior. One parent stated that the child-led play helped to improve her child's self-esteem. She noted that since participating in CPRT, her child "talks more and verbalizes more, which is a big deal."

Another parent described her child's increased self-confidence and independence. "He likes to do things, tries to do things on his own rather than me doing for him. He'll say, 'Mommy, I will try.' I think it's because of the [CPRT] letting him take the lead, so now he wants to try it himself, you know, make the bed up or whatever. He wants to do everything on his own now, so that's good."

3.2.3 Participant Dynamics

We broadly defined participant dynamics as aspects of a parent's life outside of the group context. This included interactions with their other children as well as other adults outside of the CPRT group membership. This code also applied to changes that the parents noted in their own behavior, attitudes and feelings as a result of CPRT. During the post-intervention interview, parents were asked to describe ways in which they had changed as a result of the training. One parent described improvements in her attitude and behavior toward other people. "I'm a little more patient with my husband, my mother, and other people in my life. Rather than judge people, I'm able to empathize and rather than being sarcastic, I'm able to be a good listener." Another parent described the impact of CPRT on her general interactions with her children. "I think that it has helped me become more attentive to my children's needs. It has definitely given me a more positive attitude."

3.2.4 Training Structure

Training structure referred to the organizational components of the training. This included recruitment materials (e.g. flier, incentive for participation), training location, meeting time, frequency, duration, group format, number of participants, and amenities (e.g. child care and refreshments). Other structural elements involved the required home play sessions and toy kits. During the post-intervention interview, all of the parents had positive views of the training structure. One parent commented on the length of the weekly sessions. "The length was good. [However] there were times when I wished [the sessions] were longer." Another parent noted the feasibility of having the home play sessions. "[The play sessions] passed by a lot faster than I thought they were going to be. I looked at my watch and I'm going, 'Gosh! 25 minutes has already gone.'"

3.2.5 CPRT Knowledge and Skills

Child Parent Relationship Therapy (CPRT) knowledge and skills was defined as references to CPRT content (i.e. principles, procedures and skills outlined in Landreth and Bratton, 2006). This code also included training materials (e.g. parent notebook and videos) and training methods (e.g. didactic instruction, group discussion, videos, role plays and supervision). During the post-intervention interview, all of the parents noted that they found the CPRT content to be appropriate and useful. One parent gave his impressions of the CPRT materials and group participation. "The materials I thought were well organized in a building block fashion, and also they were just abstract enough to get you to think about what it really meant. It didn't just tell you everything you needed to know. It made you think about [how it applied to you]. I was impressed with the training and the interaction required to participate." Another parent outlined her view of the limit-setting skill. "I like the A-C-T, you know, acknowledge the feeling, communicate the limit, and then target alternatives, you know... when he's doing something he shouldn't be doing. I've learned if I can just, instead of reacting and saying, 'No, don't do that,' I can stop and acknowledge, 'well, I know that's how you feel,' or, 'I know you want to do that, but...', you know."

3.2.6 Group Dynamic

Group dynamic referred to the interpersonal relationships and general interactions among Child Parent Relationship Therapy (CPRT) group members. This included references to member support and personal sharing. During the post-intervention interview, all of the parents noted an appreciation for the support they received from other group members. One parent noted that the group format of CPRT reduced feelings of parental isolation. "It was really neat to be in an environment where everybody had a different issue with their kid. It was nice knowing one, that I wasn't alone, and two, that there are ways to deal with different personalities." Another parent expressed a similar sentiment and also described the learning opportunity that the CPRT group provided. "Sometimes you don't have that, you don't have anybody to share with and it was nice to know that there are people who are having a hard time with their kids too and you can learn from them too. It's like, they learn something from me, and I learn something from them."

3.2.7 Generalizability

This theme referred to parents' use of the Child Parent Relationship Therapy (CPRT) skills in other settings outside of the CPRT group context and training requirements.

During the post-intervention interview, one parent commented on his use of one skill in regular interactions with his son. “I’m using the tracking when I remember to do the tracking. Just being a follower, letting him lead. I’m trying to get closer to him and be more engaged and just be there while he’s doing something and hopefully that brings him out to interact with me a little more.” Another parent described using choice-giving and limit-setting to get her son to take his medication. “Today I had to get him to drink a milkshake – certain medicines in it – and he wanted to play a game and I said, ‘Well, if you choose to drink the milkshake, then you can go play the game. If you choose not to drink the milkshake, then you can’t play the game today.’ And he sat there for about 15 minutes, but I was not going to give in and he finally just drank the milkshake, then he goes, ‘all done, can I play my game now?’”

3.2.8 Sustainability

We defined sustainability as parents’ intent to continue using Child Parent Relationship Therapy (CPRT) principles and skills after the training period was complete. All parents committed to continue using the CPRT skills after the training was over. Some parents did express their intent to modify the play sessions, such as incorporating other children or adjusting play session frequency. One parent stated that she would continue to do the play sessions as long as it would benefit her child. Another parent wanted to include her husband, who was not a part of the CPRT group. “I would like to do [the play sessions] once a week through the year and my husband wants to start doing [them] also. So [my son] will have two play sessions a week through the fall of next year, and then he’ll be going to kindergarten and we’ll have to see about fitting those in.”

4. Discussion

The current study utilized a mixed methods approach to examine the effectiveness of Child Parent Relationship Therapy (CPRT) with parents of preschool children at risk for school failure in reducing parent reports of parenting stress and child behavior problems. We examined parents’ perceptions of the process and effectiveness of CPRT using quantitative data, as well as in-depth post-intervention interviews. By exploring the lived experiences of CPRT group participants, the qualitative component facilitated thick descriptions based in the training setting. Parents’ responses on the *Parenting Stress Index* (PSI) and the *Child Behavior Checklist* (CBCL) and their comments throughout the post-intervention interviews indicated that they found the CPRT intervention to be an effective and useful treatment. Based on parents’ statements, the goals of CPRT were met.

The CPRT intervention group for the current study met at the focal children’s school. Collaboration between the treatment intervention team and the school personnel created a setting where parents had regular access and support. By holding CPRT sessions at their child’s school, parents were likely to attend and create relationships with others from similar demographics that experience comparable parenting and life struggles. This supports the philosophy of CPRT, which aims to create a social network of support for group members and reduce feelings of parental isolation (Landreth & Bratton, 2006). Participants of this study reported reduced feelings of isolation, increased connection with the other parents, and gratitude for receiving and providing supportive feedback in a group setting. In post-interviews, all parents noted reduced parenting stress, stronger child-parent relationships, and improved child behavior. These findings align with earlier studies on CPRT which provided evidence of increased parental empathy (Bratton & Landreth, 1995; Costas & Landreth, 1999; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002), improved child-parent relationships (Bavin-Hoffman et al., 1996; Foley, et al., 2006; Winek et al., 2003) and reduced problem behaviors of children (Harris & Landreth, 1997; Kidron & Landreth, 2010; Landreth & Lobaugh, 1998; Tew et al., 2002; Yuen, Landreth, & Baggerly, 2002).

The results of the PSI and CBCL assessments indicated clinical improvements in a variety of problem areas such as *social problems, demandingness, acceptability, depression, total stress, rule breaking behavior, aggressive behavior, attention problems, affective problems, and conduct problems*. However, one parent’s report on the PSI indicated an increase from normal to clinical range in adaptability, competence, depression, and spouse subscales. Considering the positive outcome reported by the other parents in the study and previous research results that indicate the effectiveness of CPRT in reducing parenting stress (Kale & Landreth, 1999; Kidron & Landreth, 2010; Lee & Landreth, 2003; Tew et al., 2002; Walker, 2008), this change may be attributed to the parent’s experiences of life stressors unrelated to CPRT. The parent’s report in the post-interview seemed to support this assumption. “But I forgot about the interview four or five times before this (laughs) so there’s too many issues in my life right now. I have a lot of things going on right now.”

Additionally, in contrast with the clinical improvements shown in the CBCL, one parent reported an increase in anxiety problems and pervasive/somatic problems subscales that moved from the normal to clinical range. As CPRT encourages parents to spend one-on-one time with their children and facilitates parents' understanding of their children's feelings, this parent may have developed greater understanding and awareness of her child's emotional problems. The reported increase in anxiety and somatic problems may therefore be a reflection of this increased understanding. Even though there was not a specific question in the post-interview to gather information about the changes in parents' perceptions of their children's emotional problems, our explanation may be supported by this parent's statement "I think we both got a better understanding. I mean, I got a better understanding with him especially."

Parents in underserved communities frequently report feelings of stress, which can diminish the quality of the parent-child relationship (McKelvey et al., 2002). Participants of this study reported improvements in their relationships with significant adults in their lives as well as improved relationships with their children. Parents shared that the special play times created an environment in which they were able to gain a better understanding of their child and improve their relationship with their child. Thus it appears that CPRT is a viable treatment intervention for improving the parent-child relationship. Furthermore, academically at-risk students commonly live in homes with little emotional support (Turner et al., 2009). An improved parent-child relationship, therefore, has the potential to improve academic success and reduce the risk for school failure. CPRT also meets the goals of Head Start (Head Start Bureau, 1998) by teaching parenting skills and improving the parent-child relationship.

Limitations of the current study included a lack of transferability of the research findings and possible researcher bias. Because the study involved 6 parent participants, one cannot generalize findings to the other parents in the school or even to other similar training contexts. This is however balanced by the perspective that purposeful sampling focuses on gleaning useful information, not on generalizing from sample to population (Patton, 2002). The second author's extended contact with the intervention site allowed us to be immersed in the training context and have direct access to the participants. In-depth interviews also facilitated a close examination of the parents' views of the impact of the training.

The potential for researcher bias refers to the multiple roles that the second author played. In addition to being a CPRT trainer, she was involved in data collection and analysis. Although this may have had a negative effect on the data collection and analysis process, the other two authors provided a more objective view. The third author was only involved in data collection and analysis and the first author had no direct contact with the participants. As mentioned, the second author functioned as a liaison between the intervention site and the research university. Her prolonged engagement at the research site allowed for close observation of the cultural group under study (Spradley, 1980). Additionally, her consistent presence may have increased her credibility as a research-practitioner.

The current study used a mixed methodological approach to examine parents' perceptions of the process and effectiveness of CPRT. To date, the majority of studies investigating the usefulness of CPRT have been quantitative in nature; relatively few have employed qualitative methods. Qualitative data helps to explain and interpret quantitative results (Huberman & Miles, 1994) and mixed methods enrich data collection (Powell et al., 2008). Therefore, the continued use of qualitative or mixed methods studies is recommended. This may be especially helpful for program evaluation (Nastasi et al., 2004) and adaptation of protocols to meet the unique needs of specific parent populations.

5. Conclusion

Parents of underprivileged communities often have increased parenting stress and decreased access to social and parenting support. This combination puts stress on the parent-child relationship, increases the likelihood for children's maladaptive behaviors, and puts children at risk for school failure (Baker, Grant, & Morlock, 2008). The participants of the current study reported reduced parental stress, improved parent-child relationships, and a reduction in their children's internalizing and externalizing problem behaviors. Indeed, Child Parent Relationship Therapy (CPRT) is designed to improve the quality of the child-parent relationship, and reduce children's problem behaviors. Because behavioral problems can negatively affect academic engagement (Baker et al.), CPRT also has the potential to influence academic progress.

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