FILIAL THERAPY: A COMPARISON OF CHILD-PARENT RELATIONSHIP THERAPY AND PARENT-CHILD INTERACTION THERAPY

A DISSERTATION

SUBMITTED TO THE GRADUATE SCHOOL
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE
DOCTOR OF PHILOSOPHY

BY
KATHLEEN M. DUFFY

DISSERTATION ADVISOR: DR. THERESA KRUCZEK

BALL STATE UNIVERSITY
MUNCIE, INDIANA
SEPTEMBER 2008
FILIAL THERAPY: A COMPARISON OF CHILD-PARENT RELATIONSHIP THERAPY AND PARENT-CHILD INTERACTION THERAPY

A DISSERTATION

SUBMITTED TO THE GRADUATE SCHOOL

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE

DOCTOR OF PHILOSOPHY

BY

KATHLEEN M. DUFFY

APPROVED BY:

____________________________________  ____________________
Committee Chairperson                  Date

____________________________________  ____________________
Committee Member                       Date

____________________________________  ____________________
Committee Member                       Date

____________________________________  ____________________
Committee Member                       Date

____________________________________  ____________________
Dean of the Graduate School             Date

BALL STATE UNIVERSITY

MUNCIE, INDIANA

SEPTEMBER 2008
ACKNOWLEDGMENTS

This dissertation could not have been completed without the invaluable assistance of my committee chair, Dr. Theresa Kruczek. Her guidance and advice throughout the last four years has been appreciated. Without her support, I would have faltered many times and I appreciate her faith in my abilities as a student and as a professional. Her commitment to children and her advocacy of the importance of child work in counseling psychology offers such an exceptional model to students.

Thank you also to my committee members, Dr. Donald Nicholas, Dr. Charlene Alexander, and Dr. W. Holmes Finch for their support and advice throughout the completion of this dissertation. And to the Department of Counseling Psychology and Guidance Services and Ball State University, for giving me the perfect niche for achieving my academic goals.

Thank you to all of my doctoral classmates, who made these last four years a wonderful experience. I could not have asked for a better cohort. Thank you to Erin Snyder for her friendship and optimism in the darkest of hours and for her often needed perspective. To Stephen and Dorothy Wright for their help with the coding in my dissertation and for being true and valued friends. A special thanks to Dorothy for being the other “kid person” in a world of adults and who helped me with the final push to complete my dissertation.

Thank you to my family and friends for their tolerance of my absence these past four years. I am looking forward to having more time to spend with each of you and to rejoin the circle once again.
To my fiancé, whose love and support got me through some of the most challenging parts of my doctoral journey. I will always be so grateful to Ball State for bringing us together.

Thank you to my father, who is the calm voice of reason in the back of my head when things begin to spin out of control. His guidance and fortitude are a source of strength for me and I know I can never properly express how much his support and confidence in me has meant over the years.

Last, but definitely not least, thank you to my mother, to whom this dissertation is dedicated. Her commitment and success in improving the lives of children in her own career inspired me to pursue a path that will always include trying to make a difference in the lives of children. Thank you for her infallible patience in editing a seemingly endless number of papers and for seeing me through countless nights of doubt, worry, and fear with an ever present reminder of how proud she is of me. Because of her faith in me, I never second-guessed my path toward earning a doctorate and never doubted I would get this far.
# TABLE OF CONTENTS

TABLE OF CONTENTS ........................................................................................................ v
LIST OF TABLES ................................................................................................................. vii
LIST OF FIGURES ............................................................................................................... viii
Abstract ................................................................................................................................. ix

CHAPTER ONE – Introduction .......................................................................................... 11
  Empirically Supported Treatments ................................................................................. 11
  Filial Therapy ..................................................................................................................... 12
  Child Parent Relationship Therapy ................................................................................ 15
  Parent Child Interaction Therapy (PCIT) ........................................................................ 17
  Comparing CPRT and PCIT ......................................................................................... 18
  Statement of the Problem .............................................................................................. 20
  Purpose of the Study ....................................................................................................... 22
  Research Questions ....................................................................................................... 24
  Definitions of Terms ........................................................................................................ 26
  Assumptions ..................................................................................................................... 27

CHAPTER TWO – Literature Review ............................................................................. 28
  Child Development Perspectives .................................................................................... 28
  Theories of Social Development .................................................................................... 28
  Historical Perspectives .................................................................................................... 32
  Early Child Therapy ........................................................................................................ 32
  Contemporary Perspectives ............................................................................................. 33
  Play in Therapy ................................................................................................................ 33
  Filial Therapy ................................................................................................................... 37
  Child Parent Relationship Therapy ................................................................................ 39
  CPRT Efficacy Studies ..................................................................................................... 41
  Parent Child Interaction Therapy (PCIT) ........................................................................ 45
  PCIT Efficacy Studies ....................................................................................................... 47
  Comparing CPRT and PCIT ......................................................................................... 48
  Children with Autism ...................................................................................................... 50
  Summary ........................................................................................................................... 51

CHAPTER THREE – Methods ......................................................................................... 53
  Restatement of the Purpose of the Study ...................................................................... 53
  Participants ....................................................................................................................... 54
  Procedure .......................................................................................................................... 57
  Group Therapy Procedures ............................................................................................. 59
  Instrumentation ................................................................................................................ 63
  Design ................................................................................................................................. 65
  Data Analyses .................................................................................................................. 66
  Strengths ............................................................................................................................ 68
  Limitations ........................................................................................................................ 69

CHAPTER FOUR – Results ............................................................................................. 70
  Parent Child Relationship Inventory .............................................................................. 70
  Vineland Adaptive Behavior Scale .................................................................................. 71
LIST OF TABLES

Table 1: Demographic Information of Participants Included in Study .................. 56
Table 2: Demographic Information of Participants who Discontinued Treatment ....... 57
Table 3: Vineland (VABS)= Domain/Subdomain Standard Scores for CPRT participants ........................................... 74
Table 4: Vineland (VABS)= V-scale Standard Scores for PCIT participants ............. 79
Table 5: Frequency and Percent Agreement from Progress Notes for CPRT and PCIT groups ........................................................................................................ 92
LIST OF FIGURES

Figure 1: Participant Flow in CPRT and PCIT groups………………………………… 55
Figure 2: Parent Child Relationship Inventory (PCRI) T-scores for Participant #1 in
CPRT group……………………………………………………………………… 72
Figure 3: Parent Child Relationship Inventory (PCRI) T-scores for Participant #2 in
CPRT group……………………………………………………………………… 73
Figure 4: Vineland (VABS) Domain Standard Scores for Participant #1 in
CPRT group……………………………………………………………………… 75
Figure 5: Vineland (VABS) Domain Standard Scores for Participant #2 in
CPRT group……………………………………………………………………… 75
Figure 6: Vineland Standard Scores for Maladaptive Behavior for Participant #1 in
CPRT group……………………………………………………………………… 76
Figure 7: Vineland Standard Scores for Maladaptive Behavior for Participant #2 in
CPRT group……………………………………………………………………… 77
Figure 8: Parent Child Relationship Inventory (PCRI) T-scores for Participant #3 in
PCIT group……………………………………………………………………… 78
Figure 9: Parent Child Relationship Inventory (PCRI) T-scores for Participant #4 in
PCIT group……………………………………………………………………… 78
Figure 10: Vineland (VABS)-Standard Scores for Participant #3 in PCIT group…… 80
Figure 11: Vineland (VABS)-Standard Scores for Participant #4 in PCIT group…… 80
Figure 12: Vineland Standard Scores for Maladaptive Behavior for Participant #3 in
PCIT group……………………………………………………………………… 81
Figure 13: Vineland Standard Scores for Maladaptive Behavior for Participant #4 in
PCIT group……………………………………………………………………… 82
Figure 15: Vineland (VABS) Changes in Standard Scores from Pre-test to Post-test
for CPRT and PCIT Participants……………………………………………….. 88
Figure 16: Vineland (VABS) Changes in Maladaptive Behavior Standard Scores
from Pre-test to Post-test for CPRT and PCIT Participants…………………… 90
Filial therapy, originally developed by Bernard Guerney (1964), is a form of parent child therapy utilizing child-centered skills and limit setting strategies to improve the parent child relationship and to increase positive child behaviors. Parent Child Interaction Therapy (PCIT), developed by Sheila Eyberg (1988), is an empirically supported treatment for improving parenting skills and decreasing negative externalizing behavior with children. Child Parent Relationship Therapy (CPRT), developed by Garry Landreth (2002), is an up and coming form of Filial therapy, supported in the literature for improving the parent child relationship and improving the child’s general functioning. Children diagnosed with Autism Spectrum Disorders (ASD) often present with deficits in their socialization and communication abilities. These deficiencies can cause strain on the parent child relationship because of the challenges inherent to the maladaptive interactions common among families with a child diagnosed with ASD. Therefore, there is a need for effective interventions to improve the functioning between the parent and child. However, a review of the literature discovered a lack of research using Filial therapy with children diagnosed with ASD and no research comparing different forms of Filial therapy. In order to better inform practitioners, the current study utilized qualitative analysis through a deconstructing evidence approach to examine the experience of four participants in either the PCIT or CPRT group. Participants completed pre and post assessments measuring changes in the parent child relationship and their child’s adaptive functioning. The counselors of the group also recorded the parents’ reactions to the group through their weekly progress notes. The results yielded little support for one approach over the other. One participant in the CPRT had a very
successful experience overall, reporting improvement in the parent child relationship and her child’s adaptive functioning. Furthermore, the counselors recorded a more positive reaction from the parents in the CPRT group as compared to the largely neutral or negative reactions from the parents in the PCIT group. However, overall, the study concluded that more research is needed on identifying a clearly superior Filial therapy approach for children diagnosed with ASD.
CHAPTER ONE – Introduction

Parent-child therapy is an important therapeutic tool in the treatment of family systems based problems. Different than traditional individual therapy approaches, parent-child therapy involves both parents and their children in an experiential therapy approach. Working with both parents and children can be more effective than other forms of family and individual therapy because it allows parents to learn how to relate to their children in a practical and developmentally appropriate medium (Landreth, 2002). Parent-child therapy typically includes elements of play therapy, an approach that allows a child to express emotions and problems in the natural modality of play (O’Conner, 2000). In addition, parent-child therapy gives parents hands on practice working with their children in a setting where they can receive immediate feedback from counselors or peers (O’Conner, 2000; Landreth, 2002). Although the outcome literature on psychotherapy for children generally supports the use of parent-child therapy, more research is needed regarding the relative efficacy of specific models of parent-child therapy with different populations (Kazdin & Weisz, 2003, Landreth, 2002).

Empirically Supported Treatments

In order to improve the overall efficacy of treatment oriented fields in psychology there has been a recent movement for clinicians to be able to justify the value of their treatment approach through the support of outcome related research (Kazdin & Weisz, 2003). Individual outcome studies demonstrate the effectiveness of a certain treatment modality with a stated presenting problem or diagnosis. When multiple studies reach similar conclusions, this “empirical support” validates the approach as the best treatment available for a specific problem. These empirically supported treatments (EST) provide
clinicians with a guideline for choosing treatment approaches when intervening with individuals in therapy. Therefore, the field of counseling psychology has recently emphasized the importance of identifying and utilizing interventions that have been demonstrated to be effective in working with specific clinical populations (Lambert, 2004). In order to have the distinction of being an EST, a treatment must meet specific criteria (Lambert, 2004; Kazdin & Weisz, 2003). According to Lambert (2004), EST’s typically must have demonstrated their support through: random assignment of subjects to conditions, specifying the client population, utilizing treatment manuals, and evaluating treatment outcome with multiple measures completed by “blind” raters. In addition, replication of the study by an independent researcher is often advised to establish a treatment as an EST (Lambert, 2004). Furthermore, Lambert (2004) emphasizes the importance of efficacy studies, or those in which the treatment was delivered in a highly controlled environment, which may vary from typical clinical practice verses effectiveness where the benefit of the intervention has been demonstrated in clinical settings in which conditions are much less controlled (Lambert, 2004). The current investigation is an efficacy study, which examines two different treatment modalities of Filial therapy in order to determine their relative efficacy.

Filial Therapy

Filial therapy is a specific category of parent-child therapy in which the parents are the main catalyst to the change process (Guerney, 1964). Watts & Broaddus (2002) define Filial therapy as a type of treatment in which parents are taught basic child-centered play therapy skills. Parents become therapeutic change agents with their own children and learn to create an environment that enhances the parent-child relationship.
In Filial therapy, parents learn child-centered play therapy techniques (O’Conner, 2000). This process is intended to improve the overall parent-child relationship, improve the parent’s attitude toward their children, and decrease the child’s psychological symptomatology (Landreth, 2002).

Guerney (1964), proposed Filial therapy as a variant of child-centered play therapy in which the parents learn to conduct child directed play sessions (O’Conner, 2000). In sessions, children are able to convey feelings to their parent which they may have been unable to communicate in previous encounters (i.e., hurt, anger, sadness, etc). Parents gain a better understanding of their child’s needs, thoughts, and feelings because the child feels free to express himself/herself in the session (Guerney, 1964). For example, a child may express feelings of anger toward his/her parent during the child-directed play sessions by putting the parent “in jail” in the context of play. The parent complies and does not interfere with the child’s play or expression of anger. The parents gain a better understanding of this anger because the child is not limited in terms of the types of emotional expression allowed during the session. In previous interactions the child may have not revealed this anger because of the parents’ limits on the child’s emotional expression. In addition, parents are taught to convey a more accepting attitude of their child. This attitude creates an interpersonal openness, which allows children to gain more self-confidence, esteem, and self-respect because they are able to incorporate new attitudes conveyed by their parents in the play sessions (Guerney, 1964).

In Filial therapy, the parent-child relationship is viewed as being the most important influence on the child’s behavior (Watts & Broaddus, 2002). Early on, children form different styles of attachments with their parents (Siegler, Deloache, &
Eisenberg, 2006). When a child is more “securely” attached (i.e., trusts parent, feels safe, etc.) to a parent the child is more likely to be better adjusted overall (Siegler, Doloache, & Eisenberg, 2006). Therefore the focus of Filial therapy is the remediation of deficits in the parent-child relationship (Watts & Broaddus, 2002). The therapist’s role becomes that of a teacher and supervisor with the parents as they learn new skills and ways of communicating with their child. The therapist does not necessarily interact with the child at all in therapy, but the focus in mainly on the nature of the parent child interaction (O’Conner, 2000). According to Hembree-Kigin & McNeil (1995, p. 3) “the therapist’s power to influence a young child in a one-to-one therapeutic relationship pales in comparison to the power of parents to produce change through their interactions with their children.” In addition, in accordance with various play therapy theories, Filial therapy utilizes play as a means to foster positive parent-child interactions (Watts & Broaddus, 2002). By learning play therapy techniques parents learn to help their child express himself/herself symbolically through play. The goal of therapy is to change the way the parents and the child view their relationship in order to encourage a more positive way of interacting (Watts & Broaddus, 2002). In Filial therapy there are several core treatment goals children and parents will hopefully attain. They will improve the amount of trust and confidence in the relationship. They will also be encouraged to develop proactive behaviors (i.e., emotional expression, increased communication, etc.) and problem-solving strategies (VanFleet, 1994). The parents will learn new play skills that will allow them to gain a greater recognition and acceptance of the child’s emotional world (VanFleet, 1994). Finally, parents will have increased confidence in their ability to
play with and parent their child and will demonstrate a decrease in frustration with their child (VanFleet, 1994).

Child Parent Relationship Therapy

Child Parent Relationship Therapy (CPRT), originally designed by Garry Landreth (2002), is a parent-therapy program with its roots in Filial therapy (Guerney, 1964). Therefore, it is theoretically grounded in child-centered play therapy and utilizes constructs of client-centered theory originally developed by Carl Rogers (1951) and adapted to children by Virginia Axline (1950). CPRT teaches play skills to parents in order to enable the child to express feelings he/she was previously unable to convey to his/her parents. The parents are taught skills that encourage acceptance of their child’s perspective. The parents learn these skills in a group format in order to receive feedback from other parents and counselors about their progress in implementing the techniques (Landreth, 2002). Parents bring in videotapes of their play sessions at home and the counselors and group members offer suggestions and feedback (Landreth & Bratton, 2006). CPRT has been empirically investigated and supported as an effective intervention with a variety of treatment populations (i.e., ADHD, anxiety, victims of sexual abuse, etc) (Costas & Landreth, 1999; Kale & Landreth (1999).

In early sessions of CPRT, the parent learns child-centered techniques such as tracking, reflection, empathizing, and observing (Landreth & Bratton, 2006). The parent allows the child to take the lead in the session and uses those child-centered techniques developed in early sessions to encourage the child to explore and lead the play session. Freedom to lead the play session empowers the child to develop his/her own capabilities, maximize his/her potential and creates a more trusting relationship between the parent and the child (Rogers, 1986; Landreth & Bratton, 2006). The child feels safe to express
himself/herself and allows for a parent-child relationship that promotes changes in behaviors.

Another goal of CPRT is to improve the parent’s understanding of his/her child. CPRT assumes previous interactions with their parents have left the child feeling mistrustful and misunderstood by his/her parents. By allowing the child to take the lead in the play therapy sessions, the parent is able to gain a better understanding of the child using observation and empathy while the child is able to express his/her “true self” in a safe, trusting environment. In order to keep the environment safe, CPRT utilizes strategies to set limits on unwanted behavior (i.e., limits on throwing or destroying toys), but still maintains a context in which the child feels safe to express himself/herself. The parent is encouraged to only set limits on the child’s behavior that promote safe behavior and to communicate those limits in a way that the child is still able to feel understood and loved. For example, the child is free to play with a toy the “wrong way” (i.e., holding a phone upside down), but is not allowed to throw the toy at the parent. In setting a limit on the child’s behavior in this case the parent might say “It’s ok to be angry with me, but not ok to hurt me. So, you may not throw things at me.” This new way of reacting to the child changes the pattern of interactions between the parent and the child, thus creating a more positive and trusting relationship between them. The goals of CPRT include: 1) to improve the parent child interactions through expressions of warmth, affection, and trust, 2) to reduce the child’s symptoms, 3) to increase the child’s self esteem, 4) to improve the child’s coping skills, 5) to increase the parent’s understanding and acceptance of their child and 6) to increase the parent’s encouraging behaviors with the child (Landreth & Bratton, 2006).
Parent Child Interaction Therapy (PCIT)

Parent Child Interaction Therapy (PCIT), is an empirically supported treatment (Chambless & Ollendick, 2001), originally developed by Dr. Sheila Eyberg (1988) that is based on operant models of behavior management developed by Dr. Constance Hanf (1969). PCIT is grounded in social learning theory, traditional child therapy theory, and attachment theory (Hembree-Kigin & McNeil, 1995). In accordance with a Filial therapy approach, PCIT teaches parents child-centered play therapy techniques and utilizes attachment theory to explain the change mechanism of the therapy. However, PCIT extends Filial therapy by adding a goal of teaching the parents new skills and ways of interacting with their child in order to change the behavior of both the parent and the child. Since parents are seen as the most important figure in a child’s life they are therefore assumed to be the best resource to encourage changes within the child (Eyberg, 1988).

PCIT bases it techniques on the assumption that deficits in parent-child interactions result from ineffective parenting, which encourage and reinforce the child’s disruptive behavior as opposed to discouraging the behavior. In PCIT the format of the group is divided into two segments the Child Directed Interaction (CDI) and the Parent Directed Interaction (PDI). In the first segment the parent allows the child to run the play session with minimal direction and it is this segment of PCIT which utilized Filial therapy techniques. In the second segment the parents use discipline strategies to change the child’s maladaptive behavior. The CDI component of the therapy combines child-centered techniques with social learning theory to encourage bonding between the parent and the child. The parent learns how to allow the child to direct the play session while setting minor limits on inappropriate behavior via selective ignoring and labeled praise.
Through child led play, the children are free to express themselves, which creates a more nurturing environment for improving parent-child relationships (Nixon et al, 2004). Discipline is limited in the first part of treatment to prepare the parent and the child for the parent lead interactions.

During the PDI sessions, the parents learn to use the discipline strategies such as time-outs, social reinforcement, punishment, etc and child compliance is emphasized (Herschell & McNeil, 2005; Niec et al, 2001). Parents learn more effective discipline strategies to better manage their child’s behavior and parents model appropriate ways of acting (Bandura, 1971; Chaffin et al, 2003). Parents utilize behavior modification techniques such as selective ignoring and labeled praise to increase positive behaviors and discourage undesirable behaviors (Niec et al, 2001). Parents give their child positive attention for pro-social behaviors and ignore maladaptive or negative behaviors. Children learn their positive behaviors will be rewarded and their negative behaviors will be ignored (Bandura, 1971). In addition, parents are encouraged to utilize more positive communications (i.e., encouragements, praising, etc.) and are discouraged from making criticisms or commands in order to support the child to feel better about himself/herself and his/her parent. Thus, the goals of PCIT are to improve: 1) the child’s pro-social behaviors, 2) the parents’ use of effective behavior management strategies, and 3) the parent child relationship (Niec et al, 2001).

Comparing CPRT and PCIT

Unique Features. As CPRT and PCIT are both Filial therapy approaches, they have many similarities. However, each posses a number of unique features that differentiate the approach from one another and other Filial therapies. One of the unique features of CPRT is the use of solely child-centered techniques. All of the
communication is play based and the child uses symbolic expression to convey this information to the parent. Therapy takes place in a fun and developmentally appropriate environment where the child is free to express himself/herself through play. The parent becomes skilled at paying close attention to this symbolic expression in order to learn more about his/her child. In addition, by responding to the child authentically the parent forms a greater attachment with his/her child. The child takes the lead in each of the play sessions. In order to encourage an environment of openness and trust, the child directs the action of the play session, thus facilitating open communication between the child and the parent. Finally, CPRT emphasizes accepting vs. correcting (Landreth, 2006). The parent learns to accept his/her child’s unique world view thereby improving the child’s self-esteem, capacity for emotional expression and adaptive coping skills.

As described above, the unique features of PCIT include the division of the therapy into two segments the Child Directed Interaction (CDI) and the Parent Directed Interaction (PDI). In the first segment the parent allows the child to run the play session with minimal direction. In the second segment the parents use discipline strategies to control the child’s behavior. The PDI session involve more behavioral interventions (i.e., reinforcement, punishment) than the CPRT child-lead play sessions. This is the overall distinguishing characteristic of the PCIT group.

Similarities. The differences between CPRT and PCIT make them two distinct therapies. However, there are a number of similarities that allow for direct comparisons to be made between them. Both treatments can be administered in a group format, provide immediate feedback to the parent, are manualized treatments, and have research support for their effectiveness. Further, both therapies are designed to improve parent-
child relationships and utilize limit setting strategies. CPRT utilizes the A-C-T strategy and PCIT utilizes social learning strategies, such as ignoring, to set limits on inappropriate behavior. In both CPRT and PCIT, parents receive feedback from group members and counselors after observation of their implementation of the techniques. In CPRT, parents are asked to bring in videotapes of an at-home play session with their child. In PCIT, parents are directly observed through a one-way mirror. Finally, both therapies foster positive parent behaviors such as encouragement and reflection during the child-centered interactions.

Statement of the Problem

Although both CPRT and PCIT emphasize improving the parent-child relationship through the use of child-centered play therapy, they have different conceptual bases. CPRT is based solely on child-centered play therapy theory and encourages therapeutic change processes through the parent-child relationship in the play sessions (Landreth, 2006). According to Landreth (2006), the strength of this therapy is that it does not focus on correcting the child’s behavior and does not utilize behavioral strategies to extinguish behaviors, but rather encourages the child to explore and discover his/her strengths in order to improve coping and self-esteem. In contrast, PCIT is a behaviorally based intervention that uses concepts from social learning theory to make changes in the parent’s behavior and the child’s behavior. PCIT focuses more on remediation of skill deficits by eliminating undesirable child behavior and promoting pro-social behavior (Niec et al, 2001).

Both PCIT and CPRT have been shown to be effective treatments for improving parent-child functioning with certain populations (Kazdin & Weiz, 2003; Landreth, 2002;
Chambless & Ollendick, 2001). Nevertheless, there is a lack of research comparing the two models in order to determine how effective one treatment is compared to the other treatment, especially with specific diagnoses or presenting problems (i.e., Autism) (Lambert, 2004). The goal of both PCIT and CPRT are to improve parent-child relationships and to decrease negative behaviors in the child. While both PCIT and CPRT have received general support, neither has been identified as a more effective treatment.

Families who have a child diagnosed with an Autism Spectrum Disorder (ASD) are frequently referred for therapy to cope with family interactions and parent-child conflict (Thompson & Rudolph, 2000; Seligman, 1998). The parent-child relationship is often stressed due to the high number of challenges faced in the family that are related to the ASD (Seligman, 1998; APA, 2000). Specifically, children with ASDs fail to initiate spontaneous communication with others and fail to understand basic social cues (APA, 2000). Furthermore, children with Autism often have difficulty with adaptive functioning, and are unable to have appropriate interactions with peers and adults. These communication and socialization deficits may inhibit positive interaction between a child and his/her parent. As Filial therapies are designed to help facilitate a positive relationship between the parent and the child as well as encourage child autonomy (Gerard, 1964), these interventions are therefore relevant to families in which a child is diagnosed with Autism. However, to date research examining effective interventions for children with Autism has largely focused on individual behavioral interventions with the child (Kazdin & Weisz, 2003). There has been little research examining the effectiveness of Filial therapy for children with autism. Only one study has demonstrated the efficacy
of CPRT with children who have been diagnosed with ASDs (Beckloff, 1998) and there is no research utilizing PCIT with children with Autism (Kazdin & Weisz, 2003). Nevertheless, while both CPRT and PCIT are designed to help improve family functioning as well as promote adaptive behaviors, there is currently no evidence for which approach would be the treatment of choice for families of children with ASDs. Therefore, the current study seeks to investigate the relative efficacy of CPRT and PCIT when implemented with families of children with ASD.

Purpose of the Study

The present study includes CPRT and PCIT because of the popularity of both approaches as parent-child therapy models (Landreth, 2002). Although CPRT is not an empirically supported intervention, research on the technique has supported its ability to strengthen parent-child relationships and improve overall child functioning (Landreth, 2002). PCIT, however, has been identified as an empirically supported intervention for parents (Chambless & Ollendick, 2001). As stated above, since there is a lack of research comparing the two treatment models, the current investigation seeks to compare CPRT and PCIT to determine the relative efficacy in improving the parent-child bond and the child’s certain adaptive behaviors, such as communication and socialization.

Theoretically, CPRT emphasizes improved parent-child relationships and all of the outcome studies that examined CPRT’s effect on parent-child relationships reported significant improvement in the relationship (VanFleet, 1994). In addition, CPRT encourages the child to develop adaptive behaviors through child-centered techniques. Therefore, the present study will determine the relative efficacy of the two models in
improving parent-child relationships and child adaptive behaviors in families where there is a child diagnosed with an ASD.

The current investigation is intended to aid practitioners in choosing an appropriate intervention for working with families who have a child diagnosed with ASD. In order to provide an in-depth analysis of the experience of the participants in the group and the relative efficacy of the approaches, the current study will utilize a qualitative, multiple comparative case study methodology to present a detailed examination of the response to CPRT and PCIT (Morrow, 2007). According to Morrow (2007), qualitative methods should be utilized with research related to practice because it offers a description of the treatment implications of the study. Therefore, qualitative methods are consistent with counseling and psychotherapy process and outcome research (Morrow, 2007). The present study utilized a realist/postpositivist paradigm to qualitative methodology, in which the relative efficacy of two forms of group psychotherapy was compared (Haverkamp & Yong, 2007). In addition, the study had a practice-oriented purpose, which was to provide a rich, elaborate description of the effectiveness of each group (Haverkamp & Young, 2007). Case study research is a specific type of qualitative approach in which the investigator explores multiple bounded systems over time through detailed, in-depth data collection involving multiple sources of information and which reports case descriptions and case-based themes (Creswell, Hanson, Clark, & Morales, 2007). The current study was a multi-case outcome study which utilized data from two outcome measures as well as therapist progress notes from the groups. Analyses of these multiple data sources was utilized to compare the effect of each group for each individual participant, as well as in comparison in the pairs within
groups and the participants between groups. Pre/post outcome measures and thematic analysis of progress notes provided for a detailed description of participant reactions to and experiences in the groups. This information was then used to derive generalizations about how the groups were effective or ineffective (Creswell et al, 2007).

Research Questions

Although there is research to support the use of both PCIT and CPRT to improve the relationship between parents and their children, there is no research comparing the two approaches. Many of the challenges facing parents raising a child with ASDs (i.e., difficulty with communication and socialization) are directly related to the parent child relationship. Since the primary emphasis of CPRT is to improve the way parents communicate and relate to their children, it was proposed that this approach would be more effective relative to the PCIT intervention (VanFleet, 1994) with this diagnostic group. In addition, CPRT primarily focuses on allowing the child to develop adaptive behaviors through child-centered techniques as opposed to PCIT’s emphasis on improved discipline strategies. Recall, a core assumption of PCIT is that the child’s behavior problem is grounded in parent’s discipline skills deficits. In a family where the child is diagnosed with an ASD the etiology of the behavior problems seems more likely grounded in the child’s skills deficits, rather than parent’s skills deficits. Therefore, an intervention such as CPRT, which is designed to promote more effective communication and interaction between parents and children, rather than remEDIATE parenting skills deficits, would theoretically be more effective. Furthermore, 100% of the studies, regardless of diagnosis, that examined CPRT’s effect on the child’s overall functioning found significant improvement.
According to Lambert (2004), outcome research can investigate how effective one treatment is relative to other treatments for specific populations. In the present study, the efficacy of each treatment approach was first investigated individually and then the two approaches were compared to one another. Therefore, in the current investigation the following research questions were explored:

1. Did parents in the CPRT model report changes in the parent-child relationship and in their child’s adaptive behavior functioning (i.e., communication and socialization) and maladaptive behaviors?

2. Did parents in the PCIT model report changes in the parent child relationship and in their child’s adaptive behavior functioning (i.e., communication and socialization) and maladaptive behaviors?

3. What was the relative efficacy of the CPRT group compared to the PCIT group in improving the parent child relationship?

4. What was the relative efficacy of the CPRT group compared to the PCIT group in improving the child’s adaptive behavior functioning (i.e., communication and socialization) and decreasing maladaptive behaviors?

5. What were parents’ subjective reactions to the groups as reflected in the progress notes?
Definitions of Terms

The following definitions are provided for clarification of the meaning of terms as they are used in the current study.

*Pervasive Developmental Disorders (PDD).* This includes the following diagnoses as defined by the DSM-IV-TR (APA, 2000): Autistic Disorder, Asperger’s Disorder, Rett’s Disorder, or Childhood Disintegrative Disorder. The DSM-IV-TR (APA, 2000) defines Pervasive Developmental Disorder-Not Otherwise Specified (PDD NOS) as a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities.

*Autism Spectrum Disorders (ASD).* For the purposes of the current study, this includes any child diagnosed with Autistic disorder or Asperger’s disorder as defined by the DSM-IV-TR (APA, 2000). Predominate features of these disorders include: qualitative impairment in social interaction, communication, and restricted repetitive and stereotyped behaviors, interest, and activities (APA, 2000).

*Positive parent-child relationship.* A positive parent-child relationship is defined as one in which a child can communicate his/her thoughts, needs, and feelings to his/her parents and the child has a greater feeling of self-respect, self-worth, and confidence (Guerney, 1964).

*Adaptive functioning.* In the current investigation adaptive functioning will be measured by the Vineland Adaptive Behavior Scales (VABS). On this instrument adaptive functioning is measured on the following dimensions: communication, daily living skills, socialization skills, and motor skills (Sattler, 1988)
Assumptions

1. Parents read and understood the assessments. Each parent was provided with the opportunity to ask the group leaders for clarification when completing the questionnaires.

2. Assessment questionnaires were administered in standardized manner. Group leaders were briefed on the standardized assessment procedures during the group leader orientation session.

3. Parents accurately described their progress at home to group leaders. Parents honestly reported on their practice with their children at home.

4. Parents attempted to implement the treatment protocols at home. Parents were asked to bring in homework assignments, videotapes, and to report on their efforts to document implementation of procedures at home.

5. The counselors accurately understood and recorded parent reactions to the groups in the progress notes.
CHAPTER TWO – Literature Review

Child Development Perspectives

Theories of Social Development

Within the child development literature, there are three prominent views of social development: psychoanalytic theory, learning theory, and social cognition theory. Each perspective seeks to account for aspects of development such as emotion, personality, attachment, self, peer relationships, morality and gender (Siegler, Deloache, & Eisenberg, 2006). In addition, each theory highlights how early interactions with caregivers can effect a child’s development. Both psychoanalytic and learning theories stress the importance of external influences such as parent-child interactions on child development. Social cognitive theories however, see the child as having a more active role in his/her own development and external forces as having a minor influence over development.

Psychoanalytic. Sigmund Freud’s psychoanalytic theory has been the most influential theory of social and emotional development in the history of psychology. The psychoanalytic theory states that behavior is motivated by the need to satisfy basic drives. These drives are mostly unconscious, and most individuals do not have an understanding of why they do what they do (Siegler, Deloache, & Eisenberg, 2006). Freud describes five stages of early development: the oral stage, the anal stage, the phallic stage, the latency period, and the genital stage. In each stage the child encounters a conflict related to erogenous zones relevant to that particular stage. The success or failure in resolving these conflicts affects the child’s development throughout life (Siegler, Deloache, & Eisenberg, 2006). Therefore, early relationships with caregivers are essential for successful resolution of the conflicts. The psychoanalytic perspective of child development also emphasizes the importance of the subjective experience and the
unconscious mental activity of children throughout the stages of development. Positive interactions and identification with primary caregivers usually results in better emotional and social functioning later in life. Thus, parent-child relationships are seen as one of the most important factors of healthy development.

Learning Theories. In contrast to psychoanalytic theories, learning theorists do not endorse a stage model of development. Instead, they believe that development is a continuous process of different learning principles that shape behavior (Siegler, Deloache, & Eisenberg, 2006). The founder of behaviorism, John B. Watson, believed that their social environment determined a child’s development and that learning through conditioning was the primary mechanism of development (Siegler, Deloache, & Eisenberg, 2006). In social learning theory, children are not passive participants in their development, but are active in that they are observational learners. Children learn through social interactions by observing and imitating. In order to learn this information, Albert Bandura, the founder of social learning theory, states that children must pay attention to others, must encode what is observed, must store the information in memory, and must retrieve it to reproduce the behavior (Siegler, Deloache, & Eisenberg, 2006). Overall, learning theories emphasize the importance of social interactions as influencing development. Early parent-child interactions are viewed as important because they influence development by reinforcing or punishing certain behaviors.

Social Cognition Theories. Unlike learning and psychoanalytic theories, social cognition theories do not emphasize external forces of influence on child development. Instead, social cognition theorists believe children to be active participants in the process of self-socialization by shaping their own development. A child’s own beliefs about
himself/herself and other people lead him/her to adopt goals and standards to guide his/her own behaviors (Siegler, Deloache, & Eisenberg, 2006). One social cognition theorist, Robert Selman, states role-taking is the ability to adopt the perspective of another person, and is the key to the development of social cognition. On the other hand, Kenneth Dodge’s information-processing theory states that children go through six steps. Children encode a problematic event, interpret the social cues involved in it, formulate a goal to resolve the incident in some way, generate strategies to achieve the goal, evaluate the likely success of those potential strategies, and enact a behavior (Siegler, Deloache, & Eisenberg, 2006). According to social cognitive theory, children are different because they make different attributions about a given social event. Caregivers can influence a child’s behavior by giving him/her feedback that will effect the attributions he/she is likely to make.

Parent-child Relationships. Early research on parent-child relationships highlights the importance of parental attachments to a child’s development. Studies on children raised in orphanages with inadequate care show a failure to thrive among many of the infants. This research lead to the development of the attachment literature which demonstrates the importance of good parent-child relationships throughout childhood (Siegler, Deloache, & Eisenberg, 2006). In 1950, Mary Ainsworth developed the Strange Situation to examine parent-child attachment. The child would be placed in a room and the mother would leave. The examiners would observe how the child reacted when the mother left and when she returned. From these studies Ainsworth concluded there were three types of attachments in children: secure, insecure/resistant, and insecure/avoidant. Later studies added a four attachment: disorganized/ disoriented (Siegler, Deloache, &
Eisenberg, 2006). Subsequent literature on attachment has shown that children with secure attachments demonstrate better adjustment in adulthood with more positive social relationships (Siegler, Deloache, & Eisenberg, 2006).

**Importance of Play to Development.** Play has a number of developmental factors that facilitate adaptive changes in a child including: communication, preparation for life, emotional expression, ego-boosting, teaching, relationship enhancing, and self-actualization (O’Conner, 2000). The communication powers of play teach a child language skills and appropriate ways to communicate wants and needs to another person. Play also prepares the child for life. Through role play and opportunities to practice life roles and skills, children gain skills they will use throughout their life. Also, play can teach a child coping skills, conflict resolution skills, and moral development skills, which can be applied to life situations outside of play. Play has emotional expression power since it is often cathartic for the child and gives the child a safe place to express his/her emotions. The ego-boosting power of play gives the child self-confidence and self-esteem by allowing the child to achieve success in play. Play can have teaching powers because when learning is fun, the child is more likely to retain information and seek out learning opportunities in the future. Play also has relationship enhancing power in that children learn social skills when they play with other children and adults. They learn what others like (i.e., sharing) and what they don’t like (i.e., throwing) in a playmate. Finally, play has self-actualization powers. When children have the freedom to make their own choices in play they feel freer to be themselves and to like themselves.
Historical Perspectives

*Early Child Therapy*

In the early 1900s, Sigmund Freud took on the case of little Hans, a child of five years old. Using his traditional psychoanalysis techniques, Freud was able to improve the relationship between the child and his father (Geissmann & Geissmann, 1998). In the early years of child therapy, psychoanalytic theories dominated. Therapy therefore focused on repairing ruptures in the stages of development outlined by Freud’s psychoanalytic theory. Child development centers in the United States and Great Britain later utilized a child’s play as the basis for psychoanalysis in order to repair ruptures. These trends lead to theorists such as Melanie Klein to develop theories of symbolic play as it relates to psychoanalysis. According to Klein, a child’s unrestrained play activities could be compared to what the dream represented for Sigmund Freud. Psychoanalysis remained the dominant form of child therapy being reinvented and revised with each new theorist, until the emergence behaviorism and social learning theory in the mid-1900s.

Behaviorism took hold with Watson and Skinner’s famous studies of conditioning to change a child’s behavior. Watson was able to create and extinguish fears in Little Albert, and Skinner was able to predict the salivation of dogs by ringing a bell. Both of these theorists lead to the movement of behavior modification, thus offering help to parents in changing their child’s behavior. By setting up a reinforcement/punishment plan, the unwanted behavior is extinguished and the desired behavior is reinforced. Albert Bandura used this knowledge of behavior in order to develop his social learning theory. According to Bandura, children are reinforced and punished within an environment. Through observation and imitation of their environment children learn to act out behaviors which are in turn reinforced or ignored, thus increasing or decreasing
the likelihood of the child repeating the behavior. Child therapy in the mid-1900s thus began to integrate behavioral and social learning theory principles.

Around the same time as the development of behaviorism, Carl Roger’s developed person-centered therapy. According to Landreth & Bratton (2006) child-centered therapy is based on “the belief in the innate human capacity of the child to strive toward growth and maturity and an attitude of deep and abiding belief in the child’s ability to be constructively self-directing (p. 3).” Virginia Axline utilized principles from Carl Roger’s client-centered theory and from behavioral theories to develop child-centered play and parent training therapy. According to Axline (1950), “A play experience is therapeutic because it provides a secure relationship between the child and the adult, so that the child has the freedom and room to state himself in his own terms, exactly as he is at that moment in his own way and in his own time (p.68).” Therapy becomes a process of being with the child and looking through the child’s eyes. The relationship is the agent of change (Landreth & Bratton, 2006).

**Contemporary Perspectives**

*Play in Therapy*

According to O’Conner (2000), play therapy is defined as:

“…a cluster of treatment modalities that involve the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development and the re-establishment of the child’s ability to engage in play behavior as it is classically defined (p. 7).”
In other words, play therapy is the application of the therapist’s model to the process of play in which the goal is to use the powers of play to allow the child to engage in age normative play that is meaningful and growth enhancing. Play is thought to be the language of the child and the toys his/her words. Play is one of the best developmentally appropriate ways to evoke change in a child’s behavior and to help the child gain insight into his/her systems of functioning. When involved in play, children reduce their defenses and are more likely to talk about their feelings (Hall, Kaduson, & Schaefer, 2002).

However, a child does not exist in a vacuum, thus it is important to promote change that will be adaptive to the child’s various systems. Play serves a function in each of the child’s various systems including biological, intrapersonal, interpersonal, and social systems. Biologically, play serves as a vehicle through which a child learns basic skills, such as hand-eye coordination and allows the child to expend energy as well as experience pleasure (O’Conner, 2000). Intrapersonally, play meets the need for “functionlust” or the need to do something. In addition, play allows the child to explore his/her environment and lets the child master conflicts through symbolism and wish fulfillment (O’Conner, 2000). One of the primary goals of play therapy is to explore the intrapersonal functions of play in session. Real life events are demonstrated over and over in play until a viable solution in the play is reached. In this way, children use play as a vehicle for recapitulation of familial relational patterns. Play serves as a medium in which the child practices and achieves separation/individuation from the primary caretaker and later allows the child to learn valuable social skills (O’Conner, 2000). Finally, play has a sociocultural function by teaching the child about his/her culture and
the roles of people in that culture (O’Conner, 2000). Play is a window into the child’s world.

Play therapy has been criticized because of a lack of outcome research supporting play therapy as an effective intervention (Ray, Bratton, Rhine, & Jones, 2001). As cited in, Russ (2004), a study by Levitt in 1957 found that the mean improvement rate for the children in the treatment group was not significantly better than the baseline of 72.5% of the control children. However, recent meta-analyses of the literature available have found play therapy to be an effective therapeutic technique.

A meta-analysis by Ray et al. (2001) examined the results of numerous outcome studies on play therapy interventions. This study included research on the effectiveness of play therapy as it applies to different age groups, gender, ethnicity, setting, presenting issues, theoretical model, individual vs. group, and the number and frequency of sessions. The effect sizes of the studies were compared. The results of the study confirmed that play therapy is an effective intervention for child psychotherapy. The treatment groups performed at .80 standard deviations better than non treatment groups. (Ray et al., 2001). Higher parental involvement was a greater predictor of success in treatment (treatment groups performed at 1.06 standard deviations better than non treatment groups) and play therapy appears to work for all ages of children. Finally, success in play therapy also increases with the number of sessions up to 45 sessions (Ray et al., 2001).

Another review of play therapy literature spanning the last century illustrates that play therapy is effective (Bratton & Ray, 2000). The peak of play therapy research was in the 1970s with a decline in the last few decades. Nevertheless, this meta-analysis reviewed 82 articles, 14 of which examined the effectiveness of play therapy on social
maladjustment. Out of these studies, 12 found some change. Overall, the review by Bratton & Ray (2000) found play therapy to be effective for treating self-concept, behavioral change, cognitive ability, social skills, and anxiety in children.

A meta-analysis by LeBlanc & Ritchie (2001) included 42 studies in a meta-analysis yielding an overall effect size of .66 with a standard error of .09. The authors included 6 categories of presenting problems including: emotional maladjustment, social maladjustment, reaction to or anticipation of identified traumatic event, academic problems, family maladjustment, and behavioral problems. In addition, the authors found the optimal number of sessions to be 30-35 sessions. The ages of the children included in the meta-analysis ranged from 0-12 years old.

Finally, a meta-analysis by Bratton et al. (2005) meta-analysis found play therapy to be effective as well. In the analysis 93 studies were included and a mean effect size of .80 was found. In addition, children who received play therapy did better than ¾ of a standard deviation better than children who did not receive play therapy. The analysis included articles on internalizing disorders, externalizing disorders and a combination of both. The authors also found that the optimal number of sessions is 35-40. The average age of the children was 7 years old.

Overall, in the past 5 years, four meta-analyses and reviews have been conducted in an attempt to evaluate the overall efficacy of play therapy as a treatment modality. These studies concluded that play therapy is an effective therapy for working with children exhibiting a wide range of problems. The most recent and comprehensive meta-analysis over the effectiveness of play therapy by Bratton et al. (2005) concluded that play therapy is effective (mean effect size =0.80).
Filial Therapy

Bernard Guerney was a student of the child-centered approach described by Virginia Axline, but he wanted to incorporate parents into the therapeutic process. He viewed parents as potential allies in the change process and began incorporating them as observers of the play sessions (Landreth & Bratton, 2006). He conceptualized a training model that had the parents as the primary catalyst for change by teaching them child-centered play techniques. Until this point in history, child pathology was viewed as a result of parent pathology. Thus the idea that parents could actually be the therapeutic change agent was a radical one (Landreth & Bratton, 2006). Nevertheless, in 1964, Guerney proposed a model of Filial therapy, a variant of child-centered play therapy, in which the parents are taught to conduct child directed play sessions (O’Conner, 2000). Parents were thought to have more of an effect on their children during the play sessions because of the preexisting bond that was already in place between them. Through the play sessions the children are able to convey feelings of hurt or anger to their parent, which they may have been unable to communicate in previous encounters. Parents gain a better understanding of their child’s needs, thoughts, and feelings by observing their child’s play (Guerney, 1964). In addition, children gain more self-confidence, esteem, and self-respect because they are able to incorporate new attitudes conveyed by their parents in the play sessions (Guerney, 1964).

In Filial therapy, the focus is on remediating deficits in parent-child relationship and views parents as the most significant, influential adult in the child’s life (Watts & Broaddus, 2002). Therefore, the therapist becomes teacher and supervisor to the parents and does not necessarily interact with the children (O’Conner, 2000). The parent is seen as more influential in the child’s life as they have more influence over the child’s
behavior. According to Hembree-Kigin & McNeil (1995, p. 3) “the therapist’s power to influence a young child in a one-to-one therapeutic relationship pales in comparison to the power of parents to produce change through their interactions with their children.” Filial therapy utilizes play as a fun & developmentally appropriate means to foster parent-child interactions (Watts & Broaddus, 2002). In accordance with most views on play therapy, communication within the sessions of Filial therapy is play-based and the learning process is experiential. Filial therapy allows the child to express his/her emotions symbolically and lets the child lead the focus of the play. There is absolutely no emphasis on correcting the child’s behavior in the play sessions and the objective is to change the child’s perceptions of the parent (Watts & Broaddus, 2002).

According to VanFleet (1994) the goals of Filial therapy for the child include enhancing and strengthening the parent-child relationship and improving family interactions. Filial therapy also helps to improve problem-solving strategies within the family and promotes a healthy family system. In addition, by utilizing Filial therapy, there may be a reduction of symptoms displayed by the child when he/she is able to recognize and express feelings fully and constructively. Filial therapy offers the child the opportunity to be heard and assists him/her to develop coping skills, as well as increased self-esteem and self-confidence. Finally, children who participate in Filial therapy will ideally develop increased trust and confidence in their parent and will have developed proactive behaviors (i.e., listening) that contribute to improved overall functioning.

For the parent, the goals of Filial therapy include understanding child development and developing a greater understanding and acceptance of the child’s emotional world (VanFleet, 1994). By participating in Filial therapy parents will have a better recognition
of the importance of play for child development, decreased frustration with their child and a more realistic and tolerant perception of self and child. Finally, parents will have increased confidence in their ability to parent and possess more effective and developmentally appropriate parenting skills (VanFleet, 1994).

Child Parent Relationship Therapy

Child Parent Relationship Therapy (CPRT) has a number of unique features that make it an effective means of intervening with children and their parents. CPRT is a child-centered parent training program with its roots in Filial therapy. CPRT is different from individual therapy in that it is experiential for both the parent and the child. Like Filial therapy, it allows the child to express feelings of hurt and anger he/she was otherwise unable to convey to his/her parent and the parents are able to better understand his/her child’s perspective and accept his/her child. Moreover, CPRT works to correct deficits in the parent child (p-c) relationship (Guerney, 1964) in a way that is fun and developmentally appropriate (Watts & Broaddus, 2001). CPRT was originally designed by Garry Landreth (2002) and has since been empirically supported as an effective intervention with a variety of treatment populations. This approach is grounded in child centered play therapy and is based on the constructs of client-centered theory originally developed by Carl Rogers (1951) and adapted for children by Virginia Axline (1950). According to Landreth & Bratton (2006) child centered play therapy is based on “the belief in the innate human capacity of the child to strive toward growth and maturity and an attitude of deep and abiding belief in the child’s ability to be constructively self-directing (p. 3).” In therapy, the parent is taught child-centered techniques such as tracking, reflection, empathizing, and observing (Landreth & Bratton, 2006). The parent allows the child to direct the actions in the play and the parent utilizes child-centered
techniques to encourage the child’s exploration of the play materials. Freedom to lead the session creates a permissive environment that is believed to empower the child to develop his/her own capacities and maximize his/her potential (Rogers, 1986; Landreth & Bratton, 2006).

Child centered play therapy is a process of being with the children as opposed to implementing techniques (Landreth & Bratton, 2006). “A fundamental rule of thumb in child-centered play therapy is that the child’s perception of reality must be understood if the child and behaviors exhibited by the child are to be understood (Landreth & Bratton, 2006, p. 4).” Child-centered play therapy promotes an environment where the child feels safe to express himself/herself and allows for a relationship that fosters changes in behaviors.

According to CPRT, deficits in the parent child relationship are a result of a parent’s lack of understanding of his/her child. In addition, the child does not feel a connection to the parent because previous interactions did not allow the child to trust the parent and the child did not feel comfortable showing his/her “true self”. Thus, by allowing the child to take the lead in the play therapy sessions, the parent is able to gain a better understanding of the child using observation and empathy while the child is able to express his/her emotional experience in a safe environment. In order to keep the environment safe, CPRT utilizes the A-C-T strategy to set limits on unwanted behavior. In this strategy the parents acknowledge the behavior, communicate the problem, and target the behavior to the child. In a safe context, the child is able to feel understood and loved, thus changing his/her negative view of the parent. These feelings of acceptance, manifest by the parent, allow the child to be more actualized, improve the child’s self-
concept and improve the child’s overall functioning. The goals of CPRT include: 1) to improve the parent child interactions through expressions of warmth, affection, and trust, 2) to reduce the child’s symptoms, 3) to increase the child’s self esteem, 4) to improve the child’s coping skills, 5) to increase the parent’s understanding and acceptance of their child and 6) to increase the parent’s encouraging behaviors with the child (Landreth & Bratton, 2006).

**CPRT Efficacy Studies**

The efficacy of CPRT with specific populations of parents has been demonstrated in a number of studies in recent years. Bratton & Landreth (1995) examined the use of CPRT with single parents. The participants included 29 mothers and four fathers. The children of the participating parents included 19 girls and 24 boys, ages three to seven years. In this study, the researchers utilized the Porter Parental Acceptance Scale, the Parenting Stress Index, and the Filial Problem Checklist to measure the efficacy of the group. The results of the study illustrated an increase in parental empathy, a decrease in parental stress, a decrease in the child’s aggressive behaviors, and an increase in the overall family functioning (Bratton & Landreth, 1995).

Two studies have demonstrated the efficacy of CPRT with incarcerated parents. Harris & Landreth (1997) held CPRT groups with 22 incarcerated mothers and their children, ages 3-10 years. The researchers utilized the Porter Parental Acceptance Scale, the Parenting Stress Index, and the Filial Problem Checklist to measure efficacy. This study found an increase in parent child relationships and a decrease in the child’s aggressive behavior and anxiety, but no effect on parent stress (Harris & Landreth, 1997). Landreth & Lobaugh (1998) examined the use of CPRT with 32 incarcerated fathers and their children, ages 4-9 years. The researchers utilized the Porter Parental Acceptance
Scale, the Parenting Stress Index, the Filial Problem Checklist and the Joseph Preschool and Primary Self-Concept Screening Test to measure efficacy. The results indicated an increase in parent-child relationships and a decrease in parent stress (Landreth & Lobaugh, 1998).

Researchers have also examined the use of CPRT with different ethnicities of parents. Chau & Landreth (1997) held CPRT groups with Chinese parents. The participants included 27 mothers and 7 fathers. The children of the parents included 16 boys and 16 girls, ages 4-10 years. The researchers utilized the Porter Parental Acceptance Scale and the Parenting Stress Index to measure the efficacy of the group. This study found an increase in positive parent child relationships and a decrease in parent stress (Chau & Landreth, 1997).

Another study by Glover & Landreth (2000), examined the use of CPRT with Native American parents. Participants included 18 mothers, two grandmothers, and one step-mother. The children of the participants included 10 boys and 11 girls ages 3-10 years. The researchers utilized the Porter Parental Acceptance Scale, the Parenting Stress Index, the Measurement of Empathy in Adult-Child Interaction Rating Form, Children’s Play behavior with Parent Rating Form, and the Joseph Preschool and Primary Self-Concept Screening Test to measure the efficacy of the group. This study found an increase in parent child relationship, improvement in the child’s self-concept, but no effect on parent stress (Glover & Landreth, 2000).

Two studies examined the use of CPRT with Korean parents. Jang (2000) held the group with 30 mothers with children ages 4-9 years of age. The Porter Parental Acceptance Scale, Parenting Stress Index, and the Filial Problem Checklist were utilized
to measure the efficacy of the group. This study found an increase in the parent child relationship, but no effect on the parental stress or the children’s aggressive behavior (Jang, 2000). Lee & Landreth (2003) held CPRT groups with a total of 33 Korean parents with children 2-10 years of age. They utilized the Porter Parental Acceptance Scale, the Parenting Stress Index, and the Measurement of empathy in Adult-Child Interaction. The researchers found an increase in parent empathy and acceptance, as well as a decrease in parent stress (Lee & Landreth, 2003).

Yuen, Landreth, & Baggerly (2002), studied the use of CPRT with 36 immigrant Chinese parents. The children included 19 boys and 16 girls ages 3-10 years. The examiners utilized the Porter Parental Acceptance Scale, the Parenting Stress Index, The Filial Problem Checklist, and the Self-Perception Profile for Children. The researchers found an increase in parental acceptance, a decrease in parent stress, a decrease in perceived problems and an increase in the children’s self-concept (Yuen, Landreth, & Baggerly, 2002). Finally, the use of CPRT with Israeli parents was examined by Kidron (2004). The children were 3-10 years of age. This study utilized the Child Behavior Checklist, the Parenting Stress Index, and the Measurement of Empathy in Adult Child Interaction. The researcher found an increase in empathy, a decrease in parent stress, and a decrease in the children’s externalizing behaviors (Kidron, 2004).

The efficacy of CPRT has also been demonstrated with numerous clinical populations of children in recent studies. Costas & Landreth (1999) held groups with non-offending parents of children who had been sexually abused. The parents included 20 mothers, 5 fathers, and 1 grandmother. The children of the parents included 15 girls and 7 boys, ages 4-10 years. The researchers utilized the Porter Parental Acceptance
Scale, the Parenting Stress Index, the Child Behavior Checklist, the Child Anxiety Scale, the Joseph Preschool and Primary Self-Concept Screening test, and the Draw a Person Screening to measure efficacy. The researchers found an increase in the parent child relationship, a decrease in parent stress, a decrease in the child’s emotional disturbance. There was no effect on the children’s self concept or their aggressive behaviors (Costas & Landreth, 1999).

Kale & Landreth (1999) examined the use of CPRT with children with learning difficulties, Attention Deficit Hyperactivity Disorder, or Anxiety Disorder. The parent participants were 17 mothers, 3 fathers, and 2 grandmothers, with children ages 3-10 years of age. The researchers utilized the Porter Parental Acceptance Scale, the Parenting Stress Index, and the Child Behavior Checklist to assess the efficacy of the group. They found an increase in parent child relationships, and a decrease in parent stress, but no effect on the children’s aggressive behaviors or their anxiety (Kale & Landreth, 1999).

Smith & Landreth (2004) held CPRT groups with teachers of children who were deaf and hard of hearing. In this study, 20 female teachers and 4 male teachers participated in the groups. The researchers used the Measurement of Empathy in Adult-Child Interaction, the Child-Behavior Checklist, and the Meadow-Kendall Social-Emotional Assessment for Deaf and Hard of Hearing Children to measure the efficacy of the groups. The examiners found an increase in teacher empathy, a decrease in student’s behavior problems and internalizing problems, but no effect on aggressive behaviors (Smith & Landreth, 2004).

Finally, most relevant to the current investigation, Beckloff (1998) examined the efficacy of CPRT with children with Spectrum Pervasive Developmental Disorders, ages
3-10 years. The Porter Parental Acceptance Scale, the Parenting Stress Index and the Child Behavior Checklist were used to measure the efficacy of the group. The results indicated an increase in the parent’s acceptance and overall functioning, but no significant results were found for internalizing or externalizing behaviors in the children (Beckloff, 1998).

**Parent Child Interaction Therapy (PCIT)**

Parent Child Interaction Therapy (PCIT), on the other hand, is grounded in social learning theory, traditional child therapy theory, and attachment theory (Hembree-Kigin & McNeil, 1995). PCIT utilizes the principles of Filial therapy in that it teaches parents child-centered play therapy techniques and utilizes attachment theory to explain the change mechanism of the therapy. It is also an empirically supported treatment (Kazdin & Weiz, 2003; Chambless & Ollendick, 2001). This theory, originally developed by Dr. Sheila Eyberg (1988), is based on operant models of behavior management developed by Dr. Constance Hanf (1969). It focuses on changing the behaviors of both the parents and the child in order to improve parent child relationships. According to Eyberg (1988, p. 35)

…many of the behavioral problems young children present are established through their earliest interactions with their parents. Even in those cases where the child’s problems seem to originate because of biological characteristics, such as difficult temperament, or neurological deficits suspected in autistic, hyperactive, or developmentally impaired youngsters, many of the problem behaviors seem to be intensified by the interaction patterns between parent and child.
In other words, parents have a great deal of influence over a child’s behavior, both positively and negatively, even if the child has a predisposition to behavioral difficulty. PCIT combines behavior management techniques and play therapy in order to teach parents how to positively influence their child’s behavior via consistent limit setting and consequences (Hembree-Kigin & McNeil, 1995).

PCIT employs social learning techniques such as differential attention, social reinforcement and problem solving skills training (Niec et al, 2001). PCIT uses traditional play therapy and attachment techniques to focus on improving the parent child relationship. Specifically, parents learn how to provide a nurturing environment for their child via child led play (Nixon et al, 2004). PCIT then teaches parents to utilize skills such as selective ignoring and labeled praise to increase positive behaviors and discourage undesirable behaviors (Niec et al, 2001).

PCIT proposes that deficits in parent-child interactions result from ineffective parenting techniques and family environments which encourage and reinforce the child’s unsocialized behavior as opposed to discouraging the behavior. In PCIT, parents are taught more effective discipline strategies in order to better manage their child’s behavior (Chaffin et al, 2003). According to social learning theory, people learn about the effects of their own actions by observing others and forming ideas about how behaviors are performed. In PCIT, the parents act as models to their children by demonstrating appropriate ways of acting (Bandura, 1971). When parents utilize techniques such as selective attention, they give their children positive attention for prosocial behaviors and ignore maladaptive or negative behaviors. Thus, the children are more likely to utilize adaptive behavior outside of the sessions and in the future, as they have learned that
prosocial behaviors will be rewarded (Bandura, 1971). In addition, by discouraging criticisms and commands from the parent, the parent-child relationship improves because the parent-child communications include more positive than negative messages. These verbal, social reinforcers result in the child feeling better about him/herself and her/his parent. Thus, the goals of PCIT are to improve the child’s prosocial behaviors, to improve the parents’ use of effective behavior management strategies, and to improve the parent-child relationship (Niec et al, 2001).

PCIT Efficacy Studies

As previously stated, PCIT has been established in the literature to be an empirically supported treatment for children (Chambless & Ollendick, 2001). Therefore, there is a plethora of literature supporting the efficacy of the treatment approach. For example, a study by Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hodd (2001) found parent-child interaction therapy to be effective in changing the behaviors of children with conduct disorder. The authors found 85% of the families to be successful in changing their child’s behavior (Eyberg et al, 2001).

Recently, a review of the efficacy literature was conducted by Brinkmeyer & Eyberg (2003). In this review, the authors discovered the PICT outcome studies demonstrated changes in parents’ behavior toward their children, including increased reflective listening, physical proximity, prosocial verbalization, and decreased criticism (Brinkmeyer & Eyberg, 2003). Parents’ who completed PCIT also reported less parenting stress, statistically significant improvements in their child’s behavior, and a high level of satisfaction with the content and process of the PCIT group (Brinkmeyer & Eyberg, 2003). Finally, according to Brinkmeyer & Eyberg (2003), the positive effects of PCIT have been shown to generalize to other settings and other family members.
Outcome studies demonstrated children in PCIT groups were better behaved at home and at school. Further, parent’s who completed the group showed improvement in their parenting of the treated child as well as the untreated child. Overall, the efficacy of PCIT has been well established in the literature.

Comparing CPRT and PCIT

Some of the unique features of CPRT are the use of solely child-centered techniques. All of the communication is play based. The child communicates his/her needs, wants, fears, anger through play. The child uses symbolic expression to convey this information to the parent. For example, a doll house may represent the child’s home, or a puppet show the family interactions. The parent is taught to pay close attention to this symbolic expression in order to learn more about his/her child. In this way the parent is oriented to the child for a full 30 minutes. The child takes the lead in each of the play sessions. The parent is there to reflect, observe, and empathize - but not to direct. This presents a unique opportunity for the child to be in charge and allows for greater expression of emotions when the child can use play as a facilitative communication device. Finally, CPRT emphasizes accepting vs. correcting (Landreth, 2006). If the child uses a toy in a unique way (i.e., talks on the phone upside-down), the parent does not correct the child, but accepts the child’s interpretation. The child learns to trust the parent during the interactions and that trust encourages positive self-esteem, emotional expression, and the development of adaptive coping skills.

The unique features of PCIT include the division of the therapy into two segments the Child Directed Interaction (CDI) and the Parent Directed Interaction (PDI). In the CDI component of the therapy the parent learns how to allow the child to direct the play session while setting minor limits on inappropriate behavior via selective ignoring and
labeled praise. The parents are encouraged to use PRIDE skills (praise, reflecting, imitating, describing, and enthusiasm) (Hembree-Kigin & McNeil, 1995). This portion of the therapy combines child-centered techniques with social learning theory to encourage bonding between the parent and the child while preparing the child for the PDI portion of the therapy. By utilizing limited discipline strategies at the beginning of therapy, the child is eased into the parent lead interactions. During the PDI sessions, the parents utilize the discipline strategies dictated by PCIT theory such as time-outs, social reinforcement, punishment, etc (Herschell & McNeil, 2005). Child compliance is also emphasized during this portion of the therapy (Niec et al, 2001). These aspects of PCIT allow the parent not only to learn more effective discipline strategies, but also encourage more positive parent-child interactions.

Despite the unique features of both types of therapy, both models have a number of similarities. For instance, both can be administered in a group format, both provide immediate feedback to the parent, both are manualized treatments, and both have research support for their effectiveness. Furthermore, both emphasize improving the parent child relationship through the use of child-centered play therapy. However, CPRT and PCIT have different conceptual bases. CPRT is based solely on child-centered play therapy theory and encourages therapeutic change processes through the parent child relationship in the play sessions (Landreth, 2006). This therapy is strength based in that it does not focus on correcting the child’s behavior and does not utilize behavioral strategies to extinguish behaviors, but encourages the child to explore and find his/her strength in order to improve coping and self-esteem. On the other hand, PCIT is a behaviorally based intervention that uses concepts from social learning theory to make
changes in the parent’s behavior and the child’s behavior. This intervention focuses more on remediation of skills deficits by eliminating undesirable child behavior and promoting prosocial behavior (Niec et al, 2001).

Despite these differences, both therapies are designed to improve parent-child relationships. In addition, both therapies utilize limit setting strategies during therapy. CPRT utilizes the A-C-T strategy and PCIT utilizes social learning strategies, such as ignoring, to set limits on inappropriate behavior. Both therapies promote positive parent behaviors such as encouragement and reflecting during the child-centered interactions.

Children with Autism

Children with pervasive developmental disorders and high functioning autism can benefit from CPRT and PCIT. Characteristic features of ASDs include impaired adaptive functioning, including poor social interactions and communication impairments (APA, 2000). Children diagnosed with ASDs often struggle to communicate their wants and needs to their parents because they lack the ability to use conventional communication and social skills (i.e., talking) or they do not know how to use them properly (i.e., smiling, laughing) (Seligman, 1998). Therefore, family members are left confused and trying to guess what the child wants. Children diagnosed with ASDs may not understand the function of sarcasm and may take the meaning literally. Further, they may find it difficult to control their impulses and therefore may act out behaviorally (i.e., running, touching objects) in inappropriate times and situations (APA, 2000; Seligman, 1998).

The deficits in adaptive functioning stated above can make parent-child interactions difficult and strained. Parents try, often ineffectively, to control their child’s behavior and to communicate using restraint or yelling. Interventions such as these do
not usually improve the child’s behavior and in fact, may escalate the difficult behaviors (Thompson & Rudolph, 2000). Therefore, interventions designed to teach parents more effective ways of coping with their child’s behavior is often a valued resource for families with a child diagnosed with an ASD. CPRT and PCIT both focus on improving parent-child interactions by encouraging emotional experiencing during sessions and by allowing the child to explore different ways of communicating his/her needs to his/her parents (Landreth, 2002; Niec et al, 2001). Parents learn to intervene with their child using child-focused techniques, namely play (O’Conner, 2000). In addition, both therapies teach parents appropriate limit setting strategies to utilize with their children thus improving the children’s overall adaptive functioning (Landreth, 2002; Niec et al, 2001).

Summary

Throughout history, the road for the establishment of child therapy as an established well-respected means for improving the life of a child has been a rough one. Frequently criticized for just being “fun,” play therapy has had to fight for its place in counseling psychology. However, with roots in some of the most respected theories of psychology and the existence of research supporting its effectiveness, play therapy for children has become a standard for practitioners wishing to intervene with children with a wide variety of presenting problems. Further, new advances in the field of play therapy have taken place. Given the importance of a child’s parent in the functioning of a child, it was a natural transition to combine play therapy with parent training and Filial therapy was born. Different variations of Filial therapy have grown out of the research on child therapy, such as CPRT and PCIT. The ever present need to establish empirical support
for the use of interventions for children with different presenting problems in psychology research, such as that presented in the current study, continues to be essential. Therefore, the present investigation seeks to add to the body of literature on Filial therapy by comparing the relative efficacy of CPRT and PCIT with children diagnosed with ASDs.
CHAPTER THREE – Methods

Restatement of the Purpose of the Study

In this study, two types of Filial therapy were compared in order to determine the relative efficacy of the two approaches in improving the parent-child relationship and to improve the child’s adaptive behaviors. Recall, CPRT and PCIT have different conceptual bases, which allowed for comparisons between the two techniques. A recently developed form of Filial therapy, CPRT, had been shown to be an effective intervention for improving parent-child interactions (Landreth & Bratton, 2006). Further, PCIT is an empirically supported treatment established in the field of parent-therapy models (Chambless & Ollendick, 2001). Although there was literature supporting the efficacy of each group separately, there was no research comparing the relative efficacy of the two parent-therapy models. Furthermore, while the efficacy of both CPRT and PCIT for different presenting problems and populations has been examined (Kazdin & Weisz, 2003; Landreth & Bratton, 2006), there was little research examining the efficacy of either group for children with ASDs (Beckloff, 1998).

Parents of children diagnosed with ASDs often face difficulties in their interactions with their children because these children struggle with communication and social interaction (Seligman, 1998). Therefore, it is important to identify parent-child therapy models that will improve parent-child interactions and the child’s adaptive functioning. Therefore, the current study sought to determine the relative efficacy of CPRT and PCIT in improving parent-child relationships in families with a child diagnosed with ASD and targeted child adaptive behaviors in the domains of communication and socialization.
Participants

Participants were recruited through contact with special education coordinators from the local school district and a community support group for parents of children diagnosed with ASDs. Only children who were diagnosed with ASDs by a psychologist or primary care physician were included in the study. Data was collected over a period of three semesters. Each Filial therapy group began with three to five parents and participants who were randomly assigned to either a CPRT or PCIT group. In total 9 participants started the PCIT group and eight participants started in the CPRT group (See Figure 1).

Of the 19 total participants beginning the study, only three completed a “full course” of each group treatment condition, for a total of six parents. A parent had to attend at least seven sessions to receive the “full course” of the treatment, allowing for the likelihood that parents could not attend 100% of the time (Landreth, 2002). Of the six parents who met this criterion for a full course of treatment, only four participants provided complete and valid pre and post measures. These four participants were included in the final sample and each attended eight or more group sessions (See Table 1). Of these four, two received the PCIT treatment and two the CPRT treatment. The two participants in the CPRT group participated in the same group.
The two participants in the PCIT group participated in the group during different semesters. Participant #3 participated with another group member until the 6th session, but participated alone for the remaining four sessions when the other group members discontinued participation. Similarly, Participant #4 participated with another group member until the 8th session, at which time her other group members discontinued participation. In both cases these participants completed the course of the group with the two counselors continuing to provide feedback.
Demographic information and descriptions of participants are summarized in Table 1 for the four sets of parents who were included in the final sample and their children.

Table 1: Demographic Information of Participants Included in Study

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Child’s Age</th>
<th>Child’s Sex</th>
<th>Diagnosis</th>
<th>Relationship to Child</th>
<th>Others in home</th>
<th># of sessions attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant #1</td>
<td>34</td>
<td>6</td>
<td>Male</td>
<td>Autism</td>
<td>Mother</td>
<td>Husband</td>
<td>10</td>
</tr>
<tr>
<td>Participant #2</td>
<td>28</td>
<td>8</td>
<td>Male</td>
<td>Autism</td>
<td>Mother</td>
<td>Brother, Son, boyfriend Husband, Son, Son</td>
<td>9</td>
</tr>
<tr>
<td>Participant #3</td>
<td>36</td>
<td>7</td>
<td>Male</td>
<td>Autism</td>
<td>Mother</td>
<td>Husband</td>
<td>8</td>
</tr>
<tr>
<td>Participant #4</td>
<td>32</td>
<td>4</td>
<td>Male</td>
<td>Autism</td>
<td>Mother</td>
<td>Husband</td>
<td>9</td>
</tr>
</tbody>
</table>

Participant #1 was a Caucasian mother of a six-year-old male diagnosed with Autism. She was married and had only one child. She attended all ten sessions. Participant #2 was a Caucasian mother of an eight-year-old male diagnosed with Autism. She was divorced and lives with her brother, her boyfriend, and her son. She attended nine sessions. Participant #3 was a Caucasian mother of a seven-year-old male diagnosed with Autism. She was married and lived with her husband and three sons (ages 9, 6, and 2). She attended eight sessions. Participant #4 was a Caucasian mother of a four-year-old male diagnosed with Autism. She was married and had only one child. She attended nine sessions.
Demographic information of the participants who discontinued treatment are summarized in Table 2.

Table 2: Demographic Information of Participants who Discontinued Treatment

<table>
<thead>
<tr>
<th>Group</th>
<th>Age</th>
<th>Child’s Age</th>
<th>Child’s Sex</th>
<th>Diagnosis</th>
<th>Relationship to Child</th>
<th>Others in home</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPRT</td>
<td>44</td>
<td>9</td>
<td>Female</td>
<td>Autism</td>
<td>Mother</td>
<td>Son, Son</td>
</tr>
<tr>
<td>CPRT</td>
<td>35</td>
<td>7</td>
<td>Female</td>
<td>Asperger’s</td>
<td>Mother</td>
<td>Son</td>
</tr>
<tr>
<td>CPRT</td>
<td>37</td>
<td>7</td>
<td>Female</td>
<td>Autism</td>
<td>Mother</td>
<td>Husband, Son, Daughter</td>
</tr>
<tr>
<td>CPRT</td>
<td>35</td>
<td>6</td>
<td>Male</td>
<td>Autism</td>
<td>Mother</td>
<td>Husband, Son, Son</td>
</tr>
<tr>
<td>CPRT</td>
<td>34</td>
<td>4</td>
<td>Male</td>
<td>Autism</td>
<td>Mother</td>
<td>Husband, Son, Daughter</td>
</tr>
<tr>
<td>PCIT</td>
<td>51</td>
<td>10</td>
<td>Male</td>
<td>Autism</td>
<td>Father</td>
<td>Wife, Son, Son</td>
</tr>
<tr>
<td>PCIT</td>
<td>40</td>
<td>6</td>
<td>Male</td>
<td>Asperger’s</td>
<td>Father</td>
<td>Wife, Daughter, Son, Son</td>
</tr>
<tr>
<td>PCIT</td>
<td>34</td>
<td>7</td>
<td>Female</td>
<td>Asperger’s</td>
<td>Mother</td>
<td>Mother, Son</td>
</tr>
<tr>
<td>PCIT</td>
<td>38</td>
<td>3</td>
<td>Male</td>
<td>Autism</td>
<td>Mother</td>
<td>Husband, Son, Son</td>
</tr>
<tr>
<td>PCIT</td>
<td>34</td>
<td>8</td>
<td>Male</td>
<td>Autism</td>
<td>Mother</td>
<td>Husband, Daughter, Son</td>
</tr>
<tr>
<td>PCIT</td>
<td>44</td>
<td>7</td>
<td>Male</td>
<td>Autism</td>
<td>Father</td>
<td>Wife, Daughter</td>
</tr>
</tbody>
</table>

Procedure

The present investigation was approved by the Ball State University Institutional Review Board (IRB) prior to the initiation of the study. The groups were held at a practicum clinic housed within the counseling psychology department of a mid-sized university in the Midwest. Participants’ identification and assessment results were kept confidential. Participants provided written informed consent to participate in the study (See Appendix A).
Counselor recruitment/training. Master’s student counselors in at least their second semester of training lead the groups under the supervision of counseling psychology doctoral students. Per self-report, all counselors were female and were comparable as to age (23-30 years old) and socioeconomic status. The counselors were randomly assigned to lead either the CPRT group or the PCIT group. There were two counselors for each group. The Master’s students attended or viewed a training workshop given by the experimenter in order to learn how to implement the structured treatment protocols. The training workshop given in the first semester was videotaped and then used for subsequent training workshops in the later semesters. This procedure was intended to standardize the training received by the different counselors across semesters. The counselors followed a treatment manual for their respective models and were kept blind to the research questions. The Master’s students also kept weekly progress notes for the individual treatment sessions. In those progress notes they recorded reactions reported by the parents to the treatment procedure and parent attendance in the treatment session.

Supervisor Role. Counselors attended weekly supervision with a doctoral student in the counseling psychology program. The supervisors attended the initial training workshop for their respective group (CPRT or PCIT) held by the principal investigator as described above. The supervisors were consistent across semesters and were both female. Per self-report, the supervisors were comparable as to age (28 and 32 years old) and socioeconomic status. Both supervisors were kept blind to the research questions and were given a treatment manual to assess the treatment compliance of the counselors implementing the groups.
Manipulation checks, in the form of observation ratings using videotapes of the sessions, were conducted each week by the doctoral supervisor to ensure the students were following the treatment model. Doctoral supervisors reviewed the videotaped treatment sessions and used the treatment manual to evaluate treatment adherence. Inclusion of 90% of the key components for each treatment session, as indicated in the treatment manuals, constituted treatment adherence. Any variations were to be noted in the progress notes. There were only 5 variations noted in the progress notes: 2 in the CPRT group, 2 for Participant #3 in the PCIT group and 1 for Participant #4 in the PCIT group. Only one session for Participant #3 from the PCIT group, had more than one deviation from the treatment manual.

*Group Therapy Procedures*

For both CPRT and PCIT treatment models, parents met two hours, once a week for ten weeks, in a group setting. The groups ranged from 3-5 parent participants, however, as described above, through attrition the groups concluded with only one or two participants still completing the treatment. Both treatments were closed groups since it is not possible for a parent to “catch up” on the material learned in earlier sessions (Landreth, 2002). Therefore, new parents could not join after the group had begun. The parents each had a child diagnosed with ASD. This child was the focus when completing measures. Other special activities could be arranged for the additional children in the family so they did not feel left out of the process, but these activities were not a focus of the study. In one case, one family initially had both parents expressing a desire to be a participant in the child play sessions. Although both parents were allowed to attend the therapy sessions, the child play interactions were conducted with one identified parent
throughout the study in order to increase trust and the development of themes across sessions (Landreth, 2002).

*Child Parent Relationship Therapy.* In the first session, pre-treatment assessments were given. The counselors used didactic exercises to teach the parents reflective listening and tracking (Landreth, 2002). The therapist role-played empathic responding. As homework, parents were asked to identify certain emotions (i.e., anger, sadness, happiness, etc) when they occurred at home with the identified child (Landreth, 2002). The second session consisted of reviewing the guidelines for a 30-minute play session. These guidelines included instructing the parent in child play and teaching the parent to verbally track and reflect on the child’s play without making suggestions or asking questions. The parent’s major tasks were to empathize with the child, to understand the child’s thoughts and feelings, and to carefully observe the child’s play actions. Parents were also given a list of special toys to be used with the children in the play sessions (i.e., play dough, crayons, paper, blunt scissors, nursing bottle, rubber knife, dart gun, doll family figures, dollhouse furniture, small baby doll, toy soldiers, car, tinker toys, doctor kit, play money, aggressive hand puppet, and animals) (Landreth, 2002). These toys were to be new to the child to indicate they are special and they were to be used only during the special play periods. The parents were then given the task of gathering the toys and determining a place and time, in which interruptions and external distractions would be limited, to play with their child each week (Landreth, 2002).

In the third session parents were prepared to initiate the first play session at home. The parents were asked to have their initial play session with their child and to take notes on how the session went (Landreth, 2002). In the fourth session, parents reported on their
initial play session with their child. The parents then reviewed the concepts of Filial therapy and they learned the concept of limit setting. Parents practiced setting limits on each other during the remainder of the session using role-play activities in which they were alternately the parent or child (Landreth, 2002).

In sessions five through nine, a similar format as session four was followed (Landreth, 2002). The parents reported on their progress over the past week and on their at home play sessions and the counselors answered questions. Videotapes of the parents’ sessions with the child were reviewed to provide more specific feedback about their performance and to provide another teaching resource for the counselors (Landreth, 2002).

In the final or tenth session, parents shared their experiences with the CPRT process and identified those elements of the intervention they found to be most helpful. The parents also filled out post treatment outcome measures. The counselor shared her thoughts with the parents about how the treatment progressed and her notes on the group (i.e., the parents’ performance in group or observations of the parents’ abilities to implement the treatment). The parents were given resources (i.e., a referral to individual therapy or information on the local Autism support group) if they required additional help in any area, such as sibling relationships or school problems (Landreth, 2002).

*Parent-Child Interaction Therapy.* As previously described, according to Niec et al. (2005) “PCIT integrates concepts from social learning theory, traditional play therapy, and attachment theory to enhance the parent-child relationship, increase children’s prosocial behaviors and increase parents’ behavior management skills” (p. 113). Recall, PCIT has two phases of the model, Child-Directed Interaction (CDI) and Parent-Directed
Interaction (PDI). In the CDI portion, parents learned child-directed play skills in order to increase nurturing interactions (Niec et al., 2005). During the PDI sessions parents were taught various behavior modification skills (i.e., differential attention, social reinforcement, etc) (Niec et al., 2005).

The first session of PCIT included an introduction to PCIT. Key concepts were explained and pretreatment assessments were given. In the second session, the parents learned and practiced the skills and concepts of CDI. The third through fifth sessions consisted of CDI coaching. During the coaching session the therapist and the other parents observed, through a two-way mirror, two dyads interacting with their child for 20-minute intervals. This procedure allowed the group to observe parent-child interactions in order to “coach” and give feedback about the skills being developed. The therapist coached the parents during breaks in the play session on how to interact with the child in the session. Specifically, each parent engaged in a 20 minute parent-child interaction session, followed by a 30 minute feedback discussion with the entire group. If there were more than three parents, the group was split in two and the observations took place in two separate rooms. If the group was small, less than 3 parents, then parents practiced two parent-child interaction sessions during one group.

The sixth session included an introduction to the PDI portion of the training model. Discipline strategies were discussed and the concepts of PDI were introduced. The seventh through ninth session included coaching sessions for the PDI. These sessions followed the same format as the CDI sessions, except the emphasis was on the parent leading the interaction instead of the child. The tenth session was a termination
session. The progress of the participants was discussed, questions were answered, and post-treatment assessments were completed (Niec et al., 2005).

Instrumentation

Vineland Adaptive Behavior Scales-II (VABS). This scale assesses the social competence of individuals from birth to age 90 (Sparrow, Balla, & Cicchetti, 2005). The VABS is a caregiver report questionnaire that requires the respondent to be familiar with the everyday behavior of the target individual (Sattler, 1988). Adaptive behavior is defined as the ability to perform daily activities required for personal and social sufficiency. Adaptive behavior is measured in five domains, Communication, Daily Living Skills, Socialization, Maladaptive Behavior, and Motor Skills. These domains are combined to form an Adaptive Behavior Composite (Sparrow et al, 2005). Two of the domains, Communication and Socialization, were the targets of the CPRT and PCIT therapy interventions because of the deficits children with ASDs display in these areas, as described above (Seligman, 1998). The Maladaptive Behavior Index was also a focus of the therapies because of the high instance of difficult behaviors often displayed by children with ASDs (Seligman, 1998).

The domains each evaluate different types of adaptive behaviors. The Communication domain focuses on receptive, expressive, and written communication skills. The Daily Living Skills domain measures personal living habits, domestic task performance, and behavior in the community. The Socialization domain evaluates interactions with others, use of free time, responsibility and sensitivity to others. The Maladaptive Behavior domain focuses on undesirable behaviors such as hitting or kicking, that may interfere with adaptive behavior. Finally, the Motor Skills domain measures gross and fine motor coordination (Sparrow et al, 2005).
The VABS Survey parent/caregiver self report form contains 433 rating scale (0=never, 1=sometimes/partially, 2=usually) items administered over a 20-60 minute period. The VABS Subdomain scores are converted into standard v scores, with a mean of 15 and a standard deviation of 3. Domain scores are converted into standard t scores with a mean of 100 and standard deviation of 15 for the five domain scores as well as the composite score (Sparrow et al, 2005; Sattler, 1988). Split-half, test-retest, and interrater reliability have been demonstrated for the VABS (Sparrow et al, 2005). For the Communication domain, split-half reliability mean estimates ranged from .84 to .93; for Daily Living Skills .86 to .91; for Socialization .84 to .93; for Motor Skills .77 to .90; and for the Adaptive Behavior Composite .93 to .97 (Sparrow et al, 2005). Test-retest reliability estimates range from .88 to .92. Interrater reliability coefficients for the subscales ranged from .70 to .80 (Sparrow et al, 2005). Validity studies found the VABS to be appropriate in measuring deficits in adaptive functioning with children with Autism (Sparrow et al, 2005). The VABS demonstrated good predictive validity in that it was highly correlated with the Vineland-I and the Behavioral Assessment System for Children-2nd Edition (BASC-II). Comparisons with the Wechsler Intelligence Scale for Children-4th Edition (WISC-IV) yielded low correlations, demonstrating good discriminate validity (Sparrow et al, 2005).

The Parent-Child Relationship Inventory (PCRI). The PCRI is a 78-item self-report measure in which items are rated on a four point Likert –type scale (1=Strongly Agree, 2=Agree, 3=Disagree, 4=Strongly Disagree) assessing parents’ perceptions of their relationship with their children (Suchman & Luthar, 2000). The PCRI consists of seven subscales, six of which were relevant to the current study and included: Parental
Support, Satisfaction with Parenting, Involvement, Communication, Limit Setting, and Autonomy. The seventh scale, Role Orientation, examines parents’ attitudes about gender roles in parenting and was not included as it was not relevant to the study. The Parental Support subscale measures the practical help and emotional support the client receives as a parent. The Satisfaction with Parenting subscale reflects the enjoyment a client receives from being a parent. The Involvement subscale focuses on parents’ expressed interest in their children’s activities. The Communication subscale evaluates the parents’ perception of their capacity to communicate with and be understood by their children. The Limit Setting subscale describes the parents’ self perceived ability to provide appropriate discipline. Finally, the Autonomy subscale measures the parents’ perception of their ability to promote a child’s independence. Raw scores are converted to T scores (mean=50, SD=10) based on a normative sample of 1,100 parents (Suchman & Luthar, 2000). A T score less than 40 suggests problems in the domain the scale reflects and a T score of 30 indicates the possibility of serious problems (Gerard, 1994).

The PCRI has demonstrated adequate psychometric properties (Gerard, 1994). Evaluations of internal consistency have yielded Cronbach’s alphas above .70 with a median value of .82. The PCRI also has good predictive validity based on moderate correlations with the Personality Inventory for Children (PIC). As scores on the PIC increased (indicating higher levels of child problems) PCRI scores decreased (parent-child relationships were worse) (Suchman & Luthar, 2000; Gerard, 1999).

**Design**

*Rationale for qualitative design.* Qualitative research is suited to counseling psychology because it is consistent with methods closely related to practice (Morrow, 2007). In the counseling field, one of the most common qualitative approaches is the
case study design (Creswell et al, 2007). Researchers use this design to present a detailed view of a phenomenon and to enhance our understanding of the counseling process (Creswell et al, 2007; Morrow, 2007; Haverkamp & Young, 2007). The current study was intended to provide information which could aid counselors when working with families who have a child diagnosed with ASDs. Therefore, a case study qualitative methodology was utilized to present an in-depth examination of the relative efficacy of CPRT as compared to PCIT. In a case study approach, the focus is not on the individual (or in this case multiple individuals), but on the presenting problem of the individual in order to better understand the problem (Creswell et al, 2007). The present investigation attempted to evaluate these two interventions in order to provide an in-depth, contextual understanding of the participants’ experiences, examining multiple sources of data (Creswell et al, 2007; Morrow, 2007; Haverkamp & Young, 2007).

Data Analyses

The qualitative data analyses in the present investigation utilized a deconstructing evidence approach (Yeh, Inman, 2007). In this approach, data was examined at multiple levels of complexity (individual, pairs and group) in order to locate the main essence or meaning reflected in the data (Yeh & Inman, 2007). The pre and post measures completed by the participants were examined individually and paired according to treatment group (within group analysis) and the experiences of each groups’ effectiveness as reported by the participants were compared (between group analysis). The improvement or deterioration on the subscales as reported by the participants from pre to post measures for both groups were reported to allow for direct comparisons between the groups. Comparison tables and graphs were utilized to summarize response to treatment and applied generalizations were offered about the outcome of the study (Creswell et al,
Generalizations were derived based on the information gained from the outcome instruments and the treatment goals of the study. Clinical applications of these generalizations were then derived based on relevance to the current literature on Filial therapy.

The difference between the pre and post measures was calculated and the relative significance of the change in the scores was reported. Thompson (2002) described three different types of significance for counselors to consider when reporting outcome results: statistical, practical, and clinical. The first, statistical significance, “estimates the probability of sample results deviating as much or more than do the actual sample results from those specified by the null hypothesis for the population given the sample size” (Thompson, 2002, p. 65). While often the most reported statistic for quantitative analysis, statistical significance does not have relevance in qualitative studies. Next, practical significance emphasizes “quantifying findings in service of evaluating practical noteworthiness” (Thompson, 2002, p. 65). Practical significance highlights the importance of reporting effect sizes in quantitative literature. Although this is important in outcome research, again it is not used in qualitative analysis. The last type of significance, clinical significance is “the practical or applied value or importance of the effect of the intervention, that is, whether the intervention makes a real difference in everyday life to the clients or to others with whom the client interacts” (Thompson, 2002, p. 66). This kind of significance seems to have much relevance to qualitative analyses. The current investigation utilized the concept of clinical significance to evaluate the efficacy of the two groups in question. For the purposes of the current study, a change in T-score of more than one standard deviation was reflective of “clinical significance”, in
that it was more likely to indicate meaningful or functional changes in the lives of the participants (Thompson, 2002).

Finally, the progress notes written by the Master’s counselors were utilized to identify themes in terms of participant’s core reactions to the groups (Yeh & Inman, 2007). These themes were grounded in the existing literature on general content and process for the CPRT and PCIT group therapy approaches. Key phrases from the notes were then coded into these themes by two independent raters who were kept blind to the research questions in order to eliminate researcher bias. The raters first provided the phrases independently, then worked together to reach agreement when it was absent (Yeh & Inman, 2007). These raters also identified additional themes as necessary in order to serve as auditors of the themes identified by the primary investigator and to ensure the process of identifying the themes was not influenced by bias (Yeh, & Inman, 2007). The raters then reviewed the developed themes and rated as having a positive, negative, or neutral valence. Again, the raters assigned the valences independently and then worked together to reach agreement when it was absent. The valence percentage for each theme was then calculated. The themes, key phrases, and frequencies were compiled in tables to provide an overview of the parents’ response to the groups as reflected in the progress notes.

**Strengths**

There are several strengths in the methodology. According to Lambert (2004), outcome research should meet certain criteria: participants should be randomly assigned, a specific population should be specified, a treatment manual should be utilized, and the treatment outcome should be evaluated using multiple measures. The current investigation met all these criteria. Parents were randomly assigned to the parent training
groups, thus increasing the strength of the research design. The intervention focused on parents of children diagnosed with ASDs and the participants were evaluated on two outcome measures providing divergent validity. In addition, both of the parenting programs utilized a standardized manual to ensure the treatment was implemented consistently and correctly. Furthermore, each group was of equal length, so the parents received the same treatment “dosage” in each program. Both programs included coaching sessions in which parents were given feedback on their progress. However, the programs were fundamentally different. CPRT was based on child-centered therapy and focused on communication and relationship skills. PCIT, on the other hand, was behaviorally based and emphasized limit setting and discipline strategies. Although there was an abundance of independent research supporting each of these two approaches, there is no research comparing the relative efficacy of these two types of parent training models.

**Limitations**

There were also some limitations of the methodology that should be considered. The study was limited to children with ASDs. Therefore, the results cannot be generalized to children with other presenting problems. Further, the study required participants to attend almost every session and the group was ten weeks in length. The length of the group might have contributed to the high attrition rate which resulted in a low number of participants who qualified to be included in the study. Also, the study relied on self-report parent rating scales and therefore, might have been biased as a result of a social desirability response set or hypothesis guessing. Finally, data collection took place over multiple semesters. History or cohort effects could have had an effect on the data.
CHAPTER FOUR – Results

Creswell et al (2007) emphasized the importance of utilizing multiple sources of information when conducting a qualitative case study. The results should offer case-based themes to report on the area of interest. The current study utilized information from three areas: pre and post measures of the Parent Child Relationship Inventory (PCRI), pre and post measures of the Vineland Adaptive Behavior Scale-II (VABS), and progress notes from the groups. These varied sources of data focused on different aspects of the treatment goals of the two types of Filial therapy as well as provided information about the experience of the participants in the groups. The findings from comparisons below were designed to guide practitioners when working with parents of children diagnosed with ASDs.

In determining clinically significant change, Jacobson & Truax (1991) emphasized the importance of calculating a “Reliable Change Index” (RCI) to determine the degree of clinically significant change. However, their formula relies on the notion that clinically significant change is related to a return to normal functioning. In other words, participants’ scores should move from the clinical range toward the “normal” range of functioning. However, in the current study, the participants generally either did not start off in the clinical range or changed so minimally that any move toward the normal range was slight. Therefore, a RCI could not be calculated for the present investigation.

Parent Child Relationship Inventory

As stated previously, parents evaluated the quality of their relationship with their child diagnosed with ASD using the Parent Child Relationship Inventory. Participants filled out the PCRI forms before they began the treatment and on completion of the
treatment protocol. The results of the pre and post assessments follow below. Recall, the PCRI has seven subscales, six of which were relevant to the scope of the present study: Parental Support (SUP), Satisfaction with Parenting (SAT), Involvement (INV), Communication (COM), Limit Setting (LIM), and Autonomy (AUT). The scores reported use a standard T-score format with a mean of 100 and a standard deviation of 10. As noted in the previous chapter, changes of more than one deviation were considered “clinically significant” and changes of less than one standard deviation were considered minimal (Thompson, 2002).

Vineland Adaptive Behavior Scale

Parents rated their child’s adaptive functioning using the Vineland Adaptive Behavior Scale-II (VABS). Again, participants filled out the VABS forms before they began the treatment and on completion of the treatment. The results of the pre and post assessments follow below. Recall, the VABS has two domains identified as relevant to the scope of the present investigation: Communication and Socialization. The scores for the two other domains were also presented (Daily Living Skills and Adaptive Behavior Composite) although changes in these domains were not expected given the treatment goals of the interventions. Again the scores reported are standard scores with a mean of 100 and a standard deviation of 10. Subdomain scores are also summarized. It is important to note, the subdomain scores are standard v-scores with a mean of 15 and a standard deviation of 3.

Also on the VABS, parents indicated the amount of maladaptive behavior they observed in their children, both before treatment and after the completion of the treatment. The results of the pre and post assessments are summarized below. There are three subscales for maladaptive behaviors: Maladaptive Behavior Index, Internalizing,
and Externalizing. Again, the scores reported are standard v-scores with a mean of 15 and a standard deviation of 3. As with the PCRI, changes of more than one deviation were considered “clinically significant” and changes of less than one standard deviation were considered minimal changes (Thompson, 2002).

Results of CPRT

*PCRI: CPRT Participants*

The results of the PCRI for the CPRT participants are displayed in Figures 1 and 2. Participant #1 reported improvement on five of the six subscales: SUP, INV, COM, LIM and AUT. There was no change in Participant #1 for the SAT subscale. In four of the subscales (SUP, INV, LIM, and AUT) the changes in scores reflected more than one standard deviation of improvement. Participant #2 indicated minimal improvement on only two subscales: COM and AUT and slight deterioration on the other three subscales: SUP, INV, and LIM. All of the changes for Participant #2 were less than one standard deviation.
Figure 2: Parent Child Relationship Inventory (PCRI) T-scores for Participant #1 in CPRT group

Figure 3: Parent Child Relationship Inventory (PCRI) T-scores for Participant #2 in CPRT group
VABS: CPRT Participants

VABS: Domains and Subdomains. The results of the VABS for the CPRT participants are summarized in Table 2 and Figures 3 and 4. The protocol for Participant #1 reflected improvement on three of the four domains: Communication, Socialization, and Adaptive Behavior Composite. There was minimal change in the scores for Participant #1 on the Daily Living Skills subscale. In two of the domains where improvement was indicated (Communication and Socialization) the changes in scores reflected more than one standard deviation of improvement. The scores for Participant #2 suggested minimal improvement on only one domain: Socialization and reported slight deterioration on the other three domains: Communication, Daily Living Skills, Adaptive Behavior Composite. All of the changes Participant #2 indicated were within one standard deviation.

Table 3: Vineland (VABS)= Domain/Subdomain Standard Scores for CPRT participants

<table>
<thead>
<tr>
<th>Subdomain/Domain</th>
<th>Participant #1</th>
<th>Participant #2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Receptive</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Expressive</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Written</td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td>74</td>
<td>87</td>
</tr>
<tr>
<td>Personal</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Domestic</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Community</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td><strong>Daily Living Skills</strong></td>
<td>79</td>
<td>77</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Play and Leisure Time</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Coping Skills</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td><strong>Socialization</strong></td>
<td>70</td>
<td>83</td>
</tr>
<tr>
<td><strong>Adaptive Behavior Composite</strong></td>
<td>74</td>
<td>76</td>
</tr>
</tbody>
</table>
Figure 4: Vineland (VABS) Domain Standard Scores for Participant #1 in CPRT group

![Graph showing the Vineland (VABS) Domain Standard Scores for Participant #1 in CPRT group. The graph includes data points for Communication, Daily Living Skills, Socialization, and Adaptive Behavior Composite, comparing pre and post measurements.]

<table>
<thead>
<tr>
<th>Domain</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>74</td>
<td>87</td>
</tr>
<tr>
<td>Daily Living Skills</td>
<td>79</td>
<td>77</td>
</tr>
<tr>
<td>Socialization</td>
<td>70</td>
<td>83</td>
</tr>
<tr>
<td>Adaptive Behavior Composite</td>
<td>74</td>
<td>76</td>
</tr>
</tbody>
</table>

Figure 5: Vineland (VABS) Domain Standard Scores for Participant #2 in CPRT group

![Graph showing the Vineland (VABS) Domain Standard Scores for Participant #2 in CPRT group. The graph includes data points for Communication, Daily Living Skills, Socialization, and Adaptive Behavior Composite, comparing pre and post measurements.]

<table>
<thead>
<tr>
<th>Domain</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>81</td>
<td>75</td>
</tr>
<tr>
<td>Daily Living Skills</td>
<td>71</td>
<td>70</td>
</tr>
<tr>
<td>Socialization</td>
<td>66</td>
<td>71</td>
</tr>
<tr>
<td>Adaptive Behavior Composite</td>
<td>71</td>
<td>71</td>
</tr>
</tbody>
</table>
**VABS-Maladaptive Behavior.** The results of the VABS for the CPRT participants are summarized in Figures 5 and 6. Participant #1 indicated improvement on two of the three subscales: Maladaptive Behavior Index and Internalizing both reflected at least one standard deviation of improvement. There was no change in Participant #1 for the Externalizing subscale. Participant #2 did not identify change on any of the three subscales.

Figure 6: Vineland Standard Scores for Maladaptive Behavior for Participant #1 in CPRT group.
Results of PCIT

*PCRI: PCIT Participants*

The results of the PCRI for the PCIT participants are summarized in Figures 7 and 8. The scores for Participant #3 reflected improvement on five of the six subscales: SUP, SAT, INV, COM, and LIM. There was no change in Participant #3 for the AUT subscale. In one of the subscales (LIM) the changes in scores indicated more than one standard deviation of improvement. Participant #4 described improvement on only two subscales: INV and COM, reported slight deterioration on the other three subscales: SAT, SUP and LIM, and no change on the AUT subscale. In one of the subscales (INV) the changes in scores was more than one standard deviation of improvement.
Figure 8: Parent Child Relationship Inventory (PCRI) T-scores for Participant #3 in PCIT group.

<table>
<thead>
<tr>
<th></th>
<th>Participant # 3-Pre</th>
<th>Participant # 3-Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>45</td>
<td>46</td>
</tr>
<tr>
<td>Involvement</td>
<td>39</td>
<td>47</td>
</tr>
<tr>
<td>Communication</td>
<td>34</td>
<td>36</td>
</tr>
<tr>
<td>Limit Setting</td>
<td>43</td>
<td>54</td>
</tr>
<tr>
<td>Autonomy</td>
<td>52</td>
<td>52</td>
</tr>
</tbody>
</table>

Figure 9: Parent Child Relationship Inventory (PCRI) T-scores for Participant #4 in PCIT group.

<table>
<thead>
<tr>
<th></th>
<th>Participant # 4-Pre</th>
<th>Participant # 4-Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>47</td>
<td>40</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>50</td>
<td>44</td>
</tr>
<tr>
<td>Involvement</td>
<td>37</td>
<td>49</td>
</tr>
<tr>
<td>Communication</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td>Limit Setting</td>
<td>45</td>
<td>39</td>
</tr>
<tr>
<td>Autonomy</td>
<td>43</td>
<td>43</td>
</tr>
</tbody>
</table>
**VABS: PCIT Participants**

**VABS: Domains and Subdomains.** The results of the VABS for the PCIT participants are summarized in Table 3 and Figures 9 and 10. Participant #3 reported improvement on one of the four domains: Communication. She indicated deterioration on three domains: Socialization, Daily Living Skills and Adaptive Behavior Composite. In the domain where improvement was observed, Communication, the changes in scores reflected less than one standard deviation of improvement. The scores for Participant #4 indicated minimal improvement on three domains: Socialization, Daily Living Skills, and Adaptive Behavior Composite and reported slight deterioration on the Communication domain. All of the changes Participant #4 described were within one standard deviation.

Table 4: Vineland (VABS)= V-scale Standard Scores for PCIT participants

<table>
<thead>
<tr>
<th>Subdomain/Domains</th>
<th>Participant #3</th>
<th>Participant #4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Receptive</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Expressive</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Written</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Communication</td>
<td>77</td>
<td>81</td>
</tr>
<tr>
<td>Personal</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Domestic</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Community</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Daily Living Skills</td>
<td>89</td>
<td>78</td>
</tr>
<tr>
<td>Interpersonal Relationships</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Play and Leisure Time</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Coping Skills</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Socialization</td>
<td>80</td>
<td>69</td>
</tr>
<tr>
<td>Adaptive Behavior Composite</td>
<td>80</td>
<td>74</td>
</tr>
</tbody>
</table>
Figure 10: Vineland (VABS)-Standard Scores for Participant #3 in PCIT group.

Figure 11: Vineland (VABS)-Standard Scores for Participant #4 in PCIT group.
**VABS-Maladaptive Behavior.** The results of the VABS for the PCIT participants are summarized in Figures 11 and 12. On the protocol, Participant #3 indicated slight improvement on two of the three subscales: Maladaptive Behavior Index and Internalizing both reflected less than one standard deviation of improvement. There was no change in scores for Participant #3 for the Externalizing subscale. Participant #2 suggested slight improvement on the Maladaptive Behavior Index, which was less than one standard deviation. There was no change on the Internalizing or Externalizing subscales.

Figure 12: Vineland Standard Scores for Maladaptive Behavior for Participant #3 in PCIT group.
Figure 13: Vineland Standard Scores for Maladaptive Behavior for Participant #4 in PCIT group.

<table>
<thead>
<tr>
<th></th>
<th>Participant #4-Pre</th>
<th>Participant #4-Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maladaptive Behavior Index</td>
<td>22</td>
<td>21</td>
</tr>
<tr>
<td>Internalizing</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Externalizing</td>
<td>18</td>
<td>18</td>
</tr>
</tbody>
</table>

Comparison of CPRT and PCIT

**PCRI: PCIT & CPRT**

In qualitative analysis, deconstructing evidence involves examining and reexamining the data for multiple levels of complexity (Yeh & Inman, 2007). First, the data was analyzed within groups. Second, the data between the groups was examined and compared for differential response to the two treatment conditions. Changes in T-scores on the PCRI for both the CPRT and the PCIT participants are summarized in Figure 13. Once again, recall changes of more than one standard deviation were considered “clinically significant” and assumed to reflect noticeable differences in the participants’ lives (Thompson, 2002).

In the protocol, the scores for Participant #1 suggested the most development overall in the parent child relationship. This participant indicated an improvement of 11 points on the SUP subscale, a change of greater than one standard deviation. However, there was no positive change on the SAT subscale. On the INV subscale, this
participant’s score increased by 33 points, a difference of more than three standard deviations. Her scores reflected minimal improvement on the COM subscale, only 5 points. Next her score increased by 27 points on the LIM subscale, a change of more than two standard deviations and a 18 point increase on the AUT subscale, an variation of more than one standard deviation.

The least amount of change overall in the parent child relationship was observed in the scores for Participant #2. This participant reported a deterioration of 2 points on the SUP subscale, a change of less than one standard deviation and indicated deterioration on the SAT subscale of 3 points, a difference of less than one standard deviation. On the INV subscale, this participant indicated a deterioration of 4 points, a decrease of less than one standard deviation. The scores illustrated minimal improvement on the COM subscale, only 5 points. Next she indicated a minimal 1 point deterioration on the LIM subscale and a 2 point improvement on the AUT subscale, an increase of less than one standard deviation. Overall, for the parent child relationship, there was no consistent trend in response observed for the participants in the CPRT group.

Participant #3 reported some change in a few areas of the parent child relationship. This participant described an improvement of 9 points on the SUP subscale, a difference of less than one standard deviation, but her scores implied minimal improvement on the SAT subscale, only 1 point. On the INV subscale, this participant indicated an improvement of 8 points, an increase of less than one standard deviation. She reported minimal improvement on the COM subscale, only 2 points. Next she
indicated an 11 point improvement on the LIM subscale, a change of more than one standard deviation and no change on the AUT subscale.

For Participant #4, both slight improvement and slight deterioration in the parent child relationship was apparent. This participant reported a deterioration of 7 points on the SUP subscale, a change of less than one standard deviation, and indicated deterioration on the SAT subscale of 6 points, a decrease of less than one standard deviation. On the INV subscale, this participant indicated an improvement of 12 points, an increase of more than one standard deviation. She suggested minimal improvement on the COM subscale, only 4 points. Her scores reflected a 6 point deterioration on the LIM subscale and no change on the AUT subscale. In sum, there was no trend in response observed for the PCIT participants in the parent child relationship. Further, when the two groups were compared there were no consistent tendencies for change in either the PCIT group or the CPRT group.
Figure 14: Parent Child Relationship Inventory (PCRI) Changes in T-scores from Pre-test to Post-test for CPRT and PCIT Participants

Note: positive change indicates improvement in the parent child relationship

Overall, the results of the PCRI suggested Participant #1 demonstrated the most improvement in the parent-child relationship (See Figure 13). In particular, this participant reported the most improvement in Communication and Limit Setting, which corresponded to the overall goals of the CPRT group. However, Participant #2 indicated little change in the parent child interaction, suggesting the interventions did not effect the parent child interaction for this participant. Participant #3 also described little change, with the exception of some improvement in limit setting behavior. This finding was consistent with the treatment goals of the PCIT group. Participant #4 reported little change, with the exception of some change on the Involvement subscale. This finding
was consistent with the overall goal of Filial therapy, which is to involve the parents more with the child. However, the results of the PCRI instrument did not clearly support either CPRT or PCIT as a more efficacious form of treatment with this population. However, it is noteworthy that only one participant, Participant #1 in the CPRT group described overall improvement in the parent child relationship.

**VABS: CPRT & PCIT**

*VABS: Domains and Subdomains.* The changes in T-scores on the VABS for both the CPRT and the PCIT participants are summarized in Figure 14. Participant #1 reported the most improvement overall in her child’s adaptive functioning. This participant described an improvement of 13 points on the Communication domain, a change of more than one standard deviation, but indicated a 2 point deterioration in her child’s Daily Living Skills. On the Socialization domain, this participant’s scores reflected an improvement of 13 points, an increase of more than one standard deviation. She reported minimal improvement on the Adaptive Behavior Composite, only 2 points.

Little change was reflected in the scores for Participant #2 in her child’s adaptive functioning. This participant reported a deterioration of 6 points on the Communication domain, a decrease of less than one standard deviation and indicated a 1 point deterioration in her child’s Daily Living Skills. On the Socialization domain, this participant indicated an improvement of 5 points, a difference of less than one standard deviation. No change was observed on the Adaptive Behavior Composite. As on the measure of the parent child relationship, a consistent trend in response was not observed for the adaptive functioning in the CPRT group.

Participant #3 also described little change in her child’s adaptive functioning. This participant indicated an improvement of 4 points on the Communication domain, an
increase of less than one standard deviation and indicated an 11 point deterioration in her child’s Daily Living Skills, a change of more than one standard deviation. On the Socialization domain, this participant’s scores reflected a deterioration of 11 points, a decrease of more than one standard deviation and indicated a deterioration of 6 points on the Adaptive Behavior Composite.

Similarly, in the protocol, Participant #4 suggested little change in her child’s adaptive functioning. This participant indicated a deterioration of 7 points on the Communication domain, a difference of less than one standard deviation and indicated a 4 point improvement in her child’s Daily Living Skills. On the Socialization domain, this participant reported an improvement of 2 points, an increase of less than one standard deviation and an improvement of 2 points on the Adaptive Behavior Composite. Again, no trend in response was evident for the PCIT group on the measure of adaptive functioning. Further, when there were no consistencies apparent in the changes when the PCIT and CPRT groups were compared.
Figure 15: Vineland (VABS) Changes in Standard Scores from Pre-test to Post-test for CPRT and PCIT Participants

<table>
<thead>
<tr>
<th></th>
<th>CPRT #1</th>
<th>CPRT #2</th>
<th>PCIT #3</th>
<th>PCIT #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>13</td>
<td>-6</td>
<td>4</td>
<td>-7</td>
</tr>
<tr>
<td>Daily Living</td>
<td>-2</td>
<td>-1</td>
<td>-11</td>
<td>4</td>
</tr>
<tr>
<td>Social</td>
<td>13</td>
<td>5</td>
<td>-11</td>
<td>2</td>
</tr>
<tr>
<td>Composite</td>
<td>2</td>
<td>0</td>
<td>-6</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: Positive change indicates improvement in child’s adaptive functioning

Overall, the results of the VABS indicated the child of Participant #1 demonstrated a marked improvement in adaptive functioning (See Figure 14). In particular, this participant reported the most positive changes in Communication and Socialization, which corresponded to the overall goals of the CPRT group. Her scores reflected little change in Daily Living Skills or the Adaptive Behavior Composite, although these domains were not the focus of the Filial therapy groups. Participant #2 described little change in her child’s adaptive functioning, suggesting the interventions did not appear to effect the child’s adaptive functioning. The findings from the VABS data indicated the child of Participant #1 demonstrated improvement in expected areas of adaptive functioning (Communication and Socialization), behaviors which were the focus in the CPRT group. Also, Participant # 3 reported some deterioration in Daily Living
Skills and Socialization, whereas Participant #4 reported little change overall. These results are not consistent with the overall goal of the PCIT group.

Overall, the results of the VABS instrument did not clearly support either treatment approach as more efficacious for improving adaptive functioning. Again, Participant #1 in the CPRT group described the most benefit in her child’s adaptive functioning.

**VABS-Maladaptive Behavior.** The changes in v-scores for the VABS for both the CPRT and the PCIT participants are summarized in Figure 15. Participant #1 reported the most improvement overall in her child’s maladaptive functioning. This participant indicated an improvement of 3 points on the Maladaptive Behavior Index or an improvement of one standard deviation. On the Internalizing subscale, this participant’s scores reflected an improvement of 4 points, a change exceeding one standard deviation. No change was observed on the Externalizing subscale. In general, both participants in the CPRT group did not report any changes on the Externalizing subscale, although no other trend in response was observed for this group. Participant #3 described only minimal change of 1 point on the Maladaptive Behavior Index and the Internalizing subscale and no change on the Externalizing subscale. Finally, the scores for Participant #4 reflect minimal change of 1 point on the Maladaptive Behavior Index and no change on the Internalizing and Externalizing subscales. Overall, both participants indicated consistent trends in response on Maladaptive Behavior, demonstrating similar changes on both the Maladaptive Behavior Index and Externalizing Subscales.
Overall, the only participant to report any improvement in their child’s maladaptive behavior was, again, Participant #1 in the CPRT group (See Figure 15). All of the other participants described only minimal improvement in maladaptive behaviors. Therefore, in the current study neither form of Filial therapy appears to be more efficacious in reducing maladaptive behaviors.

Progress Notes

As described earlier, the progress notes from both the CPRT and PCIT groups were coded into themes by two independent raters (See Appendix B). The themes were identified by the primary investigator based on the group process literature for the two groups (Landreth, 2002, Niec et al, 2005). Recall, the two raters served as auditors of the themes to ensure the process was not influenced by researcher bias (Yeh, & Inman, 2007). The raters then assigned either a positive, negative, or neutral valence for each theme derived. Valence frequencies for each theme were then calculated (See Table 4). The raters had good agreement on the valence for each theme as reported below. Overall,
they demonstrated 95% agreement for themes derived from the CPRT notes and 79% agreement for themes generated from the PCIT notes. As both Participant #1 & #2 in the CPRT group completed the treatment in the same semester, the progress notes were combined to calculate frequencies. However, since the participants in the PCIT group completed the group with different counselors, the frequencies are reported separately for each participant. A break down of themes in this format was conducted in an attempt to assess for potential differences in response that might have been attributable to therapist difference, group cohort effects, or historical trend differences.
The counselors in the CPRT group and the counselors for Participant #4 in the second semester PCIT group provided a higher number of group process statements in their progress notes than did the counselors for Participant #3. However, it is important to note that even given the paucity of data available for Participant #3, all but two of the

Table 5: Frequency and Percent Agreement from Progress Notes for CPRT and PCIT groups

<table>
<thead>
<tr>
<th>Theme</th>
<th>CPRT</th>
<th>PCIT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Agreement</td>
<td>Frequency</td>
</tr>
<tr>
<td>1. Implementation of Technique</td>
<td>92%</td>
<td>(+) 46%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-) 15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0) 38%</td>
</tr>
<tr>
<td>2. Parent Reaction to Technique/Treatment</td>
<td>100%</td>
<td>(+) 57%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-) 28%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0) 14%</td>
</tr>
<tr>
<td>3. Child Reaction to Technique/Treatment</td>
<td>100%</td>
<td>(+) 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-) 0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0) 0%</td>
</tr>
<tr>
<td>4. Spouse Reaction to Technique/Treatment</td>
<td>100%</td>
<td>(+) 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-) 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0) 0%</td>
</tr>
<tr>
<td>5. Participation in Group/Sessions</td>
<td>92%</td>
<td>(+) 77%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-) 15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0) 8%</td>
</tr>
<tr>
<td>6. Parent Reaction to Other Group Members</td>
<td>100%</td>
<td>(+) 83%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-) 1%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0) 0%</td>
</tr>
<tr>
<td>7. Counselor Observation of Participant</td>
<td>100%</td>
<td>(+) 78%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-) 11%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0) 11%</td>
</tr>
<tr>
<td>8. Counselor Directives/Group Procedures</td>
<td>67%</td>
<td>(+) 67%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-) 0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(0) 33%</td>
</tr>
<tr>
<td>Total</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>

Note: (+) indicates positive phrase, (-) indicates negative phrase, (0) indicates neutral phrase
themes generated in the other groups were supported in those comments. The two themes not identified for this participant/group were “Parent Reaction to Other Group Members” and “Counselor Observation of Participant.” Recall that Participant #3 lost her other group members after session 6 and this factor may account for the lack of reaction to other group members reflected in the progress notes. Analysis of the participant reactions to the two group formats follows below in terms of the valence of specific responses within each theme.

Overall, in the Implementation of Technique theme all the participants, except Participant #3 who had a largely neutral response (75%), had essentially a positive response. Further, Participant #4 reported more instances of the participants positively implementing the techniques of the therapy (55%) as compared to the CPRT group (46%). Given that PCIT is more of a technique based therapy group, these results fit with the overall approach of the PCIT group.

Next, for the Parent Reaction to Technique/Treatment theme, counselors noted more positive parent reactions to the CPRT group (57%) than Participant #4 in the PCIT group (45%). Moreover, the counselors of Participant #4 in the PCIT group reported an equally negative and positive reaction to the group (+45%, -45%) as compared to the low negative reaction in the CPRT group (28%). Participant #3 had a neutral response to PCIT. The parents’ reactions implied the participants in the CPRT group appeared to like the group better than at least Participant #4 in the PCIT group.

Similarly, in the Child Reaction to Technique/Treatment theme, the children appeared to have a more positive reaction to the CPRT group (100%) than the child of Participant #4 in the PCIT group (50%). In fact, according to this parent, the child of
Participant #4 had almost as much of a negative reaction to the group (48%) as a positive reaction. Although, the child of Participant #3 in PCIT appeared to like the group (100%), it should be noted this percentage was based on only one parent comment. Overall, the children of the CPRT participants responded positively to the group, the child of Participant #3 responded neutrally, and the child of Participant #4 responded equally positively and negatively. The results of both the Parent and Child reaction to the Technique/Treatment were consistent with the overall goal of CPRT, which is to focus on the parent learning new ways to interact with their children, thus improving the parent-child interaction.

Overall, the counselors did not report many spousal reactions to the treatment. However, the CPRT group had as many positive as negative comments (+ 50%; - 50%) and Participant #3 in the PCIT group only had one neutral comment. Participant #4 had no reaction in this category.

The counselors reported more positive Participation in Group/Sessions in the CPRT group (77%) than Participant #4 in the PCIT group (27%). In fact, combined, the participants in the PCIT group were largely neutral in their participation in group (Participant #3=100%, Participant #4=55%). This result may suggest the parents were more engaged in the group process of the CPRT group as the counselors reported more positive reaction to the group. This result also coincides with the counselors reporting more positive reactions to the treatment as noted above.

Next, in the Parent Reaction to Other Group Members theme, the counselors noted the parents were more supportive of their group members in the PCIT group (100%) for Participant #4 as compared to the CPRT group (83%). Participant #3 had no
reaction to other group members. However, the PCIT group members both completed their groups as the only group member, which may account for the difference in their reaction to other group members or lack thereof.

The last two themes, Counselor Observation of Participant and Counselor Directives/Group Procedures are based on the counselors’ assessment of the parents or the counselors reporting the objective components of the sessions. The counselors reported more positive observations of the participants in the CPRT group (78%) as compared to Participant #4 of the PCIT group (40%). In addition, the counselors noted few negative or neutral observations of parents of the CPRT group (-11%; 0=11%) as compared to Participant #4 of the PCIT group (-10%; 0=50%). Overall, in the CPRT group, not only did clients make more positive statements about their own reaction to CPRT, counselors also had a more positive assessment of the participants’ reaction to this technique. Further, for Participant #3 there were no counselor observations and the counselors for Participant #4 observed a mix of positive and neutral reactions. More positive observations for the CPRT group was somewhat surprising given the live feedback of the parent-child interactions offered to the PCIT group members verses the feedback of the taped interactions given to the CPRT members.

Finally, in the Counselor Directives/Group Procedures theme, the counselors reported a number of counselor directives and group procedures in the PCIT progress notes, but the majority of these phrases were neutral (Participant #3=100%; Participant #4=89%). In the CPRT group, the counselors reported mostly positive counselor directives (67%), with no negative reactions.
Finally, when looking at overall trends in the valence of ratings, the participants in the CPRT yielded predominantly positive valence reactions to the group. The counselors for Participant #3 in the PCIT group noted mostly neutral responses for this individual. The progress notes for Participant #4 yielded a mixed picture in terms of overall response to the group. Three themes revealed a mixture of positive and negative reactions. Two themes were a mixture of positive and neutral responses. Two themes yielded essentially neutral comments and only one theme reflected positive comments.
CHAPTER FIVE – Discussion

The present study explored the relative efficacy of two types of Filial group therapy, CPRT and PCIT with parents of children diagnosed with ASDs. Though both groups are types of Filial therapy in that they work with parents to improve parent child relationships, the conceptual basis for the two groups is different, thus allowing for comparisons between them. CPRT utilizes primarily child-centered therapy techniques in order to improve parent child interactions (Landreth, 2002). In CPRT, the parent learns to allow his/her child to take the lead during child play therapy sessions, thereby giving the child the freedom to express himself/herself, using a developmentally appropriate communication style, play (Landreth & Bratton, 2006). Conversely, PCIT integrates social learning theory and child-centered therapy techniques in order to improve the participant’s parenting skills (Eyberg, 1974). Recall, there are two phases in PCIT. In both phases, the parents learn to allow the child to lead the session, but in the second phase they also interject discipline strategies in order to change the child’s behavior (Niec et al, 2001). Furthermore, both CPRT and PCIT are relevant to children with ASDs because children with this diagnosis often display limited communication and socialization skills which can impede development of a positive parent child relationship (APA, 2000). The goal of the present study was to explore the relative efficacy of both groups on improving the parent-child relationship and the child’s adaptive behavior.

The current study was undertaken in an attempt to inform the practice of Filial therapy utilizing a multiple case comparison design. First, the data from the VABS, PCRI and the progress notes was examined individually and in pairs within a given treatment group. Next a between groups data comparison was used in an attempt to determine any
differences in the relative efficacy of each group. Toward that end, several research questions were posed to assess the efficacy of the CPRT and PCIT groups. Improvement or change in the parent child relationship was evaluated using the PCRI. The effect of the CPRT and PCIT groups on the child’s adaptive and maladaptive functioning was examined using the VABS. Finally, themes were extracted from the progress notes from both groups and key phrases were coded into these themes. Themes were derived from the conceptual literature base for each group and the associated processes expected from that literature. A deconstructing evidence approach was used to examine the qualitative data at multiple levels (Yeh & Inman, 2007).

The first research question investigated changes in the parent-child relationship and in the child’s adaptive (i.e., communication and socialization) and maladaptive behaviors when parents participated in the CPRT group. The two participants in the CPRT group indicated a mixed response to this approach. For Participant #1, the question was answered in the affirmative in that she described clinically significant improvement in her communication with her child, more involvement with her child, better limit setting, and more autonomy. In addition, she reported clinically significant improvement in her child’s communication, socialization and overall adaptive behavior. Finally, she reported a clinically significant decline in her child’s overall maladaptive and internalizing behaviors. Conversely, the results for Participant #2 were negative in terms of response to the program. She did not report any clinically significant change in the parent-child relationship or in her child’s adaptive or maladaptive functioning.

However, both parents began with a very different perspective on her parent child relationship. Participant #1 reported a much better parent child relationship at baseline as
compared to Participant #2. Given that both participants had the same group therapists, were in the same cohort group, and reported that their child was functioning at about the same baseline level (as indicated by the VABS), the differences in the changes on PCRI may be the result of a parent variable unique to this participant (i.e., personality, external support, etc). Future research should further explore this possibility in order to identify relevant parent variables which might predict those parents who would benefit from a CPRT group. Further, assessment of parental response to the CPRT group, as reflected in the progress notes, consistently revealed an overall positive response to this technique.

The second research question reviewed if parents in the PCIT model reported changes in the parent-child relationship as well as in their child’s adaptive and maladaptive behaviors. For both participants in the PCIT group, only one subscale reflected positive change and the change was for a different dimension of the parent child relationship in each participant. Participant #3 only reported clinically significant improvement on limit setting behaviors, and Participant #4 only reported clinically significant improvement in her involvement with her child. Neither participant described an improvement in her child’s adaptive and maladaptive behaviors. In fact, Participant #3 reported clinically significant deterioration on her child’s communication and daily living skills. Given the fact that both participants were in different cohorts and had different counselors, it is difficult to make any definitive conclusive statements about these results. However, when the participants reactions to the group, as indicated in the progress notes, were assessed, it was clear that Participant #3 had a largely neutral response to the group and Participant #4 had a mixed negative/neutral response. This at best neutral and at
worst negative reaction to the PCIT format may have inhibited the PCIT parents from fully investing in the technique and therefore benefitting from the group.

The third research question examined the relative efficacy of the CPRT group as compared to the PCIT group in improving the parent child relationship. The results for the group comparisons were again mixed. Recall, Participant #1 of the CPRT group reported the most improvement in the parent child relationship, but Participant #2 reported no change in the parent child relationship. Further, the PCIT group appeared to have little overall efficacy in improving the parent child relationship. Participants #3 and #4 only reported clinically significant changes on one subscale each and it was a different subscale for each parent participant. Overall, despite the fact that the CPRT participants displayed a mixed response in terms of this outcome measure, at least one participant in this approach reported success in improving the parent child relationship. Improvement on this measure was expected in the CPRT group given the fact that CPRT focuses more on improving the parent child relationship as compared to PCIT, and CPRT had previous empirical support for improving the parent child relationship (Landreth, 2002). The reason for the lack of change in the parent child relationship for the PCIT group is unclear as the first segment of this approach similarly emphasized development of parent child relationship skills. There are a number of possible explanations which will be discussed below in the context of themes reflected in the progress notes.

The fourth research question referred to the relative efficacy of the two groups in improving the child’s adaptive behavior functioning (i.e., communication and socialization) and decreasing maladaptive behaviors. Similar to parent child relationship findings, changes in the child’s adaptive functioning had mixed results following parent
participation in the CPRT group. Again recall that only Participant #1 reported any clinically significant improvement in her child’s adaptive functioning in the two target areas of adaptive functioning, communication and socialization. Participant #2 did not report any significant change in her child’s behavior. In the PCIT group, neither participant reported any clinically significant improvements in their child’s adaptive functioning. Surprisingly, Participant #3 even described clinically significant deterioration in the communication and daily living skills of her child over the course of the ten weeks. The CPRT results were expected given that the goal of this modality was to improve the child’s ability to communicate with her/his parents and the parents’ understanding of their child’s communication, thereby indirectly improving the child’s social skills. However, the PCIT group does not target improving communication or daily living skills in the child, but rather focuses on teaching the parents to utilize discipline and social learning techniques to change their child’s behavior (Herschell & McNeil, 2005). Given that PCIT does not target improvement in these two areas, it would not have been surprising to see no change, but deterioration was not expected. The reason for this deterioration remains uncertain and could be accounted for by some of the limitations of the methodology, the group as a whole, or some idiosyncratic issue with this parent and child. For example, Participant #3 participated during the summer months, thus a lack of routine/structure at home may have resulted in the deterioration.

The fifth research question explored the parents’ subjective reactions to the group as reflected in the progress notes and this level of analysis appeared to yield some information which might help explain the findings from the above participant and group comparisons. Overall, the counselors in the CPRT group described more positive
reactions of the parents to this mode of intervention than negative or neutral responses. In addition, the counselors’ assessments of the CPRT participants’ response to treatment were more positive than negative or neutral. Conversely, the PCIT counselors indicated parents in this approach had more negative and neutral responses to the group and the counselors’ assessments of the PCIT participants’ response to this method were mostly negative or neutral. Therefore, it appeared that the CPRT participants had a better reaction to the group and they seemed to enjoy the treatment and techniques they learned in the CPRT group as compared to those participating in the PCIT group.

Themes reflecting a more positive reaction to the CPRT group may have been secondary to the techniques of CPRT which emphasized positive interactions between the parent and the child as compared to PCIT which underscores the importance of correcting parenting deficits and difficult child behavior. Parent participants in the present investigation appeared to prefer to focus on improved communication and social interaction with their child as opposed to correcting their child’s negative behavior. However, before drawing any definitive conclusions about the relative efficacy of these two approaches to parent child therapy, alternative explanations for the current findings must be explored. For example, personality traits of the parents, the fact that the PCIT group was in part administered individually versus in a group format, and timing of the group (i.e., summer versus during the school year) could have been a factor in these results. Therefore, future research should further explore the role of these types of factors in determining the success of the groups.

The core conclusion from the present study was that further research is needed comparing PCIT to CPRT before a clear case can be made for which group approach is
more efficacious with parents of children diagnosed with ASDs. Although one participant in the CPRT group reportedly had a good experience and demonstrated a number of clinically significant changes, there were no appreciable differences in parent response on the outcome measures for the other three participants. Therefore, neither group was clearly more effective than the other in improving parent-child relationships or the children’s adaptive functioning. However, recall that a RCI could not be calculated due to the fact that the participants either did not start out in the clinical range or did not change enough toward the normal range. Ceiling effects could have interfered with finding more remarkable results, especially in regards to the parent-child relationship. Nevertheless, given the positive results for Participant #1, and the universal positive response to this approach reflected in the progress notes, it may be that CPRT will be more efficacious than PCIT with this population in future research.

**Theoretical Implications**

Filial therapy is grounded in the theories of child-centered and play therapies and has been developed and researched for the past 40 years (Guerney, 1964). The two different parent-child therapy approaches evaluated in the current study, CPRT and PCIT, were developed from this original research on Filial therapy. Theoretically, CPRT has a stronger emphasis on improving the parent-child relationship (Landreth & Bratton, 2006) than PCIT in which only the first segment of the group focuses on the relationship per se. In the current investigation, only one of the four participants reported improvement in the parent-child relationship as well as the child’s communication and socialization skills. That parent participated in the CPRT group. This parent reported clinically significant improvement in understanding her child and felt as though she was able to relate to her child more positively throughout the play sessions. Unfortunately only one of the parents
evaluated in the CPRT group reported improvement and therefore, future studies of CPRT need to first substantiate a more universal positive response to the approach when used with parents of children diagnosed with ASDs. Once a more generally positive response can be supported, the next step will be further investigation of those specific aspects of the play session which are particularly useful in improving the parent child relationship and how the play sessions lead to improvements in the child’s adaptive functioning.

The mechanism of change for the PCIT group is grounded in the parent child interaction by helping parents develop skill in implementing social learning techniques to improve their discipline skills. These improved parenting skills subsequently are thought to lead to more adaptive and prosocial child behavior (Eyberg, 1974). Through participation in PCIT the parent learns child lead play therapy techniques and new discipline strategies to utilize with the child at home (Niec et al, 2001). However, this theory emphasizes the importance of the second phase of the group or the behavioral change component in which parents develop improved discipline skills (Niec et al, 2001). In the current investigation, the results suggested that the parents in the PCIT group did not observe any clinically significant change in either their child’s adaptive or maladaptive behaviors. Further, they did not report significant improvement in the parent child relationship. Therefore, these preliminary findings suggest that PCIT did not accomplish either of the goals for change with these two parent participants. Again, future research should further investigate whether participation in the PCIT group results in significant improvement, particularly in development of more adaptive and prosocial behavior in children with ASD. Additionally, the mechanism of change for the PCIT
group (i.e., implementing discipline strategies, utilizing child centered techniques) should be specifically explored in future outcome research.

**Practice Implications**

The purpose of the present study was to provide a preliminary assessment of the relative efficacy of two types of Filial therapy which can be implemented with parents of children diagnosed with ASDs. The goal was to provide information which might guide practitioners considering Filial therapy with this population. The qualitative analyses in this study offered a rich description of the experiences of the four participants with the two approaches (Morrow, 2007). This information provided some preliminary information about parent and child response to the two therapeutic approaches which can be used cautiously by clinicians to make a more informed choice when working with families who have a child diagnosed with an ASD (Haverkamp & Young, 2007).

In terms of improving the parent child relationship, one participant in the CPRT group felt more supported as a parent, was more interested in her child’s play, was able to utilize limit setting more effectively, and felt more able to promote her child’s independence as measured by the PCRI. This participant demonstrated more improvement in the parent child relationship than any of the other three participants. Therefore, based on the response of these four participants, the CPRT group might be a useful therapeutic approach for practitioners who wish to promote positive parent child interactions and adaptive behaviors in families of children with ASDs. However, it should be noted that the results do not clearly support CPRT as a more efficacious treatment modality, but only indicate that one participant in the CPRT group had positive outcomes and both participants had a positive experience in the group.
Conversely, none of the participants described improved satisfaction with being a parent or in being better understood by their child. Therefore, practitioners should be aware that neither group appeared to have a clinical effect on these aspects of the parent child relationship. However, it should be noted that while both groups encourage and teach parents to understand their child better, neither group focuses on helping the parents be understood by their child (Landreth & Bratton, 2006; Eyberg, 1974).

The current investigation had hoped to identify an effective intervention for improving adaptive functioning in children diagnosed with ASD. Children with ASDs often struggle with socialization and communication (APA, 2000), thus it is important for clinicians to know the most efficacious treatments for improving functioning in these areas. Again, in the present study, only one participant in the CPRT group indicated her child improved his ability to effectively communicate and socialize appropriately. On the other hand, none of the other participants reported any improvement in adaptive functioning and in the PCIT group deterioration was reported by both participants. Further, none of the participants reported any clinically significant decrease in maladaptive functioning. This preliminary finding may be important as practitioners seeking to improve the adaptive functioning of their clients with ASDs may not want to choose a parent child therapy as the primary intervention. The present investigation suggested that if a child diagnosed with an ASD presents with concerns that are more child-based (i.e., adaptive functioning) as compared to communication and relationship based, one of the Filial therapy approaches may not be the best intervention. There are several individual, child oriented interventions, for example Early Intensive Behavioral
Intervention (Kazdin & Weisz, 2003), already well established in the literature which would likely be more effective in improving the child’s adaptive functioning.

Finally, research has demonstrated that the best predictor of treatment success is the client’s relationship with the therapist (Lambert, 2004). Therefore, it will be important for practitioners to consider therapist factors in their implementation of the techniques investigated in the current study. The parents appeared to have different reactions to the two groups as reflected in the progress note themes. Recall, the two CPRT participants completed the group with the same two counselors, however, the PCIT participants completed the group during two different semesters with a different set of therapists each semester. In all, there were four counselors implementing the PCIT group and only two counselors implementing the CPRT group. The CPRT participants appeared to have mostly positive responses to the group. However, while the combined PCIT data suggested comparatively more negative or neutral responses, when the two groups of PCIT were examined separately, it was clear that the two participants within this treatment condition had a different response to the group. These differences might have resulted from some unassessed therapist variable, even though manualized treatments were used in an attempt to minimize this effect.

Limitations

There were a number of limitations in the present investigation. First and foremost was the sample size. Initially, a large number of parents expressed an interest in the group. However, either due to the timing of the group, the commitment to ten weeks, or other unidentified factors, the number of parents expressing initial interest as compared to the number who actually signed up and participated in the groups remained low. Further, although the number of parents beginning the groups each semester was
relatively high (19 across all semesters), there was a high attrition rate in both treatment conditions. The reason for the high attrition rate remains unclear, although it is important to note there was an alternative Autism parenting group being offered in the community at the time of the current investigation. Follow up telephone contacts with parents anecdotally suggested the ten week duration of the groups was often a factor in their decision to leave the group early.

According to Topham & Wampler (2008), drop out rates for Filial therapy are on average 60%. Recall, the current study had a much higher drop out rate at 79%. In previous studies drop out rates were negatively related to the amount of social support the parent has and positively related to the degree of connection they feel toward their child (Topham & Wampler, 2008). In other words, if parents had good social supports and felt positively connected to their child, they were more likely to drop out of the treatment. These findings are intuitively easy to understand because if the parent child relationship is already functioning well and the parents feel they have adequate support, they likely do not feel they need a therapy group. In the current investigation, the parents were almost exclusively recruited from a local Autism Support group. Further, the participants who discontinued treatment often had additional social supports in the home (i.e., spouse, mother, other children). Therefore, the parents in the current study may have already had adequate social supports and the treatment offered may have been more than they needed in terms of intensity for their problem acuity.

In addition, the design of data collection procedures might also have adversely affected retention rates and validity of protocols. Parents were asked to fill out lengthy questionnaires in the first session, a procedure which likely hindered rapport building, an
essential component to the success of therapy (Prochaska & Norcross, 2002). Additionally, the assessment instruments were administered in a group format and some of the resulting protocols were invalid. Though the counselors were trained in the administration procedures for the measurements and they gave instructions to the participants on how to complete the questionnaires, several protocols for other two participants receiving a full course of treatment were invalid. Finally, it took several participants over one hour to complete the VABS and these parents may have not reached the appropriate floor and ceiling requirements for this measure in the time allotted for completing the measures.

Only four participants yielded valid assessment protocols and completed a sufficient number of groups to be included in the study. The small sample size calls into question the validity of the results and limits the generalizability of the conclusions afforded by the study. However, recall that in qualitative data analysis, a small sample size is often necessary in order to provide a description of the clients’ experiences in the group (Haverkamp & Young, 2007). In fact, according to Morrow (2007), case study methodology is particularly useful for counseling psychology in order to further inform practitioners about an individual’s experience and reaction to a treatment. Therefore, case study methodology should be used for early research designs related to practice oriented research questions (Morrow, 2007).

Another weakness appeared to result from the training tape used with the counselors in the later semesters of the group administrations. Recall that the training workshop given in the first semester was videotaped and then used for subsequent training workshops in the later semesters. A research assistant attended the later training
workshops to show the video and answer any questions. This procedure was intended to standardize the training received by the different counselors. However, this practice proved to be a weakness in the design of the study, as the counselors in the later training workshops did not appear to understand the group procedures as well as the counselors in the initial in-person training. Although, the counselors did demonstrate sufficient treatment adherence, anecdotally the supervisors reported their perception that the later counselors did not appear to have as much depth of understanding about the theoretical underpinnings of the groups.

A final limitation to the present study was the fact that not all of the participants completed the program in a group format. In fact, both of the PCIT participants had several sessions of the “group” in which they were the only participant. Although they still participated in the play sessions and received feedback from the counselors, they did not receive peer feedback for the last few sessions of the group. This situation presents a potential confound when comparing response to the PCIT and CPRT groups as the PCIT participants did not participate in all sessions in a “group” per se. Although this is a concern, it should be noted that both the PCIT participants completed most of the group (one participant had 6 and the other 8) with a peer participant. Recall, 7 sessions was considered a full course of “group,” so one of these participants received a “full course” of treatment in a true group format and the other was only one session short of having a “full course” of “group” treatment.

**Strengths**

Despite the weaknesses of the study, recall that there were a number of methodological strengths. The methodology met all the requirements for establishing empirically supported treatments (Lambert, 2004). The participants were randomly
assigned to the treatment groups, both groups were manualized treatments, the population of the group was specific (ASDs), and the treatment outcome was evaluated using multiple measures (Lambert, 2004). Bias in the study was also controlled in a number of ways. The counselors and supervisors were only trained in their respective treatment protocols and they were kept blind to the research questions. In addition, two independent raters were used to code the progress notes and determine the valence of statements reflective of each theme (Yeh, & Inman, 2007). Although the primary investigator could have biassed the results of the study when developing themes for coding the progress notes, the independent coders served as auditors of the themes to minimize experimenter bias.

In addition, the qualitative methodology yielded a description of each participant’s experience of the groups (Morrow, 2007). By examining in detail several aspects of clinically relevant change (Thompson, 2002; Haverkamp & Young, 2007), the information yielded by this investigation can be beneficial to practitioners who wish to utilize a Filial therapy approach with parents of children with ASDs. The current investigation offered some preliminary guidance for practitioners about the use of Filial therapy with families where a child is diagnosed with ASD. Practitioners were afforded some preliminary and tentative information which they can use to make a more informed decision about which treatment to utilize.

*Research Implications and Future Directions*

A qualitative approach to the examination of the relative efficacy of CPRT and PCIT was important to the field of counseling psychology in that it offered rich descriptions of the clients’ experiences and some practical suggestions when implementing the treatments (Morrow, 2007). However, the current investigation
demonstrated a number of weaknesses that should be addressed in future research studies. Although the present study did examine the effects of the group from multiple sources (i.e., questionnaires, progress notes), future studies should utilize additional sources for information about the experiences of the participants (Morrow, 2007). For example, parents could be interviewed individually before the beginning of the study and after the completion of the study to offer subjective descriptions of their views of the parent child relationship and the level of their child’s adaptive functioning. These interviews would directly address the parent’s perspective in terms of the treatment goals of the two approaches in order to further assess the clinical significance of any changes reflected in quantitative measures. In addition, researchers could utilize the participants’ tapes of the interactions with their children to code for the implementation of the technique as well as parent and child reaction to the treatment/progress toward treatment goals. These two sources of data would further enhance the richness of the descriptions offered in the analysis. Further, future studies should also include information about the psychological functioning of the parents as well as personality style of the therapists and children, in order to take into account the interaction of these factors with the treatment conditions and outcomes.

In addition to gaining additional sources of qualitative and quantitative data, future researchers should consider adding a follow-up component to assess for the long-term effect of the treatment approaches. The follow-up study would include any measures given to the parents as pre and post outcome measures. In addition, the parents could again be interviewed to assess their longer term perspective on changes to the parent child relationship and the level of their child’s adaptive functioning. This
interview would also focus on assessment of the durability of specific treatment outcomes with PCIT and CPRT.

A standardized format should be developed for the progress notes which would allow for better comparisons between the two treatment conditions. Further, the information recorded in the progress notes should not only address the process components of the group, as they did in the current study, but should also assess progress towards implementing and achieving the treatment goals of the two groups. Additionally, the progress notes could record information relevant to the theoretically based goals for the groups. These notes could then be used to assess the efficacy of the groups in obtaining these goals from the counselor’s point of view.

By combining additional objective and subjective measures, future research would be able to offer a more comprehensive analysis of the relative efficacy of CPRT and PCIT (Morrow, 2007). Investigators would have information on the subjective opinion from the participant’s of the effectiveness of the groups, the counselor’s perspective on the participant’s progress toward the treatment goals, objective coding of target behaviors via video tapes, and objective measurements of the parent child interactions and the child’s adaptive functioning. The integration of both objective and subjective measures offer a more solid foundation for the qualitative multiple case study design and would strengthen the interpretive statements that could be made about the relative efficacy of the two groups. Thus resulting conclusions would be more beneficial for practitioners when choosing the “best” treatment for improving parent child relationships and the adaptive functioning of children diagnosed with ASD (Morrow, 2007).
Another possibility for future research is the use of more traditional quantitative research designs to examine the relative efficacy of CPRT and PCIT. By increasing the sample size and utilizing additional quantitative measures, researchers could determine the respective effect sizes for each group (Furr, 2004), thus permitting a discussion of the “practical” and “statistical” significance of each group for the specified population (Thompson, 2002). Further, a mixed-methods design which combined quantitative analyses with the aforementioned qualitative approaches could be useful.

Finally, since there is no research comparing the relative efficacy of CPRT and PCIT, future research should be done with different clinical populations. CPRT has been shown to be effective with a number of clinical populations, including children with learning difficulties, ADHD, anxiety and those who have been sexually abused (Kale & Landreth, 1999; Costas & Landreth, 1999). The effectiveness of PCIT has been demonstrated with children with severe behavioral problems (Kazdin & Weisz, 2003). However, no research has compared these two approaches with any of these other clinical diagnoses.

Summary and Conclusions
The present study sought to provide some preliminary information which might inform practitioners about the relative efficacy of CPRT and PCIT with parents of children diagnosed with ASDs. Through the use of qualitative analysis and multiple sources of information a rich description of the participants’ experiences in the group was derived (Yeh & Inman, 2007). Only the CPRT group appeared to yield a positive response in the present investigation. Specifically, CPRT resulted in a more positive parent-child relationship and improvement in the child’s adaptive behavior skills for one
parent-child dyad. Furthermore, both participants in the CPRT group appeared to have a more positive therapeutic experience than those in the PCIT group.

In the current study, CPRT and PCIT techniques were used to teach play therapy skills to parents in order to facilitate more positive parent-child interactions, ideally resulting in improved mental health and wellbeing for the child (O’Conner, 2000).

Despite a number of meta-analyses confirming the benefit of play therapy, the efficacy of specific play therapy techniques with children has been questioned (Bratton & Ray, 2000; Ray et al, 2001). Therefore, continued research examining efficacy of the various types of play therapy with children is important. Although Filial therapy techniques have been utilized for many years (Guerney, 1964), there is a lack of research in comparing different models of Filial therapy. Research determining a “treatment of choice” with specific populations is especially important given the new impetus toward evidence based treatments (Wampold, 2001). The current study provided some preliminary information which could be used to guide future research investigating the relative efficacy of these two forms of Filial therapy, particularly when implemented with families in which a child has been diagnosed with ASDs. Future research should continue to advance the field of child and family therapy by providing evidence based guidelines for implementing Filial therapy approaches with a variety of child diagnoses. Such research will help practitioners to be more effective with their clients, thus improving the relationships that exist within families and adaptive behaviors of the children.
References


Filial Therapy

reservation. *International Play Therapy, 9*, 57-80.


The rewards and challenges of a group format. *Cognitive and Behavioral Practice, 12,* 113-125.


Psychologist, 35, 369-403.

Appendix A

Informed Consent

A Comparison of Child-Parent Relationship Therapy and Parent-Child Interaction Therapy

The purpose of this research project is to examine how Child-Parent Relationship Therapy or Parent-Child Interaction Therapy affects parent-child relationships. For this project, you will be asked to participate in 10 group therapy sessions. Each group therapy session will be video recorded. These tapes will be stored confidentially and locked in the Practicum Clinic and will only be viewed by members of the research team. The videotapes will be destroyed upon completion of the group. During the Parent-Child Interaction Therapy group you will be observed interacting with your child during some sessions of the program. Before beginning the group sessions, you will complete a series of questionnaires about your parenting styles and your child’s behaviors. You will fill out these same questionnaires at the end of the 10 weeks of group. It will take you approximately 60 minutes to complete the questionnaires each time.

Complete confidentiality cannot be guaranteed because the study occurs in a group setting. However, we encourage all participants to help maintain confidentiality for yourselves and other participants by keeping group discussions private and by refraining from disclosing identifiable information about other participants.

All data will be maintained as confidential. Data will be stored in a locked filing cabinet in the Ball State Practicum Clinic’s office.

The foreseeable risks or ill effects from participating in this study are minimal. There is a small possibility that answering some of the questions on the questionnaires may evoke some feelings of anxiety. Should you experience any feelings of anxiety, you can talk to one of the counselors leading your group.

One benefit you may gain from your participation in this study may be an improved relationship with your child.

Your participation in this study is completely voluntary and you are free to withdraw at anytime for any reason without penalty or prejudice from the investigator. Please feel free to ask any questions of the investigator before signing the Informed Consent form and beginning the study, and at any time during the study.

For one’s rights as a research subject, the following person may be contacted: Coordinator of Research Compliance, Office of Academic Research and Sponsored Programs, Ball State University, Muncie, IN 47306, (765) 285-5070.

**********

I, ___________________, agree to participate in this research project entitled, “A Comparison of Child-Parent Relationship Therapy and Parent-Child Interaction Therapy.” I have had the study explained to me and my questions have been answered to my satisfaction. I have read the description of this project and give my consent to participate. I understand that I will receive a copy of this informed consent form to keep for future reference.

________________________________                 ____________________
Participant’s Signature                    Date
Principal Investigator’s Signature
Kathleen Duffy, MA, Graduate Student
Counseling Psychology
Ball State University
Muncie, IN 47306
Telephone: (765) 285-8047
Email: kmduffy@bsu.edu

Faculty Supervisor:
Dr. Theresa Kruczek
Counseling Psychology
Ball State University
Muncie, IN 47306
Telephone: (765) 285-8049
Email: tkruczek@bsu.edu

Edition Date:
Appendix B

Coding of Progress Notes into Themes

<table>
<thead>
<tr>
<th>Theme</th>
<th>CPRT</th>
<th>PCIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implementation Of Technique</td>
<td>1. Demonstrated reflective responding during the role play (+)</td>
<td>1. Great job of not asking questions (+)</td>
</tr>
<tr>
<td></td>
<td>2. Tape of her play session (0)</td>
<td>2. Counselors gave a brief overview of the procedures (0)</td>
</tr>
<tr>
<td></td>
<td>3. Used appropriate limit setting and lots of reflection (+)</td>
<td>3. They provided brief rationales (0)</td>
</tr>
<tr>
<td></td>
<td>4. Last play session (0)</td>
<td>4. Counselors discussed (0)</td>
</tr>
<tr>
<td></td>
<td>5. Demonstrates appropriate skills (+)</td>
<td>5. Took turns coaching the parents in the play therapy room (0)</td>
</tr>
<tr>
<td></td>
<td>6. Play session skills (0)</td>
<td>6. Her daughter went first (0)</td>
</tr>
<tr>
<td></td>
<td>7. Making progress with her skills (+)</td>
<td>7. Commands/questions during (-)</td>
</tr>
<tr>
<td></td>
<td>8. To reflect, track, and set a limit (0)</td>
<td>8. Her son then went into the playroom (0)</td>
</tr>
<tr>
<td></td>
<td>9. Very well with reflective responses (+)</td>
<td>9. Did a lot of praising (+)</td>
</tr>
<tr>
<td></td>
<td>10. Trouble setting limits and reflecting emotions (-)</td>
<td>10. She let her child lead most of the play (+)</td>
</tr>
<tr>
<td></td>
<td>11. Much better play session (+)</td>
<td>11. She was not able to do the play therapy everyday (-)</td>
</tr>
<tr>
<td></td>
<td>12. Tape at the clinic for next week (0)</td>
<td>12. Adding more description to her statements (+)</td>
</tr>
<tr>
<td></td>
<td>13. Where there are no limits (-)</td>
<td>13. A lot of labeled praise (+)</td>
</tr>
<tr>
<td></td>
<td>14. Great job of not asking questions (+)</td>
<td>14. She did allow him to lead play (+)</td>
</tr>
<tr>
<td></td>
<td>15. She let her child lead most of the play (+)</td>
<td>15. He went to time-out (+)</td>
</tr>
<tr>
<td></td>
<td>16. She then had him pick up puzzle pieces, in which he complied and she praised him for this (+)</td>
<td>16. She then had him pick up puzzle pieces, in which he complied and she praised him for this (+)</td>
</tr>
<tr>
<td></td>
<td>17. She stated that she was not able to do the play/discipline everyday (-)</td>
<td>17. She stated that she was not able to do the play/discipline everyday (-)</td>
</tr>
<tr>
<td></td>
<td>18. She showed the timeout chair again and informed him that this is where he would be sitting (+)</td>
<td>18. She showed the timeout chair again and informed him that this is where he would be sitting (+)</td>
</tr>
<tr>
<td></td>
<td>19. We tried the discipline again (0)</td>
<td>19. We tried the discipline again (0)</td>
</tr>
<tr>
<td></td>
<td>20. She tried to do it everyday (+)</td>
<td>20. She tried to do it everyday (+)</td>
</tr>
<tr>
<td></td>
<td>21. She showed the timeout chair again and explained the holding chair. She let him know if he did not obey her, he would be sitting in the timeout chair. (0)</td>
<td>21. She showed the timeout chair again and explained the holding chair. She let him know if he did not obey her, he would be sitting in the timeout chair. (0)</td>
</tr>
<tr>
<td></td>
<td>22. She gave him a warning (+)</td>
<td>22. She gave him a warning (+)</td>
</tr>
<tr>
<td></td>
<td>23. She was able to use the hold on him. She held him for thirty seconds. (+)</td>
<td>23. She was able to use the hold on him. She held him for thirty seconds. (+)</td>
</tr>
<tr>
<td></td>
<td>24. She explained that he needs to sit in time out (+)</td>
<td>24. She explained that he needs to sit in time out (+)</td>
</tr>
<tr>
<td></td>
<td>25. He did scream a little, but then got very quiet (0)</td>
<td>25. He did scream a little, but then got very quiet (0)</td>
</tr>
<tr>
<td></td>
<td>26. She then asked him to pick up the toys (0)</td>
<td>26. She then asked him to pick up the toys (0)</td>
</tr>
<tr>
<td></td>
<td>27. She gave him a command to put away a toy (0)</td>
<td>27. She gave him a command to put away a toy (0)</td>
</tr>
<tr>
<td></td>
<td>28. She asked him to put the puzzle up (0)</td>
<td>28. She asked him to put the puzzle up (0)</td>
</tr>
<tr>
<td></td>
<td>29. She asked him to stop or he would</td>
<td>29. She asked him to stop or he would</td>
</tr>
</tbody>
</table>
### Filial Therapy

#### 2. Parent Reaction to Technique/Treatment

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reported being glad (+)</td>
</tr>
<tr>
<td>2.</td>
<td>She reported being surprised (0)</td>
</tr>
<tr>
<td>3.</td>
<td>She was bored (-)</td>
</tr>
<tr>
<td>4.</td>
<td>She stated the play sessions gave her new insight to her son’s imagination and her own patience (+)</td>
</tr>
<tr>
<td>5.</td>
<td>Being tired and bored (-)</td>
</tr>
<tr>
<td>6.</td>
<td>She has benefitted the most from letting her son take the lead (+)</td>
</tr>
<tr>
<td>7.</td>
<td>Also found the rule to be the most helpful for her (+)</td>
</tr>
<tr>
<td>1.</td>
<td>Parents discussed benefits and difficulties that occurred during the special play time at home. (0)</td>
</tr>
<tr>
<td>2.</td>
<td>Discussed concerns over not wanting to be told how to be a parent (-)</td>
</tr>
<tr>
<td>3.</td>
<td>Trouble with commands/questions (-)</td>
</tr>
<tr>
<td>4.</td>
<td>Did not role play due to the parents not wanting to (-)</td>
</tr>
<tr>
<td>5.</td>
<td>Most of the parents were hoping that this group was going to teach their child how to be more verbal (0)</td>
</tr>
<tr>
<td>6.</td>
<td>Has trouble with commands/questions (-)</td>
</tr>
<tr>
<td>7.</td>
<td>She gives her daughter a lot of commands (+)</td>
</tr>
<tr>
<td>8.</td>
<td>Play therapy is going very well at home (+)</td>
</tr>
<tr>
<td>9.</td>
<td>She is still seeing benefit from the play (+)</td>
</tr>
<tr>
<td>10.</td>
<td>She was very eager to learn about the discipline lesson (+)</td>
</tr>
<tr>
<td>11.</td>
<td>She felt very comfortable with this type of punishment (+)</td>
</tr>
<tr>
<td>12.</td>
<td>She agreed that she has noticed an increase in verbalization during their special playtime (+)</td>
</tr>
</tbody>
</table>

#### 3. Child Reaction to Technique/Treatment

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Son took an interest (+)</td>
</tr>
</tbody>
</table>
| 2. | Son’s creativity(+)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The child from the parent child dyad that had been waiting to be observed ran into the play therapy room (+)</td>
</tr>
<tr>
<td>2.</td>
<td>Daughter does not really communicate well (-)</td>
</tr>
<tr>
<td>3.</td>
<td>He kicked and screamed and wanted attention (-)</td>
</tr>
<tr>
<td>4.</td>
<td>He sat on time-out for one minute and then obeyed the command that was originally given (+)</td>
</tr>
<tr>
<td>5.</td>
<td>He would constantly scream and want attention (-)</td>
</tr>
<tr>
<td>6.</td>
<td>He is beginning to speak more appropriately and for longer periods of time (+)</td>
</tr>
<tr>
<td>7.</td>
<td>She agreed that she has noticed an increase in verbalization during their special playtime (+)</td>
</tr>
<tr>
<td>8.</td>
<td>He screamed a couple times, but for the most part he was very quiet (0)</td>
</tr>
<tr>
<td>9.</td>
<td>He still screams and does a lot of...</td>
</tr>
<tr>
<td>4. Spouse Reaction to Technique/Treatment</td>
<td>1. Reports spouse is very involved (+)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>2. Not married and child’s father is not very involved (-)</td>
<td>1. Parent child dyad that had been waiting to be observed ran into the play therapy (+)</td>
</tr>
<tr>
<td>2. Spouse Reaction to Technique/Treatment</td>
<td>1. The client participated well (+)</td>
</tr>
<tr>
<td>1. Reports spouse is very involved (+)</td>
<td>6. Participated throughout the session (+)</td>
</tr>
<tr>
<td>2. Not married and child’s father is not very involved (-)</td>
<td>7. She participated in the role plays but was hesitant to get started (0)</td>
</tr>
<tr>
<td>3. Does not do role play during session (-)</td>
<td>4. Did not do role play during session (-)</td>
</tr>
<tr>
<td>5. Showed a tape and shared the progress (+)</td>
<td>5. One father informed the co-leaders that his pre-test was not complete and asked if he could take it home and have his wife return it during the next session (0)</td>
</tr>
<tr>
<td>6. Participated throughout the session (+)</td>
<td>7. For got her homework (-)</td>
</tr>
<tr>
<td>6. Participated throughout the session (+)</td>
<td>8. She also talked about issues (+)</td>
</tr>
<tr>
<td>7. She participated in the role plays but was hesitant to get started (0)</td>
<td>10. Did not do role-play during session (-)</td>
</tr>
<tr>
<td>7. She participated in the role plays but was hesitant to get started (0)</td>
<td>11. Participated in the role play (+)</td>
</tr>
</tbody>
</table>
Filial Therapy

128

bad and that is why she was not able to make it. She plans to continue next week. (0)

12. We then discussed his behaviors and any questions that she might have (0)

13. Two did not bring their homework back this week (-)

14. She wants to try to use the holding chair today (0)

6. Parent Reaction to Other Group Members

1. Was very supportive when watching his tape (+)
2. Open to feedback (+)
3. Helpful toward other members of the group (+)
4. Appears to be forming closer relationships with the other group (+)
5. Indicated concern about being videotaped and viewed by others (-)
6. Gave lots of feedback (+)

1. They were encouraging to other parents (+)
2. Good bonding experience for the group (+)

7. Counselor Observation of Participant

1. She did very well at allowing her son to take the lead (+)
2. Was quiet and unresponsive (-)
3. Consistent improvement (+)
4. She is realistic (0)
5. Improved on her skills a great deal and is open to suggestions (+)
6. Insightful about her change (+)
7. Seemed more involved this week (+)
8. Did well at ‘being a thermostat’ (+)
9. She is getting better at catching herself (+)

1. Daughter 4 ½-hyperfocused, social delays, repetitive behavior, self soothe, mom wants to increase interaction—words to feelings (0)
2. Son 4-speech (repetitive language), tantrum (screaming/whining), sensory issues—noise, mom wants him to be able to handle his frustrations (0)
3. Son 7- non verbal, pounds wrists when angry (0)
4. Son 3-repetitive behavior with hand, screams—doesn’t communicate, doesn’t sleep, tantrums when he doesn’t get his way, low socialization, doesn’t like to wear clothes, bedroom is the safe spot, hair pulling/scratching (0)
5. Son 9- not able to express feelings, little social skills (0)
6. She did fairly well (+)
7. She did very well (+)
8. She was very active (+)
9. I noticed that he was very verbal in this session (+)
10. He started throwing an orange
1. Suzie agreed to bring a video tape next week (+)
2. Seemed open to suggestions (+)
3. Counselor will suggest continuing with family therapy in the fall at the clinic (0)

1. Remember to describe colors, shapes, actions (0)
2. Label praise (0)
3. Counselors did not deviate from the manual during this session (0)
4. While in the play room, counselors gave an age appropriate explanation of the special play time to the child (0)
5. Coached for approximately 5 minutes during the play therapy time for each parent (0)
6. Counselors provided brief and precise statements (0)
7. Then offered live coaching for 15 minutes (0)
8. Informed them that they did not need to bring their children (0)
9. We explained what the process was for the evening (going into the room, observing, recording, etc.). We then went over the do’s and do not’s as a reminder for the parents. They were written on the board. (0)
10. Guide her more towards labeled praise (0)
11. We went through the powerpoint with the parents and tried to give as many examples as possible so the parents could understand all of the information. As a group, we also went over examples and situations. (0)
12. Then handed out the homework sheets and briefly described what they were to do with them (0)
13. We introduced this coaching session and took her into the room (0)
14. I told her to ignore his behavior (0)
15. I gave her feedback on all of her improvements and went over any questions that she had (+)
16. We gave her more feedback and gave her information of the autism society on campus (0)
17. Co-facilitators presented the Teaching Behavioral Play Therapy PowerPoint presentation. Both parents received copies of the slideshow. The 5-minute play time homework, current challenges, and foreseeable difficulties were discussed. (0)
18. The counselors began the session by
reviewing the special play time assignment with the parents. (0)

19. The co-therapists checked in with the parents regarding the 5 minute play therapy homework. The co-therapists presented the Discipline Skills PowerPoint. (0)

20. Went over homework. (0)

21. As a group, we went over any questions they had and reminded them to do their homework for the next week. (0)

22. We explained that we will be doing the same as last week. We went over the do’s and do not’s as a reminder for the parents. (0)

23. We then went back into the room to give feedback. As a group, we went over any questions or concerns. We reminded them to do homework for the next week. (0)

24. We went over the powerpoint and discussed different scenarios and what she would do. She was very active in this presentation compared to the first one. We then explained that homework would still continue and handed her a new sheet along with handouts regarding the discipline diagram. (+)

25. She informed us that she will no longer be attending due to her son participating in sporting events on Monday evenings. We gave her a copy of the discipline powerpoint since she missed the last session. We briefly went over a couple of things from the powerpoint with her just for her general information. (0)

26. We went over how the following week was with discipline. (0)