

A STUDY OF THE UTILIZATION OF BRIEF, BIBLICALLY INTEGRATED CHILD
PARENT RELATIONSHIP THERAPY WITH MOTHERS FROM
CHRISTIAN FAMILIES AND THEIR 11-14 YEAR OLD CHILDREN

By

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Liberty University

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by

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ABSTRACT

A STUDY OF THE UTILIZATION OF BRIEF, BIBLICALLY INTEGRATED CHILD PARENT RELATIONSHIP THERAPY WITH MOTHERS FROM CHRISTIAN FAMILIES AND THEIR 11-14 YEAR OLD CHILDREN

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Twenty-six mothers and their 11-14 year old children participated in the Child Parent Relationship Therapy (CPRT). Although designed for elementary-aged children, CPRT was modified for pre-teens and biblically integrated worldview. An analysis of data obtained from the Parenting Relationship Questionnaire-CA (Kamphaus & Reynolds, 2009), Conflict Behavior Questionnaire-20 (Robin & Foster, 1989), and Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987) revealed meaningful trends in the decrease of frustration, levels of conflict, and negative communication within family systems. It is hoped that these findings will encourage additional research to help Christian mothers and therapists with an effective tool that can be utilized to enhance mother-child relationships while assisting adolescents to develop executive skills which will empower them to successfully bridge into adulthood.

Dedication

I would like to dedicate this to my husband, Bob. Writing this dissertation has been more challenging and difficult than I could ever have imagined. I am glad that I was not alone on this journey, and want you to know how much I appreciate all of your support and encouragement. I would also like to dedicate this to my children, Becky, Andy, Katie, and David. This has taken a long time and I want to thank you for all of your support, understanding, patience, and prayers – you guys rock!!!

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One of my favorite Bible verses is Psalm 127:1, “Unless the Lord builds the house, its builders labor in vain. Unless the Lord watches over the city, the watchmen stand guard in vain” (NIV). All comes from God through His providence, grace, and mercy. It is my desire and prayer to seek and follow Him in all things, and I want to acknowledge His guidance and blessings that I experienced throughout my life and the undertaking of this project. What an awesome, indescribable journey!!! To Him be the glory.

TABLE OF CONTENTS

	Page
Abstract.....	iii
Dedication	iv
Acknowledgements	v
List of Tables.....	xi
CHAPTER ONE: INTRODUCTION.....	1
Background of the Problem.....	4
Purpose of the Study.....	9
Assumptions and Limitations.....	10
Definition of Terms.....	12
Adolescent.....	12
Caregiver.....	13
Experiences of intense trauma or stress.....	13
Externalized behavior.....	13
Relationship.....	14
Relationship enhancement program.....	14
Religious families.....	15
Significance of the Study.....	15
Theoretical and Conceptual Framework.....	16
Organization of Remaining Chapters.....	21
Summary.....	23

CHAPTER TWO: REVIEW OF THE LITERATURE.....	25
Relationship in Philosophy.....	26
Relationship in Psychological Theory and Therapy.....	28
The Neuroscience of Relationships.....	31
Research on Relationship.....	32
Resiliency and Self-efficacy.....	33
Mentoring.....	36
Therapeutic Alliance.....	38
Social Support.....	39
Section Summary.....	51
Specific Relationship Enhancement Programs.....	53
Relationship Enhancement and Attachment Focused Family Therapy.....	53
School Based Programs.....	57
Parent-Child Relationship Enhancement Programs.....	61
Brief Therapy.....	69
Faith Based Therapy.....	70
Modified CPRT.....	73
Summary.....	75
CHAPTER THREE: METHODS.....	78
Research Design.....	80
Research Hypothesis.....	80
Selection of Participants.....	81

Instrumentation.....	84
Duke University Religion Index.....	85
Inventory of Parent and Peer Attachment.....	86
Conflict Behavior Questionnaire.....	87
Parenting Relationship Questionnaire Child and Adolescent.....	89
Demographic Surveys.....	92
Generic Questions.....	93
Research Procedures.....	94
Data Processing and Analysis.....	101
Obtaining Data.....	101
Statistical Analysis.....	103
Ethical Considerations.....	105
Summary.....	107
CHAPTER FOUR: RESULTS.....	109
Summary of Research Design.....	110
Summary of Findings.....	111
Results.....	112
Demographics.....	112
Analysis of Assessments	114
Summary.....	123

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS.....	125
Summary of Findings.....	126
Implications for Counseling.....	128
Limitations.....	131
Recommendations for Further Research.....	135
Chapter Summary.....	136
Closing Summary and Final Comments.....	136
REFERENCES.....	140
Appendixes	
Appendix A: Mother Consent Form.....	170
Appendix B: Mother Demographic Questionnaire.....	173
Appendix C: Flyer.....	177
Appendix D: Script for Brief Explanation of Program.....	178
Appendix E: Adolescent Assent Form.....	183
Appendix F: Treatment Manual.....	186
Appendix G: Mother Handout.....	219
Appendix H: Flow Chart for Recruitment and Screening Procedures.....	230
Appendix I: Adolescent Demographic Questionnaire.....	233
Appendix J: Flow Chart for Proposed Study.....	235
Appendix K: Summary of Assessments.....	236
Appendix L: Modifications to CPRT.....	237

Appendix M: Details and Descriptions to Modify and Utilize Handouts.....250

List of Tables

Table 4.1: Means, Standard Deviations, and Statistical Results for Demographic Variables.....	113
Table 4.2: CBQ-20 Mother Scores.....	116
Table 4.3: PRQ-CA Relationship Frustration Scores.....	117
Table 4.4: PRQ-CA Attachment Scores.....	118
Table 4.5: PRQ-CA Communication Scores.....	119
Table 4.6: PRQ-CA Involvement Scores.....	119
Table 4.7: PRQ-CA Parental Confidence Scores.....	120
Table 4.8: CBQ-20 Adolescent Scores.....	121
Table 4.9: IPPA Scores.....	122
Table 4.10: Mother Responses to Generated Questions Regarding Relationship Satisfaction.....	122
Table 4.11: Adolescent Responses to Generated Questions Regarding Relationship Satisfaction.....	123

CHAPTER ONE: INTRODUCTION

Adolescence, the transitional stage during which children approach and enter adulthood, is a time of challenges and changes. Physical and cognitive development, negative influences such as drugs, alcohol, and sex; and fluctuating social networks and emotions can evoke excitement, anxiety, confusion, guilt, loneliness, isolation, and despair (Feldman, 2006; Golden, 2002; Guerney, 1990; M. L. Jaffe, 1998). During this time, teens will begin to ask questions, such as “who am I” and “where do I belong in this world”; make choices, and develop beliefs, values, and behaviors which will shape and define their identity as they transition into adulthood (Feldman; M. L. Jaffe). Healthy, positive choices can lead to a productive, satisfying, and well-adjusted future; whereas negative attitudes and behaviors can have devastating consequences.

While a majority of adolescents successfully navigate through life changes, others “choose to participate in high-risk activities that could jeopardize their health and survival” (M. L. Jaffe, 1998, p.33) as well as endanger the well-being of others. Over the last decade, tragedies such as the deaths at Columbine and Virginia Tech indicate that the expression of these behaviors has become more violent and overt (Trollinger, 2007). Families, relationships, and classrooms can become immobilized, weakened and destroyed as frustration, resentment, helplessness, and hopelessness begin to emerge and dominate (Barkley & Robin, 2008; Delbert, Hatot, Sirovatka, & Potter, 2001; Trollinger; White, 2006). Parents, teachers, and other caregivers report that assisting adolescents to manage negative externalized and internalized behaviors and symptoms, and develop a healthy sense of self with positive values and beliefs is a priority and challenge.

Common practices of applying external control have shown to be ineffective (Barkley & Robin, 2008; Baumrind, 1996; Glasser, 2002; M. L. Jaffe, 1998; White, 2006). Glasser (2002) stated that attempting to control other's behavior through force or coercion is ineffective, he artfully writes, "it hasn't worked in the past, it isn't working now, and it won't work in the future" (p. 1). Other theorists echo these statements and agree that seeking control of teen behavior "is not the key" (Sanford, 2009, p.2) to use when assisting adolescents to make the wise choices they will need to promote their psychological stability and well-being. Their suggested alternative is to utilize the power of personal relationships (Ansbacher & Ansbacher, 1956; Axline, 1974; Bandura, 1997; Barkley & Robin; Ginsberg, 1997; Pianta & Hamre, 2001).

The significance of relationships has been portrayed in a wide variety of venues. Man's interactions have been immortalized in classic literature and film such as *Romeo and Juliet* and *Gone with the Wind*, captured in mythology, art, poetry, and cherished photograph albums; pondered by philosophers and neuroscientists (Cozolino, 2006; Schore, 2003a, 2003b), and used to sell products and motivate athletic teams to victory. How man relates with himself, the world, or a supreme being is discussed in almost all of the grand Personality theories, and the lack of relationship or a support group is considered to be a risk factor when considering the possibility of suicide and the prognosis for the successful management of mental illness (W. Chung, Edgar-Smith, Palmer, Bartholomew, & Delambo, 2008; Ezzell, Swenson, & Brondino, 2000; Kirkpatrick, 1999; National Institute of Mental Health, 2009; Stoufe, 2005).

In further examination of the power of human interactions, Frankl (1984, 2000) implied that positive relationships may be a critical factor in ascertaining the meaning

and purpose of life, and Glasser (1998) wrote that if one is not “poverty stricken, or suffering the ravages of old age, the major human problems we struggle with...are caused by unsatisfying relationships” (p. ix). Other theorists such as Bratton, Landreth, Kellam, and Blackard (2006); Pianta and Hamre (2001), and Barkley, Edwards, and Robin (1999); have begun to develop and implement relational programs and therapeutic interventions geared at assisting teachers, parents, and other caregivers when helping children make choices which will allow them to manage negative attitudes, symptoms, and behaviors.

In addition to relationship enhancement, another promising area of study is faith-based therapy and treatment. Favorable, empirically supported, results have been reported when doctors included the utilization of prayer and scripture in their treatment of cardiovascular and AIDS patients (Maier-Loretz, 2004). Psychotherapists have also reported positive results when using spiritually and biblically integrated treatments to assist patients who have been diagnosed with internalized behavioral symptoms such as depression and anxiety (Children’s Better Health Institute, 1999; Francis & Gibbs, 1996; Hurst, Williams, King, & Viken, 2008). The effects of faith-based therapy have also been examined in the treatment of marital conflict and children’s negative attitudes towards school (Butler, Stout, & Gardner, 2002; Francis & Gibbs).

Although much research has been conducted regarding the benefits of healthy relationships between adults and younger children, a literature review yields less data about older children. Due to the positive results being reported from the relational enhancement programs of Bratton and associates (2006), Pianta and Hamre (2001), Glasser (1998; 2002), Barkley’s group (1999), and faith-based therapy; it seems

reasonable that applying biblically integrated, relational management interventions to young people in this age bracket may be an appropriate area of study. Based upon this premise, this paper intends to discuss the implementation and results of the utilization of a biblically integrated relational development and intervention program in an adolescent population.

Background of the Problem

When talking to parents and therapists of adolescent children, one often hears words that reflect frustration, hopelessness, confusion, and turmoil (Glasser, 2002; M. L. Jaffe, 1998; Robin & Foster, 1989; Trollinger, 2007; White, 2006). Parents report that their children face pitfalls, stressors, and negative influences daily and want to provide assistance, yet feel that their children are shutting them out and withdrawing from them (Glasser; Golden, 2002; M. L. Jaffe; Robin & Foster; Trollinger). Glasser states that parents often choose to retaliate with ineffective controlling behaviors which, in turn, result in their children becoming frustrated, defiant, and more distant. Therapists report that assisting these parents and children is a challenge which needs to be addressed and managed in order to “stabilize teens and parents in a world of chaos” (Trollinger, p. xx).

Robin and Foster (1989) focused upon parent-adolescent discord and conflict resolution as children transition into greater independence and adulthood, and family roles change. These clinicians stated that while some families navigate these changes with little difficulty, others greatly benefit from therapeutic intervention. Glasser (2002) has also joined the ranks of theorists and clinicians who have begun to implement specific relational therapeutic teachings and programs (Barkley et al., 1999; Bratton et al.,

2006; Ginsberg, 1997; Glasser, 1998; McGrath & Noble, n.d.; Pianta & Hamre, 2001; Van Fleet, 2005). He reminds parents that, as they cannot directly control their teens' behaviors and choices when they are not with them, it is critical to maintain closeness and open communication. In addition, Glasser stated that the way to do this is to develop and enhance the parent-adolescent relationship, and made the bold claim that building close relationships will promote happiness and psychiatric well-being for both parties.

Following the tenants of Choice Theory, Glasser (1998; Glasser Institute, n.d.) has developed the Quality School program in which students are managed without coercion. Currently, 22 of these schools have been established in America and three internationally. In these schools, students, teachers, and parents are taught to “reach a common ground in establishing a supportive, caring environment and in building healthy relationships that contribute to school success” (Glasser Institute, ¶ 5).

McGrath and Noble (n.d.) and Pianta and Hamre (2001) have developed programs geared at assisting students and teachers through the development of caring and nurturing relationships. The former have named their program Bounceback, which they describe as being resiliency intervention for classrooms. These clinicians posit that “the quality of teaching and the teacher-student relationship, above all else, make the most significant difference to student learning outcomes” (McGrath & Noble, 2003, ¶ 9). Teachers are instructed to affirm student strengths and take time to get to know their students as people, not just pupils (McGrath & Noble, 2003, n.d.). This program also strives to include parents or other caregivers in the relationship process. It is hoped that through these relationships, students will develop social skills and a sense of belonging,

companionship, and healthy self- esteem which will enable them to develop resilience that they will need to “survive and thrive” (McGrath & Noble, 2003, n.d.).

In their Students, Teachers, and Relational Support (STARS) program, Pianta and Hamre (2001) focused upon assisting teachers to “make decisions about how best to use student-teacher relationships to help improve the educational outcomes of students, particularly those students for whom the risk of failure is high” (p. 1). It was proposed that “the relationship that a child has with his or her teacher in the early elementary grades is associated with a range of child outcomes, including children’s competent behavior in relationships with peers and their relationships with future teachers” (Birch & Ladd as cited in Stuhlman & Pianta, 2001, p. 148). Through their program, counselors work with teachers to increase the number of positive interactions with challenging students. They reported that this builds supportive and effective relationships, which enables them to “influence children’s understanding, expression, and control of emotion” (Pianta & Hamre, 2001, p. 2) in their classrooms.

Although the word “relationship” is not stressed in their work, Barkley, Edwards, and Robin (1999) have developed a program to assist families with older adolescent children, who have been diagnosed with oppositional defiance disorder (ODD) or attention deficit hyperactive disorder (ADHD). This program combines Barkley’s work, which focused upon “developing an effective program for training parents of defiant children (p. vii), and Edwards and Robin’s method of family therapy, Problem-Solving Communication Training (PSCT). This training and treatment presents parents and other significant caregivers with ten steps to resolve conflict and rebuild relationships, with the

goal of advancing family harmony and communication through the “improvement of parental use of positive attention” (p. 4).

Bratton, Landreth, Kellam, and Blackard (2006) have authored a “10-session Filial Therapy model for training parents” (p. vii) which they have titled Child Parent Relationship Therapy (CPRT). This program is geared towards assisting caregivers, through the use of play therapy, to develop and focus upon a meaningful relationship with their child which can be used to “provide closer happier times...more joy and laughter, warm memories” (p. 3). Through this relationship, parents are taught to enter their child’s inner world and assist him or her to develop self-control, esteem, and efficacy. Through this use of Filial play therapy, it is hoped that the parent-child relationship will be strengthened and caregivers will learn to become therapeutic agents in promoting their child’s overall growth and development (Landreth, 2002; Rennie & Landreth, 2000; Sensus, 1981; Sweeney, 1996; Sweeney, Homeyer, & Pavlishina, 2000). Van Fleet (2005) also employs Filial play therapy in her practice as an “effective intervention for children and families experiencing a variety of social, emotional, and behavioral difficulties” (p. xi).

As previously noted, favorable results in assisting children to manage of both internalized and externalized behaviors have been reported through the use of faith-based therapies (Butler et al., 2002; Francis & Gibbs, 1996; Hurst et al., 2008). Various theorists and clinicians have stressed the importance of including spirituality in therapy with religious clients and have outlined procedures, techniques, and methods of integration (Beach, Fincham, Hurt, McNair, & Stanley, 2008; Entwistle, 2004; Garzon, 2005; Jones & Butman, 1991; McMinn & Campbell, 2007; Pargament, 1997; Richards &

Bergin, 2005; Tan, 2007; Walker & Quagliana, 2007). Of particular interest to the study proposed in this paper, is a program which has been designed and utilized by Walker and Quagliana that integrates scripture, behavior management, and relationship enhancement. This team posited that psychotherapy and biblical theology teachings regarding parenting can be harmonious, and reported that they obtained positive results from the utilization of their integrated therapy to assist parents with children who had displayed negative behaviors, such as disrespect and defiance.

Research has yielded mixed findings regarding the effect and value of corporal punishment. Data has been obtained which indicated that corporal punishment is counterproductive with the goal of building healthy relationships and open lines of communication (B. K. Barber, Olsen, & Shagle, 1994; Baumrind, 1996; Harvard Mental Health Letter, 2002; Holden, 2002; M. L. Jaffe, 1998; Kazdin & Benjet, 2003; Saadeh, Rizzo, & Roberts, 2002; Straus, 1993, 2001). Additional research supports the premise that there may be a connection between “beliefs in biblical inerrancy and the parental use of corporal punishment” (Ellison, Bartkowski, & Segal, 1996, p. 671), and that religious affiliation may be a determinant of parental corporal punishment (Ellison, 1996; Ellison & Sherkat, 1993; Firmin & Castle, 2008; Gershoff, Miller, & Holden, 1999).

As most relationship enhancement programs seek to find alternatives to corporal punishment, they can present as being in opposition to Christian beliefs. Due to this, McClung (2007) chose to explore the applicability of the utilization of the previously mentioned CPRT program with religious populations. In her dissertation, she specifically focused upon Christian parents and reported data which supports that this population prefers to have their Christian beliefs and values included in therapy, and were more

receptive to biblically integrated programs. McClung went on to examine the validity and efficacy of integrating these beliefs within the CPRT program, stating that it had previously shown to be effective when used with other cultural populations. She reported that favorable results can be obtained with some modifications that do not compromise the validity and constructs of this program. In her study, McClung focused upon CPRT's suggested population of children between the ages of two and ten.

Of further interest to this paper is the time needed to effectively initiate CPRT. In her dissertation, Ferrell (2003) discussed the financial and time needs of her clients. This therapist condensed Landreth's ten week Filial Therapy Training model into four weeks. Her research found no significant differences between these two treatments and reported improvement in the areas of parental stress, empathetic behavior, and acceptance towards their children; and that parents reported fewer problems with their children's behaviors. These findings are important as some insurance companies and health management organizations limit the number of sessions for which they will provide payment (Carlson & Sperry, 2000; Ferrell; Garfield, 1997; Stuart, 2000). Time constraints can also be a large issue when working with the adolescent population, due to their wide variety of commitments and obligations, such as after school activities and lessons, and responsibilities at school and church (Ferrell; M. L. Jaffe, 1998).

Purpose of the Study

Support has been provided above that parents are seeking assistance in building healthier, more positive relationships with their adolescent children. It follows that effective methods and treatments that assist parents and teens to manage conflict and

discord would be beneficial. Various programs have been discussed above which report promising results when utilizing relationship enhancement to manage unwanted behaviors and symptoms. In addition, research has been reviewed which supports that faith based and spiritually integrated treatments may be effective in managing both physical and psychological symptoms and concerns, and that Christian parents want their beliefs and values to be incorporated into treatment (McClung, 2007; Richards & Bergin, 2005; Walker & Quagliana, 2007). A need for short-term therapy has also been indicated as preferred by some insurance companies and clients' hectic schedules (Ferrell, 2003). The purpose of this study, therefore, is to explore the efficacy of a biblically integrated, brief version of CPRT when utilized as a psychoeducational wellness program to enhance relationships between mothers and their 11-14 year old children from Christian families.

Assumptions and Limitations

It is assumed that caregivers will follow the instructions and training they receive and that family members possess communication skills which will enable them to develop positive and supportive relationships. It is further assumed that the assessment tools utilized in this study possess the ability to measure changes in the participants' perception of relationship quality. Although it is acknowledged that discipline, relational, and communication patterns differ for each family, it is assumed that relationship enhancement is a desirable entity which can occur and be beneficial for all persons involved.

In considering limitations of this research, setting criteria for participant selection was a major challenge. Although this study used age as a delimitation, significant

variance in maturity, cognitive, social, and emotional development may have existed. Gender and social economic status (SES) was also taken into account and participants were expected to complete the entire six week program. Another delimitation employed by this study was omitting adolescents with severe substance abuse or recent experiences of intense trauma or stress, as these factors may alter cognitions, motivations, and behaviors; and require special services and more intense care and treatment (Cantrell & Dean, 2005; Dinigris, 2009; Feldman, 2006; M. L. Jaffe, 1998; Mash & Dozois, 1996). Questions were included in a demographic survey to determine the above. This survey also included questions that assessed for any risk of harm to self or others and the presence of active audio or visual hallucinations. Any questions replied to in the affirmative resulted in that adolescent being excluded from this study, and referrals to licensed professionals were made for further assessment and treatment as needed.

Obtaining data through self-report is another concern which needed to be addressed by this study. Self-report was utilized to determine the existence of at risk behaviors and clinical symptoms and to rate changes in relationships. In relaying and evaluating the severity of problems and concerns it is acknowledged that subjectivity, temperament, personality, and various cultural beliefs and practices may have resulted in different estimates and definitions of relationship satisfaction. Kazdin (2003) states that additional considerations when using only self-reported measurements are that “responses to items can be greatly influenced by the wording, format, and order of appearance of the items” (p. 373) and “there is a possibility of bias and distortion on the part of the subjects” (p. 373). Even with these concerns, self-report inventories, questionnaires, and scales continue to be “the most commonly used types of measures

within clinical, counseling, and educational psychology” (Kazdin, p. 372). To diminish the strength of this concern, reports regarding behavior and relationship were obtained from both the parents and adolescents involved in this study.

A major concern of this study is that the researcher resides in a small city and has been unable to secure the assistance of professionals with training in CPRT to deliver the treatment. Due to this, the researcher personally delivered all treatment. Although the researcher is aware that this presents a significant threat to the internal validity of the study, she has discussed this concern with Landreth, one of the developers of this therapy (personal communication, March 4, 2010), and continues to put forward that the integrity of the study was maintained and carried out with limited contamination. It is also posited that this study, as described, provided a valuable intervention to the participants as well as data and information which can contribute to the base of knowledge regarding the utilization of brief, biblically integrated, therapy and psychoeducational wellness programs to enhance relationships in an adolescent population.

Definition of Terms

In an effort to more precisely present what is being examined and explored in this study, the following terms will be operationally defined:

Adolescent

In considering a definition of adolescence, this study used age as the criteria and adopted M. L. Jaffe’s (1998) suggestion that “given the length of the adolescent period, it is helpful to divide it into three sub stages that correspond to three important school

transitions” (p. 26). This study focused upon his early adolescence stage, ages 11 through 14 inclusive.

Caregiver

An adult who has the principal responsibility for caring for the adolescent, especially in the home (Encarta Dictionary, 2008).

Experiences of Intense Trauma or Stress

In considering the results of a literature review of current research in this area, intense trauma and stress, for the purpose of this study, was defined as experiencing the permanent loss of a main caregiver, legal conflicts and concerns, witnessing or being involved in an act of violence, natural disaster, or accident resulting in severe loss; or being a victim of sexual or physical abuse (Craig & Sprang, 2007; Denigris, 2008; Hecker, 2007; Phoenix, 2007; Sitler, 2009). Persons who had experienced intense trauma and stress within the past sixty days were not accepted into the program.

Externalized Behavior

Behavior that can be observed and is outwardly displayed. Negative externalized behaviors, as discussed in literature, consist of aggression and fighting, delinquency, substance abuse, smoking, not completing homework and other assigned tasks, academic underachievement and difficulty, truancy and dropping out of school, teenage pregnancy, oppositionality, noncompliance, participating in risk taking behavior, hyperactivity, impulsivity, antisocial behavior, bullying or intimidating others, cursing and swearing,

resistance to control, and negativity (Berdan, Keane, & Calkins, 2008; DeRosier & Gilliom, 2007; DeYong, Peterson, Séquin, & Tremblay, 2008; Jafee & D’Zurilla, 2003; McKee, Colletti, Rakow, Jones, & Forhant, 2008; Mrug & Windle, 2009; Ontai & Conger, 2008; Valkenburg & Peter, 2007).

Relationship

The connection between two or more people or groups and their involvement with one another, especially in regards as to how they behave toward and feel about each other (Encarta Dictionary, 2008)

Relationship Enhancement Program

A program which “integrates psychodynamic, behavioral, communications, and family systems perspectives, emphasizes the importance of identifying beliefs about how problems arise and helping clients learn skills that will enable them to address these problems” (Ginsberg, 1997, p. 1), in order to develop a more positive and rewarding perspective of one’s interactions with others. Pianta and Hamre (2001) add to this a focus on changing the involved individuals’ representational models of each other which have been “based on the sum of his or her real-life experience” (p. 21) in order to alter “behavior and feelings over time” (p. 21). Glasser (2002) states that relationship enhancement is the process by which one learns to do things with other people instead of to them.

Religious Families

As defined by Manlove, Logan, Moore, and Ikramullah (2008), religious families are those who attend church at least monthly, pray daily, and disagree with statements such as “God has nothing to do with what happens to me personally” and “I don’t need religion to have good values” (p. 108). These families also participate in religious activities weekly such as attending church, reading scripture, and praying together. This study administered the Duke University Religion Index (DUREL, Hill & Hood, 1999) to all participating mothers and included a question to determine religious beliefs on the demographic information sheet. For the purpose of this study, mothers who scored ≥ 10 on the DUREL, as suggested by this test’s authors (Hill & Hood) as being an indicator of religiosity, and answered in the affirmative to the question, “Does your family profess to be Christian and have a personal relationship with Jesus Christ”?, were considered as being religious.

Significance of the Study

In considering the adolescent population, M. L. Jaffe (1998) states that “about 2,245 adolescents in this age group take their own lives each year in the United States” (p. 530), “approximately 381,000 students drop out” (p. 435) of school, and violence has soared (Trollinger, 2007). “Tens of thousands of children and adolescents live in poverty and are exposed daily to violence and drugs” (M. L. Jaffe, p. 33) and “the use of mood-altering drugs to relieve boredom, pressure, and stress is so common that many teenagers come to see it as ‘no big deal’” (M. L. Jaffe, p. 518). Parents, teachers, and caregivers have expressed feelings of frustration and helplessness as corporal punishment has shown

to be ineffective and devalued by society in attempting to assist teens to manage this risky and dangerous behavior and achieve psychiatric well-being (Glasser, 1998; Harvard Mental Health, 2002; Holden, 2002; Kazdin & Benjet, 2003; Paolucci & Violato, 2004; Sanford, 2009; Straus, 2001).

The power and value of relationships is heavily discussed in philosophical and psychological teaching and theory and has become a popular area for research. Several programs have been developed to assist students, young children, and those diagnosed with attention deficit disorder; which have reported progress and success (Barkley & Benton, 1998; Barkley & Robin, 2008; Bratton et al., 2006; McGrath & Noble, 2003; Pianta & Hamre, 2001). None of these, however, specifically address the special needs and concerns of religious parents of adolescents who wish their spirituality to be incorporated into therapy and treatment. Through an exploration of the use of a biblically integrated, brief relationship enhancement program with a adolescent population, it is hoped that this study will provide support for an intervention that parents and caregivers can utilize when assisting teens and pre-teens in the development and maintenance of psychiatric well-being and maturity, thus turning the tide on the devastating statistics and destructive practices which are encountered and participated in by many of today's youth.

Theoretical and Conceptual Framework

It is not difficult to find information regarding the significance of man's interpersonal relationships. Even before the dawn of psychological thinking and research, philosophers have had much to say regarding relationships. Man's interpersonal interactions have been viewed as objects to be used and manipulated, a venue through

which to teach, train, and guide others; a mechanism to promote the development of character and being in an effort to define one's self, and an interactive environment through which one may obtain love, comfort, support, self-actualization, and immortality (Barry, 1980; Gilson, Langan, & Maurer, 1966; Herman & Steban, 1999; Krell, 1933; Osborne, 1992; Stokes, 2002). Through interactions and interconnections with others, man can experience information and guidance at a core level which will enable him to move this knowledge into the realm of understanding (Durant, 1933; Osborne), or as Frankl (1984) states, find the "why" for his existence which can direct and sustain him through any "how."

A review of psychological theory and teachings reveals a plethora of information regarding relationship. Interaction with others is a prominent consideration in Bandura's social cognitive approach which posits that people can learn from observing and modeling the behaviors of others and develop self-efficacy through external praise and inducement (Jones & Butman, 1991). Another prominent psychologist, Adler, addressed relationships in that he proposed man will develop a lifestyle and psychological map of self and the world through family interactions (Milliren, Evans, & Newbauer, 2007). Rogers (1951) also acknowledged the power and importance of man's connections with others in stating that "the probability of therapeutic movement in a particular case depends primarily not upon the counselor's personality, nor upon his techniques, nor even upon his attitudes but the way all these are experienced by the client in the relationship" (p. 65).

Another theory with strong relational components is Transactional Analysis which asserts that "acceptance and value are fundamental to all persons" (Jones & Butman,

1991, p. 325). Interactions with parents or others in the child's social environment are viewed as having the power to determine one's concept of "OKness" (Jones & Butman), with positive strokes exchanged through relationships in which true intimacy is "the most powerful stroke of all" (Jones & Butman, p. 327). Attachment theory also stresses the importance of connection and involvement with others in stating that well-being is promoted by the ability of "significant adults to respond appropriately to the young child's normal needs for closeness" (Cole, Michel, & O'Connell-Teti as cited in Stroufe, Egeland, Carlson, & Collins, 2005, p. 37), especially during threatening or stressful situations.

Relationship building is also a strong component and central motivation in Choice therapy. Glasser states that unsatisfying relationships are a major human problem which must be improved to promote happiness and well-being. In addition, he stated that "to belong, to love and be loved" (Jones & Butman, 1991, p. 244) is a fundamental need which can only be fulfilled through establishing satisfying relationships and connectedness with others (Glasser, 1998). Only through healthy, supportive relationships with others and positive experiences, can man develop the success identity which he will need to assess and utilize in order to build a healthy and satisfying "quality world" (Glasser; Glasser & Glasser, 2007).

In considering specific relational interventions, one of the goals of Filial play therapy is to strengthen parent, child, and family relationships in order to prevent problems and treat children with social, emotional, and behavioral difficulties (Axline, 1974; VanFleet, 2005). Axline states that through play, children learn to share both toys and ideas, develop social skills, learn about human interactions, explore values, beliefs,

and feelings of autonomy, isolation and separation; obtain and develop abilities, and build self-efficacy and esteem (O’Conner, 2000). Landreth (2002), another prominent play therapist, suggests that play may be a method of communication which comes from one’s inner being. If this is true, persons may be able to utilize play as a non-threatening method to facilitate and develop emotional and effective communication and relationships at a primal, core level, which can be utilized to promote well-being.

As previously mentioned, Bratton and colleagues (2006) have developed a brief relational enhancement intervention, Child Parent Relationship Therapy (CPRT). CPRT is a 10-session training program to “help strengthen the relationship between a caregivers and their elementary school aged children by using 30-minute playtimes once a week ...parents learn how to respond empathically to their child’s feelings, build their child’s self-esteem, help their child learn self-control and self-responsibility, and set therapeutic limits” (Bratton et al. p. 10). The goal of this therapy is to encourage child lead interactions which develop and nurture a special relationship without “reprimands, put-downs, evaluations, requirements [or] judgments” (Bratton et al. p. 10). It is theorized that this will allow children to feel accepted, understood, and cared for, enhancing their self-esteem and efficacy which should empower them to “behave in more self-enhancing ways rather than self-defeating ways” (Bratton et al., p. 10). Although no specific research is listed regarding the utilization of this program with adolescents, statistical support has been obtained for the efficacy of play therapy with elementary age children.

In further considering the employment of relationship enhancement interventions, Pianta and Hamre (2001; 2009) have reported success utilizing their Students, Teachers, and Relational Support program (STARS). STARS promotes relationship development

between teachers and students to “create pathways toward healthy outcomes” (Pianta & Hamre, 2001, p. 1). This program incorporates “concrete techniques referred to as Banking Time strategies that the consultant can use to enhance and improve the relationship between teacher and student” (Pianta & Hamre, p. 1). The desired outcome of this program is to assist children for whom “school is not a place of personal success and reward, either interpersonally or academically” (Pianta, 1999, p. 183), through the development of relationships that will “enrich the child’s life, build confidence and self-esteem, support the child’s learning and performance, and motivate the child to explore new ideas and new roles” (Pianta, p. 183). Pianta states that more research is needed in the area of adult-child relationships to advance theory and practice, and suggests that this program can be applied to different populations of children.

Barkley and associates (1999) have also reported obtaining positive results with PSCT, which focuses upon assisting “families of adolescents having Oppositional Defiant Disorder” (p. vii). The goal is “to improve parent-teen relationships and teen adjustment” (p. vii) through focusing “on the adolescent’s as well as his or her parents’, need for interaction management, and so must make the adolescent an active participant in any family change program” (p. vii). These authors report “a substantial amount of research supporting their efficacy with children up to approximately age 12 years of age” (p. 4) and that “typically, up to 64% or more of the families of defiant children undergoing training in such methods report significant improvement in their children’s behavior and their own parenting abilities” (p. 5). Little information has been generated regarding the use of this program with other adolescent populations and a literature review did not yield any studies which focused upon teens from religious families.

Integrating scripture with parent training is a focus of a program developed by Walker and Quagliana (2007) who integrated scripture into Barkley's (1997) *Defiant Children* treatment manual. In their article describing this, they outlined procedure and provided theoretical support that biblical and psychological teachings regarding parenting are harmonious. The pair proposed that through this integration of spirituality, behavior management, and relationship enhancement; parents will learn to respond to their children with consistency, warmth, and acceptance; while promoting, encouraging, and supporting the development of unique talents and strengths.

Organization of the Remaining Chapters

Chapter Two presents a literature review of theory, and research regarding relationships. Specific results and findings are discussed with an emphasis on relationships between children and caregivers; and programs which have reported positive progress in this area are examined. This chapter also explores the efficacy and need for spiritually integrated therapy and possible benefits of brief therapy. Based upon the findings of this review, it is proposed that there exists a need for biblically integrated treatment which is focused specifically upon assisting Christian parents in their quest and ministry to successfully guide their adolescent children into adulthood. It is proposed that study and research in this area would be valuable and beneficial.

Chapter Three proposes and outlines procedures and analysis for carrying out the implementation of a brief, biblically integrated relationship enhancement intervention aimed at strengthening and improving parent-adolescent relationships. Participant selection and methods taken to increase and secure study validity are discussed and

rationale presented to support statistical analysis choices. A treatment manual is included in the appendix section (see Appendix F) which contains training procedures, session outlines, directions for use of modified handouts, and instructions to caregivers.

Chapter Four briefly outlines the purpose and procedures of this study, and presents information collected from the 26 mothers and their children who participated in this study. Demographic data is discussed, and results from assessments presented and analyzed in relationship to the hypothesis and research question: Does CPRT which has been condensed into a brief six week format and biblically integrated, promote positive change in relationships between mothers and adolescents from religious families? Tables are included as appropriate and beneficial to the study. Data was analyzed through the use of 10 repeated measures Analyses of Variance (ANOVA), and Bonferroni's correction was utilized to "adjust the significance level in order to control for Type 1 error" (Shannon & Davenport, 2001, p. 279). Although no statistically significant results were obtained, the analysis of data yielded meaningful trends regarding improvement in levels of relationship frustration, conflict, and negative communication between mothers and their adolescents.

Chapter Five presents a discussion of the study and conclusions developed from obtained results. The contribution of this study was explored and recommendations were given for further areas of research. This study had several limitations and concerns that were discussed and assessed within this chapter. It is presented that this study provided support in the form of meaningful trends that, with the proposed and examined modifications, CPRT can be an effective and desirable tool to utilize when assisting mothers and their 11-14 year old children to improve the quality of their relationships. It

is hoped that the program outlined in this study will generate additional research and provide a springboard that encourages the biblical integration of additional treatments and interventions.

Summary

This chapter examined and discussed a need for treatment and therapy which can maintain and improve parent-child relationships throughout the middle school years. Psychological theory and research indicate that relationship is crucial to positive growth and well-being, and programs, such as STARS and CPRT, have reported success in using relationship enhancement techniques to reduce undesirable behaviors. Additionally, data and discussion have been provided which support a need for the development and utilization of biblically integrated programs for use with religious families who desire that their religious beliefs, practices, and lifestyles be included in therapy and treatment. Benefits of and a need for brief therapy were also presented and discussed.

In considering the focus of these programs and their accompanying research, there appears to be a lack of application to and consideration of the specific needs and wants of a Christian population, especially for parents with children over the age of 10. It would appear that a brief program which takes into consideration the special wants and needs of a religious population would be of value. As this chapter has reviewed promising literature that CPRT would lend itself to being modified to accommodate this population, it is hypothesized that this program can be effectively condensed and biblically integrated. It is presented that such a tool would make it possible for Christian parents and therapists to more effectively utilize the power of relationship, as they strive to assist

children to successfully navigate through their middle school years and become productive and healthy adults.

CHAPTER TWO: REVIEW OF THE LITERATURE

Recent statistics reveal a bleak picture in which thousands of teens drop out of school each year and participate in substance abuse, promiscuous sexual activities, and aggressive and illegal behaviors (M. L. Jaffe, 1998; National Youth Violence Prevention Resource Center, 2008; Trollinger, 2007). It has also been noted that these illegal behaviors have been escalating in intensity; while yesterday's youth may have participated in petty larceny and "school-yard fights", today's young people have been convicted of drug trafficking, prostitution, and mass murders (M. L. Jaffe; Trollinger). Teen participation in risky, dangerous, and rebellious behaviors, which may be harmful to themselves and others, continues at an unprecedented and alarming rate, motivating society to find a solution (Barkley & Robin, 2008; Glasser, 2002; M. L. Jaffe; Trollinger, White, 2006).

Several programs and therapies, such as Relational Enhancement therapy (Ginsberg, 1997), Attachment-Focused Family therapy (D. A. Hughes, 2007), Bounceback (McGrath & Noble, n.d.), Students, Teachers, and Relational Support (STARS; Pianta & Hamre, 2001), Child Parent Relationship therapy (CPRT; Bratton et al., 2006), and Problem-Solving Communication Training (PSCT; Barkley et al., 1999), have been developed and report success in utilizing relationship as a curative factor in assisting children and teens to become more stable in their emotional health. Parents, teachers, and other caregivers, who are enrolled in these programs, are trained to use supportive strategies and skills which have been shown to increase the level of child's and caregiver's satisfaction with their relationship. Research supports that these enhanced

and improved relationships are then utilized by children to increase and strengthen their ability to cope with stressors and bring about improvement in both internalized and externalized behaviors (DeJames, 2001; Pardini, 2008).

This chapter presents a discussion regarding the definition and power of relationship through a review of philosophical and psychological teachings and theories. The benefits of integrating spirituality into treatment for religious clients are discussed and examined, and literature regarding the utilization of relationship enhancement therapy to bring about desired changes and well-being reviewed. It is the premise of this paper and study that brief, biblically integrated; relationship enhancement therapies will provide a tool which can be utilized by parents and therapists to provide a supportive base for middle school children and decrease caregivers' feelings of stress, frustration, and hopelessness. It is further proposed that these new methods will empower parents and caregivers in their mission and ministry to assist children, more specifically adolescents, to make wise choices and develop positive behaviors and values. This will, in turn, facilitate children' successful and positive progress as they strive to become healthy, happy, and productive adults.

Relationship in Philosophy

Pondering the ways in which man relates to himself and others is a major philosophical theme (Barry, 1980). Philosophers have reasoned and posited that relationships are objects or entities in and of themselves to be created, examined, and explored (Janaro, 1975; Strathern, 2002; Stokes, 2002); mechanisms which lead to goals and understanding (Barry; Osborne, 1992), methods to obtain power and self-definition

(Barry; Durant, 1933; Herman & Stebben, 1999), and the noblest of “external aids to happiness” (Durant p. 60). Viewing relationships in this way makes it possible to utilize them as therapeutic tools to facilitate communication at an inter-connected, true self level (Bandler & Grinder, 1975; Osborne). Through this type of communication, persons will be able to share and exchange experience and knowledge needed to shape and form beliefs which can then be manifested through changes in action (Osborne).

Relationships have been examined when considering the process of teaching, training, and guiding others. Philosophers have theorized that one’s definition of self and behavior is a function of experience which is always in relation to someone or something other than self and that man is in a constant state of “dialectical becoming” (Krell, 1977; Laing, 1967; Osborne, 1992). Through relationships, man can obtain an intimate and ongoing opportunity to work with teachers and mentors who can provide positive discourse and interactions (Osborne; E. Steinberg, 1977). More specifically, through the parent-child relationship, children and adolescents may be provided with guidance, acceptance, and a safe place within which to process data, emotions, and contradictions. It is posited that these healthy and supportive relationships will assist children to obtain higher stages and levels of functioning (Osborne).

During adolescence, children may begin to consciously or unconsciously question their purpose and identity, and explore the desires and lifestyles they will want to obtain or avoid (Frankel, 1972). A prominent philosophical tenet is that man may find and discover information and answers to questions such as “what is the best life? – what is life’s supreme good? – what is virtue? – how shall we find happiness and fulfillment?” (Durant, 1933, p. 60), and who or what am I?; only through relationship and interaction

with others (Barry, 1980; Janaro1975; Osborne, 1992; Stokes, 2002). Positive and supportive interactions with parents and caregivers can supply adolescents with advice, teaching, feedback, hope, hands-on experience, and motivation which they can utilize to synthesize and develop the unique, distinct, and individualized set of beliefs, values, characteristics, and behaviors that will become their definition of self.

Relationship in Psychological Theory and Therapy

It has been theorized that the human ego, whether in a healthy or pathological manner, develops through interactions with others (Jones & Butman, 1991). It is, therefore, no surprise that relationships are directly or indirectly discussed in all of the grand Personality theories. Apart from developmental considerations, Hubble and associates stated that relationship is one of the common therapeutic factors that “seem to account for outcomes regardless of model or technique” (Hubble, Duncan, Mille, & Lambert as cited in McMinn & Campbell, 2007, p. 67). Through the specificity of the therapeutic relationship, it is hoped that clients will obtain awareness and insight, explore feelings, emotions, and motivations; and “become more efficient, effective, independent, and resourceful in their abilities to solve the problems they face” (Gladding, 2007, p. 275) throughout their life span.

In considering specific theory, the Neo-Freudians may be the first promoters of the importance of relationship as they moved away from basic drives and instincts and placed emphasis upon “ego, self and relationships” (Jones & Butman, 1991, p.93). Personal growth was understood as being rooted in the “environment of personal relations” (Jones & Butman, p. 94), and Horney proposed that “neuroses are caused by disturbed human

relations...more specifically...in the relationship between parent and child” (Hengenhahn & Olsen, 1999, p. 132) in which needs for safety and satisfaction are not met. Later, Erickson built upon this and stated that positive relationships and experiences are needed to strengthen one’s ego and allow it to adapt through the various crises he will encounter throughout his life (Feldman, 2006; Hergenhahn & Olson; Ryckman, 2004).

Research of therapists such as Luria, Vygotsky, Meichenbaum, and Bandura supports the premise that change in cognitions and behavior can be obtained through observations of, encouragement from, and relationships with others (Bandura, 1997; K. S. Dobson & Dozois, 2001; Feldman, 2006; Jones & Butman, 1991). Bandura went on to state that shared social appraisals obtained from relationships with others serve as persuasory modes of influence which shape children’s beliefs of personal efficacy (Bandura). Another prominent psychologist, Adler, stated that persons utilize their relationship with their family unit to manage feelings of inferiority and form a guiding psychological map of their self and the world (Ansbacher & Ansbacher, 1956; Jones & Butman; Milliren et al., 2007). More specifically, he proposed that a child will utilize a safe and supportive relationship with his parents to develop benevolence, confidence, a responsible attitude, and the ability to manage life’s challenges (Ansbacher & Ansbacher).

The power and importance of relationship is the backbone of Glasser’s Choice Theory which maintains that positive relationships are one of man’s fundamental needs and essential for the development of a successful life (Glasser, 1998). This psychiatrist stated that parents of adolescents need to focus on doing things with their children through relationships rather than to them. These positive interactions will then assist

these adolescents to incorporate positive externalized and internalized behaviors and a success identity into their quality world (Glasser, 2002). Transactional Analysts also focus upon the power of relationships in that they assert that “acceptance and value are fundamental to all persons” (Jones & Butman, 1991) and contribute to personality development and how one perceives the world and others (Jones & Butman).

Relationship is also a main focus for person-centered therapists who maintain that through intimate interactions, one can enter into the awareness of the subjective reality of others and provide the positive support and acceptance that they will need to develop healthy self-concepts (Hergenhahn & Olson, 1999; Jones & Butman, 1991; Rogers, 1951). It is proposed that through receiving unconditional positive regard and “warmth, love, sympathy, care, respect and acceptance” (Hergenhahn & Olson, p. 474) from a significant other, persons will explore, adjust, and reorganize their concepts of self into a healthy and congruent construct. This will then enable and empower them to work toward achieving self-actualization (Hazler, 2007; Hergenhahn & Olson; Jones & Butman; Rogers).

Filial play therapy is of specific interest to this paper as CPRT incorporates its teachings and techniques. In this therapy parents are trained to become the “primary change agents as they learn to conduct child-centered play sessions with their own children” (VanFleet, 2005, p.1) and convey acceptance and unconditional positive regard. The goal is to develop positive interactions and strengthen relationships between parents and their children in order to proactively limit or prevent future problems and concerns (Jang, 2000). It is hoped that Filial therapy will not only assist in the treatment of children with social, emotional, and behavioral problems (Axline, 1974; Landreth &

Lobaugh, 2006; Lobaugh, 1991; VanFleet); but allow families to increase “communication, coping, and problem-solving skills so they are better able to handle future problems independently and successfully” (VanFleet, p. 4).

The Neuroscience of Relationships

Neuroscience has provided interesting information regarding the formation and function of the human brain. Schore (2003a) states that a human infant’s brain is linked to that of his or her caregiver and his or her “immature and developing internal homeostatic systems are co-regulated by the caregiver’s more mature and differentiated nervous system” (p. 149). He also states that maternal deprivation and neglect can induce neuronal death and, if this occurs during a critical phase of development, may result in abnormalities and pathologies. This is also addressed by Cozolino (2006) who states that both nature and nurture, which can take the form of interpersonal relationships, “contribute to the building of the brain via the template and transcription functions of our genes” (p. 40). Other neuroscientists have also focused upon the effects of adverse social experiences on brain development and report that this may “result in permanent alterations in opiate, corticosteroid, corticotrophin releasing factor, dopamine, noradrenalin, and serotonin receptors” (Cozolino, p. 290) which leave behind “permanent physiological reactivity in limbic areas of the brain” (Cozolino, p. 290). As a consequence, this individual may experience complications in the ability to regulate and regain homeostasis.

In specifically considering healing relationships, Schore (2003b) proposes that the attachment formed during a therapeutic intervention grasps the “patient’s inner world as

it intersects the therapist's own" (p. 92). He goes on to theorize that this creates possibilities to alter the "structural growth of right-lateralized internal psychic systems that unconsciously process emotional communications and regulate stressful emotional states" (p. 92). Of particular interest to this paper and study is Cozolino's (2006) discussion of the development of the adolescent brain. This neuroscientist states that the "teenage brain undergoes disorganization and reorganization from the onset of puberty into the early 20s" (p. 44), and hypothesizes that during this time, interpersonal relationships actually play a role in determining changes and organizations of neural systems and networks. In turn, the organizational pattern of the neurons in the "orbital medial prefrontal, insula, anterior cingulate cortices and other areas of the social brain" (p. 64) enables humans to modulate emotions, "fine-tune" sympathetic arousal, and maintain continued social engagements.

Research on Relationship

With the establishment of the significance of relationship, this paper will now focus upon a review of related programs, hypotheses, research, findings, and discussions which utilized or explored this entity. Relationship has been examined in a wide range of settings and conditions. It has been studied in the roles of both dependent and independent variables and analyzed for mediating and moderating qualities. Results discuss multiple outcomes, regarding character development and changes, in both internalized and externalized behaviors. In addition to this, factors that affect relationship development and quality have also been studied. This review presents data and findings

which will support the value of, and need for, study that is specifically focused upon parent-adolescent relationships and their enhancement.

Resiliency and Self-Efficacy

Empirical support has been presented which indicates that relationship and connectedness with others can assist persons to adjust effectively to life circumstances and stressors (Higgins, 1994; M. L. Jaffe, 1998; Pianta & Hamre, 2001; Randolph & Johnson, 2008; Reese & Roosa, 1991; Resnick et al., 1997; Rhodes, 2002). In considering traumatic events, resilience has been defined as “the ability to function psychologically at a level far greater than expected given a person’s earlier developmental experiences” (Higgins, p. 17). Higgins reports the emergence of three factors when evaluating resilient persons, the ability to be flexible and think positively when considering present and future circumstances while optimizing opportunities, the tendency to be proactive in facing stressors or negative experiences, and the ability to “effectively recruit other people’s invested regard” (p. 20). Through relationship and interaction with others, it is thought that resilient persons can form attachments which provide positive experiences and foster hope and motivation to strive toward well-being and self-actualization (Higgins; Randolph & Johnson; Reese & Roosa; Resnick et al.).

In an attempt to specifically examine and study resiliency in children, the National Institute of Child Health and Human Development funded the National Longitudinal Study on Adolescent Health which focused upon at-risk children and the factors which assist them to reduce, manage, or successfully cope with unwanted, dangerous, and negative behaviors. This study assessed for emotional distress, sociality, violence,

substance and cigarette use, sexual behaviors, and history of pregnancy. Resulting data indicated that “parent-family connectedness and perceived school connectedness were protective against every health risk behavior measure except history of pregnancy” (Resnick et al., 1997, p. 823).

Reese and Roosa (1991) discussed the stress process model and provided data which supports their hypothesis that the loss of a parent and lack of supportive relationships with caring adults can increase the risk that children will be unable to successfully manage stressful conditions. These young people can then become more vulnerable to experiencing negative mental health outcomes such as depression, acting-out behavior, and the development of low-self-esteem. The correlation between securely attached family relationships and resiliency in children was also discussed by Levy and Orlans (1998), who reported finding that “the most basic and important protective factor is the history of caregiver-child attachment” (p. 52). Based upon this, recommendations have been made that the development and inclusion of parent-child relationship enhancement and support become components in the treatment plans for all youth with serious emotional or behavioral problems (Armstrong, Birnie-Lefcovitch, & Ungar, 2005).

Another factor in resiliency may be self-efficacy, which Bandura (1997) defines as being a belief “in one’s capabilities to organize and execute the courses of action required to produce given attainments” (p. 3). Children and adolescents who have parents or other caregivers who provide positive feedback, instruction, support, and acceptance have been shown to learn and develop strategies that they can use to strengthen their emotional intelligence and overcome challenges and diversity (Goleman,

1995; Schunk & Meece, 2006). Though interactions with others, children learn vicariously as well as directly, the skills that they will need to control their lives and “approach difficult tasks as challenges to be mastered rather than as threats to be avoided” (Bandura, 1998, p. 71). Interactions with others also provide social persuasion which motivates and empowers the child to believe in his capabilities to bring about change (Bandura; Bandura, Barbaranelli, Caprara, & Pastorelli, 2001).

In considering specific research in self-efficacy, support has been provided that children aspire to careers as moderated by their parent’s belief in their capabilities to be successful (Bandura et al., 2001). The support and encouragement of significant others has also been shown to equip persons to structure their environment and cultivate competencies to successfully manage depression, and teachers’ beliefs in their efficacy to share knowledge and the students’ ability to learn may positively affect academic achievement (Bandura et al.; Fernández-Ballesteros, Díez-Nicolás, Caprara, Barbaranelli, & Bandura, 2002; Jonson-Reid, Davis, Saunders, Williams, & Williams, 2005). Additional research suggests that empowerment may be obtained through collective agency and efficacy, and school performance may be raised thorough interactions with others who support and value academic achievement (Bandura, 1993, 2001; Fernández-Ballesteros et al.).

These studies provide support that interactions with others and relationships may act as moderators in the developing and attainment of goals. An additional study by Capraram and associates (Capraram, Pastorelli, Regalia, Scabini, & Bandura, 2005) focused upon adolescents’ satisfaction with family functioning and found that those who experienced efficacy within the family unit reported more fulfilling relationships. This

may indicate that a bi-directional effect exists between one's sense of efficacy and his ability to form effective relationships.

Mentoring

Mentors are adults who develop a relationship with a younger or less skilled person in order to provide “ongoing guidance, instruction, and encouragement aimed at developing the competence and character of the protégé” (Rhodes, 2002, p. 3).

Depending on the motives, level of commitment, and stability of the mentor, this process can be either positive, leading to a higher level of functioning for the person being mentored, or negative, leading to the development of antisocial behavior and a declination in that person's sense of self and faith in others (Rhodes). With growing numbers of women in the workforce, the soaring rate of divorce, limited funding for extracurricular activities and mental health services, and swelling classroom sizes, it is hoped that mentors can augment the care received by an adolescent from family members, school personnel, and therapists in order to decrease the risk of the occurrence of negative behaviors and increase positive values, beliefs, attitudes, and behaviors.

Research has supported this in finding that adolescents with effective, caring mentors are less likely to participate in smoking, drug use, the carrying of weapons, and unsafe sex; and have lower rates of truancy from school. Other reported results have been more positive peer and family relationships, elevations in self-esteem, self-efficacy, and resiliency; increased academic achievement, a willingness to participate in additional community and mental health services; and less noted aggressive behavior (Britner, Balcazar, Blechman, Blinn-Pike, & Larose, 2006; Converse & Lignugaris/Kraft, 2009;

DeSocio, et al., 2007; Gibson & Jefferson, 2006; Langhout, Rhodes, & Osborne, 2004; Randolph & Johnson, 2008; Rhodes, 2002; Rhodes, Grossman, & Resch, 2000; Southwick, Morgan, Vythilingam, & Charney, 2006; Thompson, Longden, Harrison, & Valentine, 2007). School, community, church, and mental health agency based mentoring programs have all been a focus for study and credited with positive results (Hamilton et al., 2006; M. L. Jaffe, 1998; Randolph & Johnson; Rhodes).

Three human capital programs, Big Brothers Big Sisters of America, Club Amigas, and Gaining Early Awareness of Readiness for Undergraduate Programs (GEAR UP) are specifically addressed in research (Gibson & Jefferson, 2006; Kaplan, Turner, Piotrkowski, & Silber, 2009; Maldonado, Quarles, Lacey, & Thompson, 2008; Rhodes, 2002). Over two million youth in America are involved in the Big Brothers Big Sisters mentoring program in which volunteers attempt to act as surrogates for parents and teachers in order to “improve the lives of children and youth around the world” (Maldonado et al., p. 223). Caregivers apply to this program and children are matched to a mentor based upon gender, location, and interests. In a national evaluation of this organization, applicants were either matched with a mentor or placed on a wait list. Youth with mentors missed fewer schooldays, skipped fewer classes, and reported “lower levels of substance use, less physical aggression, more positive parent and peer relationships, and higher scholastic competence and grades” (Rhodes, p. 18) than children in the control group.

Club Amigas is a mentoring project for Hispanic adolescent girls developed by the Institute for the Education of Women and Girls (Kaplan et al., 2009). This program works on the premise that forming emotionally close and supportive relationships with

culturally similar mentors will assist Hispanic teens, between the ages of 11 and 15, to increase their academic goals, self-esteem, and positive cultural identification; and “serve as protective factors to help build resilience and mitigate potential negative outcomes” (Kaplan et al., p.213). Data analysis indicated that girls who completed this program exhibited increased levels of self-esteem and cultural identity, and a stronger desire to attend college. This study lists as a limitation that it did not include a control group (Kaplan et al.). Gibson and Jefferson (2006) chose to examine GEAR UP, which is a federally funded program, with a goal of encouraging middle school students to consider attending college and assisting parents with admission procedures. As part of this program, students are paired with mentors from the community to promote growth-fostering relationships with the objective of elevating self-concept and college readiness. Increases were noted in both areas.

Therapeutic Alliance

In his classic text, *Client-Centered Therapy*, Rogers (1951) wrote:

It has become increasingly evident that the probability of therapeutic movement in a particular case depends primarily not upon the counselor’s personality, not upon his techniques, nor even upon his attitudes, but upon the way all these are experienced by the client in the relationship. (p. 65)

Most therapeutic approaches accept the importance of this therapeutic relationship (Corey, 1982; Green, 2009; Pinsker, 1997; Ross, Polaschek, & Ward, 2008), and feeling understood, respected, accepted, and safe may account for 25 to 30 percent of the success in psychotherapy outcome research (Gladding, 2007; Horvath & Symonds, 1991; McMinn & Campbell, 2007; Ross et al.). A skilled therapist will maintain a relationship which is supportive within safe boundaries, with the goal of encouraging and assisting the

patient to discover and develop the skills and knowledge he will need to effectively cope with symptoms of mental illness, concerns, and stressors. Within the safe environment of the therapeutic relationship it is hoped that the client will feel free to practice these new skills, ventilate, put things into perspective, and learn to accept and identify his strengths and weaknesses as he learns to respond positively to challenges and crises and work toward obtaining maturity and self-actualization (Green; Jones & Butman, 1991; Krupnick et al., 1996; Pinsker; Ross et al.; Street, Makoul, Arora, & Epstein, 2009).

In reviewing specific research, the impact of the alliance in various therapeutic orientations has been examined, in regards to a wide range of goals and concerns, in both long and short term interventions, from the perspectives of the client, therapist, and independent observers (Horvath & Symonds, 1991). The cultural and spiritual beliefs, values, backgrounds, and influences of both the therapist and client have also been considered as well as factors and characteristics of a healthy therapeutic relationship such as collaboration, mutuality and engagement (Brammer, 2004; Furman et al., 2009; Horvath & Symonds; Korin & Petry, 2005; Richards & Bergin, 2005; Zea, Mason, & Murguía, 2000). Studies almost unanimously support the importance of this curative factor which may also prove to be of universal importance in transdiagnostic assessment and treatment (McEvoy, Nathan, & Norton, 2009).

Social Support

Gottlieb (as cited in Armstrong et al., 2005) defined social support as “verbal and non-verbal information or advice, tangible aid, or action that is proffered by social intimates or inferred by their presence and has beneficial emotional or behavioral effects

on the recipients” (p. 271). These relationships with others begin at a very early age as evidenced by social smiles and separation anxiety (Feldman, 2006). It has been posited that through supportive interactions, children will participate in social referencing to understand and form appropriate responses to uncertain stimuli and events (Feldman; Morris, Silk, Steinberg, Myers, & Robinson, 2007; Moustakas, 1959; Mumme & Fernald, 2003; Parrott, 2000; Rosen, Adamson, & Bakeman, 1998). Interactions with others may enable them to develop the life skills they will require to grow and prosper, form attachments, and gain support which will assist in the regulation of emotions and successful management of negative or traumatic events, emotions, situations, and times of distress (Bowlby, 1988; Feldman; D. A. Hughes, 1997; Jackson & Warren, 2000; Kobak, 1999; Levy & Orlans, 1998; Pickle, 2000; Sroufe et al., 2005).

After completing a review of current literature, Jackson and Warren (2000) reported that “a substantial body of research supports the notion that social support plays a role in the relation between stressful life events and behavioral outcome” (p. 1441). Effects can be direct, in that a rise in social support will yield an increase in adaptive behavior, or act as a moderating buffer in which high levels of support interact with increases in stressors and distress allowing the individual to respond with effective and productive adaptive behavior. Other findings presented by this study were that children were less likely to demonstrate psychopathology when they perceive global social support and that “simply having a significant relationship with an adult is important as a buffer from major life events for children” (p. 1142). A discussion of current mentoring programs and review of research generated from studies focusing specifically upon adolescent relationships should prove to be beneficial in clarifying and illustrating the

effects, mechanics, and possibility of relationship enhancement utilization to bring about change for this age group.

Neighbors and unrelated adults.

The Carnegie Council on Adolescent Development and the National Commission on Children indicated that “a relationship with at least one caring adult, not necessarily a parent, is perhaps the single most important element in protecting young people who have multiple risks in their lives” (Scales & Gibbons, 1996, p. 366). Children become increasingly mobile as they approach their teen years. This enables them to develop more extensive relationships within the community, and interactions with persons outside of their nuclear families will become increasingly important (Feldman, 2006; M. L. Jaffe, 1998). The influence of relationships between adolescents and unrelated adults including neighbors, friends, teachers, coaches, clergy, parents of friends, friends of parents, and youth workers, has also been a focus of research and study (H. L. Chung & Steinberg, 2006; Cunningham, Kliewar, & Garner, 2009; Higgins, 1994; Jackson & Warren, 2000; Mrug & Windle, 2009; Scales & Gibbons).

An interesting study focused upon influences presented by the neighborhood in which the teen resides. Data from this study presented support that a “sense of mutual trust and shared values and expectations” with others effects teen’s externalizing behaviors. Higher levels of desirable behavior and lower levels of adolescent deviant behavior were noted within communities in which members interacted with and were supportive of their young people through programs such as youth centers and athletic organizations (Mrug & Windle, 2009).

Rutten and associates (2007) focused on relationships with coaches and reported support that “coaches who maintain good relationships with their athletes reduce antisocial behavior” (Rutten et al., p. 255). This group also presented data which indicates that “mutual respect, care, trust, responsibility, and shared prosocial norms about what constitutes appropriate behavior” (p. 256) between peers and coaches increased the occurrence of positive behaviors. In another study involving coaches and adolescent team members, Allen and Howe (1998) reported that “perceptions of competence could be enhanced by positive reinforcement from significant others for mastery attempts” (p. 281). In considering supportive relationships with additional community members, research has reported that interactions with authoritative peer parents contributed to lower levels of misconduct and internalized distress, higher degrees of academic competence, lower levels of minor delinquency and substance abuse, and higher levels of self-esteem and self-reliance in adolescent female participants (Fletcher, Darling, Dornbusch, & Steinberg, 1995; Scales & Gibbons, 1996).

Teachers.

As adolescents spend an average of six to eight hours per day in school related activities and consistently include teachers when asked to list adults who are important and influential in their lives, research focused upon their relationships with teachers and school personnel has also been of interest to clinicians (Britner et al., 2006; Buyse, Verschueren, Doumen, Von Damme, & Maes., 2008; DeJames, 2001; Duncan-Poitier, n.d.; Hamre & Pianta, 2005; Murray & Pianta, 2007; Pianta & Stuhlman, 2004a, 2004b; Randolph & Johnson, 2008; Resnick, et al., 1997; Scales & Gibbons, 1996;

Southwick, et al., 2006; Stuhlman, Hamre, & Pianta, 2002; Stuhlman & Pianta, 2001). In his book, *Enhancing Relationships between Children and Teachers*, Pianta (1999) states that “child competence is often embedded in and a property of relationships with adults” (p. 17). In addition, he discusses teachers’ opportunity to pattern, encourage, and promote healthy development, stability, and well-being in their students.

This author states that support from school personnel and staff is especially significant for those students who have been identified as “at risk” (Pianta, 1999), as positive teacher-student relationships have been shown to promote resilience in students who are experiencing stressors and abuse in their home environments. These children may utilize school as a safe haven and reach to teachers for validation, acceptance, and hope that negative situations and circumstances will change and improve (Higgins, 1994). Support exists that students who reported positive relationships with teachers and greater levels of school connectedness, displayed higher levels of self-esteem, worth and efficacy, and academic achievement; and lower incidences of drug abuse, early withdrawal from school, depression, anxiety, emotional distress, suicidal involvement, problem behaviors and nonviolent delinquency, than those who did not (Britner et al., 2006.; Buyse et al., 2008; DeJames, 2001; Hamre & Pianta, 2005; Delbert, Hatot, Sirovatka, & Potter, 2001; Murray & Pianta, 2007; Pianta & Stuhlman, 2004a, 2004b; Randolph & Johnson, 2008; Resnick et al., 1997; Southwick et al., 2006; Stuhlman et al., 2002; Stuhlman & Pianta, 2001).

The importance of the teacher-student relationship is also emphasized by Glasser and is a crucial component in his Quality School program (Glasser Institute, n.d.).

Teachers are trained and instructed to respond to students with respect and fairness, while

acknowledging their individual talents, values, strengths, and challenges. In this supportive environment, students are encouraged to think positively regarding learning, teachers, and possibly, adults in general; and continue to include them in their quality world. It is hoped that students will learn what is practical and useful and utilize this to make wise and responsible choices that will result in positive growth and well-being. Glasser also maintains that caring, skilled, and competent teachers can become invaluable resources in providing acceptance, nurturance, and direction to students who lack a positive parental foundation, which will result in favorable academic and psychological outcomes (Glasser, 1998).

Friends and peers.

It has been posited that peers play a more important role during adolescence than any other stage of development and teens will begin to utilize them as reference groups for social comparison and sources of information. Through the development of equitable relationships with peers, adolescents will attempt to obtain the companionship, feedback, social support, prestige, acceptance, validation, and status they will require to develop healthy identities (Feldman, 2006; Ginsberg, 1997; E. F. Gross, Juvonen, & Gable, 2002; M. L. Jaffe, 1998; Parrott, 2000; Peat, Dalziel, & Grant, 2001; Sabrahmanyam & Lin, 2007). It has been hypothesized with statistical support that adolescents who are accepted by their peers will develop healthy levels of self-esteem, social skills, efficacy, and satisfaction with their school experiences while those who are rejected may develop longstanding interpersonal problems and symptomatic behaviors (Ezzel et al., 2000;

Feldman; Gazelle, 2008; Hammen & Rudolph, 1996; M. L. Jaffe; Londahl, Tverskoy, & D’Zurilla, 2005; Parrott; Rubin & Stewart, 1996).

In further considering pathology management, Ezzell and associates (2000) reported that “peer support was found to contribute significantly to reductions in child- and parent-reported depression and anxiety” (p. 647). Children in their studies, who reported positive peer relationships, presented with fewer feelings of loneliness and an “increased sense of belonging, and greater validation and sense of self-worth” (p. 648). Due to these positive outcomes, these clinicians put forward that increasing and developing healthy relationships with peers may assist in reducing internalizing difficulties in at-risk children. Other studies collaborate with their results and indicate “children’s overall acceptance by the peer group and the extensiveness of children’s friendship networks as factors that might protect or buffer children from the risks associated with an array of negative family” (Criss, Pettit, Bates, Dodge & Lapp, 2002, p. 1220) and life experiences such as divorce, conflict, abuse, school concerns, and physical illness and injury (Bal, Crombez, Oost, & Debourdeaudhuij, 2003; Londahl et al., 2005; Peat, Dalziel, & Grant, 2001; Prigatano & Saurabb, 2006). Other studies focused upon negative attributes of peer relationships finding that “young people who affiliate with delinquent or substance-using peers are at increased risks of crime, substance use, and mental health problems” (Fergusson, Vitaro, Wanner, & Brendgen, 2007, p. 34); and posit that teens participate in these negative behaviors due to social imitation, peer pressure, and social facilitation. It is emphasized, however, that all adolescents who associate with deviant peer groups do not develop negative attributes and behaviors, and suggested that positive and supportive family relationships and attachments may act as

buffers in protecting these children from negative choices, decisions, activities, and outcomes (Feldman, 2006; Fergusson et al., M. L. Jaffe, 1998; Parrot, 2000).

Extended family members.

Relationships with grandparents, aunts, uncles, and cousins have also been a focus of research and study, with data indicating that relatives provide encouragement, hope, knowledge, information, advice, and nurturance; influence adolescent's feelings about themselves, maintain tradition and family heritage, and provide buffers and opportunities to process conflicts with parents or other family members (Ellingson & Sotirin, 2006; Higgins, 1994; Langer & Ribarich, 2007; Milardo, 2005; Owens, Scofield, & Taylor, 2003; Rubin & Stewart, 1996; Scales & Gibbons, 1996). Kalil and associates (1998) posited and presented empirical support that healthy and positive relationships with grandmothers can assist adolescent mothers to learn and practice efficient child-rearing practices and exhibit higher levels of self-esteem and efficacy than peers who do not experience this support. They also reported that adolescents with supportive grandparent relationships experienced lower levels of depression and stated that "the more negative the relationship between adolescents and their family members in general and grandmothers in particular, the worse the prognosis for adolescents' psychological well-being" (p. 439). Similar results were reported by Ruiz and Silverstein (2007) and Pittman (2007) who found support that grandparents who provide warmth, support, and comfort assist adolescents in the development of healthy self-identities, while reducing depressive symptoms and increasing self-esteem.

Others studies chose to focus upon emotionally close and invested relations with aunts and uncles. Empirical support exists which states that when relating with young adults, aunts and uncles frequently take on the roles of teacher, confidante, advisor, wise peer, encourager, and role model which become factors in empowering these young people to develop healthy self-identities and relationships throughout their lifespan (Ellingson & Sotirin, 2006; Langer & Ribarich, 2007; Mallon, 1992; Milardo, 2005; Pashos & McBurney, 2008). Ellingson and Sotirin state that the lack of the need to enforce everyday rules and punishments, and occupying a more neutral niche outside the boundaries of the nuclear family, provide attractiveness and strength to aunt-adolescent relationship and removes the need for teens to rebel to establish an independent identity. This relationship is also thought to be strengthened through shared histories and common values (Langer & Ribarich).

Although the positive aspects of supportive relationships have been discussed, research exists which supports negative consequences as well. As it is supported that teens may look to relatives for guidance and advice (Ellingson & Sotirin, 2006; Langer & Ribarich, 2007; Milardo, 2005; Scales & Gibbons, 1996), it follows that both positive and negative traits will be accepted and incorporated into identity. This can be supported through statistics regarding smoking behaviors in which 60% of children and adolescents who report that they have observed this behavior in parents, grandparents, aunts, and uncles (Bricker, Peterson, Sarason, Andersen, & Rajan, 2007; Drahoslava & Žaloudiková, 2008). Research has shown that poor relationships with extended family members may hinder teens from the creation of healthy positive relationships with other members of the community and lessen feelings of self-esteem and efficacy. It has further

been posited that relationships which are high in conflict may become stressors for these young people and contribute to symptom formation and development (Johnson & Tyler, 2007; Kalil et al., 1998; Oberlander et al., 2007; SmithBattle, 1996).

Parents.

Considering the importance of parent-adolescent relationships, L. Steinberg (2001) wrote:

while fads and fashion in other topic areas have come and gone, research on parent-adolescent relationships has maintained a constant presence in the literature, dominating the scientific journals, overwhelming the review panels of funding agencies, and capturing the lion's share of popular publications on teenagers and how to ensure their health and well-being. (p. 2)

This was further emphasized by Adler who stated that parent-child relationships are the main factor of influence and predictor when considering personality development, psychological adjustment, and well-being. Current research (C N. Barber, Ball, & Armistead, 2003; Gfroerer, Kern, & Curlette, 2004; Heath, 1980; M. L. Jaffe, 1998), such as findings from the National Longitudinal Study on Adolescent Health which reported "that parent-family connectedness and perceived school connectedness were protective of every health risk behavior measured" (Resnick et al., 1997, p. 823) except history of pregnancy, provides additional support regarding the importance of these relationships.

Due to the significance of this topic, it follows logically that attempting to identify the factors and qualities of healthy, productive parent-child relationships would be a prominent focus of research and study. Findings from these studies overwhelmingly support that authoritarian parenting styles, characterized by "positive effect, child-centeredness, proactive teaching, positive reinforcement, inductive discipline, and the

provision of appropriate play experiences” (Pettit, Bates & Dodge, 1997, p. 908), mitigate situational circumstances and adversity, and result in the presentation of fewer behavioral problems and concerns in children and adolescents (C. N. Barber et al., 2003; Baumrind, 1966; Gfroerer et al., 2004; Heath, 1980; M. L. Jaffe, 1998; W. B. Jaffe & D’Zurilla, 2003; Pettit et al.; L. Steinberg, 2001; Viikinsalo, Crawford, Kimbrel, Long, & Dashiff, 2005). In addition, it has been posited that parents who convey high levels of commitment and investment in their relationships with their teens, through spending quality time with them, responding to their needs and providing, supportive guidance, warmth, firmness, psychological autonomy granting, and unconditional positive regard; enhance their children’s psychosocial growth and maturity, promote healthy adolescent functioning, and facilitate attachment security and development (Campbell, 1993; Cassidy, 1999; Dickerson & Crase, 2005; D. A. Hughes, 2007; M. L. Jaffe; L. Steinberg).

Grotevant and Cooper (1985) studied healthy adolescent maturity and reported that it “is gained in the context of progressive and mutual redefinition of the parent-child relationship” (p. 425) in which there exists a “period of gradual renegotiation between parents and children from the asymmetrical authority of early and middle childhood toward, potentially, a peerlike mutuality in adulthood” (p. 415). Other studies, which focused upon the quality of these relationships, supported their findings stating that healthy psychological outcomes and autonomy are fostered within positive mutual attachments between teens and their parents (C. N. Barber et al., 2003). Within these accepting and supportive authoritative relationships, with the guidance and nurturance of their parents, it is posited that adolescents will feel free to explore their talents, abilities,

values, and preferences; and begin to form, as proposed by Erickson, an identity and “definition of a sense of self as distinctive from others” (Grotevant & Cooper, p. 425).

Support has been presented that the quality of parent-child and parent-adolescent relationships is a factor in the development of both internalized and externalized behaviors (Bandura, 1993; C. N. Barber et al., 2003; Barkley & Robin, 2008; Baumrind, 1966; Bratton & Landreth, 1995; Bratton et al., 2006; W. Chung et al., 2008; Davenport, Hegland, & Melby, 2008; Ezzell et al., 2000; M. L. Jaffe, 1998; Landreth & Bratton, 2006; Londahl et al., 2005; McKee et al., 2008; Owens et al., 2003; Paulussen-Hoogeboom et al., 2008; Pettit et al., 1997; Safford, Alloy, & Pieracci, 2007; Sanford, 2009; Scaramella, Neppi, Ontai, & Conger, 2008; Smalley, 1992; Sorensen, 1998; L. Steinberg, 2001; Stormshack, Bierman, McMahon, & Lengua, 2000; Trollinger, 2007). More specifically, literature suggests that, as parents provide the main context for their children’s socialization and are in the top position to impact their lives, those who supply verbal persuasion and validation may facilitate the development of healthy levels of self-efficacy, worth and esteem in their children (Bandura, 2000; C. N. Barber et al.; Barkley & Robin; Baumrind; Bratton et al.; M. L. Jaffe; Landreth & Bratton; Owens et al.; Sanford; Smalley; Sorensen; Trollinger). In addition, supportive empirical data has been provided that positive parental influences decrease the development, presentation, and intensity of anxiety, depression, social withdrawal, and fearfulness; and decrease the need for adolescent and child psychiatric rehospitalizations (C. N. Barber et al; Baumrind; W. Chung et al.; Ezzell et al.; M. L. Jaffe; Londahl et al.; Paulussen-Hoogeboom et al.; Safford et al.; L. Steinberg)

In examining children's externalized behaviors, some interesting studies focused upon parents who are highly demanding, utilize disaffiliated punishment, and display low levels of warm involvement. Reported findings indicated an increased risk for children and adolescents to develop concerns such as aggression, noncompliance, difficulties in school, substance abuse, social cognitive deficits, oppositional behaviors, and limited conscience development (Baumrind, 1966; Kochanska, 2002; McKee, et al., 2008; Pettit et al., 1997; Scaramella et al., 2008; Schneider, Cavell, & Hughes, 2003; L. Steinberg, 2001; Stormshak, Bierman, McMahon, & Lengua, 2000). Inversely, children who reported positive and supportive relationships with their parents were found to exhibit fewer negative concerns and behaviors, possess better problem solving and impulse management skills, and obtain higher levels of academic competence (Davenport et al.; 2008; Petit et al., Schneider et al.). Additional research reported success in utilizing behavioral parent training programs to improve parent-child interactions to reduce unhealthy and undesirable behaviors (Barkley et al., 1999; Barkley & Robin, 2008; Bratton et al., 2006; Brooks, Guernsey, 1990; Guernsey, & Mazza, 2001; Glasser, 2002; McKee et al.).

Section Summary

This section outlined current thinking and research regarding the mechanisms and effects of healthy relationships in adolescents. It was presented that healthy relationships may act as a buffer in the face of crises, trauma, and stressors; and assist adolescents to develop resiliency to successfully manage and experience growth from these situations (Higgins, 1994; Pianta & Hamre, 2001; Reese & Roosa, 1991; Resnick et al., 1997).

Research has been presented and discussed which indicates and maintains that interactions with caring and supportive adults and mentors reduce the experience of negative mental health outcomes such as depression, acting-out behavior, drug use, school truancy, and the development of low-self-esteem; and facilitate the development of greater levels of self-efficacy, successful coping skills, and increased school achievement, (Bandura, 1997; DeSocio et al., 2007; Gibson & Jefferson, 2006). Praise, acceptance, support, and authoritarian guidance have been indicated as decreasing negative externalized and internalized behavior and assisting adolescents to make wise choices, set goals, and strive to obtain mastery in tasks at hand (Allen & Howe, 1998; Gibson & Jefferson).

Study and theory have presented that learning to manage inappropriate or harmful behaviors and change faulty cognitions may be facilitated within the safe environment of a relationship in which one feels free, supported, and accepted to practice new skills, ventilate, put things into perspective, and learn to accept and discover limitations, strengths, and preferences (Green, 2009; Jones & Butman, 1991; Krupnick et al., 1996). When considering relationships, literature suggests and supports that the quality and strength of the parent-child bond is the most significant factor of influence when predicting psychiatric stability and well-being in adolescents (C. N. Barber et al., 2003; Gfroerer et al., 2004; Heath, 1980; M. L. Jaffe, 1998). Research indicates that parents who convey commitment and support to their teens, through spending quality time with them and supplying unconditional positive regard and authoritarian guidance, enhance their children's healthy and positive growth and development (Bandura. 1993; C. N. Barber et al.; Landreth & Bratton, 2006; Londahl et al., 2005).

Specific Relationship Enhancement Programs

A review of current literature yields supportive data regarding the success of several relationship enhancement programs which focus upon improving interactions, within families, and between couples, students and teachers, and parents or other caregivers and their children. Several of these utilize various play therapy techniques while others focus upon the development of healthy communication, conflict resolution skills, and attachments; and the conveyance of acceptance, support, and unconditional positive regard. All of these programs have in common, however, a focus upon the utilization of the power and vehicle of relationship to bring about positive and desired changes in the interactions, behavior, and overall well-being of those involved (Barkley et al., 1999; Bratton et al., 2006; Brooks et al., 2001; Casado-Kehoe, Vanderbleek & Thanasin, 2007; Ginsberg, 1997; Glasser, 1998; Griffin & Apostol, 1993; D. A. Hughes, 2007; Pianta & Hamre, 2001; McGrath & Noble, 2003; VanFleet, 2005).

Relationship Enhancement and Attachment-Focused Family Therapies

In further exploring the importance of relationship to identity formation and well-being, it should prove to be advantageous to discuss the works of Ginsberg (1997) and D. A. Hughes (2007) who have written books which focus upon relationship and attachment enhancement within families. Ginsberg states that Relationship Enhancement (RE) therapy is “based on education rather than treatment. This program emphasizes the importance of learning certain skills □ how to cope with and enhance relationships, improve self-concept, and thereby achieve personal and interpersonal satisfaction – rather than curing or solving a particular problem” (p. 2). RE is founded upon the theories of

Harry Stack Sullivan and posits that all persons are “members of a relationship system” (p. 5) which shapes personalities throughout the lifespan and must be considered and utilized as the context for all therapeutic interventions (Ginsberg).

In assisting families, RE emphasizes “emotional expression and acknowledgment in a nonjudgmental, accepting environment” (Ginsberg, 1997, p. 7) in order to enhance family cohesion and adaptability during times of situational or developmental stress. Skills which foster, facilitate, and promote empathy, language, and relationship strengthening and development; emotional expression, and acceptance are taught, coached, and modeled to a family unit by a practitioner. This clinician eventually shifts from teacher to consultant with the goal that skills will be learned and successfully utilized independently to resolve conflict and ease experienced and reported difficulties and concerns. RE teaching and practice sessions occur within a designated time frame after which family members utilize newly acquired skills independently with the option of videotaping in-home family interactions. The practitioner then rejoins the family to review progress and address questions and concerns and, upon agreement of all parties, therapy is terminated. It is hoped that improved communication and conflict resolution skills will assist family members to understand their motives and the motives of others, and use this to “resolve past hurts, act more effectively in the present, and cope with life’s disruptions in the future” (Ginsberg, p. 10).

RE accepts Roger’s premise that “each of us has the capacity to master our own experience and resolve our own interpersonal conflicts” (Ginsberg, 1997, p. 15). To this, Ginsberg adds the premise that positive “therapeutic change occurs primarily in the context of one’s significant others and one’s living system” (Ginsberg, p. 12), in which

there exists an inherent equivalence among all persons as human beings and nonjudgmental acceptance. A goal of RE therapy is that families will develop nurturing environments and relationships. Within the accepting atmosphere of these positive environments, family members will be encouraged to openly express emotions and concerns and calmly confront honest thoughts and feelings without experiencing guilt, blame or defensiveness. This should decrease the use of psychological defense ploys and promote the development and use of positive and healthy problem-solving skills, increase feelings of well-being, confidence, self-esteem, and ego strength; maximize the potential for happiness and satisfaction with self and others, and ensure positive healthy growth and the attainment of satisfying and fulfilling lives (Ginsberg).

In examining empirical support for the effectiveness of this therapy, a study by Griffin and Apostol (1993) found that couples who had completed RE reported higher levels of differentiation of self, lower levels of anxiety, and greater satisfaction with their marital relationship immediately after training and at a one-year follow-up interview. This was echoed by Brooks and associates (2001) who reported that marital adjustment, trust, intimacy, and marital communication increased with the implementation of RE therapy. Other studies reported favorable results in the areas of utilizing RE to expand support systems and increase skills in empathetic understanding, effective communication, and positive conflict resolution (Overton & Avery, 1984; Waldo, 1989).

In specifically considering children, Vogelsong and associates (1979) reported success in utilizing a RE training program to increase empathetic understanding skills in preadolescents which enabled them to recognize, express, and effectively respond to emotions and feelings with the expectation that these children would experience

improved interpersonal relationships. Another study, conducted by Guerney (1991), discussed successfully teaching parents to utilize Child Relationship Enhancement Family Therapy (CREFT) in order to partner with school systems in the management of early childhood behavior problems. These parents were trained to respond to their children with acceptance and support so as to increase self-esteem and decrease frustration, anger, social anxiety, and fears; such as separation and abandonment, which are thought to be “manifested in inappropriate and maladaptive behaviors” (Guerney, ¶ 14). Favorable results were obtained and reductions in negative externalized behaviors in both home and outside settings were noted.

In considering attachment issues and family therapy, it has been proposed that triads may be the basic building block of relationships and that emotion, difficulties, needs or concerns resulting from interactions with one person or group of people may be rerouted to another relationship or interaction. Path-analytic statistics have presented some support for this in reporting that internalized and externalized behaviors may be directly related to one’s relationships with his family and parents and the existence or lack of a secure and caring base (Byng-Hall, 1999). D. A. Hughes (2007) states that children, whose parents are available, sensitive, and responsive to their needs and communications; attain physical and psychological safety through the parent-child relationship as well as confidence to initiate social engagement activities. At this point, the child and caregiver begin to have intersubjective experiences which contribute to the identity, development, and well-being of each.

D. A. Hughes (2007) goes on to propose that absent, inconsistent, or out of time responses to children’s positive experiences limit their potential to experience joy,

excitement, efficacy, and self-esteem, and give birth to negative internalized and externalized behaviors. If this continues, the child may begin to develop a self-identity of being unlovable and powerless to bring about positive affect and results. In utilizing Attachment-Focused family therapy, the clinician addresses the entity of intersubjective experiences and assists the family to provide a safe and nurturing environment for each of its members which promotes playfulness, acceptance, curiosity, and empathy (PACE). This model of family therapy goes on to suggest that the “ongoing, present, moment-to-moment intersubjective experiences that occurs among child, parents, and therapist” (D. A. Hughes, p. 95), in and of themselves, may be the central agent of all intrapsychic change.

School Based Programs

Several programs have suggested the efficacy of utilizing relationship enhancement programs within the school system to manage externalized behaviors and promote resiliency in at risk students. One such program is the Bounce Back Classroom Resiliency Program which focuses upon relationship building between students and teachers. Facilitators in this program attempt to instill hope for the existence and possibility of a brighter future through the “teaching of coping skills to help children and young people respond positively to the complexity of their everyday lives” (McGrath & Noble, 2003, ¶ 1). Teachers are taught to interact with their students to model successful and productive behaviors and skills and provide acceptance, warmth, positive expectations, and encouragement. McGrath and Noble (n.d.) additionally propose that in this way, teachers who “get to know their students as people, not just pupils” (¶ 9)

become caring and supportive adults in the child's life and invaluable protective resources. Although this program presents tenets which are promising, no current research has been presented regarding its efficacy (Noble, personal communication, June 1, 2009).

Glasser (n.d.) has also been interested in utilizing the education process to promote well-being in at-risk students. He proposes that "these students need to form satisfying relationships with loving, patient teachers, who may be the only reliable source of love they have" (Glasser, 1998, p. 251). Teachers in Glasser's Quality Schools are taught to discover and utilize the strengths and learning style of their students and to support and encourage their development. All subjects, therefore, are taught in a way which is relevant to the quality world of each child. Parental involvement is encouraged and welcomed to enhance their relationships with their children and school personnel, and blaming and negative communications are avoided. To strengthen student-peer and student-teacher bonds, students are graded and compared to their personal best and student ranking and competition is neither used nor encouraged (Glasser).

In evaluating the efficacy of these schools, Glasser (1998) discusses that involved students report increased self-esteem and efficacy, greater satisfaction with learning and their accomplishments, a desire to succeed and do their best, and improved relationships with peers, teachers, and parents. Quality School students have proven to be academically efficient and surpass public school students in state proficiency tests and college entrance examinations. As a further testimony to the success of this program, these students are eager to volunteer to discuss their school experience at workshops and other presentations and are extremely positive regarding their current school experiences

when compared with previous educational endeavors (Glasser, 1998; Glasser, personal communication, October 13, 2007).

An additional program, Pianta and Hamre's (2001) STARS, also focuses upon relationship enhancement within the school setting. Pianta (1999) posits that student-teacher relationships are important influences upon student's lives, effect and shape their development, and can be used as preventive interventions for at-risk children. He examines the current situations in today's schools and states that grades are falling, while drop-out rates and violence are on the rise. Pianta contributes this to high poverty and divorce rates, low standards and limited regulations regarding child care, and the fact that "many school-age children are unsupervised both before and after school, do not have a secure and safe adult to whom to turn, and live in dangerous, and, at best, unpredictable and unstimulating environments" (p. 8).

In an effort to change negative trends, Pianta presents research which supports the efficacy of relationship enhancement programs, between teachers and students, to promote mental health and school success and decrease negative behaviors and outcomes (Hamre & Pianta, 2005; Murray & Pianta, 2007; Pianta & Hamre, 2001, 2009; Pianta & Stuhlman, 2004a, 2004b; Stuhlman & Pianta, 2001). Pianta and Hamre (2009) found that relationships "involve three components—features of the individuals, feedback processes, and external forces" (p. 5) and set out to develop a program to address all three. The STARS program includes assessment procedures as well as techniques which instruct teachers as to the nature of relationships and how to create effective interactions with students. The program begins by assessing the relationship through the teacher's and student's personal perspectives. If concerns are noted, a consultant will then assist the

teacher to observe and understand the student's behaviors differently in order to form a more positive representation and encourage the use of positive feedback.

During the assessment process, the consultant will co-concurrently assist the teacher to address external behaviors through the use of Banking Time interventions which allow the teacher to “interact positively and non-directively with the child, thereby creating a different set of relationship feedback processes” (Pianta & Hamre, 2001, p. 29). Banking Time interventions consist of consistent and predictable, child directed interactions between the teacher and target student with the goal of creating more personal and authentic relationships. During these sessions, the student selects and participates in an activity while the teacher actively observes or reflectively interacts, conveying interest and acceptance. In this way, the teacher becomes a “supportive and uncritical adult who is available as an emotional resource” (Pianta & Hamre, p. 36) and conveys the role of “helper” or “safe person”.

Pianta and Hamre (2001) stress that the relationship between the teacher and student, and the opportunity to share positive experiences, initiates and establishes desired positive changes and well-being. They also propose that Banking Time is appropriate for classroom and small group use and suggest these techniques should be extended into all daily interactions with students. In examining supportive research, these authors state that their program extensively uses “theory and research as a basis for each step” (p. 47). Pianta's (1999) studies present detailed case examples in which both students and teachers reported greater levels of satisfaction and productivity and less anxiety regarding the school and classroom environment.

Additional research supports the findings that relationship enhancement between teachers and students, and students and peers, decreases internalized and externalized behaviors and symptoms and promotes increased social interaction and acceptance, as well as academic success. In examining specific studies, support was presented which indicated that students who report a supportive accepting relationship with peers and teachers experience less delinquency, drop out, incarceration, and substance abuse; fewer incidences of aggressive behavior, and increased levels of self-esteem, successful coping skill use, positive social and emotional adjustment, and productivity (Al-Yagon & Mikulincer, 2004; J. N. Hughes, Cavell, & Jackson, 1999; Jenkins, Antil, Wayne, & Vadasy, 2003; Murray & Greenberg, 2001; Murray & Pianta, 2007). Cooperative learning and school based mentoring programs such as Peer Assisted Learning Strategies (PALS), Club Amigas, Check & Connect, and GEAR UP; which provide interaction with peers, increased opportunities for participation, more immediate and personal feedback, and increased social support; have also reported success and shown to be effective in increasing school satisfaction, academic productivity, and general well-being (Anderson, Christenson, Sinclair, & Lehr, 2004; Converse & Lignugaris/Kraft, 2009; DeSocio et al., 2007; Fuchs, Fuchs, Mathes, & Martinez, 2002; Gibson & Jefferson, 2006; Jenkins et al.; Kaplan et al., 2009).

Parent-Child Relationship Enhancement Programs

Child Parent Relationship Therapy (CPRT) is a brief, 10 session, parent-child relational enhancement intervention developed by Bratton and associates (Bratton et al., 2006). The goal of this program is to “help strengthen the relationship between a parent

and a child by using 30-minute playtimes once a week” (Bratton et al., p. 10). Parents are taught to “respond empathically to their child’s feelings, build their child’s self-esteem, help their child learn self-control and self-responsibility, and set therapeutic limits” (Bratton et al. p. 10). These special play sessions are child directed and led, with the parent following and reflecting, in order to develop and nurture a special relationship in which there are no “reprimands, put-downs, evaluations, requirements [or] judgments” (Bratton et al. p. 10). In this way, it is theorized that caregivers will learn to focus on their children, rather than conflicts and problems, and allow them to “feel accepted, understood and cared for...discover their own strengths, and assume greater self-responsibility” (Bratton et al., p.10). It is further theorized that the child’s self-concept will affect his behavior and that increases in this area will lead to the development and utilization of emotions, feelings, and actions which are positive and effective rather than negative and self-defeating (Bratton et al.).

CPRT is based upon the works of several psychologists and therapists and springs from the efforts of Landreth to encourage mental health workers and professionals to train and assist parents in obtaining the skills they will need to enhance the mental health of their children, and in so doing, of future adult populations (Landreth & Bratton, 2006). Landreth and Bratton credit prior works of Freud, Fuchs, Baruch, Axline, Rogers, the Guerneys, and Moustakas, who reported successful utilization of parents as change agents in play therapy-type home play sessions, as providing a theoretical foundation for their program. During CPRT, parents are provided with “scheduled systematic training, close supervision, and opportunity to explore their feelings with peers in a group process/therapy type format” to develop appropriate goals and improve outcome (p. 3).

This pair go on to state that their program is a form of Filial play therapy which “applies the constructs and skills of child-centered play therapy to parent and child relationships, in a manner similar to the relationship between a play therapist and a child” (Landreth & Bratton, 2006, p. 3). CPRT accepts Roger’s premise that all persons are in a stage of becoming and Moustakas’ (1959) proposal that children will be internally motivated toward “self-realization, positive growth, improvement, independence, maturity, and enhancement of the self” (Landreth & Bratton, p. 4). It is hoped that within a safe, accepted environment and significant relationship with the parent or other caregiver, maximum probability for growth will be developed and maintained. The goal of this program, therefore, is to facilitate “a permissive and growth-producing atmosphere in which the child can reach his or her full potential” (Landreth & Bratton, p. 3).

CPRT has been widely studied and has accumulated empirical support utilizing a “total of 33 studies involving over 800 subjects” (Landreth & Bratton, 2006, p.457). Results support that parents, including those from diverse cultural populations, who were trained using the 10 session Filial therapy model had statistically significant increases in empathetic interactions with their children and parental acceptance, and decreases in stress related to parenting, family conflict, and children’s behavior problems and concerns. Increases were also reported in child self-concept and esteem (Bratton & Landreth, 1995; Guo, 2005; Z. L. Harris, 1995; Yuen, Landreth, & Baggerly, 2002). An additional study indicated that children whose parents were trained in CPRT reported similar results to those who participated in formalized, one on one individual therapy with professional therapists as compared to a no treatment control group (Landreth & Bratton). Several studies utilized CPRT within a school setting with teachers and

reported favorable results in that, when compared to a control group, teachers exhibited more empathy and understanding of difficult students, and student behavior problems decreased (Landreth & Bratton).

These authors report that other studies have utilized CPRT to train older students to become mentors of younger students. Results were favorable in that these participants exhibited higher levels of empathetic interactions than control group peers. Another interesting study compared results of parents and graduate students who were trained utilizing CPRT. Results supported both Landreth's original premise that parents can be taught to use professional therapeutic skills, as scores for parents and graduate students were very similar; and Guerney's proposition that parents have greater emotional significance to their children than do therapists. If this is true, utilizing parents as therapeutic agents may bring about larger and more substantial changes in behaviors and identity development (Landreth & Bratton, 2006).

As previously mentioned, Filial therapy, which was based upon the precursor to CPRT, Landreth's proposed 10-week model, has been utilized and studied with different child concerns. Clinicians have reported successful results when assisting parents to improve relationships with children who have been diagnosed with hearing deficits, pervasive developmental disorders, chronic illness, and learning disabilities. Children who have been classified as at risk, experienced difficulty in adjusting to school, been victims of sexual abuse, or witnessed domestic violence have also been participants in Filial therapy studies in which improvement in relationships have been noted (Beckloff, 1998; Costas & Landreth, 1999; Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Hess, 2004; Kale, & Landreth, 1999; Kot, Landreth, & Giordano, 1998; Post,

McAllister, Sheely, Hess, & Flowers, 2004; D. M. Smith & Landreth, 2004; N. Smith & Landreth, 2003; Steen, 2005; Tew, Landreth, Joiner, & Solt, 2002; Tyndall-Lind, Landreth, & Giordano, 2001). Landreth and Bratton proposed that due to the promising results of these studies, which indicate the effectiveness of this program, CPRT is a viable method of treatment and intervention for “children exhibiting a variety of emotional and behavioral difficulties” (2006, p. 471).

Additional studies noted that they specifically utilized Landreth’s 10-week Filial therapy program and focused upon families with specific concerns. Promising results have been reported, in regards to relationship development and enhancement, when working with single and incarcerated parents (Bratton & Landreth, 1995; Z. L. Harris & Landreth, 1997; Landreth & Lobaugh, 1998) as well as those from diverse cultural backgrounds. Researchers have studied and reported positive results and improvement in relationships between participants from Native American, Chinese, Korean, Israeli, and African American families (Chau & Landreth, 1997; Glover & Landreth, 2000; Jang, 2000; Kidron, 2004; M. Lee & Landreth, 2003; Yuen, 1997; Yuen et al., 2002; Solis, Meyers, & Varjas, 2004). More specifically, the above researchers indicated finding significant results in the areas of increased parent empathy, awareness, tolerance, and acceptance, of their children; and more effective and positive parent-child communication. These results were of particular interest to McClung (2007) who considered persons from religious families as being a culture with specific needs, beliefs, and values.

Although CPRT is reported to exhibit success with children between the ages of four and 10, no studies have focused upon utilizing parents to assist children within the

adolescent population. As reported by two of CPRT's authors, Landreth (personal communication, March 4, 2010) and Bratton (personal communication, December 5, 2009), this program could be effectively modified and utilized with children through age 14 and be a valid area for further study and research. In considering this, interesting work has been presented by one of their students, Brown (C. J. Brown, 2005), who provided specific suggestions for modifying and using CPRT with older children. Brown suggests more interaction between the adult and child, more hands on and creative activities, and less reflecting.

Lastly, in this section, this paper examines and discusses the work of Barkley and associates (1999). Their clinician's manual combines the program developed by Robin and Foster, known as Problem-Solving Communication Training (PSCT), with Barkley's work in training parents of defiant children. PSCT has "been shown previously to be of assistance in clinical work with families experiencing significant parent-adolescent conflicts" (Barkley et al., p. vii). By adding it to Barkley's program, an intervention results which has the goal of improving parent-teen relationships and teen adjustment (Barkley et al.). These authors state that although Barkley's programs, which focus on "giving parents sufficient skills to manage disruptive, defiant, and noncompliant child behavior through controlling the antecedents and consequences" (Barkley et al., p.vii); have proven to be effective with younger children, they do not take into account the increased autonomy and individuation needs of adolescents. Combining his teachings with the techniques of PSCT allows this program to focus upon "training both the parents and the adolescent in more effective ways of negotiating conflicts, resolving problems or disputes, [and] developing more effective communication styles" (Barkley et al., p. viii).

Barkley and associates have developed separate programs for use with younger children and adolescents (Barkley, 1997; Barkley et al., 1999). The later is divided into two parts and is recommended for use with adolescents between the age of 13 and 18 with a mental age of a 10-year-old or higher. It focuses upon teens who “display noncompliant, defiant, oppositional, stubborn, or socially hostile behavior toward their parents” (Barkley et al., p. 2) and/or carry diagnoses of oppositional defiant disorder (ODD), attention-deficit hyperactivity disorder (ADHD), conduct disorder (CD), or bipolar disorder “providing that noncompliant or defiant behavior is a primary problem” (Barkley et al., p. 2). The first part of this intervention focuses upon educating parents, usually in the absence of their teens, regarding their children’s needs, motivations, and symptoms; and teaches techniques to manage externalized behaviors and defiance.

Once parents feel comfortable that they can execute child behavior management techniques and plans, teens join the sessions and the second part of the program, family training, is initiated which “focuses on teaching both the parents and the adolescent methods of proper problem solving and skills in communication with each other during negotiations over conflicts” (Barkley et al., 1999, p. 75). The power of relationships to convey support and caring and initiate healing is acknowledged during this part of the program. Attention is given to repairing and strengthening relationships which may have been weakened or damaged due to the teen’s externalized and defiant behaviors, and the family is taught to practice effective communication skills and develop non-judgmental realistic expectations. Parents are also assisted to re-examine the parent-teen relationship and a shaping process is initiated to prepare and allow teens to begin to assume greater levels of autonomy, involvement in decision making, and responsibility (Barkley et al.).

The authors present goals for this program as being the improvement of parental management skills, increased knowledge of parents and caregivers regarding the nature and causes of defiant behavior, addressing and changing any unreasonable beliefs, and promoting an increase in cooperation; the use of effective problem-solving skills and communication styles, and family harmony (Barkley et al., 1999). In evaluating support for the efficacy of this intervention, the authors stated that a substantial amount of supportive research exists with children up to approximately 12 years of age. Specific studies reported statistically significant improvement in parental selective attending skills, consistence in utilizing management interventions, and child behaviors in which “up to 64% or more of the families of defiant children undergoing training in such methods report significant improvement in their children’s behavior and their own parenting abilities” (Barkley et al., p. 5).

In further examining research on this program, a study by Barkley and associates (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992) indicated that the above reported percentage of benefit drops to 25% when utilizing the behavioral training program alone and 35% when utilizing a separate PSCT component in reports obtained from parents with adolescent children with a diagnosis of ADHD, the adolescents themselves, and observational evaluators. Barkley and colleagues (1999) state that even though percentages of benefit decreased, they are significantly higher than those produced by “more traditional family therapy programs” (p. 5). Although this data was obtained from one study, it not only provides support that the benefits from the relational portion of this intervention may prove to be more effective and important than the implementation of behavioral management techniques, but also suggests that, as indicated in the classic

work, *Dare to Discipline* (J. Dobson, 1970), discipline administered within a relationship characterized by love and affection may prove to be a key in assisting children to become healthy, responsible, productive, and self-actualized adults.

Brief Therapy

It has been noted that patients often show improvement with limited therapeutic intervention. Due to this, there is interest in finding treatments that are flexible, brief, and time-efficient (Carlson & Sperry, 2000; D. R. Gross & Capuzzi, 2007). It has been reported that utilizing fewer sessions assists with attrition concerns and is more cost effective. Providing and receiving services that are reasonably priced, is a consideration for patients as well as service and insurance providers (Allison, Roeger, Dadds, & Martin, 2000; Girling-Butcher & Ronan, 2009). Additionally, needing to provide fewer sessions to patients will allow clinicians to have a larger caseload and treat more persons who are in need of assistance. In specifically considering the needs of the 11-14 year-old age range, brief therapy may fit more easily into hectic schedules which are already filled with sports, dance and other classes, school, and church activities (Ferrell, 2003; M. L. Jaffe, 1998). This study explored the efficacy of brief therapy in the form of psychoeducational wellness intervention to enhance relationships between these children and their mothers.

In examining the possible benefits of brief therapy, and of particular interest to this study, Ferrell (2003) hypothesized that Landreth Filial Therapy Training (LFTT), which is the forerunner of CPRT, could be modified into a fewer number of intense sessions and continue to be effective. The parents in her study met for four sessions.

Ferrell obtained pre and post-treatment measurements from parents on stress relating to parenting, empathetic behavior and acceptance towards their children, and perceived child behavior concerns and compared these to 10 session measurements. When comparing outcomes of these two programs, no statistically significant differences were noted.

Faith Based Therapy

Even though empirical support exists which suggests that:

religious practices can serve as a key protective factor that shields individuals, especially youth, from harmful outcomes, such as drug and alcohol abuse, promiscuous sexual behavior, suicide, and delinquency...[and increases] levels of well-being, emotional adjustment, and academic attainment (Ferguson, Wu, Spruijt-Metz, & Dyrness, 2007, p. 265);

utilization of spirituality within a professional setting continues to be minimal and research in this area is limited and sparse (Kahle & Robbins, 2004). With 95% of America reporting religious affiliation and professing belief in God, 65% stating that they attend church, and 62% professing belief that the Bible and religion hold the answers to all important human questions (Mahoney, Pargament, Tarakeshwar, & Swank, 2001; Richards & Bergin, 2005), it seems that the time has arrived to consider providing “therapy which is sensitive to both psychology and faith” (McMinn & Campbell, 2007, p. 13). Based upon this data and statistics, Mahoney and associates suggest, that clinicians would benefit greatly from familiarizing themselves with available spiritual integration research.

Maier-Lorentz (2004) stated that prayer and scripture utilization has gained increased acceptance worldwide as complementary and alternative medicine and “is the

fastest-growing sector of health care in the United states today” (p. 23). She goes on to discuss specific medical studies performed by Byrd (1988), and Sicher and associates (Sicher, Targ, Moore, & Smith, 1998), in which intercessory prayer was utilized with patients who were diagnosed with cardiovascular disease and AIDS, respectively. Both studies presented support that prayer facilitated healing, in that the patients who were the target of prayer showed greater improvement than those in no-prayer control groups. The Children’s Better Health Institute (1999) also provided support for greater healing in cardiovascular patients when prayer was utilized.

More specifically to the field of mental health, several authors have outlined procedures to integrate scripture and prayer into psychotherapy (Beach et al., 2008; Entwistle, 2004; Garzon, 2005; Jones & Butman, 1991; McMinn & Campbell, 2007; Pargament, 1997; Richards & Bergin, 2005; Tan, 2007; Walker & Quagliana, 2007). In further considering integration, empirical support has been provided which suggests that the utilization of prayer and scripture in therapy may reduce conflict and soften relationships between religious couples (Butler et al., 2002), decrease depression, anxiety, anger, and irrational fear (Hurst et al., 2008); assist persons to develop a purpose and direction in their lives, assist in alcohol avoidance, positively affect one’s attitude toward school (Francis & Gibbs, 1996), and create and strengthen effective coping skills to manage additional symptoms of mental illness (Heilman & Witztum, 2000).

Additional studies focused on specific programs, such as Steps to Freedom and Alcoholics Anonymous, which acknowledge the existence of a power greater than man, include the use of prayer and/or scripture in treatment, and have reported promising results (Hurst et al.; Pargament). An additional Christ-centered recovery program,

Celebrate Recovery, has also reported promising and positive results. This was developed by Baker at Saddleback Church in 1991 and has been utilized by more than 700,000 persons worldwide to overcome “hurts, hang-ups, and habits through recovery, wholeness, growth, and spiritual maturity” (Celebrate Recovery, 2010, ¶ 1). Included in this program is a module, Celebration Station, which was developed for use with children between the ages of five and 13 (Celebrate Recovery). Although positive results have been reported (A. E. Brown, Whitney, Schneider, & Vega, 2006; Celebrate Recovery), a literature review yielded no specific empirical studies to support this.

In considering the focus of this paper, Walker and Quagliana (2007) found “psychological research regarding the importance of the parent-child relationship in determining children’s behavioral outcomes to be in broad agreement with biblical theology regarding parenting” (p. 124), and discussed the integration of scripture into a relationship enhancement program geared at assisting parents to support children in the management of behaviors. This team integrated biblical teaching with Barkley’s *Defiant Children* treatment manual (1997), which assists parents to develop an understanding of their children’s behavior and provides instruction regarding attending skills and the use of time-outs and token economies. Cautioning against taking verses out of context or simply “adding Biblical verses to behavioral interventions” (p. 124), this pair utilized Scripture to provide reasons and a basis for each step of the behavioral intervention, as encouragement for parents when difficulties were encountered, and to establish faith-based goals for therapy. Through the utilization of the scripture enhanced behavioral therapy, Walker and Quagliana reported an increase in the valuing of positive parent-child interactions by conservative Christian parents and an emphasis upon “discipline as

well as love and grace” (p. 125). Although it was suggested that this integrated program was successful in building parent-child relationships and decreasing the frequency of the occurrences of negative behaviors, this was not empirically supported.

Richards and Bergin (2005) suggest that ethics mandates researchers and clinicians to remain mindful of the needs, cultural style, beliefs, values, and preferences of the client which would include the integration of spirituality into therapy when patients want this to be addressed and utilized in their treatment and clinical care. In addition, empirical data exists which supports the possible efficacy of including prayer and scripture in treatment, and numerous proposals have been presented as to how to successfully develop and utilize faith-based interventions, with the assumption that “people who have faith in God’s power and draw on spiritual resources during treatment will have added strength to cope, heal, and grow” (Richards & Bergin, p. 13). As empirical research in this area continues to be sparse and a literature review did not yield specific research in the area of utilizing biblically integrated relationship-enhancement programs with an adolescent population, it would seem that a study on this topic would be appropriate and of value to religious parents and families.

Modified CPRT

The literature presented above supports the premise that there exists a need for effective therapies that focus upon assisting parents and adolescents to improve their relationships and interpersonal interactions (Glasser, 2002; M. L. Jaffe, 1998; Trollinger, 2007; White, 2006). It has also been indicated and supported that Christian parents prefer and are seeking treatment that is sensitive to their beliefs and values (McClung, 2007;

Richards & Bergin, 2005), and that brief therapy holds benefits and value for use with persons who have hectic schedules or insurance concerns (Allison et al., 2000; Ferrell, 2003; Girling-Bucher & Ronan, 2009). It follows that a brief, faith based relationship enhancement program which focuses upon parents and their 11-14 year old children would be desirable and of benefit to this population.

In considering the research presented in this chapter, a need and gap can be identified in that a specific therapy which addresses these three concerns does not currently exist. In considering prior research regarding CPRT, it has been found to be compatible with Christian beliefs and values (McClung, 2007) and support has been presented that it can be effective when utilized in four condensed intense sessions (Ferrell, 2003). In addition, although CPRT is recommended for use with children between the ages of four and 10 (Bratton et al., 2006; Landreth & Bratton, 2006), informal support exists and has been presented that it has been successfully utilized with adolescents and may be appropriate for use with this population (Bratton, personal communication, December 5, 2009; C. J. Brown, 2005; Landreth, personal communication, March 4, 2010). Following the recommendations of Ferrell, McClung, Brown, and Landreth, (as cited in C. J. Brown); this study proposed that CPRT could be modified and effectively utilized to fill the above identified gap, and become an effective treatment when assisting Christian parents and their adolescent children to improve their relationships.

Summary

A review of philosophy, the Grand theories, neuroscience, and research; focused upon interpersonal relationships, revealed a wealth of discussion, information, and data regarding their definition, characteristics, mechanisms, significance, and power (Barry, 1980; Durant, 1933; McMinn & Campbell, 2007; Osborne, 1992; Rogers, 1951; Stokes, 2002). While some studies suggested that relationship and connectedness with others can act as buffers in assisting persons to adjust effectively to life circumstances and stressors (Higgins, 1994; M. L. Jaffe, 1998; Pianta & Hamre, 2001; Resnick et al., 1997; Rhodes, 2002), others focused upon the interactions between supportive relationships and the development of specific behaviors, habits, and choices. The later presented results that indicate that children who report satisfying and supportive relationships with adults and peers exhibit fewer negative internalized and externalized behaviors, and possess higher levels of self-esteem and efficacy than those who do not (Bandura, 1993, 2000; C. N. Barber et al., 2003; Baumrind, 1966; Bratton et al., 2006; W. Chung et al., 2008; Davenport et al., 2008; Ezzell et al., 2000; M. L. Jaffe; Londahl et al., 2005; McKee et al., 2008; Owens et al., 2003; Paulussen-Hoogeboom et al., 2008; Pettit et al., 1997; Safford et al., 2007; Sanford, 2009; Scaramella et al., 2008; Smalley, 1992; L. Steinberg, 2001; Stormshack et al., 2000).

Specific programs, such as CPRT, STARS, Glasser Quality Schools, RE, and PSCT, which utilize relationship enhancement techniques and interventions to increase communication and positive interaction between children and care giving adults were presented and discussed. Research on these programs has proven to be favorable and promising, providing support that they strengthen relationships and decrease negative,

undesirable, unhealthy, and possibly destructive internalized and externalized behaviors (Barkley et al., 1999; Bratton et al., 2006; Glasser, n.d.; Ginsberg, 1997; D. A. Hughes, 2007; McGrath & Noble, n.d.; Pianta & Hamre, 2001). The benefits of integrating spirituality were also presented and recommended when interacting with religious clients who wish for this to be included in their care and treatment (Kahle & Robbins, 2004; Mahoney et al., 2001; McMinn & Campbell, 2007; Richards & Bergin, 2005).

This paper has examined the significance and power of relationships through examining philosophical and psychological teachings and discussed the continued need for an effective intervention to assist teens and caregivers to improve their relationships and open lines of communication. The favorable results reported by research on current relationship enhancement programs, in particular, CPRT, were reviewed and presented, and the findings of McClung (2007) and Walker and Quagliana (2007) regarding the compatibility of these programs with biblical teachings were discussed. As limited research in this area has been undertaken that specifically focused upon an adolescent population, this paper proposed that CPRT, which had been biblically integrated and condensed into six weekly sessions, would better meet the hectic and busy time schedule of teens and be more acceptable to Christian populations.

Bowlby (1988) proposed that parents and children form inner working models of their relationship which include feelings, memories, expectations, and experiences. It is thought that children will utilize these models to organize, evaluate, and process future information which will affect their choice of values and behaviors, and as supported by the teachings of Glasser (1998), their emotions. The research presented in this chapter further supported the importance, influence, and power of children's relationships with

others. It has been presented and reported by frustrated caregivers, however, that some teens tend to withdraw from family figures and close communications during this time (Edgette, 2006; Glasser, 2002; M. L. Jaffe, 1998; Trollinger, 2007; White, 2006). It is hoped that the psychoeducational wellness intervention of this study will become a valuable and effective tool to utilize in assisting mothers and their 11-14 year old children to improve the quality of their communications, interactions, and relationships, and empower these adolescents to become happy, healthy, and productive adults.

CHAPTER THREE: METHODS

The literature reviewed in Chapter Two, which included positive results reported from studies on interpersonal programs (Barkley et al., 1999; Bratton et al., 2006; Glasser, 2002; Pianta & Hamre, 2001), supported the premise that relationships are significant in obtaining and maintaining positive mental health and well-being. Based upon this assertion, it is proposed that relationship enhancement and utilization will prove to be beneficial in assisting people, more specifically, adolescents, to achieve homeostasis and obtain a higher degree of regulation and self-actualization (Bromfield, 2005; Cozolino, 2006; Edgette, 2006; Forbes & Post, 2006; Gil, 1996; Guerney, 1991; Landreth & Bratton, 2006; Maslow, 1968; Oppenheim & Goldsmith, 2007; Schore, 2003a, 2003b; Straus, 1999; N. L. Thomas, 1997). Additionally, it has also been discussed that Christians have indicated that they would like to have their beliefs and values incorporated into treatment (Garzon, 2005; McClung 2007; Richards & Bergin, 2005; Walker & Quagliana, 2007). This study explored the efficacy of the utilization of a brief form of Child Parent Relationship Therapy (CPRT), which had been biblically integrated, in assisting Christian mothers to improve their relationships with their 11 through 14 year old children.

In order to promote homogeneousness of the treatment population, this study focused upon biological or adopted at birth mother-adolescent pairs, from families who profess to be religious, as measured by the Duke University Religion Index (DUREL; Hill & Hood, 1999) and information gleaned from the demographic survey. These

mothers were trained to participate in non-directive, supportive, biblically integrated Filial therapy with their teens and preteens through the utilization of a relationship enhancement intervention that had been patterned upon a previous modification of the CPRT program (Bratton et al., 2006; McClung, 2007). Based upon successful and positive results regarding the use of brief therapy (Allison et al., 2000; D. F. Gross & Capuzzi, 2007; Ferrell, 2003; Iveson, 2002, Lethem, 2002; Stuart, 2000), and more specifically, the use of brief CPRT (Ferrell), this intervention utilized a six week treatment format.

To assess the effectiveness of this program, pre and post-test measurements of mother-adolescent relationships were compared and analyzed. In addition, this study considered the long-term effects of this intervention through the re-administration of these assessments six weeks following therapy completion. As previous specific CPRT research had not included this component, a literature review was expanded to include other areas of study. Several interesting studies were considered including Sandage and Worthington's (2010) study on empathy, and Laithwaithe and associates' (2009) work on compassion, which re-administered assessments six weeks after treatment in order to measure long-term effects. Although this is not a long period of time, this study proposed that this measurement would assist in exploring the maintenance of any noted changes and followed these time frame guidelines. Following is a description of the methods and procedures that were utilized during this study.

Research Design

This quantitative study utilized a quasi-experimental, pretest-posttest design (Kazdin, 2003). Assessments were re-administered to participants six weeks following the completion of this study to assess for maintained and continued progress. The independent variable was participation in a modified relationship enhancement therapy program, CPRT. The dependent variable was scores obtained from administering the Parenting Relationship Questionnaire (Pearson Education, 2009) and the Conflict Behavior Questionnaire-20 (Robin & Foster, 1989) to the mothers; and the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987) and the Conflict Behavior Questionnaire-20 (Robin & Foster) to adolescent participants.

Additional information was obtained through the administration of three generalized questions, regarding relationship satisfaction, to all participants. To strengthen the validity of this study, demographic information, as delineated in the instrumentation and data processing sections of this chapter, was obtained from all participants and analyzed (see Appendixes B & I). The DUREL (Hill & Hood, 1999) was administered to the mothers, and questions were included in the demographic survey (see Appendix B) to ascertain that participants professed to be Christians.

Research Hypothesis

The hypothesis of this study was that brief CPRT that was biblically integrated and offered in a six week format, could be utilized to promote positive change in relationships between mothers and their 11-14 year old children, from Christian families.

Selection of Participants

The treatment in this study was presented to mothers as a parenting intervention to improve relationship and communication quality between parents and their adolescent children. It was a modified form of CPRT which had reported success when addressing younger populations (Bratton et al., 2006). This study adopted suggestions made by M. L. Jaffe (1998) and Landreth (personal communication, March 4, 2010) in its decision to focus upon youth and adolescents whose ages fell between 11 and 14 inclusively. Additional criteria included completion of all paperwork and assessment tools and willingness of both members of the team to participate in a six-week program and follow the directives of the study.

In further considering these treatment pairs, participants consisted of biological or at birth adoptive mothers and their adolescent children who resided with each other a minimum of five days per week. Mother's marital status was not a determining factor for inclusion in this study. Mothers were recruited through announcements at churches and child focused nonclinical service providers, the distribution of fliers to youth leaders and three Christian high schools, and a posting on a home school list serve. The researcher also attended Sunday school meetings; and worked with a Christian radio station to explain the program and recruit additional participants. Although it was additionally proposed that the researcher would attend local PTA and PTO meetings, this was not possible due to lack of availability.

Mothers and adolescents, who responded to these announcements, fliers, and information sessions, or indicated interest to the researcher during school meetings, were given the option to attend a pre-session. During this session, the research project was

discussed in greater detail, and mothers and teens who wished to participate were requested to complete an informed consent (see Appendixes A & D) and assessments to determine appropriateness for inclusion. Participants also completed demographic questionnaires (see Appendixes B & I). Mothers who did not choose to attend the pre-session completed assessments, provided demographic information, and signed consents at the beginning of the first session. Mothers who agreed to participate in this study were then instructed to have their children complete assessments and informed consents prior to participation in the first activity session. Based upon a mean effect size of $.81 \pm .04$, which was reported in a meta-analysis of over “5 decades of play therapy...across 93 treatment-control comparisons” (Landreth & Bratton, 2006, p. 458) performed by Bratton, this study required a minimum sample size of 25 to yield a power of 80 with the alpha set at .05 (Kazdin, 2003).

In considering criteria for exclusion, Barkley, Edwards, and Robin (1999) reported that positive treatment outcomes decreased as the severity of the child’s behavioral problems increased, and Landreth and Bratton (2006) recommended the exclusion of children who exhibited significant emotional disturbance which “extends beyond the capability of the parent” (p. 118) and requires professional intervention. Due to this, and to maintain the safety of all persons, adolescents who exhibited behaviors which indicated that they or others may be at risk for harm were excluded from this study and referred to a qualified therapist for assessment and treatment.

Questions to determine at risk behaviors and clinical symptoms were included in both mother and child assessment packets to evaluate adolescents’ suicidal ideations or prior attempts, physical harm to self or others, including self-mutilation and purging;

homicidal ideations or history of violence, current legal issues, active psychotic symptoms, and alcohol or non-prescribed substance abuse. For the purpose of this study, substance abuse was defined as behaviors that extended beyond mild curiosity and exploration and consisted of frequent use, or choices and actions which have required intervention by personnel who are external to the family.

In an effort to avoid the possibility of multiple treatment interference, adolescents who were currently participating in treatment with a licensed professional clinician were excluded from this study. Children who were currently taking medications for residual symptoms, and not actively involved in therapy, were considered for inclusion in this study. This exclusion assisted with management of any ethical concerns regarding supplying treatment to therapists' patients and removed any need for information sharing. In order to facilitate the safety of study participants, and those who did not meet criteria for inclusion, area clinicians were contacted before the beginning of the study to ascertain their willingness to accept referrals, and contact information was given to mothers in their initial paperwork.

As the goal of this study was to show the efficacy of its relationship enhancement program, and it was suspected that it would be difficult to measure changes in a nonclinical population, prospective participants who reported limited relationship concerns were also excluded from this study. This was determined through the use of the PRQ (Kamphaus & Reynolds, 2009), in which mothers needed to acquire a t-score of 59 or below in at least one of its included scales (i.e. attachment, communication, involvement, parenting confidence). As the relational frustration scale is reverse scored,

t-scores of 40 or above were considered for inclusion. These scores are indicative of average or below performance in these areas (Kamphaus & Reynolds).

As prior research indicated that recent experiences of intense trauma or stress may alter cognitions, motivations, and behaviors; and require special services and more intense care and treatment (Cantrell & Dean, 2005; Dinigris, 2009; Feldman, 2006; M. L. Jaffe, 1998; Mash & Dozois, 1996), adolescents who had experienced the temporary or permanent loss of a main caregiver, witnessed or been involved in an act of violence, natural disaster, or accident resulting in severe loss; been a victim of sexual or physical abuse, or been involved in major legal conflicts and concerns within sixty days prior to the beginning of this program were excluded. A final cause for exclusion was mothers' responses to the DUREL that scored less than or equal to 10 (Hill & Hood, 1999), which, according to this test's authors, would be an indicator of limited religiosity; or indicated that they did not profess to be of the Christian faith. The presence of these factors was determined through questions on participant demographic surveys (see Appendixes B & A) and additional questions which were included in adolescent assessments.

Instrumentation

Several instruments were utilized in this study to assess communications and strength of parent-child relationship, and to determine caregivers' index of religiousness. These included the Parenting Relationship Questionnaire (Kamphaus & Reynolds, 2009; Pearson Education, 2009), the Conflict Behavior Questionnaire-20 (Robin & Foster, 1989), the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987), and the Duke University Religion Index (Hill & Hood, 1999). Demographic questionnaires

(see Appendixes B & I), including available times to attend sessions, three questions asking parents and children to rank the quality of their relationship, and questions to assess criteria for inclusion; were also administered to mothers and adolescents.

Duke University Religion Index (DUREL)

The DUREL is an easy to administer, five question assessment tool, geared at measuring “religiosity in a comprehensive yet brief and non-offensive manner” (Hill & Hood, 1999, p. 130). In considering norming, Koenig and associates (Koenig, Parkerson, & Meador, 1997) report that the first two items were administered to over “7,000 persons aged 18-90 participating in three separate studies” (p. 886). The last three items were obtained from the Hoge Intrinsic Religiosity Scale which was normed in a “study of 458 medical patients in the Duke Hospital Study” (Hill & Hood, p. 130). Reliability for the last three items had a Cronbach’s alpha of .75, and the authors indicate that a strong correlation between this test and Hoge’s ($r = .85$) supports its validity (Hill & Hood). As the dissertation study did not focus upon specific religious beliefs, it was posited that this test, which indicates if the participant believes in the presence of the divine, attends church services, participates in private religious activities, and the extent to which religious beliefs impact his or her life; along with a question in the demographic section regarding whether the mother considers herself to be a Christian, adequately met the need to assess for religiosity and inclusion.

Inventory of Parent and Peer Attachment (IPPA).

Based upon “attachment theory’s formations concerning the nature of feelings toward attachment figures” (Armsden & Greenberg, 1987, p. 487), the 75 item, self-report, IPPA was developed by Armsden and Greenberg to measure the “behavioral and affective/cognitive dimensions of adolescents’ attachments to their parents and peers” (Armsden & Greenberg, p. 431). This test utilizes a 5-point Likert scale with response categories of almost never or never, seldom, sometimes, often, and almost always or always. With the goal of measuring the nature of test taker’s feelings and expectations about attachment figures, “Items were designed to assess the adolescent’s trust (felt security) that attachment figures understand and respect her/his needs and desires, and perceptions that they are sensitive and responsive to her/his emotional states and helpful with concerns” (Armsden & Greenberg, p. 432). The IPPA yielded scores in trust, communication, and alienation. The trust and communications scores were added together and the alienation reverse scored total subtracted. This provided one summary score of the adolescent’s perceived quality of parent/adolescent attachment. This assessment tool also supplied a separate score for peer attachment which was not used in this study (Simons, Paternite, & Shore, 2001).

In further considering information provided by this test’s developers, it was reported that the utilization of Cronbach’s Alpha, indicated that results provided evidence of favorable internal reliability. These were obtained in three scales, trust, communication, and alienation; for parents and peers with loadings of between .72 and .91. Test-retest reliabilities were run after three weeks which resulted in scores of .93 for the parent attachment measures and .86 for the peer attachment measures (Armsden &

Greenberg, 1987). High internal consistency of between .86 and .97 was also reported in studies by Cavell and associates (Cavell, Jones, Runyen, Constatin-Page, & Velasquez 1993) and Papin and Roggman (1992).

The authors report that the IPPA has been widely utilized in more than 73 different studies. Reported statistics and data from this research supported that it could be used to evaluate levels of trust and communication, psychological security, perceived support availability, responsiveness, and quality of attachment, connectedness, and relationship to parents (Blain, Thompson, & Wiffen, 1993; Formoso, Gonzales, & Aiken, 2000; Lyddon, Bradford, & Nelson, 1993; Moon, Dekovic, & Meeus, 1999; Paterson, Field, & Pryor, 1994; Rhodes, Grossman, & Resch, 2000; Schultheiss & Blustein, 1994). The test developers, Armsden and Greensberg (1987), used this assessment tool in their research to provide support for their hypothesis that adolescents' perceived quality of attachment to their parents was positively correlated with psychological well-being.

Conflict Behavior Questionnaire (CBQ-20)

The CBQ-20, which is a shortened form of the original CBQ, has been utilized in literature to measure and provide an estimate of “the degree of conflict and negative communication experienced within a family system” (Breen & Altepeter, 1990 , p. 94). Research has supported that “distressed dyads reported significantly more intense discussions of conflicts and significantly more negative communication than non-distressed dyads” (Robin & Weiss, 1980, p. 339), and the authors of this assessment tool developed it based upon the presumption that “family conflict is marked by disapproval of and complaints about the behavior of the other member or members” (Prinz, Foster,

Kent, & O’Leary, 1979, p. 693). The CBQ-20 was designed to obtain evaluations of parent and adolescent behavior directly from mother and adolescent through an examination of parents’ and teenagers’ perceptions of shared interactions which occurred during a two or three week time span prior to administration (Grace, Kelley, & McCain, 1993; M. A. Harris, Harris, & Mertlich, 2005; Robin & Foster, 1989; Schubiner & Robin, 1990). The CBQ-20 focuses upon “two potential sources of complaints: (1) dissatisfaction with the other person’s behavior, and (2) evaluations of the interactions between the two members” (Prinz et al., p. 693).

This assessment tool has parallel versions for parents and adolescents, consists of 20 true/false statements, takes approximately five minutes to administer, and yields a single summary score that correlates .96 with scores from the longer version. Robin and Foster (1989) report that “the original CBQ was based on an item pool initially generated by eighth-grade students and refined based on responses of college students and mothers with teenage children” (Robin & Foster, p. 78). Summary scores are converted to t scores utilizing a table that allows the clinician to “determine roughly how distressed the family is with respect to normative distressed and non-distressed samples” (Robin & Foster, p. 79).

In considering specific studies, Okon and associates (2003) reported finding that the CBQ-20 possessed high internal consistency for the adolescents’ “appraisal of her mother and the dyad, with coefficient alpha values of .95 and .94 respectively” (p. 453). Additional positive data regarding internal consistency was provided by Schudlich and colleagues (2008) who reported an alpha of .94 in their sample of children aged 11-17 when utilizing the CBQ-20 to assess family conflict; and A. M. Thomas and Forehand

(1993), who used this assessment tool to measure the relationship between fathers and their adolescent children. The later pair reported finding internal consistency in their study as being .88 (A. M. Thomas & Forehand). In considering reliability, Gunlicks-Stoessel and colleagues (Gunlicks-Stoessel, Mufson, Jekal, & Turner, 2010) utilized Cronbach's alpha to analyze data obtained from their study, which used the CBQ-20 to assess for parent-child communication and conflict style when comparing treatment for depression, and reported a score of .93. This assessment tool is currently unpublished.

Additional studies which used the CBQ-20 were performed by Grace and associates (Grace et al., 1993) and Sheeber and Sorensen (1998) who utilized this tool's ability to assess parent's and teenagers' perceptions of the negative communication and conflict they experience within their familial dyads to order to examine parent-adolescent discord. In another study, Pearson and Love (1999) used a modified version of this assessment to measure "perceived communication and conflict with their parents, from the perspective of the adolescents" (p. 65). Another interesting study, performed by Schubiner and Robin (1990) utilized a modified version of the CBQ-20 to study parent-teenager conflict in ambulatory medical settings. This team proposed that adolescents at risk for morbidity and mortality could be identified by examining their levels of depression and parent-teen conflict. This study used the CBQ-20 to measure parent-child communication and conflict style

Parenting Relationship Questionnaire Child and Adolescent (PRQ-CA)

The Parenting Relationship Questionnaire (PRQ) was developed to "capture a parent's perspective on the parent-child relationship" (Pearson Education, 2009, ¶ 1). It

was created by the authors of the BASC-2, Randy W. Kamphaus and Cecil R. Reynolds, in 2009, and is currently distributed by Pearson Psychological Corporation. The PRQ has two forms, one for use with pre-school age children, and a second for use with children and adolescents between the ages of 6 and 18. Either form can be administered to any primary caregiver in approximately 15 minutes and used in clinical, pediatric, counseling, school, and other settings (Kamphaus & Reynolds, 2009). This assessment tool may be utilized in individual or group settings. The authors recommended that this test be administered directly by a clinician but put forth that its integrity would not be threatened if self-administered at offsite locations (Kamphaus & Reynolds).

The PRQ provides measurements utilizing seven different scales: Attachment, Communication, Discipline Practices, Involvement, Parenting Confidence, Satisfaction with School, and Relational Frustration (Kamphaus & Reynolds, 2009). According to the authors, “the Attachment scale measures 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” (Kamphaus & Reynolds, p. 3). The Communication scale measures information sharing, understanding, and parent listening skills. The Discipline Practices scale, which will not be used in this study, explores consistency in applying consequences to undesired behaviors and choices and adherence to rules. Another scale, the Involvement scale, was created to measure “the extent to which a parent and child participate together in a variety of common activities” (Kamphaus & Reynolds, p. 3).

The PQR also contains a scale to measure Parenting Confidence. This scale examines a “parent’s feelings of comfort, control, and confidence when actively involved

in the parenting process” (Kamphaus & Reynolds, 2009, p. 3). Additional scales in this assessment are the Satisfaction with School scale, which will not be used in this study, and the Relational Frustration Scale. This scale assesses the parent’s “level of stress or distress in relating to and controlling the behavior and affect of the child, along with the tendency to overreact and become frustrated in common parenting situations” (Kamphaus & Reynolds, p. 4). The PRQ-CA also incorporates “faking good” and “faking bad” scales.

In considering validity and reliability, this assessment was normed for both female and male raters and used samples that are closely matched to the U.S. Census population estimates. Internal consistency has been reported for each of the seven scales, which had been divided into five age groups, and range from .76 to .93. The assessment manual reports that test-retest reliability is “.89 for the PRQ-P level and .72 at the PRQ-CA level” (Kamphaus & Reynolds, 2009, p. 47). In addition to this data, the authors reported that “the median standard error of measurement value across all PRQ norm-group samples is 3.9 T-score points” (Kamphaus & Reynolds, p. 47), and that the reliability of the scores is such that it should be sensitive to change in the parent’s perception and experience of the parent-child relationship on all scales (Reynolds, personal communication, August 10, 2010). In discussing validity, correlations between scales are reported to be moderate and in the expected directions and test results were rated as favorable when compared to those from the Parent-Child Relationship Inventory, Parenting Stress Index, and Stress Index for Parents and Adolescents (Kamphaus & Reynolds).

Although the PRQ is fairly new, it has been used in several studies. Sofronoff utilized pre and post-treatment scores, from the Involvement and Parenting Confidence scales of this questionnaire, to measure changes in relationship between parents and teens when using the Positive Parenting Program. Although this work is not published, it was presented at the University of Queensland's 2010 Helping Families Change Conference (University of Queensland, 2010). This Questionnaire has also been utilized in a study conducted by the Substance Abuse and Mental Health Services Administration to assess and evaluate parents' relationship with their children in the Pregnant and Postpartum Women Program (Daneshvar, 2010). C. S. Lee and associates (C. S. Lee, Anderson, Horowitz, & August, 2009) also effectively utilized the PRQ-CA to measure quality of parenting. This team reported using scores obtained from the Communication, Involvement, Parenting Confidence, and Relational Frustration scales to measure the quality of the parent/child relationship when evaluating the role of parental depression and social support as mediators of the effect of family income on the quality of the parent/child relationship.

Demographic Surveys

Demographic surveys were completed by all participants to strengthen internal and external validity (see Appendixes B & I). As the DUREL (Hill & Hood, 1999) does not measure specific Christian beliefs, a question was included regarding whether or not the caregiver professed to be of this faith. This survey also included items which assessed the caregiver's economic status, age, educational background, degree of religiosity as determined by DUREL (Hill & Hood) scores, custody status, relationship to the

adolescent, and marital status. In addition, questions were included that assessed the adolescents' age, gender, type of school attended, if the child was currently receiving professional mental health treatment or had legal charges, and if the focus child had experienced severe trauma within sixty days prior to enrolling in this program.

Generic Questions

Three generic and untested questions were also included in the demographic information survey to assist in assessing parents' and children's overall opinions as to whether or not the adolescent-parent relationship had improved during the time they participated in this program. These questions were formulated by the researcher based upon the core goals of the above described assessment tools. The questions were, attached to the assessment packet, administered at all three times, and consisted of the following: (A) On a scale of 1 through 10, with 10 being the best, please rate your satisfaction with the overall quality of relationship between you and your child (or mother), (B) On a scale of 1 through 10, with 10 being the best, please rate the truth of the following statement "I enjoy spending time with my child (or mother) and feel understood and respected", and (C) On a scale of 1 through 10, with 10 being the best, please rate the truth of the following statement "I find it easy to talk to my mother (child) and feel that our communication skills are positive and effective". One final question was included to assess the participants' expectations regarding treatment results: "On a scale of 1 through 10, with 10 being the best, how optimistic are you that this program will result in positive results and changes in the quality of the relationship between you and your mother (or child)?"

In addition to the above tests and questions, information was collected to assess for child at risk behaviors and choices, and clinical symptoms. Adolescents and mothers were instructed to answer true or false to questions which focused upon exploring thoughts or actions regarding possible harm to self or others, including purging and self-mutilation; the presence of hallucinations, greater than exploratory substance use or abuse, and recent traumatic experiences. Any question answered in the affirmative resulted in the child being excluded from the study and referred to a professional clinician for evaluation and possible treatment. These questions were based upon similar items utilized in the Achenbach Youth Self-Report for Ages 11-18 (YSR/11-18) (T. M. Achenbach, 1991a, 1991b; J. Achenbach, 2009).

Research Procedures

After receiving approval from the Liberty University Institutional Review Board (IRB), volunteers were recruited in several ways. The researcher attended Sunday school classes, held at local churches to discuss this program and invite mothers, who have adolescent children between the ages of 11 and 14 inclusively, to participate. Appeals were made for additional participants through the use of an announcement that was placed in church and school bulletins, newsletters, and email; and posted on church and school message boards and a home school information list serve. Fliers and information were distributed at an event sponsored by a Christian radio station, through three Christian schools, and mailed, emailed, or faxed with a follow-up phone call, to area youth pastors (see Appendix C).

In addition, as it was anticipated that it would be difficult to enlist participants who met all of the inclusion criteria, parent-teen pairs were also recruited through the utilization of snowball sampling (Shtayermann, 2008; Trochim, 2006). With this method, persons who met criteria for inclusion were asked to make referrals or recommendations of acquaintances, friends, or relatives who may wish to participate. Although this type of sampling may have proposed a minimal threat to the validity of this study, it was thought that this method would assist the researcher to overcome barriers to recruitment and obtain the needed number of volunteers. This study continued to form and run groups, using applicants from all methods of recruitment based upon their availability for group time slots, until the required number of participants had been secured (see Appendixes H & J).

All persons who responded to the above announcements and invitations, and indicated interest in this study, were invited to attend an information meeting. These initial meetings were held in area churches and Christian schools and lasted approximately one hour. Meetings began with a brief introduction and opening prayer, and the goal of enhancing parent-teen relationships while placing Jesus at the center of every endeavor in order to bring glory to His name, was clearly stated. A brief explanation of the study followed (see Appendix D) and parent-child pairs who wished to participate in this research were asked to complete needed paperwork and assessments. Mothers who could not, or did not wish to attend an initial pre-session meeting, were given the option to receive information about the study in an individual phone conversation. Mothers who chose this option, completed assessments and supplied needed information at the beginning of the first session. These mothers were then given

envelopes with instructions, assessments, and paperwork that their children needed to complete before having their first activity session. In order to be included in the study, children's completed assessments and paperwork, including signed consent forms, were required to be returned prior to the beginning of the second training session. All assessments and forms were in paper and pencil format and took approximately 30 minutes total time to complete.

Numbers were assigned to completed assessments and questions to assist with confidentiality and they were evaluated to assess for inclusion in this study or needed referrals. If teen or mother responses indicated that the child may be at risk, this pair was excluded from this study and contact information for professional therapists or clinicians was given to provide and facilitate further assessment and follow-up treatment as needed. Mothers of teens who met criteria to be included in this study were placed into a group and notified of the date, time, and place where sessions would be held. Mothers who did not fit into group time slots were presented with alternate time possibilities and notified that their treatment would begin as soon as a group could be formed to accommodate their schedules and time preferences.

As suggested by previous literature (e.g., Icenogle, 1994; Jacobs, Masson, & Harvill, 2002; Yalom, 1995), including the developers of CPRT, Landreth and Bratton (2006), and taking into account prior specified time preferences; parents were divided into groups of 3 to 12 with an effort to form smaller groups in an effort to keep groups within a two hour time frame. All groups were closed and met at the same day and time for six consecutive weeks. Parents attended the first five weeks alone and were given the option to be accompanied by their child for the final session. If mothers did not wish to

bring their child to the last session, they were given assessments during the 4th session to take home, as previously described, with the instructions that their child must complete these after their fifth activity session so that they could be returned at the beginning of the final session. All sessions began with informal interaction time and an opening prayer, and utilized handouts (see Appendix M), homework, and guidelines, as set forth in the *Child Parent Relationship Treatment Manual* (Bratton et al., 2006), which had been biblically integrated and modified to be utilized with an adolescent population and fit into a six-week format (see Appendix L).

Once groups were formed and participants notified, treatment began (see Appendix F). Treatment consisted of six sessions with activity sessions assigned as homework following each of the first five. Each psychoeducational session was geared towards teaching parents a new skill to increase their efficacy and promote relationship enhancement and healthy communication with their child. The overall aim of the classes was “for the parent to relate to the child in ways that will release the child’s inner-directed capacity for constructive forward-moving growth” (Landreth & Bratton, 2006, p. 78).

In an effort to obtain data which may be helpful when considering the need for resources and interventions that are culturally diversified and acceptable to Christian parents, this study utilized treatment that was biblically integrated, following recommendations of Carter and Narramore (1979), Entwistle (2004), McClung (2007), Walker and Quagliana (2007), and Garzon (2005) (see Appendix L). First, it was clearly stated in informed consents that this program was founded upon Jesus and His love, truth, timing, omnipotence, and power to heal. For this study, professing belief in Jesus and in

being religious, as assessed by the DUREL (Hill & Hood, 1999) and questions on the demographic survey, was a prerequisite for inclusion. Secondly, outside prayer was requested and intersession made for participants and the program before and during treatment. Thirdly, all sessions included and were founded upon scripture and prayer, were led and facilitated by a therapist who professed to be a Christian, and took place in a church or Christian school setting (Walker & Quagliana). Lastly, examples from scripture were introduced and examined as appropriate to provide insight, prospective, guidance, and direction in building relationships with children and developing parenting skills.

In considering actual treatment, the goal of session one was to introduce mothers to the program and concept of Filial therapy and begin to build group cohesion. During week one, the concept of and rules for play sessions were explained and a timeline for sessions and activities was discussed. The benefit of being accepting and non-judgmental of children was stressed. It was thought that this would assist parents to improve their communication skills and encourage involvement with their teens. These are constructs which were measured by the PRQ-CA (Pearson Education, 2009) and IPPA (Armsden & Greenberg, 1987). Mothers who did not attend a pre-session were asked to come to this session 30 minutes early to complete assessments and received instructions regarding securing needed paperwork and assessments from child participants.

Session two had several goals. The first was to continue to build group cohesion and assist the mothers to feel more comfortable with weekly play sessions with their children. The next goal for this session was to teach empathy and emotion identification, and the last was to discuss the importance and benefit of building and strengthening

confidence and self-esteem in children. The intent of teaching these skills was to improve communication, involvement, empathy, understanding, and common activity. These relationship constructs were measured by the IPPA (Armsden & Greenberg, 1987), CBQ-20 (Robin & Foster, 1989), and PRQ-CA (Pearson Education, 2009).

Session Three focused upon providing mothers with skills to positively set limits with their children, and continued to assist them to effectively support their children during play sessions. Mothers also reviewed emotion reflecting. These activities, along with weekly play sessions, were geared at facilitating conflict resolution and problem solving in mothers when interacting with their teens, improving communication and trust, and reducing frustration and negative feelings. These constructs are also measured by the above assessments.

The focus of Session Four was to teach listening skills to mothers, including being attentive to body language and tone of voice, and improve communication skills. This session also included a discussion regarding the healing power of hugs and touch, and the benefit of supplying children with choices to teach problem solving skills. The goal of this session was to assist mothers to improve attachment and involvement with their teens. The main goal of Session Five was to discuss the benefit of providing children with encouragement and praise. It is posited that this would improve trust, attachment, and communication between mothers and their children. This was measured by the IPPA (Armsden & Greenberg, 1987) and CBQ-20 parent and adolescent versions (Robin & Foster, 1989), the generated relationship questions, and the Attachment, Communication, and Involvement scales of the PRQ-CA (Pearson Education, 2009).

The last session, Session Six, provided an opportunity for participants to share with peers, review all that has been learned and discussed, and debrief. Time 2 assessments were completed and participants were encouraged to continue to have special times. Mothers were reminded that they would be returning, with their children, to complete time 3 assessments in six weeks or receive these in the mail to complete and return. Mothers were given an option to have their children attend this session. When children attended this session, they participated in an activity with their mother and were included in the debriefing and sharing process.

Biblical teachings, scripture, and values were incorporated into each session and parents were instructed to pray for their children daily during the six weeks of treatment. Mothers were expected to attend all six sessions; children had the option to attend the initial information session and last session. Both mothers and adolescents could choose either to meet six weeks following treatment to complete follow-up assessments or have these mailed to them. Homework involved weekly, 30-45 minute child-led play therapy sessions and other assignments (see Appendix F). Weekly treatment sessions were targeted to last approximately two hours each, depending upon group size and level of interaction, and incorporated CPRT handouts that had been modified with permission from Landreth (personal communication, March 10, 2010) as appropriate (see Appendix M). The researcher utilized role playing and video excerpts from *Child Centered Play Therapy: A Clinical Session* conducted by Landreth (1997) as recommended by the CPRT program.

An important part of learning in this program was the ability to receive feedback from the facilitator and fellow group members. To increase the amount of feedback and

assess level of mastery in application of learned skills, each mother was given the opportunity to share an actual play session with the group through videotaping an activity time with her child. Mothers were given an option to attend a videotaping session with their child or to do this on their own at home. Mothers who chose not to be taped, or whose children indicated that they were uncomfortable with this, were given the opportunity to role play in front of the group with the group facilitator or other group member. In addition, the group members brainstormed real life situations to receive immediate feedback through the group process. It should be noted that all children in this study did not consent to participate in a taped session, and this activity was omitted due to ethical concerns and participants' right to refuse any part of the intervention. This is discussed in greater detail in the limitations section of Chapter Five. Finally, all mothers were requested to log date, time spent, and activity chosen for each play session, and indicate if they had prayed daily for their child.

Data Processing and Analysis

As previously discussed, this study utilized a quasi-experimental, pre-test, post-test, design and included follow up analysis. In an effort to increase the external validity of this study, demographic data was also analyzed. Following is a description of data analysis and processing procedures.

Obtaining Data

Demographic data was obtained to provide a description of the participants and determine if inclusion criteria were satisfied (see Appendixes B & I). Information was

collected regarding the gender of adolescents, family status, socio economic status, ages of mothers and adolescents, mothers' highest level of education, mothers' marital status, custody status of mother and adolescent, and school status of adolescent. In more specifically defining these categories, family status consisted of three levels: single parent, both parents, and other. Socio economic status was based upon the 2006 annual survey of the United States Bureau of Labor Statistics and broken into five categories: \$0-\$19,999, \$20,000 -\$39,000, \$40,000-\$59,000, \$60,000-\$79,000, and \$80,000 and above (U.S. Census Bureau, 2006).

Age of mothers' had five, ten-year categories: ≤ 29 , 30-39, 40-49, 50-59, and ≥ 60 . Age of adolescents' had five categories: 11, 12, 13, 14, and 15. Highest level of education obtained by mothers' held three categories: did not earn a high school diploma or equivalent, high school diploma or equivalent, and post high school education. School status of adolescents' consisted of three categories: private education, public education, and home schooling. Data was also obtained from mothers' responses to The DUREL (Hill & Hood, 1999) and additional questions to assess for inclusion criteria were included in the demographic questionnaires. All demographic information was evaluated and totals are reported in table 4.1. As previously discussed, a score of ≥ 10 was required on the DUREL and a criterion for inclusion.

Additional data was obtained through administering assessments to parents and adolescents at times 1, 2, and 3. The CBQ-20 (Robin & Foster, 1989) and parent portion of the IPPA (Armsden & Greenberg, 1987) were administered to children; and the PRQ-CA (Pearson Education, 2009) and CBQ-20 were administered to mothers. Three questions regarding relationship quality and a question to investigate opinion of value of

participating in this program were also answered by all participants. All data was analyzed to address the main research question of this study (see Appendix K) and evaluate support for accepting the hypothesis.

Statistical Analysis

The hypothesis of this study was that CPRT which had been biblically integrated, modified for use with adolescents, and presented in a brief, six session time frame, could be an effective intervention when utilized to improve relationships between 11-14 year old children and their mothers from Christian families. The research question was: Does CPRT, which had been offered in a brief, six week format and biblically integrated, promote positive change in relationships between mothers and adolescents from religious families? If the hypothesis was true, then participation in this modified program would result in reported increases in relational satisfaction between mothers and their adolescent children, as measured by assessment and question scores.

To acquire data to address the research question, the PRQ-CA (Pearson Education, 2009), IPPA (Armsden & Greenberg, 1987), CBQ-20 (Robin & Foster, 1989), and three generalized questions were administered to participants at three time points: pre-test (time 1), post-test (time 2), and 6-week follow up (time 3); and results were analyzed. In considering changes between time 1 and time 2, scores in the Attachment, Communication, Involvement, and Parenting Confidence scales of the PRQ-CA (Kamphaus & Reynolds, 2006) and the combined question response score should increase while scores in the Relational Frustration scale of the PRQ-CA (Kamphaus & Reynolds), the IPPA (Armsden & Greenberg), and the CBQ-20 (Robin & Foster) should

decrease if the hypothesis is true. Although significant two way interactions of treatment by time were not obtained, and the null hypothesis could not be rejected, positive meaningful trends were noted that provided support that the intervention was successful in improving parent-child relationships. Weaker trends were obtained from an analysis of time 3 scores which hints that long term effects from program participation may exist. Following is the method of data analysis that was utilized to explore this proposal.

As assessment and question scores yielded measures of 10 outcome variables, several factors merited consideration in choosing a statistical tool to process this obtained data. One could choose to either run multiple ANOVAs and increase the possibility of committing a Type 1 error (Biskin, 1980), or perform one MANOVA which would include “a condition that maintains the overall error rate at the .05 level” (Harris as cited in Mertler & Vannatta, 2005). A literature review indicated that experts in the field have provided support for each choice and presented mixed findings (Huberty & Morris, 1989; Mertler & Vannatta). As outcomes in this study were conceptually independent, there was no interest in exploring possible interactions and relationships between assessment scores (Huberty & Morris, 1989; Kazdin, 2003), and N was not large, this study chose to utilize multiple univariate analyses. Each of the assessments and combined question scores was then analyzed through the use of a repeated-measure ANOVA. In order to protect against Type 1 error, a Bonferroni correction was performed which converted the level of significance to an alpha of .005.

Although statistically significant scores were not obtained, this study examined contrasts for linear and quadratic trends to gather additional information and pinpoint times of noted improvement. In addition, logged hours of time spent in relationship

enhancement activities were considered for all groups to assure that treatment procedures were initiated, completed, and uniform. All analyses were processed with Statistical Package for the Social Sciences (SPSS) Version 19 software (2010).

Ethical Considerations

It is thought that the intervention undertaken in this study was minimally evasive for the participants and presented little mental or physical risk. Possible risk was explained to all participants and included in consents, along with notification that anonymous results would be reported in a study with the possibility of later publication in a professional journal (see Appendixes A & D). Fliers were distributed to school principals and youth leaders with the understanding that they possessed the training and expertise to maintain confidentiality in recruitment. To further ensure confidentiality, all forms and assessments were coded and no names were or will be used or divulged. All data, except the code key, continues to be stored in a locked filing cabinet in the researcher's home. The code key is currently being stored in a separate locked cabinet. All data is accessible only to the researcher, and will be destroyed three years following the dissertation review. The possibility exists that mothers may have required adolescents to participate in this intervention above their objection. It is thought, however, that this risk was overshadowed by perceived benefits and that no harm resulted from any procedure undertaken during this study.

An additional concern is that participants may have wished to receive feedback related to the assessment materials. It was explained to participants and included in the informed consent that all information would be used solely for the purpose of obtaining

data for analysis, and results would not be discussed. This study proposed that perceived benefits from enhanced parent-child relationship and communication skills would outweigh the desire to obtain specific assessment results and produce a minimal amount of distress to the participants.

The procedures outlined in this section and the minimal risk which may have been encountered and experienced by the participants falls favorably within the guidelines set forth in the ethical codes of both the American Association of Christian Counselors (AACC; Clinton & Ohlschlager, 2002) and the American Counselors Association (ACA; 2005) regarding research and testing. The AACC code of ethics indicated that counselors must be qualified and knowledgeable in the tests they administer and discouraged the use of any unnecessary testing. All tests should also be “appropriate to the needs, resources, capabilities, and understanding of the client” (Clinton & Ohlschlager, p. 281). Competent clinicians are also directed to “recognize the limits of test interpretation and avoid exaggeration and absolute statements” (p. 282). In considering research, counselors should “honor accepted scientific standards and research protocol in all research activities” (p. 282), and strive to insure that all procedures are ethically planned, competently conducted, and minimally evasive. Informed consents must be obtained from all participants and their confidentiality and privacy must be ensured (Clinton & Ohlschlager).

The ACA code of ethics has similar requirements and guidelines. All tests must yield reliable and valid results and only be administered by a trained and competent clinician. The purpose of the test and how scores will be reported and used must be explained to the test takers prior to administration as part of the informed consent

process. All research must be planned, designed, conducted, and reported “in a manner that is consistent with pertinent ethical principles, federal and state laws, host institutional regulations, and scientific standards governing research (American Counseling Association, 2005, p. 16). Researchers should consult with an Institutional Review Board (IRB) to assure that guidelines are followed to insure minimal interference to the regular lives of the participants, and materials that are not necessary for the replication of the study should be destroyed in a timely fashion to further maintain the confidentiality and privacy of the participants (American Counseling Association). This study addressed all of the above issues and followed all guidelines in executing the methods and assessments included in this program.

Summary

This chapter provided a detailed description of background information, theoretical support, and procedures for the implemented study. The purpose of this study was to explore the effects of the utilization of CPRT, which had been biblically integrated and shortened from ten to six sessions, upon the perceived degree of satisfaction of parent-teen relationships of mothers and their 11-14 year old children, from religious families. Selection and recruitment of participants and use of assessment and analysis tools were discussed along with procedures for administering treatment, processing data, and evaluating the results. Ethical concerns, in particularly maintenance of confidentiality, were considered, and effort was made, including demographic information analysis and the development of a treatment manual, to insure the internal and external validity, and repeatability of this study. It is the intent of this study to

provide information which can be utilized to improve parent-teen relationships, and replicated and expanded upon by future research and exploration in this area.

CHAPTER FOUR: RESULTS

In previous chapters, a literature review revealed that it is common for parents of teens and pre-teens to report feelings of being overwhelmed, stressed, and frustrated when assisting their children to make wise choices and develop the skills they will need to become happy and productive adults (Edgette, 2006; Glasser, 2002; M. L. Jaffe, 1998; Trollinger, 2007; White, 2006). Additionally, people frequently express a desire to have their spiritual beliefs and needs addressed in therapy and treatment (Garzon, 2005; McClung 2007; Richards & Bergin, 2005; Walker & Quagliana, 2007). The literature review also indicated that brief therapies can be advantageous due to time restraints and insurance preferences (Allison et al., 2000; D. F. Gross & Capuzzi, 2007; Ferrell, 2003; Iveson, 2002; Lethem, 2002; Stuart, 2000). Although many programs have been developed and studied which focus upon children up through the age of 10, few programs focus specifically upon helping parents with middle school aged children. A literature review yielded no information regarding programs that attend to all three of the above concerns. A goal of this study is to address this gap.

In considering the above noted need, this present study explored the entity of relationship and suggested that it could be utilized to bring about change, healing, and well-being (Glasser, 1998, 2002; Landreth & Bratton, 2006; Mullahy, 1952; Rogers, 1951; Schore, 2003a, 2003b). Child Parent Relationship Therapy (CPRT) is a widely used and researched program that focuses upon the parent child relationship, which it uses as a vehicle to bring about growth and change (Landreth & Bratton). More

specifically, the hypothesis of this study is that CPRT which has been biblically integrated, modified for use with older children, and presented in a brief, six session time frame; can be an effective intervention for positive improvement in the relationship between 11-14 year old children and their mothers from Christian families. Based upon this hypothesis, a research question was developed to evaluate the efficacy of this modified therapy program: Does CPRT, which was presented in a brief, six week format and biblically integrated, promote positive change in relationships between mothers and their adolescents children from religious families?

Summary of Research Design

Following the recommendations of Brown (2005), Walker and Quagliana (2007), McClung (2007), Landreth (personal communication, March 4, 2010), and Ferrell (2003); this study outlined and presented proposed modifications (see Appendixes L & M). This modified program was then implemented with mothers of children between the ages of 11 and 14, who professed to be of the Christian faith. In order to assess the efficacy of this program, in regard to the research question, a quasi-experimental study was designed and completed that utilized a pretest-posttest design (Kazdin, 2003). The independent variable was participation in the modified CPRT relationship enhancement therapy program, and the dependent variable was relationship quality as represented by scores obtained from administering several assessments and questions to participants which provided a measure of change in relationship quality.

In order to measure and analyze perceived relationship changes, the above mentioned assessments consisted of the Parenting Relationship Questionnaire (PRQ-CA)

(Pearson Education, 2009) and the Conflict Behavior Questionnaire-20 (CBQ-20) (Robin & Foster, 1989) which were completed by the mothers. Adolescent participants were asked to complete the Inventory of Parent and Peer Attachment (IPPA) (Armsden & Greenberg, 1987) and the Conflict Behavior Questionnaire-20 (Robin & Foster). Assessments were administered at the beginning and end of treatment, and again, after six weeks to assess for maintained and continued progress. In addition, three researcher-generated questions were asked of all participants at all three times, in order to gain additional information regarding the participant pair's perceptions of the quality of their mother/child relationship. To strengthen the validity of this study, demographic data was collected and analyzed in the areas of mother's age, level of education, and income (see Appendix B); children's age, type of school, and custodial arrangements; and inclusion criteria, as previously described in this paper (see Appendix J). The Duke University Religion Index (DUREL; Hill & Hood, 1999) was administered to mothers in order to assess for Christian identification.

Summary of Findings

Twenty-six mothers completed the described training and all assessments. All of their children participated in required activity sessions and 25 completed necessary assessments. Obtained data was examined through the use of repeated measures analysis of variance (ANOVA) to determine if there were significant changes between scores at time 1, at the beginning of treatment, time 2, at treatment completion, and time 3, six weeks following treatment termination; and processed using Statistical Package for the Social Sciences (SPSS) Version 19 (2010). Due to the choice of this study to utilize

multiple univariate analysis, a Bonferoni correction was utilized to control possible risk of committing a Type 1 error. This study then utilized an adjusted alpha level of .005 in considering statistical significance. As statistically significant results were not obtained, it was not necessary to examine contrasts to test the significance of linear and quadratic trends in scores. The results and generated data, from this intervention, are presented below.

Results

The results of this study are presented. Demographics were analyzed to examine and describe the population, and results from analyses of the assessments and study questions are put forth. Although the data analysis did not reveal statistically significant results, meaningful trends were noted and identified.

Demographics

A total of 26 mothers and 25 children completed the training and all required assessments. One child agreed to participate in activity sessions with his mother, but refused to complete the assessments. Of these 26 children, 15 (57.69%) were male and 11 (42.31%) were female. In considering the ages of child participants, five were 14 (19.23%), six were 13 (23.08%), six were 12 (23.08% each), and nine (34.62%) were 11 years of age. The mean of these ages is 12.27 and the standard deviation is 1.32. Twenty-one of the children lived with both biological parents, three lived with parents who adopted them at birth, and two lived primarily with their biological mother.

Table 4.1*Means, Standard Deviations, and Statistical Results for Demographic Variables*

Demographic	Type, Number, Score, or Range	N	%
Family Status	Child living in home with both married, biological parents	21	0.77
	Child living primarily with biological mother	2	7.69
	Child living with both married, adoptive from birth parents	3	11.54
Age of Mother	50-59	3	11.54
	40-49	14	53.85
	30-39	7	26.92
	Chose not to respond	2	7.69
Type of School	Public school	5	19.23
	Private school	16	61.54
	Home school	5	19.23
Mother's Level of Education	Post high school education	26	100.00
Family Income	\$80,000 and above	14	53.85
	\$70,000 - \$79,999	0	.00
	\$60,000 - \$69,999	2	7.69
	\$50,000 - \$59,999	1	3.85
	\$40,000 - \$49,999	3	11.54
	\$30,000 - \$39,999	1	3.85
	\$20,000 - \$29,999	0	.00
	\$0 - \$19,999	1	3.85
	Chose not to respond	4	15.39
Results of DUREL	25	5	19.23
	24	6	23.08
	23	8	30.77
	22	1	3.85
	21	0	.00
	20	5	19.23
	19	1	3.85
Age of Child M=12.27 SD=1.32	14	5	19.23
	13	6	23.08
	12	6	23.08
	11	9	34.62
Gender of Child	Male	15	57.69
	Female	11	42.31

In looking at the mother's ages, three were between the ages of 50 and 59, 14 were between the ages of 40 and 49, 7 fell between the ages of 30 and 39, and two chose not to provide this information. All mothers reported possessing post high levels of education which may not be indicative of the population norm.

Other demographics considered were type of school that the children attended and family income. In considering school type, five children received education through the public school system, 16 attended private schools, and five were home schooled. Another factor examined was family income. An unexpected finding in this area was that more than half of the mothers (53.85%) reported having an annual household income of \$80,000 or more which is higher than the general population norm of \$42,279 as reported by the U.S. Census Bureau (US Census Bureau, 2012). More specifically, fourteen mothers reported family income of \$80,000 or more, two stated their family earned between \$60,000 and \$69,000, one fell between \$50,000 and \$59,000, three were between \$40,000 and \$49,000, one reported income between \$30,000 and \$39,000, and one mother reported that the income for her family was at or below \$19,000. Four mothers chose not to respond to this question. The DUREL (Hill & Hood, 1999) was also included in the demographic questionnaire. All mothers scored well above the base score of 10, which was a criterion to be included in this study. More specifically, five mothers received a score of 25, six scored 24, eight received a score of 23, one scored 22, five scored 20 and one mother received a score of 19. The demographics results are presented in Table 4.1.

Analysis of Assessments

Two factors should be considered when interpreting analysis results. First, a limitation of this study is that it involved a limited number of participants, which increases the probability of obtaining non-significant findings (Creswell, 2003; Mertler & Vannatta, 2005). A second consideration is the utilization of the the Bonferroni correction. Although it is undesirable to commit a Type 1 error, this adjustment is very conservative, making it difficult to secure significant results (Brand, personal communication, August 13, 2012; Perneger, 1998). It would be appropriate to consider the possibility that results could have been significant if these factors and concerns did not exist. This possibility is strengthened in noting that all scores improved at time 2.

In addition, although analysis did not reveal significant results at the adjusted alpha level of .005, it should be noted that two of the assessments taken by the mothers, were significant prior to the addition of the Bonferroni correction. The mothers' Child Behavior Questionnaire-20 (CBQ-20) and the Relationship Frustration scale of the Parenting Relationship Questionnaire for Children and Adolescents (PRQ-CA), yielded scores that indicated meaningful positive trends when comparing time 1 and time 2 scores. According to the test developers findings and research, this would support that mothers reported experiencing less stress, frustration, and conflict when managing their children's behavior and affect, and an increase in positive communication (Kamphaus & Reynolds, 2006; Robin & Foster, 1989). Although these scores did not provide support to accept the study hypothesis, the noted meaningful trends do put forth and provide support that participation in this program was successful in enhancing the relationship between mothers and their adolescent children. These findings are detailed below.

Child Behavior Questionnaire-20 (CBQ-20) mother.

Data from mothers' responses to the CBQ-20 is presented in Table 4.2.

Obtained scores presented a meaningful trend from time 1 to time 3, $F(2,24) = 4.041, p = .031$. Although these scores were not statistically significant at the .005 alpha level, contrasts were examined to pinpoint areas of reported improvements. This analysis revealed that the trend was strongest between time 1 and time 2., $F(1) = 7.375, p = .012$. This variance in scores before and after treatment suggests that the degree of conflict and negative communication experienced within a family system, as perceived by the mother, decreased between times 1 and 2. Based upon the findings of previous research and theory that communication, attachment, and interaction style are constructs to be considered when analyzing relationship (Kamphaus & Reynolds, 2006), these findings indicated that the relationship did change in a positive manner. Although this does not provide support to accept the study hypothesis, the trends do imply that utilization of CPRT (Bratton, Landeth, Kellam, & Blackard, 2006) which had been modified as previously discussed (see Appendix L), did have some degree of positive effect upon these relationships.

Table 4.2

CBQ-20 Mother Scores

Time	M	SD
1	6.270	5.632
2	4.040	4.162
3	4.770	6.088

Parenting Relationship Questionnaire (PRQ-CA) Relationship Frustration.

Scores on the PRQ-CA Relationship Frustration scale across time are shown in Table 4.3. A repeated measures ANOVA revealed no statistically significant differences in scores across time points, $F(2,24) = 5.832, p = .009$. It should be noted, however, that the p value of .009 did approach the level of significance and reveal the presence of a strong and meaningful positive trend. Analysis of the trend in scores revealed that although this trend was largest between times 1 and 2, $F(1) = 4.983, p = .035$, additional support for the existence of a long term effect was provided, $F(1) = 4.936, p = .036$. As the authors of the PRQ-CA, Kamphaus and Reynolds (2006) put forth that positive changes in scores from this scale are indicative of perceived improvement in relationship quality, the results from this assessment supply support that positive change did occur from participation in this program.

Table 4.3

PRQ-CA Relationship Frustration Scores

Time	M	SD
1	57.810	13.523
2	52.730	8.702
3	53.230	16.217

Parenting Relationship Questionnaire (PRQ-CA) Attachment.

Scores on the PRQ-CA Attachment scale across time are shown in Table 4.4. Although scores did improve between times 1 and 2, the repeated measures ANOVA did not reveal significant differences across time points, $F(2,24) = 1.463, p = .251$. According to Kamphaus and Reynolds (2006), PRQ-CA developers, this indicated that participation in this program may have produced some improvement in mothers' feelings

of closeness, empathy, and understanding towards their adolescents. The non-significant results also did not provide support that long term effects were present. Although the results from this scale's scores were not significant, their positive trend provided support that participation in modified CPRT produced short term improvement in relationships between mothers and their adolescent children.

Table 4.4

PRQ-CA Attachment Scores

Time	M	SD
1	46.000	10.617
2	47.880	11.276
3	45.880	11.653

Parenting Relationship Questionnaire (PRQ-CA) Communication.

Scores on the PRQ-CA Communication scale across time are reported in Table 4.5. Although the repeated measures ANOVA did not reveal significant differences in scores across time points, $F(2,24) = .203, p = .817$, very slight improvement was noted in time 2 scores. No support was provided that participation in this program had long term effects in this area. This scale provided a measure of mothers' listening skills and amount of positive communication with their children (Kamphaus & Reynolds, 2006). Although an analysis of this scale's scores provided the least amount of positive change, data does add support that there exists a meaningful trend in scores which indicated that relationships did improve following the implementation of modified CPRT.

Table 4.5

PRQ-CA Communication Scores

Time	M	SD
1	47.460	11.907
2	47.730	11.722
3	46.500	12.722

Parenting Relationship Questionnaire (PRQ-CA) Involvement.

Scores on the PRQ-CA Involvement scale across time are shown in Table 4.6.

The repeated measures ANOVA did not reveal significant differences in scores across time points, $F(2,24) = 1.167, p = .328$. Although results were not statistically significant, improvement was noted in scores at both times. A decrease occurred between time 2 and time 3 scores, which does not support the presence of long term effects. This scale was developed to measure parents' interaction with their children and knowledge "of the child's activities" (Kamphaus & Reynolds, 2006, p. 25). Results from this scale's scores strengthen the meaningfulness of the overall positive trend noted from analysis. As improvement is shown between time 1 and time 3 scores, these results support the possibility that participation in this program may have long term effects.

Table 4.6

PRQ-CA Involvement Scores

Time	M	SD
1	45.040	10.709
2	47.650	9.143
3	46.040	11.431

Parenting Relationship Questionnaire (PRQ-CA) Parental Confidence.

Scores on the PRQ-CA Parental Confidence scale across time are reported in Table 4.7. The repeated measures ANOVA did not reveal significant differences in scores across time points, $F(2,24) = 1.121, p = .342$. In examining obtained scores, improvement can be noted between times 1 and 2. This indicated that mothers' reported feeling more self-assured and comfortable with the parenting process (Kamphaus & Reynolds, 2006) during the time that they participated in the program. Analysis of the scores from this scale resulted in a positive trend which provided additional support that participation in modified CPRT produced improvement in perceived quality of mother-child relationships. No support was provided for the existence of long term effects.

Table 4.7

PRQ-CA Parental Confidence Scores

Time	M	SD
1	42.620	11.384
2	45.310	12.979
3	42.380	13.078

Conflict Behavior Questionnaire (CBQ-20) adolescent.

In order to obtain a better picture of study results, adolescents were also asked to complete assessments. One of these was the CBQ-20 whose scores and ratings across time are presented below in Table 4.8. The repeated measures ANOVA did not reveal significant differences in scores across time points, $F(2,24) = .991, p = .387$. In looking more closely at scores, a meaningful positive trend was noted between time 1 and times 2 and 3. Although there was not enough variance to be significant, this presents the possibility that participation in the program resulted in improvement in communication

conflict as perceived and reported by the adolescent children of mothers who were participating in this program (Robin & Foster, 1989). In addition, progress continued throughout the six weeks following program termination. This means that, although they did not meet the level of significance, positive results were reported that may have long term effects and provided support to accept the study hypothesis that participation in modified CPRT improves relationship quality between mothers from Christian families and their 11-14 year old children.

Table 4.8

CBQ-20 Adolescent Scores

Time	M	SD
1	5.000	5.934
2	4.080	5.073
3	4.080	5.413

Inventory of Parent and Peer Attachment (IPPA).

Scores on the IPPA are shown in Table 4.9. The repeated measures ANOVA did not reveal significant differences in scores across time points, $F(2,24) = 1.070, p = .359$. In considering scores at times 2 and 3, very mild variance was noted at time 2 with a slight rise in scores at time 3. The limited variance in these scores added little information regarding perceived change in levels of trust, communication, and alienation (Armsden & Greenberg, 1987), and did not provide support to accept the study hypothesis.

Table 4.9*IPPA Scores*

Time	M	SD
1	58.400	20.22581
2	58.320	19.54636
3	61.840	21.25378

Mother responses to generated questions regarding relationship satisfaction.

Mothers' responses to the three generated questions were totaled at each time point; the analysis of these scores is reported in Table 4.10. The repeated measures ANOVA did not reveal significant differences in scores across time points, $F(2,24) = 2.774, p = .082$. In considering means for scores across times, scores improved between times 1 and 2 but decreased between times 2 and 3. In other words, although variance between scores was not significant, support was provided regarding this program's effectiveness in that mothers reported that they experienced improvement in the quality of the relationship between themselves and their adolescent while they were participating in the study program. This improvement did not have long term effects. All of the mothers responded favorably to a fourth question indicating that they were optimistic regarding the outcome of participating in this treatment.

Table 4.10*Mother responses to generated questions regarding relationship satisfaction*

Time	M	SD
1	21.500	6.813
2	23.519	4.7507
3	22.540	6.401

Adolescent responses to generated questions regarding relationship satisfaction.

Adolescents' responses to the three, researcher generated questions regarding ratings of overall satisfaction were totaled and analyzed as a whole for each time point. The results are shown in Table 4.11. Score means revealed little variance and analysis did not reveal significant differences in scores across time points, $F(2,24) = 2.051, p = .140$. In other words, responses from these three questions provided no grounds or support to accept the study hypothesis. As with previously discussed results, noted improvement contributed to an overall positive trend in which all ANOVAs produced and indicated improvement between times 1 and 2. All adolescents indicated in a fourth question that they were optimistic that participation in this program would be a positive experience which would be beneficial to them and their mothers.

Table 4.11

Adolescent responses to generated questions regarding relationship satisfaction

Time	M	SD
1	24.440	6.021
2	24.620	5.6592
3	23.400	6.576

Summary

The goal of this study was to provide Christian mothers and therapists with a tool to improve and enhance relationships between these mothers and their 11-14 year old children. As it had been noted that people prefer to have their spiritual beliefs and values included in their treatment and therapy, CPRT was biblically integrated to address these concerns. The program was also shortened from a 10 to six week format to better

accommodate the hectic schedules often experienced by children in this age range. Methods and procedures were then developed and implemented with 26 mother-adolescent pairs to investigate the efficacy of this modified program.

Participants provided demographic information which was evaluated to assess group homogeneity, completed assessments, and responded to questions at times 1, 2, and 3. These assessments and question responses yielded scores that were analyzed through the use of repeated measures ANOVAs. Although this analysis did not yield statistically significant results, all scores improved between times 1 and 2. This identified a meaningful positive trend which supported that participation in this program resulted in participants' reports of enhanced and improved relationships as experienced through decreases in relational frustration and the amount of negative communication and conflict within the family unit. All participants were optimistic that participation in this study would be a positive and beneficial experience.

CHAPTER FIVE: SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

A prominent theme in literature is that parents and other caregivers report a need and desire for resources, information, programs, and interventions that will assist them as they successfully guide the children under their care into adulthood. Often these caregivers report feelings of frustration, confusion, helplessness, and even dread when parenting their middle school and teen aged children (Edgette, 2006; Glasser, 2002; M. L. Jaffe, 1998; Trollinger, 2007; White, 2006). Another frequent topic of interest and research has been the exploration of the causes, benefits, improvement, development, and utilization of relationships (Frankel, 1984, 2000; Glasser, 1998, 2000; Moustakas, 1959; Mullahy, 1952; Rogers, 1951). It has been hypothesized in previous studies that healthy relationships are necessary for well-being and that they can be utilized to promote growth and healing (Glasser, 1998, 2002; Mullahy; Rogers). It seems logical that these two areas of interest could be combined, and that programs specifically targeted at helping parents and their children to develop and strengthen relationships may prove to be valuable and efficacious for clinical work.

In further examining literature, several programs have been developed that focus upon using relationships to foster well-being and provide a vehicle for intervention. Few were indentified, however, that specifically targeted relationships between parents and their older children. This study examined Child Parent Relationship Therapy (CPRT; Bratton, Landreth, Kellam, & Blackard ,2006; Landreth & Bratton, 2006) and proposed that it could be modified for use with mothers and their 11-14 year old children.

Modifications included biblical integration to address parents' spiritual preferences and concerns (see Appendix L), and offering the program in a brief, 6 week format. It was utilized with 26 mothers who participated with their children in weekly activity sessions and completed homework assignments. Assessments were completed by participants and analyzed for significant changes.

Summary of Findings

The research question of this study is: Can CPRT, which had been biblically integrated and offered in a six week format, promote positive change in relationships between mothers and adolescents from religious families? It was hypothesized that such a program would successfully yield statistically significant changes between pre- and post- test assessment scores. It was also hoped that significant findings would continue through time 3 assessments which could indicate a long-term effect. In considering specific results and data, although no scores or question responses were found to be significantly significant, improvement was noted for all assessments and questions between times 1 and 2. Although this does not supply direct support to accept the study hypothesis, it is indicative of the presence of meaningful positive trends. All participants indicated that they were optimistic regarding the outcome and progress of their participation in this program. This provided an indicator that mothers and adolescents possessed motivation to participate in this program and perceived that they could reap benefit from their effort.

In considering implications from positive changes by assessment, improvement was indicated by increases in scores on the Attachment, Communication, Involvement,

and Parenting Confidence scales of the PRQ-CA (Kamphaus & Reynolds, 2006) and the combined question response score and decreases in obtained from the Relational Frustration scale of the PRQ-CA (Kamphaus & Reynolds), the IPPA (Armsden & Greenberg), and the CBQ-20 (Robin & Foster). According to the authors of the PRQ-CA, the Attachment scale was developed to measure changes in “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” (Kamphaus & Reynolds, 2006, p. 3). Scores in this scale revealed a slight improvement between times 1 and 2 and contributed to the overall trend of positive results that indicated relationship improvement.

In addition, positive results were also obtained on the Communication, Involvement, Parenting Confidence, and Relationship Frustration scales of the PRQ-CA (Kamphaus & Reynolds, 2006). The authors stated that these measure changes in the quality of exchanged communication and parent’s listening skills, the extent to which parents and children participate in common activities, parents’ confidence in making decisions and being actively involved in the parenting process, and parent’s level of stress when “relating to and controlling the behavior and affect of the child” (Kamphaus & Reynolds, p. 4). Kamphaus and Reynolds state that these are constructs of relationships. As previously noted, progress was reported between times 1 and 2 on all of these scales. It should also be noted that results obtained from an analysis of Relationship Frustration, Parental Confidence, and Involvement scale scores were indicative of long term effects.

In evaluating data obtained from the CBQ-20 which, according to the test developers, provides a general estimate of the amount of conflict and negative

communication experienced within the family unit (Robin & Foster, 1989), improvement was noted in scores from all participants across all time points. Although the effect is strongest between times 1 and 2, these results support the possibility of long term effect from participation in modified CPRT and contribute to this study's overall positive trend.

The final scores to consider are those obtained from the IPPA and the generated relationship questions. The IPPA's developers, Armsden and Greenberg, (1987) stated that the function of this assessment tool is to measure the "behavioral and affective/cognitive dimensions of adolescents' attachments to their parents and peers" (p. 431) through examining adolescent's perceptions regarding trust, communication, and level of alienation within their family system. Scores on this assessment resulted in very slight improvement between times 1 and 2 and contributed little to the evaluation of the studied program. This study developed and asked three questions regarding relationship quality to all participants. The results showed slight improvement between times 1 and 2 which did contribute strength to the positive trend of the study. These results did not support the existence of long term effects.

Implications for Counseling

It has been noted that it is not uncommon for parents of middle school aged children to report feelings of stress and frustration when attempting to help their children learn skills and make wise decisions (Edgette, 2006; Glasser, 2002; M. L. Jaffe, 1998; Trollinger, 2007). The goal of this study was to develop and evaluate a program to help these parents. In examining related literature, Glasser (2002) encouraged parents to not use external control with their adolescents, but instead, to develop and strengthen their

relationships with them. He states that these positive relationships will draw parents and adolescents closer together, and that they will be able to build upon these positive relationships to establish and develop well-being. Lehman (2002), A noted psychologist, would agree with this and stated that “We don’t parent teenagers by rules; we parent teenagers by relationships” (pp, 80-81). He also encouraged parents to teach through modeling and the utilization of strong and positive communication skills. Other clinicians such as Ginsberg (1997), Barkley and associates (1999), Hughes (2007), and Pianta and Hamre (2001) have also, as mentioned in previous chapters, focused upon utilizing the development of positive relationships to assist caregivers to successfully guide and nurture their children.

Although the above clinicians have developed programs and reported success in helping parents, a literature review did not yield information regarding the existence of brief programs that had focused specifically upon assisting parents of middle school children who wish for their Christian beliefs and values to be incorporated in treatment and interventions. In considering implications for counseling, the meaningful positive trend in results obtained through this study indicated that modified CPRT (Bratton, Landreth, Kellam, and Blackard 2006) could be successful in enhancing relationships between mothers and their 11-14 year old children. It is proposed then, that the program developed and utilized in this study may prove to be an effective tool and intervention which may be able to fill this gap in available services.

Although not directly addressed by this study, there exists the possibility that enhanced positive relationships may provide adolescents with a secure base and the motivation to make choices that will promote positive internalized and externalized

behaviors (Bandura et al., 2001; Barkley & Robin, 2008; Baumrind, 1966; Bowlby, 1988; Feldman, 2006; Glasser, 1998; Higgins, 1994; M. L. Jaffe, 1998; Landreth & Bratton, 2006; Moustakas, 1959; Pianta, 1999; Pittman, 2007; Resnick et al., 1997; Rhodes, 2002; Scales & Gibbons, 1996; Silverstein, 2007) . In addition, as obtained data supported that mothers experienced a decline in frustration and less conflict and negative communication within their family system, this program may be particularly beneficial when focusing on these concerns. As this program has a strong psychoeducational component, and study participants were from a sub-clinical population, a further clinical implication could be the use of this program to maintain and improve healthy interactions and levels of functioning within family systems, or to proactively prevent the development or exasperation of concerns and symptoms.

Further consideration of study results indicated that this program not only expanded the population base for which CPRT may be an appropriate choice for intervention, but also provided information regarding biblical integration. The meaningful positive trends obtained from this study's data, indicated that this biblically integrated program was successful in bringing about the desired changes and results and infers that it may also be possible to biblically integrate additional programs, without interfering with their integrity and effectiveness. It is hoped that this information will be applied and utilized in order to provide a greater range of tools for clients who wish their Christian beliefs and values to be incorporated in their treatment (Ferrell, 2003, McClung, 2007; Walker & Quagliana, 2007).

Additionally, the findings from this study are also consistent with study results that advocate value oriented counseling (Brammer, 2004; Diller, 2010; Furman et al.,

2009; Richards & Bergin, 2005). With additional research, it is hoped that this program may become a resource for all Christian caregivers who wish to improve the quality of their relationship with the middle school aged children that they guide and nurture. It is also hoped, as proposed by Glasser (1998, 2002), Rogers (1951), and Sullivan (Mullahy, 1952); that these improved relationships could then become a positive factor which would improve the quality of life for all persons.

It is hoped that the meaningful positive trends obtained in this study will encourage practitioners to consider the possibility that play therapy, and more specifically, CPRT, may be a viable treatment when working with middle school aged children. This would be particularly appropriate when parents report feelings of frustration with dealing with their children and want to improve communication and decrease conflict within their family system. It would also be of benefit to proactively focus upon the development of healthy relationships and to utilize this program as a vehicle and agent for change. Finally, it would be advantageous to expand areas and thinking related to biblical integration and consider the possibility that this could be successfully incorporated into all therapy and treatment when aligned with the values and beliefs of the client.

Limitations

This study had several limitations. Although the repeated measures ANOVA is a powerful statistical analysis tool, caution should be utilized when interpreting significance due to this study's small sample size (i.e., 26). In addition, as 10 outcome measures were obtained through the use of multiple univariate analyses, a Bonferroni

Correction was utilized to guard against committing a type 1 error. As this is a conservative tool, which set the alpha at .005, the ability of this study to find statistically significant results may have been limited. Another consideration is that as all adolescents in this study were from a non-clinical population, the possibility existed that participants may have been functioning at a high and satisfactory relationship level prior to participation in this program. This may affect the implemented program's ability to produce significant positive improvement. To assist with this, a criterion of inclusion was that mothers scored in the average or below range for one of the scales of the PRQ-CA. No such criterion was included for adolescents.

An additional limitation involved the design of the study. This study did not implement random assignment, as mothers were placed into groups based upon their availability, and the researcher opted not to include a control group. As the goal of this study was to evaluate the efficacy of the modified program, which was not compared to another treatment, it was decided that a control group would not add a significant amount of additional information. Another concern is that all data was obtained through self-report and relied on the honesty and accuracy of provided responses. Although this is a widely used method of information collection (Atkinson, Zibin, & Chuang, 1997; Dickey & Wagenaar, 1994), collecting second party information could possibly have changed the findings of this study. In an effort to control for this, data was collected from adolescents and mothers.

An additional consideration regarding limitations of this study is the ability to apply its results to a generalized population. As there were multiple criteria for admission into this study, the participants represent a specific population. It could follow

that generated data could also be very specific and not easily applicable to the population as a whole. Due to this, caution should be utilized when applying the data generated from this study. A final design consideration is that all intervention was implemented by the researcher. Although the researcher is aware that this could present a threat to the internal validity of the study, this was discussed with Landreth (personal communication, March 4, 2010), one of the developers of CPRT, who indicated that this would not affect the integrity of the study and that it could be carried out with limited contamination. In addition, the researcher received training directly from Landreth to assure that the essence and intent of original CPRT procedures were properly taught and utilized.

In further considering this study, a major concern could be the possibility that the activity sessions were not properly executed. To address this concern, CPRT utilizes actual videotaped activity times as a learning tool and a way to monitor and assess mothers' ability to skillfully apply learned procedures (Bratton et al., 2006). Although this program had intended to include this procedure, all adolescents in this study reported that this would cause them to feel uncomfortable and would not grant permission to be taped. Due to ethical considerations and Internal Review Board policy and procedures, this activity was omitted. In order to address this concern, extensive role play was utilized during the first five sessions and mothers were encouraged to act out real life scenarios. In additions, all mothers reported that guidelines were followed and they held weekly activity times as directed and prayed several times throughout the week for their children, each other, and the program.

An unexpected result of this study was all mother participants indicated that they possess post high school education and more than half (53.85%) reported yearly family

incomes of \$80,000 or above. This, along with the multiple criteria for inclusion in this study, generated the possibility that this may have had some effect on the study's outcome and ability to be generalized. Another concern and limitation of this study was that attrition was extremely high, which is not uncommon in studies that require regular attendance to the independent variable and that employ repeated measures for time (Flick, 1988; Young, Powers, & Bell, 2006). Most mothers who withdrew from the program contacted the researcher and stated that their children's extra-curricular activities prevented them from being able to have scheduled activity times. This may add support that the development of brief therapy for this population would prove to be beneficial. In order to control for some attrition, mothers were permitted to miss one week of group instruction if they completed all homework assignments, participated in the weekly scheduled activity session with their child, and had an individual session, either in person or on the phone, with the researcher to discuss missed information and share handouts. This session was required to be completed prior to attendance in the next scheduled group session.

The possibility of interference by factors or life stressors, which occurred outside of the focus of the study, on assessment responses is another concern of this study. Although participants were instructed to consider behaviors and feelings from the past two weeks when completing assessments, one mother informed the researcher that she had had a major confrontation with her child during the day on which she completed time 2 assessments and stated that this most likely affected her responses. A final concern or limitation was that there exists a lack of standardized assessments that have been developed to target this precise age range and that different choices in measurement tools

could possibly have been more sensitive to the identification of changes and shifts in relationships.

Recommendations for Further Research

In considering suggestions for further research in this area, the development of additional assessment tools that focus on this precise age range, 11-14 or middle school aged children, should prove to be of value. As it was difficult to find assessments to utilize in this study, the increased availability of sensitive and specific assessments may have yielded additional significant results and target areas of applicability. It would also be of interest to utilize this program with fathers, or other caregivers, and their adolescent children in order to expand the applicability of results and compare these to those obtained from mother participants. Another possibility would be to repeat this study with a larger population as this may allow for additional significant findings.

Another area for suggested research would be to develop a biblically integrated 10 week program to compare to the program implemented in this study, as the original CPRT is a 10 week program, and to compare a condensed six week program which has not been biblically integrated to one that includes this factor. This would provide a stronger base of information for comparisons and help to pinpoint specific factors that contributed to the success of this program. It would also be beneficial to study the implementation of this program with parents' of children in a clinical population or in a school setting with teachers and students. Results from these studies could also increase the applicability of study findings. A final recommendation would be to question participants' regarding their satisfaction with the amount of biblical integration that was

included in this program to explore this factor. This could prove to be of value when considering the possibility of biblically integrating additional programs.

Chapter Summary

Chapter Five discussed and evaluated the study and its generated results. Limitations were discussed to address procedural choices, challenges, and complications. Recommendations for further research were provided in the hopes that this program will be able to be utilized with other populations in a variety of settings. It is hoped that this study will provide motivation and become a springboard for researchers to biblically integrate additional programs, thus providing a wider range of options for persons who wish to look to God for guidance and direction in all things. As obtained meaningful positive trends provided support that the program described and outlined in this present study may be effective in assisting mothers to improve their relationships with their middle school aged children, it was implied that it may prove to be a beneficial and effective tool for treatment and intervention in this area.

Closing Summary and Final Comments

Transitioning from childhood to adulthood can be a challenging, confusing, and frustrating process. Due to this, parents of teens and pre-teens who are striving to assist their children to make wise choices and develop effective life skills often report feelings of frustration, confusion, helplessness, and sometimes desperation (Edgette, 2006; Glasser, 2002; M. L. Jaffe, 1998; Trollinger, 2007; White, 2006). A common solution has been to utilize corporal punishment to manage behaviors and concerns, but this has

often proven to be ineffective and have negative effects (B. K. Barber, Olsen, & Shagle, 1994; Baumrind, 1996; Harvard Mental Health Letter, 2002; Holden, 2002; M. L. Jaffe, 1998; Kazdin & Benjet, 2003; Saadeh, Rizzo, & Roberts, 2002; Straus, 1993, 2001). Additional concerns, which have been identified, are that people report a preference to have their spiritual beliefs addressed in their therapy and treatment (Beach, Fincham, Hurt, McNair, & Stanley, 2008; Entwistle, 2004; Garzon, 2005; Jones & Butman, 1991; McMinn & Campbell, 2007; Pargament, 1997; Richards & Bergin, 2005; Tan, 2007; Walker & Quagliana, 2007), and that middle and high school aged children tend to have busy and hectic schedules. A literature review indicated that there are few programs which address all of these concerns, and fewer still that focus specifically upon assisting parents and their middle school aged children.

In looking for alternatives, this study chose to focus upon and discuss the entity of relationship, which has been widely studied as a vehicle to bring about positive growth and healing (Glasser, 1998, 2002; Mullahy, 1952; Rogers, 1951). Several programs were identified such as STARS (Pianta & Hamre, 2001), Bounceback (McGrath & Noble, 2003), PSCT (Barkley et al., 1999), and Glasser's Quality Schools (Glasser Institute, n.d.), which utilize relationship to help children. Another program, CPRT, was of particular interest to this study as it has been researched and shown to be effective with children in a wide range of settings and populations (Landreth & Bratton, 2006). Additionally, previous research provided support that CPRT may be compatible with Christian beliefs and values, and suggestions had been made as to how it could be modified successfully to target an adolescent population (Brown, 2005; Ferrell, 2003; Landreth, personal communication, March 4, 2010).

A research question was then developed: Does CPRT, which has been condensed into a six week format and biblically integrated, promote positive change in relationships between 11-14 year old children and mothers from religious families? Following recommendations of Brown (2006), Ferrell (2003), and Walker & Quagliana (2007); CPRT was modified to address the research question and utilized in a study to explore its efficacy to assist this population (see appendixes L & M). Twenty-six mothers and children participated in this study and completed assessments to supply data. Although no statistically significant results were obtained from an analysis of the data, an overall meaningful positive trend was reported in that all scores improved between times 1 and 2. The largest changes in mothers' responses were obtained from scores indicative of a reduction in perceived relational frustration and the amount of conflict and negative communication experienced within their family. It was concluded that this study did provide support that CPRT, which was biblically integrated, shortened in length, and modified for use with parents of children between the ages of 11 and 14, could be effectively utilized as a psychoeducational wellness program to enhance parent child relationships. In considering these results, limitations and recommendations for additional areas and topics for further research were discussed.

The verse for this study was Deuteronomy 31:8, "The Lord himself goes before you and will be with you; he will never leave you nor forsake you. Do not be afraid; do not be discouraged" (NIV). A goal of CPRT is to enhance the relationship and increase the amount of positive interaction between children and their caregivers. It is hoped that participation in this modified program will provide mothers with insight, information, experience, and confidence that will assist them to more effectively and skillfully "go

before and be with” their children. This should provide a secure base that middle school aged children can utilize to maintain balance as they step into adulthood without being “afraid and discouraged.” It is also hoped that the results of this research effort will generate additional studies that will expand the effectiveness of this intervention to other populations, and promote the biblical integration of additional programs. These programs could then become powerful tools for all persons who strive to provide competent Christian care in order to promote healing, growth, and well-being for all of God’s children.

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Appendix A

CONSENT FORM FOR MOTHER

Exploring the utilization of brief, biblically integrated, relationship enhancement therapy to improve relationships between mothers and adolescents from Christian families.

Valerie Waruszewski

Liberty University-Campus North
Center for counseling and Family Studies

You are invited to take part in a study to research and explore the efficacy of using brief, biblically integrated, relationship enhancement therapy to improve relationships between mothers and their adolescents children from Christian families. Your assistance, participation, and interest are greatly appreciated by the researcher who is seeking 25 mother-adolescent pairs who are willing to participate in a six-week, parent driven, relationship enhancement program. Please read through this form and feel free to ask any questions that you may have before agreeing to enroll in this study which is being conducted by Valerie Waruszewski, Doctoral Candidate, Counseling Department of the Center for Counseling and Family Studies at Liberty University which is located in Lynchburg, Virginia.

Background Information

A broad base of research exists which has shown that children are happier, healthier, and more productive when they are provided with encouragement, protection, support, and direction from caring adults. In trying to supply this support, however, parents of adolescents often report feelings of frustration and confusion when their child presents as being moody, standoffish, disrespectful, troubled, or quiet; and begins to become increasingly more involved with activities outside of the home. Child Parent Relationship Therapy (CPRT) has proven to be a successful tool to utilize to improve relationship and communication between parents and younger children. The purpose of this study is to modify this program so that it can be utilized with adolescents between the ages of 11-14. This study also intends to provide this therapy in a six week format to better fit the time restraints and hectic schedule of teens and their parents, and to incorporate Christian values and beliefs. It is hoped that this modified program can then be utilized to help Christian parents improve the relationships with their adolescent children.

Procedures

Participation in this study will involve the following steps. Today you will be asked to sign this consent form and complete a demographic information sheet. You will also be asked to complete two assessment tools, the Parenting Relationship Questionnaire and the Conflict Behavior Questionnaire-20, now, at the end of the program, and after a six week follow-up period. All forms will take approximately 30 minutes to complete. Your son or daughter will also be asked to complete a demographic survey and two assessment tools, the Conflict Behavior Questionnaire-20 and the Inventory of Parent and Peer Attachment; as well as signing a consent form. The assessments will also be repeated at the end of treatment and after a six week follow-up period. If you agree to participate in this study, you will be placed into a group based upon your day and time preferences and asked to attend six training sessions. You will also be directed to take part in one relationship building activity with your child per week. This activity will take place the same time and day every week and last a minimum of 30-45 minutes. Activity chosen and time involved will be logged on a form which will be provided to you in the treatment manual. In addition, you will be given the option to have a play session with your child videotaped. This will be utilized to provide personalized and specific feedback.

Risks and Benefits of being in this Study

This study has several risks. First, there is a risk of becoming fatigued from completing the assessments. To keep this at a minimum, every effort has been made to only include needed assessments and participants are also encouraged to take breaks as needed when completing all forms. Second, there exists the possibility that involvement in this program may impose time constraints upon participants. It is hoped that benefits obtained from interactive parent-adolescent time will prove to be both enjoyable and beneficial to both parties and outweigh the effort needed to schedule and set aside this time each week. Third, parents and their adolescent may become upset and conflict may arise during relationship enhancement time. Due to the accepting and positive procedures outlined for these interactions, it is expected that conflict will be minimal. Contact information for professional counselors will be provided in the treatment manual given to each mother if additional assistance is desired. Finally, there is the risk that responses to assessments may be viewed without your consent. To minimize this possibility, no names will be used and numbers will be randomly assigned to assessment and information packets which will be safely secured and stored in locked cabinets. No study is without risk, those outlined above are minimal and only slightly more than the participant would encounter in everyday life. In considering benefits, it is hoped that through this study, the parent-adolescent bond will become stronger and more positive, and that communication and relationship quality and satisfaction will increase.

Confidentiality

Please be assured that the confidentiality of all participants is a top priority of the researcher. In an effort to assure confidentiality, only the researcher will have access to data and records and all assessments and demographic information will be assigned a code number. All scores and information, except the code key, will be stored in a locked filing cabinet in a secured room in the researcher's home, to which only the researcher has access. The code key will be stored in a separate locked cabinet in the same room. All video-taped information will be stored on a computer which has a password and locked in this same cabinet. Only the researcher will have access to this computer and password. Participants who choose to self-record a session will retain possession of this information; this will not be given to or stored by the researcher. Role play sessions during class will not be recorded. Following the completion of this study, all video-taped information will be transferred to a single flash drive which will be stored with the assessment data in the locked filing cabinet and files will be erased from the computer. All information and data will be stored for three years. After this time period, all files will be erased and all paperwork, including assessments, consents, demographic information, and the code key will be shredded and destroyed. The results of this study may be published in a professional journal. If this should happen, only statistical data and themes without identifying information will be shared or provided.

Voluntary Nature of the Study

All participation in this study is voluntary and participants may withdraw at any time.

Contacts and Questions

The researcher conducting this study is Valerie Waruszewski, MA, LPC, NCC. Please do not hesitate to contact her at any time should you have questions or concerns. She can be reached by telephone at ###-###-#### or emailed at vawaruszewski@liberty.edu. (Dissertation Chair: Dr. John Thomas, Liberty University Center for Counseling and Family Studies, 434-592-4047, jcthomas2@liberty.edu). If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, you are encouraged to contact the Human

Subject Office at Liberty University, 1971 University Blvd, Suite 1582, Lynchburg, VA 24502 or email at irb@liberty.edu.

Contact information for referrals for more intensive, crisis, or one on one counseling and therapy:

1. William Haynes, LPC. Abingdon, VA. (276)- 971-9715.
2. Tri-Cities Center for Christian Counseling. 1111 N. Eastman Road, Kingsport, TN. And 112 E. Myrtle Avenue, Johnson City, TN. (423)-246-5111.
3. Mustard Seed Ministries. 214 East Wanola Avenue, Kingsport, TN. (423)-245-3721.

Please read the above completely and ask any questions that you may have, then sign and return to researcher.

Statement of Consent:

I have read and understand the above information. If desired, I have asked questions and have received answers. I understand that I am free to refuse to answer any questions presented in this study, and to withdraw at any time. I consent to participate in the study.

I also give permission for my son or daughter to participate in this study.

_____ I will like to have a play session videotaped _____ I would not like to have a play session videotaped

Signature: _____ Date: _____

Print Name: _____

_____ Date: _____

Signature of Investigator: Valerie Waruszewski, LPC, NCC, CT/RTC

IRB Code #1072.032911

IRB Expiration Date: March 29, 2013

Appendix B

Please complete the following information.

Name (Please Print)

Name of Child _____ **Child's Date of Birth** _____

Parent or Caregiver Address _____

Parent Email _____

Preferred Phone Number _____

I prefer to be contacted through ___Phone ___Mail ___Email ___Text

Are you your child's biological mother? ___Yes ___No

Does your child reside with you at least five days per week? ___Yes ___No

Family Status

___ Child living in home with both married, biological parents

___ Child living primarily with one biological parent with or without a step-family

___ Child living part time with each biological parent with or without step-families

___ Child living primarily with other caregiver/s who is not a biological parent

Does your child currently receive professional mental health treatment from a licensed counselor, psychiatrist, or therapist? ___Yes ___No

If yes, where and from whom? _____

Age of Parent or Caregiver

___ 60 or older

___ 50-59

___ 40-49

___ 30-39

___ 29 or younger

Type of School Child Attends

___ Public School

___ Private School

___ Home Schooled

___ Other (Please Specify) _____

**Family Income
Caregiver**

- ___ \$80,000 and above
- ___ \$70,000-\$79,999
- ___ \$60,000-\$69,999
- ___ \$50,000- \$59,999
- ___ \$40,000-\$49,999
- ___ \$30,000-\$39,999
- ___ \$20,000-\$29,999
- ___ \$0-\$19,999

Highest Education of Participating

- ___ Post high school education
- ___ High school graduate or GED
- ___ did not earn high school diploma or GED

Has your child experienced or been involved in any of the following within the past sixty days?

- Sexual or physical abuse ___ Yes ___ No
 - Acts of violence or a natural disaster which resulted in severe loss ___ Yes ___ No
 - Permanent loss of a primary caregiver ___ Yes ___ No
- Please elaborate on any responses of yes to the above

Does your child:

- Drink alcohol or use non-prescribed drugs or substances? ___ Yes ___ No
- Participate in or talk about behaviors that would be harmful to others? ___ Yes ___ No
- Participate in or talk about behaviors that would be harmful to him or her? ___ Yes ___ No
- Hurt animals or set fires? ___ Yes ___ No
- Hear sounds or voices that are not there? ___ Yes ___ No
- Cut him or herself or pick at his or her skin? ___ Yes ___ No
- See things that are not there? ___ Yes ___ No
- Talk about killing him or herself? ___ Yes ___ No

Please elaborate on any responses of yes to the above and talk to researcher before leaving today. _____

Does your child have any current legal charges?

Yes No

If yes, Please elaborate _____

Does your family profess to be Christian and have a personal relationship with Jesus Christ?

Yes No

The following questions are taken from the Duke University Religion Index, please check the response which best applies to you personally.

1. How often do you attend church or other religious meetings?

More than once a week

Once a week

A few times a month

A few times a year

Once a year or less

Never

2. How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?

More than once a day

Daily

Two or more times/week

Once a week

A few times a month

Rarely or never

3. In my life, I experience the presence of the Divine

Definitely true of me

Tends to be true

Unsure

Tends *not* to be true

Definitely *not* true

4. My religious beliefs are what really lie behind my whole approach to life.

Definitely true of me

Tends to be true

Unsure

Tends *not* to be true

Definitely *not* true

5. I try hard to carry my religion over into all other dealings in life.
- Definitely true of me
 Tends to be true
 Unsure
 Tends *not* to be true
 Definitely *not* true

1. Your satisfaction with the overall quality of relationship between you and your child.

2. Please rate the truth of the following statement “I enjoy spending time with my child and feel understood and respected.” _____

3. Please rate the truth of the following statement “I find it easy to talk to my child and feel that our communication skills are positive and effective.” _____

4. Please rate the truth of the following statement. “I feel that participation in this program will improve the quality of the relationship between me and my child.” _____

If selected to participate in this program, what time slot will fit into your schedule?

Please indicate times when you would be able to attend sessions. Sessions will occur at the same time for 6 consecutive weeks and last from 2 to 2 ½ hours. Mothers will attend all sessions; adolescents will accompany their mother to the final session only.

Day and Time	Can Attend these sessions	Can't Attend these sessions
Tuesday night from 6:00pm to 8:00pm		
Saturday morning from 9:00am to 11:00am		
Sunday afternoon from 2:00pm to 4:00pm		
Thursday night from 6:00pm to 8:00pm		
Saturday afternoon from 12:00pm to 2:00pm.		
Thursday morning from 8:00am to 10:00am		

Other times that would work better for me:

Appendix C



Mothers: Would you Like a Better Relationship with Your Adolescent??

You are invited to participate in a six-week intervention program and research study that may help. This program is based upon the promising results of leading theorists, and focuses upon the utilization of relationship enhancement to help parents and caregivers as they lovingly assist and guide their children to discover and answer God's calling for their lives. If you are the parent of an 11-14 year old and would be willing to participate in this study, please plan to attend an information meeting to be held [date] at Celebration Church, 429 Shipley Ferry Road, Blountville, TN

Or phone Valerie Waruszewski at ###-###-#### for more information.

Your participation in this program will be greatly appreciated!!

Appendix D

Script for Brief Explanation of Program

Thank-you so much for your interest in my research project. I have been studying a program called Child Parent Relationship Therapy which was developed by Bratton, Landreth, Kellam, and Blackard (2006). The goal of this program is to improve and strengthen the relationship, interactions, and “sense of trust, security, and closeness” (Landreth & Bratton, 2006) between parents or caregivers and their children. The original program takes ten weeks to implement and has been widely utilized with children up through the age of ten. What I would like to do for my dissertation, is to shorten this program from ten to six weeks, add biblical integration so that it will be established upon a strong and firm foundation, and extend its use to include the adolescent population.

During this program it is hoped that parents will develop improved empathy, sensitivity, understanding, and acceptance of their teens and pre-teens; and learn how to better encourage their children’s self-direction, self-responsibility, and self-reliance (Landreth & Bratton). Biblically speaking, and loosely translated, I hope that we, as parents, will learn to train up our children in the way that they should go, as commissioned by Proverbs 22:6, without provoking them to wrath as mentioned in Ephesians 6:4. This study also takes into consideration that God has knit everyone, including our children, together, stitch by stitch (Psalm 139:13), and infused each of us with special talents and abilities, that we must use in order to become unique and precious members of the Body of Christ (Ephesians 4:11-13). This program also sets a goal that children will become more skilled at communicating their thoughts, needs, and

feelings; and develop increased trust in the acceptance and security of their parents or caregivers. It is hoped that this will facilitate the changing of any negative perceptions regarding parents' feelings, attitudes, or behaviors into positive ones. In other words, it is hoped that your children will come to believe that you as parents "have their backs" and only their best interests at heart. This should encourage adolescents to honor their mothers and fathers and heed their advice, wisdom, instruction, and counsel; as commanded in Exodus 20:12 and Proverbs 1:8, which states "My son, hear the instruction of thy father, and forsake not the law of thy mother" (NIV).

Ok, so what will you need to do if you agree to help in my quest to obtain my doctorate degree and develop this relationship program? Good question. kids, your part is easy; you will just need to complete some assessments and commit to participating in activities with your mother once every week for five weeks. It can be anything you choose, as long as it is not dangerous or too expensive. These activities will take place at the same time and day each week and need to last for a minimum of 30-45 minutes. During this time, you will be in charge and can do what you like, without violating moral and safety limits. I will also need for you to do two more things. The first is to consider allowing your mother to videotape one of your play sessions to share with her group. This may seem a little weird, but it will allow the group and your mother to experience feedback and share in a hands-on learning experience which will be very beneficial to our program. The second thing I will ask is that you complete assessments that will allow change and progress to be monitored. If you agree, you will complete these tonight. You will then complete these again when you finish this program in six weeks and then, one final time six weeks after that. This will provide measures to examine lasting effects.

Because God has given parents the responsibility to see that children are trained in the way that they should go (Proverbs 22:6), mothers will need to do most of the work. In addition to completing assessments, mothers will need to attend six training sessions that will last between two and three hours, along with participation in the taping session that I just mentioned. You will also have the option of bringing your child with you to the final closing session. Based upon times of availability, parents will be placed into small groups for training sessions which will address the development of empathy and communication, motivational, and listening skills. You will also be asked to pray daily for your child.

As this is a study, there will need to be a way to measure the expected improvement in your relationships. This is the reason that everyone will be asked to complete some assessment tools at the beginning and end of this program, and pre and post-treatment scores will be compared. Participation in this study is totally and completely voluntary and you may withdraw at any time. Be assured that confidentiality is of the utmost importance. If you choose to participate, all assessments will be given a code number and no names will be used. All information will only be in the form of data and scores with absolutely no identifying factors or elements, and assessments will be kept in a locked filing cabinet in a secured room. There exists the possibility that the results of this study may be published in a professional journal. If this should happen, as previously mentioned, only statistical data and themes will be used and no identifying or personal information will be shared.

All studies involve a degree of risk. In this study, there is definitely the risk of being inconvenienced by needing to find and take time for sessions and activities. It is

hoped that this inconvenience will prove to be mild and manageable, and that supplying this information at this time will provide you the opportunity to easily rearrange schedules if needed. Another risk is that you may experience fatigue in taking the required assessments. To assist with this, every effort has been made to keep assessments at a minimum. Everyone is also encouraged to break and rest when needed while completing these forms and refreshments will be provided. A final risk is the possibility of a breach in confidentiality. Again, I would like to assure you that this is a top priority and every effort will be made, as previously discussed, to prevent this from occurring.

- At this time, a question and answer period will be held. During this time, no specific data will be shared which could contaminate the internal validity of the study.
- A closing prayer will be said asking for wisdom and blessings upon parents and children as they decide if they should participate in this study, and that it will prove to be beneficial to all and bring glory and honor to God.

The script will continue: I would like to assure you that much prayer has been lifted to cover this program and ask God to send people who will benefit from it. At this time, if you are agreeable to participate in my study, I would like to distribute the assessments and a consent form for you to complete. We have previously reviewed most of the information on the consent form, please read it carefully and feel free to ask any questions that you may have before signing it. Please feel free to use the restrooms or get refreshments as needed while you complete these forms. I would like to take this time to thank you again for your participation in my study and hope that it will prove to be beneficial to you. When you have finished the forms, please

put everything back into the envelope and leave them on your table or give them to me. After doing this, you will be free to leave. I will review the assessments and your time preferences and notify you as to when your group will be beginning the program. If you would like a copy of the consent form for your records, additional unsigned copies will be available on the front table as well as cards with my contact information. Again please do not hesitate to contact me should you have any questions, comments, or concerns. Thank-you.

ASSENT FORM FOR ADOLESCENT, AGES 11-14

Exploring the Utilization of Brief, Biblically Integrated, Relationship Enhancement Therapy to Improve Relationships Between Mothers and Adolescents from Christian Families
Valerie Waruszewski
Liberty University Center for Counseling and Family Studies



Hello, my name is Valerie Waruszewski and I am a doctoral student at Liberty University. I have invited you and your mother to be in a study to learn about relationships. My study has a big, scary name, but we are going to take time to break it down and explain it. I would like you to consider taking part in my study, but want you to know that choosing to participate or not is totally and 100% up to you (and your mother). Please look over this form, while we read it together, and ask any questions you may have.



Why Do this Study?

A lot of research has been done with younger kids, but this study would like to look at relationships between adolescents who are your age, 11-14, and their mothers. To do this, we will be using a program called Child Parent Relationship Therapy. This program helps persons learn to respect and listen to each other without judging. This study also wants to shorten this treatment so that it will fit into busy schedules, and include Christian values and beliefs. It is hoped that this program and study will be able to help you and your mom get along better, and tell us stuff that may help other kids and their parents too.



So, what will I Need to Do if I Agree to be in this Study?

1. First, you will be asked to read and sign this form and answer some questions about yourself.
2. Next, you will be asked to take two tests, at three different times. These will take you about 30 to 40 minutes to complete; and, if you agree to participate in this study, you will take them today, in six weeks, and in 12 weeks. (Your mother will be asked to answer some questions and take tests too!!) The questions and tests will show if you are a good fit for this program and if it is working.
3. After this, you will be asked to participate in five activity times with your mother. These will happen one time per week, and will last between 30 and 45 minutes. During these special times, you will be in charge and get to pick what you and your mother will

do. This can be anything you want from sports, to taking a walk, to making things, to cooking. There is one rule - have fun!! (oh, and the activities can't be dangerous, disrespectful, or megaexpensive).

4. The last thing you will be doing, if you want to and say it is ok, is that you and your mother will have the opportunity to have part of a session videotaped. If you chose to be videotaped, it will be used by your mother to check out what she is doing and saying during your activity times. As stated above, you may refuse to participate in this study, or in any part of it that makes you feel uncomfortable or threatened, at any time.



What could be Yucky about this Study?

This study includes several things that may be a little yucky or a pain in your neck:

1. First, you may become tired while taking the tests. To help with this, you can take breaks and get a snack whenever you want.
2. Second, the activity sessions with your mother will take up some of your time. It is hoped that this time will be fun for you and your mother and help you to get along better.
4. Finally, there is a risk that someone could see your test answers. To keep this from happening, I promise to keep everything safe and locked up.

I know you may be thinking that being in this study may be yucky and a lot of work, but I think you will have fun and, hopefully, your relationship with your mother will become stronger and more positive.



Keeping Things Private

Protecting your privacy and making sure that no one sees your test answers is very important to me. To help with this, I am the only one who will be able to see your answers and your name will be replaced with a secret code number. All tests will be locked in a filing cabinet in a safe place.



Voluntary Nature of the Study

Remember, all participation in this study is voluntary and you can quit at any time and refuse to do anything that makes you feel uncomfortable. You can also refuse to be videotaped if you are given that option.



What if you have Questions Later?

If you have any questions, at any time, you can call or text at ###-###-#### or email at vawaruszewski@liberty.edu.



Statement of Assent (Assent Means to Agree and Approve):

I have read the above information along with the researcher or my mother and understand it. I have been able to ask questions and received answers. I understand that my mother has given her permission for me to be in this study.

I agree to have a play session with my mother videotaped.

I prefer not to have a session videotaped.

I Have Read and Understand the above. I Understand the Purpose of this Study and What will be Expected of Me, and Agree to Participate.

Please Sign Your Name

Here: _____

Date: _____

Please Print Your Name

Here: _____

Date: _____

Signature of Investigator: Valerie Waruszewski, LPC, NCC, CT/RTC Date: _____

IRB Code# 1072.032911
IRB Expiration Date: March 29, 2013

Appendix F

Treatment Manual

Treatment Outline

Pre-session (optional, attended by mothers and adolescents)

Goal: Explain program and expectations, motivate participants, answer questions, and obtain needed paperwork.

1. Welcome mothers and adolescents, opening prayer.
2. Introduce and explain purpose and procedures of study to mothers and adolescents.
3. Answer any questions
4. Adolescents and mothers will complete assessments and any other needed forms.

Session One (attended by mothers only)

(See Appendix M for information and directions regarding handouts)

Goal: Introduce mothers to the program and concept of Filial therapy and begin to build group cohesion, explain activity sessions, share timeline for treatment.

1. Welcome Parents, opening prayer (3 minutes)
2. Introductions (10-15 minutes)
3. Complete assessments and needed paperwork if mother did not attend pre-session, explain procedure to obtain child assessments and paperwork.
4. Discuss background information regarding original CPRT (15 minutes)
5. Discuss goals and timeline and explain reasoning behind program procedures (15 minutes)

6. Distribute parent packet and have detailed discussion of weekly activities (20 minutes)
7. Distribute and discuss Handout #1, *Basic Principles of Activity Sessions*, show clip from DVD *Child Centered Play Therapy: A Clinical Session by Garry, Landreth* and highlight main points (20 minutes)
8. Break (15 minutes)
9. Questions and role play (30-45 minutes)
10. Discuss homework and review prior information regarding content of sessions (10 minutes)
 - 10.1 Set up time for sessions with your adolescent
 - 10.2 Review rules
 - 10.3 Same rules and session time every week
 - 10.4 No interruptions including cell phones and pagers
 - 10.5 Only parent and focus child included in sessions
 - 10.6 All activities are adolescent chosen and driven
 - 10.7 Stay non-judgmental and accepting, no suggestions or negative statements, no questions, have fun!
 - 10.8 If child has not previously completed needed paperwork and assessments, have these completed prior to participating in first activity session and return at the beginning of Session Two.
11. Discuss needed logs and paperwork
12. Pray daily for child and program
13. Distribute, read, and ask for comments regarding the poem, *If I Had My Child to*

Raise over Again by Diane Loomans (Handout #2). (5-10 minutes)

14. Questions and closing prayer (15-20 minutes)

Session Two (attended by mothers only)

Goal: Continue to build group cohesion and assist mothers to feel more comfortable with weekly play sessions, teach empathy and emotion identification, discuss importance of building and strengthening confidence and self-esteem in children.

1. Informal interaction and snacks (10-15 minutes)
2. Opening prayer
3. Collect children's assessments and paperwork if they did not attend pre-session.
4. Review homework (30-45 minutes)
5. Discuss activity noting any barriers or concerns, role play if appropriate (30-45 minutes)
6. Distribute and discuss Handout #3, *Do's and Don'ts* (20 minutes)
7. Distribute and discuss Handouts #4 and #5, *Esteem and Confidence Building Responses and Positive Character Qualities* (20 minutes)
8. Break (15 minutes)
9. Distribute *Feelings Response: In-Class Practice Worksheet* and *Emotions Vocabulary Chart* Handouts #6 and #7, and discuss and role play reflecting emotions (30 - 45 minutes)
10. Discuss Homework
 - 10.1. Second activity session – focus on including more emotional reflection

10.2. Find a Bible verse that will be encouraging to the other parents for closing next week.

10.3. Continue to pray for our children, each other, and this program.

11. Closing activity for session (5 minutes)

12. Read the *Butterfly Story*, Handout #8.

13. Closing Prayer

Session Three (attended by mothers only)

Goal: Teach mothers skills to set limits and reinforce emotion reflecting.

1. Time for informal interaction, sharing, and snacks (15 minutes)

2. Opening Prayer

3. Review last week's homework, discuss, barriers, complications, concerns, and praise reports (30-45 minutes)

4. Practice reflecting emotions in pairs (20 minutes)

5. Break (15 minutes)

6. Distribute and discuss *Limit Setting A-C-T* Handout #9 (10 minutes)

7. Role play scenarios (30 minutes)

8. Distribute and discuss *Common Problems in Activity Sessions* Handout #10 (20 minutes)

9. Discuss videotaping session and set up schedule (10 minutes)

10. Discuss homework (5 minutes)

10.1. Videotaping session

10.2. 3rd activity session

- 10.3. Pray daily for each other, our children, and the program
11. Share Bible verses and encourage parents (15 minutes)
12. Questions
13. Closing Prayer

Session Four (attended by mothers only)

Goal: Teach listening skills, including being attentive to tone of voice and body language, discuss importance of touch and giving choices to improve problem solving skills.

1. Informal interaction, sharing, and snacks (15 minutes)
2. Pray
3. Discuss homework and play sessions
4. Watch two (or more as needed depending upon size of group) videos or role plays and comment utilizing the *Activity Session Skills Checklist* Handout #11, comment on what is child feeling, what is parent feeling? Mothers will be given the opportunity to brainstorm real life situations and concerns. (45 minutes)
5. Break (15 minutes)
6. Watch remaining video/s or role play and comment utilizing the *Activity Session Skills Checklist*, Handout #11 (30 minutes)
7. Review limit setting; distribute and discuss Handouts #12 and #13 *Choice-Giving 101* and *Advance Choice-Giving: Providing Choices as Consequences* (20 minutes)
8. Discuss Homework
 - 8.1. 4th play session

- 8.2. Attend videotaping session if not previously done
- 8.3. Pray daily for your child, each other, and the program
- 8.4. Attempt to use choice giving in daily interactions with adolescent
- 8.5. Utilize the sandwich hugs and kisses intervention with adolescent if parent feels comfortable with this and adolescent is receptive.
9. Briefly discuss importance of touch, introduce sandwich hugs and kisses and encourage parents to use this intervention with their teens if they feel comfortable doing this and the teen is receptive. (5 minutes)
10. Questions
11. Closing Prayer

Session Five (attended by mothers only)

Goal: Discuss importance of encouragement and praise.

1. informal interaction, sharing, and snacks (15 minutes)
2. Opening Prayer
3. Discuss homework, including any comments regarding choice giving experiences, focus on praise reports from activity sessions (15 minutes)
4. Expand on choice setting stressing being firm, matter of fact, and consistent, hand out and discuss *Generalizing Limit Setting to Outside the Activity Sessions*, Handout #15 (30 minutes)
5. Review do's and don'ts of Filial therapy (10 minutes)
6. Watch one or two videos (or more as needed) or role plays and comment utilizing the *Activity Session Skills Checklist*, Handout #11 (45 minutes)

7. Break (15 minutes)
8. Watch remaining video/s or role play and comment (45 minutes)
9. Distribute and discuss Handout #14 *Encouragement vs. Praise* (15 minutes)
10. Discuss Homework
 - 10.1. 5th activity session
 - 10.2. Daily prayer for your child, each other, and program
 - 10.3. Mail letter of encouragement, appreciation, and praise to child.
 - 10.4. Have children complete time 2 assessments after completion of 5th activity session and return next week if children will not attend Session Six.
11. Graduation ceremony, distribute certificates to parents, if children will attend the final session, and group time for encouragement (10 minutes)
12. Questions
13. Closing Prayer

Session Six (attended by mothers, optional for children to attend)

Goal: Debrief, review, and encourage mothers and adolescents to continue to work toward improving their relationships, complete time 3 assessments.

1. Informal interaction and snacks (15 minutes)
2. Opening prayer
3. Discuss therapy experience noting any changes between first and last play session and any thoughts or suggestions (30 minutes)
4. Review highlights of videoed sessions allowing any attending adolescents to comment on how they felt or role play and address any concerns or challenges.

- Review information from previous sessions utilizing the *Rules of Thumb* Handout, #16 sharing concerns, questions, and successes (30 min.)
5. Break (15 minutes)
 6. Debrief, discuss and encourage the continuation of sessions (10 minutes)
 7. Closing, bonding activity if children attend or graduation ceremony is they do not (10 min.)
 8. Discuss procedures to obtain follow-up assessments in six weeks
 9. Final discussions, comments and questions
 10. Closing Prayer
 11. Complete time 2 assessments

Script for Sessions

Pre-session (optional, attended by mothers and adolescents)

1. Welcome mothers and adolescents and open with prayer. (5 minutes)
2. Introduce and explain study purpose and procedures to mothers and adolescents.
(30 minutes)

Thank-you so much for your interest in my research project. I have been studying a program called Child Parent Relationship Therapy which was developed by Bratton, Landreth, Kellam, and Blackard (2006). The goal of this program is to improve and strengthen the relationship, interactions, and “sense of trust, security, and closeness” (Landreth & Bratton, 2006) between parents or caregivers and their children. The original program takes ten weeks to implement and has been widely utilized with children up through the age of ten.

What I would like to do for my dissertation, is to shorten this program from ten to six weeks, add biblical integration so that it will be established upon a strong and firm foundation, and extend its use to include the adolescent population. During this program it is hoped that parents will develop improved empathy, sensitivity, understanding, and acceptance of their teens and pre-teens; and learn how to better encourage their children’s self-direction, self-responsibility, and self-reliance (Landreth & Bratton). Biblically speaking, and loosely translated, I hope that we, as parents will learn to train up our children in the way that they should go, as commissioned by Proverbs 22:6, without provoking them to wrath as mentioned in Ephesians 6:4. This study also takes into consideration that God has knit everyone, including our children, together, stitch by stitch (Psalm 139:13),

and infused each of us with special talents and abilities, that we must use in order to become unique and precious members of the Body of Christ (Ephesians 4:11-13).

This program also sets a goal that children will become more skilled at communicating their thoughts, needs, and feelings; and develop increased trust in the acceptance and security of their parents or caregivers. It is hoped that this will facilitate the changing of any negative perceptions regarding parents' feelings, attitudes, or behaviors into positive ones. In other words, it is hoped that your children will come to believe that you as parents "have their backs" and only their best interests at heart. This should encourage teens and pre-teens to honor their mothers and fathers and heed their advice, wisdom, instruction, and counsel; as commanded in Exodus 20:12 and Proverbs 1:8, which states "My son, hear the instruction of thy father, and forsake not the law of thy mother" (New International Version).

Ok, so what will you do if you agree to help in my quest to obtain my doctorate degree and develop this relationship program? Good question. Kids, your part is easy; you will complete some assessments and commit to participating in activities with your mother once every week for five weeks. These activities will take place at the same time and day each week and will last for a minimum of 30-45 minutes. During this time, you will be in charge and can do anything you choose, as long as it is not dangerous or expensive. There will be two additional things that you will be asked to do. The first is to consider allowing your mother to videotape one of your play sessions to share with her group. This may seem a little

weird, but it will allow the group and your mother to experience feedback and share in a hands on learning experience which will be very beneficial to our program. The second thing you will need to do is complete assessments that will facilitate the monitoring of change and progress. If you agree, you will complete these tonight. You will then complete these again when you finish this program in six weeks and then, one final time six weeks after that. This will allow for the measurement of lasting effects.

Because parents have been given the responsibility by God to see that children are trained in the way that they should go (Proverbs 22:6), mothers will need to do most of the work. In addition to completing assessments, mothers will be asked to attend six training sessions that will last between two and three hours, in addition to the taping session that I just mentioned. You will also attend the final closing session with your child. Based upon times of availability, parents will be placed into small groups for training sessions which will address the development of empathy and communication, motivational, and listening skills. You will also be asked to pray daily for your child, the program, and other participants.

As this is a study, improvement in relationships will be measured. This is the reason that everyone will be asked to complete some assessment tools at the beginning and end of this program, (pre and post-treatment). This will provide scores which can then be analyzed to examine for significant change. Participation in this study is totally and completely voluntary and you may withdraw at any time. I would like to assure you that confidentiality is of the utmost importance. If you choose to participate, all assessments will be given a code number and no

names will be used. All information will only be in the form of data and scores with absolutely no identifying factors or elements, and assessments will be kept in a locked filing cabinet in a secured room. There exists the possibility that the results of this study may be published in a professional journal. If this should happen, as previously mentioned, only statistical data and themes will be used and no identifying or personal information will be shared.

All studies involve a degree of risk. In this study, there is definitely the risk of being inconvenienced by needing to find and take time for sessions and activities. It is hoped that this inconvenience will prove to be mild and manageable, and that supplying this information at this time will provide you the opportunity to easily rearrange schedules if needed. Another risk is that you may experience fatigue in taking the required assessments. To assist with this, every effort has been made to keep assessments at a minimum. Everyone is also encouraged to break and rest when needed while completing these forms, and refreshments will be provided. A final risk is the possibility of a breach in confidentiality. Again, I would like to assure you that this is a top priority and every effort will be made, as previously discussed, to prevent this from occurring.

3. At this time, a question and answer period will be held. During this time, no specific data will be shared which could contaminate the internal validity of the study. (20 minutes)
4. A closing prayer will be said asking for wisdom and blessings upon parents and children as they decide if they should participate in this study. Prayer will also ask that this participation in this program, will prove to be beneficial to all and

bring glory and honor to God.

5. Children and mothers will complete assessments, demographic surveys, and informed consents. (45 min)

The script will continue: I would like to assure you that much prayer has been lifted to cover this program and ask God to send people who will benefit from it. At this time, if you are agreeable to participate in my study, I would like to distribute the assessments and a consent form for you to complete. We have previously reviewed most of the information on the consent form, please read it carefully and feel free to ask any questions that you may have before signing it. Please feel free to use the restrooms or get refreshments as needed while you complete these forms. I would like to take this time to thank you again for your participation in my study and hope that it will prove to be beneficial to you. When you have finished the forms, please put everything back into the envelope and leave them on your table or give them to me. After doing this, you will be free to leave. I will review the assessments and your time preferences, and notify you as to when your group will be beginning the program. If you would like a copy of the consent form for your records, additional unsigned copies will be available on the front table as well as cards with my contact information. Again please do not hesitate to contact me should you have any questions, comments, or concerns. Thank-you.

Session One (attended by mothers)

(See Appendix M for information and details regarding handouts)

1. Mothers who did not attend the pre-session will be expected to come to this session 30 minutes early. Pre-session information will be shared and assessments, information sheets and consent forms completed.
2. Mothers are encouraged to interact prior to the beginning of this session and refreshments will be served.
3. Welcome parents (30 seconds) –
Hello, I think that I have already met everyone. My name is Valerie Waruszewski and I would like to welcome you all here (today or tonight) and thank you again for agreeing to participate in this study program that will focus upon helping our adolescents make choices that will honor God in their desires, thoughts, emotions, and actions.
4. Open with prayer (2 minutes) —
Prayer will request blessings upon the caregivers and children involved in this study, and ask for wisdom to follow God’s will in all things. It will also ask for healing for prior conflict and hurt, and Gods guidance and leadership for this session and the program.
5. Introductions (10-15 minutes) —
We are here today to learn skills which will hopefully improve our communication and relationship with our children. I would like for us to introduce ourselves. Could everyone share about yourself, your child of focus, and what brings you here today?

6. Discuss background information regarding CPRT (15 minutes)—

The program that we will be discussing and using is called Child Parent Relationship Therapy, CPRT for short, which was developed by Bratton, Landreth, Kellam, and Blackard (2006). This program has been widely used and has been the focus of numerous studies that have reported favorable results in reducing and managing conflict with children and increasing relationship satisfaction (Landreth & Bratton, 2006). The goal of the original ten-week program is to improve and strengthen the relationship, interactions, and sense of trust, security, and closeness between parents or caregivers and their children up through the age of ten. What we will be doing is taking CPRT, condensing it into six weeks, adding biblical integration and prayer so that it will be established upon a strong and firm foundation, and extending its use to include the 11-14 year old population.

Without boring everyone, CPRT is based upon the works of several great theorists who proposed that relationship is the most important element of all therapy, and that strong, positive, and healthy relationships with others are necessary in order for persons to become mentally and physically healthy. When our children are defiant, rebellious, and make choices that appear to be disobedient and disrespectful, parents often think that this is a decision of the will or a head problem. The Bible supports this through speaking of behaviors such as being a sluggard, lying, arrogance, stealing, mocking, and gloating (Exod. 20:15; Lev. 19:11; Prov.6:6; Ps. 17:4-7, NIV), and tells us, in Proverbs 13:24, that “He who spares the rod, hates his son.” Punishments that we sometimes use, such as

grounding and removing privileges, are based upon this and are often successful in bring about desired behaviors (Holden, 2002; Slade & Tapping, 2008). As our children begin to approach adulthood, however, they begin to form their own preferences and styles of doing things, and begin to consider their own values and belief systems when making choices and decisions (Jaffe, 2003). Behavior then, begins to become a heart problem and to involve feelings, respect, insight, understanding, and rationalization (Bratton et al., 2006). Do you believe that spanking can change values and beliefs? (parent response)

In returning to the Bible and thinking of personal experiences, does our Father, God, always apply the rod to us when we make a mistake or are lazy, disobedient or rebellious? When Jesus encountered Zacchaeus in Luke 19, He did not condemn or judge him; instead, He took the time to personally accompany him to his home and ate supper with him. Likewise, when He met the woman at the well in John 4, He sat down, asked for a drink of water, and talked to her, one on one. Jesus, Himself, became man and came to earth to live with us and give us a model to live by, and God tells us to pray and communicate with Him, and gave us the Bible, itself, to instruct and guide our lives. Through His relationship with us, God lovingly guides and teaches us how to follow His commands and to discern and reach for “whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable” (Phil. 4:8), and to think about what is excellent or praiseworthy.

In the very next verse, Philippians 4:9, Paul goes on to say “whatever you have learned or received or heard from me, or seen in me—put it into practice.” I

think that this verse implies taking time to personally instruct, teach, and model. The goal of this program is not to imply that your teens should not complete their obligations and responsibilities at home and in school. This would be contrary to Proverbs 6:6 which tells sluggards to consider the way of the ant and become wise, and Ephesians 6:1 which instructs children obey their parents “in the Lord, for this is right.” The goal, instead, is to focus upon slowing down and taking the time to develop, build, repair, and enhance personal relationships with your child, as instructed in Deuteronomy 6:6-7, which tells parents to train their children in righteousness.

“These commandments that I give you today are to be upon your hearts. Impress them on your children. Talk about them when you sit at home and when you walk along the road, when you lie down and when you get up.” Do we take time, as these verses direct to talk to our children every morning and night? Do we sit with them and walk with them, or merely present them with orders that we expect to be obeyed, with no thought as to how they can best utilize the special talents, abilities, and creative styles that God lovingly knit into their beings (Psa. 139:13)? During these next five weeks, it is my goal and desire to assist you and your child to develop a strong and healthy relationship that will enable him or her to feel that you love, understand, support, and accept them. This should, in turn, motivate and inspire them to make the healthy, positive, and productive choices they will need to follow God’s commands and plans for their lives.

7. Discuss program procedures and timeline (20 minutes)—

(Distribute parent packets) In these packets I have included a brief background of relationship enhancement therapy and CPRT, a timeline, suggestions for activities, an activity log, and my contact information. Please feel free to contact me at any time during this program should you have any questions or concerns.

- Distribute and complete time 1 assessments and paperwork if this has not previously been completed.

OK, let's talk about our program. It consists of several steps, one of which you have already completed – yeah!!

- You have all previously completed the assessments that I needed for this study and did a great job, thank-you.
- For this week and each of the next five weeks, we will meet as a group during this same time slot to learn skills that will assist you to build a stronger relationship with your teen.
- You will be participating in a total of five activities with your child, which we will be discussing in greater detail in a few minutes.
- You will log the activity every week on the sheet provided in your packet, listing date, duration, and a brief description of the activity.
- You will be given the option of attending a taping session with your child in order to obtain feedback.
- You and your teen or pre-teen will have the option to attend the final session together to share experiences, debrief, and complete assessments.

- You and your child will be requested to complete assessments after a six week period to ascertain if progress will be maintained after this program has ended.
- And finally, but most importantly, you will be asked to pray daily for your child, the other parents in your group, and this program.

8. Detailed discussion of weekly activities (20 minutes)—

Now, I would like to consider the activity portion of this program. In order to build and strengthen your relationship with your child, you will be asked to participate in one activity per week that must last a minimum of 30-45 minutes. This activity needs to occur on the same time and day each week for five consecutive weeks. When you go home today, part of your homework assignment is to sit down with your child and work this out. It can be anytime that works for both of you, it can be before or after school, or on a weekend, it does not matter as long as it is the same time and day for five consecutive weeks and decided upon by both of you. Depending upon the day you choose, you will participate in an activity later this week or begin next week, as today is_____. Setting a specific time and day is important as it will allow your child to know that spending time with him or her is important to you and that you will be setting this as a priority in your life.

There will be several rules and guidelines for these activities. The first is that there are to be no cell phones, pagers, or Blackberries so that you and your teen will have each other's total attention for the full length of the activity. As a goal of this program is to help your child feel that he or she is valued, supported, and

accepted by you, your teen or pre-teen will choose and lead all activities. During activities, you will support and encourage your child, focus upon his or her strengths and achievements, and place yourself on a level that is equal to him or her rather than the normal authoritarian role of a parent. There should be no directing or requirements, no judging, evaluating, or advice giving; and no reprimands, put-downs, or negative communications; only encouragement and positive interactions must occur. In this way, you will learn to focus upon your child and his or her needs, feelings, questions, and wants without the need to address problems or promote an agenda.

These activities enable us to learn more about each other as people and develop closeness, support, and understanding. It is hoped that your desire to spend time with your child and sincere attempt to get to know him or her on an intimate level, will improve the quality and depth of your relationship. When your child begins to feel valued and understood, it is thought that he or she will want to form an even closer relationship with you and feel confident in accepting and using your advice and guidance in making choices and decisions (Glasser, 1998; 2002).

Through allowing your child to choose the activity and set the tone, pace, and direction, you will be showing him or her that you are aware of his or her unique concerns, feelings, strengths, and identity; and value him or her as an individual.

Your participation in these weekly activities will also enable you to glean information that will make it possible for you to look beyond your child's disobedience and defiance and focus upon discovering the underlying reasons for these. These reasons can then be addressed through interactive relationship in

which the child is held accountable for his behaviors (Allison & Allison in Walker & Quagliana, 2007) and learns problem solving skills to manage and change them (Barkley et al., 1999). In another program, developed by Pianta and Hamre (2001) for use in school systems, this activity time is referred to as “Banking Time” during which teachers and students save up positive experiences so that their relationship can “withstand conflict, tension, and disagreement without deteriorating and returning to a negative state” (p. 30). It is hoped that the child and teacher, or in our case, you and your teen will be able to build up enough positive relationship “capital” so that you can “withdraw” from it during times of conflict, disagreement, and stress.

Let’s consider specific activities which will be conducive to relationship enhancement and positive outcomes. If you look at page five of the handout, which has just been distributed to you, there is a list of suggested activities. As you will notice, activities do not have to be complicated and can be as simple as putting together a puzzle, taking a walk, or grabbing some fast food and going to a park for a picnic. Although going to see a movie is a listed activity, make sure that you have time to communicate and interact before or after this to help increase your knowledge and understanding of your child and promote communication. On page six is an activity which asks questions in order to facilitate a deeper level of communication and understanding between you and your child. The sentences can be cut out, their numbers can be copied and placed in a container and randomly drawn, or each party may choose what they would like to ask the other. If your teen or pre-teen chooses this activity, it is important

that he or she makes all decisions regarding how it should be used, as the parent must not take on a role of leader or teacher.

To recap, what we want to do is establish a special designated time during which you and your teen or pre-teen will be focusing on a common activity which is selected and led by him or her. During this time, your child should feel as though he or she has all of your attention, is totally loved and accepted by you, and, for this special time, occupying the place which is at the very center of your universe where you will display the following four attitudes: *I am here, I hear you, I understand, and I care.*

9. Distribute and review Handout #1, *Basic Principles of Activity Sessions* (Landreth & Bratton, 2006) , show clip from DVD *Child Centered Play Therapy: A Clinical Session by Garry, Landreth* (Play Therapy Institute, 1997) and highlight main points (20 min)—
10. Break (15 min)—
11. Discuss what mothers have viewed in videos and answer any questions. Discuss any concerns and brainstorm regarding possible ideas for activities. Stress that activities need to be chosen and led by the child. Discuss handout sheet with suggestions. Role play activity sessions as needed. Discuss benefit of working through silence and quiet times and encourage mothers to only include the focus child and avoid distractions. (30 min)—
12. Mothers will practice reflecting statements as a group and any questions or concerns will be addressed. (15 min)—
13. Discuss homework (10 min)—

- Participate in an activity with your adolescent and be prepared to discuss this next week.
- Discuss procedures to complete and return children's assessments and distribute these to parents if not previously completed. Stress that these must be completed prior to the first activity session and returned at the beginning of Session Two.

14. Review rules for sessions

- All sessions must occur at the same time and day every week for the next five weeks and last for at least 30-45 minutes.
- No interruptions including cell phones and pagers.
- Only parent and adolescent involved in activity sessions.
- All activities are adolescent chosen and driven.
- Stay non-judgmental and accepting, no suggestions or negative statements.

15. Discuss needed logs and paperwork.

16. Pray daily for child and program. A final consideration of this study is the importance of praying for our children every day (Hindson, Ohlschlager, & Clinton, 2002; Richards & Bergin, 2005). I know that many of you currently do this, but praying specifically for God's guidance as you and your child undergo this program and for improvement in your relationship with your child, will prove to be invaluable and a major determinant of outcome. I promise to be in prayer for each of you as well, during the next six weeks.

17. Read Poem in Handout #2, *If I Had My Child to Raise over Again* by Diane Loomans (2008).

18. Questions and closing prayer. Discuss Deuteronomy 31:8, “The LORD himself goes before you and will be with you; he will never leave you nor forsake you. Do not be afraid; do not be discouraged.” It is hoped that through this program, your child will gain the confidence and reassurance to know that you can be a strong support for them and not forsake them as they make the choices and decisions that will enable them to follow the special and unique calling and ministry that God has established for them.

Session Two (attended by mothers)

1. Informal interaction and snacks (10-15 minutes) –
2. Opening Prayer
3. Review last week’s homework, collect children’s assessments if needed (30-45 minutes)—
 - Discuss activities, noting any barriers or concerns, role play concerns if appropriate.
 - Encourage the parents and reinforce that the goal of the first session was to have a positive sharing experience with their teen.
4. Distribute and discuss *Activity Session Do’s and Don’ts* Handout #3 (adapted from Bratton et al. , 2006, p. 18) adding don’t do for a child what he can do for himself (20 minutes)—
5. Distribute and discuss Handout #4, *Esteem and Confidence Building Responses* (adapted from Bratton et al., p. 216) and Handout #5, *Positive Character Qualities* (Bratton et al., p. 217) (20 minutes)—
6. Break (15 minutes)—

7. Distribute, discuss, and complete Handout #6, *Feelings Response: In-Class Practice Worksheet* (Bratton et al., pp. 184-185) role play being attentive to and reflecting emotions (30-45 minutes)—
 - Share Landreth’s and Bratton’s (2006) analogy of being a mirror that reflects back the child’s feelings. The power of the reflection depends upon how closely the parents’ words can capture the content and intensity of what the teen is feeling. “Children whose mirror reflects acceptance, encouragement, and affirmation will feel accepted, valued, and worthwhile” (p. 138).
 - Two volunteers role play in which one person is discussing a concern and the other is portraying a lack of interest by not making eye contact and not listening to what is being said. The therapist will then ask a volunteer to discuss something that happened with their teen this week and model positive and accurate emotion reflection. Discuss these role plays with the group.
 - Distribute and briefly discuss Handout #7, *Emotions Vocabulary Chart* (ami-tx, n.d.). Have parents divide into pairs and role play in which one parent is instructed to discuss a concern while the other parent reflects back emotions. Discuss how parents feel when emotions were accurately and inaccurately reflected.
8. Discuss homework (5 minutes)—
 - Second activity session –encourage parents to utilize emotional reflection.

- Find a Bible verse that has been encouraging to you to share with other parents during closing next week.
 - Continue to pray for our children, each other, and this program.
9. Closing activities for session (5 minutes)—
- Encourage parents regarding activity sessions and applaud their willingness to commit this time to strengthen their relationship with their teen.
 - Handout # 8, *Butterfly Story* (Bratton, et al., 2006, p. 216).
10. Questions and closing prayer.

Session Three (attended by mothers only)

1. Informal interaction and snacks (10 minutes) –
2. Pray
3. Review last week’s homework (30-45 minutes)—
Discuss activity, any barriers or complications? Role play concerns if appropriate.
4. Practice reflecting emotions in pairs (20 minutes)—
5. Break (15 minutes)—
6. Distribute and discuss Handout #9, *Limit Setting A-C-T* (adapted from Bratton, et al., 2006, p. 196) (30 minutes)— Discuss Hebrews 5:12-14, 1 Corinthians 3:1-3, and Proverbs 22:6 and God’s desire for His people to develop problem solving skills which are guided by the Spirit and not the world.

7. Role play scenarios - Ask group for suggestions for scenarios for parent pairs to role-play. Possible topics may be concerns regarding cell phone, car, or computer use; homework, chores, curfews, disrespectful language or speaking, interactions with siblings, and choice of friends. (30 min)—
8. Distribute and discuss Handout #10, *Common Problems in Play Sessions* (adapted from Bratton, et al., pp. 210-211) (20 min)—
9. Discuss videotaping session and set up schedule to be taped (if desired), and reviewed during the next two sessions (10 minutes)—

Each parent-child couple will be asked to video tape 20-30 minutes of their activity time. They will be given the option of doing this independently, with their own equipment to bring to class, or coming to the church to be videotaped. If possible, parents who choose the first option will be asked to give the therapist a copy of their tape or memory card to be used during the final session. At the church, play dough, a deck of cards in a basket, two Etch a Sketches, water colors, paper, brushes, and water; a Nerf basketball and hoop, a Slinky, and checkers will be available on a table. The couple will enter the room and the child will be requested to lead an activity and informed that this will be videotaped and used to provide his or her parent with feedback. This session will be videotaped by an assistant with no interaction with the parent-child pair. A final option is that the mother can opt to role play an interaction with another group member or the group facilitator during the fourth or fifth session.
10. Homework (5 minutes)—
 - Attend videotaping session or videotape an activity session

- 3rd activity session
- Daily prayer for children, each other, and the program

11. Closing sequence (15 minutes)—

- Share and briefly discuss Bible Verses
- Question and answer period

12. Closing Prayer

Session Four (attended by mothers only)

1. Informal interaction, sharing, and snacks (15 minutes)
2. Opening prayer
3. Discuss homework and activity sessions (15 minutes)
4. Group will watch and evaluate two (or more as needed depending upon size of group) videos utilizing Handout #11, *The Activity Session Skills Checklist* (Bratton et al., 2006, p. 203), which encourages parents to be attentive to reflections of child's non-verbal and verbal communications, feelings, and wants; as well as the parent's use of encouragement/self-esteem building responses, empathy, and the "Be With" attitudes. If mothers and children opt to not be videotaped, this can be role played with other group members or facilitator. (45 minutes)—
5. Break (15 minutes)—
6. Watch and evaluate remaining video/s or role play. (30 minutes)—
7. Review limit setting; distribute and discuss Handout #12, *Choice-Giving 101* (Bratton et al., p. 208) and Handout #13, *Advance Choice-Giving: Providing*

Choices as Consequences (Bratton et al., p. 209) and ask parents to give suggestions and opinions regarding applying this to real-life situations (20 minutes)—

8. Discuss new homework assignments (5 minutes)—

- 4th play session
- Attend videotaping session if not previously done
- Pray daily for children, each other, and the program
- Attempt to use choice giving in daily interactions with teen.
- Practice the intervention of “sandwich hugs and kisses” (Landreth & Bratton, 2006) with your child if parent feels comfortable with this and child is receptive.

9. Briefly discuss importance of touch, introduce sandwich hugs and kisses. (5 minutes)—

- In his book, *The Neuroscience of Human Relationships*, Cozolino (2006) states that touch is an important element for healthy physiological regulation and helps to activate several parts of human brains including the “insula, anterior cingulate, and orbital medial cortex” (p. 103). Cozolino states that “the skin is our largest sense organ” (p. 102) and when it is touched or massaged oxytocin and endorphins are released which bring about a decrease in stress hormone levels and an increase in one’s sense of well-being. This neuroscientist also presents research which supports that touch has been shown to decrease negative symptoms in adolescents who are depressed and aggressive.

- Landreth and Bratton suggest the use of sandwich hugs and kisses as a fun way to share touch with their children. A sandwich hug is when you and another person act as the bread and “sandwich” your child between you for a “big physical, noisy hug, umm-ummm” (pg. 268). A sandwich kiss is defined as putting your fists on your “cheeks and pushing in while making a big kissing noise ummm-smack” (pg. 268). It is hoped that Sandwich Hugs and Kisses will assist parents to regain some joy in their parenting as well as build some warm and happy memories.
- Discuss Jesus’ use of touch in allowing the children to be brought to Him in Mark 10:13-16, and to provide acceptance, support, and healing to the leper in Mark 1:40-42. (5 minutes)—

10. Questions and comments

11. Closing prayer

Session Five (attended only by mothers)

1. Informal interaction, sharing, and snacks (15 minutes)—
2. Opening prayer
3. Discuss homework, including any comments regarding choice giving experiences, focus upon praise reports from activity sessions. Role play as needed. (25 minutes)—
4. Briefly review choice setting, stressing the importance of being firm, matter of fact, and consistent (15 minutes)—
5. Distribute and discuss Handout #15, *Generalizing Limit Setting to Outside the Activity Sessions* (Bratton et al., p. 230) .

6. Review Do's and Don'ts of Filial therapy (10 minutes)—
7. Watch and evaluate one or two (or more as needed) videos or role plays utilizing Handout #11, *The Activity Session Skills Checklist* (Bratton et al., p. 203) (30-45 minutes)—
8. Break (15 minutes)—
9. Watch and evaluate remaining video/s or role play as needed. (30 minutes)—
10. Distribute and discuss Handout #14, *Encouragement vs. Praise* (Bratton et al., 2006, p. 222). Discuss that the word encourage is used 54 times in the Bible, and that God instructs His people to encourage one another in 2 Corinthians 13:11. Brain storm and role play using encouraging statements rather than praise. (30 minutes)—
11. Assign and discuss new homework
 - 5th activity session
 - Daily prayer for children, each other, and the program
 - Mail letter of encouragement, appreciation, and praise to teen
 - Parents who independently taped an activity with their children, and did not provide the therapist with a copy, will need to bring tapes and equipment as needed, for a sharing exercise next week.
 - Distribute children's assessments and discuss procedures for administration if children will not attend the final session. Assessments should be completed after having the 5th activity session and returned at the beginning of Session Six.

12. Give certificates of completion or ribbons to parents if children will attend the final session and have group time for review and encouragement (10 minutes)
13. Questions and comments. Ask mothers, what is one thing that they learned today that they will try to apply during their activity session this week?
14. Closing Prayer

Session Six (mothers attend, optional child attendance)

1. Informal interaction and snacks (15 minutes)—
2. Opening prayer
3. Collect child assessments if they do not attend this session.
4. Discuss therapy experience noting any changes between first and last play session and any thoughts or suggestions (30 minutes)—
5. Share any comments or praise reports from last week's activity (10 minutes)—
6. Review highlights of videoed sessions allowing parents and any attending adolescents to comment on their thoughts, behaviors, and emotions (30 minutes)—
 - The researcher will review videos if available and make one tape which captures all of the previously discussed and taught skills and show this to the group for feedback and comments, or show a random, brief excerpt from each taped session, and focus upon asking children and parents how they felt during each interaction. Parents who independently taped will need to bring their equipment, CD, tape, or memory card to this session for this exercise. If parents are not agreeable to this, a parent-adolescent activity will be substituted.

7. Break (15 minutes)—
8. Distribute and discuss Handout #16, *Rules of Thumb* (Bratton et al., pp. 239-239), to review (20 minutes)-
9. Debrief, discuss, and encourage the continuation of sessions (10 minutes)—
 - Review goal of therapy, to improve and strengthen the relationship, interactions, and sense of trust, security, and closeness between parents or caregivers and their children and allow parents and teens to make any comments or observations.
10. Remind the group of the need for follow-up assessments to be completed in six weeks.
 - Researcher will verify contact information and discuss procedure to complete these assessments. Parents and adolescents will be given a time, date, and location when assessments will be administered, preferably this will be the same time as previous parent sessions, or given the option to have these mailed.
11. Final discussions, comments, and questions. Distribute certificates and ribbons if not done during Session Five.
12. Closing Prayer
13. Complete and secure time 2 assessments (45 minutes)—

Appendix G

Mother Handout

“The LORD himself goes before you and will be with you; he will never leave you nor forsake you. Do not be afraid; do not be discouraged.” (Deut. 31:18, NIV).

Dear Parent or Caregiver:

Thank-you for agreeing to participate in this research project. Your participation will assist in exploring and determining the efficacy of short-term, biblically integrated relationship enhancement therapy in improving relationships between mothers and adolescents from Christian families. It is hoped that instructing and encouraging Christian parents to spend time interacting with their children will provide them with an additional tool to utilize in fulfilling their ministry of training their children in the way they should go (Proverbs 22:6).

As previously mentioned, this therapy is based upon the work of Rogers (1951), Sullivan (Mullahy, 1952), Glasser (1998), and Landreth (2002) who maintain that relationship and interactions with others are the key to growth. It is believed that, through participation in the suggested activities in a positive and non-judgmental way, parents and adolescents will be able to communicate simultaneously on several levels, such as emotional, visual, tactile, and cognitive, to strengthen their relationship. It is hoped that your child will feel accepted and supported, and begin to express, explore, and identify feelings, motivations, values, beliefs, talents, abilities, and preferences; and that creative forces will be released that will generate a process for change and growth (Landreth).

In examining specific programs and therapies, Relational Enhancement therapy (Ginsberg, 1997), Attachment-Focused Family therapy (Hughes, 2007), Bounceback (McGrath & Noble, n.d.), Students, Teachers, and Relationship Support (Pianta & Hamre, 2001), Child Parent Relationship Therapy (Bratton, Landreth, Kellam, & Blackard, 2006), and Problem Solving Communication Training (Barkley, Edwards, & Robin, 1999); have been developed and reported success in utilizing relationship as a curative factor in assisting children and teens to become more stable in their emotional health, increase and strengthen their ability to cope with stressors, and bring about improvement in both internalized and externalized negative behaviors (DeJames, 2001). This study and program plans to utilize a modified and biblically integrated form of Bratton, Landreth, Kellam, and Blackard's Child Parent Relationship Therapy (2006) to assist you, as parents, to develop a better relationship with your teen in the hopes that they will become more open and receptive to your guidance and leadership.

Please find in this handout, a timeline of procedures, an activity log, a list of suggested activities, contact information, and references for utilized studies and theories. Do not hesitate to contact the researcher or the listed supervisor if you have any questions or concerns. Thank-you once again for your willingness to participate in this study, it is hoped that this will be a beneficial and positive experience for you and your child. It is anticipated that the data and information that you and your child provide will be utilized to assist adolescents in normal and at-risk populations to manage behaviors and make wise choices which will allow them to lead meaningful, satisfying, and productive lives; in which they are able to discover and accept God's calling to minister in the Body of Christ.

Timeline of Procedures

- Mothers and children will receive information about this program and/or attend an optional initial meeting.
- Time 1 assessments and paperwork will be completed.
- Parents will begin the six-week program and participate with their child in an activity during the same time and day each week for five consecutive weeks. All activities will last a minimum of 30-45 minutes.
- Parents record activity chosen, time, date, and duration on activity log each week.
- During the third or fourth week, parents and teens will videotape a play session to assist in providing parents with feedback, encouragement, and insight; or mothers will role play a session with the group facilitator or other group member. Mothers will be presented with the opportunity to brainstorm real life concerns and situations with the group.
- Parents will complete homework assignments as follows:

Session One.

- Set up time for activity sessions with child and participate in first activity.
- Record information on activity log
- If not completed, have child complete time 1 assessments and paperwork.
- Pray daily for your child, other study participants, and the program.

Session Two

- Participate in second activity session
- Record information on activity log
- Pray daily for your child, other study participants, and the program.
- Select a Bible verse that will be encouraging to other mothers to share during Session Three.

Session Three

- Participate in third activity session
- Record information on activity log
- Pray daily for your child, other parents, and the program.
- Attend videotaping session with your teen or videotape a session.

Session Four

- Participate in fourth activity session
- Record information on activity log
- Pray daily for your child, other parents, and the program.
- Attempt to use and practice choice giving in daily interactions with your adolescent.
- Use sandwich hugs and kisses if this feels comfortable to you and your adolescent is receptive to this.
- Attend videotaping session or videotape a session if did not do so following Session Three

Session Five

- Participate in fifth activity session
- Record information on activity log
- Pray daily for your child, other parents, and the program.
- Mail letter of encouragement, appreciation, and praise to your child
- Children will complete time 2 assessments after last play session if opt not to attend the final session.

Session Six

- Mothers attend session and complete necessary assessments and paperwork. Children are given the option to attend this session.
- Adolescents will be given the option to accompany mother to final session and complete needed paperwork and assessments or complete at home and return.
- Parents and children will be notified of a date, time, and place to come and complete follow-up assessments after six weeks have elapsed to analyze for maintenance of progress and continuing positive effects from treatment, or have the option to have these mailed.

Activity Log

Name _____

I did _____ did not _____ pray *daily* for my child.

	Date	Time Spent	Type of Activity
W E E K 1			
W E E K 2			
W E E K 3			
W E E K 4			
W E E K 5			

Suggestions for Activities

All activities should be chosen by your teen and be interactive.

- *What Is* activity. (questions for this on next page)
- Build or assemble something: puzzles, crafts, or projects from a kit
- Watch a movie or television show – allow time for discussion and interaction
- Walk or hike
- Go on a picnic or out to eat, go for coffee or ice cream
- Volunteer at an organization
- Participate in sports: play catch, fish, hunt, golf or Putt Putt, shoot hoops, go to batting cages, play tennis, or go bowling; or attend a sporting event
- Play air hockey or pool
- Cook: make cookies, candy, or try a new recipe
- Listen to or create music
- Be creative: paint, sculpt, sew, quilt
- Take a class together
- Go shopping
- Take a drive
- Go on a cooperative scavenger hunt
- Garden
- Play a game: board games, cards, or computer games
- Go boating
- Write a collaborative story or poem
- Go to a museum
- Have a spa day or do nails and hair
- Attend a special activity or event
- Child can teach parent or caregiver a new skill such as skate boarding, roller blading, using My Space, or share a special interest or collection
- Any interactive activities suggested by child – the possibilities are endless!!

Questions for *What Is Activity* – questions may be asked directly from this sheet or the questions or numbers may be cut or copied and drawn at random from a container.

1. What is your favorite color and food and what is the weirdest thing you've ever eaten?
2. What is your favorite flavor of cake, cookie, and ice cream? If you were an ice cream flavor, which one would you be and why?
3. If you were an animal, what would you be and why?
4. What is one goal you'd like to accomplish during your lifetime?
5. If you could be a superhero, who would you be and why (can be made up)? Who is your hero?
6. If someone made a movie of your life would it be a drama, a comedy, a romance, action film, or science fiction? What would it be about and which actor would you want to play you?
7. What's your favorite cartoon character, and why?
8. What's the ideal dream job for you?
9. Are you a morning or night person? What are your pet peeves or interesting things about you that you dislike? Do you have any quirky habits? If you had to describe yourself using three words, it would be...
10. What are your favorite hobbies and your favorite thing to do when "just hanging?"
11. Name one of your favorite things about someone in your family.
12. If I could be anybody besides myself, I would be...
13. If you were a comic strip character, who would you be and why?
14. What thought or message would you want to put in a fortune cookie?
15. If you won the lottery and had a million dollars, what would you do with it?
16. If you could add any person to Mount Rushmore, who would you add and why?
17. What award would you love to win and for what achievement?
18. If you could transport yourself anywhere in the world at any time instantly, where would you go and why?
19. What is one item that you really should throw away, but probably never will?
20. Growing up, what were your favorite toys to play with as a child?
21. What are your favorite song, book, movie, and TV program?
22. If you could be a kind of cereal, what kind would you be and why?
23. If you could be any dessert or food, what would you be and why?
24. If you could be any color of crayon, what would you be and why?
25. Who is your best friend?
26. What is the nicest thing that anyone has ever said to you?
27. Who was your best and favorite teacher? Why?
28. What is the best dream you ever had or favorite childhood memory?
29. If you were going to be stuck on a deserted island for a year, what three things would you take?
30. What is the nicest thing that I (caregiver or adolescent) have ever done for you?
31. What is your favorite outfit or piece of clothing?
32. What is the hardest part of being (fill in adolescent or caregiver age)?

(Icebreakers Ws, 2008; Jaynes, 2004; Procter & Gamble, 2009).

Contacts and Questions

The researcher conducting this study is Valerie Waruszewski, MA, LPC. Please do not hesitate to contact her at any time should you have questions or concerns. She can be reached by telephone at ###-###-#### or emailed at vawaruszewski@liberty.edu. (Dissertation Chair: Dr. John Thomas, Liberty University Center for Counseling and Family Studies, 800-424-9596).

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher(s), you are encouraged to contact the Human Subject Office at Liberty University, 1971 University Blvd, Suite 2400, Lynchburg, VA 24502 or email at irb@liberty.edu.

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Appendix H

Flow Chart for Recruitment and Screening Procedures

1. Researcher attended Sunday school classes at area churches and meetings at local Christian middle and high schools.
2. Fliers were sent to youth group leaders and pastors at local churches, and distributed at an event held by a Christian radio station, to solicit participants.
3. An invitation to attend this program, which was described as parenting improvement classes, was placed in bulletins at several local churches, on a home school list serve and in the newsletters of the above mentioned Christian schools.
4. Participants were asked for referrals of friends and family members who may meet inclusion criteria and wish to participate in this program.

Screening and Information Sharing Procedures

1. Information and inclusion criteria were shared with potential participants by the researcher at meetings and Sunday school classes. Persons who met criteria and wished to participate were invited to attend An optional pre-session with their child to complete time 1 assessments and ask questions.
2. Persons who responded to fliers were instructed to attend an information session with their child. Information was provided during this session regarding the program and inclusion criteria was discussed. Persons who wished to participate and met criteria were asked to remain and complete time 1 assessments.
3. Persons who were recruited by previous and current study participants were provided with information regarding the program by the researcher. Mothers and

adolescents, who met inclusion criteria, were invited to attend a pre-session to complete time 1 assessments.

4. Attendance at the pre-session was optional. If mothers choose not to attend this, time 1 assessments were completed at the beginning of the initial session and mothers were given assessments to take to their children. Adolescent take home, time 1 assessments, were required to be completed prior to the first activity session and returned at the beginning of the second session.

Determination of Eligibility for Inclusion

Demographic surveys and assessments were assessed to determine eligibility for inclusion as previously outlined and discussed in this paper. Responses that indicated the presence of clinical symptoms, or behaviors and choices that could result in risk of physical harm to self or others, resulted in referrals to professional therapists and clinicians for further evaluation and treatment as needed. Children and mothers who met inclusion criteria were scheduled in a group, notified of time, day, and location through their indicated choice for method to receive communications, and began the program. Mothers who could not be scheduled were contacted with additional scheduling options.

Criteria for inclusion:

1. Adult participants were biological or from birth adoptive mothers of the focus children.
2. Adolescents must reside with their biological or from birth adoptive mother for a minimum of five days per week and be between the ages of 11 and 14 inclusively.

3. Responses to questions did not indicate the presence of any at risk clinical symptoms (any thoughts to harm self, others, including cutting, purging, interest in setting fires, and harm to animals; and psychotic symptoms).
4. Major trauma was not experienced within the past 60 days.
5. No current legal issues or substance abuse existed that had resulted in intervention by services outside of the home.
6. Adolescents were not currently receiving treatment from a licensed clinician.
7. Mother and adolescent were willing to participate in treatment and complete consent forms and all needed paperwork.
8. At least one of mother's PRQ scores fell within the average or below average categories.
9. Participants possessed reading and comprehension skills to complete assessments.
10. Mother's score on the DUREL was ≥ 10 .

Appendix I

Please complete the following information.

Name (Please Print) _____

Date of Birth _____

Do you have any current legal charges? Yes No

If yes, please elaborate

Have you experienced or been involved in any of the following within the past sixty days?

Sexual or Physical abuse Yes No

Acts of violence or a natural disaster which resulted in severe loss Yes No

Permanent loss of a primary caregiver Yes No

Please elaborate on any responses of yes to the above.

Do you:

Drink alcohol or use non-prescribed drugs or substances? Yes No

Participate in or talk about behaviors that would be harmful to others? Yes No

Participate in or talk about behaviors that would harm yourself? Yes No

Hurt animals or set fires? Yes No

Hear sounds or voices that are not there? Yes No

Cut yourself or pick at your skin? Yes No

See things that are not there? Yes No

Think about or talk about killing yourself? Yes No

Please elaborate on any responses of yes to the above and talk to me before leaving today.

Do you profess to be a Christian and have a personal relationship with Jesus Christ?

___ Yes ___ No

Please rate the following with a number between 1 and 10, with 10 being the best.

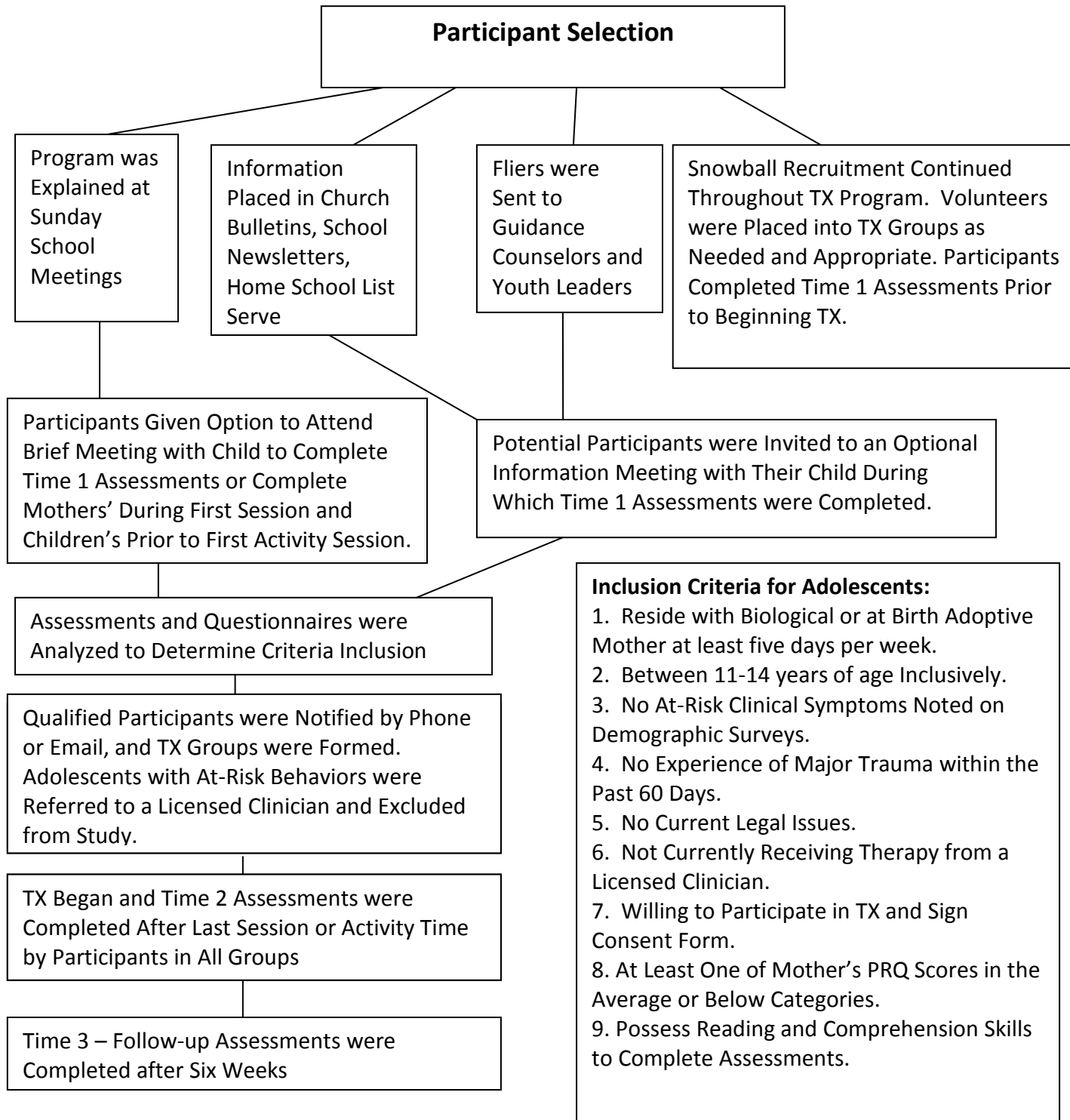
1. Your satisfaction with the overall quality of relationship between you and your mother.

2. Please rate the truth of the following statement. "I enjoy spending time with my mother and feel understood and respected." _____

3. Please rate the truth of the following statement. "I find it easy to talk to my mother and feel that our communication skills are positive and effective." _____

4. Please rate the truth of the following statement. "I feel that participation in this program will improve the quality of the relationship between me and my mother." _____

Flow Chart for Study



Summary of Assessments

Mothers were asked to complete three assessments.

1. Duke University Religion Index (DUREL)
 - A. Administered at time 1
 - B. Utilized to assist with inclusion requirements.
 - C. Mothers needed to obtain a minimum score of 10 on this assessment which, according to the authors of this assessment, indicated strong religious values, beliefs, and practices.
2. Conflict Behavior Questionnaire- 20 (CBQ-20)
 - A. This test yielded one score. Higher scores are indicative of greater levels of experienced parent-adolescent conflict.
 - B. This test was administered to mothers at times 1, 2, and 3.
3. Parenting Relationship Questionnaire-CA (PRQ-CA)
 - A. Used to capture a parent's perspective of the parent-child relationship.
 - B. Contains seven scales, five of these, Attachment, Communication, Involvement, Parenting Confidence, and Relational Frustration, were utilized by this study. The Satisfaction with School and Discipline Practices scales was not considered.
 - C. Higher scores in all scales, except the Relational Frustration Scale, were indicative of fewer relational problems. Higher obtained scores on the Relational Frustration Scale are indicative of higher levels of frustration.

Adolescents were asked to complete two assessments at times 1, 2, and 3.

1. Conflict Behavior Questionnaire- 20 (CBQ-20)

This test yielded one score. Higher scores were indicative of greater levels of experienced parent-adolescent conflict.
2. Inventory of Parent and Peer Attachment (IPPA).
 - A. This assessment was developed to explore adolescents' perceptions of their relationship with parents and close friends and how well these persons provide psychological security.
 - B. Only the parent attachment summary score was utilized by this study.
 - C. This test yielded one score. Higher scores were indicative of greater satisfaction with the parent-adolescent relationship.

Appendix L

Modifications to CPRT

This study modified CPRT by adding biblical integration, condensing it into a brief therapy format of six sessions, and making changes so that it would be appropriate for use with an 11-14 year old, adolescent population. Following the suggestions of Brown (2005), Carter and Narramore (1979), Entwistle (2004), Ferrell (2003), Garzon (2005), Landreth (as cited in Brown; personal communication, March 4, 2010), McClung (2007), and Walker and Quagliana (2007); and with the permission of the authors as granted in the CPRT manual, the modifications are outlined below:

Brief therapy modifications are presented in Brush Script font.

Spiritual integration modifications are presented in Britannic Bold Font.

Modifications for use with and adolescent population are presented in Papyrus Font.

1. Following suggestions of Brown and Landreth, all sessions focused on and encouraged more active interactions and communications between mothers and their adolescent children rather than reflection. Instruction and examples focused on utilizing age appropriate language, limits, and choices; and were mindful of the developmental framework of 11-14 year old children.

2. Following the suggestions of Walker and Quagliana (2007) and Garzon (2005), all sessions were facilitated by a Christian therapist and held in a church facility or Christian school. All teachings were grounded in scripture, which was utilized to clarify ideas and concepts. Additionally, prayer was

included prior to, during, and between all sessions and included in homework assignments. In accordance with the Allies paradigm of integration discussed by Entwistle (2004) and Carter and Narramore's Integrates model (1979), this study incorporated psychological theory and understanding with biblical insights and teachings and maintains that both hold merit and insight. McClung (2007) also cautioned that training be sensitive to parents' specific religious beliefs regarding discipline, and their desire to teach these beliefs to their children.

3. In considering condensing the CPRT program into a six week program, following Ferrell's recommendations and procedures, this study formed smaller groups when possible and based all decisions upon the goal of assisting parents to develop skills to better understand their children, spend improved quality time with them, and portray the core "be with" attitudes of CPRT: I am here, I hear you, I understand, and I care (Bratton et al., 2006). Some material from the original program was omitted based upon the developmental needs of this older population.

Session Procedures:

Pre-session (optional, attended by mothers and teens)

Goal: Assist participants to stay motivated in the program, answer questions, obtain needed paperwork. (The pre-session is an addition to the basic CPRT program, and is needed to address needs of the study to obtain time 1 assessments and recruit participants.

Biblical integration included prayer and established that all healing comes from God.

1. Welcome mothers and adolescents.
2. **Opening prayer.**

3. Introduce and explain study purpose and procedures to mothers and adolescents.
Establish that all healing comes from God and He will be the foundation of this treatment and study. All examples and wording will be appropriate to adolescent participants' needs and developmental level.
4. Answer any questions
5. Adolescents and mothers will complete assessments and any other needed forms.

Session One (attended by mothers only)

Goal: Introduce mothers to the program and concept of Filial therapy and begin to build group cohesion, explain play sessions, and share timeline for treatment.

1. Welcome Parents,
2. **Opening prayer** (3 minutes)
3. Introductions, mothers complete time 1 assessments if not done during pre-session (20-30 minutes)
4. Discuss background information regarding original CPRT (15 minutes)
5. Discuss program procedures and timeline (15 minutes) **Discuss that all procedures and treatment will be rooted in scripture and utilize a biblical frame of reference. Discuss Philippians 4:8-9, Ephesians 6:1, Proverbs 6:6, Deuteronomy 6:6-7, and Psalms 139:13.**
6. Detailed discussion of weekly activities (20 minutes)
7. Distribute and discuss handout #1, *Basic Principles of Activity Sessions*, (*This handout has been changed from Session Two to Session One so that parents will be ready to have a*

*play session during the first week, original CPRT begins play sessions following session three) show clip from DVD *Child Centered Play Therapy: A Clinical Session* by Garry, Landreth and highlight main points (20 minutes) (*Training on reflective responding and emotion identification have been moved to later sessions to allow time to focus on preparing parents for initial play session*).*

8. Break (15 minutes)
9. Questions and role play (30-45 minutes) Role play geared as addressing possible resistance. *Information will be presented in a role play format in addition to handouts to present more information in a shorter period of time and provide parents with confidence and encouragement to begin their first play session with their child. **Role play reinforces the power of prayer, having faith and trust in God, and following His direction.***
10. Discuss homework and review for sessions (10 minutes) *Homework has been modified from original CPRT to include a play session during the first week and address the developmental level of adolescent children. Mothers will be given assessments and directions for children if they did not attend the pre-session.*
 - 10.1 Set up time for sessions with your adolescent
 - 10.2 Rule review
 - 10.2 Same rules session time every week
 - 10.4 No interruptions including cell phones and pagers
 - 10.5 Only parent and adolescent
 - 10.6 All activities are adolescent chosen and driven

- 10.7 Stay non-judgmental and accepting, no suggestions or negative statements, no questions, have fun!
11. Discuss needed logs and paperwork
12. **Pray daily for child and program**
13. Distribute handout #2, read, and ask for comments regarding the poem, *If I Had My Child to Raise over Again* by Diane Loomans. (5-10 minutes)
14. Questions and **closing prayer** (15-20 minutes) **Discuss Deuteronomy 31:18 and establish this as the main verse and focus for this treatment and program.**

Session Two (attended by mothers only)

Goal: Continue to build group cohesion and assist mothers to feel more comfortable with weekly play sessions, teach empathy and emotion identification, discuss importance of building and strengthening confidence and self-esteem in children.

1. Informal interaction and snacks (10-15 minutes)
2. **Opening Prayer**
3. Review homework, collect time 1 assessments if needed. (30-45 minutes)
 - 3.1 Discuss activity noting any barriers or concerns, role play if appropriate (30-45 minutes)
4. Distribute and discuss *Do's and Don'ts* handout #3 (20 minutes) *Moved from Session Two to facilitate and clarify play sessions.*
5. Distribute and discuss *Esteem and Confidence Building Responses* handout #4
(This handout has been moved to Session Two from Session Seven, and more time is spent on this

issue to address this developmental need for adolescents). Distribute and discuss *Positive Character Qualities* handout #5. (*This handout was moved from Session Seven to address this developmental need in adolescents*) (20 minutes)

6. Break (15 minutes)

7. Distribute handout *Feelings Response: In-Class Practice Worksheet*, handout # 6, and discuss and role play reflecting emotions (30 - 45 minutes) *This handout has been moved from Session One to Session Two to provide additional time to discuss play sessions.*

Distribute *Emotions Vocabulary Chart*, handout # 7 (ami-tx, n.d.) (This chart was not included in original CPRT and has been added to address the wider range of expression and experiencing of emotions in the adolescent population).

8. Discuss Homework

8.1 Second activity session – focus on including more emotional reflection. *In original CPRT, play sessions do not begin until Session Three. Collecting toys on the checklist has been omitted.*

8.2 **Find a Bible verse that will be encouraging to the other parents for closing next week. Original CPRT requests parents to find an encouraging saying or story to share.**

8.3 **Continue to pray for our children, each other, and this program.**

9. Closing activity for session (5 minutes)

10. Read the *Butterfly Story* (*moved from Session Seven to illustrate the teachings of this session,*

ask mothers for thoughts regarding biblical implications of this story).

11. Closing **Prayer**

Session Three (attended by mothers only)

Goal: Teach mothers skills to set limits and reinforce emotion reflecting.

1. Time for informal interaction, sharing, and snacks (15 minutes)
2. **Opening prayer**
3. Review last week's homework (30-45 minutes). Discuss, barriers, complications, concerns, and praise reports
4. Practice reflecting emotions in pairs (20 minutes)
5. Break (15 minutes)
6. Distribute and discuss *Limit Setting A-C-T* handout #9 (*This handout was moved to Session Three from Session Four from session four*) wording has been modified per the recommendations of Landreth (personal communication, March 4, 2010) to apply to the adolescent population. (see Appendix M for detailed description regarding handout modifications).

(30 minutes). **Due to possible resistance by mothers to allow adolescents to develop their own alternate choices and decisions, as identified and reported by McClung (2007), this study plans to spend time to address this. Hebrews 5:12-14 will be discussed and God's desire for His people to grow in wisdom and make wise choices. Hebrews 5:14 states that by using God's truth and teachings one can train himself to distinguish**

between good and evil. This will be related to developing and using problem solving skills. The benefit of training children to make choices guided by the Spirit and not the world as discussed in 1 Corinthians 3:1-3 will also be illustrated as well and discussed in relationship to Proverbs 22:6.

7. Role play scenarios (themes are presented by parents and relate to the needs and concerns of an adolescent population)
8. Distribute and discuss *Common Problems in Play Sessions* handout #10(*moved to this session from Session Six due to beginning play sessions earlier in the program.* (20 minutes))
9. Discuss videotaping session and set up schedule (10 minutes)
10. Discuss homework (5 minutes)
 - 10.1 Videotaping or role play session (*these sessions begin in Session Five of original CPR7*).
 - 10.2 3rd activity session
 - 10.3 **Pray daily for each other, our children, and the program**
11. **Share Bible verses and encourage parents** (15 minutes)
12. Questions
13. **Closing Prayer**

Session Four (attended by mothers only)

Goal: Teach listening skills, including being attentive to tone of voice and body language, discuss importance of touch and giving choices to improve problem solving skills.

1. Informal interaction, sharing, and snacks (15 minutes)
2. **Pray**
3. Discuss homework and play sessions
4. Watch two (or more as needed depending upon size of group) videos or role play with group facilitator or other group member and comment, utilize handout #11, *Activity Session Skills Checklist* focusing on what child and parent are thinking. *(these sessions began in Session Six of original CPR7)*. Mothers had the option to role play brainstorm real life situations or concerns with the group as all adolescents in this study did not give consent to be videotaped. (45 minutes)
5. Break (15 minutes)
6. Watch remaining video/s or role play and comment using *Activity Session Checklist*, handout #11 (30 minutes).
7. Review limit setting; distribute and discuss *Choice-Giving 101* handout #12 and *Advance Choice-Giving: Providing Choices as Consequences*, handout #13 *(moved to this session from Session Six)*. **(Utilize the parable of the prodigal son in Luke 15:11-32, to illustrate the principal of choice and consequences, and discuss concepts of grace and mercy)**. (20 minutes)

8. Discuss Homework
 - 8.1 4th play session
 - 8.2 Attend videotaping session if not previously done
 - 8.3 **Pray daily for child, each other, and the program**
 - 8.4 Attempt to use choice giving in daily interactions with teen
 - 8.5 Utilize the sandwich hugs and kisses intervention if parent feels comfortable with this and child is receptive (*moved to this session from the original CPRT Session Five*).
9. Briefly discuss importance of touch, introduce sandwich hugs and kisses and encourage parents to use this intervention with their teens if they feel comfortable doing this and the teen is receptive (*Moved from Session Five to Session Four; Will discuss Jesus' use of touch in allowing the children to be brought to Him in Mark 10:13-16 and to provide acceptance, support, and healing to the leper in Mark 1:40-42. (5 minutes)*)
10. Questions
11. **Closing Prayer**

Session Five (attended by mothers only)

Goal: Discuss importance of encouragement and praise.

1. Informal interaction, sharing, and snacks (15 minutes)
2. **Pray**
3. Discuss homework, including any comments regarding choice giving experiences, focus on praise reports from activity sessions (15 minutes)

4. Expand on choice setting stressing being firm, matter of fact, and consistent.
Distribute and discuss *Generalizing Limit Setting to Outside the Activity Session* handout #15 (*moved from Session Nine*) (30 minutes)
5. Review do's and don'ts of Filial therapy (10 minutes)
6. Watch one or two videos (or more as needed) *or role plays* and comment utilizing the *Activity Session Checklist* handout #11 (45 minutes)
7. Break (15 minutes)
8. Watch remaining video/s *or role play* and comment utilizing the *Activity Session Checklist*, handout #11 (45 minutes).
9. Distribute and discuss *Encouragement vs. Praise* handout #14 (*moved to Session Five from Session Eight*): **Discuss that the word encourage is used 54 times in the Bible and God instructs His people to encourage one another in 2 Corinthians 13:11.** (15 minutes)
10. Discuss Homework
 - 10.1. 5th activity session
 - 10.2. **Daily prayer for child, each other, and program**
 - 10.3. Mail letter of encouragement, appreciation, and praise to child.
11. Certificates to parents and group time for encouragement if children will attend Session Six. (10 minutes)
12. *Child time 2 assessments distributed and discussed if child will not attend Session Six.*
13. Questions
14. **Closing Prayer**

Session Six (attended by mothers, optional for children)

Goal: Debrief, encourage mothers and children to continue to work toward improving their relationships, complete time 3 assessments.

1. Informal interaction and snacks (15 minutes)
2. **Opening prayer**
3. Discuss therapy experience noting any changes between first and last play session and any thoughts or suggestions, collect children's time 2 assessments if they do not attend this session. (30 minutes)
4. Share any comments or praise reports from last week's activity. (10 minutes)
5. Review highlights of videoed sessions allowing adolescents (if present) to comment on how they felt. Review information from previous sessions utilizing *Rules of Thumb* handout #16 (*moved from Session Ten*), sharing concerns, questions, and successes (30 minutes.)
6. Break (15 minutes)
7. Debrief, discuss and encourage the continuation of sessions (10 minutes)
8. Closing, bonding activity, distribute certificates if not done during Session Five. (10 minutes)
9. Discuss follow-up assessments in six weeks
10. Final discussions, comments and questions
11. **Closing Prayer**
12. Complete time 2 assessments

The following handouts were omitted from this program due to adolescents' developmental framework and shortening the program from 10 to 6 sessions: What is It, How can It Help?, Basic Principles of Play Sessions, Toy Checklist for Play Sessions,

Play Session Procedures Checklist, Parent Play Session Notes, Structured Doll Play for Parents, and Parent Notes & Homework.

A detailed description regarding modifications of handouts is presented in Appendix M.

Appendix M

Details and Descriptions to Modify and Utilize Handouts

Due to copyright considerations, the actual handouts utilized in this study are not included. Below are descriptions and directions for handout modification and utilization. All original handouts were secured from the Child Parent Relationship Therapy (CPRT) Treatment Manual (Bratton et al., 2006) which grants permission to reproduce to the purchaser. The goal of modifications was to accommodate the developmental framework of adolescents, include biblical integration, and offer the intervention in a brief, six session format.

1. *Basic Principles of Activity Sessions*. This handout is a modification of the *Basic Principles of Play Sessions* handout (Bratton et al., 2006, p. 189) that was used in Session Two of CPRT. Modifications consisted of replacing the word “child” with “adolescent”, and changing the title to reflect that this is an activity session rather than play session. This handout was utilized during Session One.
2. *If I Had My Child to Raise Again* by Diane Loomans (2008). This was downloaded from the internet and utilized as a motivational poem or story during Session One as recommended by CPRT Treatment Manual (Bratton et al.)
3. *Activity Session Do’s and Don’ts* (adapted from *Play Session Do’s and Don’ts*, Bratton et al., p. 192). This was moved from Session Two to Session One. This handout began with the CPRT listed “major task.” “Setting the stage” was omitted other than stating that it is important to

plan ahead for activity times to eliminate conflicts. “Do set financial, moral, safety, and time limits” was added as a “Do”. In the “don’t” section, don’t praise the child, and don’t initiate new activities were omitted.

4. *Esteem and Confidence Building Responses* (adapted from *Esteem Building Responses: Developing Your Child’s Sense of Competence*, Bratton et al., p. 216). This was moved to Session Two from Session Seven. The “Rule of Thumb” was kept, along with the first paragraph. The “examples for esteem-building responses” section was included. 1 Thessalonians 5:21-22 and Matthew 25:14-30 (NIV) were added to support the value of leaning problem solving skills and the importance of utilizing the gifts and talents that God has given. The *Butterfly Story* was removed from this handout and added as Handout #8.
5. *Positive Character Qualities* (Bratton et al., p. 217). This handout was used as it was written, but moved to Session Two from CPRT’s Session Seven.
6. *Feelings Response: In-Class Practice Worksheet* (Bratton et al., p. 184). This handout was moved from CPRT’s Session One to Session Two and used as written, other than omitting the clip art. It was discussed that although the examples involved younger children, feelings apply to persons of all ages. The goal was to evaluate and practice basic feeling responses regarding non-threatening concerns as a learning tool.

7. *Emotions Vocabulary Chart* (ami-tx, n.d.). This was not included in the original CPRT, but was added during Session Two to supplement handout #6 and illustrate the wide complexity of adolescent emotions.
8. *Butterfly Story* (Bratton et al., p. 216). This was taken from CPRT's *Esteem Building Responses* handout and moved for use as a handout in Session Three. The wording was kept intact.
9. *Limit Setting: A-C-T* (adapted from *Limit Setting: A-C-T Before It's too Late!*, Bratton et al, p. 196). This handout kept the description of A-C-T, but omitted the examples and the "Rule of Thumb" section. The questions, "Is this limit necessary?, Can I consistently enforce this limit?, and If I don't set a limit on this behavior, can I consistently allow this?" were included without the examples. The "Why Establish Consistent Limits?" section was omitted. This was moved from Session Four in the original CPRT to Session Three.
10. *Common Problems in Activity Sessions* (adapted from *Common Problems in Play Sessions*, Bratton et al., pp. 210-211). This was moved from Session Six to Session Three. All language and examples were adjusted and modified for use with an adolescent population. The last question, "My child wants me to shoot at him during the play session, what should I do?" was omitted. Based upon recommendations from Brown (2005) and Landreth (personal communication, March 4, 2010), the question prior to this regarding playing with toys was changed to "My child wants to participate in activities or use language that I feel are not appropriate."

The answer provided for this was: “During activity time, it is desirable that your adolescent feel accepted and understood. If the chosen activity, behaviors, or language cross a boundary or limit that you have set and feel needs to be enforced, utilize the A-C-T method of limit setting that we have previously discussed. 1. Emphasize that you are taking his or her feelings, wants, and preferences into consideration; 2. Communicate the limit, and 3. Present alternatives. You may say “I understand that you would like to go out to eat at _____, I would like that too, but this week, we don’t have the money to do that; we could eat at _____, _____, or _____ instead; or you may choose a different activity”; or “I know that you are expressing an important concern, and I am very interested in what you have to say, but we have set a limit of not using curse words (or whatever limit you have previously set), do you think that you could make another word choice?” If your child continues with the undesirable behavior, you may patiently remind him or her of the limit up to three times and then state the alternatives more clearly and precisely, such as “we have discussed not using that word and this is the third time that you have chosen to use it, you may either choose to stop cursing and continue with our activity, or continue to break this limit and end our activity, which do you choose?”

11. *Activity Session Skills Checklist* (Bratton et al., p. 205). This checklist was used as it was written. The mothers utilized this as a tool to evaluate role

plays during Sessions Four, Five, and Six. Original CPRT uses this checklist during Sessions Five through Ten.

12. *Choice-Giving 101: Teaching Responsibility & Decision-Making* (Bratton et al., p. 208). This handout was utilized as written, but moved from Session Six to Session Four.
13. *Advance Choice-Giving: Providing Choices as Consequences* (Bratton et al., p. 209). This handout was utilized as written, but moved from CPRT's Session Six to Session Four.
14. *Encouragement vs. Praise* (Bratton et al., p. 222). This handout was moved from CPRT's Session Eight to Session Five and used as written.
15. *Generalizing Limit Setting to Outside the Activity Session* (Bratton et al., p. 230). This handout required considerable modification to accommodate adolescents' developmental framework. The A-C-T method of limit setting at the beginning of the handout was included. The concept of non-compliance was then discussed with a focus on precise intervention. This goal of this handout was to assist mothers to place responsibility for their adolescent's choices and actions back onto their child. Age appropriate examples were utilized that substituted for the "Three-step A-C-T method of limit setting followed by choices" section. These were written as follows: "If your child is non-compliant state "you have chosen... so you have chosen..." Example: You have chosen to not have your homework completed by 8:00 so you have chosen not to have computer time this evening, or you have chosen not to take the trash out

by 6:00 so you have chosen not to watch TV this evening. Make sure that limits and consequences are enforceable and consistently enforced. The “What to do when limit setting doesn’t work” was copied into this handout with the addition of “You may need to suspend a responsibility or duty for a time—show mercy” to the end of #1. A section was included which was titled “When considering a compliance interaction.” This consisted of the following statements: “Your child may ask questions or argue about the limit: 1. You may say, we have already discussed this. Do you remember what we decided?” (the following sentence was taken from #3, page 231 of the CPRT handout) “Go sit down in a quiet place and think. I know you’ll be able to remember.” The following was then added: “2. If the child asks to renegotiate, you can consider and do this or say, we have discussed this and came to a decision. You may then ask if there is anything you can do to help your child with compliance such as writing the chore or activity on a calendar as a memory aide or discussing and considering motivation and scheduling concerns. 3. If you are not sure about a child’s suggestion, you can say, “I need time to pray about this or discuss it with your father or time to think and gather additional information.” This handout was moved from CPRT’s Session Nine to Session Five.

16. *Rules of Thumb* (Bratton et al., pp.238-239). This handout was utilized as written. It was moved to Session Six from CPRT’s Session 10.