IMPACT OF TWO-SESSION MODEL OF CHILD PARENT RELATIONSHIP TRAINING ON PARENTS OF CHILDREN DIAGNOSED WITH ADHD

by

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ABSTRACT

SARAH ALYCE MOORE. Impact of two-session model of child parent relationship training on parents of children diagnosed with ADHD. (Under the direction of DR. PHYLLIS POST)

The purpose of this study was to assess the impact of a Two-session Child Parent Relationship Training on parental perception of children's problem behaviors; parental acceptance of child; parental stress; and parental attitudes, knowledge and skills about child-centered play therapy. All of the parents of children with Attention-Deficit Hyperactivity Disorder (ADHD) in grades one to five in a small southern county were eligible for the study. Sixty parents were randomly assigned to the experimental and control groups.

A two-way ANOVA with one between subjects and one within subjects effects was used to examine differences between the experimental and control groups on the VADPRS pre-test and post-test, and independent t-tests were used to compare the experimental and control groups for each of the dependent variables. The statistical analyses found no differences between the experimental and control groups with regard to parental perception of child problems, parental acceptance of child and parental attitudes about child-centered play therapy. There were differences with regard to parental stress and parental knowledge, such that parents in the experimental group reported lower levels of stress and more play therapy knowledge than the parents in the control group. These findings are promising in terms of both helping parents of children with ADHD and exploring alternative models of CPRT that could be more widely used.

DEDICATION

I dedicate my dissertation to my wonderful husband, Marc, my children, Lilley, Rose and Henry and my mother, Marilyn Moore.

ACKNOWLEDGMENTS

My deepest appreciation is expressed to those individuals who played a vital role in the completion of the doctoral program and this research study. Sincere gratitude goes to my dissertation chairperson, Dr. Phyllis Post, for her guidance and patience throughout the dissertation process. I am thankful to Dr. Post for introducing me to CCPT and CPRT. The lives that I impact through my work are a credit to her. I would also like to express my appreciation to my dissertation committee members, Dr. Claudia Flowers, Dr. Peggy Ceballos, Dr. Susan Furr, and Dr. Ryan Kilmer, for their suggestions and support in completing this research study. I would like to thank Dr. Furr for her faith in me and her encouragement throughout my doctoral studies and Dr. Flowers for supporting me as I 'crunched' the numbers.

I am grateful to the students, staff, and parents of Stanly County Schools for their cooperation and participation in this research study. I thank my mother for believing in me and teaching me a strong work ethic and determination. Finally, I wish to thank my extended family and especially my husband, Marc, and my children, Lilley, Rose and Henry. My children are my inspiration and motivation. Marc has been by my side every step of the way through this seemingly never-ending journey. His love and support have made it all possible.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1: INTRODUCTION

Greenburg (1978) noted that "anything that limits children's interests, abilities, and knowledge is hardly the way to prepare…for an eighty year lifespan" (p. 234). One such limitation to children's interests, abilities, and knowledge is Attention Deficit Hyperactivity Disorder (ADHD). Three to 7% of children are diagnosed with ADHD, the most frequent diagnosis for children (American Psychiatric Association [APA], 2000). Children who are diagnosed with ADHD have many difficulties including trouble paying attention, trouble controlling impulsive behaviors, and in some cases, being overly active (Centers for Disease Control and Prevention [CDC]; 2012).

ADHD is defined as:

> a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development…hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years…some impairment from the symptoms must be present in at least two settings…clear evidence of interference with developmentally appropriate social, academic or occupational functioning; the disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorders and is not better accounted for by another mental disorder. (APA: Diagnostic and statistical manual of mental disorders [DSM-IV-TR] 4th ed., text rev., 2000, p. 85)

In 2006, more than 4.5 million children in the United States had been diagnosed with ADHD. In fact, Pastor and Reuben (2008) found that the average number of children, ages 6-17 years old, diagnosed with ADHD increased by 3% annually between 1997 and 2006. With an estimated 7% of children between the ages of 3 and 17 years

being diagnosed with ADHD, there is a tremendous economic impact on families, schools, and the health care system. Pelham, Foster, and Robb (2007) estimated that the annual "cost of illness" for society is between $36 and $52 billion dollars being spent on identifying and treating ADHD. The National Health Interview Survey found that children with ADHD were more likely than children without ADHD to be in contact with a mental health professional, use prescription medication, and have frequent health care visits (Pastor & Reuben, 2008).

Because ADHD diagnoses continue to increase, there has been an increase in research studies considering the origin and treatment of ADHD. The National Institute of Mental Health (1999) published findings indicating that combination treatments (i.e., medications and therapy) were the most effective treatments for ADHD. Although many children are being helped through various therapies and medications, more needs to be done to support children and their families.

When a child is diagnosed with ADHD, parents usually need to be educated about the diagnosis, the implications for their child's life, treatments, and the support that they can offer as their child learns to manage the symptoms of ADHD. The stress of not understanding the child's diagnosis, along with the stress of dealing with the child's symptoms and behavioral issues at school, can be overwhelming (Vaughan, Feinn, Bernard, Brereton, & Kaufman, 2012). In fact, Vaughan and colleagues found that parents of children who had internalizing and externalizing behaviors had higher levels of caregiver strain and parenting stress. In addition, ADHD has been associated with strained familial and peer relationships, suboptimal educational achievement, and increased risk for unintentional injuries (Dulcan, 1997; Rowland, Lesesne, &

Abramowitz, 2002; Subcommittee on Attention-Deficit/Hyperactivity Disorder et al., 2011).

ADHD has a significant impact on the child's ability to function in school, at home, and in extracurricular activities; it also meaningfully influences the parents' experiences in the world. Given that an increasing number of children are being diagnosed with ADHD, there is a need for clinicians to develop interventions that will reduce parental perception of children's problem behaviors, decrease parental stress, and increase parental acceptance of children. Parenting is a difficult task for anyone but particularly when the child has been diagnosed with ADHD. The purpose of this study was to assess the effectiveness of an intervention designed to help parents interact more positively with their children and reduce their perceptions of children's problems, increase parental acceptance of children, and decrease parental stress; and report more positive attitudes about child-centered play therapy, more knowledge about child-centered play therapy and more skills in child-centered play therapy.

Child Parent Relationship Training (CPRT) Intervention and Modifications

Play therapy is defined as "a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play" (Landreth, 1991, p.14). There have been several studies utilizing play therapy, and in particular, child-centered play therapy (CCPT), in an effort to reduce symptoms of ADHD in children. Schottelkorb and Ray (2009) conducted a single-case design study to examine the effectiveness of CCPT on ADHD symptoms, and

their results showed that two of their four subjects showed a substantial reduction and two demonstrated questionable reduction in symptoms. Other studies have shown improvement in symptoms by children with ADHD who participated in CCPT (Naderi, Heidarie, Bouron, & Asgari, 2010; Ray, Schottelkorb, & Tsai, 2007).

While there is an abundance of literature on providing direct services to children, less research has been completed on supporting parents. In many cases, parents become frustrated with the difficulties of managing the symptoms in their children and in seeking assistance for their children. Currently, a number of interventions, including behavioral parent training (BPT), Behavior Contingency Management in the classroom (BCM), social skills training or other peer-group-based interventions, cognitive interventions, and classroom interventions (see, e.g., Antshel, Macias, & Barkley, 2009; Pelham, Wheeler, & Chronis, 1998) are used to assist families dealing with ADHD; however, few interventions exist in the behavioral health realm that have been proven to have lasting effect. With the growing concerns about ADHD, mental health clinicians are seeking effective long-lasting interventions to use with parents whose children are diagnosed with ADHD and with their children.

The tenets of CCPT were used to develop parent training programs to encourage better communication with their children. Filial therapy was developed in the early 1960s by Bernard Guerney in response to an increase in mental health needs in the United States. B. Guerney (1964) combined his theoretical background in CCPT with his belief that group work was a more efficient way to meet the needs of parents. The goals of filial therapy are to teach parents basic play therapy skills, to strengthen and enhance

parent-child relationships, and to help children reduce problem behaviors and internal emotional distress (Guerney, L., 1997; VanFleet, 2005).

Guerney's model (1964) was developed for children ages 3-12 and over a period of 3-6 months taught primary caregivers how to interact therapeutically with their children using CCPT skills. VanFleet (2005) noted that "parents become the primary change agents as they learn to conduct child-centered play sessions with their own children" (p. 1). Van Fleet (2005) continued the Guerneys' work on filial therapy with the publishing of her book, *Filial Therapy*, which provides a detailed description of the concepts and specific methods used in filial therapy.

CPRT, a type of filial therapy, is "a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children" (Landreth, 2002, p.11). CPRT is a ten-week model of filial therapy that was developed by Landreth to be used with a small group of parents. When parents learn to use the skills taught in CPRT on a consistent basis, their relationships with their children are impacted in many ways including a decrease in parental perception of children's behavior problems, a reduction in parental stress, and an increase in parental acceptance (Kidron & Landreth, 2010; Lee & Landreth, 2003; Tew, Landreth, Joiner, & Solt, 2002).

Because most children are diagnosed with ADHD before the age of 10 and CPRT is most suitable for children aged 3-10 years old, CPRT is an intervention with much promise. CPRT has been found to be very effective in assisting parents and their children with regard to parental perception of children's problem behaviors, parental stress, and parental acceptance of the child. In fact, these findings have consistently found that CPRT is successful with many different populations, including parents of children

experiencing learning difficulties (Kale & Landreth, 1999), parents with chronically ill children (Tew et al., 2002), Israeli parents (Kidron & Landreth, 2010), and immigrant Korean parents in the United States (Lee & Landreth, 2003). Kale and Landreth's (1999) study is the only one that has focused on parents of children with learning problems. This was the first study that focused on parents of children with ADHD specifically and the impact of CPRT. Because this intervention model has been a viable resource for many populations and it addresses many of the behavioral issues that children with ADHD struggle with on a daily basis, there was a need to determine if this resource could also be helpful to parents of children with ADHD.

At times, community clinicians encounter parents who are in dire need of the training, but for various reasons, a traditional CPRT is not feasible including parents not being willing or able to commit to a 10-week program due to financial constraints, child-care limitations, and overextended schedules. When studying dropout rates in filial therapy, Topham and Wampler (2008) found that in their study 51% of parents who came to the first session of the training completed the training. However, when the families who completed initial assessments but did not start treatment were included, the completion rate dropped to 40%. In one review of studies, the filial therapy programs had dropout rates of 0 to 42% reported (Kazdin & Mazurick, 1994). The present study sought to address this issue, utilizing a brief model that required less time commitment from parents.

In the body of literature on the traditional model of CPRT, random samples were not used in many of the earlier studies. In some studies, the group leaders overcame the obstacle of differing parent schedules by creating the experimental and control groups

based on whether or not parents were available for the scheduled training. Bratton and Landreth (1995) used this approach in their study on single parents. Using this system to determine participants may have inadvertently excluded parents with the most obstacles to receiving assistance. The generalizability of the studies was limited because they did not use random samples.

However, in the last few years, several CPRT studies (Carnes-Holt, 2011; Ceballos & Bratton, 2010; Sheely-Moore & Bratton, 2010) have used random samples. In fact, Ceballos and Bratton (2010) used random sampling to determine the treatment and no-treatment groups and then arranged to have the trainings at the home school of the children for the convenience of parents. Sheely-Moore and Bratton (2010) used random sampling with the exception of four parents who noted before the random selection that there were unable to meet during the training times. These studies added to the recent body of CPRT studies in which random sampling was used to create the experimental and control groups. The use of random samples gives a better representation of the population in need but may impact dropout rates.

At this time, there is research investigating variations of the model (Eardley, 1978; Ferrell, 2003; Grskovic & Goetze, 2008; Harris & Landreth, 1997; Jang, 2000; Landreth & Lobaugh, 1998; Smith & Landreth, 2004) which were developed with the intent of reaching more families and achieved findings similar to those found with the traditional CPRT model. In much of the research based on the traditional CPRT model and its variations, the content and structure remain virtually the same. In order to meet the needs of the participants or the setting, the number of times and the length of time between meetings was changed in various studies. To date, there have been no known

studies that have significantly changed the model to eliminate the experiential component of the program.

Because of the number of families that are suffering due to the implications of ADHD and the shortage of mental health resources, the present research addressed the need for a modification of a successful training program for parents which could help in the lives of children with ADHD and their families. In cases in which parents cannot or will not commit to the traditional filial training, sharing the didactic information would expose them to the material and give them some tools to use to assist the child. The CPRT literature supports the notion that the combination of psychoeducational and experiential training is effective at showing long-term change for participants. However, recent research (Berge, Law, Johnson, & Wells, 2010) has shown that psychoeducational training was beneficial on a significant level for family functioning and parents' perception of their children's behavior. To address this need, the training used in this research was designed to teach the skills, demonstrate the skills and have parents practice the skills but attend only two didactic sessions.

Introduction of Variables

The independent variable in the study was the CPRT intervention. The six dependent variables were 1) parental perception of children's problem behaviors; 2) parental acceptance of child; 3) parental stress; 4) parental attitudes, 5) parental knowledge and 6) parental skills about child centered play therapy. The goals of the program were to assess the impact of the training on these six dimensions which are commonly used in the CPRT literature. Each of the dependent variables was addressed below.

Parental Perception of Children's Problem Behaviors

Many families struggle to maintain a healthy environment for individual family members because they do not know how to deal with the behaviors of the child with ADHD. Raviv and Stone (1991) found that parents of children with learning disabilities (LD) and their children did not have the same perception of the children's self-image. Significant, but moderate relationships were found between parents' perception and adolescent self-image scores. When parents were knowledgeable about the LD, open about the LD and accepted the child's problem, self-image of the child tended to be higher. In the study, when parents were more accepting of the LD, children had higher impulse control, better family relationships and superior adjustment.

In addition, Oncu and Unluer (2012) taught a parent education class for 10 weeks and considered whether parental perception of children changed after completing the class. The parents in the study had preschool aged children and lived in Kocaeli, Turkey. The researchers found that there was a small effect on the perception of the parents. More importantly, they found that parents changed their way of being with their children based on that perception and the education they had received. Based on this literature, it appears that parents' perception of children does impact the behaviors of children. It also appears that parents can change their perception of their children. Working with parents to change their perception of their children can help to build the parent-child relationship.

There is an extensive body of research that considers the impact of CPRT on the parent's perception of the child. Tew et al. (2002) found that parents of chronically ill children in the experimental group scored their children significantly lower on the Child Behavior Checklist (CBCL; Achenbach & Edlebrock, 1983) after the filial therapy

training versus children in the control group. Parents reported fewer problematic behaviors in their children following the training. In a study of parents of children who had been sexually abused (Costas & Landreth, 1999) and a study of parents of children with learning problems (Kale & Landreth, 1999), parental perception of child's problem behaviors decreased after completion of the CPRT. Landreth and Lobaugh (1998) found that incarcerated fathers scored significantly lower on the number of child problem behaviors identified on the Filial Problems Checklist (FPC) after completing the CPRT.

Based on the above studies, it is clear that parents' interactions with their children had a tremendous impact on their children's experience of the world. In addition, the research shows that the traditional model of CPRT is effective in impacting parental perception of their child's behavior. This study assessed the effectiveness of a Two-session CPRT relative to parental perception of child's problem behaviors with the goal of making a positive impact on the parent and child's experience in their relationship.

Parental Acceptance of Child

Often, parents have a difficult time accepting their child, particularly when the child exhibits difficult behaviors (Lee & Landreth, 2003; Yeun, Landreth, & Baggerly, 2002). Khaleque and Rohner (2011) completed a meta-analysis of worldwide research that was based on 66 studies involving 19,511 respondents from 22 countries on five continents. Parental Acceptance/Rejection (PAR) Theory's personality sub-theory (Rohner, R. P., 1975, 1986) was utilized and asserted that, humans have developed the enduring biologically-based emotional need for positive responses from attachment figures and from other people emotionally important to them (). Results from the meta-analysis showed strong relationships between perceived parental acceptance and

children's psychological adjustment across cultures (Khaleque & Rohner, 2011). It is clear from the 66 studies in the meta-analysis and their conclusions that children have a strong need to be accepted by their parents.

Because parents of children with ADHD can become frustrated with the condition of their children and children respond to their parents' emotions, there is a need to provide interventions for these parents which will help parents accept their children. There have been many CPRT studies that have considered the impact of CPRT on parental acceptance of the child. Specifically, studies have assessed parental acceptance before and after the CPRT training and found that Korean parents (Jang, 2000), Chinese parents (Chau & Landreth, 1997), parents of chronically ill children (Tew et al., 2002), incarcerated fathers (Landreth & Lobaugh, 1998), Israeli parents (Kidron & Landreth, 2010), parents of children with learning problems (Kale & Landreth, 1999), parents of children who have been sexually abused (Costas & Landreth, 1999), single parents (Bratton & Landreth, 1995), and incarcerated mothers (Harris & Landreth, 1997) all showed a significant increase in the acceptance of their children after participating in filial therapy. The difficulties of reaching families with the traditional model of CPRT and the strong body of research on CPRT and parental acceptance are indicators of the need for this study.

Parental Stress

Johnston and Mash (2001) noted that one well-accepted consequence of ADHD in children is increased parental stress. In addition, Theule, Wiener, Rogers, and Marton (2011) recommended that stress reduction for parents should be considered in the development of interventions for families with children with ADHD. Barkley (1998)

stated that families of children with ADHD report higher rates of conflict within the family and more negative parent-child relationships.

There is a need for an intervention to support the parents of children with ADHD by decreasing parental stress. Many different populations, including Israeli parents (Kidron & Landreth, 2010), incarcerated fathers (Landreth & Lobaugh, 1998), immigrant Korean parents (Lee & Landreth, 2003), and immigrant Chinese parents (Yeun et al., 2002), showed significant decline in stress after parents completed the CPRT training. The extensive research on various populations has shown that CPRT does decrease parental stress. This research supported the goals of this study of assessing the impact of a Two-session CPRT on parental stress.

Parental Attitudes, Knowledge and Skills

Kao and Landreth (1997) found that students who completed a graduate course in play therapy showed a significant increase in positive attitudes, knowledge and skills pertaining to children and play therapy. In addition, Kagan and Landreth (2009) taught a short-term CCPT training with school counselors and teachers in Israel and found that there was a statistically significant improvement in the group's play therapy knowledge as measured by the Play Therapy Attitudes Knowledge Skills Scale (PTAKSS; Kao & Landreth, 1997).

The attitudes, knowledge and skills learned in a play therapy course are the same as would be learned in a traditional CPRT. With the traditional CPRT being offered over 10 weeks and with many opportunities for experiential learning, it is important to know if the Two-session CPRT is sufficient to facilitate an increase in parents' attitudes, knowledge and skills within a shorter time period and with no experiential education.

Significance of the Study

An examination of the filial therapy research indicates a thorough base of research on the effectiveness of the traditional model of CPRT (Bratton & Landreth, 1995; Chau & Landreth, 1997; Lee & Landreth, 2003; Smith & Landreth, 2004; Yuen et al., 2002). However, there is no known research available on the use of a didactic version of CPRT. To address the need for a less time intensive format, this study investigated an alternative didactic version of CPRT, presented in a workshop format, for parents of children who had been diagnosed with ADHD.

Research Questions

The purpose of this study was to assess the impact of a Two-session CPRT, with parents of children diagnosed with ADHD with regard to parent's perception of children's problem behaviors; parental acceptance of child; parental stress; and parental attitude, knowledge and skills about child centered play therapy.

1. What is the impact of the Two-session CPRT with parents' of children with ADHD on parental perception of children's problem behaviors as compared to the control group?
2. What is the impact of the Two-session CPRT with parents' of children with ADHD on parental acceptance of child as compared to the control group?
3. What is the impact of the Two-session CPRT with parents' of children with ADHD on parental stress as compared to the control group?
4. What is the impact of the Two-session CPRT with parents' of children with ADHD on parental attitudes about child centered play therapy as compared to the control group?

5. What is the impact of the Two-session CPRT with parents' of children with ADHD on parental knowledge about child centered play therapy as compared to the control group?
6. What is the impact of the Two-session CPRT with parents' of children with ADHD on parental skills about child centered play therapy as compared to the control group?

Assumptions

The proposed study had the following assumptions:

1. The parents would respond honestly to both the pre-test and post-test surveys.
2. The same parent would follow the instructions and complete all of the assessments.
3. The random assignment of the participants to the experimental and control groups would ensure equal opportunity to participate in the parent workshop groups and helps create similar samples of participants and non-participants.
4. The parents would commit to the duration of the study and agree to meet at a designated location within the county to participate in the study.
5. The didactic format would have the same learning content as the traditional format.

Limitations

The limitations of the study were:

1. Four weeks between pre-test and post-test may not have allowed enough time for parents to integrate the information learned in the training.

2. Participants in the study used self-report about their child's diagnosis of ADHD and could have misunderstood the requirement or not had an official medical diagnosis.
3. Because the participants were solicited from one small southern county and the children had been diagnosed with ADHD, the results may have limited generalizability to participants who do not live in small southern towns.
4. Because the participants were volunteers, they may have been more willing to change than non-volunteers.
5. Participants in the study used self-report for the VADPRS, PPAS, PSS and the PTAKSS and because of the self-report the parent's perception could have been different from their actual behaviors.

Delimitations

The delimitations of the study were:

1. The child participants in the study were in grades first through fifth grade in Stanly County Public Schools.

Threats to Internal and External Validity

Internal validity is "the degree to which observed differences on the dependent variable are a direct result of manipulation of the independent variable" (Gay, Mills, & Airasian, 2006). Threats to internal validity in this study are factors other than the independent variable, CPRT, and could affect the dependent variables which were: parental perception of children's problem behaviors, parental acceptance of child, parental stress; and parental attitudes, knowledge, and skills of CCPT. When developing the groups for the study, random assignment was utilized to avoid internal validity issues.

The researcher selected instruments with reported satisfactory reliability and validity to control for instrumentation threat. In order to avoid a threat to internal validity due to the different format of CPRT being utilized, an expert in the field confirmed that the didactic content was identical to that in the traditional CPRT.

External validity is "the degree to which study results are generalizable, or applicable, to groups and environments outside the experimental setting" (Gay et al., 2006). Since the sample consisted of 60 participants from a small southern county in North Carolina, generalizability of the results is limited to parents of children with ADHD residing in small towns.

Operational Definitions

This study examined the impact of a CPRT intervention using a modification of the 10-week filial training model (Bratton, Landreth, Kellam, & Blackard, 2006) as the independent variable.

Parental Perception of the Children's Problem Behaviors

Parental perception of children's problem behaviors was measured by parents' scores on the VADPRS (Wolraich et al., 2003). The total score was used in this study. The VADPRS was administered during the pre-test and post-test assessment time.

Parental Acceptance of Child

Parental acceptance of child was measured by parents' responses on the PPAS (Porter, 1954). The PPAS provides a total scale score and four subscale scores which are: (a) respecting the child's feelings and the child's right to express these feelings, (b) appreciating the uniqueness of the child, (c) recognizing the child's need for autonomy

and independence, and (d) loving the child unconditionally (Porter, 1954). The total score was used in the study.

Parental Stress

Parental stress is the level of perceived stress on the part of the parent in the parent-child relationship as measured by the PSS (Berry & Jones, 1995). The total score was used as measurement of change in parental stress.

Parental Attitudes, Knowledge and Skills

Parental attitudes, knowledge and skills were assessed utilizing the PTAKSS (Kao & Landreth, 1997). The total score was used to determine changes from pre-test to follow-up test.

Diagnosis of ADHD

Diagnosis of ADHD was defined as parental self-report in response to the following question on the Parent Demographics Questionnaire: "Has your child been diagnosed by a pediatrician, psychiatrist, psychologist, family physician or other professional as having ADHD/ADD?" If the parents responded "Yes" to this question, they were eligible to participate in the study.

Organization of the Study

This dissertation is presented in five chapters. Chapter 1 included the introduction, purpose and significance of the study, research questions, statement of hypotheses, assumptions, limitations, delimitations, threats to internal and external validity, operational definitions and organization of the study. In addition, Chapter 1 familiarized the reader with the research topics of children with ADHD and its impact on parental perception of children's problem behaviors, parental acceptance of child,

parental stress; and parental attitudes, knowledge and skills about CCPT and children. Chapter 2, the literature review, presented the theoretical literature and empirical research on the variables of interest including filial therapy literature. Chapter 3, methodology, addressed the participants, the procedures, the instruments, and the data analysis in the implementation of the study. The description of participants and results are presented in Chapter 4. The overview of study, results and conclusions, contributions of the study, limitations of the study, implications of the findings, recommendations for future research, parent comments, and concluding remarks are in Chapter 5.

CHAPTER 2: REVIEW OF THE LITERATURE

The purpose of this study was to assess the impact of a Two-session Child Parent Relationship Training (CPRT) with parents of children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) on: parental perception of children's problem behaviors, parental acceptance of child, parental stress; and parental attitudes, knowledge, and skills.

The main focus of this chapter is to review empirical literature that emphasizes the need for this study. The chapter is divided into five main sections. The first section describes the history of ADHD and treatment of ADHD. The second section examines empirical literature that is related to the outcome variables important for parents with children with ADHD which are: a) parental perception of children's problem behaviors, b) parental acceptance of child, c) parental stress, and d) parental attitudes, knowledge, and skills about child-centered play therapy (CCPT). The third section provides a wide-ranging review of the literature related to play therapy and ADHD. The fourth section focuses on filial therapy and the modifications to the CPRT model. The final section summarizes the chapter and discussed conclusions related to the importance of the study.

Attention Deficit Hyperactivity Disorder

History of Attention-Deficit Hyperactivity Disorder

Although ADHD has become more widely known and diagnosed over the last several decades, ADHD has a long history beginning as early as the mid-1800s. Hoffman (1848), a German physician, described the characteristics of ADHD in a children's book

with two of his characters—Fidgety Phil and Harry Who Looks in the Air. Fifty years later, Still (1902) described a disease resulting from a defect in moral character and suggested that the problem resulted in children not being able to internalize rules and limits, being restless, inattentive, and over aroused. Still (1902) believed that brain damage was probably the cause but that the behavior might also stem from hereditary and environmental factors.

Between 1917-1918, some children who recovered from the global epidemic of influenza with encephalitis, showed symptoms of restlessness, inattention, impulsivity, easy arousal, and hyperactivity (Ebaugh, 1923) and a stronger connection was made between ADHD and brain damage. Over the next 45 years, there was a shift from the cause of ADHD being attributed to brain damage to the cause being behavioral in nature. Studies during the 1970s (Douglas, 1974; Douglas & Peters, 1979) led to a focus on inattention as the primary deficit, which led to a change of the diagnostic label to attention-deficit disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, American Psychiatric Association [APA], 1980). As more knowledge was gained about ADHD, the diagnostic label changed to attention-deficit/hyperactivity disorder in DSM-III-R (APA, 1987) and DSM-IV (APA, 1994). Eventually in 2000, the APA added impulsivity to the description listed in the DSM-IV Text Revision.

Treatment of Attention-Deficit Hyperactivity Disorder

As more has become known about ADHD, more interventions have become available to help children and their families. Families are more likely to approach medical and mental health professionals for assistance. In fact, the National Health Interview Survey found that children with ADHD were more likely than children without

ADHD to be in contact with a mental health professional, use prescription medication, and have frequent health care visits (Pastor & Reuben, 2008).

In addition, Pastor and Reuben (2008) found that the average number of children, ages 6-17 years old, diagnosed with ADHD increased by 3% annually between 1997 and 2006. In 2006, more than 4.5 million children in the United States had been diagnosed with ADHD. With an estimated 7% of children between the ages of 3-17 years diagnosed with ADHD, there is a tremendous economic impact on families, schools, and the health care system. Pelham, Foster, and Robb (2007) estimated that the annual "cost of illness" for society is between $36 and $52 billion dollars being spent on identifying and treating ADHD.

As the diagnosis of ADHD has increased, research has increased in the areas of origin and treatment. Although many children are being helped through various therapies and medications, more needs to be done to support children and their families. Although there is a basic knowledge in the general community about ADHD, parents typically do not know a lot about ADHD and need to be educated about the diagnosis. The stress of not understanding the children's diagnosis, along with the stress of dealing with the children's symptoms and behavioral issues at school, can be overwhelming.

Two predominant treatment options are medications and behavioral intervention strategies. Medication is an option that most parents learn about early in the process of trying to assist their children with managing ADHD, and it can offer help to the children in managing the daily challenges of life associated with ADHD. In addition, the Centers for Disease Control and Prevention (CDC; 2012) stated that behavioral intervention strategies are very important in treating ADHD and should be implemented as soon as the

children are diagnosed with ADHD. The CDC (2012) website listed some strategies including creating a routine, getting organized, avoiding distractions, and limiting choices, changing interactions with the children (use clear, brief directions to remind the children of responsibilities), using goals and rewards, disciplining effectively, and helping the children discover a talent.

Also, parent education is very important. Parents can learn how to teach their children skills such as organization, problem-solving and coping with their symptoms. Currently, parent education is conducted with individual parents and in groups. One group, Parent to Parent, that is available is through Children and Adults with Attention Deficit-Hyperactivity Disorder (CHADD, 2012), offers an educational program to help children and adults with ADHD with lifespan issues.

The research indicates that parents and their children with ADHD find behavioral intervention strategies useful because they are provided with practical ways to alleviate some of the stress associated with managing ADHD. Unfortunately, medication and behavioral interventions do not solve all of the issues that are associated with ADHD (Rowland, Lesesne, & Abramowitz, 2002). However, even if they did, the strategies take a lot of time and energy which can be taxing for both the children and parents. Because of this, there are many other behavioral intervention strategies that are being developed and implemented with this population. Many families are impacted by ADHD and seek assistance within the mental health community. There is a great deal of research that shows CPRT being helpful to many populations (Carnes-Holt, 2011; Ceballos & Bratton, 2010; Kidron & Landreth, 2010; Lee & Landreth, 2003; Sheely-Moore & Bratton, 2010; Yeun, Landreth, & Baggerly, 2002). Because many of the externalizing problems that

children may present are symptoms of ADHD and research demonstrates that CPRT helps with externalizing behaviors (Carnes-Holt, 2011; Ceballos & Bratton, 2010; Lee & Landreth, 2003; Sheely-Moore & Bratton, 2010; Yeun et al., 2002), it is likely that the symptoms of ADHD would be helped by this training as well. This condensed format has the potential to reach many families because it is more accessible and because it addresses the externalizing behaviors that are characteristic of ADHD.

Outcome Variables Important for Parents with Children with ADHD

In this section, the outcome variables that are important for parents and children with ADHD were discussed. The outcomes are a) parental perception of children's problem behaviors with a subheading on parental perception and CPRT, b) parental acceptance of child with a subheading on parental acceptance and CPRT, c) parental stress with a subheading on parental stress and CPRT, and d) parental attitudes, knowledge, and skills about CCPT.

Parental Perception of Children's Problem Behaviors

Raviv and Stone (1991) found that parents of children with learning disabilities (LD) and their children did not have the same perception of the children's self-image. This finding suggests that communication between children with LD and their parents is lacking or that children with LD may not have the ability to utilize good communication skills. When good communication exists between parents and children, parental perceptions are more likely to be accurate. In general, children reported a higher self-image than their parents thought they would have.

Significant, but moderate relationships were found between parents' perception and adolescent self-image scores. When parents were knowledgeable about the LD, open

about the LD and accepted the children's problem, self-image of the children tended to be higher. Educating parents about the children's LD, so that they can begin to accept the LD, appears to be a factor that can help to increase the children's self- image. In this study, when parents were more accepting of the LD, children had higher impulse control, family relationships and superior adjustment.

Oncu and Unluer (2012) taught a parent education class for 10 weeks and examined whether parent perception of children changed after completing the class. They found that there was a small effect on the perceptions of the parents. More importantly, they found that parents' changed their way of being with their children, based on that perception and the education they had received.

Based on the above literature, research demonstrates that parents' perception of children impacts the behaviors of children. In addition, parents can change their perception of their children. Working with parents to change their perception of their children, can help to build and strengthen the parent-child relationship. CPRT is a model that has been shown to impact parental perception of the child. Unfortunately, the traditional model of CPRT is not accessible to many families. In addition, the population of this study was parents of children with ADHD. The research shows that parents of children with ADHD are likely to have a more negative perception (Ho, Chien, & Wang, 2011; Lench, Levine & Whalen, 2013) of their children because of the problem behaviors that their children present and the frequency with which they present the behaviors. This study utilized a modified CPRT in an effort to impact parental perception for parents of children with ADHD.

Parental Perception and CPRT.

Parental perception of children's behavior has been studied extensively within the literature as it relates to filial therapy and in particular, CPRT, and its impact on children. In Germany, Grskovic and Goetze (2008) used a brief form of the VanFleet filial training approach with a group of mothers and found that the mothers' perceptions of their children's behavior difficulties decreased as a result of the filial training. In the United States, Bratton and Landreth (1995) studied a group of single parents in a CPRT program and found that parents' perceptions of their children's difficulties significantly decreased as a result of the training. Glazer-Waldman, Zimmerman, Landreth, and Norton (1992) found that parents of children with chronic illness, after completing the CPRT, were better able to accurately judge the children's report of anxiety indicating that CPRT positively impacted the parents' perceptions of the children. Yuen et al. (2002) found that immigrant Chinese parents in Canada had a significant change in their perception of their children as a result of the CPRT. The new parenting information from CPRT may have allowed the experimental group parents to handle many child behavior situations that they had not been able to before the training.

Overall, there have been a variety of populations and measures of parental perception reported in the research, and the results consistently demonstrate that children are impacted by their parents' perceptions. However, there is a scarcity of literature on ADHD and the impact of parental perception on children with ADHD. With the number of children being diagnosed with ADHD increasing, particularly in the United States, it is imperative that we find additional resources to meet the needs of children with ADHD

and their families. This study considered the impact of the Two-session CPRT on parental perception of children's behaviors after parents completed the training.

Parental Acceptance of Child

There is an abundance of research that shows a link between parent-child relationship and various impacts on the children and parents' lives including personality dispositions, behavioral functioning of children and their parents, and psychological adjustment (Rohner, R. P., 1975; Rohner, R. P., 1986; Rohner & Rohner, 1980). The parental acceptance-rejection theory (PARTheory) is an evidence-based "theory of socialization which attempts to explain and predict major consequences of parental acceptance and rejection for behavioral, cognitive, and emotional development of children and for the personality functioning of adults everywhere" (Rohner, E. C., 1980, p.1). This theory and the accompanying assessment, Parental Acceptance-Rejection Questionnaire (PARQ; Rohner, E. C., 1980), have been utilized in many studies that reinforce E. C. Rohner's theory that behavioral, cognitive and psychological adjustment of children is impacted by parental acceptance or rejection.

Research has extended beyond the boundaries of the United States to show that parental acceptance is important to children in many cultures. R. P. Rohner (2010) studied parental acceptance and found that the adjustment, achievement and behavior of school-going youths internationally were impacted by the level of parental acceptance. Researchers from 17 countries responded to an invitation to participate in the study and collect data, with six completing their studies in time for the publication of the article. The six countries, Bangladesh, Estonia, India, Kuwait, Turkey, and the United States, from which researchers returned data showed a positive impact of parental acceptance on

the children. In terms of youth's school conduct, parental acceptance tended to be significantly correlated with the school conduct of both boys and girls. There were some variations in some of the cultures, with gender of children and/or the parent impacting where the influence was strongest.

Uddin (2011) found that adolescents in Bangladesh were more successful academically in school when parental warmth was higher. Dwairy's (2010) study with Arab, Indian, French, Polish, and Argentinian adolescents found that the more connected parents felt with their children, the more years of education parents had and the higher the family income, the more accepting parents' were of their children. Male adolescents were more rejected and less accepted by their parents than female adolescents; and fathers were more rejecting and less accepting than mothers. In addition, parental rejection was associated with adolescents' psychological disorders and parental acceptance was associated with better psychological adjustment. This supports E. C. Rohner's early studies which determined that parents have an impact on the psychological well-being of their children. The PARTheory (Rohner, E. C., 1980) continues to be tested across various cultures and continues to show that parental acceptance is vitally important in the lives of children.

A study (Erkan & Mehmet, 2010) of children in Turkey found that mothers' socioeconomic status (SES), age and the number of children in the family impacted parental acceptance-rejection behaviors, such that the higher the SES, the higher the acceptance of the children. When lower SES mothers had more children, they became even more rejecting of their children, and the rejection increased as the mothers got older. L. F. Guerney and Gavigan (1981), in the United States, found that parental acceptance

was an important quality in the helping relationship. They also had similar findings to Erkan and Mehmet (2010) in that higher SES and education led to higher parental acceptance and that lower SES led to higher parental rejection.

There have been numerous studies in the United States that have considered parental acceptance. Eunjung (2008) studied a group of adolescent Korean Americans and found that parental acceptance contributed to the psychological adjustment of children. Consistent with other findings in this area, the adolescents with higher parental acceptance were more stable, more emotionally responsive, and less hostile that the adolescents who perceived lower parental acceptance. Khan, Haynes, Armstrong, and Rohner (2010) found that parental acceptance is important for dealing with the developmental tasks of seventh grade adolescents in the Mississippi Delta region of the United States. However, they also noted that impoverished children such as these need additional resources in order to be successful.

The relative influence of parental and peer acceptance were compared in one study (Sentse, Lindenberg, Omvlee, Ormel, & Veenstra, 2010) to determine which had the most impact. When considering both parental and peer acceptance, the more acceptance by both, the less maladjustment in early adolescence. When considered separately, being rejected by parents was more detrimental for adolescents' adjustment than rejection by peers. When the parent and peer context were considered at the same time, peer had less impact in relation to early adolescent externalizing problems and disappeared in relation to internalizing problems.

Because dealing with ADHD can be very frustrating for parents and children, it is important to identify strategies for helping parents move towards more acceptance of

their children and their behaviors. The extensive research on CPRT and parental acceptance supports the notion that parental acceptance can be increased. CPRT has been found to reduce many externalizing behaviors of children including acting out and aggressive behavior. These behaviors, while common in children with various issues in their lives, are characteristic of children with ADHD. One study (Taylor, Purswell, Lindo, Jayne, & Fernando, 2011) utilized CPRT to assist families that were separated or divorced. Although this study did not determine if the children were diagnosed with ADHD, the children did exhibit externalizing behaviors that children with ADHD tend to exhibit. After the study was complete, parents reported, during the qualitative interviews, that the communication skills they learned allowed them to better manage their children's behaviors. Because only three parents completed the Child Behavior Checklist (CBCL), clinical findings were discussed instead of statistical findings. All three parents reported a decrease in at least one subscale on the CBCL after completing the training. The subscales on the CBCL that changed from pre-training to post-training included sleep problems, externalizing problems, affective problems, oppositional defiant problems, and aggressive behavior. These subscales include many of the symptoms that children with ADHD present.

A qualitative study with Hispanic parents participating in CPRT (Garza, Kinsworthy, & Watts, 2009) found that parents reported a reduction in negative behaviors and an increase in positive behaviors. Some of the behaviors that the parents mentioned were rebelliousness, negative attitude, not following directions, and lack of calmness. Again, these behaviors are behaviors that children with ADHD present. A second qualitative study (Edwards, Sullivan, Meany-Walen, & Kantor, 2010) with a diverse

sample of parents and children also found that parents reported a decrease in children's negative behaviors including anxiety, impulsiveness, talking, acting out and other maladaptive classroom behaviors after completing the training. These behaviors are typical of children who struggle with ADHD.

The VanFleet model (2005) of filial therapy was utilized (Topham, Wampler, Titus & Rolling, 2011) in another study and the researchers found that parent and child outcomes could be predicted by their scores on the Eyberg Child Behavior Inventory (ECBI; Eyberg, & Pincus, 1999). The ECBI focuses on externalizing behaviors including conduct and acting out behaviors, in children ages 2-16. Children who scored higher on the ECBI, and thus had more trouble regulating emotions, had a greater decrease in behavior problems.

A study that focused on Puerto Rican families (Matos, Torres, Santiago, Jurado, Rodriguez, 2006) and parent–child interaction therapy (PCIT) found that externalizing behaviors in children decreased significantly after parents had completed the training. Again, many of the externalizing behaviors that children presented included behaviors that are common for children with ADHD. Seven of the 10 children that participated in this study with their parents met the criteria for ADHD based on their mothers' responses on the diagnostic interview. In this study, the CBCL, ECBI, and Behavioral Assessment System for Children- Parent Rating Scales (BASC-PRS; Reynolds & Kamphaus, 1998) were used to evaluate children's behaviors. Based on all three assessments, there was a significant reduction in externalizing behaviors after completing the training. The follow-up study (Matos, Bauermeister, & Bernal, 2009) utilized the PCIT that was modified (Matos et al., 2006) to meet the needs of the Puerto Rican families that were participating

in the study. Mothers in this study reported a significant decrease in hyperactivity, inattention, aggression and oppositional defiant behaviors. In both PCIT and CPRT training, parents reported a decrease in externalizing behaviors.

Ceballos and Bratton (2010) utilized the traditional model of CPRT with Latino families and found that there was a significant decrease in externalizing behaviors of children on the CBCL when the pre-tests and post-tests of parents were compared. Sheely-Moore and Bratton (2010) preformed a similar study with Black Americans and had similar results. The Black American parents also reported a significant decrease in children's externalizing behaviors on the CBCL after completing the traditional CPRT. In addition, a study of adoptive parents (Carnes-Holt, 2011) found that parents reported a significant reduction in total behaviors on the CBCL after completing CPRT. In each of these studies, the externalizing behaviors that were identified by the CBCL are behaviors that are characteristics of ADHD. A mixed methods study (Dillman, Purswell, Lindo, Jayne, & Fernando, 2011) also considered the implications of CPRT on children's externalizing behaviors. They found a decrease in externalizing behaviors from the clinical to borderline range. In addition, parents reported a decrease in children's behaviors on the following subscales: affective problems, oppositional defiant problems, anxious/depressed, aggressive behavior, and total problems.

The above research on parental acceptance and externalizing behaviors of children strongly supports the notion that parent-child relationship is integral to the healthy development of children and that parent acceptance increases when children's problem behaviors decrease. Although there has been a great deal of research internationally about parental acceptance, none of the literature considered the impact of

parental acceptance on children with learning problems or ADHD. The research showed that children's externalizing problems can be decreased. The externalizing behaviors discussed in the above literature are characteristic of children with ADHD. Thus, the current study considered parents of children with ADHD and the reduction of externalizing/ADHD behaviors through completion of the Two-session modified CPRT and its impact on parental acceptance.

Parental Acceptance and CPRT.

Parental acceptance of children has been a factor of interest in many studies on the impact of CPRT. Jang (2000) reported that the experimental group's acceptance of their children did not significantly increase. However, when the parents were asked qualitatively they all reported positive change in parental acceptance. In many studies of the 10-week CPRT, (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew, Landreth, Joiner, & Solt, 2002; Yuen, 1997) there was a significant increase by the experimental group in their perceived acceptance of their children as measured by the PPAS.

Many studies have considered the four dimensions of acceptance on the PPAS which are: a) respect for the child's feelings and right to express them; b) appreciation of the child's uniqueness; c) recognition of the child's need for independence and autonomy; and d) unconditional love (Porter, 1954). Lee and Landreth (2003) found that parents showed a statistically significant increase in their perceived acceptance of their children on three of the four subscales and on the total score of the PPAS. The parents reported significant growth in respect for their children's feelings and right to express them, in

recognition of their children's need for autonomy, and in unconditional love. These parents learned to be more accepting of their children. Harris and Landreth (1997) had similar findings when considering the four dimensions. In their study, mothers reported significant growth in acceptance of their children's feelings and their children's rights to express those feelings, in recognition of their children's need for autonomy and independence, and appreciation for their children's unique makeup.

In particular, Kale and Landreth (1999) investigated the impact of CPRT on parents of children with learning difficulties. They had parents participate in the traditional 10-week model. They investigated whether parental acceptance, parental stress and parental perception of children's behavior was impacted. Parental acceptance was measured using the PPAS and the Parental Stress Index (PSI; Abidin, 1995) was used to measure parental stress. The CBCL and Child Behavior Checklist Teacher Report Form (CBCL- TRF) were used to measure the children's behavior problems. Kale and Landreth (1999) found a significant increase in parental acceptance of the children. Their study did include a few students who were diagnosed with ADHD, with 18% in the experimental group and 36% in the control group having been diagnosed and receiving medication. Out of 22 parents completing the training, only six children were diagnosed as having ADHD. The rest of the children had other learning problems.

There is a great deal of evidence that parental acceptance is vital in the development of healthy, well-adjusted children. Parents play a crucial role in providing an environment in which children feel safe to explore and grow into psychologically healthy adults. Parents can be taught the skills they need to be better able to meet their children's needs. The CPRT research shows that parental acceptance can be increased

and that parental acceptance is important in the emotional development of children. When you consider that many parents of children with ADHD feel overwhelmed, the modified Two-session CPRT offered these parents a feasible opportunity to make positive changes in the lives of their children and themselves. This study investigated the impact of the Two-session CPRT on parental acceptance.

Parental Stress

There is a body of research regarding the impact of parents' level of stress on their parenting. Parental stress is caused by a variety of factors such as work, finances, illness, moving, grief and loss, separation, sleep deprivation, and behavioral concerns (Abidin, 1992). Parental stress impacts parents' interactions with their children and may lead parents to respond in ways that are against their beliefs about parenting (Abidin, 1992).

Research with parents of children with developmental disabilities, such as pervasive development disorder (Doo & Wing, 2006) and autism spectrum disorders (Zaidman-Zait et al., 2010); have shown that these parents experience higher levels of stress than parents of normally developing children. In addition, Hill and Rose (2009) noted that the mothers of adult children with intellectual disabilities, tended to have lower levels of stress when they had higher levels of satisfaction in their lives and an internal locus of control. These studies noted the impact of the children's disability on the parents as well as the children's response to the level of parental stress.

When considering internalizing and externalizing problems of children, Mäntymaa et al. (2012) found that parental stress during toddlerhood tended to be a predictor of internalizing problems for the children. In fact, parental stress at age two of

children predicted later internalizing problems and was a marginally significant predictor of externalizing problems. Early detection of maternal distress and family stress is useful in predicting the severity of symptoms for children and allows for the children to be treated sooner. With parental stress having such an important impact on parenting and the parent–child relationship, early intervention is essential in meeting the needs of both the parents and their children. Sipal, Schuengel, Voorman, Van Eck, and Becher (2009) analyzed parental stress in relation to children with cerebral palsy and found that behavior problems in the children were directly related to the amount of parental stress and to the support that parents received from family and friends.

The above body of literature on parental stress is consistent in reporting that as parental stress goes up, negative symptoms in children go up. The research also shows that parents with children with learning and behavioral problems tend to have more stress. Since the parent-child relationship is so important and it is negatively impacted by stress, we need to find ways to alleviate stress for parents so that they can better connect with and parent their children. CPRT has been shown extensively in the literature to have a positive impact on parental stress. The current study focused on parental stress for parents of children with ADHD.

Parental Stress and CPRT.

The impact of CPRT on parental stress has been measured using the PSI and has demonstrated a statistically significant decrease in experienced stress on the Parent Domain and Child Domain subscales and on the total scores on the PSI. The majority of studies investigating the impact of CPRT on parental stress have utilized the PSI to measure change. Most of the studies considered the total scores on the PSI while some

analyzed the parent and child domains. In all of the cases, parental stress decreased significantly when parents completed the CPRT training (Bratton & Landreth, 1995; Ceballos & Bratton, 2010; Chau & Landreth, 1997; Costas & Landreth, 1999; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Kidron & Landreth, 2010; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Sheely-Moore & Bratton, 2010; Tew et al., 2002; Yuen et al., 2002).

Only one study, conducted by Kale and Landreth (1999), focused on children with learning problems. They found a decrease in parental stress related to parenting after parents had completed the traditional 10-week model of CPRT. Some of the participants in their study were identified as having ADHD. Although ADHD is not considered a learning disability, many children who have ADHD struggle with learning problems due to inattention, impulsivity and other characteristics of ADHD. In addition, many children with ADHD are also diagnosed with learning disabilities. With so little literature focusing on children with learning problems and parental stress, the need for this study was apparent. The Two-session CPRT added to the body of literature by assessing the impact of CPRT on parental stress.

Parental Attitudes, Knowledge and Skills

This section introduced the Play Therapy Attitudes-Knowledge-Skills Scale (Kao & Landreth, 1997) and the body of literature utilizing the assessment. The PTAKSS has been used in CPRT studies to measure these three areas: attitudes, knowledge and skills. Kagan and Landreth (2009) used the PTAKSS to determine if teachers and school counselors in Israel were able to increase their play therapy knowledge. The teachers and school counselors did increase their play therapy knowledge, but they did not

significantly increase their attitudes, skills or confidence in doing play therapy skills. The teachers and school counselors gained understanding of play therapy but perhaps, due to lack of confidence, did not change their attitude or skill level.

Landreth and Wright (1997) suggested that the best way to introduce new information is through a didactic presentation. They had graduate students in counseling complete an assessment of their play therapy skills before and after completing a course in play therapy. In particular, they considered the important skill of limit setting. The students' responses changed dramatically between beginning and completing the course, such that at the beginning of the course, student scores were very different from that of professional counselors but were the same as professional counselors after having taken the course. The students had learned the material and were able to apply it appropriately.

Another study (Arnold, 1976) taught three specific play therapy skills to pre-practicum Master's level counseling students using micro-counseling skills: limit setting, reflections of feeling, and reflection of behavior statements. The skills were exhibited at a higher rate by students who were trained using the micro-counseling skills as compared to the counseling students in the control group. Arnold (1976) determined that students, who had the opportunity to practice the skills that they were learning, were better able to remember and utilize them.

In previous studies, this assessment was utilized with counseling students, teachers and counselors. This study is the first known project to assess parents using this instrument. When presenting parenting education, it is important to observe whether or not parents are changing their attitudes, gaining knowledge and gaining skills. There is evidence that the skills can be taught but some concern about whether or not attitudes of

participants change, especially when training is over a short period of time. There is a need for continued research about interventions that can help parents. This study looked at the changes in parental attitudes, knowledge and skills of parents who completed the Two-session CPRT.

Play Therapy and ADHD

There are many theories of play therapy but this study has a foundational basis in CCPT. CCPT, or nondirective play therapy, was defined by Axline (1969) as "an opportunity that is offered to the child to experience growth under the most favorable conditions" (p.16). CCPT is based on providing a space where children feel free to express themselves in ways they choose. In addition, Axline (1969) developed a list of the eight basic principles of play therapy which are:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world and reality and to make the child aware of his responsibility in the relationship. (pp. 73-74)

All of these principles impact children's sense of safety in the play room and their willingness to practice free will with trust of play therapists' acceptance of them.

Play therapy is defined as "a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play" (Landreth, 1991, p.14). Because many children with ADHD have difficulty with relationships, the therapy relationship is in itself, helpful in teaching children life skills. In addition, in the context of therapy, children are allowed the freedom to create and accomplish tasks which produce a sense of competency that must be experienced by rather than taught to the children. As the children with ADHD assume responsibility for various components of the therapeutic relationship, the children are able to take more responsibility for self and develop more confidence in their ability to handle difficult situations associated with the ADHD and other life difficulties.

Play therapy has been researched as an applicable strategy to support the needs of children with ADHD. Although not CCPT, Kaduson and Schaefer (2006) recommended short-term play therapy for assisting clients with ADHD. On a practical level, medical insurance usually covers a limited number of therapy sessions for a client. Short-term play therapy falls within the limits of many insurance companies. Kaduson and Schaefer's study combined play therapy sessions with interventions by school personnel and parents. Not only did the children have the opportunity to participate in play therapy but the children, parents and school personnel were taught the main components of ADHD and were assisted in developing treatment goals to assist the children, parent and school personnel with issues that they encountered due to the ADHD.

Over a 10-week period, the families learned to function better and manage the problems associated with ADHD. In the Kaduson and Schaefer (2006) model, emphasis was placed on working with parents to help decrease the negative impact that ADHD was having on them as well so that they could be more receptive to the needs of the children. Not only did children gain understanding and control through this experience but the parents did as well. If parents are able to decrease the level of stress that they are feeling and increase their understanding of their children's situation, then the parents will be better able to assist their children with overcoming the difficulties associated with ADHD.

Earlier studies with CCPT as the intervention showed mixed results in terms of the impact of CCPT on children with ADHD. Hannah (1986) found that play therapy did reduce the behavioral symptoms of ADHD. However, Blinn's (1999) results found play therapy not to be effective with children with ADHD. . However, more recent studies have compared CCPT with other interventions such as reading mentoring (Ray, Schottelkorb & Tsai, 2007), person-centered teacher consultation (Schottelkorb & Ray, 2009), and different lengths of treatment periods (Cochran, Cochran, Nordling, McAdam & Miller, 2010) and shown that CCPT does impact children with ADHD. For instance, Ray et al. (2007) found with a sample of 60 children exhibiting ADHD symptoms that those children showed a statistically significant decrease in ADHD symptoms after 16 sessions of CCPT in comparison to children who were in a reading mentor program. Schottelkorb and Ray (2009) also found, when using single-case design, that the children exhibited improvement of ADHD symptoms during or following treatment. Cochran et al. (2010), although focused on children with attention and aggression issues but not

diagnosed with ADHD, also found that CCPT had an impact on behaviors. This body of research indicates that there are several studies in the play therapy literature about the impact of play therapy on children with ADHD. Although the results varied, it appears that play therapy, and specifically CCPT, is helpful to children with ADHD.

Filial Therapy and ADHD

The above studies offer a strong foundation to support the use of CCPT in assisting children with ADHD and other behavioral issues and their families. Although there is some indication that CCPT is effective in addressing the needs of children with ADHD, the research has not been extended from CCPT to parent training. Training parents to work with their own children as an alternative to therapy with the children is called filial therapy and was created by Louise and Bernard Guerney in the 1950s (Guerney, B., 1964). During the 1950s, there was a shortage of mental health clinicians and the demands in the community could not be met. In response to this, the Guerneys developed filial therapy from their work doing play therapy, with the belief that they could train parents in the CCPT skills and that parents would be able to meet their own children's therapeutic needs through structured, weekly 30-minute play sessions with their children (Guerney, B., 1964).

The Guerneys discovered that parents could be taught to use the skills that the play therapists were using. In fact, parents were more successful using the play therapy skills, because they already had a relationship developed with their children. The Guerneys were able to implement their model, but it was a very time-intensive and expensive program that was only accessible to parents with personal, financial and other resources. Originally, the Guerneys met with filial groups in a structured program for

two hours per week for a year. They later streamlined the groups to meet twice per week for five to six months and produced similar results. During the meetings, they taught parents basic CCPT principles and skills. Although they did see very positive results from their model, many parents and clinicians did not have access to it (Guerney, B., 1964). VanFleet (2005) studied with the Guerneys and continued the work of developing filial therapy.

Landreth (2012) created the 10-week filial model, CPRT, based on CCPT and filial therapy. Landreth condensed the Guerney's model into one that is less time-intensive and less expensive. The present study modified the approach such that parents were taught the skills so they could assist their own children rather than clinicians using CCPT with their children. Since CPRT, a model of filial therapy, is based on CCPT, the researcher suggested that CPRT might also be effective in reducing ADHD symptoms and their impact on children and their parents. With no known research to date, there is a need for research on the effectiveness of CPRT with parents of children with ADHD.

Child Parent Relationship Training Research

This section focuses on filial therapy and the modifications to the CPRT model. Because there is little research that relates specifically to filial therapy and ADHD, this section reviews literature that has been reported in social work, counseling and psychology regarding ADHD and the approach of play therapy. Landreth worked on fine-tuning this program for many years, and he, along with many others, did extensive research to show its effectiveness with many populations, including Native Americans on the Flathead Reservation (Glover & Landreth, 2000), deaf and hard of hearing parents (Smith & Landreth, 2004), incarcerated fathers (Landreth & Lobaugh, 1998), single

parents (Bratton & Landreth, 1995), Chinese parents (Chau & Landreth, 1997), and parents of children with learning difficulties (Kale & Landreth, 1999). Besides Kale and Landreth's CPRT study, only one other (Goetze & Grskovic, 2009) considered the impact of filial therapy on children with learning disabilities, however, it focused on peer-facilitated filial therapy rather than with parents.

Bratton, Landreth, Kellam, & Blackard, (2006) authored the Child Parent Relationship Therapy (CPRT) treatment manual: A 10-session filial therapy model for training parents. After years of work in developing a more manageable model to reach clients, the book and training manual allowed for greater access by clinicians and potential clients.

At present, there have been many studies of filial therapy and, in particular, CPRT. CPRT has been found to be effective at addressing many variables such as parental stress (Kidron & Landreth, 2010; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Yeun et al., 2002), parental acceptance of child (Lee & Landreth, 2003; Yeun et al., 2002), parental empathy (Lee & Landreth, 2003; Yeun et al., 2002), and decreasing behavior problems in children (Yeun et al., 2002).

Glover and Landreth (2000) applied the CPRT model with Native American parents on the Flathead Reservation in Montana and their children. The children's behaviors improved and the parents significantly increased their level of empathy in their interactions with their children. Smith and Landreth (2004) employed CPRT with teachers of deaf and hard of hearing preschool children. The teachers developed non-directive involvement with the students and significantly improved their ability to communicate acceptance and empathy. The overall behavior problems, including

withdrawn and externalizing behaviors, decreased for the students whose teachers were in the experimental group.

Landreth and Lobaugh (1998) used CPRT with incarcerated fathers and found that fathers in the experimental group scored significantly lower on parental stress and identifying child behavior problems and significantly higher on attitudes of acceptance and empathic behavior towards their children. In addition, the self-concept of the children increased as a result of the sessions with their fathers. Bratton and Landreth (1995) utilized CPRT with a group of single parents. The parents significantly reduced their stress related to parenting and had fewer problems with their children's behavior. Also, they increased their acceptance and their empathic behavior toward their children.

Kale and Landreth (1999) had parents participate in the traditional 10-week model and investigated whether parental acceptance, parental stress and parental perception of children's behavior was impacted when the children had learning disabilities. The parents in the experimental group had a significant increase in parental acceptance of their children over those in the control group. The parents in the experimental group had a significantly lower mean total score on stress related to parenting than the control group parents. Goetze and Grskovic (2009) found that when older children with learning disabilities used CPRT skills with younger children with learning disabilities, the younger children's behaviors in the classroom improved. They found that the parents did not rate their children's behavior as improving but the teachers' showed a significant decrease in total problematic behavior, especially internalizing behavior.

Modifications to Child Parent Relationship Training

As the literature reviewed above demonstrates, the 10-week model of CPRT is a viable method of meeting the therapeutic needs of children and teaching parenting skills to parents. Over the last 15 years, researchers have begun to consider how to modify the 10-week model in order to meet the needs of families. Numerous studies have shown that shortening the length of the training does not impact the effectiveness of the program. Jang (2000) implemented the CPRT over four weeks with the parent group meeting twice per week for two hours, for a total of eight sessions. Jang found a significant increase in levels of empathic parental interactions and a significant reduction in parents' perception of children's behavioral problems. A condensed five-week model (Landreth & Lobaugh, 1998) found that participants increased empathic responses and their attitude of acceptance of their children and had a significant decrease in the perception of behavior problems in their children. In another study, a two session per week model, for five weeks, for a total of 10 sessions, was implemented with Israeli parents (Kidron & Landreth, 2010). The findings indicate that parents were better able to effectively communicate empathy to their children, decrease their level of parental stress, and facilitate change in their children's externalizing behavior problems. Ferrell (2003) compared the traditional model with a four-session weekend model and found that there were no significant differences on parental stress, parental empathy, parental acceptance, and child's behavior problems. Eardley (1978) shortened L. Guerney's (1964) filial therapy from six months to only 10 weeks. Eardley's model was more didactic than L. Guerney's model but was still an extensive investment of time for parents and continued to include a formal phase of clinical practice of the skills. A study with witnesses of

domestic violence and their mothers (Smith & Landreth, 2003) implemented 12 sessions over a two to three week period. They found that there was a significant reduction in behavior problems in children and a significant increase in their self-concept. In addition, mothers scored significantly higher after training on their attitudes of acceptance and their empathic behavior.

Harris and Landreth (1997) implemented a 5-week, 10-session model with children and their incarcerated mothers and found that problematic behaviors of children decreased and that there were improvements in parental empathy, acceptance, ability to communicate acceptance, and mothers' perception of children. Finally, Grskovic and Goetze (2008) had German mothers complete a filial training over a 2-week period with a total of eight sessions. They found a decrease in children's behavior problems and an increase in parental acceptance and empathy, positive attention, and educational competence for mothers.

Clearly the research shows that CPRT can be effective when administered under a different timeline than two-hour sessions once a week for 10 weeks, as was developed by Bratton et al. (2006). However, there is no research that considers modifications, other than timeline, to CPRT. The current study included the didactic information that was taught to parents in the traditional CPRT and taught it to parents while removing the experiential training which allowed for a much shorter time commitment from parents. The researcher examined the impact of a Two-session CPRT on parent's perception of children's problem behaviors, parental acceptance of child, and parental stress; and parental attitude, knowledge and skills. Thus this research extended the body of knowledge about the impact of CPRT on parents of children with ADHD and examined

the impact of a new modification in CPRT in an effort to reduce the dropout rate of participants.

Summary and Conclusions

This chapter provided an in-depth examination of the current literature relating to ADHD and filial therapy with attention to the outcome variables used in this research: parental perception of children's problem behaviors, parental acceptance of children, and parental stress; and parental attitudes, knowledge, and skills. This study added to the breadth of literature about CPRT and also focused on a population, children with ADHD, which has not been studied with CPRT. Chapter Three outlines the methodology used in conducting this research.

CHAPTER 3: METHODOLOGY

This chapter presents the methods that were used in the research study. In the first section, there is a description of how participants were recruited and selected. In the second section, the procedures for the study are discussed. In the third section, the instruments that were used are described. In the fourth section, the data analysis, which includes the study design and the statistical procedures that were used to analyze the results of the study, are explained. In the final section, a summary of the chapter is provided.

Participants

The participants in this study were the parents, guardians, or primary caretakers of children with Attention Deficit Hyperactivity Disorder (ADHD). The word "participants" and "parents" is used interchangeably. The participants were 60 parents of children in first through fifth grade who attended public schools and resided in Stanly County, North Carolina. The parents' reported that the children were diagnosed with ADHD/ADD (Attention Deficit Disorder) by a pediatrician, psychiatrist, psychologist, family physician or other professional.

Procedures

Prior to recruiting participants and collecting data, permission was obtained from the Institutional Review Board for Human Subjects of the University of North Carolina at Charlotte and the county school system. The researcher worked directly with the Director of Student Services in the School System to solicit participants from the 11 public elementary schools in the county.

A two-step dissemination process was developed and implemented to distribute flyers to each of the elementary schools. The marketing flyer was sent home in students' weekly folders by the individual classroom teachers. The completed flyer was returned to the school counselor's office by the individual classroom teachers at the respective schools and then sent through the school system courier service to the School System Central Office. Once the Director of Student Services collected the responses, the researcher picked them up.

Several alternative processes for collecting data were used. Parents could respond directly to the researcher by email, telephone or U.S. postal service and a few parents chose to do so. In addition, flyers were sent to the various agencies in the county including Boy Scouts, Girl Scouts, 4-H, United Way, pediatric offices, Department of Social Services, mental health agencies and private practices, Partnership for Children, and two private schools in the county.

Parents had two weeks to return the marketing flyer if interested in participating in the study. To ensure privacy, parents were asked to return the forms in an envelope with their signatures across the sealed flap. After the first week, a second flyer was sent to all potential participants via weekly folders. At the end of the two-week period, the researcher collected all marketing flyers that had been returned. Initial emails (or phone calls for families that did not have email) were sent the week before the training. The families who did not have email were called and had the information mailed to them. The email asked parents to confirm that they were able to participate and to let the researcher know how many children they would be bringing to the free childcare. The day before the

training, an additional email reminder was sent to families and each of the families received a phone call reminder.

Parents returned the flyer with their contact information on it and were then given the Informed Consent Form. Prior to participating in the study, parents were required to sign the Informed Consent Form. This form included the following information: the invitation to participate, the purpose of the research study, description of the Two-session Child Parent Relationship Training (CPRT); eligibility criteria; expectations of participants; confidentiality; procedures for maintaining confidentiality of research records, including information about the fact that the trainings would be videotaped; foreseeable risks; potential benefits; procedures for addressing questions about the study; review for protection of participants; and research participants' rights. The Informed Consent Form stated that participation was completely voluntary and confidential and that participants could stop at any time without penalty.

To determine eligibility for the study, parents were asked in the Informed Consent Form, "Has your child been diagnosed with ADHD/ADD by a pediatrician, psychiatrist, psychologist, family physician or other professional?" The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) defines both ADD and ADHD as ADHD. To avoid excluding parents who might not be aware of this classification, ADD and ADHD were used in correspondence. Only parents who responded 'yes' to this question were eligible to participate in the study. If parents responded 'no' to the eligibility requirement, they were invited to participate in the training along with the control group, which was offered when the intervention was completed and the final assessments were gathered from all participants. Only one parent per child with ADHD

was allowed to participate in the study unless the family had more than one child with ADHD. In that case, each parent focused on a different child. Parents were informed that the parent who completed the training should also be the one who completed all of the assessments related to that particular child for the study.

To protect the identity of the participants and their children, a participant code number was used to identify those parents who agreed to participate. The code was needed so that the pre-test and post-tests scores could be linked. This code was used to identify all participant information, including the demographic survey and questionnaires. All participant information was stored in a locked file cabinet in the researcher's home office and on a password protected file on the researcher's home computer.

Once the Informed Consent Forms were returned, parents were randomly assigned to the experimental or control groups. Before taking the initial assessments, parents were reminded that only one parent per child with ADHD would be allowed to participate in the study, and the parent completing the training should also be the one who completed all of the assessments related to the study.

Pre-tests

Once participants were randomly assigned to experimental (Time 1) and control (Time 2) groups, the experimental group was assigned to a training schedule. There were two training groups in the experimental group. The Vanderbilt Attention Deficit/Hyperactivity Disorder Parent Rating Scale (VADPRS) and demographic survey were administered to both experimental and control group participants before the experimental group began their training. The administration of the VADPRS and

demographic survey for each of the experimental training groups took place just before that group's first session.

Participants who were in the control group were emailed via Adobe Forms Central or mailed the informed consent, demographic survey and VADPRS and these control group participants were asked to respond within 48 hours. Adobe Forms Central allowed the researcher to create a web form that was emailed to the parents. The parents accessed the required forms via a web link and then submitted their responses. The researcher was then able to compile the responses and view the results. For parents who did not have access to email, the forms were mailed to them with a self-addressed stamped envelope enclosed so that they could return the forms to the researcher. Parents in the control group did not respond to the survey initially and after several email or telephone reminders, only about 50% had completed the VADPRS and demographic survey. At that point, the researcher called families and completed the rest of the assessments over the telephone except for one family that the researcher met with to do the assessments in person.

A script that included the instructions for completing each of the assessments was followed when administering the assessments at the pre- and post-test. For the pre-tests, the script was in written form for the control group that received the assessment by email and on paper. The script was read to the experimental group. For the post-test, all participants had the script read to them.

Training

Participants in the experimental group were assigned to two groups with 15 participants in each group. The primary investigator conducted the training at different

times and days to best accommodate the schedules of the parents. A few parents requested that they be allowed to move from one group to another based on scheduling needs and they were allowed to do so.

The participants attended 2 three-hour trainings (six hours of training) of the Two-session CPRT over a two-week period. These trainings were videotaped to enable assessment regarding the fidelity of the training program. If parents in the experimental group missed the first session, they were allowed to participate in the other experimental group's first training session. In addition, both experimental groups had the opportunity to participate in a make-up session for the first training session that was offered before the second training session. If parents in the first group missed their second session, they could attend the other group's second training session. Both groups also had the opportunity to attend a make-up session for the second training session during the week the training ended.

Child-care was provided during all of the training sessions, and many parents took advantage of this resource. The childcare provider(s) were available 15 minutes before the training started and for 15 minutes after the training ended. Parents were encouraged to bring their children early to allow them to become comfortable in the childcare room. There were snacks and drinks for the children as well as activities for them to do (e.g., crafts and age-appropriate movies).

Post-tests

The VADPRS was used as a pre-test and post-test and the other assessments as post-test only. The decreased amount of paperwork of only one pre-test required by parents supported retention by requiring less time from participants. Two weeks after

completion of the training by the experimental group, the experimental and control group parents met to complete the VADPRS, Porter Parental Acceptance Scale (PPAS), Parental Stress Scale (PSS), the Play Therapy Attitudes-Knowledge-Skills Scale (PTAKSS) and the Program Satisfaction Survey. The reason for waiting two weeks after the training was to allow time for the experimental group parents to assimilate the skills that they learned and assess their level of parental perception of children's problem behaviors; parental acceptance; parental stress; parental attitude, knowledge and skills of CCPT; and satisfaction with the program. Parents from the experimental and control groups met at the training site to complete the assessments and were provided free childcare while they did so. It took approximately 45 minutes to complete the assessments.

Following completion of all assessments by both the experimental and control groups, the control group began their first training session, along with any parents who expressed interest in the training but were not eligible for participation in the study. The training was offered over two weeks with 1 three-hour meeting per week. All of the assessments, except the pre-test of the VADPRS and the Demographic Survey with the control group, were administered by the researcher in a group setting. Upon receipt of the completed assessments, the names were redacted and replaced by the appropriate participant code. The data collection took place during June and July of 2013.

Instrumentation

The assessments in this study were: a Demographic Survey, VADPRS, PPAS, PSS, PTAKSS, and Program Satisfaction Survey. In addition, the Two-Session Modified CPRT Agenda was included. Each is described below.

Demographic Survey

The participants completed the Demographic Survey (see Appendix B) that included the following information: gender, age, grade level of child; ethnicity of the child; with whom the child lived; any parent training in the last year; who diagnosed the child with ADHD; and the person who would be attending the training and completing the assessments.

Vanderbilt Attention Deficit/Hyperactivity Disorder Parent Rating Scale (VADPRS)

The VADPRS (Wolraich et al., 2003; see Appendix E) has 55 items and is used to assess symptom assessment and impairment of performance at home, in school, and in social settings. This rating scale is widely used to screen for symptoms of ADHD, predominantly inattentive type; ADHD, predominantly hyperactive-impulsive type; ADHD, combined type; oppositional defiant disorder screen; conduct disorder screen; and the anxiety/depression screen in children ages 6–12. The VADPRS screens for the performance of the child academically and the child's classroom behavior and differentiates children diagnosed with ADHD from children in the general population. The VADPRS is a 4-point Likert scale for the first 47 items and then is a 5-point Likert scale for the last eight items. Items 1-18 and 48-55 of the VADPRS are used to determine if the children met the criteria for the DSM diagnosis. The assessment takes 10 minutes to complete and is available in paper-and-pencil or computerized format. The paper-and-pencil version was used for this study. The items 1-18 and 48-55 of the VADPRS were used in this study.

Norms for the VADPRS were based on a sample of 1,536 children, with 234 completing the entire study. An analysis comparing the VADPRS with the Vanderbilt

ADHD Diagnostic Teacher Rating Scale (VADTRS) and Computerized Diagnostic Interview Schedule for Children (CDIS-IV) using available samples, including teacher and parent ratings of clinical samples and a large screening sample of school children, showed internal consistency reliability of the VADPRS (Wolraich et al., 2003). In the seven studies, internal consistency reliability was between .90 and .95 (r = .90 - .95).

For item analysis, Wolraich et al. (2003) compared the VADPRS with the VADTRS and C-DISC-IV. Since the VADTRS and C-DISC-IV were instruments with established reliability and validity, a correlation of these instruments with the VADPRS supported reliability and validity of the VADPRS. When items on the VADPRS were compared with items on the VADTRS and C-DISC-IV, all items proved to be reliable. The correlations were similar to those on the teacher or parent ratings based on the C-DISC-IV. There was good reliability under a variety of conditions, including different respondents (parent and teacher), different methods (Vanderbilt checklists vs. C-DISC-IV interview), and different severities (ranging from the 4,582 children who did not have ADHD to the various clinical samples) (Wolraich et al., 2003). The VADPRS's internal consistency was acceptable and consistent with DSM-IV and accepted measures of ADHD such as the VADTRS and the C-DISC-IV.

Porter Parental Acceptance Scale (PPAS)

The PPAS (Porter, 1954; see Appendix F) is used to measure parents' perception of parent-child relationship as indicated by parents' feelings and the behavior parents expressed towards, with, or about their child. The PPAS is a 40 item self-report inventory on a 5-point Likert scale requiring approximately 20-30 minutes to complete. It consists of the following four sub-scales: respect for the child's feelings and the child's

right to express them; appreciation of the child's uniqueness; recognition of the child's need for autonomy and independence; and a parent's experience of unconditional love for a child. There are 40 items that measured parental acceptance. The assessment uses a multiple-choice format with five choices per question and is completed in 20 minutes. The possible range of scores is 40 to 200, with higher scores indicating higher levels of acceptance in the area for which the subscale is named. Porter (1954) reported a total score range of 87 to 187 and a mean of 139.86. However, there was no attempt to have a representative sample population in his study and the population in the study was more highly educated, higher socioeconomic, more predominately Protestant, and with a larger representative of rural areas than the true population. The total score was used in the current study.

The PPAS demonstrated reasonable internal consistency, acceptable test-retest reliability, concurrent and predictive validity and was not influenced by social desirability response set (Porter, 1954). Internal consistency was established through an item analysis which found that 39 of the 40 items discriminated between high and low scoring mothers and fathers. The reliability was established by using the split-half method (r = .77). The validity was established by agreement on all items by at least three out of five expert judges.

Parental Stress Scale (PSS)

The PSS (Berry & Jones, 1995; see Appendix G) is used to measure parental stress for both mothers and fathers and for parents of children with and without clinical problems. The PSS is a self-report scale with 18 items representing pleasure or positive themes of parenthood (emotional benefits, self-enrichment, and personal development)

and negative components (demands on resources, opportunity costs, and restrictions), used to assess parental stress for both mothers and fathers and for parents of children with and without clinical problems. Scores on the scale range from 18-90 with higher scores indicating greater stress for the parent. The PSS is used with parents of children ages 0-18 years old and takes approximately five minutes to complete. The PSS has 18 items, and each item uses a 5-point Likert-type scale with anchors of "strongly agree" to "strongly disagree."

Berry and Jones (1995) found a mean PSS score for mothers in the clinical group (behavior problems) of 43.2 while the mean for the mothers in the non-clinical sample was 37.1. The difference indicated that the PSS significantly differentiates between mothers of children who are receiving treatment for behavioral problems as compared to mothers of children who are not receiving treatment. This study used the total score to determine the impact of the intervention on the participants.

The PSS demonstrated satisfactory levels of internal reliability ((α = .83), and test-retest reliability (r =.81). The PSS showed satisfactory convergent validity with various measures of stress, emotion, and role satisfaction, including perceived stress, work/family stress, loneliness, anxiety, guilt, marital satisfaction, marital commitment, job satisfaction, and social support (Berry & Jones, 1995). Validity was measured by comparison with the Perceived Stress Scale and the Parental Stress Index. Discriminant analyses demonstrated the ability of the scale to discriminate between parents of typically developing children and parents of children with both developmental and behavioral problems.

Play Therapy Attitude-Knowledge-Skills Survey (PTAKSS)

The PTAKSS was developed to gain an understanding of the process of CCPT training and explore the impact of CCPT training on counselor trainees' in "(a) improving positive attitudes and beliefs toward children, (b) improving play therapy knowledge, (c) improving confidence in applying play therapy skills, (d) reducing dominance tendencies in trainees, and (e) increasing intellectual efficiency in trainees" (Kao & Landreth, 1997, p. 3). Since the survey was originally designed to measure students' attitudes, knowledge and skills about CCPT, determining its usefulness when assessing parents' attitudes, knowledge and skills is a contribution to the play and filial therapy research.

The PTAKSS (Brown, C. J., 2000, Kao & Landreth, 1997; see Appendix H) takes approximately 15 minutes to complete and is an 80-item self-administered instrument consisting of three subscales, on a 5-point Likert scale with five indicating high agreement or ability and one indicating low agreement or ability. Items 1-33 measure the attitude scale, questions 34- 54 measure the knowledge scale, and questions 55-80 measure the skills scale. The scoring for items, #5, 13, 17, 20, 22, 23, 26, 28, 29, 31, 33, 34, 35, 36, 37, 38, 39, 42, had to be reversed at the Likert scale because a low score was the preferred answer. The attitude subscale contains items that reflect the beliefs and interaction patterns trainees are expected to learn in the training. The knowledge subscale contains items reflecting what trainees should know as a result of the training. The skills subscale demonstrates the degree of trainee confidence in using the skills. There are four different scores for the PTAKSS including the total score, the attitude

score, the knowledge score and the skills score. The score for each of the subscales was used in this study.

Reliability coefficients (Cronbach's alpha) for the PTAKSS were total scale (r = .98), attitude scale (r = .73), knowledge scale (r = .94), and skill scale (r = .99). A criterion validity test was calculated by using correlation coefficients (number of graduate play therapy courses each participant had and total score on the PTAKSS). The correlation coefficients were total scale .70 ($p < .001$), attitude scale .34 ($p < .001$), knowledge scale .71 ($p < .001$), and skill scale .68 ($p < .001$).

Program Satisfaction Survey

The Program Satisfaction Survey (see Appendix D) was used to measure parent satisfaction with the Two-session CPRT. It has six questions including a section for comments. The first four questions are on a 5-point Likert scale, ranging from strongly disagree to strongly agree. The remaining questions ask for specific feedback. It takes approximately five minutes to complete. Parents completed the survey immediately following the second training session.

Two-Session Child Parent Relationship Training Agenda

The Two-Session CPRT Agenda (see Appendix I) outlines all of the information that was included in the training. Each of the CPRT skills was explained, demonstrated, and parents had the opportunity to practice. The skills that were taught were reflective responding, limit-setting, choice-giving, returning responsibility, self-esteem building, encouragement versus praise, and responding to effort. The training also included the ‘rules of thumb’ and ‘be with’ attitudes which are an integral part of the traditional CPRT. The proposed model did not include participants taping play sessions or have

group supervision of the sessions; however, it still taught the skills, modeled the skills and allowed participants to practice the skills.

Prior to beginning the study, a pilot study was completed and videotaped. The pilot study was reviewed by Dr. Phyllis Post (Dissertation Chair) to verify that the protocol was followed. Dr. Post used the CPRT Therapist Skills Checklist (Bratton et al., 2006; See Appendix J) to evaluate the videotapes of the session. The form was adapted by adding 'allowed time to practice and process skills'. The following recommendations were made for the study trainings: work on being concise, make sure to go through four steps with each skill (tell, show, remember, role play), balance didactic with experiential, stay in teaching role instead of counseling role, do not make promises about results, use PowerPoint instead of hard-copy notes. Dr. Post determined that the content for the training was presented in its entirety.

The pilot study was completed with one mother in the community. After the training was completed, the researcher asked the parent for feedback on the process. The parent was asked to share any concerns she had about the training, what was difficult to her, what she would have liked presented in a different way and what she liked about the training. When talking with the parent at the end of the training, she expressed that she was very intimidated and felt awkward doing role-plays. She suggested that this might be easier if there were other parents present who were also struggling. The parent also completed the Program Satisfaction Survey that would be completed by the parents who participated in the study. On the survey, the parent strongly agreed that the training gave her information that improved her parenting skills and relationships in her family. She agreed that her communication with her children had improved and that she would

recommend the training to a friend. She stated that the most important thing she learned in the training was the parent's response in the situation is important.

The feedback received was reviewed and utilized to improve the training before beginning the study. Some of the feedback issues were resolved as a result of having a group in the training instead of the one parent doing the pilot study. The parent in the pilot study was uncomfortable and embarrassed about her son's behavior and was concerned that the researcher would think that she was a bad parent. Because of her experience, the researcher was more aware during the training to encourage parents and remind them that no parent is perfect and that everyone in the group struggles with parenting, particularly with their child who has ADHD. In addition, the parents received more encouragement to feel secure and accepted in order to share their parenting experiences and to be open to trying the new skills with the other parents in the training. As a result, the researcher incorporated more experiential activities, such as stories and a 'color your heart' activity in the intervention. These activities allowed parents to begin talking with each other and allowed the researcher to reinforce that many parents struggle and sometimes have negative feelings towards their children. As the researcher considered changes to make based on the pilot study, the researcher considered the flow of the training which went well for most of the pilot training. However, the researcher did cover material out of order because the mother asked questions that related to another skill. Therefore, with the group intervention, the researcher was mindful to address participants' concerns and questions without disrupting the flow of the training. With a limited amount of training time, the researcher had to maintain focus and assist the group in doing so as well.

To ensure fidelity of the protocol during the study, the training was videotaped and reviewed by Dr. Post. Each time the training was reviewed via videotape, Dr. Post completed a checklist (Appendix J), which included all of the skills from the traditional model of CPRT. Dr. Post verified that the training included all of the elements that were included in the training agenda (see Appendix I). The parent and child participants were not identified in these discussions ensuring fidelity.

Data Analysis

Descriptive statistics, gathered through the demographic survey, were used to describe the gender, age, grade level of child, ethnicity of the child, and with whom the child lives of the participants who took part in the study. This study's research design was an experimental quantitative design with an experimental and control group. G*power was used for a power analysis and determined the sample size of 60 parents for the study. The participants were randomly assigned with the experimental group receiving treatment and the control group not receiving treatment.

For the purposes of statistical analysis, all data were entered and analyzed by the researcher using a statistical computer program, Statistical Program for the Social Sciences (SPSS; IBM, 2013). Both descriptive and inferential statistics were used to analyze the data collected from the participants in the study. Because the assumption of homogeneity of regression li was violated, independent t-tests were performed on each of the dependent variables. A two-way ANOVA with one between subjects and one within subjects effects was used to examine differences between the experimental and control groups on the VADPRS pre-test and post-test. An alpha level of .05 was established as a significance criterion for all tests.

Summary

The purpose of this chapter was to provide the methodological framework that was used in this research study. The sections within this chapter described the participants, procedures, instrumentation, and data analysis.

CHAPTER 4: RESULTS

The purpose of this study was to assess the impact of a Two-session Child Parent Relationship Training (CPRT) on parental perception of children's problem behaviors; parental acceptance of child; parental stress; and parental attitudes, parental knowledge and parental skills about child-centered play therapy. Parents were randomly assigned to either the experimental group that received the training or the control group that did not receive the training. This chapter presents the findings. The first section provides a description of the sample population. The second section presents the results of the data analyses.

Description of Participants

All of the parents of children in first through fifth grades in the county, a total of 4,046, were invited to participate in the research study. However, only children with Attention-Deficit Hyperactivity Disorder (ADHD) were eligible for the study. Given that approximately 3-7% (American Psychiatric Association [APA], 2000) of children were diagnosed with ADHD, there was a potential sample of 121-283 children.

Ninety-four parents responded to the information flyer that was sent home. Of the 94 responses, 14 of the parents did not complete the initial paperwork. The remaining 82 parents were randomly assigned to the experimental and control groups, with 41 parents in each group. Out of the 82 parents that were assigned to either the experimental or control group, seven parents completed only the pre-tests and the first session of the

Two-session CPRT, and 13 parents completed only the pre-tests. When the VADPRS pre-tests from the 20 parents who did not complete the process were analyzed, the scores (M = 86.30; SD = 19.30) were not significantly different from the scores (M = 88.00; SD = 24.10) of the parents who did complete the study (t=.72, p=.47). Therefore, the attrition was not caused by the intervention. In the experimental group, 31 of the 41 parents completed the Two-session CPRT and all of the assessments. In the control group, 29 of the 41 parents completed the Two-session CPRT and all of the assessments. Depending on the true percentage (between 3-7 %) of children with ADHD, the return rate for this study was between 21% and 49%. However, 73% of the 82 parents who were randomly assigned to the experimental and control groups completed the Two-session CPRT, yielding a dropout rate of 27%.

As reported in Table 1, of the parents who completed the assessments, 29% (n = 9) of the parents in the experimental group and 34% (n = 10) in the control group were the father of the child, while 71% (n = 22) of the parents in the experimental group and 66% (n = 19) in the control group were the mother of the child. The majority of participants in both of the groups were mothers. None of the parents had completed a parent training within the last 12 months. As reported in Table 1, in response to the question about who diagnosed the child with ADHD, both the experimental and control groups had a majority of children diagnosed by a psychologist; however, the control group also had a large percentage diagnosed by a pediatrician.

Table 1: Demographic characteristics of parents

	Experimental (n = 31)		Control (n = 29)	
Characteristic	Frequency	Percentage	Frequency	Percentage
Gender				
Male	9	29	10	34
Female	22	71	19	66
ADHD Diagnosis				
Family Physician			1	3.45
Psychiatrist	4	12.90	3	10.34
Pediatrician	3	9.68	9	31.03
Psychologist	20	64.52	13	44.83
Other	4	12.90	3	10.34

With regard to the demographic characteristics of the children of focus, the children were between the ages of five and 11 years old. Although the modal grade level was 3rd for the experimental group and 2nd for the control group, the mean age of children in the experimental group was 7.55 years with a standard deviation of 1.89, and the mean age of children in the experimental group was 7.52 years with a standard deviation of 1.80. This indicates that there was no meaningful difference between the children in the experimental and control groups.

As reported in Table 2, the gender distribution of child of focus in the experimental group was 61% (n = 19) boys and 39% (n = 12) girls, and the control group was composed of 62% (n = 18) boys and 38% (n = 11) girls. There were more boys in both the experimental and control groups. With regard to ethnicity, in the experimental group, most children were reported to be White, with the remainder Multi-racial. In the control group, the majority of children was reported as White with the remainder African American or Multi-racial. The high percentage of multi-racial participants in the

experimental group may be from word-of-mouth during the recruiting process. There were no children reported as Asian/Pacific Islander, Hispanic/Latino or Other. Several Hispanic/Latino parents were interested in participating, but were not able to because they did not speak English.

Table 2: Demographic characteristics of children of focus

	Experimental Group		Control Group	
Characteristic	Frequency	Percentage	Frequency	Percentage
Gender				
Male	19	61	18	62
Female	12	39	11	38
Grade				
K	6	19.35	2	6.90
1	4	12.90	7	24.14
2	3	9.68	10	34.38
3	10	32.26	0	0
4	5	16.13	3	10.34
5	1	3.23	6	20.69
6	2	6.45	1	3.45
Race/Ethnicity				
African American	0	0	3	10.34
White	23	74.19	24	82.76
Multi-racial	8	25.81	2	6.90
Asian/Pacific Islander	0	0	0	0
Hispanic/Latino	0	0	0	0
Other	0	0	0	0

Results

The purpose of this study was to assess the impact of a Two-session CPRT on parental perception of children's problem behaviors; parental acceptance of child;

parental stress; and parental attitudes, parental knowledge and parental skills about child-centered play therapy.

Data Collection Anomaly

A mistake was made during data collection that prohibited reporting on parental skills. The researcher intended to use the PTAKSS-R (Kao & Change, 2007) but inadvertently used the first 54 questions out of 80 questions on the PTAKSS (Kao & Landreth, 1997), which was also used by Brown (2000). In the version used by Brown (2000), the first 33 items measured the attitude scale, the items 34-54 measured the knowledge scale, and items 55-80 measured the skills scale. The skills scale was not administered, so data were not collected on that variable.

Reported in Table 3 are the range of scores, means, standard deviations, and effect sizes as measured with Cohen's *d* (i.e., standardized difference between experimental and control conditions) of parent ratings, in the experimental and control group, on parental perception of children's problem behaviors; parental acceptance of child; parental stress; and parental attitudes, and knowledge about child-centered play therapy.

Table 3: Range of scores, means, and standard deviations of dependent variables for the experimental and control groups

	Range of Scores	Pretest		Posttest		
		M	SD	M	SD	Effect Size
Parental Perception of Child's Problem Behaviors						
Experimental	0-181	93.65	18.88	82.32	26.57	.17
Control		81.97	27.65	77.07	23.74	
Parental Acceptance						
Experimental	40-200			138.26	15.25	.21
Control				135.69	12.33	
Parental Stress						
Experimental	18-90			44.29	8.45	-.40
Control				49.07	12.07	
Parental Attitude						
Experimental				3.46	.267	.01
Control				3.42	.184	
Parental Knowledge						
Experimental				3.51	.472	.41
Control				2.75	.450	

Participants completed the Vanderbilt Attention Deficit/Hyperactivity Disorder Parent Rating Scale (VADPRS) as a pre-test and post-test, and the other assessments were completed as post-test only. The rationale for this process was to decrease the amount of paperwork required by parents and thus increase retention. Prior to conducting the major analysis, the data were screened for missing values, outliers, and normality. There were no missing values and no outliers were detected. All skewness values were less than the absolute value of 1.0. This would suggest that normality was tenable.

A correlation coefficient was used to examine the relationship between the pre-test and the dependent variables. The significant correlations were between the pre-VADPRS and post-VADPRS ($r = .715$, $p < .01$) and the pre-VADPRS and parental stress ($r = .45$, $p < .01$). There was no significant relationship between the pre-VADPRS and parental acceptance ($r = -.029$, $p < .41$), pre-VADPRS and parental attitude, ($r = .061$, $p < .322$), and pre-VADPRS and parental knowledge ($r = .208$, $p < .055$). Because the assumption of homogeneity of regression lines was violated, it was determined that *t*-tests would be computed on each of the variables to determine differences between the experimental and control groups. The results of the analysis for each of the questions are presented below.

Question 1: What is the impact of the Two-session CPRT with parents' of children with ADHD on parental perception of children's problem behaviors between the experimental and control group from pre-test to post-test? A two-way ANOVA with one between subjects and one within subjects effects was used to examine differences between the experimental and control groups on the Vanderbilt pre-test and post-test. The statistical test of interest for examining this research question is the interaction. The assumption of equality of covariance matrices (Box's $M = 8.09$, $p > .05$) was satisfied. There was a statistically significant within subject effect $F(1, 58) = 11.56$, $p < .001$, $\eta^2 = .16$) but the interaction $F(1, 58) = 1.81$, $p = .183$, $\eta^2 = .03$) was not statistically significant. There was not a statistically significant between subjects effect ($F(1, 58) = 2.105$, $p = .152$, $\eta^2 = .04$). While both groups improved, there was not a significant interaction. Therefore the treatment had no impact on parental perception of children's problem behaviors.

Question 2: What is the impact of the Two-session CPRT with parents' of children with ADHD on parental acceptance of child as compared to the control group? The potential range of scores on parental acceptance was 40 to 200. The means and standard deviations of the experimental (M = 138.26; SD = 15.25) and control groups (M = 135.69; SD = 12.33) are shown in Table 3. An independent t-test was performed to compare the means of the two groups. The equality of variances was satisfied (Levene's test, F = 1.417, p = .239). There was no difference in the mean scores for the experimental group and control group t(.05, 58) = .714, p = .239) indicating that the Two-session CPRT intervention did not have a significant impact on parental acceptance.

Question 3: What is the impact of the Two-session CPRT with parents' of children with ADHD on parental stress as compared to the control group? The total possible score on parental stress was between 18 and 90. The larger the mean, the more stress the parents indicated having in relation to their role as a parent. The means and standard deviations of the experimental (M = 44.29; SD = 8.45) and control groups (M = 49.07; SD = 12.07) are shown in Table 3. An independent t-test was performed to compare the means of the two groups. The equality of variances was not satisfied (Levene's test, F = 7.94, p = .007). There was a significant difference in the mean scores for the experimental group and control group t(.05, 49.79) = 1.765, p = .042) indicating that the Two-session CPRT intervention did have a significant impact on parental stress.

Question 4: What is the impact of the Two-session CPRT with parents' of children with ADHD on parental attitudes about child centered play therapy as compared to the control group? The means and standard deviations of the experimental (M = 3.46; SD = .267) and control groups (M = 3.43; SD = .185) are shown in Table 3. An

independent t-test was performed to compare the means of the two groups. The equality of variances was satisfied (Levene's test, $F = 3.796$, $p = .056$). There was no difference in the mean scores for the experimental group and control group $t(.05, 58) = .535$, $p = .2975$) indicating that the Two-session CPRT intervention did not have a significant impact on parental attitudes about CCPT.

Question 5: What is the impact of the Two-session CPRT with parents' of children with ADHD on parental knowledge about child-centered play therapy as compared to the control group? The means and standard deviations of the experimental ($M = 3.51$; $SD = .472$) and control groups ($M = 2.75$; $SD = .450$) are shown in Table 3. An independent t-test was performed to compare the means of the two groups. The equality of variances was not satisfied (Levene's test, $F = .081$, $p = .777$). There was a significant difference in the mean scores for the experimental group and control group $t(.05, 57.975) = 6.326$, $p < .01$) indicating that the Two-session CPRT intervention did have a significant impact on parental knowledge about child-centered play therapy.

Summary

This chapter presented the results of the study. The first section included a description of the 60 participants and their children. The majority of the parents who participated in the study were white females, and the majority of children in the study were seven year old white males. The diagnosis of ADHD was made predominantly by psychologists. The second section presented the initial analysis of the data including the means and standard deviations as well as the statistical analysis that compared the experimental and control groups.

The results of the repeated measures and independent *t*-tests were reported and each hypothesis was tested. While both groups improved on parental perception of children's problem, there was not a significant interaction. Therefore this suggests that the treatment had no impact on parental perception of children's problem behaviors. The statistical analyses found no differences between the experimental and control groups with regard to parental acceptance of child and parental attitudes about CCPT. There were differences between the experimental and control groups with regard to parental stress and parental knowledge, such that parents in the experimental group reported lower levels of stress and more play therapy knowledge than the parents in the control group. In Chapter 5, a discussion of the results, contributions, limitations of the study, implications of the findings, as well as recommendations for future research are presented.

CHAPTER 5: SUMMARY

This study assessed the impact of a modified version of Child Parent Relationship Training (CPRT) on the parents of children with Attention Deficit Hyperactivity Disorder (ADHD). Specifically, the study addressed whether or not the parent training impacted parental perception of children's problem behaviors; parental acceptance of child; and play therapy attitudes and play therapy knowledge of the experimental group when compared with the control group who did not receive the parent training. This chapter discusses the results of the study. It is divided into several sections including the overview of study, results and conclusions, contributions of the study, limitations of the study, implications of the findings, recommendations for future research, parent comments, and concluding remarks.

Overview of Study

This purpose of this study was to assess the impact of a modified Two-session CPRT on the parents of children with ADHD. Currently, there is a large body of research on the effectiveness of the traditional model of CPRT (Carnes-Holt, 2011; Ceballos & Bratton, 2010; Kidron & Landreth, 2010; Lee & Landreth, 2003; Sheely-Moore & Bratton, 2010; Smith & Landreth, 2004). The research has shown that the traditional model of CPRT increases parental acceptance, decreases parental stress and decreases parental perception of child's problem behaviors. Numerous studies have utilized the Play Therapy Attitudes-Knowledge-Skills Scale (PTAKSS) with graduate students (Kao

& Landreth, 1997), school counselors and teachers in Israel (Kagan & Landreth, 2009), and school counselors in the United States (Pereira & Smith-Adcock, 2013). This body of research has shown that child-centered play therapy (CCPT) training increased play therapy attitudes, play therapy knowledge, and perception of play therapy skills of students and professionals.

Although the traditional 10 week, two-hours/week model of CPRT has been found to be effective, as stated above, a major obstacle to parent participation is the time required. Parenting children with special needs requires even more time and energy, so creating effective resources to assist these families is critical to providing the best opportunities for their children to success. Thus, a modified 2 three-hour sessions CPRT was developed for this study. The researcher invited the parents of children in first through fifth grade who had a child diagnosed with ADHD, and resided in the county in North Carolina to participate in the study.

Of the 94 parents who responded to the initial information, 60 parents completed the training and assessments, yielding a retention rate of 73% which is comparable to studies using the traditional model of CPRT (Carnes-Holt, 2011; Ceballos & Bratton, 2010; Sheely-Moore & Bratton, 2010). Studies of retention in filial studies have shown retention rates between 58-100% (Kazdin & Mazurick, 1994) and 51% (Topham and Wampler, 2008). Recent CPRT studies using a random sample had retention rates of 74% (Sheely-Moore & Bratton, 2010) and 77% (Ceballos & Bratton, 2010). The current research demonstrated a similar retention rate as previous research regarding the impact of filial therapy.

In this study, there were some differences in information taught compared to the traditional CPRT. The modified version included the major teaching points from the traditional model but did not include home play sessions or supervision of play sessions. Because parents were not taught to have play sessions at home, there was no need to address some of the areas of the traditional training such as choosing toys for the playroom, preparing for a play session, and understanding play themes.

The results of this research indicate that parents who participated in the training, compared to non-participants, showed less parental stress and more parental knowledge of CCPT. However, participants in the program did not show a difference in parental perception of children's problem behaviors, parental acceptance of child, or parental attitudes about play therapy.

Results and Conclusions

This section discusses the results of the data analysis including both the description of the participants and the impact of the modified training of CPRT on the parents of children with ADHD. The research questions addressed whether the parent training impacted parental perception of children's problem behaviors; parental acceptance of child; parental stress; and play therapy attitudes and knowledge about CCPT of the experimental group compared to a control group that did not receive the parent training. Another limitation is that a modified training, Two-session CPRT, was used with a new population, children with ADHD. It is difficult to determine how much the results were impacted by the introduction of a new population and how much the results were impacted by the introduction of a modified training.

A main difference in the traditional model and the Two-session CPRT is that the parents practiced the skills in a controlled setting rather than between sessions in their homes with their children. In addition, because the training was over a shorter time period, there was not as much time for the parents to build a stronger relationship with their child and change their attitudes about their child. It is recommended that additional activities such as the sandwich hug be added to the training to encourage relationship building between the parent and child. Because this population had significant findings, it is possible that the power of the Two-session model is stronger than demonstrated in this study. It is possible that there would have been more change in the variables if the children had not had ADHD.

In this study, the majority of participants in the experimental and control groups were mothers with 71% (n = 22) of the parents in the experimental group and 66% (n = 19) in the control group. This study was similar to earlier studies in that the majority of participants were mothers including Chau and Landreth (1997) with 81% mothers and 19% fathers, Grskovic and Goetze (2008) with 100% mothers, and Glazer-Waldman, Zimmerman, Landreth, and Norton (1992) with 83% mothers and 17% fathers. What is noteworthy is that this study had a higher percentage of fathers than previous studies. Traditionally, mothers are more available for training than fathers. The results of greater participation by fathers in this study may be because the modified version of the training that required only two training sessions made it more accessible to fathers that the traditional model.

The mean age of the children was 7.55 for the experimental group and 7.52 for the control group. In Ray, Bratton, Rhine and Jones' meta-analysis study (2001), 28

studies were analyzed and a mean age of 6.8 years was found out of 768 subjects. The current study had a similar mean age of the children who participated in the study.

The current study had 61% male children in the experimental group and 62% of male children in the control group. Previous research also reports more males than females. For example, Grskovic and Goetze (2008) reported 55% males and 45% females, and Harris and Landreth (1997) reported 53% males and 47% females. The current study had a slightly higher percentage of males than previous studies. The fact that more male children are diagnosed with ADHD and exhibit ADHD behaviors may explain the higher percentage of males in this study.

Because this study focused on children with ADHD, parents reported who had diagnosed their child with ADHD. For the total sample, parents reported that the majority of the children were diagnosed by psychologists (65% for the experimental group, 45% for the control group) and pediatricians (31% for the experimental group, 10% for the control group).

To date, while there were no studies looking at the impact of CPRT on ADHD, there were several that considered the impact of CCPT on ADHD. In the CCPT studies, several definitions were used to determine the participants in the study including that the child was diagnosed by a licensed psychiatrist (Blinn, 1999), children were identified and diagnosed in counseling clinics (Naderi, Heidarie, Bouron, & Asgari, 2010), teachers identified students who exhibited attention problems and hyperactivity in the classroom (Ray, Schottelkorb, & Tsai, 2007) and children were identified as borderline or clinical in the ADHD categories by teachers completing a Teacher Report Form and the Conners' Teacher Rating Scale-R Short Form (Schottelkorb & Ray, 2009). It is difficult to

compare studies because researchers have used different ways of determining eligibility of participants. This needs to be addressed in future research.

With regard to ethnicity, Ray et al. (2001) compiled information on 28 filial studies and found that ethnicity was not reported in the majority of studies. Many studies of filial therapy focused on a particular population. In the current study, ethnicity was reported and the majority of children in the experimental group (74.19%) and control group (82.76%) were white with the rest being either African American or multi-racial.

To summarize, the participants in this study were mostly mothers, although there were more fathers than in earlier studies. Most of the children were male and white, with the mean age of about 7.5 which is similar to other studies. Most of the children were diagnosed with ADHD by psychiatrists or pediatricians. The next section addresses each of the five questions.

The first question addressed whether parents in the experimental group would change in their perception of children's problem behaviors, as indicated by a decrease in the total score on items 1-18 and 48-55 of the Vanderbilt Attention Deficit/Hyperactivity Disorder Parent Rating Scale (VADPRS) from pre-test to post-test compared to parents in the control group. The data analysis indicated there was no difference in parental perception of children's behavior of the experimental and control groups. Thus, the findings of this study did not support earlier research demonstrating that CPRT training had an impact on parental perception of children's problem behaviors (Bratton & Landreth, 1995; Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Yuen, Landreth, & Baggerly, 2002). There are several possible explanations for this. Because this study focused on children who had been diagnosed with ADHD, the VADPRS was

chosen to measure parent's perception of children's problem behaviors as it specifically focused on ADHD behavioral characteristics. There may not have been a change because the instrument was designed to diagnose ADHD, not to measure changes. Another possible explanation is that the time period between administering the pre and post-tests was too short to discern changes.

Nevertheless, the VADPRS does introduce a valid and reliable instrument to this area of study. Use of this assessment may be helpful to future researchers as they reach out to parents with children who have been diagnosed with ADHD because many parents are familiar with the VADPRS. Several of the instruments previously used when considering changes in parental perception of children's problem behaviors include the Child Behavior Checklist (CBCL; Ceballos & Bratton, 2010; Sheely-Moore & Bratton, 2010), the Social Skills Rating Scale (SSRS; Kascsak, 2012) and the Behavior Assessment System for Children (BASC; Garza, 2005). Utilizing these instruments that other studies have used would allow for easier comparison of results and could be a focus of future research.

The second question addressed whether parents in the experimental group would report higher parental acceptance of child, as indicated by total score on the Porter Parental Acceptance Scale (PPAS), compared to parents in the control group. The findings showed no difference in level of parental acceptance of parents of children in the experimental and control groups. These findings differed from many studies utilizing the traditional model in which significant differences in parental acceptance were found (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth,

2003; Tew et al, 2002; Yuen, 1997). One possible explanation for the lack of significance in the current study is that social desirability resulted in parents expressing high acceptance of their children. Parents of children with ADHD experience high levels of frustration and anger at their children because of the behavioral issues that their children exhibit, and may, consciously or unconsciously, report higher levels of acceptance than they feel. While this issue is outside of the scope of this research, it emerged as an area that needs consideration with parents of children with ADHD. Another possible explanation for the findings is that parents felt uncomfortable about their part in the diagnosis of their children and with them completing the assessments in a group setting, parents may have feared other parents would think less of them if they shared their real feelings about their child. Although this is outside of the scope of this project, it did emerge as an area that needs consideration.

The third question addressed whether parents in the experimental group would report less stress, as indicated by total score on the Parental Stress Scale (PSS), compared to parents in the control group. Parents in the experimental group reported less stress than parents in the control group which is consistent with research outcomes using the traditional CPRT model (Bratton & Landreth, 1995; Carnes-Holt, 2011; Ceballos & Bratton, 2010; Chau & Landreth, 1997; Costas & Landreth, 1999; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Kidron & Landreth, 2010; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Sheely-Moore & Bratton, 2010; Tew et al., 2002; Yuen et al., 2002). In the above studies of the traditional model, the Parental Stress Index (PSI; Achenbach & Edlebrock, 1983) was utilized. Although the results of this study were similar to studies of the traditional model, it is possible that parental stress

decreased because of the group process. In the group process, parents are supportive of each other and normalize their experiences. For this study, the Parental Stress Scale (PSS; Berry & Jones, 1995) was used to measure parental stress because it was shorter, was free, and was easy for parents to understand but still showed strong reliability and validity. This finding, using a different assessment, adds to the body of research that CPRT reduces parental stress and offers another option for an assessment that can be used. This finding is encouraging and provides support for use of the modified CPRT to support parents struggling with managing parental stress.

The fourth question addressed whether parents in the experimental group would report more positive attitudes about CCPT, as indicated by higher scores on the attitudes subscale on the PTAKSS, compared to parents in the control group. In this study, parents in the experimental group reported no difference in attitude about CCPT than parents in the control group. Kagan and Landreth (2009) considered the impact of short-term intensive CCPT training, 15 hours in two days, on teachers and school counselors in Israel and found that they did not show a significant increase in positive play therapy attitudes. However, Crane and Brown (2003) found that undergraduate students in a human services course scored higher on positive play therapy attitudes than students who were not in the course. In addition, Homeyer and Rae (1998) had participants complete either a 3-week, 5-week or 15-week play therapy course. The students' scores on all three scales of the PTAKSS increased except for the attitude scale for the 5-week class. Another study (Lindo et al., 2012) also found all three scales significantly increased after completing a play therapy course.

Although there is some disparity in the results of studies utilizing the PTAKSS in terms of differences in play therapy attitudes between the experimental and control groups, it appears that in some other formats of CPRT training, participants also had no differences in attitudes about play therapy. Except for the three week training, the trainings that were over a shorter time span were the ones that did not show a change in positive play therapy attitudes. It may be that completing the training over a shorter time span decreases the participants' ability to shift their attitude about play therapy.

The fifth question addressed whether parents in the experimental group would report more knowledge about CCPT, as indicated by a higher score on the knowledge subscale on the PTAKSS compared to parents in the control group. The result was that the experimental group reported more parental knowledge about CCPT than the control group. These findings are similar to an earlier study that found that teachers and school counselors in Israel were able to increase play therapy knowledge as a result of training (Kagan & Landreth, 2009). In addition, studies with undergraduate and graduate students have shown an increase in knowledge after completion of a course in play therapy (Crane & Brown, 2003; Homeyer & Rae, 1998; Lindo et al., 2012). This finding is encouraging and provides support for use of the modified CPRT to support parents in their struggle to meet their children's needs.

Parent Comments

Parents who participated in the training were asked to complete a brief survey about their experience (See Appendix D). The comments indicated that the training was helpful and made an impact on the lives of the 60 families who participated. For example, one mother said, "I think using these techniques will help better me and my

children in the long run." Throughout the training, parents reported that they were using the skills they were learning and were pleased with the response from their children. Many parents expressed appreciation for the information that they learned during the training as indicated by another mother's comment, "This was excellent. Every parent should be required to take this course." One parent summed up the experience when she said, "I learned how to help my children become responsible, self-controlled adults with healthy self-esteem and able to make their own choices".

Many parents commented on how critical providing child care was to their ability to participate in the training. Also, the VADPRS was used to assess parent's perception of children's behavior, and parents reported that this was reassuring and helped to ease the initial stress related to participating in the training because many parents were familiar with the assessment.

Contributions of the Study

A major contribution of this study is that it assessed the impact of a Two-session CPRT using a random sample of parents of children with ADHD. After completing this modified version of CPRT, parents in the experimental group reported less stress and more knowledge about CCPT. This finding supports that a shorter model can be effective using the same variables as in past studies. Many clinicians do not provide any parent training because providing the traditional model of CPRT requires more in terms of time and financial commitment than many families can afford. Particularly with the restricted number of sessions that insurance companies allow, having an alternative model that is conducive to the schedules of families and the mental health professional and allows for a need to be met that has not been met previously in many communities, is vital. This

model was more accessible to fathers than the traditional model, as exhibited by the fact that more fathers participated than in earlier research. Finding a model that is conducive to fathers was a much needed contribution to the CPRT body of literature.

This was the first known study to consider the impact of CPRT with parents' of children with ADHD. With the continued rise in diagnoses of children with ADHD, it is important that more resources are available for parents and their children. Given that this study showed a decrease in parental stress and an increase in parental knowledge for participants, this Two-session CPRT shows great promise for helping the parents of ADHD children.

Another contribution of this study is that it identified who had made the ADHD diagnoses. With so many children being diagnosed with ADHD, it is helpful to know who is making the diagnoses so that the model can be made accessible to professionals working with children with ADHD. This study also pinpointed the professionals who were not making ADHD diagnoses which provides the opportunity to share information with them to allow them to better serve their patients.

Another contribution is that this study was the first use of the VADPRS, which assesses the behaviors of children with ADHD, in the CPRT literature. In particular, as researchers consider ADHD, the VADPRS is a useful tool that is recognized by parents, is free, and has been used extensively in the ADHD research community. While many past studies have utilized a general assessment to assess for behaviors, this study used an assessment specifically for the population being studied.

An additional contribution of this study is that it reported the ethnicity of the children. This has not been common in the literature. While this study did not consider

the relationship between ethnicity and the dependent variables, collecting this information is important for future research.

Another contribution of this study is that the Parental Stress Scale (PSS) was introduced as an assessment to measure parental stress of parents of children with ADHD. The PSS had consistent results with previous research, was free, and required less time by parents. As a more recently developed instrument for assessing parental stress, this study added to the literature, thus supporting the efficacy of the assessment.

Limitations of the Study

This section addresses the limitations that may have impacted the generalizability of the study. One limitation of the study is its structure. Parents in the experimental group had only two weeks between completing the training and completing the post-tests. In previous studies of the traditional model, participants were post-tested after a longer period of time. It may be that some variables did not show significant change because the participants did not have time to assimilate the information they had learned, apply it to their lives and begin to see positive results.

Another limitation of this study is that parents reported who diagnosed their child with ADHD. Parents were asked to report an official medical diagnosis for their child and may not have had an official diagnosis. In addition, there was self-report by parents on each of the assessments. When using self-report, the researcher has no way of knowing if the parents' perception was different than the actual behaviors. Although self-reporting may limit the findings, most studies also used self-report because of the difficulty of obtaining medical records.

Although attrition in this student was similar to that of other studies using random sampling, the rate of attrition was still 27%. While there is evidence that the group that dropped out from the study was similar to those that stayed in the study, there may be differences that the researcher could not detect.

Conducting multiple inferential tests, which increases the Type 1 error rate, is an additional limitation of the study. The researcher did not adjust the original alpha level because of the potential increase in the Type 2 error rate. Readers should be cautious in interpreting all statistically significant results and use the effect sizes for determining a meaningful difference. Completing the research study in a small southern county is another limitation because it reduces generalizability. A characteristic of having a sample population from a small southern town is that many people know each other and may talk about the training in between sessions which may impact their responses. Although the results were notable, this modified version needs to be replicated in other environments.

Another limitation is that a modified training, Two-session CPRT, was used with a new population, children with ADHD. It is difficult to determine how much the results were impacted by the introduction of a new population and how much the results were impacted by the introduction of a modified training. That the training was not available in Spanish was another limitation. There were three Hispanic/Latino parents who were interested in participating in the training, but were not able to because they did not speak English.

A final limitation of this study is that it was the first known study to use the PTAKSS to measure parental attitudes and parental knowledge of CCPT. As a result, it is difficult to compare the results to other studies in which the participants were students

and professionals (Crane & Brown, 2003; Homeyer & Rae, 1998; Kagan & Landreth, 2009; Kao & Landreth, 1997; Lindo et al., 2012).

Implications of the findings

This section covers the implications of this study including the impact of the Two-session CPRT on counselor education, mental health clinicians and parents; and the introduction of assessments to the CPRT body of research. The most important implication is that counselor educators, mental health clinicians and parents have another viable option, the Two-session CPRT, available to them. Counselor educators can share this modified CPRT in the classroom with graduate students who will be working with children and their parents.

As mental health clinicians enter the school counseling arena and begin to experience the many components of the school counselor's job, this model provides a format that is more conducive to the school environment. In addition, students entering agency counseling positions have an additional tool that will allow them to meet the needs of families by providing parent training in a shorter format. Also, as mental health agencies continue to be stretched to meet the mental health needs of communities, it is likely that parents would be more able to make the time commitment, as well as be able to afford transportation and childcare necessary to participate in the training. This project demonstrates one way the traditional 10-week CPRT model can be modified to accommodate more parents and professionals serving parents.

A second important implication was from the assessments that were introduced to the CPRT literature through this study. The VADPRS was utilized for this study and had not been used in studies of the traditional model of CPRT. This instrument is a valuable

tool to consider using when evaluating ADHD behaviors and the impact of CPRT. In addition, the PSS is another viable tool to measure parental stress that requires less time than the Parental Stress Index while still gathering the information being sought. Both of these instruments offer another valid and reliable option to researchers in the counseling field.

Recommendations for Future Research

Based on the findings of the current study, the recommendations for future research include continuing to develop modifications of the CPRT traditional model, a follow-up study with the current sample, studies that replicate the Two-session CPRT with other populations, a comparison study of the Two-session CPRT and the traditional CPRT, studies to examine the relationship between ethnicity and the impact of the Two-session CPRT, studies that utilize alternative assessments, and a study using the modified CPRT with the addition of play sessions. An important area for future research is to continue to develop and assess the effectiveness of other modifications to CPRT to find additional formats that are more accessible to families with different needs.

Because this study showed such promising results, it is recommended that a follow-up study be conducted with the current sample to determine if parents of children with ADHD who have completed the Two-session CPRT continue to show change in level of parental stress and parental knowledge after an extended period of time. In addition, a follow-up study could determine if the variables that did not show change (parental perception of child's behavior, parental acceptance, and parental attitudes about CCPT) would change given more time for parents to incorporate the training information

into their lives. A follow-up study could also assess parents on their perception of parental skills via the parental skills scale on the PTAKSS.

Another area for future research is to replicate the Two-session CPRT with the populations in studies of the traditional model including single parents (Bratton & Landreth, 1995), adoptive parents (Carnes-Holt, 2011), non-offending parents of children who have been sexually abused (Costas & Landreth, 1999), incarcerated mothers (Harris & Landreth, 1997), and parents of children with learning disabilities (Kale & Landreth, 1999) to assess the effectiveness of using this model with these populations.

Because there no known studies considering ADHD using the traditional CPRT, it is recommended that future research include studies of the traditional model in comparison with the modified CPRT with parents of children with ADHD. In order to allow for relationship building between the parent and child, it is recommended that the Two-session CPRT be studied with the addition of play sessions between the parent and child.

Additional research could examine the relationship between ethnicity and the impact of the Two-session CPRT. Many previous studies focused on a specific population or did not identify ethnicity. It would be helpful to consider ethnicity with the Two-session CPRT to determine if the training impacts parents from different ethnic backgrounds in similar or different ways. This information would allow counselors to modify the training to meet the needs of the studied populations.

In the past CPRT literature, there has been very little variation in assessments used to measure the different variables. The current study introduced the VADPRS, the PSS, and the PTAKSS to the CPRT literature. Although it would be more difficult to

compare outcomes with past studies, future research should continue the approach used in this study of using assessments specifically designed for particular populations to better understand the needs of those populations and determine ways to help the child-parent relationship with those children. For example, when working with a population such as children with Autism, the Childhood Autism Rating Scale could be used to evaluate behaviors before and after the CPRT.

In summary, this study serves as a springboard for continued research on the Two-session CPRT including applying the model to other populations, comparing to the traditional model to support the modified model and find ways to strengthen it, considering the impact on particular ethnicities, and to utilizing a greater variety of assessments to measure the variables associated with the model.

Concluding Remarks

The Two-session CPRT was found to be helpful for parents of children with ADHD especially in terms of reducing parental stress and increasing parental knowledge of CCPT. In order to expand the reach of CPRT, studies are needed using the modified version of CPRT with populations that have been considered by the traditional model. CPRT has helped many parents and their children and it is vital that researchers continue to consider different formats and different ways of assessing in order to continue providing the best, most efficient services to clients.

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APPENDIX A: INFORMED CONSENT FORM

Informed Consent Form

You are invited to participate in a dissertation study titled *Investigation of a Two-session Modification of Child Parent Relationship Training and its impact on parental perception of child's problem behaviors, parental acceptance of child, parental stress; and parental attitudes, knowledge and skills of child centered play therapy among parents of children with ADHD.*

Purpose of the Study: This study will evaluate the effectiveness of a program designed to improve parent-child relationships. The program will assist you in learning communication skills designed to improve child behavior and parenting. The training will include information on the following skills: reflective responding, limit setting, choice-giving, returning responsibility, self-esteem building, encouragement vs. praise and responding to effort. For each of the new skills, parents will be taught the skill, shown the skill and then have a chance to practice the skill.

The researcher is not an employee of Stanly County School System, but has been granted permission for research by the system. The school system will not release any information about the children. The principal investigator for this study is Sarah Moore, and the study is being completed as a requirement for earning a doctoral degree in the Department of Counseling at UNCC, under the supervision of Dr. Phyllis Post, Professor in the Department of Counseling at UNCC.

Expectations of Participants:
Before agreeing to participate in this research study, it is important that you read and understand the purpose, benefits and risks of the study and how it will be conducted. In addition, you must be able to answer 'yes' to the following question to be eligible for participation. Please check yes or no below.

Has your child been diagnosed with ADHD/ADD by a pediatrician, psychiatrist, or psychologist, family physician or other professional?

Yes____
No ____

This research study is limited to parents of children in 1st through 5th grade. If this is true for your child, please continue to read this letter; if this is not true for your child, you are not eligible for participation. However, if you are not qualified but would like to receive the training, please let me know and I will make the training available to you at a later date. Only one parent per child with ADHD will be allowed to participate in the study.

The parent completing the training should also be the one who completes all of the assessments related to the study.

The trainings will be held at Central Elementary School. There are three groups offered. You will only need to participate two nights of training and one night to complete assessments. Your training schedule will be determined after all participants have returned their informed consent forms. Since the groups will be randomly assigned, you must to be available on:

Group 1: Tuesdays, June 18th and June 25th from 6-9p.m, and two weeks later on July 9th from 5-5:45 to complete assessments
Group 2: Saturdays, June 22nd and June 29th from 1-4p.m and two weeks later on July 13th from 1-1:45p.m. to complete assessments
Group 3: Tuesday, June 18th (complete assessment by email/mail within 24 hours), meet on Tuesday, July 9th from 5:15-9p.m. to complete assessments and first night of training and Tuesday, July 16th from 6-9pm.

At the conclusion of the research project, everyone that completes the training and all assessments will be entered in a drawing for a $75.00 gift card to Wal-Mart. Three cards will be given to different participants.

Confidentiality: Anything expressed during the training will be kept confidential unless imminent harm to a child or yourself is expressed. If the facilitator believes there is a risk, the facilitator will evaluate the status of parent to make sure they are not a danger to self or others. If appropriate, the parent will then be referred to one of two local mental health providers in Stanly County, Daymark and Monarch. The reseacher will do her best to protect you and our child's confidentiality throughout the study and afterwards.

You will return your consent form to the school in a sealed envelope in order to safeguard your privacy. Your name and your child's name will be removed from all identifying materials related to this research and replaced with a random code number. Only the researcher will have a list of the participants' names corresponding to the coded numbers. Consent forms will be stored in a location separate from coded materials. All research records, including the videotaped trainings, will be kept in a locked cabinet in the researcher's office and be accessible only to the researcher. Video recordings will be used to ensure the fidelity of the training. Research records will be kept for a period of 3 years following the conclusion of this study. At that time, all records will be properly destroyed. The confidentiality of you and your child's individual information will be maintained in any professional publications or presentations regarding this study for the purposes of maintaining the best interests of, and to diminish any potential harm to you or your child, as a result of this program. You and your child will not be identified in discussions, publications and presentations and only group data will be presented.

Foreseeable Risks: The potential risks involved in this study are minimal. Parenting is a challenge and discussing your child in a group might be upsetting. If you become upset in the group, be sure to let the facilitator know. If you become upset, the facilitator will

step outside the room with you and talk with you to help you calm down. You will be encouraged to take a break from the training and to return to the training when ready. You do not have to share in the group if you don't want to.

Potential Benefits: We expect the project to benefit you and your child by teaching you parenting skills that will help you communicate better and build a stronger relationship with your child.

Procedures for Addressing Questions about the Study: If you have any questions or concerns, please contact Sarah Moore, a doctoral student in the Department of Counseling at the University of North Carolina at Charlotte at (704) 796-7046 or saramoor@uncc.edu or the chair of her dissertation project, Dr. Phyllis Post, at ppost@uncc.edu or (704) 687-8961.

Review for the Protection of Participants: This research study (Protocol # 13-03-31) has been reviewed and approved by the University of North Carolina at Charlotte's Human Subjects Review. If you experience any concerns, you can contact the Office of Research Compliance by calling (704) 687-1871.

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

- You understand why the study is being conducted and how it will be performed.
- Mrs. Sarah Moore or Dr. Phyllis Post has answered any questions you may have about the study.
- Your participation in this study is completely voluntary, and your refusal to participate or your decision to withdraw from the study will involve no penalty or loss of rights or benefits.
- You understand your rights as the research participant in this study.
- You attest that you are 18 years of age or older.
- You have been told you will receive a copy of this form.
- You understand that the researcher will maintain confidentiality and will encourage participants to do so as well.
- The training sessions will be recorded in order to make sure that the training includes the same material each time.
- If you choose to take advantage of the free childcare for the trainings, you must sign a childcare waiver.

If you would like to participate, please return this form in a sealed envelope, with the flap signed to ensure privacy, to your child's teacher or school counselor by June 5th, 2013.

_____

Name of Parent/Guardian Name of Child

_____

Signature of Parent/Guardian Date

_____

Home Address

APPENDIX B: DEMOGRAPHIC SURVEY

DEMOGRAPHIC SURVEY Code _____

Please answer the following questions as they apply to your child whose name appears on the previous page of this packet.

1. My child is a: (Check one) ____male ____female.

2. My child is _____ years old.

3. My child is in the _____ grade.

4. Which of the following best identifies your child's ethnicity? (Check one)
   ____African American ____Asian/Pacific Islander
   ____White ____Hispanic/Latino
   ____Multi-racial ____Other

4. Who did the assessment that identified the child as ADHD/ADD?
   ____Family Physician ____Pediatrician
   ____Psychiatrist ____Psychologist
   ____other

5. Have you completed a parent training in the past 12 months?
   ____yes ____no

6. The person that commits to the training should be the same person who completes the pre-test and post-test assessments and completes both sessions. How is this person related to the child of interest? _____

APPENDIX C: MARKETING FLYER

The researcher is not an employee of Stanly County School System, but has been granted permission for research by the system. The school system will not release any information about the children.

Parenting Can Be Difficult…

FREE Training for Parents of children with ADHD
1st-5th graders in Stanly County Public Schools

$225.00 in drawings FREE Childcare & snacks

- Do you feel like you have *lost control* of your role as a parent?
- Do you find yourself *yelling at more often* than laughing with your child?
- Do you feel you have *lost touch* with your child?
- Do you find yourself *saying the same things over and over* with no results?

If you answered "Yes" to any of these questions,

Child-Parent-Relationship (C-P-R) Training May Help!

Training topics:
Regain control as a parent Help your child develop self-control
Effectively discipline & limit inappropriate behavior Understand your child's emotional needs
Communicate more effectively with your child

The trainings will be held at Central Elementary School. You need to be available on the following days but will only be required to attend 2 of the days of training and return a 3rd time for assessments.

Group 1: Tuesdays, June 18th and June 25th from 6-9p.m, and two weeks later on July 9th from 5-5:45 to complete assessments
Group 2: Saturdays, June 22nd and June 29th from 1-4p.m and two weeks later on July 13th from 1-1:45p.m. to complete assessments
Group 3: Tuesday, June 18th (complete assessment by email/mail within 24 hours), meet on Tuesday, July 9th from 5:15-9p.m. to complete assessments and first night of training and Tuesday, July 16th from 6-9pm.

If interested, complete the contact form below and return to your child's teacher or school counselor by June 5th, 2013. Contact Sarah Moore at 704-796-7046/saramoor@uncc.edu with any questions or concerns.

Name of Parent/Guardian Name of Child

Home Address

Cell phone Home phone

Email Address

APPENDIX D: PROGRAM SATISFACTION SURVEY

Program Satisfaction Survey

NAME _____DATE _____

Directions: Circle the number that is closest to your reaction to each statement.

1. This parenting course has given me information that is improving my parenting skills.
   strongly disagree disagree neutral agree strongly agree

2. This parenting course has helped improve relationships in our family.
   strongly disagree disagree neutral agree strongly agree

3. As a result of this parenting course, my communication with my child/children has improved.
   strongly disagree disagree neutral agree strongly agree

4. I would recommend this parenting course to a friend.
   strongly disagree disagree neutral agree strongly agree

5. What did you learn in this parenting course?

_____
_____
_____

6. Do you have suggestions for improving this parenting course? _____YES _____NO
If you answered "YES" please write your ideas here.

_____
_____
_____

Additional Comments:

APPENDIX E: VANDERBILT ATTENTION DEFICIT/HYPERACTIVITY DISORDER PARENT RATING SCALE

myADHD.com
Vanderbilt Assessment Scale—Parent Informant

Name of child:_____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form please think about your child's behavior in the past 6 months.

Is this evaluation based on a time the child __ was on medication __ was not on medication __ not sure?

	Symptoms	Never	Occasionally	Often	Very Often
1.	Does not pay close attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2.	Has difficulty keeping attention to what needs to be done	0	1	2	3
3.	Does not seem to listen when spoken to directly	0	1	2	3
4.	Does not follow through on instructions and fails to finish schoolwork, chores, or duties	0	1	2	3
5.	Has difficulty organizing tasks and activities	0	1	2	3
6.	Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework)	0	1	2	3
7.	Loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)	0	1	2	3
8.	Is distracted by extraneous stimuli	0	1	2	3
9.	Is forgetful in daily activities	0	1	2	3
10.	Fidgets with hands or feet or squirms in seat	0	1	2	3
11.	Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12.	Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13.	Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14.	Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15.	Talks excessively	0	1	2	3
16.	Blurts out answers before questions have been	0	1	2	3

	completed					
17.	Has difficulty waiting in line		0	1	2	3
18.	Interrupts or intrudes on others (e.g., butts into conversations/games)		0	1	2	3
19.	Argues with adults		0	1	2	3
20.	Loses temper		0	1	2	3
21.	Actively defies or refuses to go along with adult requests or rules		0	1	2	3
22.	Deliberately annoys people		0	1	2	3
23.	Blames others for his or her mistakes or misbehaviors		0	1	2	3
24.	Is touchy or easily annoyed by others		0	1	2	3
25.	Is angry or resentful		0	1	2	3
26.	Is spiteful and wants to get even		0	1	2	3
27.	Bullies, threatens, or intimidates others		0	1	2	3
28.	Starts physical fights		0	1	2	3
29.	Lies to get out of trouble or to avoid obligations (i.e., "cons" others)		0	1	2	3
30.	Is truant from school (skips school) without permission		0	1	2	3
31.	Is physically cruel to people		0	1	2	3
32.	Has stolen things that have value		0	1	2	3
33.	Deliberately destroys others' property		0	1	2	3
34.	Has used a weapon that can cause serious harm (bat, knife, brick, gun)		0	1	2	3
35.	Is physically cruel to animals		0	1	2	3
36.	Has deliberately set fires to cause damage		0	1	2	3
37.	Has broken into someone else's home, business or car		0	1	2	3
38.	Has stayed out at night without permission		0	1	2	3
39.	Has run away from home overnight		0	1	2	3
40.	Has forced someone into sexual activity		0	1	2	3
41.	Is fearful, anxious, or worried		0	1	2	3
42.	Is afraid to try new things for fear of making mistakes		0	1	2	3
43.	Feels worthless or inferior		0	1	2	3
44.	Blames self for problems, feels guilty		0	1	2	3
45.	Feels lonely, unwanted, or unloved; complains that "no one loves him or her"		0	1	2	3
46.	Is sad, unhappy, or depressed		0	1	2	3
47.	Is self-conscious or easily embarrassed		0	1	2	3
..	Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a	Problematic

					Problem	
48.	Reading	1	2	3	4	5
49.	Mathematics	1	2	3	4	5
50.	Written expression	1	2	3	4	5
.	*Classroom Behavioral Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
51.	Relationship with peers	1	2	3	4	5
52.	Following directions	1	2	3	4	5
53.	Disrupting class	1	2	3	4	5
54.	Assignment completion	1	2	3	4	5
55.	Organizational skills	1	2	3	4	5

Comments:

For Office Use Only

Total number of items scored 2 or 3 in items 1-9: _____ (ADHD, predominantly inattentive type—6 or more symptoms)

Total number of items scored 2 or 3 in items 10-18:_____ (ADHD, predominantly hyperactive-impulsive type—6 or more symptoms)

Total number of items scored 2 or 3 for items 1-18:_____ (ADHD, combined type—6 or more symptoms of both types)

Total number of items scored 2 or 3 in items 19-26:_____ (oppositional defiant disorder screen—4 or more symptoms)

Total number of items scored 2 or 3 in items 27-40:_____ (conduct disorder screen—3 or more symptoms)

Total number of items scored 2 or 3 in items 41-47:_____ (anxiety/depression screen—3 or more symptoms)

Scoring Instructions for the Vanderbilt Assessment Scale—Parent Informant

The Vanderbilt Assessment Scale has two components: symptom assessment and impairment of performance.

For the ADHD screen, the symptoms assessment component screens for symptoms that meet the criteria for both inattentive (items 1-9) and hyperactive-impulsive ADHD (items 10-18). To mee*t DSM-IV* criteria for the diagnosis of ADHD, one must have at least 6 responses of "Often" or "Very Often" (scored 2 or 3) to either the 9 inattentive or 9 hyperactive-impulsive items, or both and a score of 4 or 5 on any of the Performance items (48-55). There is a place to record the number of symptoms that meet this criteria in each subgroup.

The Vanderbilt Assessment Scale also contains items that screen for 3 other co-morbidities: oppositional defiant disorder, conduct disorder, and anxiety/depression.

For the oppositional defiant disorder screen there must be a score of 2 or 3 on 4 of the 8 items (19-26) on the subscale and a score of 4 or 5 on any of the Performance items (48-55).

For the conduct disorder screen there must be a score of 2 or 3 on 3 out of the 14 items (27-40) on this subscale and a score of 4 or 5 on any of the Performance items (48-55).

For the anxiety/depression screen there must be a score of 2 or 3 on 3 of the 7 items (41-47) and a score of 4 or 5 on any of the Performance items 48-55).

The Vanderbilt Assessment Scale should NOT be used alone to make a diagnosis. The practitioner must consider information from other sources.

APPENDIX F: PORTER PARENTAL ACCEPTANCE SCALE

Porter Parental Acceptance Scale

Please fill out the attached questionnaire as frankly and as carefully as possible. Your answers as well as the responses will be treated confidentially and will be used only for purposes of scientific research. Please answer all questions. If you cannot give the exact answer to a question, answer the best you can. Be sure and refer only to this child while answering all of the following questions.

Information about your child

Many parents say that their feeling of affection toward or for their child varies with his behavior and with circumstances. Will you please read each item carefully and place a check in the column which most nearly describes the degree of feeling or affection which you have for your child in that situation?

Check one column for each item below	Much more than usual	A little more than usual	The same	A little less than usual	Much less than usual
1. When he is obedient					
2. When he is with me					
3. When he misbehaves in front of special guests					
4. When he expresses unsolicited affection "You're the best mommy (daddy) in the whole world."					
5. When he is away from me					
6. When he shows off in public					
7. When he behaves according to my highest expectations					
8. When he expresses angry and hateful things to me					
9. When he does things I have hoped he would not do					

10. When we are doing things together					

Listed below are several statements describing things which children do and say. Following each statement are five responses which suggest ways of feeling or courses of action. Read each statement carefully and then place a circle around the letter in front of the one response which most nearly describes the feeling you usually have or the course of action you most generally take when your child says or does these things. It is possible that you may find a few statements which describe a type of behavior which you have not experienced with your child. In such cases, mark the response which most nearly describes how you think you would feel or what you think you would do. Be sure that you answer every statement and mark only one response for each statement.

11. When my child is shouting and dancing with excitement at a time when I want peace and quiet, it:
    a. Makes me feel annoyed
    b. Makes me want to know more about what excites him
    c. Makes me feel like punishing him
    d. Makes me feel that I will be glad when he is past this stage
    e. Makes me feel like telling him to stop

12. When my child misbehaves while others in the group he is with are behaving well, I:
    a. See to it that he behaves as the others
    b. Tell him it is important to behave well when he is in a group
    c. Let him alone if he isn't disturbing the others too much
    d. Ask him to tell me what he would like to do
    e. Help him find some activity that he can enjoy and at the same time not disturb the group

13. When my child is unable to do something which I think is important for him, it:
    a. Makes me want to help him find success in the things he can do
    b. Makes me feel disappointed in him
    c. Makes me wish he could do it
    d. Makes me realize that he can't do everything
    e. Makes me want to know more about the things he can do

14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, it:
    a. Makes me realize that he is growing up
    b. Pleases me to see his interest widening to other people
    c. Makes me feel resentful
    d. Makes me feel that he doesn't appreciate what I have done for him
    e. Makes me wish he liked me more

15. When my child is faced with two or more choices and has to choose only one, I:
    a. Tell him which choice to make and why

b. Think it through with him
c. Point out the advantages and disadvantages of each, but let him decide for himself
d. Tell him that I am sure he can make a wise choice and help him see the consequences
e. Make the decision for him

16. When my child makes decisions without consulting me, I:
a. Punish him for not consulting me
b. Encourage him to make his own decisions if he can foresee the consequences
c. Allow him to make many of his own decisions
d. Suggest that we talk it over before he makes his decision
e. Tell him he must consult me first before making a decision

17. When my child kicks, hits or knocks his things about, it:
a. Makes me feel like telling him to stop
b. Makes me feel like punishing him
c. Pleases me that he feels free to express himself
d. Makes me feel that I will be glad when he is past this stage
e. Makes me feel annoyed

18. When my child is not interested in some of the usual activities of his age group, it:
a. Makes me realize that each child is different
b. Makes me wish he were interested in the same activities
c. Makes me feel disappointed in him
d. Makes me want to help him find ways to make the most of his interests
e. Makes me want to know more about the activities in which he is interested

19. When my child acts silly and giggly, I:
a. Tell him I know how he feels
b. Pay no attention to him
c. Tell him he shouldn't act that way
d. Make him quit
e. Tell him it is alright to feel that way, but help him find other ways of expressing himself

20. When my child prefers to do things with his friends rather than with his family, I:
a. Encourage him to do things with his friends
b. Accept this is part of growing up
c. Plan special activities so that he will want to be with his family
d. Try to minimize his association with his friends
e. Make him stay with his family

21. When my child disagrees with me about something which I think is important, it:
a. Make me feel like punishing him
b. Pleases me that he feels free to express himself
c. Makes me feel like persuading him that I am right

d. Makes me realize he has ideas of his own
e. Makes me feel annoyed

22. When my child misbehaves while others in the group he is with are behaving well, it:
    a. Makes me realize that he does not always behave as others in his group
    b. Makes me feel embarrassed
    c. Makes me want to help him find the best ways to express his feelings
    d. Makes me wish he would behave like the others
    e. Makes me want to know more about his feelings

23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
    a. Give him something quiet to do
    b. Tell him that I wish he would stop
    c. Make him be quiet
    d. Let him tell me about what excites him
    e. Send him somewhere else

24. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
    a. Try to minimize his association with that person
    b. Let him have such associations when I think he is ready for them
    c. Do some special things for him to remind him of how nice I am
    d. Point out the weaknesses and faults of that other person
    e. Encourage him to create and maintain such associations

25. When my child says angry and hateful things about me to my face, it:
    a. Makes me feel annoyed
    b. Makes me feel that I will be glad when he is past this stage
    c. Pleases me that he feels free to express himself
    d. Makes me feel like punishing him
    e. Makes me feel like telling him not to talk that way to me

26. When my child shows a deep interest in something that I don't think is important, it:
    a. Makes me realize he has interests of his own
    b. Makes me want to help him find ways to make the most of this interest
    c. Makes me feel disappointed in him
    d. Makes me want to know more about his interests
    e. Makes me wish he were more interested in the things I think are important for him

27. When my child is unable to do some things as well as others in his group, I:
    a. Tell him he must try to do as well as the others
    b. Encourage him to keep trying
    c. Tell him that no one can do everything well
    d. Call his attention to the things he does well
    e. Help him make the most of the activities which he can do

28. When my child wants to do something which I am sure will lead to disappointment for him, I:
    a. Occasionally let him carry such an activity to its conclusion
    b. Don't let him do it
    c. Advise him not to do it
    d. Help him with it in order to ease the disappointment
    e. Point out what is likely to happen

29. When my child acts silly or giggly, it:
    a. Makes me feel that I will be glad when he is past this stage
    b. Pleases me that he feels free to express himself
    c. Makes me feel like punishing him
    d. Makes me feel like telling him to stop
    e. Makes me feel annoyed

30. When my child is faced with two or more choices and has to choose only one, it:
    a. Makes me feel that I should tell him which choice to make and why
    b. Makes me feel that I should point out the advantages and disadvantages
    c. Makes me hope that I have prepared him to choose wisely
    d. Makes me want to encourage him to make his own choice
    e. Makes me want to make the decision for him

31. When my child is unable to do something which I think is important for him, I:
    a. Tell him he must do better
    b. Help him make the most of the things which he can do
    c. Ask him to tell me more about the things which he can do
    d. Tell him that no one can do everything
    e. Encourage him to keep trying

32. When my child disagrees with me about something which I think is important, I:
    a. Tell him he shouldn't disagree with me
    b. Make him quit
    c. Listen to his side of the problem and change my mind if I am wrong
    d. Tell him maybe we can do it his way another time
    e. Explain that I am doing what is best for him

33. When my child is unable to do some things as well as others in his group, it;
    a. Makes me realize that he can't be best in everything
    b. Makes me wish he could do as well
    c. Makes me feel embarrassed
    d. Makes me want to help him find success in the things he can do
    e. Makes me want to know more about the things that he can do well

34. When my child makes decision without consulting me, it:
    a. Makes me hope that I have prepared him adequately to make his decisions

b. Makes me wish he would consult me
c. Makes me feel disturbed
d. Makes me want to restrict his freedom
e. Pleases me to see that as he grows he needs me less

35. When my child says angry and hateful things about me to my face, I:
a. Tell him it's all right to feel that way, but help him find other ways of expressing himself
b. Tell him I know how he feels
c. Pay no attention to him
d. Tell him he shouldn't say such things to me
e. Make him quit

36. When my child kicks, hits or knocks his things about, I:
a. Make him quit
b. Tell him it is all right to feel that way, but help him find other ways of expressing himself
c. Tell him he shouldn't do such things
d. Tell him I know how he feels
e. Pay no attention to him

37. When my child prefers to do things with his friends rather than with his family, it:
a. Makes me wish he would spend more time with us
b. Makes me feel resentful
c. Pleases me to see his interests widening to other people
d. Makes me feel he doesn't appreciate us
e. Makes me realize that he is growing up

38. When my child wants to do something which I am sure will lead to disappointment for him, it:
a. Makes me hope that I have prepared him to meet disappointment
b. Makes me wish he didn't have to meet unpleasant experiences
c. Makes me want to keep him from doing it
d. Makes me realize that occasionally such an experience will be good for him
e. Makes me want to postpone these experiences

39. When my child is not interested in some of the usual activities of his age group, I:
a. Try to help him realize that it is important to be interested in the same things as others in his group
b. Call his attention to the activities in which he is interested
c. Tell him it is all right if he isn't interested in the same things
d. See to it that he does the same things as others in his group
e. Help him find ways of making the most of his interests

40. When my child shows a deep interest in something I don't think is important, I:
a. Let him go ahead with his interest

b. Ask him to tell me more about this interest
c. Help him find ways to make the most of this interest
d. Do everything I can to discourage his interest in it
e. Try to interest him in more worthwhile things

Scoring of the Scale

If sub-scores are desired, the item numbers are listed below for the respective dimensions.

A. An acceptant parent is one who regards his child as a person with feelings and respects the child's right and need to express these feelings.
Items: 11, 17, 19, 21, 23, 25, 29, 32, 35, 36

B. An acceptant parent is one who values the unique make-up of his child and does what he can to foster that uniqueness within the limits of healthy personal and social adjustment.
Items: 12, 13, 18, 22, 26, 27, 31, 33, 39, 40

C. An acceptant parent is one who recognizes the child's need to differentiate and separate himself from his parents; to become an autonomous individual.
Items: 14, 15, 16, 20, 24, 28, 30, 34, 37, 38

D. An acceptant parent is one who loves his child unconditionally.
Items: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Responses to items 1-10 are scored with the following weight.

Much more than usual	a little more than usual	the same	a little less than usual	much less than usual
1	3	5	3	1

Responses to items 11-40 are weighted as follows:

11	a. 3	12	a. 1	13	a. 5	14	a.4	15	a. 2
	b. 5		b. 2		b. 1		b.5		b. 3
	c. 1		c. 3		c. 2		c.1		c. 4
	d. 4		d. 4		d. 3		d.2		d. 5
	e. 2		e. 5		e. 4		e.3		e. 1
16	a. 1	17	a. 2	18	a. 3	19	a.4	20	a. 5
	b. 5		b. 1		b. 2		b.3		b. 4
	c. 4		c. 5		c. 1		c.2		c. 3
	d. 3		d. 4		d. 5		d.1		d. 2
	e. 2		e. 3		e. 4		e.5		e. 1
21	a. 1	22	a. 3	23	a. 4	24	a.2	25	a. 3
	b. 5		b. 1		b. 3		b.4		b. 4

	c. 2		c. 5		c. 1		c.3		c. 5
	d. 4		d. 2		d. 5		d.1		d. 1
	e. 3		e. 4		e. 2		e.5		e. 2
26	a. 3	27	a. 1	28	a. 5	29	a.4	30	a. 2
	b. 5		b. 2		b. 1		b.5		b. 3
	c. 1		c. 3		c. 2		c.1		c. 4
	d. 4		d. 4		d. 3		d.2		d. 5
	e. 2		e. 5		e. 4		e.3		e. 1
31	a. 1	32	a. 2	33	a. 3	34	a.4	35	a. 5
	b. 5		b. 1		b. 2		b.3		b. 4
	c. 4		c. 5		c. 1		c.2		c. 3
	d. 3		d. 4		d. 5		d.1		d. 2
	e. 2		e. 3		e. 4		e.5		e. 1
36	a. 1	37	a. 3	38	a. 4	39	a.2	40	a. 3
	b. 5		b. 1		b. 3		b.4		b. 4
	c. 2		c. 5		c. 1		c.3		c. 5
	d. 4		d. 2		d. 5		d.1		d. 1
	e. 3		e. 4		e. 2		e.5		e. 2

APPENDIX G: PARENTAL STRESS SCALE

Parental Stress Scale

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided.

1= Strongly disagree
2 = Disagree
3 = Undecided
4 = Agree
5 = Strongly agree

___I am happy in my role as a parent.
___There is little or nothing I wouldn't do for my child(ren) if it was necessary.
___Caring for my child(ren) sometimes takes more time and energy than I have to give.
___I sometimes worry whether I am doing enough for my chiId(ren).
___I feel close to my child(ren).
___I enjoy spending time with my child(ren).
___My child(ren) is an important source of affection for me.
___Having child(ren) gives me a more certain and optimistic view for the future.
___The major source of stress in my life is my child(ren).
___Having child(ren) leaves little time and flexibility in my life.
___Having child(ren) has been a financial burden.
___It is difficult to balance different responsibilities because of my child(ren).
___The behavior of my child(ren) is often embarrassing or stressful to me.
___If I had it to do over again, I might decide not to have child(ren).
___I feel overwhelmed by the responsibility of being a parent.
___Having child(ren) has meant having too few choices and too little control over my life.
___I am satisfied as a parent.
___I find my child(ren) enjoyable.

Reference:
Berry, J. 0., & Jones, W. H. (1995). The Parental Stress Scale: Initial psychometric evidence. Journal of Social and Personal Relationships, 12, 463-472.

Scoring

To compute the parental stress score, items 1, 2, 5, 6, 7, 8, 17, and 18 should be reverse scored as follows: (1=5) (2=4) (3=3) (4=2) (5=1). The item scores are then summed.

APPENDIX H: PLAY THERAPY ATTITUDE-KNOWLEDGE-SKILLS SURVEY

Play Therapy Attitude-Knowledge-Skills Survey

This survey is designed to provide the trainer information regarding the attitude, knowledge and skills of a group of trainees. It is not a test. No grade will be given as a result of completing this survey. Please read each statement/question carefully. From the available choices, circle the one that best fits your reaction to each statement/question.

On the following statements, please indicate your response with each statement in the following manner:

1 --- Never
2 --- Seldom
3 --- Sometimes
4 --- Often
5 --- Always

1. I enjoy being child-like sometimes.	1	2	3	4	5
2. I am accepting of the child part of myself.	1	2	3	4	5
3. I enter new relationships with children with confidence and relaxation.	1	2	3	4	5
4. I am a warm and friendly person to children.	1	2	3	4	5
5. I usually provide too many answers to children.	1	2	3	4	5
6. I have a high tolerance for ambiguity.	1	2	3	4	5
7. I am vulnerable and make mistakes at times.	1	2	3	4	5
8. I know myself and accept myself as who I am.	1	2	3	4	5
9. I have a sense that children trust me.	1	2	3	4	5
10. I appreciate my childhood.	1	2	3	4	5

On the following statements, please indicate your agreement or disagreement with each statement in the following manner:

1 --- Strongly Disagree
2 --- Disagree

3 --- Undecided
4 --- Agree
5 --- Strongly Agree

	SD				SA
11. Children's behavior is usually unpredictable.	1	2	3	4	5
12. The underlying motivation of children's behavior can be understood.	1	2	3	4	5
13. Children are basically miniature adults.	1	2	3	4	5
14. Children are irresponsible.	1	2	3	4	5
15. Children possess a tremendous capacity to overcome obstacles and circumstances in their lives.	1	2	3	4	5
16. Children's behavior is usually explainable.	1	2	3	4	5
17. Since children are in the process of developing, they do not usually experience the depth of emotional pain adults are capable of experiencing.	1	2	3	4	5
18. Children are capable of positive self-direction if given the opportunity to do so.	1	2	3	4	5
19. How things seem to children is more important than what has actually happened.	1	2	3	4	5
20. Children's behavior needs to be molded and directed for optimal growth and adjustment.	1	2	3	4	5
21. Children's behavior is usually understandable.	1	2	3	4	5
22. Children can be helped to grow and mature faster.	1	2	3	4	5
23. Children usually need considerable structure and direction since they are still learning and developing.	1	2	3	4	5
24. Children are capable of figuring things out.	1	2	3	4	5
25. Children are resourceful.	1	2	3	4	5

26. Children are unkind.	1	2	3	4	5
27. Children tend to make the right decision.	1	2	3	4	5
28. Children need a capable adult to point them in the right direction.	1	2	3	4	5
29. Children think before they act.	1	2	3	4	5
30. Children are capable of insight into their own behaviors.	1	2	3	4	5
31. Children are unfeeling.	1	2	3	4	5
32. Children can be trusted.	1	2	3	4	5
33. Children will out grow most of their problems.	1	2	3	4	5
34. Most children are able to express their feelings, frustrations, and personal problems through verbal expression.	1	2	3	4	5
35. Adjusted and maladjusted children express similar types of negative attitudes.	1	2	3	4	5
36. Most children need direction from a counselor to work out solutions to their own problems in a counseling relationship.	1	2	3	4	5
37. Typically, an adult must intervene physically or directly to stop most children's aggressive and/or destructive behavior.	1	2	3	4	5
38. Children communicate in much the same way as adults.	1	2	3	4	5
39. Adult counselors and play therapists use similar techniques.	1	2	3	4	5
40. Children's natural medium of communication is play and activity.	1	2	3	4	5
41. How the therapist feels about the child is more important than what the therapist knows about the child.	1	2	3	4	5

42. Children do not have emotional disturbance problems. They just lack education and training. 1 2 3 4 5

On the following statements, please indicate your response with each statement in the following manner:

1 --- None
2 --- Very Limited
3 --- Limited
4 --- Good
5 --- Very Good

43. In general, how would you rate your knowledge of play therapy as an approach for counseling with children? 1 2 3 4 5

44. How would you rate your understanding of the reasons for selecting and excluding toys and materials in play therapy? 1 2 3 4 5

45. How would you rate your awareness of your own feelings when you are relating to children? 1 2 3 4 5

46. In general, how would you rate your knowledge of how children communicate? 1 2 3 4 5

47. In general, how would you rate your knowledge of identifying areas where limits should be set. 1 2 3 4 5

At the present time, how would you rate your own understanding of the following terms:

48. "Play theme" 1 2 3 4 5

49. "Tracking"
1 2 3 4 5

50. "Returning responsibility" 1 2 3 4 5

51. "Therapeutic limit setting" 1 2 3 4 5

52. "Choice giving" 1 2 3 4 5

53. "Play materials" 1 2 3 4 5

54. "Play therapy" 1 2 3 4 5

APPENDIX I: TWO SESSION CHILD PARENT RELATIONSHIP TRAINING AGENDA

Session 1

Hour 1: slide 1

_____I. Give Name Tags and Parent Notebooks to All Parents as They Arrive

(Ask parents who need to complete intake information to stay afterward.)
Introduce self/welcome group—have parents briefly share about themselves and why they are here; help them feel supported and that they are not alone in their struggles
Make generalizing/normalizing comments to other parents (Example: "Anyone else feel angry with his or her child this week?")
Do 'Color your heart' activity with parents coloring in the different feelings they have for their child.

20 minutes
Slide 2

_____II. Overview of CPRT Training Objectives and Essential Concepts

- Rule of Thumb: "Focus on the donut, not the hole!"

CPRT focuses on the relationship, your strengths and your child's strengths, NOT the problem.
Play is the child's language
Helps prevent problems because parent becomes aware of child's needs

Slide 3, 4

Use these skills (when you choose to):
To allow the child—to communicate thoughts, needs, and feelings to his parent, and for the parent to communicate that understanding back to the child. Provide example from my life.
[use active listening: Lilley falls on concrete and is crying- "Did that hurt?" is not as helpful as "that hurt" - this goes to the child's heart; Say, "I didn't hear what you said," rather than "What did you say?"]
Through feeling accepted, understood, and valued—for the child to experience more positive feelings of self-respect, self-worth, confidence, and competence—and ultimately develop self-control, responsibility for actions, and learn to get needs met in appropriate ways.
To strengthen the parent-child relationship and foster a sense of trust, security, and closeness for both parent and child.

Slide 5

These skills will:
Return control to you as parent and help child develop self-control
Provide closer, happier times with your child—more joy and laughter, warm memories
Ask parents: "What do you want your child to remember about you/your relationship 20 years from now?" (What are parents' best memories from childhood?)
Give key to your child's inner world—learn how to really understand your child and how to help your child feel that you understand

Patience is important in learning a new language

Slide 6

- Rule of Thumb: "What's most important may not be what you do, but what you do after what you did!"

We are certain to make mistakes, but we can recover. It is how we handle our mistakes that make the difference.

Slide 7

- Rule of Thumb: "Be a thermostat, not a thermometer!"

Learn to RESPOND (reflect) rather than REACT. The child's feelings are not your feelings and needn't escalate with him/her.
When your child's feelings and behaviors escalate, you can learn to respond in a helpful way, rather than simply reacting and allowing your feelings and behaviors to escalate, too. Remember: In-control parents are thermostats; out-of-control parents are thermometers.
You will learn the same basic play therapy skills that graduate students learn in a semester course.

20 minutes
Slide 8, 9

_____III. Tell: Reflective Responding
Way of following, rather than leading
Reflect behaviors, thoughts, needs/wishes, and feelings (without asking questions)
Helps parent understand child and helps child feel understood
Example: Trying to cook dinner, Rose hanging on my leg crying. Rather than encouraging her to leave room or telling to stop crying. Saying, You are tired and hungry. Have a snack and sit at table with me while I finish cooking.

Slide 10

"Be With" Attitudes:
Your intent in your actions, presence, and responses is what is most important and should convey to your child:

"I am here—I hear/see you—I understand—I care."

"Be With" Attitudes Convey:	Not:
I am here; I hear you	I always agree
I understand	I must make you happy
I care	I will solve your problems

____ IV. Optional – Show Video Clips: Life's First Feelings
Video clip #1: Discuss reactions (especially difference in mad/sad) as lead-in to Feelings Response:
In-Class Practice Worksheet

Hour 2:
Slide 11
____ V. Complete Feelings Response: In-Class Practice Worksheet
Complete worksheet together with parents, asking them, as a group, to decide on the feeling word that best describes how the child is feeling and next, as a group, decide on a short response. Go over 2 from completed worksheet.
Think about this morning with your child. Describe you could have responded to your child and share with neighbor.
15 min

____VI. Show, have parents remember a time, Practice
Role-Play
Demonstrate - ask a parent to tell you about his or her day and simply reflect on feelings as the parent talks about it; then pair up parents and have them take turns being the "listener"

10 min

- Rule of Thumb: "The parent's toes should follow his/her nose."

Body language conveys interest and full attention.
To increase the level of playfulness and enjoyment between parent and child

5 minutes
Slide 12 and 14
_____VII. Tell
My story- Rose throwing toy angry. Rose, I know that you are angry, but toys aren't for throwing. You can hit a pillow when you are angry.
Handout: Limit Setting: A-C-T Before It's Too Late
(optional) Show video clip on limit setting
Briefly review the A-C-T model—go over importance of consistency
Slide 13
Child is responsible for choices and decisions, within the limits set by parent
The parent is to be clear and firm about the few "limits" that are placed on the

child's behavior
Gives child responsibility for behavior
Limits set on time, for safety, and to prevent breaking toys or damaging play area
Stated only when needed, but consistently
Briefly give a few examples of possible limits to set, give personal example

Slide 15

- Rule of Thumb: "Limits are not needed until they are needed!"

Slide 16

- Rule of Thumb: "You can't give away that which you don't possess."

(Analogy: oxygen mask on airplane: take care of yourself first, then your child)

You can't extend patience and acceptance to your child if you can't first offer it to yourself. As your child's most significant caregiver, you are asked to give so much of yourself, often when you simply don't have the resources within you to meet the demands of parenting. As parents, you may be deeply aware of your own failures, yet you can't extend patience and acceptance to your child while being impatient and un-accepting of yourself.

Slide 17

- Rule of Thumb: When a child is drowning, don't try to teach her to swim. When a child is feeling upset or out of control, that is not the moment to impart a rule or teach a lesson.

Slide 18, 19

Review Limit Setting: A-C-T Practice Worksheet

Read over and do at least two or three examples together, tell me some times you would like to have set a limit discussion; point out question #7, where parents are asked to write down a limit they think they will need to set for their child

15 min

_____VIII. Show, have parents remember a time, Practice

Live Demonstration of Limit Setting
Always allow time for parents to see a demonstration of skills that you want them to emulate, focusing on those skills they report the most difficulty with

After viewing demonstration, ask parents to role-play a few scenarios they believe are most difficult for them, including at least one limit-setting role-play
Take poster board with A-C-T on it and have them use when in role-play, have group say together

30 min

____ IX. Close with Motivational Poem, Story, or Rule of Thumb (optional)
End session with a motivational book, poem, or story, such as "I'll Love You Forever"

Slide 20

Homework Assignments:
Notice one physical characteristic about your child you haven't seen before.

Practice reflective responding (complete Feeling Response: Homework Worksheet and bring next week).

Bring your favorite, heart-tugging picture of your child of focus.

Practice giving a 30-second Burst of Attention. If you are on the telephone, say, "Can you hold for 30 seconds? I'll be right back." Put the phone aside, bend down, and give your child undivided, focused attention for 30 seconds; then say, "I have to finish talking to ___." Stand back up and continue talking with your friend.

Complete Limit Setting: A-C-T Practice Worksheet.

Read over handouts: Read A-C-T, Choice giving, esteem building and encouragement vs. praise handouts.

Give each of your children a Sandwich Hug and Sandwich Kiss.

Read Esteem-Building Responses—practice giving at least one esteem-building response based on experience with your child (provide example)
What happened _____
What you said _____
What you could have said_____

Session 2 Limit-Setting Review

Slide 21

_____I. Review A-C-T Method
Limit Setting: A-C-T Before It's Too Late!

Emphasize importance of using all three steps

Ask for questions
Emphasize the importance of stating clear and concise limits

Recommendations

Parents share limit-setting attempts

Parents share an intense feeling they were aware of when trying to set a limit

Focus on importance of self-awareness of parents' feelings in the play session; model by reflecting parents' feelings

Remember the Donut Analogy: Focus on the Positive! Find something in each parent's sharing that can be encouraged and supported—facilitate "connecting" among group members.

Slide 22

___ II. Choice-Giving

Tell: Rose wanting a cookie before dinner. Before dinner, you have to eat dinner before you can have a cookie for dessert. If you choose to eat dinner, then you are choosing to have a cookie. I know that you want a cookie but when you chose not to eat your carrots, you chose not to have a cookie.

Review handout: *Choice-Giving 101: Teaching Responsibility & Decision-Making*

👍 Rule of Thumb: "Big choices for big kids, little choices for little kids."

Choices given must be commensurate with child's developmental stage.

Slide 23 Show video: *Choices, Cookies, and Kid*s (suggest showing 15 minutes)

As time allows, review second choice-giving handout: *Advanced Choice-Giving: Providing Choices as Consequences*

Read *Choice-Giving 101: Teaching Responsibility & Decision-Making* and *Advanced Choice-Giving: Providing Choices as Consequences.*

Slide 24

___ III. Show, have parents remember a time, Practice

Live Demonstration of Choice-Giving

Always allow time for parents to see a demonstration of skills that you want them to emulate, focusing on those skills they report the most difficulty with

Practice giving choices as a method of discipline (where choice-giving is used to provide a consequence for noncompliance of limit, family rule, or policy)
What happened_____

What you said_____
How child responded_____

After viewing demonstration and exercise, ask parents to role-play a few scenarios they believe are most difficult for them, including at least one choice-giving role-play

Slide 25, 26

____IV. Returning Responsibility

Tell: give example from my life

Allows the child to be in control of making choices, reinforces that they are capable. Used when the child asks, "What should I do now? What is this?"

You can decide.

That can be whatever you want it to be.

You can choose what you'd like to do.

Slide 27

____ V. Self-Esteem Building

Tell: Give an example from my life.

Review handout: *Esteem-Building Responses*

Slide 28

- Rule of Thumb: "Never do for a child that which he can do for himself."

When you do, you rob your child of the joy of discovery and the opportunity to feel competent. You will never know what your child is capable of unless you allow him to try!

Slide 29

____ VI. Show, have parents remember a time, Practice

Live Demonstration of Skills, Self-Esteem-Building Responses, and Responses that Return Responsibility to the Child

Always allow time for parents to see a demonstration of play session skills that you want them to emulate, focusing on those skills they report the most difficulty with

After viewing demonstration, ask parents to role-play a few scenarios they believe are most difficult for them, including at least one self-esteem-building response in role-play.

Slide 30, 31, 32

_____VII. Encouragement vs. Praise

Rule of Thumb: "Encourage the effort rather than praise the product."

Children need encouragement like a plant needs water.

Slide 33

____VIII. Live Demonstration of Skills and Prizing (Encouraging) Responses

Tell about with my example

Show, have parents remember a time, Practice

Always allow time for parents to see a demonstration of skills that you want them to emulate, focusing on those skills they report the most difficulty with

Remember a time for you and your child
What happened or what child said (outside of play session)
What you said
How child responded (verbally to nonverbally)

After viewing demonstration, ask parents to role-play a few scenarios they believe are most difficult for them, including at least one encouragement in role-play

Slide 34

____ IV. Closing Process

Review important things each parent learned

Don't wait for big events to enter into your child's world—the little ways are always with us. Hold onto precious moments!

Close With Motivational Poem, Story

APPENDIX J: FIDELITY CHECKLIST

Child Parent Relationship Therapy (CPRT)
Therapist Skills Checklist—Session #_____
(for novice CPRT therapist and student interns to self-assess skill; complete weekly)

Sarah Moore – Fidelity Check Date: _____
Group 1 2 Session: 1 2

- ✓ +	SKILLS	Examples/Comments (*Star your strengths)
	Structure:	
	Organized	
	Stay on track	
	Stay within time limits	
	Responses:	
	Modeled Reflective Responding	
	Balanced attention between group process and didactic instruction	
	Allowed time to practice and process skills	
	Forged connections between group members	
	Nonverbals:	
	Modeled "Be With" attitudes: Genuine/Authentic	
	Relaxed/Comfortable/Confident	

1. Feelings/Thoughts during session to discuss in supervision:

2. Strengths:

3. Areas for growth:

APPENDIX K: CHILDCARE WAIVER OF LIABILITY

Child Parent Relationship Training
Sarah Moore's Dissertation Study

Childcare Waiver of Liability

_____
Child's Last Name, First Name Date of Birth

_____
Parent/Legal Guardian Last Name, First Name

_____
Address City State Zip

_____
Cell Phone e-mail

_____
Emergency Contact Name & Phone

In Diapers Yes No
Would you like child care attendee to change diaper if needed? Yes No

Allergies:
_____

Special
Instructions:_____

Waiver of Liability, Release, Assumption of Risk & Indemnity Agreement
Notice: This is a legally binding agreement.
I understand that by signing this Childcare Waiver of Liability, I release and hold harmless Sarah Moore, the University of North Carolina at Charlotte and Stanly County School Systems and their owners, directors, officers, advisors, employees, agents, instructors, volunteers, childcare workers, and all other persons or entities acting for them from any and all claims, demands, suits, cost and charges, in connection with or arising out of Sarah Moore's 'dissertation research training' childcare service, including but not limited to, personal injury, bodily harm, injury, or property damage occurring while the above child/children is/are in their care at Central Elementary School in Albemarle, N.C.

I understand that childcare services are provided free of charge to participants in the study only. I understand that if my child should become inconsolable during the training, I am responsible to leave class and attend my child. I will be responsible to feed my child and have my child use the restroom prior to start of training time to the best of my abilities. I understand I must remain in Central Elementary School at all times.
I have read and understand the 'Sarah Moore dissertation training' expectations.

_____

Signature of Parent / Legal Guardian Printed Name of Parent/Legal Guardian