Child Parent Relationship Therapy's Effects on Stress Levels, Behavioral Concerns, and Parenting Efficacy in Military-Involved Families

By

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CHILD PARENT REALTIONSHIP THERAPY'S EFFECTS ON STRESS LEVELS, BEHAVIORAL CONCERNS, AND PARENTING EFFICACY IN MILITARY-INVOLVED FAMILIES

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ABSTRACT

Military involved families are subject to military deployment which can lead to numerous adverse effects throughout the family system. Such effects can include heightened household tension, increased chances of developing mental health disorders, child behavioral concerns, and difficulty with the returning member incorporating into the family dynamic. Child-Parent Relationship Therapy (CPRT) is an intervention based on the principles of child-centered play therapy that works to improve the overall filial bonds between parent and child. A mixed method explanatory sequential design was utilized including pre-intervention and post-intervention assessments in addition to exploratory interviews. The research included two participants and their chosen child of focus. Quantitative results indicated no significant statistical differences in parent-child stress or child behavior concerns but are trending in a positive direction. Practical significance was determined with medium to large effect sizes on stress levels and behavioral concerns (d=0.35-2.59). Qualitative results indicated CPRT had an effect on the participant's stress levels, child behavioral concerns, and parenting efficacy as well as overall improvements in the parent-child relationship. Results are discussed in terms of implications for interventions with military-involved families as well as future research recommendations.

Keywords: military, military deployment, play therapy

Introduction

Nearly 1 in 5 children and adolescents experience some degree of mental health concern (Committee on School Mental Health 2004; Mellin 2009). In addition, attachment is viewed as the foundation of healthy early childhood mental health development (Post, 1999). When the development of attachment is inadequate, this can lead to difficulty forming emotional regulation skills (Post, 1999; Thompson, 2002). When these deficiencies are not addressed, they can intensify over time and lead to academic as well as home-life difficulties (Ackerman, Brown & Izard, 2003; Keiley, Bates, Dodge, & Pettit, 2000). This has the potential to cause a cycle of improper social-emotional development which follows an individual throughout their life (Muthen, van der Sar, & Crijnen, 2004; Myers & Pianta, 2008; van Lier). This cycle of improper social-emotional development can be especially harmful when a client is a member of a special population already at-risk of maladaptive development due to the nature of their life.

Active-duty military enrollment currently stands at 1,304,443 (DoD, 2015). When the 1,728,710 family members are considered, this places the grand total at over 3,000,000 individuals who share the experiences of military life. The military deployment process predisposes military involved families to a number of adverse outcomes including feelings of uncertainty, disruptions in the parent-child attachment process, and the returning member struggling to integrate into the family hierarchy (Allen, Rhodes, Stanley, & Markham, 2010, Chartrand, Frank, White, & Shope, 2008, Page & Bretherton, 2008). Such events leave military spouses predisposed to mental health disorders and marital difficulties (Green, Nurius, Milburn & Lester, 2013, Eaton, et al., 2008, Lester et. al., 2016; Paley, Lester, & Mogil, 2013;). Due to deployment's unique effects that resonate throughout the entire family, interventions adopting a holistic approach with

military families are more preferred than those addressing individual family members (Chawlas & Solinas-Saunders, 2011; Lincoln, Swift, & Shorteno-Fraser; 2008; Lester et. al, 2016; Sories, Maier, Beer, & Thomas, 2015). Therefore, interventions involving both parents and children are much more favored over those that address individual member pathology.

Child-Centered Play Therapy (CCPT) is a developmentally appropriate, research-validated intervention allowing children to express emotions through play (Bratton, 2006; Erikson, 1964; Moustakas, 1953; Piaget, 1962; Vygotsky, 1966). During CCPT, children are allowed freedom to play and fully express their inner world within the limits of a secure therapeutic environment highlighted by empathy, genuine-ness, and unconditional positive regard (Axline, 1947, Guerney, 1983, Landreth, 2012). When a child is given this environment to express their inner world, they are able to learn to accept and respect themselves as well as assume responsibility for their actions (Landreth, 2002). CCPT is an effective intervention for decreasing parental stress, reducing child-parent relationship stress, and bolstering parental empathy towards the child (Bratton, Landreth, & Lin, 2010; Bratton et. al., 2018). However, one facet of CPPT is it often relies on a trained mental health provider without directly involving caregivers. Meta-analyses results demonstrate child centered play therapy outcomes are statistically significantly improved when there is direct caregiver involvement. (Bratton, Ray, Rhine, & Jones, 2005; Dowell & Ogles, 2010; Bratton et. al., 2018; Lin & Bratton, 2015; Weisz, Weiss, Han, Granger, & Morton, 1995). To address this, effective child interventions need to include caregivers to support treatment outcomes and significantly reduce the chance of maladaptive social-emotional development.

Child-Parent Relationship Therapy (CPRT) is an empirically based, manualized counseling intervention for children who present with an array of social, emotional, and behavioral issues (Bratton et. al., 2018). The central goal of CPRT is to enhance the parent's attunement to their child and create an accepting, understanding, and non-judgmental environment for their child (Landreth, 1991). When this process occurs, it allows children to discover hidden parts of themselves and new ways of interacting with the parent. When a parent displays empathetic communication with their child, this leads to self-regulation skill development, prosocial behavior, and empathetic peer communication (Kilpatrick, 2005; Liew et. al., 2003; Valiente et. al., 2004). Due to the unique needs of military involved families and its research validated benefits, CPRT can be an efficacious intervention for supporting military involved families and the needs of all family members.

CPRT addresses many military family stressors including separation, changes in family hierarchy, and chronic stress (Hicks, Lenard, & Brendle; 2016). CPRT is also an intervention that fits the needs of military involved families including its strength-based nature and transportability (Hicks et. al., 2016; Lester et. al, 2011; Lester et. al., 2012). However, previous published research regarding CPRT and military involved families has only been conducted with individual cases (Hicks et. al., 2016; Myrick, Green, Barnes, and Nowicki, 2018). While these studies indicate CPRT can be an effective intervention with military involved families in a single case study design, there need to be more studies with larger samples to demonstrate efficacy and promote generalizability.

Purpose of Study

The purpose of this mixed methods study is to examine the efficacy of Child Parent Relationship Therapy (CPRT) with military involved families. Specifically, this

study is designed to examine the effects of CPRT on child behavior concerns and parent-child relationship stress. Child behavior problems were assessed using the Achenbach Child Behavior Checklist (CBCL) and parent-child relationship stress was assessed using the Parenting Stress Index (PSI). In addition, this study sought to understand the parent's perceptions regarding their abilities to use CPRT techniques to support their children's socio-emotional development as well as their personal experiences completing the CPRT intervention by using semi-structured exploratory interviews.

Research Questions

This study addresses the following research questions:

1. Is CPRT effective in decreasing children's behavior problems in military involved families?
2. Is CPRT effective in reducing parent-child relationship stress in military involved families?
3. What are parents' experiences of completing CPRT?
4. Following the completion of the CPRT intervention, how do parents perceive their ability to use CPRT skills to support their children's social-emotional health?
5. In what ways do the follow-up interview results help to explain the quantitative results?

Significance

Due to the family-wide, long-reaching struggles military families may face; it is important to discover interventions addressing the diverse needs of military involved families and specifically address the parent-child relationship. CPRT is an empirically validated intervention demonstrating positive results with diverse families but has not

been widely nor rigorously studied within a military involved population (Cabellos & Bratton, 2010; Carnes-Holt & Bratton, 2014). Throughout the study, the researchers filled this gap in the literature by examining the effects CPRT had on child behaviors, parental stress in military involved families, and ability for military involved parents to support their child's social emotional health. Due to limited attempts to address this research gap, this study is an important step toward identifying an effective intervention for this population. This study applied interventions to a typically underserved population. In addition, due to utilizing a mixed methods approach, researchers gathered both quantitative and qualitative data. This facilitated the depth of exploration and increased the knowledge of CPRT effects within the military population. The researchers aspired to increase the amount of support for a research-supported intervention that specifically addresses the unique needs of military involved families and increase the ability families have to access such treatment.

Delimitations

Heppner and Heppner (2004) defined delimitations as purposeful, researcher-imposed set of intentional parameters for a given research study. The following delimitations apply to this study:

1. Participants in this study are active duty military involved families who have experienced at least one deployment.
2. The population was limited to the Clarksville, TN area.
3. Only military families with children between 3-10 were used for this study

Participants who were not in the military nor had a currently deployed spouse were excluded because the researchers believe Child-Parent Relationship Therapy would provide them maximum benefit as compared to other populations. Participants from

outside of Clarksville, TN area were excluded for convenience purposes. Participants with children outside of the 3-10 age range were excluded because children in this age range are ideal for Child-Parent Relationship Therapy's therapeutic benefits (Bratton, Landreth, Kellam, & Blackard, 2018).

Key Terms

Attachment. Kamphaus & Reynolds (2006, p.23) defined attachment as "the affective, cognitive and behavioral relationship between parent and child that results in feelings of closeness, empathy, and understanding on the part of the parent for the child".

Attunement. Erksine (1998, p.156) stated that attunement "is a kinesthetic and emotional sensing of others knowing their rhythm, affect and experience by metaphorically being in their skin, and going beyond empathy to create a two-person experience of unbroken feeling connectedness by providing a reciprocal affect and/or resonating response".

Child Stress. Child Stress is a construct measured on the Parent-Stress Index (PSI) and defined as "child characteristics that may be contributing to overall stress" (Abidin, 2012, p. 3).

Child-Centered Play Therapy. The National Institute of Relationship Enhancement (2013) defines Child-Centered Play Therapy (CCPT) as

> "the method of play therapy developed by Virginia Axline, an associate of Carl Rogers. CCPT follows the principles of Client-Centered Therapy of creating a non-judgmental, emotionally supportive therapeutic atmosphere, but with clear boundaries that provide the child with psychological safety to permit the learning of emotional and behavioral self-regulation."

Child-Parent Relationship Therapy (CPRT). Landreth and Bratton (2018, p. 11) defined CPRT as:

> "A unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent."

Externalizing behaviors. Externalizing behaviors is a construct measured by the Child Behavior Checklist (CBCL) and defined as "behaviors that cause conflicts with other people and their expectations of the child" (Achenbach & Rescorla, 2001, p. 24).

Internalizing behaviors. Internalizing Behaviors is a construct measured by the CBCL and are defined as "problems that are mainly within the self" (Achenbach & Rescorla, 2001, p. 24).

Military deployment. Military deployment is defined as a temporary assignment away from home within the United States or overseas lasting an undefined amount of time.

Parent Stress. Parent Stress is a construct measured by the PSI and defined as "parent characteristics that may be contributing to overall stress" (Abidin, 2012, p. 3).

Self-efficacy. Self-efficacy is defined as the belief in a personal ability to influence life events and control how life events are experienced.

Total Behavior. Total Behavior is a construct measured by the CBCL and consists of the sum of total Internalizing Behaviors and Externalizing Behaviors reported (Achenbach & Rescorla, 2001).

Total Stress. Total Stress is a construct measured by the PSI and defined as "overall parental experience of stress and risk for dysfunctional parenting and child behavior problems" (Abidin, 2012, p. 3).

Summary

In conclusion, this study examined the effects of CPRT on parent-child stress levels as well as child behavioral concerns in military involved families, parent's perceptions of CPRT's ability to help support their child's social-emotional health and examined the participants' experiences of the CPRT intervention. Interventions addressing the diverse needs of military involved families and specifically address the parent-child relationship are especially important due the specific struggles experienced by military involved families. CPRT is an empirically validated intervention demonstrating positive results with diverse families but has not been widely nor rigorously studied within a military involved population (Cabellos & Bratton, 2010; Carnes-Holt & Bratton, 2014). The researchers examined the effects CPRT had on child behaviors and parental stress in military involved families o fill this gap in the research. Due to limited attempts to address this research gap, this study is an important step toward identifying an effective intervention for this population.

In the following chapter, early childhood mental health, secure child-parent relationship benefits, interventions, and the consequences of deployment in military involved families are discussed. The literature review includes an expanded look into all of these areas of focus. The struggles of military involved families and the rigors

experienced by individual members are examined. Child-Parent Relationship Therapy is discussed as a potential intervention for improving the overall parent-child relationship when experiencing these struggles.

Chapter 2

Literature Review

Foundations of Early Childhood Mental Health

There is a never-ending call for children's mental health services in the United States. Nearly 1 in 7 of children between the ages of 2 to 8 years old have a diagnosed mental, behavioral, or developmental disorder (Bitsko et. al., 2016). Unfortunately, only 20% of these youth receive access to needed mental health services (Martini et. al., 2012). Only one in ten children received some access to mental health counseling within the past year (Data Resource Center for Child & Adolescent Health, 2016). Hodginkonson, Godoy, Beers, & Lewsin (2017) believed finding mental health interventions which are primarily family driven and target children in their natural environment is imperative to improving access to mental health services in the United States. In addition, attachment and attunement are two of the foundational concepts of promoting early childhood mental health (Bowlby; 1977; Purvis, Cross, & Sunshine, 2007; Ryan & Bratton, 2008; Siegel & Hartzell, 2004; Van Fleet & Sniscak, 2003).

Attachment

Attachment is the degree of prosocial relationship which exists between a child and caregiver. Interaction and attachment, especially between the parent and child, is the child's introduction into relationships as it provides children with a sense of security and assurance the parental figure can be looked at as a source of comfort when the child experiences distress (Purvis, Cross, & Sunshine, 2007; Ryan & Bratton, 2008; Siegel & Hartzell, 2004; Van Fleet & Sniscak, 2003). Secure attachment occurs when a child shows some emotional dysregulation when the caregiver leaves but is able to properly regulate their own emotions; knowing the caregiver will return (Bowlby; 1977).

Developing secure parent-child attachment is pertinent to both a child's social-emotional as well as holistic development, particularly when developing emotional self-regulation skills (Albright & Tamis-LeMonde, 2002; Berk, 2013; Ryan & Bratton, 2008; Thompson, 2002). A child's confidence in a secure attached relationship allows a child to explore new environments, master difficult situations, and explore further social relationships (Ahnert, Gunnar, Lamb, & Bethel, 2004; Belsky & Fearon, 2002; O'Connor & McCartney, 2007; Sroufe, 2005). Bowlby (1977) asserted intimacy and social attachments are necessary to avoid emotional difficulties, health problems, and personality disturbances as children transition into adulthood.

However, there are many children who do not have the opportunity to develop secure parent-child attachments, resulting in an insecure attachment style. Insecure attachment occurs when children's needs are met with infrequent or minimal caregiver response as well as responses which are detrimental to their physical or emotional needs (Bowlby; 1977). This can include children who experience frequent changes in caregivers, repeated neglect, and those subjected to physical, sexual, or emotional abuse. When these events occur in a child's life, the child can experience difficulty feeling safe in a relationship, depression, anxiety, risk taking behaviors, and low self-esteem (Forbes & Post, 2006; Purvis et al., 2007; VanFleet & Sniscak, 2003). Attunement can also play a crucial part in proper early childhood social-emotional development.

Attunement

Attunement is the amount of emotional intelligence a parent possesses regarding their child's inner world. Attunement plays a major part in promoting attachment between a child and caregiver and is essential in the development of secure attachment which fosters future relationships (Seigel & Hartzel, 2004). A caregiver's ability to openly

communicate empathetic understanding and acceptance promotes a parent-child relationship built on attunement. Attunement is often communicated nonverbally between the caregiver and child in which the child's internal emotional state is congruent with the child's external emotional experience (Gottman, 1997). When a parent is able to respond in a manner that is focused on emotions, this helps to increase the child's emotional awareness and promote problem solving (Gottman, 1997). Through this congruence between their external and the parent's internal experience, the child begins to feel a sense of satisfaction in developing interpersonal connections with others. Healthy attunement and secure attachment function as protective factors to mitigate deficits in a child's social-emotional development. Unfortunately, healthy attunement and secure attachment are not always present to promote healthy early childhood mental health.

Behavioral Categories

Children's behavioral issues are classified into two different categories: internalizing and externalizing behaviors. Externalizing behavioral problems are those that cause problems with other people. This includes behaviors that do not meet adult expectations of childhood behavior; particularly rule-breaking and aggressive behaviors (Achenbach & Rescorla, 2001). While aggression such as pushing, punching, and kicking are consistent with the normal development of most children; these behaviors normally decrease or cease altogether after kindergarten (Peterson & Flanders, 2005). However, Bloomquist and Schnell (2002) approximated between 42-75% of children who show aggressive conduct issues in early childhood will persist with these difficulties throughout their childhood. Untreated externalizing behaviors show a heightened intensity over time (Barkley, 2007; Brinkmeyer & Eyburg, 2003). These aggressive behaviors are postulated to have numerous causes; including general temperament,

genetic predisposition to aggression, exposure to an aggressive family dynamic, and a peer dynamic supporting aggressive behavior (Boxer & Frick, 2008).

Internalizing behavioral issues involve descriptive problems of the self. This includes depression, anxiety, withdrawal, and somatic symptoms. While externalized behaviors are easily observable and thus have more devoted research, internalized behaviors tend to be more harmful for children as they develop (Merrell & Walker, 2004). Extreme dependency of young children on their mothers, having few playmates, inadequate social skills, and maternal depression are factors that contribute to the development of internalizing behavioral issues in children between two to six years of age (Merrell, 1996; Zahn-Waxler, 1987). Other factors can also contribute to internalizing behaviors are insecure attachment and early childhood learned helplessness (Cantwell, 1990; Miller, Boyer, & Rodelitz, 1990). When these deficits are not addressed, they can lead to disrupted childhood social-emotional development.

Progression of Deficits in Early Childhood Mental Health

A child who has secure parent-child attachment is able to explore new environments, learn self-mastery of difficult situations, and engage in social relationships outside of the family (Ahnert et. al., 2004; Belsky & Fearon, 2002; O'Connor & McCartney, 2007; Sroufe, 2005). This parent-child attachment relationship is bolstered by the parent displaying attunement towards the child's inner emotional world which encourages the child to engage in future relationships. When early childhood mental health concerns and maladaptive behaviors are not targeted by intervention, they can worsen over time in school as well as at home (Ackerman et. al., 2003; Keiley et. al., 2000). Preschool children are displaying a significant increase of disruptive behaviors which are associated with negative trajectories in an early childhood environment

(Barfield, Dobson, Gaskill & Perry, 2012; Brickmeyer & Eyberg, 2003; Teisl & Cicchetti 2008; Tremblay, 2000). These disruptive behaviors tend to remain generally stable throughout the child's life (Brinkmeyer & Eyberg, 2003; Hinshaw, 2002; Webster-Stratton & Reid, 2003). When early childhood behavioral issues are not addressed, children are more at risk for developing serious mental health issues later on in life which can negatively impact a child's academic and personal success (Flahive & Ray, 2010; NCCP, 2012; Peth-Pierce, 2000; Thompson, 2002; U.S. Department of Health & Human Services, 2010).

Disruptive behavioral issues in early childhood can affect an individual's life in a multitude of dimensions. Children who exhibit disruptive behaviors often have difficulty building positive social relationships with teachers and peers which negatively impact their ability to learn adaptive social skills such as intimacy and cooperation (Abidin & Robinson, 2002; Hamre, Pianta, Downer, & Mashburn, 2007; Myers & Pianta, 2008). If these difficulties in building social relationships are not addressed, this results in a cyclical pattern of strained relationships and inadequate social-emotional development which can have negative implications on a child throughout their lifespan (Myers & Pianta, 2008; van Lier et. al., 2004). These untreated mental health needs have been linked to adverse impacts including antisocial personality disorder, juvenile delinquency, violence, and drug abuse (Barkley, 2007; Walters, Ronen, & Rosenbaum, 2010). To ensure these mental health needs do not go unnoticed and lead to behavioral issues, it is crucial to find available interventions that bolster attachment and promote attunement. This type of intervention is especially important for military-involved populations who are subject to unique life experiences such as deployment, stressful parent-child

relationships, and child behavioral concerns that can affect healthy attachment and secure attunement.

Military Involved Families

The United States military boasts 1,301,443 current active-duty military personnel who are dwarfed by their 1,728,710 associated family members (Department of Defense, 2015). The Department of Defense (2015) stated the total number of active duty military spouses is

649,631 with 36.9% of active duty personnel being married with children. Reports show the largest age group of military children fall in the range of 0 to five years old representing 452,119 total children. The second largest group children between the ages of 6 to 11 whose total sum is 340,317. All in all, active duty military children between the ages of birth to 11 years constitute 73.6% of the total active duty military member's children.

Deployment

Previously, the total amount of military members serving in Operation Iraqi Freedom (OIE) and Operation Enduring Freedom (OEF) was believed to be at least two million with those members subjected to at least 3.2 million total military deployments (DoD, 2012). Shanker (2008) reported 38% of Army active-duty soldiers serving in Iraq between 2003 and 2008 were deployed more than once. Of the 2 million children affected by their parent's military deployment to Iraq and Afghanistan, nearly 72% of these children are younger than 11 years old (Office of the Deputy Under Secretary of Defense Military and Family Policy, 2005). While military involved families were previously allowed a "rest time" of 18-24 months, current military personnel are usually given a period of 9-12 months before they are redeployed and given short periods of deployment

notification (Paley et. al., 2013). Additionally, military deployments are becoming longer and more frequent by extending deployment time and including additional training. (Paley et. al., 2013)

Deployment Cycle

Every stage of military deployment is characterized by certain events and emotional experiences for the family members involved. Before military deployment occurs, the parent and children who remain at home often experience heightened tension, stress, anger, frustration, and a loss of social support (Chandra, 2008; Tanielian & Jaycox, 2008). After military deployment occurs, the civilian parent may have to adopt all of the household responsibilities and may struggle to cope with this alternative family structure (Mansfield et. al., 2010; Pincus, House, Christenson, & Adler, 2007; Sheppard, Malatras, & Israel, 2010). For the child, military deployment reactions differ dependent on the child's developmental stage (Chawla & Salinas-Saunders, 2011). Preschool children may regress to behaviors they had outgrown whereas school age children may fear for their loved-one's safety due to their understanding of war (Murray, 2002; Pincus et. al, 2011). The child may begin to anticipate further separation from the remaining caregiver and begins to exhibit symptoms of separation anxiety (Hueber et. al., 2007; Lester et al.; 2012). Before an active duty member returns, family members may hope for the potential changes in the family dynamic due to the family member returning. However, these expectations may be met with disappointment from the non-deployed family member and uncertainties from children (Chawla & Solinas-Sanders, 2011; Pincus et. al, 2007).

After the active duty member returns, there can be difficulties including the returning family member conflicting with existing family norms, restructuring parental

responsibilities, and the need to accommodate for physical and psychological injuries sustained in combat by the active-duty member (Allen et. al., 2010; Goff, Crow, Reisbig, & Hamilton, 2007; Willerton, Schwarz, Wadsworth, & Oglesby, 2011). The active-duty member may experience feelings of uncertainty, vagueness, and indeterminacy (Chartrand et. al., 2008). These feelings may only further increase as the member attempts to integrate within the family system and face difficulties (Hueber et. al., 2007). These difficulties can include reconnecting with their children, diminished parental alliance, and an increased risk for mental health issues (Chawla & Solinas-Saunders; 2011; Lester et. al, 2016; McFarlane, 2009; Scharfe, 2011; Tanielan, 2008). These struggles with rejoining the family system and underlying mental health disorders due to deployment resonate throughout the entire family system and can disrupt adaptive family dynamic development (Eaton et. al., 2008; Maholmes, 2013; Mansfield, et. al., 2010; Paley, et. al., 2013).

Adverse Effects of Deployment

Deployment can lead to numerous negative consequences that affect family members and individual family dynamics; including parent-child attachment, the deployed family member, the non-deployed family member, and military children.

At-home parent. While typically resilient during military deployment, military spouses can face their own variety of struggles. These issues begin while the partner is deployed but can also continue after the spouse returns from deployment (Wicker, 2015). Non-deployed primary caregivers are at a higher risk of mental health issues including depression, posttraumatic stress, anxiety, sleep disorders, and impaired parental functioning (Eaton et. al., 2008; Green, Nurius, Mansfield et. al., 2010; Lester et. al, 2016; Milburn & Lester, 2013). Concerns such as these can lead to feelings of boredom,

anger, social impairment, and deployment uncertainty (Erbes, Meis, Polusny, & Arbisi, 2012; Faber, Willton, Clymer, MacDermid, & Weiss, 2008; Wheeler & Torres Stone, 2010). These feelings can cause the non-deployed caregiver to experience feelings of being emotionally and physically drained (Kees, Nerenberg, Bachrach, & Sommer, 2015). The stress experienced by the non-deloyed spouse can be aggravated by increased communication with the deployed family member about the deployed member's stressful circumstances as well as media coverage documenting the war-time risks (Kelley et. al., 2001).

Family system. While military deployment most notably affects the relationship between the deployed parent and their children, it has resounding effects on the entire family system. This includes the parental marriage relationship, the co-parenting relationship, and the non-deployed parent-child relationship (Creech et. al., 2014; Lincoln et. al., 2007; Palmer, 2008; Waldrep, Cozza, & Chun, 2004). Military deployment can cause agitation in the marital relationship which can include increased conflict and decreased collaborative problem solving for both martial relationship and family problems which can resonate into the parent-child relationship (Lester et. al., 2016; Paley et. al, 2013). Such experiences in the parent-child relationship can include difficulty setting limits and establishing boundaries (Paley et. al, 2013).

Continuous and repeated military deployments also may place military involved families at a higher risk of unhealthy communication patterns, reduced emotional involvement, and ineffective problem-solving skills (Lester et. al, 2016). Unfortunately, these maladaptive communication skills can have negative effects on family resiliency during military deployment as well as overall child well-being (Saltzman, et. al., 2011; Riggs & Cuisimano, 2014; Walsh, 2003; Walsh, 2006). These negative effects

experienced during military deployment were influenced by previous history of life stressors, an absence of comfort in dealing with Army organizations, and general struggles experienced in the Army lifestyle (Saltzman et. al., 2009). The non-deployed parent's reaction to military deployment and the social support they received can significantly impact how the child will react to deployment (Flake et. al., 2009; Rosen, Teitelbaum, & Westhuis, 1993).

Deployment and attachment. Military deployment can disrupt the attachment process between child and caregiver. Secure attachment styles can develop when a caregiver is able to appropriately respond to their child's physical and emotional needs (Bowlby; 1977). However, a child can develop an insecure attachment style when their needs are not appropriately met or infrequently met by their caregiver (Bowlby; 1977). Due to the increased emotional stress that occurs during deployment, at-home parents often do not have the necessary mental resources to tend to their child's emotional wants and needs. This highlights the need to develop secure parent-child attachment. Regardless of the parental role, the mother-child relationship and father-child relationship have similar attachment patterns and outcomes (Page & Bretherton, 2001). Unfortunately, parental and spousal stress can be inversely correlated with a child's attachment security (Page & Bretherton, 2001). At-home parental distress can be positively correlated with reports of family disruption and can negatively impact the child's attachment security (Medway, Davis, Cafferty, Chappell, & O'Hearn, 1995). In addition, at-home parent's stress levels can be indicative of their child's stress level (Medway et. al.; 1995). Due to the extra demands put on the non-deployed family member and the unavailability of the military involved caregiver during deployment, deployment can inhibit military children

from developing secure attachment styles with both the non-deployed and deployed parent.

Military children. Children of frequently deployed military members can suffer behavioral and emotional difficulties due to more chronic and longer military deployments. Approximately two million children have experienced a single military deployment and nearly 800,000 have experienced multiple military deployments (Canfield, 2013). Children of deployed military members can experience fear, anger, worry, and concern (Canfield, 2013). They may also experience thoughts of guilt regarding their parent's departure, worry about both parents, and feelings of loneliness and abandonment (Canfield, 2013). These complex emotions can result in children feeling fearful, angry, worrisome, shy, jealous, and confused as well as struggling with emotional adjustment (Canfield, 2013; Chawla & Solinas-Sanders, 2011; Gorman, Eide, & Hisle-Gorman; 2010; James & Countryman, 2012; Lester, et. al., 2016). Military children may display anger and emotional outbursts, temper tantrums, poor social skills, and modifications in their eating and sleeping habits as compared to other children (Canfield, 2013; Creech et. al., 2014). Military children may display greater difficulty with peers and forming prosocial peer relationships (Lester et. al., 2016). The changes in family structure due to deployment can be further exacerbated by the fact that younger children often do not have the necessary coping mechanisms nor access to external supports as compared to older children (Hodges & Bloom, 1984). This inadequate possession of support can lead to the parent-child attachment process being disrupted as the child feels insecure in their parent's warmth, responsiveness, and consistency to fit their needs (Medway et. al., 1995).

Children who have been affected by military deployment may have an increased risk of internalizing and externalizing difficulties, difficulty forming interpersonal relationships with peers, and decreased prosocial behaviors (Eaton et. al., 2008; Lester et. al, 2016; Mustillo, Wadsworth, & Lester, 2016). Jensen, Martin, & Watanabe (1995) found children affected by military deployment suffered higher rates of depression. Chartrand et. al., (2008) contends children with deployed parents typically show more behavioral problems compared to their peers without deployed parents which has been further supported by Erbes et. al. (2012). Children with deployed parents also may experience a more stressful lifestyle, anxiety, attitude problems, rule breaking, aggressive behaviors, and complicated attachment behaviors (Barnes, Davis, & Treiber, 2007; Creech, Hadley, & Borsari, 2014; Chawla & Solinas-Saunders, 2011; Flake, Davis, Johnson, & Middleton, 2009; Huebner, Mancini, Wilcox, Grass, & Grass; 2007; Kelley et. al., 2001; Lester et. al, 2016). In addition, children during deployment may exhibit irritability, impulsivity, heightened tearfulness, greater needs for attention, and difficulty with discipline (Eaton et. al., 2008).

Maltreatment during deployment. Military involved families may be more at-risk for child maltreatment during military deployment periods. Specifically, the parent living at home may become more prone to engage in child maltreatment while their partner is absent during deployment when compared to periods when the partner is not deployed (Clark & Messer, 2006; Gibbs, Martin, Kupper, & Johnson, 2007; McCaroll, Fan, Newby, & Ursano, 2008; Rentz et. al., 2007). The gender of the abuser has been considered but the findings have been inconsistent across studies. Gibbs and colleagues (2007) find that female spouses are more likely to be the abuser during deployment. Specifically, they are three times more likely to commit maltreatment, four times more

likely to neglect, and two times more likely to physically abuse their children. However, Gibbs et. al. (2008) attest fathers are more abusive, especially in instances in which drugs or alcohol are involved. Gibbs et. al. (2007) concluded that these higher reports of neglect are due to stress experienced by the civilian parent. Military family stress may be further exacerbated by more frequent and longer military deployments (Rentz et. al, 2008; Sheppard et. al., 2010).

Protective Factors

Despite the negative impacts of deployment, many protective factors exist that can deter adverse effects. Nyaronga, Posada, MacDermid, & Schwarz (2008) indicate a child's attachment security may be stronger when a parent is involved with their child and maintains regular communication with the parent. Support, both emotional and instrumental, may also help to alleviate some of the stresses caused by military deployment (Paris, DeVoe, Ross, & Acker, 2010; Spera, 2009). This includes socially supportive agents who can complete tasks to assist the family in household responsibilities as well as outside agents providing emotional support to children when the parent's emotional capacities are depleted (Paris et. al., 2010; Spera, 2009). Werner and Smith (1982, 1992, 2001) studied developmental trajectories for at-risk children and concluded key mechanisms for resiliency skill formation can include the quality of the parent-child relationship, self-confidence, and supportive relationships with family and community members.

Recommendations to Address Concerns

In 2007, the American Psychological Association (APA) proposed a Task Force on Military Deployment Services for Youth, Family, and Service Members to address the effects of military deployment (APA, 2007). This report includes recommendations that

military involved families receive access to high-quality mental health services and focus on diagnoses such as adjustment disorder, depression, PTSD, and family violence. However, receiving proper interventions has proven difficult for military involved families due to numerous factors. Family members who do not live on a military base may have difficulty receiving mental health interventions and may experience difficulty getting access to treatment due to work schedules, financial reasons, and lack of knowledge about available options (Huebner et. al., 2007; Paley et. al., 2013). Additionally, mental health interventions have been primarily aimed at addressing the needs of the deployed member. It is only recently researchers have addressed the entire family system through intervention. Due to military deployment's resounding effects throughout the entire family system, approaches addressing every family member are needed to support positive outcomes for military children and families (Chawlas & Solinas-Saunders, 2011; Lester et. al, 2016; Lincoln et. al., 2008; Sories et. al., 2015).

Child Centered Play Therapy

Child-Centered Play Therapy (CCPT) is a developmentally appropriate, research-validated method of providing mental health services to children that allows them to express emotions through play (Bratton, 2006; Erikson, 1964; Moustakas, 1953; Piaget, 1962; Vygotsky, 1966). Landreth (2002) defines CCPT as a "dynamic interpersonal relationship between a child and a counselor trained in play therapy who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self through the child's natural medium of expression – play. (p. 11)". During CCPT, children are provided the free direction to play and fully express their inner world within the limits of a safe and predictable therapeutic environment

characterized by empathy, genuine-ness, and unconditional positive regard (Axline, 1947, Guerney, 1983, Landreth, 2012).

CCPT Philosophy

CCPT is heavily rooted in the person-centered counseling approach of Carl Rogers (1942). Rogers (1942) believed people possessed the innate ability to set their own goals and work towards their own progress. Guerney (2001) contends client self-direction is efficacious for any therapy modality regardless of age or severity of the mental health issue. Virginia Axline, a student of Rogers, took Rogers' person-centered therapy foundation and applied it to children (Axline, 1947). Axline developed the eight basic principles of nondirective play therapy: establishing a caring relationship between the child and therapist, fully accepting of the child for who he or she is, creating a free atmosphere in which the child feels capable of expressing a wide range of emotions, recognizing and reflecting a child's feelings, respecting the child's ability to internally solve problems and providing opportunities to establish responsibility, allowing the child's leadership in play therapy sessions, understanding the gradual process of therapeutic change, and providing therapeutic boundaries only when it deemed necessary (Axline, 1947). Axline (1947), Moustakas (1953) & Landreth (2002) asserted children have the inner ability to develop self-actualization through self-direction when provided an environment fully accepting of the child. It is this dogmatic belief in self-direction that separates CCPT from other models of play therapy (Bratton et. al., 2018).

CCPT Benefits

According to Landreth (2002), there are eight basic benefits of CCPT. These include that children learn to accept their feelings, express their feelings responsibly, respect themselves, assume responsibility for themselves, be creative and resourceful in

confronting problems, learn self-control and self-direction, and make choices and be responsible for their choices. All of these help a child grow and mature. When a child is able to mature, then they are more able to easily develop into fully functional and self-actualized individuals. Mousatkas (1959) contends when a child is able to value themselves and others, then the child makes significant gains.

Conceptualization

Maladaptive behaviors are conceptualized as an incongruence between a child's environment and their self-concept which keeps the child from reaching self-actualization (Axline, 1947). Inappropriate behaviors are acquired in an attempt to cope with the distortion between the environment and one's self concept. Axline (1969) explains:

> "The various types of maladjusted behaviors, such as daydreaming, withdrawal, regression, repression….seems to be the evidences of the *inner self's* attempting to approximate a full realization of the self-concept. But this realization is an 'underground nature'…The further apart the behavior and the concept, the greater the maladjustment… When the behavior and the concept are consistent…there is no longer inner conflict. (p. 13)"

The therapist's accepting attitude towards a child allows a child to accept the different parts of themselves including maladaptive behaviors. Landreth (2002) states the most important aspect of CCPT is the presence of an empathetic and understanding adult that can allow a child to meet their self-needs in a socially appropriate manner. Empathy is one of the most important factors to influence children in developing emotional self-regulation especially when resolving aggressive behaviors (Peterson & Flanders, 2005; Trotter, Eshelman, & Landreth, 2003).

Factors and Instruments for Change

Landreth (2002) expresses the importance of a CCPT therapist fully conveying a sense of "being with" the child. It is only when the child feels safe, accepted, and

understood they will begin to explore and express experiences they consider the most emotionally meaningful. During a CCPT session, the therapist accomplishes this through tracking of nonverbal behavior (e.g. "You decided to play with that instead"); reflecting content and feelings (e.g. "You are sad that happened"); encouraging (e.g. "You were able to do it."); returning responsibility to the child (e.g. "You decide what that is in here."); facilitating the relationship (e.g. "You wanted to know what I thought about that."), and, when necessary, setting limits (e.g. "I am not for hitting") (Landreth, 2002). Bettleheim (1987) postulates it is essential for children to transform previous aversive events that have been experienced. When the child is able to change their role in an aversive event from passive to having active control, then the child is able to grow and develop. The replaying of stressful events is a cathartic process that children engage in to deal with their own psychic trauma (Schaefer, 1994). Children can deal with their own psychic trauma and change their role in the event from passive to active using play materials.

Toys are provided during a CCPT session that support the acting out of aggressive, regressive, independence, and mastery issues. There are three categories of toys used in the play room: real-life toys, aggressive or acting out toys, and toys for creative expression and emotional release (Landreth, 2002). Real-life toys can include baby dolls, doll houses, nursing bottles, and medical kits. Aggressive toys can include toy soldiers, handcuffs, dart guns, and aggressive hand puppets. Expressive toys can include construction paper, playdoh, egg cartons, and cotton rope. With these toys, the child is allowed the opportunity to put their feelings into developmentally appropriate medium which assists them in making sense of their feelings while supported in a therapeutic environment (Landreth, 2002).

Limit Setting

While all emotions, thoughts, and feelings are accepted in the CCPT session, not all behaviors are given the same level of acceptance. When it is determined that it is necessary, limits can be set on the child's behavior. These limits include hurting the therapist or self, the destruction of possessions, or any other behavior that would make it difficult for the therapist to fully accept the child (Axline, 1969). These limits provide a sense of security for the child as well as to keep the child from feeling guilty as it might occur if the child were allowed to violate the world of reality. When the child is allowed a safe environment to regulate their own emotions and exercise self-control, this translates to practicing and implementing those skills outside of the therapy session.

CCPT's Benefits

There are numerous benefits to CCPT as a behavioral intervention. CCPT can be an effective intervention in externalized behavioral issues in preschool as well as elementary-school children (Baggerly, Ray, & Bratton 2010; Bratton et. al., 2012; Cochran, Cochran, Nordling, McAdam & Miller, 2010; Flahive, 2005; Garza & Bratton, 2005; Karcher & Lewis, 2002; Kot, 1995; Kot, Landreth, & Giordano, 1998, Packman & Bratton, 2003, Ray, Blanco, Sullivan, & Holliman, 2009; Ray, Schottelkorb, & Tsai, 2007; Schottelkorb & Ray, 2009; Schumann, 2005; Tyndall-Lind, Landreth, & Giordano, 2001). CCPT can be effective in treating general behavioral issues, internalizing problems, self-efficacy, self-concept, depression, speech difficulties, diabetes medication compliance, and anxiety (Baggerly, 2004; Clatworthy 1981; Danger & Landreth, 2005; Fall, Balvanz, Johnson, & Nelson, 1999; Gould, 1980; Jones & Landreth, 2002; Kot, 1995; Kot et. al, 1998; Packman & Bratton, 2003; Post, 1999; Raman & Kapur, 1999; Shashi, Kapur, & Subbakrishna, 1999; Tyndall-Lind, Landreth, & Giordano, 2001;

Quayle, 1991). In addition, CCPT can decrease parental stress, child-parent relationship stress, and bolster parental empathy towards the child (Bratton et. al., 2010; Bratton et. al., 2018).

CCPT's Cultural Sensitivity

CCPT is also a culturally sensitive intervention for children. Developmental theories contest that cultural values, traditions, roles, and ethnic identity are expressed and practiced through play (Vanderberg & Khielhofner, 1972; Vgotsky, 2002). CCPT is a research supported approach for an array of cultures including Hispanic children, witnesses of domestic violence, Chinese earthquake victims, Ugandan orphans, students with learning disabilities, homeless children, and children who are chronically ill (Baggerly, 2004; Garza & Bratton, 2005; Jones & Landreth, 2002; Kot, 1995; Kot, Landreth, & Giordano, 1998; Ojiambo & Bratton, 2013; Packman & Bratton 2003; Shen, 2002). In addition, meta-analysis conducted by Lin & Bratton (2015) demonstrates a larger effect size with studies whose samples include >60.0% non-Caucasian participants; further supporting CCPT's cultural sensitivity.

Meta-Analyses

While there are many approaches to play therapy, meta-analyses indicate humanistic nondirective play therapy demonstrates a statistically significantly larger treatment effect (effect size (ES)=0.92, Large) compared to directive play therapy (ES=0.72, Medium) (Bratton et. al., 2005). Play therapy is equally efficacious with internalizing behavioral problems (ES=0.81, Large) as well as externalizing behavioral problems (ES=0.78, Medium) and is more effective when clients presented with co-occurring behavioral problems (ES=0.91, Large; Bratton et. al., 2005). These effect sizes indicate play therapy has a medium-to-large benefit on behavioral concerns. Students

who receive CCPT interventions have shown significant decreases in behavioral and emotional issues when compared to control or comparison groups with treatment effects being in the medium-to-large range (Flahive & Ray, 2007; Garza & Bratton, 2005; Helker, 2007; Jones, Rhine, & Bratton, 2005; Packman & Bratton, 2005; Shen, 2002; Smith & Landreth, 2004). Ray, Bratton, Rhine, & Jones (2005) find play therapy groups performed at 0.73 standard deviations better as compared to nontreatment groups. These findings are an improvement on previous meta-analyses including Casey & Berman (2005) who reported an effect size of 0.71 (Medium) in addition to LeBlanc & Ritchie (1999) who stated an effect size of 0.66 (Medium) in a meta-analysis of their 42 play therapy studies. Throughout all studies analyzing CCPT treatment efficacy, these treatment effects range from medium (ES=0.47), medium (ES=0.66), and high (ES=0.85) (Bratton et. al., 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015).

Parental Importance in CCPT

Although play therapy is effective across numerous age ranges, cultural groups, and theoretical modalities; there is at least one factor that influences effectiveness of play therapy: parental involvement (Bratton et. al., 2005; LeBlanc & Ritchie, 2001; Ray et. al, 2011). While play therapy is effective without parental influence, the level of change is of greater clinical significance when the intervention makes use of routine caregiver involvement. Ray et. al. (2011) considers routine family involvement as "parental participation in each child play therapy session" and is a significant predictor of play therapy outcome. Researchers found CCPT involving professionals is efficacious (ES=0.72, Medium) (Bratton et. al. 2005). However, when comparing studies directly involving caregivers, CCPT is more effective (ES=1.25, Very Large; Bratton et. al., 2005). Lin & Bratton (2015) also found a differences in effect sizes between play therapy

with little or no parental involvement and play therapy involving caregivers; 0.33 (Low) and 0.59 (Medium) respectively. These findings, consistent with other studies, underscore the importance of involving parents in the treatment process (Bratton et. al., 2005; Dowell & Ogles, 2010; Bratton et. al., 2018; Lin & Bratton, 2015; Weisz et. al., 1995).

Filial Therapy

In the early 1960's, Bernard Guerney recognized the significant demand for children's mental health services and wanted to develop a modality that took advantage of the natural relationship between parent and child (Guerney, 1964). With this foundation, Guerney developed filial therapy (FT). Filial therapy is a methodology that facilities parents learning play therapy skills to become more emotionally involved with their child at home for a prescribed period of time (Andronico, Fidler, Guerney, & Guerney, 1967; Gurney, 1964; Guerney, Guerney, & Andronico, 1966). The parents are supervised by play therapy professionals who provide support regarding their play therapy sessions. Although play therapy can be effective for all ages, filial therapy is a method of primarily treating children with emotional disturbances from three to ten years of age (Andronico et. al., 1967; Fidler, Guerney, Andronico, & Guerney, 1964; Gurney, 1964; Guerney et. al., 1966).

Theoretical Foundation for FT

Filial therapy is grounded in client-centered therapy and builds upon the foundation of child-centered play therapy. There are a multitude of beliefs inherent in filial therapy. One belief is, when parents are actively involved in their child's treatment, they will maintain a positive attitude and high motivation towards treatment (Andronico & Guerney, 1967). This differs greatly from traditional forms of child therapy, that are imbued with an implicit attitude a parent cannot deal with a child and therefore must be

taken away from them for a period of the week to be helped. There is also the covert belief that the parent was the root cause of the child's maladaptive behavior. Filial therapy, much in contrast, supposes parents are a necessity to be involved in the treatment process and whose role as an agent of change cannot be replicated by anybody else. Another belief is, if parents are given the adequate skills to facilitate major changes in their child's life, a caregiver has more opportunities to bring about change due to the nature of the parent-child relationship (Guerney, 1964).

FT Approach

The approach for filial therapy is parents can be taught the necessary skills to improve their interactions with their children. Indeed, Guerney (1964) states many issues which occur in the family are not due to pathology but rather due to a lack of parenting knowledge or skills. This approach rests on the belief parent are more emotionally significant to a child and any behavioral issues learned from the parent or influenced by parental attitudes can be more effectively ceased if given similar circumstances. In addition, misperceptions that occur between a parent and a child can be easily fixed by the parent learning what is and what is not appropriate behavior given the place, time, and circumstances. (Guerney et. al., 1966).

FT Structure

Filial therapy is conducted with groups of six to eight parents over the span of at least thirty weeks. The parents are taught basic skills and interventions of a child-centered play therapist. These skills include structuring of the play session, behavior tracking, reflecting feelings and content, facilitation of decision making and creativity, limit setting, and self-esteem building. This role emphasizes genuine acceptance of a child's

needs and feelings and unconditional positive regard towards the child. Andrico & Guerney (1967) define the goals of filial therapy as:

> "to help the child change his perceptions or misperceptions of the parents feelings, attitudes, and behavior; to allow the child-mainly through the medium of play-to communicate thoughts, needs, and feelings to his parents that he had previously kept from awareness, thereby helping to resolve anxiety-producing internalized conflicts; and to bring the child a greater feeling of self-respect, self-worth, and confidence. (p. 1)"

At the beginning of filial therapy, parents observe the trained clinicians having individual play therapy sessions with their children. Throughout the course of observations, parents have play therapy sessions with their children under the supervision of clinicians and other group members. Parents have the ability to observe clinicians, be observed by the clinicians and other group members, role play scenarios that occur or could occur during their play sessions and observe other group members conducting play therapy sessions (Guerney, 1964).

This training period typically lasts approximately eight weeks and afterwards play sessions are conducted at home. The time of the play sessions begins at 30 minutes and then gradually extend to 45 minutes after more experience is gained. While these play sessions occur at home, the filial therapy group members also have group sessions to discuss the previous week's play sessions with the clinician and other group members to elicit feedback. The beginning of these group sessions is focused primarily on the members learning the techniques via didactic group instruction and supervision. The clinician does not encourage the parent to use these techniques outside of the play sessions and instead relies on the parent to generalize these skills when they feel like they are capable. After the basic techniques and skills are solidified, the sessions begin to focus on exploring the parent's emotions, problems, and attitudes in relation to their

child; particularly those that are experienced during the play sessions and other significant people in their lives. Through these discussions, parents are able to increase their self-awareness and open themselves up to other view-points that can create a stronger parent-child relationship (Guerney, 1964). Filial therapy emphasizes the importance of including parents in the intervention process as it can statistically improve outcomes and potentially provide a more effective treatment (Bratton et. al., 2005; Dowell & Ogles, 2010; Bratton et. al., 2018; Lin & Bratton, 2015; Weisz et. al., 1995).

Advantages of FT

Filial therapy has several advantages as compared to play therapy with a clinician. Filial therapy avoids a rivalry between the therapist and parent that can develop when affection between the child and therapist increases and dependency on the parent decreases (Stover & Guerney, 1967). FT helps to reduce the feelings of guilt and helplessness that could develop when the parent relies on the therapist for problem resolution (Stover & Guerney, 1967). Finally, filial therapy avoids problems that can develop when a parent does not develop adaptive responses to a child's emerging behavioral patterns (Stover & Guerney, 1967).

Goals of FT

Filial therapy originally started as a catalyst to promote the emotional growth of children, but it blossomed to help children and parents with various relationship problems. VanFleet (2007) considers the three central goals of filial therapy to be the elimination of the presenting problem, the development of positive interactions between parent and child, and an improvement in the family's communication, coping, and problem-solving skills which will help them to address future conflicts autonomously and successfully. Rennie & Landreth (2000) believe filial therapy has the ability to strengthen

parent-child relationships, increase parental acceptance of and empathy for their children, improve the home environment, improve child self-esteem and adjustment, decrease parental stress, and decrease child behavior concerns.

Child-Parent Relationship Therapy

Child-Parent Relationship Therapy (CPRT) is an empirically based, manualized counseling intervention for children who present with an array of social, emotional, and behavioral issues. CPRT is grounded on the same foundation as FT and relies on the parent-child relationship is the primary factor for change. However, Garry Landreth wished to build upon the work of the Guerneys and wanted to make a more structured and condensed form of filial therapy to cut down on constraints such as finances and time (Landreth 1991; Landreth, 2002). Instead of the span of thirty plus weeks in filial therapy, Garry Landreth and Sue Bratton (2018) condensed the intervention into 10 structured sessions and formally published the intervention with *Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model*. To enhance implementation and treatment fidelity, the 10 sessions are manualized (Bratton et. al., 2018). The central goal of CPRT is to enhance the parent's sensitivity to their children and help create an accepting, understanding, and non-judgmental environment with their child (Landreth, 1991). When this occurs, children are able to discover new parts of themselves and different ways of interacting with their parents.

CPRT Structure

CPRT uses a small group format that includes both didactic and supervision experiences. It is designed for groups that include, on average, six to eight parents that meet in weekly two-hour groups over the course of 10 weeks. Parents conduct weekly supervised play sessions with their children and are encouraged to incorporate CCPT

skills and attitudes and help to promote a more attuned and empathetic parent-child relationship. When a parent is able to communicate more empathetically with their child, the child can develop self-regulation, appropriate behaviors with others, and empathetic communication with peers (Guthrie, & Murphy, 2003; Kilpatrick, 2005; Liew et. al., Valiente et. al., 2004). Parents especially value the group portions of CPRT as it allows them a safe environment that promotes learning and being vulnerable (Ceballos & Bratton, 2010; Chau & Landreth, 1997)

Differences between CPRT and FT

CPRT differs significantly from other forms of filial therapy. CPRT's purpose is not problem-solving but rather working on the parent-child relationship which can lead to cooperative problem solving in the future (Bratton et. al., 2018). The focus is on acceptance of a child's behaviors rather than teaching or correcting them. Another difference is all play sessions are child-led with no direction from the parent rather than to establish the therapeutic environment (Bratton et. al., 2018). The parent is taught, using the child-centered play therapy skills, to create an environment that sends a message that conveys "I am here. I hear you. I care. I understand" (Bratton et. al., 2018). These child-centered play therapy skills include tracking behavior, reflective responding, esteem-building, encouragement, therapeutic limit setting, and choice giving (Bratton et. al., 2018). CPRT also makes use of specific toys that are only to be used during the play therapy sessions including baby dolls, doll houses, nursing bottles, medical kits, toy soldiers, handcuffs, dart guns, aggressive hand puppets, construction paper, playdoh, egg cartons, and cotton rope (Bratton et. al., 2018).

Benefits of CPRT

CPRT has numerous effects on the parent, the child, and the parent-child relationship as a whole. The child is able to learn to identify their feelings, discover adaptive ways to express feeling, control their impulses, understand choices they have, problem solve, responsibly make decisions, and trust themselves (Bratton et. al., 2018). CPRT increased the parent's feelings of acceptance and unconditional love for their child and reduced the child's behavioral concerns (Chau & Landreth, 1997; Harris & Landreth, 1997; Jang, 2000; Landreth & Lobaugh, 1998; Lee & Landreth; 2003; Tew et al., 2002). The parents experienced a reduction in parent-child relationship stress, a decrease in parent-child conflict, a greater understanding of the child's play, greater respect for the child's feelings, recognition of their child's autonomy, increased the child's self-esteem, and developed a closer parent-child relationship (Chau & Landreth, 1997; Glass, 1987; Kale & Landreth; 1999; Kidron, 2004; Lee & Landreth, 2003). Children participating in CPRT also can demonstrate a decrease in anxiety and depression, develop greater adaptability and leadership, and develop social skills (Post, et. al., 2004). In addition, CPRT is effective at addressing attachment disruptions (Carnes-Holt & Bratton, 2014; Opiola & Bratton, 2018). The group structure of CPRT is especially advantageous as it allows a safe environment where participants can receive support from participants, have cathartic reactions, practice behavioral management skills, and be vulnerable with other participants (Bratton et al., 2018; Ceballos & Bratton, 2010; Chau & Landreth, 1997).

Diversity Issues in CCPT

CPRT and its earlier forms developed by Landreth have been successfully utilized with a diverse array of parent and children populations including single parents, non-offending parents of sexually abused children, children who have chronic illnesses,

Native American parents, incarcerated mothers, Korean parents, parents children with learning difficulties, incarcerated fathers, Chinese immigrant parents, adopted children, Latino families, Israeli parents, and African Americans parents (Bratton & Landreth, 1995; Cabellos & Bratton, 2010; Carnes-Holt & Bratton, 2014; Chau & Landreth, 1997; Costas & Landreth, 1999; Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Kale & Landreth, 1999; Kidron, 2003; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Sheely-Moore & Bratton, 2010; Tew, Landreth, Joiner, & Solt, 2002; Yuen, Landreth, & Baggerly, 2002). Due to it being utilized with a varying array of cultures and populations, research supports CPRT as a culturally efficacious intervention.

CPRT and Military Involved Families

CPRT addresses the challenges which deployment can predispose military involved families to including family separation, changes in the family's structure and roles, and chronic exposure to stressful circumstances (Hicks et. al., 2016). CPRT can address these challenges military involved families are exposed to by helping parents form a tighter bond with their children, reducing the child's behavioral issues, and decreasing the amount of parent-child stress in the household (Chau & Landreth, 1997; Chawla & Solinas-Saunders, 2011; Glass, 1987; Harris & Landreth, 1997; Kale & Landreth; 1999; Kidron, 2004; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002). In addition, play therapy is the preferred treatment modality for children who are experiencing grief or trauma associated with military deployment (Sories et. al, 2015). Military involved families can enefit from CPRT through helping the entire family adjust to immediate as well as long-term emotional effects of military deployment

(Myrick et. al., 2018). These emotional effects can include stress induced by multiple deployments and feelings of helplessness (Myrick et. al., 2018).

CPRT is a holistic approach which can be effective in improving child emotional and behavioral health as well as decreasing parent stress (Chau & Landreth, 1997; Harris & Landreth, 1997; Kale & Landreth; 1999; Kidron, 2004; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002). This is especially important given the non-deployed parent's maladaptive emotional symptoms can correlate with children's negative emotional experiences (Chawla & Solinas-Sanders, 2011). Military involved families prefer strengths-based mental and those which focus on family members' current effectiveness (Hicks et. al., 2016; Lester et. al, 2011; Lester et. al., 2012). Additionally, CPRT is ideal for military involved families because it is an easily transportable and accessible intervention that can be carried with military involved families incase another deployment occurs (Hicks et. al., 2016).

Previous Research involving CPRT and Military Involved Families

Despite the congruence between the intervention's benefits and population needs, there is a dearth of research of regarding filial therapy and military involved families. This research includes theoretical applications and case studies of filial therapy with military involved families.

Hicks et. al. (2016) explores the case of 3-year-old Trent and his family. At the beginning of the study; Trent's father, Brandon, was set to deploy in three weeks and his mother, Julie, had anxiety about Trent's reaction to the deployment. With assistance from her therapist, Julia learned the child-centered play therapy techniques over the course of two weeks and incorporated them into her relationship with Trent. After training and receiving feedback, Julie's relationship and ability to set limits with Trent improved.

Brandon returned from deployment and went through the same training as Julie. Brandon stated the training reduced the uncertainty Trent was feeling after his father returned and also provided a manner in which limits could be positively set. Julie also expressed the "entire family is now better off because Brandon and I now both participate in discipline. Even better, we know how to handle limits in a positive way. This helps our whole family feel better" (Hicks et. al., 2016). In this study, CPRT was considered a success by Susan and Brandon, improved their parenting skills, and helped to resolve Trent's emotional issues due to Brandon's deployment.

Myrick et. al. (2018) launched a case study with one military family: Susan, John, and their 5-year-old son, J.J. Susan reported, since John's deployment and the birth of her second child, J.J. had become more distant from her. He also displayed aggressive behaviors with peers and had difficulty concentrating during class. At home, J.J. had trouble falling asleep and displayed attention-seeking behaviors such as tantrums and disobedience. Susan would avoid mentioning these issues to her husband as she did not want to add to his list of worries and for fear of John becoming angry with J.J. The events at home and deployment after-effects caused Susan mental health disturbance and negatively affected her relationship with J.J.

Upon suggestion from her therapist, Susan engaged in filial therapy to improve J.J.'s behavioral issues and assist in repairing the parent-child relationship. Susan, under instruction from her therapist, learned the child-centered play therapy techniques over the course of four weeks and practiced applying them at home. Overall, filial therapy had positive individual effects on Susan and J.J. including increasing Susan's parenting confidence and decreasing J.J.'s behavioral problems. While the benefits first began at school, it soon translated into home with increased affection towards his mother and then

little brother. It also gave Susan and J.J. significant one-on-one time that helped improve the overall parent-child relationship. Susan also planned on having the therapist teach the skills to John after he returned from military deployment. In this case, Susan was able to learn the foundation of child-centered play therapy, increase her parenting confidence, and reduce J.J's behavioral problems.

Vivona (2015) wanted to investigate the effectiveness of CPRT in improving attachment between eight post-deployment families and their children. The children were examined on a single case, multiple baseline basis. Attachment was measured using Caregiver Child Social/Emotional and Relationship Rating Scale, The Child Observation Checklist, and the Parenting Relationship Questionnaire. All eight of the parents reported they experienced a statistically significant increase in awareness of attachment and their abilities to create a bond of attachment with their child. The parents, as well as all of their children, reported a statistically significant increase in attachment that consistently trended upward throughout the study. The parents also disclosed the experience of learning CPRT skills helped to feel as though the intervention experience was positive and they intended to transition the learned skills to use with their other children. Many of the families also reported CPRT helped to improve their marital relationship. These results indicate that CPRT can be an effective intervention to improve attachment and strengthen the parent-child relationship between post-deployment families and their children.

Gaps and Limitations in Literature

Based on research, CPRT can be used to decrease child-parent stress and child behavioral concerns (Chau & Landreth, 1997; Glass, 1987; Harris & Landreth, 1997; Kale & Landreth; 1999; Kidron, 2004; Landreth & Lobaugh, 1998; Lee & Landreth,

2003; Myrick et. al., 2018; Tew et al., 2002). While there exist theoretical applications and case studies of CPRT utilized with military involved families, there are no studies that examine the statistical significance of CPRT on child-parent stress and child behavioral concerns in military involved families. While CCPT has been utilized to examine the significant differences in stress and child behavioral concerns in military families, no study has attempted to examine the differences using CPRT. Our study fills this gap in literature by determining the effects CPRT has on child-parent stress, child behavioral concerns, and parents' ability to support their child's social-emotional health in military involved families.

Summary

In conclusion, positive early childhood mental health is bolstered by a child forming secure parent-child attachment (Thompson, 2002). Due to the nature of deployment, military involved families are subject to several factors that can interfere with positive early childhood mental health formation including difficulty forming adaptive parent-child relationships, increased parental stress, and greater behavior concerns in children (Canfield, 2013; Creech et. al., 2014; Lincoln et. al., 2007; Lester et. al., 2016; Palmer, 2008; Waldrep et. al., 2004). CPRT is an intervention that can improve child-parent relationship formation, decrease parental stress, and decrease behavioral concerns in children (Chau & Landreth, 1997; Harris & Landreth, 1997; Kidron, 2004; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002). In addition, CPRT also caters to many of the preferred intervention styles of military involved families including building on existing family strengths, being transportable, and addressing the entire family unit rather than a single member (Chawlas & Solinas-Saunders, 2011; Hicks et. al., 2016; Sories et. al., 2015; Lester et. al., 2012; Lester et. al, 2016; Lincoln et. al.,

2008). Our current study examined the effects CPRT has on parent-child stress and child behavioral concerns, examined the participant's experiences of the CPRT intervention, and determined the effects CPRT had on the participant's ability to support their child's social-emotional health.

Chapter 3

Methodology

This study examined the efficacy of Child-Parent Relationship Therapy in reducing parent-childhood stress and child behavioral concerns as well as to examine the experiences of military involved families throughout the CPRT process. In addition, the researchers examined how CPRT helped the participants to support their child's social-emotional health. A mixed methods design utilizing quantitative assessments and semi-structured qualitative interviews was employed to examine parent-child stress, child behavioral concerns, the participant's individual experiences of CPRT and their ability to support their child's social-emotional health. This chapter includes research design, research procedures, data collection, and data analysis.

Research Design

A mixed methods design was employed to explore the perceived effectiveness of CPRT through postintervention individual assessments and interviews (Creswell, 2003). Mixed methods design is defined as a way for the collection, analysis, and integration of both quantitative and qualitative data within a single study to obtain a more complete understanding of the research topic (Creswell, 2014; Creswell & Plano Clark, 2011; Ivankova, Creswell, & Stick, 2006). This mixed methods design used quantitative assessment to examine parent-child stress and child behavioral concerns. In addition, the researchers employed semi-structured qualitative interviews to examine the participant's experience of the CPRT intervention and how the intervention helped to change the participant's ability to support their child's social-emotional health. By utilizing a mixed methods approach, the researchers gained an understanding of the participant's perception on how CPRT affected their child-parent stress and child behavioral concerns.

Sequential Explanatory Design

Specifically, this study utilized an exploratory mixed methods design to both quantitative and qualitative data with the other to provide a more thorough understanding that one set of data could not provide by itself (Creswell & Plano Clark, 2011). The primary reason for implementing a sequential explanatory design is quantitative results, data, and analysis can provide a greater overall understanding of the research problems. Contributing to these results, the qualitative results, data, and analysis can help explain the quantitative results through an exploration of participants' experiences that can provide a greater depth not reflected by the quantitative data (Creswell & Plano Clark, 2011; Ivankova et al., 2006).

The strengths of the sequential explanatory design include honesty and the ability to have the data explained in greater detail (Ivankova et al., 2006). Limitations included the robust amount of time invested to complete a sequential explanatory design and difficulty in obtaining the necessary resources to conduct data collection and analysis for quantitative as well as qualitative data (Creswell & Plano Clark, 2011; Ivankova, Creswell, & Stick, 2006). Others have successfully utilized a mixed-methods design to evaluate play therapy interventions including CPRT (Edwards, Sullivan, Meany-Walen, & Kantor, 2010; Garza, Kingsworthy, & Watts, 2009; Grskovic & Goatze, 2008; Taylor, Purswell, Lindo, Jayne, & Fernando, 2011).

Research Questions

The following research questions guided the study of Child-Parent Relationship Therapy (CPRT):

QUANTITATIVE

1. Is CPRT effective in reducing parent-child relationship stress in military involved families?
2. Is CPRT effective in decreasing children's behavioral concerns in military involved families?

QUALITATIVE

1. What are parents' experiences of completing CPRT?
2. Following the completion of the CPRT intervention, how do parents perceive their ability to use CPRT skills to support their children's social-emotional health?

MIXED METHODS

1. In what ways do the follow-up interview results help to explain the quantitative results?

Sample Selection & Target Population

To recruit participants, convenience as well as snowball sampling was used with the primary resource being a university in the central southern United States where the research was conducted. Recruitment took place primarily via word-of-mouth through research staff who were familiar with military-involved families in the research area. Recruitment materials were also distributed to military centers, community mental health agencies serving military populations, local day cares, and schools throughout the area. The recruitment materials included details of the CPRT group including date, location,

time, cost, and benefits. This sample was drawn from the population of active duty military members or partners of active duty military members who met the following inclusion criteria: parent is over the age of 18, parent is in a family in which at least one of the parents is an active duty military member, military member parent has experienced at least one deployment, parent has at least one child between the ages of 3 and 10, parent identifies issues with their child's behavior, the parent gives permission to participate in the CPRT program, and the parent is able to speak and read English.

Ethical Procedures

The researchers ensured the group was a safe environment where the participants could share all thoughts and feelings that would allow them to get maximum benefit from the group. Confidentiality was repeatedly emphasized throughout the group process to assist with procuring a safe environment, although it was emphasized confidentiality could be ensured from the researchers but not from other participants. The researchers also discussed there would be a learning and implementing of new skills that could cause some personal discomfort. In addition, the researchers mentioned no prejudice or penalty would befall the participants if they decide to withdraw early from the group process.

Procedures were taken to ensure participant's quantitative and qualitative data was protected. All obtained data was stored in a storage container accessible by lock and key only the research team had access to. All participants were assigned a code number with which their data was identifiable. The confidentiality of participants was protected by having all personal identifying information removed from the qualitative interviews as well as assigning numbers to all participants' quantitative assessments. All personal information was removed from the qualitative interviews after transcription. To ensure treatment fidelity, the groups were led by the primary researcher who has completed 119

hours of training in child-centered play therapy and CPRT facilitation as well as over 200 hours of supervised experience leading CPRT groups. The groups were co-facilitated by a graduate student with 10 hours of CPRT training who was supervised by the primary researcher. The qualitative interviews were conducted by a graduate student with 10 hours of CPRT training who was supervised by the primary researcher.

Quantitative Phase

The basic intent of a quantitative design is "to test the impact of a treatment (or an intervention) on an outcome, controlling for all other factors that might influence that outcome" (Creswell, 2014, p. 156). The researcher used a one group pretest-posttest design to quantitively examine parent-child stress and child behavioral concerns before and after the 10-week training that specifically addressed the following research questions: Is CPRT effective in reducing children's behavior problems in military involved families and is CPRT effective in reducing parent-child relationship stress in military involved families? (Creswell, 2014).

Instrumentation

The instruments chosen for the quantitative phase of research include the Child Behavior Checklist-Parent Report Form (CBCL; Achenbach & Rescorla, 2001) and Parenting Stress Index (PSI; Abidin, 2012). Each instrument was selected based upon previous literature, as well as the distinct psychometric property it measures and its applicability to the research purpose. In the following paragraphs, the characteristics of both measures are expanded upon.

Child Behavior Checklist-Parent Report Form Revised

The Child Behavior Checklist-Parent Report Form (CBCL) composed by Achenbach & Rescorla (2001) measures the parent's report of children's behavioral and

emotional issues primarily through the child's social relationships, recreational activities, and academic performance. The CBCL has parents rate a child's behavioral and emotional concerns on a 0-2 scale: (0) *Not True*, (1) *Somewhat or sometimes true*, (2) *Very true or often true*. The CBCL includes a Total Behavior scale with two subscales: Internalizing Behaviors and Externalizing Behaviors. These subscales consist of 118 clinical items divided into eight domains: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention, Aggression, and Rule-Breaking Behavior. Internalizing Behavior scales include Social Withdrawal, Somatic Complaints, and Anxious/Depressed. Externalizing Behavior scales include the domains of Delinquent Behavior and Aggressive Behavior. Each of the subscale and factor scores can be computed to determine *T* scores and percentiles. A decrease in scores indicates a child's targeted behavior has decreased (Achenbach & Rescorla, 2001).

The CBCL was normed with a diverse sample and included children referred for clinical and special education services as well as children from various preschool, pre-kindergarten, and child-care settings. The children were also residents of various countries that included the United States, Canada, Australia, and Jamaica. Test-retest reliability for CBCL is 0.90 for Total Problems, 0.91 Internalizing Behaviors and 0.92 for Externalizing Behaviors (Achenbach & Rescorla, 2001). Long term scaled score stability is 0.70 for Internalizing Behaviors and 0.83 for Externalizing Behaviors. The internal consistency of the empirical problem scales was bolstered by alpha coefficients of 0.78 to 0.97. In congruence with Cronbach's alpha, these estimates are considered Clinically Acceptable to Clinically Excellent. Both constructs are strong as supported by the evidence of every item, but items were differentiated between referred and non-referred

children. Criterion-related validity is also well established for the CBCL as supported by all the items differentiating between referred and non-referred children.

Parenting-Stress Index

The Parenting Stress Index (PSI) is intended for use by parents of children between the ages of 1 month to 12 years old which determines stress within the parent-child system and identifies those at risk for problematic parent and/or child behavior (Abidin, 2012). The PSI is divided into two domains, Child and Parent, which when combined form the Total Stress Scale. Within the Child Domain, six subscales including Distractibility/Hyperactivity, Adaptability, Reinforces Parent, Demandingness, Mood, and Acceptability evaluate the sources of stress related to the child from the parent's report. The Parent Domain consists of seven subscales including Competence, Isolation, Attachment, Health, Role Restriction, Depression, and Spouse-Parenting Partner Relationship. Parents can complete the 101 Likert-like scale questions in approximately 20 minutes. Clinical scores in the 85th to 89th percentile is considered high while those in the 90th or higher percentile are considered significant.

The PSI has been normed for diverse populations and maintains its efficiency with non-English speaking cultures including Chinese, Portuguese, French Canadian, and Dutch populations (Abidin, 2012). Internal consistency for the Child Domain scale ranges between 0.78 and 0.88 and between 0.75 to 0.87 for the Parent Domain scale. The reliability coefficients for both domains as well as the Total Stress scale were 0.96 or larger indicating a high degree of internal consistency. Test-retest reliability was obtained from four different studies and the latest study included a reliability coefficient of 0.55 for the Child Domain scale, 0.70 for the Parent Domain scale, and 0.65 for the Total Stress Score which supports the PSI's stability over time. The PSI's construct and

predictive validity are supported by its more than 250 studies, translation into 40 official languages, and application to diverse populations suggesting parenting stress is a universal concept that transcends cultural groups (Abidin, 2012).

Intervention

The CPRT intervention used a small group format that included both didactic and supervision experiences. CPRT began with the participants learning the theoretical and philosophical approach of CCPT. CPRT then transitioned into the facilitators teaching CCPT skills and techniques to the participants. After the techniques and skills had been practiced, the participants were encouraged to begin incorporating the skills and techniques gradually. Then, the participants conducted weekly supervised play sessions with their chosen child. After conducting the weekly individual play sessions, the participants were encouraged to share feedback regarding their sessions and other participant's sessions.

Data Collection

Data from the CBCL was collected as a pre-survey prior to the implementation of CPRT. Likewise, data from the PSI was collected as a pre-survey prior to the implementation of CPRT. At the end of the group intervention, the participants completed the CBCL and PSI. The instruments from these two points in time were completed in paper and pencil format and collected by the primary researcher for further analysis.

Data Analysis

To ensure accuracy on the CBCL and the PSI, parent responses on these measures were scored using the appropriate computer scoring software. These numbers were entered into SPSS so reliability could be assessed. Once the assessments were scored, a

repeated samples t-test was conducted for both child behavior problems and parent-child relationship stress (Field, 2013; Plano Clark & Creswell, 2015). For the purpose of this study, alpha level was set at the .05 level of significance. Effect sizes were calculated to assess the magnitude of the differences over time and to establish practical significance using Cohen's d (*d*; Cohen, 1988)

Qualitative Phase

This phase of the research utilized a basic qualitative research design. The goal of the qualitative phase was to "further expand on the data analysis steps and the methods used for presenting the data, interpreting it, validating it, and indicating the potential outcomes of the study" (Creswell, 2014, p. 184). A basic qualitative research design usually collects data through multiple sources including analyzing interviews, examining documents, or observing behaviors (Creswell, 2014). Because the purpose of the qualitative phase of the study was to understand how military involved families understand and experience the group intervention as well as how CPRT helped to support their child's social-emotional health, implementing a basic qualitative approach for the qualitative phase of the research study was a straightforward choice. This choice was due to the researchers believed participants have a greater credence in their belief of a problem or issue compared to the researcher's understanding or interpretations from previous literature (Creswell, 2014).

Role of the Researcher

Because qualitative research is an interpretive process and the researcher is an essential part of the study, it is important for the researcher to be cognizant of their personal biases and maintain objectivity to the greatest degree possible (Glesne, 2011). Considering how researcher, research participants, setting, and research procedures

influence one another is necessary to achieve this objective (Glesne, 2011). The primary researcher specializes in play therapy and lead the CPRT groups. In addition, primary and secondary researchers hold the personal belief CCPT and CPRT are valid interventions that have positive effects on childhood mental health. Therefore, an emotional investment in the data and the participants exists, making it difficult to assert absolute objectivity (Glesne, 2011). Maintaining an awareness of biases helped to ensure all results gathered from the data are trustworthy and credible.

Ensuring Trustworthiness and Credibility

Several measures were employed throughout the data collection and analysis processes to ensure trustworthiness and credibility during the qualitative research phase. The primary researcher used a reflective journal throughout the research study which allowed the primary researcher to explore her own subjectivity as well as challenge her thought processes and biases regarding the collected data (Plano Clark & Creswell, 2015). Three researchers independently analyzed the data for codes and themes to reduce the impact of individual bias on data analysis. There were consistent coordinated communication between coders to share analysis and cross-check codes independently developed by coders. This included meetings to discuss similar codes, dissimilar codes, similar themes, and dissimilar themes. In addition, researchers checked their themes to determine if there were commonalities between each researcher's themes to differentiate and synthesize themes. After the data was analyzed, member checks were coordinated with participants to bolster the data's trustworthiness and credibility. Data obtained from qualitative and quantitative methods was triangulated by checking with each researcher and individual participants to determine commonalities between themes.

Participant Selection Criteria

Two individuals from the research study participated in the qualitative phase. Participants for the qualitative phase were purposefully selected based on the following characteristics:

1. Participants must have participated in at least 2/3 of the CPRT trainings.
2. Participants must have received feedback on at least 4 of their video-recorded sessions.

Participants who did not experience 2/3 of CPRT trainings were excluded because participants not participating in this amount of trainings would not know the material nor have a full understanding of the provided skills and techniques. Participants who did not receive feedback on at least four of their video-recorded sessions were excluded due to not receiving enough refinement of their CPRT sessions in addition to not having a full understanding of the provided skills and techniques. All participants from the study were interviewed so the researchers could obtain a more thorough understanding of the data due to low sample size. The low sample size is attributed to a number of reasons, particularly the intervention being offered was new to the area and the uncertainty of military life caused some participants to discontinue participation in the research.

Data Collection

The researchers further explained the quantitative results by conducting semi-structured interviews after the CPRT training. The qualitative interviews were conducted by a graduate student with 10 hours of CPRT training who were supervised by the primary researcher. The interviews were conducted in a counseling laboratory on a college campus in the central southern United States and ranged between twenty minutes to fifty-five minutes in length. Parents responded to open-ended interview questions and

the interviewers used appropriate probes to elicit in-depth answers. Interviews were recorded on an audio recorder and transcribed verbatim. Through these interviews, the researchers explored the participant's general reactions to CPRT including the most beneficial characteristics and suggestions to improve further CPRT trainings. The researchers examined how CPRT has specifically changed the participant's interactions with their child, the ways in which the learned skills helped to support their child's social-emotional health, and whether CPRT has changed the overall home environment. In addition, the interview questions explored how CPRT generally worked within the participant's military lifestyle.

Two research questions were addressed through one-on-one interviews conducted with participants. The first research question addressed was: "*What are parents' experiences of completing CPRT?*" The second research question addressed was: "*Following the completion of the CPRT intervention, how do parents perceive their ability to use CPRT skills to support their children's social-emotional health?*" The interviews were transcribed for analysis. Interviews were conducted 3 weeks after CPRT group ending. The data obtained from the qualitative phase was triangulated with data obtained from the quantitative phase.

Interview Questions

The following were questions asked during the qualitative interviews:

1. What are your reactions to CPRT?
2. How has CPRT changed the way you relate to your children?
3. How has CPRT changed the way you view yourself as a parent?
4. How has CPRT changed your home environment?
5. How would you describe your ability to use these skills to support your child?

6. What part of the training has been most beneficial to you?
7. What are your suggestions for improving this type of training?
8. How do you see this type of training as it relates to your military lifestyle?

Data Analysis

Qualitative data analysis followed the process of coding, refining codes, and building findings described by Creswell (2008): (1) Read through all data, (2) Divide the data into smaller segments, (3) Label each segment with a relevant code, (4) Reduce redundancy among codes, and (5) Organize codes into themes. The data was analyzed by multiple coders independently and qualitative reliability procedures were put into place to support consistency. These procedures included checking all transcripts for errors, collaborating to form consistent definitions of each code, scheduled meetings to promote communication between coders, and cross-checking codes to secure inter-coder consistency (Creswell, 2014).

Mixing of Data

The mixed-method research question "*In what ways do the follow-up interview results help to explain the quantitative results?*" was expanded upon by comparing the qualitative and quantitative data. Analysis occurred which examined the manner in which the themes and quotes from the qualitative phase help to explain the results from the quantitative phase during this comparison.

Summary

The research study utilized a sequential explanatory mixed methods approach to examine the efficiency of CPRT on parent-child stress, child behavioral concerns, and the ability of CPRT to support child social-emotional health. In accordance with the mixed methods approach, the study consisted of both a quantitative phase and a qualitative

phase. In the quantitative phase of the study, two participants took part in CPRT. Participants completed the CBCL and PSI in a pre-test and post-test format. Data was collected from each participant and afterwards qualitative phase occurred three weeks after CPRT cessation. During the qualitative phase of the study, two participants were interviewed to determine their perceptions of CPRT and how the training changed their ability to support their child's social-emotional health. Analysis of the qualitative data was conducted to determine codes and themes. Finally, after the quantitative and qualitative data were analyzed, the qualitative results were compared to the quantitative results with an examination of how the qualitative data explained the quantitative data.

Chapter 4

Results

This chapter presents the results of the qualitative and quantitative analyses for the research questions presented in this study. This research was conducted to evaluate the impact of CPRT on stress and child behavioral concerns between parent and child in military involved families. The first two research questions were evaluated using pre-test and post-test data utilizing the Parenting Stress Index (PSI) and the Child Behavior Checklist-Parent Report Form (CBCL). The third and fourth research questions were evaluated using qualitative interviews to determine the parents' experiences of completing CPRT and how CPRT changed the participant's perception to support their child's social-emotional health. The fifth research question was evaluated using qualitative data obtained from qualitative interviews which was then mixed with the quantitative data to determine how the follow-up interview results help to explain the quantitative analysis results. Mixed method procedures were utilized in accordance with guidelines delineated by Creswell (2014), Creswell & Plano Clark (2011) & Ivankova, Creswell, & Stick (2006). In addition, a data analysis summary is provided.

Types of Significance

The results were evaluated with regards to three types of significance: statistical significance, practical significance, and clinical significance.

Statistical significance. Statistical significance involves the likelihood of obtaining the results given the sample size (Armstrong & Henson, 2004; Thompson, 2002). Statistical significance for the current study was measured using alpha level (α) and p value. Alpha level (α) is the probability of a study stating the intervention has no effect on a variable when the intervention actually did have an effect (Dalgaard, 2008). *P*

value is the probability of study stating the intervention has an effect on a variable when the intervention actually did not have an effect (Dalgaard, 2008). A repeated samples t-test was conducted for both child behavior concerns and parent-child relationship stress (Field, 2013; Plano Clark & Creswell, 2015). While statistical significance is generally considered the top standard of significance, there can be situations in which results are not statistically significant but do have real-world applicability. Practical significance has merit in cases such as this.

Practical significance. Practical significance describes the difference among groups or the importance of findings amongst a particular population (Armstrong & Henson, 2004). Practical significance is measured and reported using effect sizes, which describe group differences and assist in determining the importance of results (Armstrong & Henson, 2004; Sink & Stroh, 2006). Practical significance is especially helpful when studies have a small sample size due to the sample size's effect on statistical significance (Armstrong & Henson, 2004). Small sample sizes can increase the chances of results showing the intervention has no effect on the sample when in actuality it does (Armstrong & Henson, 2004; Sink & Stroh, 2006; Thompson, 2002). Practical significance allows researchers to examine the strength of a relationship even when there is no statistical difference present when this occurs (Armstrong & Henson, 2004). Practical significance was reported using Cohen's d (*d*, Cohen, 1988). Cohen's d interprets practical significance using the following framework: (a) $0.20 \geq$ small (b) $0.50 \geq$ medium (c) $0.80 \geq$ large. However, there can be instances in which an intervention has affected the participant in ways that are not shown by analyzing statistical or practical significance. Clinical significance is another type of significance that can evaluate changes not measured or demonstrated by the other two significance measures.

Clinical significance. Clinical significance is a third method of evaluating the importance the intervention has for participants (Kazdin, 2003; Thompson, 2002). In the behavioral science field, decisions are often interpreted through categorical framework and are thus dependent upon diagnostic criteria or other measures to determine functioning (Thompson, 2002). Statistical significance and practical significance can fail to convey the ways in which the intervention has benefitted participants and are not sufficient enough to adequately describe the intervention's benefits (Kazdin, 2003; Thompson, 2002). Clinical significance measures the "the practical or applied value or importance of the effect of an intervention, that is, whether the intervention makes a real (e.g., genuine, palpable, practical, noticeable) difference in everyday life to the clients or to others with whom the clients interact" (Kazdin, 2003, p. 691). Through examining clinical significance, researchers seek to determine if the intervention caused a change in participants which led to a deviation in their normal lives and affected their overall functioning (Kazdin, 2003). Clinical significance is measured using criteria that relate to functioning in everyday life in order to accurately assess the applied value of the intervention (Kazdin, 2003). These measures are categorized thusly: (a) Comparison method; participants are compared to normative samples or dysfunctional samples following the intervention; (b) Absolute Change methods; researchers measure the amount of change participants make without comparing to an external sample; (c) Subjective Evaluation methods; Participants changed their perceptions of the changes following the intervention or those who interact with the participant regarding their perceptions of the changes following the intervention; and (d) Social Impact methods, which include measures of client change on criteria that are recognized as a critical part of daily functioning, such as level of parent-child stress or number of behavioral concerns

(Kazdin, 2003). In this study, clinical significance was measured using the Subjective Evaluation and Social Impact methods through the semi-structured follow up interviews. These interviews elicited participants' perceptions of the changes they experienced following the CPRT intervention and the changes to their families' daily functioning.

Sample Demographics

Parents from two active duty military-involved families participated in the study. Both participants were 34-year-old Caucasian females. One participant possessed a bachelor's degree while the other possessed an associate degree. Both participants chose to utilize the intervention with their 8-year-old sons. One participant's child is white while the other is multiracial. The number of deployments experienced by the participants' children ranged between 3 deployments to 4 deployments with an average of 3.5 deployments. The total amount of months the deployments encapsulated ranged between 16 months to 34 months in total with an average of 25.5 months. Both participants were affiliated with the Army branch of the armed services.

Quantitative Results

Participants completed the Parenting Stress Index (PSI) and Child Behavior Checklist(CBCL) before and after the CPRT intervention. The instruments were scored, and results were reported in Table 1 for the two CPRT participants. The current study's first research question was "Is CPRT effective in decreasing children's behavior problems in military involved families?". The CBCL included Internalizing Behaviors, Externalizing Behaviors, and Total Behaviors subscales. Each of these subscales were evaluated using a paired samples *t*-tests. There was not a significant statistical difference in the scores for child internalizing behaviors before the intervention (μ=64.00, *SD*=8.485) and after the intervention (μ=61.00, SD=0.000); $t(1) = 0.500$, p=0.71, d=0.35.

There was not a significant statistical difference in the scores for child externalizing behaviors before the intervention (M=60.00, SD=8.485) and after the intervention (μ=55.50, *SD*=13.435); *t*(1) =1.286, *p*=0.42, *d*=0.91. There was not a significant statistical difference in the scores for total child behaviors before the intervention (μ=65.00, *SD* =0.000) and after the intervention (μ=60.00, *SD*=9.899); *t*(1) =0.714, *p*=0.61, *d*=0.51. Cohen's *d* was calculated to assess practical significance by examining the magnitude of the treatment effects. Results indicated CPRT had small-to-large treatment effect sizes (*d*= 0.35, 0.91, 0.51) on children's Internalizing Behaviors, Externalizing Behaviors, and Total Behaviors respectively when compared with participants' baseline assessments.

The current study's second research question addresses "Is CPRT effective in reducing parent-child relationship stress in military involved families?". The PSI included Child Stress, Parent Stress, and Total Stress subscales. Each of these subscales were evaluated using a paired samples *t*-tests. There was not a significant statistical difference in the scores for total child stress before the intervention (μ=63.00, *SD*=5.657) and after the intervention (μ=56.00, *SD*=12.728); *t*(1) =1.14, *p*=0.40, *d*=0.99. There was not a significant statistical difference in the scores for total parent stress before the intervention (μ=53.00, *SD*=8.485) and after the intervention (μ=49.50, *SD*=4.950); *t*(1) =1.14, *p*=0.40, *d*=0.99. There was a significant statistical difference in the scores for total stress before the intervention (μ=58.00, *SD*=7.071) and after the intervention (μ=52.50, *SD*=8.485); *t*(1) =3.667, *p*= 0.17, *d*=2.59. Cohen's *d* was calculated to assess practical significance by examining the magnitude of the treatment effects. Results indicated CPRT had large treatment effect sizes (*d*= 0.99, 0.99, 2.59) on Child Stress, Parent Stress, and Total Stress respectively when compared with participants' baseline assessments.

See Table 1 for Quantitative Data Results.

Table 1. Quantitative Data Results

		Pre-test		Post-test				Cohen's
Outcome	n	μ	SD	μ	SD	*t*	*p*	*d*
Child Stress	2	63.00	5.66	56.00	12.72	1.4	0.40	0.99
Parent Stress	2	53.00	8.49	49.50	4.95	1.4	0.40	0.99
Total Stress	2	58.00	7.07	52.50	9.19	3.67	0.17	2.59
Internalizing Behaviors	2	64.00	8.49	61.00	0	0.50	0.71	0.35
Externalizing Behaviors	2	60.00	8.49	55.50	13.44	1.29	0.42	0.91
Total Behaviors	2	65.00	0	60.00	9.90	0.71	0.61	0.51

Qualitative Results

The study addressed the following research questions through qualitative analysis: "What are parents' experiences of completing CPRT?" and "Following the completion of the CPRT intervention, how do parents perceive their ability to use CPRT skills to support their children's social-emotional health?". Seven themes emerged among CPRT participants with regular frequency and saliency. Each theme included in the content analysis was referenced by all respondents and cited multiple times.

Member Checks

Member checks were coordinated with participants after researchers followed the qualitative procedures outlined by Creswell (2008) including reading through all data, dividing the data into smaller segments, labeling each segment with a relevant code, reducing redundancy among codes, and organizing codes into themes. A researcher sent out an e-mail to participants asking participants to communicate the tentative findings and request feedback regarding the final themes. One participant responded and generally agreed with the themes. She provided further information related to the themes of "Benefits Specific to Military Lifestyle" and "Elimination of Household Chaos"

including expanding on CPRT's ability to provide an avenue for the deployed member to reconnect with their child, develop a parent's emotional regulation skills during stressful situation, and support their child's daily routines. The other participant did not respond to the researcher's e-mail.

Themes

Themes are listed in order of the amount of supporting evidence. The following themes

were identified for CPRT participants:

a) Individual Techniques Changed Participant's Parenting Abilities & Efficacy
b) Enhanced Parent-Child Relationship
c) Developed Parent-Child Connection
d) Positive Intervention Experience
e) Benefits Specific to Military Lifestyle
f) Relinquishment of Control
g) Elimination of Household Chaos

For a list of theme definitions, see Table 2.

Table 2
Qualitative Themes and Definitions Derived from Content Analysis of Interviews for CPRT participants (n=number of statements)

n	Theme	Definition
52	Individual Techniques Changed Participant's Parenting Abilities & Efficacy	The participant learned specific skills and techniques which changed their parenting abilities as well as perception of their parenting abilities.
38	Enhanced Parent-Child Relationship	The overall relationship between the parent and child was enhanced by emphasizing patience, developing listening skills, increasing empathy, and promoting communication.
30	Positive Intervention Experience	The participants believed the intervention experience was beneficial to their needs.
27	Developed Parent-Child Connection	The connection between the participant and their child was developed through increased awareness of the parent-child connection and the importance of collaboration.
24	Benefits Specific to Military Lifestyle	The intervention provided skills and techniques which would be especially valuable to the military lifestyle as well as the deployed service member.
11	Relinquishment of Control	The participants experienced a relinquishment of control to their child which allowed them to feel more in control as a result.
5	Elimination of Household Chaos	The skills helped to make the participant's household less chaotic and more structured.

In the following section, each theme is defined and ordered by the frequency of supporting statements. Identified statements that support each theme are listed as quotes from participants.

Theme 1: Individual Techniques Changed Participant's Parenting Abilities & Efficacy

The theme depicted across CPRT participants ways in which the skills and techniques acquired through CPRT helped to change the participant's efficacy in their parenting abilities. The following statements were made by participants' regarding CPRT's ability to make their child's behavioral concerns more manageable and thus gain confidence in their ability to handle behavioral concerns as they arise.

- "It's often in the back of my mind when I feel like I'm not being the parent I want to be. And the things that I learned and the thoughts and phrases that went over in the class will pop up….and I'm usually able to use that.

- "So…I can see that being really useful…Yea. Because even for me, not being gone, not being active duty. It definitely gives you confidence in your parenting ability like I said. Because you have those resources. So I can see how that can make things easier.

- "But to know we have little tools that we can take and work together so that I don't feel that he is lost and I am a terrible parent and I don't…we're just sort of drowning in this terrible sadness or anxiety or whatever is going on….we do have that connection and we can do it together".

Theme 2: Enhanced Parent-Child Relationship

The theme states CPRT helped the participants to improve the overall parent-child relationship by communicating they were aware of their child's experience and improving their overall communication skills with their child. The participants made the following statements regarding CPRT's effects on the parent-child relationship:

- "Individually is important. Um, and this allowed me to do that and actually have one-on-one with thirty minutes uninterrupted time with my kid. And, um, I think it helped me to actually kinda slow down a little bit and think things through a little bit more and not just react, or just be like 'No, you can't do that!' And not

give an explanation. And try, you know…..to just, you know, help them and guide them a different way"

- "...or they're telling me that, you know, this toy, something about this toy, I'll just, you know, I just track them, and I just help make sense. And then they know, yeah I'm listening and I'm with you…."

- "...Just spending that time with him in play session and...learning how to connect and follow his lead...made him feel more confident in our relationship."

- "I guess it's because, like, he'll, you know, if my kids say, you know, 'I want ice cream.' And I'm like, 'Okay, you want ice cream. I know you want ice – you know – I know you want ice cream.' And so that just validates them that I heard, 'yes I heard you. I know exactly what you're saying.' Like I – 'I heard you and...' Yeah, you know. Just, whatever they say 'Oh, I wanna go to the park.' 'Okay, let's go - you wanna go to the park so let's..' You know, I just like, repeat and I don't know just feel like it helps validate them, they know that I'm listening and I'm right there with them….."

Theme 3: Positive Intervention Experience

This theme depicts the participants belief that the overall CPRT group experience was beneficial to their needs including meeting their needs through group objectives, having their concerns validated, and being surrounded by a support system during the process.

- "Oh it feels good when I'm not messing up as a parent. Absolutely yeah. Uhm…definitely. It's just good to know that you have something to fall back on. Something to use, a way to relate to the kids."

- "So it's nice if you don't have that sort of support to help you when times get rough, to just have something internally."

- "So I think it's really beneficial to let them know that if they need me to be available there, they can tell me and we can arrange a time to do it."

Theme 4: Developed Parent-Child Connection

This theme describes CPRT helped to develop the feelings of connectedness between the participant and their child. This included both the participant and the child

having an awareness of their connection as well as realizing any issues that arose could be solved collaboratively.

- "….Realize the importance of our connection with each other rather than rushing around, accomplishing whatever task that seemed so important before….I think now we put more of a focus on our relationship and seeing things eye to eye and collaborating and that kind of stuff….. knowing that the relationship is so important…."

- "Before I thought…. Bigger picture: 'My child's not happy' or 'he's whining' or 'he's depressed and there's something that's bothering him'. Now I'm realizing, after taking the class, that there are small things throughout the day that I can do…That will help shape and improve that. And it's not just the big overall picture where we are a problem. It's like we have the little tools that will help us get there."

- "…Just slowing down, the connection, the empathy portion, and understand and empathize with them. And play with them. Even though I was less verbal, I still felt like there was as much of a connection; if not more."

Theme 5: Benefits Specific to Military Lifestyle

This theme describes how participants received benefits from CPRT which were especially beneficial considering their military lifestyle. This includes giving the deployed family member skills to more easily integrate back into the family such as choice giving and limit setting, an avenue with play which assists deployed family members in building rapport with their children and promoting consistency for the children in a lifestyle prone to uncertainty.

- "Um, just because there's so many other variables that can change. Like, you know, Dad picks up and leaves and goes TDY for a week here, and three days there, and then he's gone for a month, and then six months, and you know, it's just so much back and forth. I mean, and he could come home tomorrow and say 'we're going to another state,' you know? And just, you know, having something that's consistent is important for kids growing up."

- "But I could see the active duty service member really benefiting it-from it after a deployment. Because I think there are a lot of insecurities. At least, personally in our family…From the service member coming back and how they're gonna be able to relate to their children."

- "When the service member returns…they come back finding everything out; where they fit in. They want to be close to their children and reconnect. So, when you want to discipline but have to reconnect, there's this fear of being the bad guy. So, I think when you're using CPRT to do limit-setting, choice giving – those sorts of things can help diffuse the situation before the parent has to get angry."

Theme 6: Relinquishment of Control

This theme describes the ways CPRT gave the participants an opportunity to exercise proactive parenting instead of reacting to their child. Parents were given an opportunity to not control their child's behavior and instead let the child guide them especially in household routines which assisted the parent in regulating their own emotions. This led to the participant feeling more in control of their child and within the household.

- "…It gives me more options on, like, how to respond to be more of, um, a thermostat and not a thermometer, and you know, actually give them choices…and…and actually makes me think of, uh, you know, in what-in different situations, what I can do differently instead of just reacting immediately…"

- "Um, I feel that it's really helped me..um, like I said before, like, think things through before, like, reacting, and getting me some more tools to use, like choices and, you know, boundary-setting, and, you know, different things like that, that I can, you know, pull out and say, 'Okay you wanna do this, but, you have this choice.' You know? So, that has been extremely valuable to me and helped me and changed me on how I reaction. So… I guess it makes me feel more in control of the situation."

- "I think we're often on a tight schedule and so I'm thinking about where we have to be and when we have to be there. And all the things we talked about….during sessions…was to just have that patience…Not be over-reactive, slow down, and listen…"

Theme 7: Elimination of Household Chaos

This theme describes how the participants were able to make their house less chaotic through the use of CPRT skills. This included giving their children choices during daily life activities and reducing the intensity of problematic emotional responses.

- "…In the morning; getting ready for school: 'Which would you like to do?', 'Would you like to have breakfast first?', 'Would you like to get dressed first', "would you like to take a shower first?'…little things like that…helped it be less chaotic.

- "And asking him one hundred questions…Yeah so I guess homework times has been much less chaotic…less…uhm…just emotional breakdowns and less anxiety about it on both of our parts I would say."

- "That was taken off of me and it sort of…like I said…it minimized the chaos that was there before and like the heightened emotions because of this sense of urgency."

Mixed Method Results

A mixed methods explanatory sequential design utilizing quantitative assessments and semi-structured qualitative interviews was employed to examine parent-child stress, child behavioral concerns, participant's perceptions on how CPRT helped to support their child's social-emotional health, and the participant's individual experiences of CPRT. The study's fifth research question addressed "How do the qualitative results help to explain the quantitative results?". The researchers examined the manner CPRT had helped to change the participant's perception of their parenting abilities. While the quantitative results do not reveal statistically significant differences, the reduction in PSI and CBCL mean scores indicate a positive trend and CPRT may be efficacious in reducing parent-child stress and decreasing child behavioral concerns. However, the results do indicate practical significance. The effect sizes indicate CPRT had large effect sizes on Child Stress, Parent Stress, Total Stress, and Externalizing Behaviors. In

addition, there are medium effect sizes on Total Behaviors and small effect sizes on Internalizing Behaviors. While the results were not statistically significant, the effect sizes indicate practical significance.

Qualitative interviews lend credence to CPRT's clinical significance. Clinical significance was determined through subjective evaluation and social impact methods in which participants stated their perceptions of personal as well as general lifestyle changes following the intervention. The participants stated CPRT helped to eliminate household chaos by improving the participant's interactions with their children. This included behavioral management interventions which helped to reduce the conflict in routine activities such as clothing choices and dietary options. This perception could support the reduction in Internalizing Behaviors, Externalizing Behaviors, and Total Behaviors evaluated through the PSI. These effect sizes could also be support by the participant's perception that CPRT helped to improve the overall parent-child connection which emphasizes the parent-child relationship being collaborative rather than authoritarian. This perception the parent and the child could solve issues collaboratively, an assurance there was a solution to any issues that occur, and a development of the parent-child connection could have explained a reduction in behavior concerns.

Qualitative themes could have explained the reduction in stress levels within the household. Stress levels for all participants could have decreased by eliminating household chaos through utilizing behavioral interventions which could have made the overall home environment less stressful for all individuals. The participants reported CPRT helped them to relinquish control and let their child take a more autonomous approach with their behavior. The participants stated they were able to consider all possibilities and become more in-tuned with their child's world view rather than reacting

immediately, which helped them feel more in control of the situation. This perception of control could have alleviated participant stress which in turn resonated to their child. The participants also discussed how CPRT had benefits specific to their military lifestyle, especially in regard to integrating the deployed member back into the household. This is especially crucial considering military members experience heightened stress levels after deployment in part due to the service members' undefined role within the household (Chawlas & Solinas-Saunders, 2011; Hicks et. al., 2016; Lester et. al., 2016; Myrick et. al., 2018). In the next chapter an evaluation of the research questions will be presented. In addition to this evaluation, discussion of limitations, research implications, and recommendations for future research and practice will occur.

Chapter 5

Discussion

This study explored the impact of Child Parent Relationship Therapy (CPRT) on parent-child stress levels and child behavioral concerns for military-involved families who have experienced deployment. In addition, this study also examined CPRT's effect on the participant's ability to support their child's social-emotional health as well as the participant's experiences of CPRT to gain a more refined understanding to explain the qualitative data. Specifically, this study used a mixed-methods explanatory sequential design to examine the effect of CPRT on parent-child stress levels using the Parenting Stress Index (PSI), child behavioral concerns using the Achenbach Child Behavior Checklist (CBCL), and participant experiences through semi-structured qualitative interviews. A discussion of the significance of these results is included in this section. Specifically, a review of CPRT's implications on stress levels, child behavioral concerns, CPRT's ability to support the participant's child's social-emotional health, and shared intervention experiences are provided. This section also includes limitations of the current study, implications for practice, and recommendations for future research.

Stress

Military families may be exposed to chronic stress due to their lifestyle (Canfield, 2013; Chandra, 2008; Hicks, Lenard, & Brendle; 2016). This stress may be experienced before and after the military-involved member's deployment and has been experienced by the at-home parent, the deployed family member, and their children (Barnes, Davis, & Treiber, 2007; Eaton et. al., 2008; Green, Nurius, Mansfield et. al., 2010; Lester et. al, 2016; Milburn & Lester, 2013; Kelley et. al., 2001). Interventions addressing stress are especially important within military-involved families. Heightened stress levels can lead

to higher reports of neglect cases in military-involved families which can be further exacerbated by more frequent and longer deployments (Gibbs et. al., 2007). In addition, military-involved children's stress levels are often indicative of their parents' stress level (Medway et. al., 1995). Stress levels can affect child attachment security causing family disruptions and can lead to greater child irritability, impulsivity, fearfulness, greater needs for attending, and issues with discipline (Eaton et. al., 2008; Medway et. al., 1995). Children who have been affected by military deployment may be at a higher risk of internalizing and externalizing difficulties, difficulty forming interpersonal relationships with peers, and decreased prosocial behaviors (Eaton et. al., 2008; Lester et. al, 2016; Mustillo, Wadsworth, & Lester, 2016).

Military families can be exposed to stressful circumstances including family separation, changes in the family's dynamics, and constant exposure to stressful circumstances (Hicks et. al., 2016). CPRT addresses these concerns by allowing military families to form a tighter bond with their children and decrease the amount of parent-child stress in the household (Chau & Landreth, 1997; Chawla & Solinas-Saunders, 2011; Glass, 1987; Harris & Landreth, 1997; Kale & Landreth; 1999; Kidron, 2004; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002). CPRT also caters to military-involved family's needs as it is an easily transportable intervention which can be carried with participants in the event the family has to change locations; a perspective which was further supported by the participants in the current study (Hicks et. al., 2016; Lester et. al, 2011; Lester et. al., 2012). Our current research practically and clinically impacts military family's experiences of stress which can mitigate the adverse effects of stress throughout the household.

In this study, stress was assessed utilizing the Parenting Stress Index (PSI). A paired samples t-test was conducted to compare total stress before the intervention and after the intervention. The paired samples t-tests did not present statistically significant findings for Child Stress ($p = 0.395$), Parent Stress ($p = 0.395$), or Parent-Child Stress ($p = 0.170$). However, differences in preintervention and postintervention stress levels' means were found; Pre-Intervention Child Stress: 63.00, Post-Intervention Child Stress: 56.00; Pre-Intervention Parent Stress: 53.00, Post-Intervention Parent Stress: 49.50; Pre-Intervention Parent-Child Stress: 58.00, Post-Intervention Parent-Child Stress: 52.50. A reduction in numerical scores indicates a reduction of stress (Abidin, 2012).

While the analyses indicate there is not a statistically significant difference, the data is trending a positive direction. The trends determined from decreasing means is more positive than the statistics appear to represent. There are also notable effect sizes with Parent Stress (d=0.99, Large), Child Stress (d=0.99, Large), and Total Stress (d=2.59, Large). With a larger sample size, the researchers believe this trend in reduction of scores can continue and further legitimize CPRT as an intervention to reduce parent-child stress in military involved families. It should be noted data was collected from one participant the day before their partner returned from deployment which could have affected overall parent-child stress levels and potentially contributed to reporting bias. While our results did not display statically significant results; the modest changes in pre-intervention and post-intervention means, large effect size, and the shared experiences of participants appear to further expand on these results. These findings help to support CPRT's efficacy in decreasing parent-child stress indicating clinically significant results.

Participants reported the military lifestyle is often stressful, prone to uncertainty and inconsistencies, and difficulties with the deployed family member integrating back

into the household which is commonly shared amongst military-involved family members (Allen et. al., 2010; Chawla & Solinas-Sanders, 2011; Goff, et. al., 2007; Pincus et. al, 2007; Willerton et. al., 2011). While there were not statistically significant results, practical and clinical results indicate CPRT impacts military families' stress levels. Participants in the current study reported CPRT assisted in eliminating household chaos which helped to reduce behavioral struggles between the participant and their child which could have assisted in reducing stress levels in the household. Participants also disclosed CPRT helped them relinquish control which could have allowed the participants to engage in a proactive parenting style rather than a reactive style. One participant disclosed:

> "….I feel that it's really helped me.....think things through before, like, reacting, and getting me some tools to use, like choices and, you know, boundary-setting, and, you know, different things like that, that I can, you know, pull out and say, 'Okay, you wanna do this, but, you have this choice.'…..So, that has been extremely valuable to me and helped me and changed me on how I react. So...I guess it makes me feel more in control of the situation."

When this "relinquishment" occurred, the participants gave their child more autonomy to make decisions and effectively allowed themselves the opportunity to alleviate themselves of extraneous responsibilities; potentially reducing stress levels and is consistent with previous research with different populations (Chau & Landreth, 1997; Glass, 1987; Kale & Landreth; 1999; Kidron, 2004; Lee & Landreth, 2003). These results suggest CPRT may have some effect on decreasing parent stress, child-stress, and parent-child stress levels in military involved families. Further research is needed to reinforce these conclusions.

Behavioral Concerns

Childhood behavioral concerns are especially important to address through early intervention. Preschool children have been known to display a significant increase of disruptive behaviors which are associated with negative trajectories in an early childhood environment and tend to remain generally stable throughout life (Barfield et. al., 2012; Brickmeyer & Eyberg, 2003; Hinshaw, 2002; Teisl & Cicchetti 2008; Tremblay, 2000; Webster-Stratton & Reid, 2003). When early childhood behavioral issues are not addressed, children are more at risk for developing serious mental health issues later on in life which can negatively impact a child's academic and personal success (Flahive & Ray, 2010; NCCP, 2012; Peth-Pierce, 2000; Thompson, 2002; U.S. Department of Health & Human Services, 2010). If these difficulties in building social relationships are not addressed, this could result in a cyclical pattern of strained relationships and inadequate social-emotional development that has negative implications on a child throughout the lifespan and can lead to antisocial personal disorder, juvenile delinquency, violence, and drug abuse (Barkley, 2007; Myers & Pianta, 2008; van Lier et. al., 2004; Walters, Ronen, & Rosenbaum, 2010).

However, there are more positive outcomes when these behavioral concerns are addressed through early intervention. CPRT can reduce parent-child conflict, reduce child behavioral concerns, promote parent-child attachment, and improve a child's ability to adapt to new situations (Chau & Landreth, 1997; Chawla & Solinas-Saunders, 2011; Glass, 1987; Harris & Landreth, 1997; Kale & Landreth; 1999; Kidron, 2004; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002). Attachment is the degree of prosocial interactions which exist in a parent-child relationship and is a child's introduction into relationships as it provides children with a sense of security and

assurance that the parental figure can be looked at as a source of comfort when the child experiences distress (Purvis, Cross, & Sunshine, 2007; Ryan & Bratton, 2008; Siegel & Hartzell, 2004; Van Fleet & Sniscak, 2003). When a child is able to view the world as a safe place due to secure parent-child attachment, this can allow them to explore new environments, learn self-mastery of difficult situations, and engage in social relationships outside of the family (Ahnert et. al., 2004; Belsky & Fearon, 2002; O'Connor & McCartney, 2007; Sroufe, 2005). Our current research suggests CPRT practically and clinically impacts child behavioral concerns which can mitigate the adverse effects behavioral concerns have on a child throughout their entire life.

Utilizing data from the Achenbach Child Behavior Checklist (CBCL), child behavior concerns were assessed. The paired samples t-test did not present statistically significant findings for Internalizing Behaviors, Externalizing Behaviors, or Total Child Behaviors; $t(1) = 0.500$, $p = 0.705$, $\mathbf{t}(1) = 1.286$, $p = 0.421$, and $t(1) = 0.714$, $p = 0.605$ respectively. However, differences were found in Pre-Intervention and Post Intervention Internalizing Behaviors, Externalizing Behaviors, and Total Child Behaviors Means: Pre-Intervention Internalizing Behaviors: 64.00, Post-Intervention Internalizing Behaviors: 61.00; Pre-Intervention Externalizing Behaviors: 60.00, Post-Intervention Externalizing Behaviors: 55.50; Pre-Intervention Total Behaviors: 65.00, Post-Intervention Total Behaviors: 60.00. A reduction in CBCL mean scores indicate a reduction in child behavioral concerns (Achenbach & Rescorla, 2001).

While the analyses indicate there is not a statistically significant difference, the data is trending a positive direction. There are also notable effect sizes with Internalizing Behaviors ($d = 0.35$, small), Externalizing Behaviors ($d = 0.91$, large), and Total Behaviors ($d = 0.51$, medium) (Cohen, 1988). With a larger sample size, the researchers believe this

trend in reduction of scores can continue and further legitimize CPRT as an intervention to reduce child behavioral concerns. It should be noted data was collected from one participant the day before their partner's returned from deployment which could have affected the child's behavioral concerns and the overall environment within the household. While our results did not display statically significant results, modest changes in pre-intervention and post-intervention means, small to large effect sizes, and the shared experiences of participants appear to further expand on these results and help to support CPRT's efficacy in decreasing child behavioral concerns.

Military-involved children may exhibit behavioral concerns due to the stressors of their lifestyle including emotional outbursts, temper tantrums, poor social skills, and modifications to their sleeping and eating habits (Canfield, 2013; Creech et. al., 2014). Children of frequently deployed military members can suffer behavioral and emotional difficulties due to military deployments including feelings of fear, anger, worry, concern, guilt about their parent's departure, loneliness, and abandonment (Canfield, 2013). These complex emotions can result in the child feeling fearful, angry, worrisome, shy, jealous, confused, and difficulty emotionally adjusting (Canfield, 2013; Chawla & Solinas-Sanders, 2011; Gorman, Eide, & Hisle-Gorman; 2010; James & Countryman, 2012; Lester, et. al., 2016). al., 2016). CPRT addresses these concerns through decreasing parent-child conflict, reducing behavioral concerns, assisting parents in respecting their child's feelings and recognizing their child's autonomy, increasing child self-esteem, and forming a closer parent-child relationship (Chau & Landreth, 1997; Glass, 1987; Kale & Landreth; 1999; Kidron, 2004; Lee & Landreth, 2003). These findings are consistent with our current study and are especially aligned with the participants' responses during the interviews.

The participants reported CPRT had effects on the behavioral concerns in their individual lives. The participants stated the techniques and skills learned in CPRT helped to modify their parenting abilities which could have explained the reduction in behavioral concerns. The specific skills and techniques learned from CPRT could have contributed to effectively managing the child's behavioral concerns and thus reduced them as a whole which is consistent with previous research (Glass, 1987; Kale & Landreth; 1999; Lee & Landreth, 2003). One participant stated regarding her ability to more effectively manage her child's behavior: "…we have little tools that we can take and work together so that I don't feel that he is lost, and I am a terrible parent…". The participant felt as though CPRT helped her approach behavioral issues through a collaborative approach rather than assuming complete authority of their child's behavior. In addition, the participants disclosed CPRT was able to improve the parent-child relationship as a whole which is also consistent with previous research (Chau & Landreth, 1997; Glass, 1987; Kale & Landreth; 1999; Kidron, 2004; Lee & Landreth, 2003). One participant stated the following regarding CPRT's effects to improve the parent-child relationship: "Just spending that time with him in play session and... learning how to connect and follow his lead...made him feel more confident in our relationship." The parents felt as though they were more aware of their child's experience and thus the entire relationship was improved. One participant stated: "I……just feel like it helps validate them, they know that I'm listening and I'm right there with them…..". The child was able to feel validated by the relationship-building skills which could have led to the reduction in child behavioral concerns. These results suggest CPRT may have some effect on reducing externalizing behaviors, internalizing behaviors, and total behaviors in children in military involved families. Further research is needed to reinforce these conclusions.

Limitations

Limitations of the study include the small sample size which could affect quantitative data analysis and ultimately generalizability to a larger population. In addition, the differences in participant potential and ability to execute CPRT skills and techniques could also affect results. For example: participants could be pre-disposed to individual differences in adopting CPRT philosophy and ultimately executing the CPRT skills and techniques. Participants could also have been influenced by their own perceptions when completing the quantitative assessments. As previously reported, one participant completed the post-intervention assessment the day before their partner returned from deployment which could have affected responses due to recency bias. Participant perception could have also affected the responses such as different perceptions of vocabulary used on assessments and unwillingness to disclose certain information. All assessments were self-report which could have affected the validity of the responses. As with all self-report measures, the accuracy of data is dependent upon the ability of the participant to be completely open and honest.

Qualitative interviews could also have been subjected to participant bias. Participants were aware the researchers believed in the efficacy of CPRT to reduce parent-child stress, reduce child behavioral concerns, and overall provide positive outcomes. Accordingly, this perception could have influenced the participants to give statements which focused more on positive aspects of CPRT rather than qualities which the participants perceived as negative. Participants could have wished to fulfill the desire of the researchers to obtain positive results and thus tailored their responses to fit this desire. While this is a reality experienced with qualitative research, the only manner in

which this can be controlled is to allow participants the opportunity to give all feedback and trust in participants to be as open and honest as possible.

Implications for Practice

Future interventions with military-involved families need to focus on decreasing stress and reducing child behavioral concerns. Military-involved families can be prone to heightened stress reactions during deployment which can be further exacerbated by longer and more frequent deployments (Chandra, 2008; Gibbs et. al., 2007; Tanielian & Jaycox, 2008). Deployment can cause military children to experience feelings of worry, anger, and confusion as well as temper tantrums, poor social skills, and modifications to their sleeping and eating habits (Canfield, 2013; Chawla & Solinas-Sanders, 2011; Gorman, Eide, & Hisle-Gorman; 2010; James & Countryman, 2012; Lester, et. al., 2016). CPRT can help to reduce family member stress, child behavioral concerns, and promote the overall relationship between child and parent (Chau & Landreth, 1997; Chawla & Solinas-Saunders, 2011; Glass, 1987; Harris & Landreth, 1997; Kale & Landreth; 1999; Kidron, 2004; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002). Our current research participants stated CPRT helped them to more effectively resolve child behavioral concerns and gave them techniques which assisted in reducing the participants' stress levels. Future interventions need to pinpoint skills and techniques which can assist military families in reducing the overall stress within the household while simultaneously reducing child behavioral concerns.

In addition, future interventions need to focus on challenges which are unique to the military population including providing consistency and avenues to assist with deployed family members' integration back into the family dynamic. This is often a challenge experienced by military involved families as the deployed family member has

difficulty adjusting to the family dynamic, feeling uncertain in their family dynamic role, and difficulty reconnecting with their children (Creech et. al., 2014; Chawla & Solinas-Saunders; 2011; Lester et. al, 2016; Lincoln et. al., 2007; McFarlane, 2009; Paley et. al, 2013; Palmer, 2008; Scharfe, 2011; Tanielan, 2008; Waldrep et. al., 2004). Participants in the current study discussed difficulty with their deployed partner integrating back into the family dynamic including difficulty reconnecting with their child and properly managing behaviors without using punishment. Participants reported the use of toys helped the deployed family member have a common avenue through which rapport could be built with children and behaviors appropriately managed. Future interventions need to provide opportunities which assist the deployed family member to integrate back into the family dynamic, establish rapport with their children, appropriately manage behaviors, and foster a secure parent-child relationship.

Military involved families have stated they prefer interventions which are easily transportable and readily accessible (Hicks et. al., 2016; Lester et. al, 2011; Lester et. al., 2012). Participants valued CPRT for its applicability to their specific challenges experienced in the military lifestyle including providing stability and consistency in a lifestyle which can be prone to constant uprooting and moving. CPRT's materials allow it to be readily accessible and include manualized mobile play kit list in addition to promoting consistent behavioral strategies to manage child behavioral concerns (Bratton et. al., 2018). Future interventions need to respond to frequent lifestyle changes and preferences expressed by military-involved families including being easily transportable and readily accessible by military families.

Future Research

Future research needs to include randomized control trials that allow researchers to randomly assign participants to treatment conditions including intervention and control groups. Future research needs to focus on gaining a larger sample size to promote generalizability to a larger population. In addition, future research needs to recruit a more diverse population of military-involved individuals. While CPRT is an efficacious intervention for a diverse array of populations, the study includes only middle-aged Caucasian females (Bratton & Landreth, 1995; Cabellos & Bratton, 2010; Carnes-Holt & Bratton, 2014; Chau & Landreth, 1997; Costas & Landreth, 1999; Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Kale & Landreth, 1999; Kidron, 2003; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Sheely-Moore & Bratton, 2010; Tew et. al., 2002; Yuen, Landreth, & Baggerly, 2002). Future research would benefit from having an array of participants who are deployed and non-deployed to assist in generalizability within the military culture as well as recruiting participants from different branches of the armed services.

Future research would benefit from implementing a longitudinal research approach including six-month and one-year follow up qualitative interviews. Longitudinal approaches have the benefit of following changes over time in a particular cohort as well as excluding individual recall bias (Caruana, Roman, Hernández-Sánchez, & Solli, 2015). Quantitative assessments could be re-administered and assessed for significant differences. In addition, qualitative interviews could be conducted to determine if similar themes emerged or whether CPRT has provided additional effects within the household. A longitudinal approach could assist in determining whether reduction of stress and child behavior concerns in the household were due to the novelty

of CPRT or through CPRT's skills and techniques. This approach could also control of contextual concerns such as a partner's future deployment which could have influenced post-test data in the current study.

Conclusion

In conclusion, positive early childhood mental health is bolstered by a child forming secure parent-child attachment (Thompson, 2002). Due to the nature of deployment, military involved families are subject to several factors that interfere with positive early childhood mental health formation including difficulty forming adaptive parent-child relationships, increased parental stress, and greater behavioral concerns in children (Canfield, 2013; Creech et. al., 2014; Lincoln et. al., 2007; Lester et. al., 2016; Palmer, 2008; Waldrep et. al. 2004). CPRT is an intervention that improves child-parent relationship formation, decreases parental stress, and decreases behavioral problems in children (Chau & Landreth, 1997; Harris & Landreth, 1997; Kidron, 2004; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew et al., 2002). CPRT is also ideal for many of the preferred intervention styles of military involved families including building on existing family strengths, being transportable, and addressing the entire family unit rather than a single member (Chawlas & Solinas-Saunders, 2011; Hicks et. al., 2016; Sories et. al., 2015; Lester et. al., 2012; Lester et. al, 2016; Lincoln et. al., 2008).

Our research did not produce statistically significant differences between pre-intervention and post-intervention parent-child stress or child behavior concerns. However, the reduction in pre-intervention and post-intervention means indicate CPRT could have had some effect on parent-child stress and child behavioral concerns (Abidin, 2012; Achenbach & Rescorla, 2001). In addition, practical significance was determined with the medium to large effect sizes on stress levels and behavioral concerns (d=0.35-

2.59). Future research needs to continue to focus on developing and refining interventions which assist in developing the parent-child relationship and addressing specific challenges faced by military-involved families including heightened stress in the household, difficulty maintaining secure parent-child relationships, and difficulty of the deployed family member re-integrating into the family dynamic (Creech et. al., 2014; Lester et. al., 2016; Lincoln et. al., 2007; Palmer, 2008; Paley et. al, 2013; Waldrep et. al., 2004). CPRT provides an outlet both for potential interventions within military involved families and for accessible early childhood mental health interventions that create meaningful change in the lives of children who are at-risk for failing to live up to their full personal and social potential as well as families prone to stress due to their lifestyle. By incorporating this training, mental health professionals and military involved families can partner together to significantly and remarkably impact young children at-risk to adverse behavioral health outcomes and improve their overall life trajectories.

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