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Filial Therapy and Parent-Child Interaction Therapy:

Building Bonds that Heal

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Acknowledgments

This paper is dedicated to all of the hard-working individuals – from researchers to professors to therapists – across the country and around the world, who persist in discovering, sharing, and putting into practice new ideas to help families.
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Abstract

This literature review discusses researchers’ findings in recent decades regarding the effectiveness of two parent-child relationship building programs – filial therapy and Parent-Child Interaction Therapy. It explores the versatility of the two treatment models for application to various populations and in multiple settings, both in their traditional forms as well as in modified forms. Psychological concepts from classical Adlerian literature are also considered, as they relate to the topic.
Purpose

A school of thought which began in the 1960’s developed the concept that parents could effectively do therapeutic work with their children. Called filial therapy, this philosophy placed caretakers in the role of healing agents by teaching them how to play with their children. In 1983, a similar program – called Parent-Child Interaction Therapy - was created, under much the same premise as the filial model. Both of these plans have been tested on an ever wider scope of populations, with researchers hypothesizing that the models would translate effectively to parent-child dyads of many different backgrounds, and examining the transportability of the two programs to a variety of settings.

This paper attempts to consolidate, through a literature study, the findings of the studies conducted in recent decades. It asks what conclusions can be drawn as to for whom and under what circumstances filial and PCIT therapies are useful and whether the programs are more effective in their scripted/manualized forms or whether modifications made to the plans find better results. This review defines the two programs and then examines peer-reviewed articles, analyzing them in terms of variables, methods, findings, and limitations. The paper then discusses clinical implications of the articles’ findings and juxtaposes PCIT and filial therapies with Adlerian philosophy.

The Argument for Parent-Child Relationship Training

Researchers cite many reasons for the relevancy of these two parent-child relationship building programs for the current times. Eyberg et al. (2001) speak of the rate of mental and behavioral health issues among young children and the poor prognosis for those who do not receive adequate treatment with long-term gains. Early behavior problems tend to persist, such that they have been called a “chronic illness with a relatively clear course.” The risks for
behaviorally challenged young children include social, academic, and emotional problems, along with delinquency and likelihood of becoming abuse victims (Eyberg et al., 2001). In addition, behavior dysfunction among youth has been called an externalization of problems in the parent-child relationship (Timmer et al., 2005).

The articles speak to the value of having an intervention which helps re-build bonds between family members who have experienced some kind of domestic violence. Children exposed to domestic abuse tend to demonstrate higher levels of psychopathology, even symptoms of Post-traumatic stress disorder, and can be more “difficult to parent” than other children (Timmer, Ware et al., 2010, p. 487). An escalating cycle of negativity can develop between children who are noncompliant (perhaps as a result of having been abused) and their parents, who for a lack of parenting skills turn to coercive and violent practices (Chaffin et al., 2004). Sexual abuse of a child has been linked to a multitude of future problems. The relationship with the mother as well as the empowerment of the child (both of which are addressed by filial and PCIT treatments) are seen to have restorative value (Costas & Landreth, 1999). The development or healing of bonds between caregiver and child – through the use of PCIT or filial therapy - can extend to other types of relationships, too, including foster parent and child (Timmer et al., 2006).

The literature addresses the need for successful interventions for families of minority cultural backgrounds, and hypothesizes that the family-based values espoused by the two parent-child relationship training programs are a good fit with many cultural groups. Capage et al. (2001) state that minority children are more often diagnosed with serious problems than non-minority children; and that the children with the most severe treatment concerns are also those least likely to attend full-term treatment. Their study examined the usefulness of PCIT for families of African-American heritage. Garza et al. (2009) applied filial techniques in the
Hispanic community, citing data about less healthy parent-child interactions in that population as well as the “resonation between Hispanic cultural values and the principles of [Child Parent Relationship Training] (p. 218).

The studies also cite the higher incidence of immigrant families needing and seeking support, and the importance of family-based interventions for such families. For instance, Latinos represent the fastest growing group in the United States; and Latino children experience a higher probability of academic and behavior problems than the average child in the country (Ceballos & Bratton, 2010). Filial therapy was seen as an appropriate model for cultural groups whose values. Ceballos and Bratton (2010) call family-based treatments such as filial therapy a “particularly good fit” for Latino immigrants, based on the paramount value traditionally placed on the family unit.

Lee and Landreth (2003) suggest that the disorder within immigrant families which can result from the conflict of cultures (i.e. the home culture as it clashes with the dominant culture children encounter in the schools) can cause tension in the parent-child relationship. They cite the specific differences between Korean and American values which often cause this “major source of conflict” and challenges Korean-American parents to feel like competent caregivers (p. 68). The need to address the problem of discord between dominant and non-dominant cultures is also discussed by Glover and Landreth (2000) who applied filial therapy techniques to a Native population. They hypothesized that the parenting program was a good fit with the traditional values of the Native population. PCIT has also been studied in other parts of the world, such as Hong Kong. Leung et al.’s 2009 study discovered that PCIT had positive effects for families in China, despite what were considered cultural “hurdles” differentiating the PCIT parenting philosophy from traditional Chinese parenting (p. 305).
Treatment costs are another concern which fuels the search for efficient therapy methods. Behavior disorders, which PCIT pointedly addresses, are one of the most costly public mental health concerns, and constitute the highest number of referrals of children. Reaching these families early and training the parents is considered a highly beneficial course of action (Boggs et al., 2004). The argument is made for the need for therapies which address children in the pre-school years, rather than waiting until they are school age or older, as the behaviors are likely to have become increasingly fossilized as time goes on (Nixon et al., 2003). The research also examines cost-effective approaches for delivering behavioral health services. Nixon et al.’s study incorporated videotapes (as opposed to in-person therapy) as part of its methodology (2003).

The efficacy of in-home PCIT was researched, to determine whether the training could be effective without the use of technical equipment (Ware et al., 2008) or whether additional coaching in the home would enhance the parents’ acquisition of skills (Timmer, Zebell, et al., 2010). Ceballos and Bratton (2010) brought treatment into the schools, making reference to research showing that in-school interventions result in cognitive and social benefits for Latino children. Glover and Landreth (2000) transported filial techniques to a Native American reservation, citing the need for higher availability of services in that setting.

A final problem addressed by the two models of parent-child relationship training is the drop-out rate of the average family involved in therapy. Most families stop attending treatment after 10 sessions. Brief therapy models are considered more family-friendly and reality-based (Nixon et al., 2003).
Filial Therapy

Filial therapy was developed by Bernard and Louise Guerney in the 1960’s in response to a need for a cost-effective and more widely available therapy model for children with mental health issues (Landreth & Lobaugh, 1998; Kinsworthy & Garza, 2010). The Guerneys believed that child-centered play therapy (CCPT) techniques could be taught to parents. Play therapy is based on the premise that children spontaneously move toward growth and that a therapeutic relationship with an adult can help assist that movement (Ceballos & Bratton, 2010). The Guerneys brought the idea that the parent’s relationship with the child, because it is already developed and contains an emotional component, could be a more efficient vehicle than a therapist-child relationship to facilitate growth (Landreth & Lobaugh, 1998; Kinsworthy & Garza, 2010).

The aim of filial therapy is not to focus on any particular behavior problem, but to promote lifelong skills for parents to maintain a supportive (and therefore therapeutic) relationship with their children (Glover & Landreth, 2008; Ceballos & Bratton, 2010). Thus, the training model is seen as both a current intervention and a tool for the prevention of future problems (Landreth & Lobaugh, 1998). The theory purports that underneath children’s maladaptive behaviors are feelings; such as fear or frustration; which can be properly addressed by parents who have learned to empathize with their children. A healthy bond between caregiver and child helps to increase the child’s self-esteem, resulting in more positive behaviors (Glover & Landreth, 2008; Ceballos & Bratton, 2010).

Garry Landreth and Sue Bratton created a manualized version of filial therapy in 2006 titled Child Parent Relationship Training (CPRT) (Ceballos & Bratton, 2010). While most parent training programs are primarily didactic, this approach involves parents in actual practice.
During ten weeks of training sessions, parents learn to respond to their child’s emotions by using such skills as reflective reasoning, which they then put into practice during weekly 30-minute play sessions at home (which are videotaped) (Sangganjanavanich, Cook, & Rangel-Gomez, 2010; 8, Landreth & Lobaugh, 1998). Parents are taught to follow their child’s lead and to influence the child’s behavior more through acceptance than by the more common approach of correction. There is also a limit-setting component (Landreth & Lobaugh, 1998). Filial training utilizes a group format wherein caregivers support each others’ growth by addressing concerns together as well as sharing feedback with one another while viewing videotapes of the home play sessions (Sangganjanavanich et al., 2010, Landreth & Lobaugh, 1998). Sessions are led by a trained therapist and the program is intended for children ages three to ten years old, and their families.

*Parent-Child Interaction Therapy*

Parent-Child Interaction Therapy (PCIT) was developed by Sheila Eyberg as an intervention for children between the ages of two and seven who have extreme behavior issues. The theory behind the program asserts that behavior change in the parents will affect behavior change in their children, which in turn will reinforce positive parent behavior, perpetuating a positive cycle (Timmer, Zebell, Culver, & Urquiza, 2010). PCIT shares many features of filial therapy. For example, the goal of the therapy is behavior change and this is accomplished through the use of the parent-child relationship; and both models attempt to build the warmth and understanding between child and adult (Eyberg, Funderburk, Hembree-Kigin, McNeil, Querido, & Hood, 2001).

In contrast to filial therapy, PCIT focuses half of its sessions on parent-directed (as opposed to mainly child-directed) play. In this model, once a trusting, supportive bond has been developed, parents are taught to manage their child’s behavior through more active means.
Good parenting is seen to comprise of both warmth and control (Leung, Tsang, Heung, & Yiu, 2009). Another difference from filial therapy is that PCIT takes place in individualized training, while filial therapy utilizes a group format. Live coaching sessions are a major component. These occur in the therapy setting and are traditionally held in spaces with a one-way mirror, behind which the therapist sits to observe the parent’s use of the identified skills. PCIT participants are allowed the amount of coaching required to master the taught skills, and mastery is defined in a pre-determined number of particular types of interaction observed in a five minute period of play (Timmer, Zebell et al., 2010). It is believed that if caregivers “overlearn” the skills, they will be more likely to employ them outside of the therapy setting (Timmer, Zebell et al., 2010p. 36).

The first phase of Parent-Child Interaction Therapy, called Child-Directed Interaction (CDI), is based on attachment theory (Eyberg et al., 2001), and involves parents in incorporating non-directive play therapy techniques (similar to filial therapy) to interact with their child (Schuhmann, Foote, Eyberg, Boggs, & Algina, 1998). This phase, which generally requires 7-10 sessions, has been called the relationship-enhancement phase (Leung et al., 2009). Parents learn to describe their child’s behavior, reflect their child’s words, and praise their child’s appropriate actions. These skills help the parent to shift their focus from the child’s negative behavior to the child’s positive behavior. Once the parent shows a grasp on these competencies, they are ready to move into the next stage of treatment (Timmer, Zebell et al., 2010).

The second phase, called Parent-Directed Interaction (PDI), is formatted on social learning theory (Eyberg et al., 2001), and focuses on enhancing child compliance, or diminishing noncompliance (Leung et al., 2009). In this phase, which generally requires 7-10 sessions, parents learn to decrease their use of commands, questions, and critical statements, while increasing their use of praise and selective attention (Timmer, Urquiza, Herschell, McGrath,
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Zebell, Porter, & Vargas, 2006). When parents are observed to give sparing and clear commands, and to use other positive discipline strategies, they are considered competent enough to end treatment (Timmer, Zebell, et al., 2010).

Both phases begin with one session of didactic instruction followed by multiple practice play sessions (Leung et al., 2009). The educational sessions involve explanation, role-play, and demonstration. Both parent and child attend these initial trainings (Leung et al., 2009; Timmer et al., 2006). Subsequent meetings focus on practice of the skills presented by the therapist and incorporate real-time coaching by the therapist. Parents, who wear a hearing device, are able to receive feedback and suggestions as they interact with their child, while the therapist sits behind a one-way mirror (Timmer et al., 2006; Timmer, Zebell et al., 2010).

Parents “graduate” from the PCIT training when they are able to meet specific criteria at each stage (typically within 14-20 weeks) (Timmer, Zebell et al., 2010). At that point, they are felt to have sufficiently mastered the skills which allow their playtime relationship with their child to be of therapeutic benefit (Eyberg et al., 2001).

Variables and measures

*Filial Therapy*

Variables most frequently tested in the studies of filial therapy reviewed by this article included parental acceptance of child, parental stress, and parental empathy toward child. The PPAS (Porter Parental Acceptance Scale) was most utilized to assess parents’ acceptance of their children, including acceptance of the child’s unique qualities, of the child’s feelings and the child’s right to express those feelings; the recognition of the child’s right to make independent decisions, and unconditional love for the child (Bratton & Landreth, 1995). The PPAS is a 40-

Parents’ level of stress was commonly determined using the PSI (Parenting Stress Index), a 101-item self-report inventory developed by Abidin in 1983 which has been demonstrated to have a high level of internal consistency and a strong correlation with other tests of parent distress and parent perception of child behavior. The PSI measures parental distress in two domains: their perception of themselves as parents, and their perception of their child’s behavior (Landreth & Lobaugh, 1998; Timmer et al., 2010). Parent variables include perceptions of depression, isolation, competence, spousal relations, health, attachment, and restriction of roles. Child variables include mood, distractability, demandingness, adaptability, and acceptability (Lee & Landreth, 2003).

Also incorporated in the collection of data was the MEACI (Measurement of Empathy in Adult-Child Interactions). This test was developed by Stover, B. Guerney, and O’Connell in 1971 and is an observational measure of empathy which operationalizes ‘empathy’ as communication of acceptance, allowing child autonomy, and parental involvement. Trained observers use a coding system to record 20-30 minutes of play between parent and child (Lee & Landreth, 2003).

Several studies did not include data collected by a trained observer, and depended primarily on parent report of behavior change (Landreth & Lobaugh, 1998; Glover & Landreth, 2008). Landreth & Lobaugh (1998) and Costas & Landreth (1999) also incorporated tests geared toward the children involved in their studies, such as the Joseph Preschool and Primary Self-Concept Scale (JSCS). This evaluation tool assesses children’s self-concept by using pictures to elicit responses, which are analyzed to give information regarding their sense of significance, competence, virtue, and power (Landreth & Lobaugh, 1998).
Variables most commonly assessed for in the reviewed studies of PCIT included parental stress and the frequency and intensity of child problem behaviors. The PSI (described above) and the ECBI (Eyberg Child Behavior Inventory) were frequently used to determine these variables. The ECBI is a parent-report based index with established reliability and validity and a high correlation with the CBCL (Child Behavior Checklist). The ECBI includes an Intensity Scale, which measures the frequency of problem behaviors, and a Problems Scale, which measures the severity of the behaviors and the degree to which they are perceived by parents as problematic (Timmer, Zebell et al., 2010).

The CBCL was also employed by researchers. This tool, developed by Achenbach (2001), is a parent-report of the frequency of 100 children’s problem behaviors, including both internalizing and externalizing behaviors (Timmer, Ware, Urquiza, & Zebell, 2010). The DSM-IV Structured Interview, which shows very high interrater reliability, was sometimes used to determine child diagnoses (Nixon, Sweeney, Erickson, & Touyz, 2003).

Some studies depended principally on parent report to determine changes in behavior and the relationship (Timmer et al., 2005; Timmer, Ware, et al., 2010; Boggs et al., 2004). Others utilized an observed measure of parent-child interactions, called the DPICS (Dyadic Parent-Child Interaction Coding System) (Schuhmann et al., 1998; Leung et al., 2009; McCabe & Yeh, 2009; Timmer, Zebell, et al., 2010; Chaffin et al., 2004; Ware et al., 2008; Matos et al., 2009; Eyberg et al., 2001). This evaluation, developed by Eyberg and Robinson in 1983, has been determined to show adequate reliability and validity (Eyberg et al., 2001). One study also researched teacher reports (Chaffin, Silovsky, Funderburk, Valle, Brestan, Balachova, Jackson, Lensgraf, & Bonner, 2004). Eyberg et al. (2001) also looked at children’s internal change, with the use of the both the
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Werry-Weiss-Peters Activity Rating Scale and the Pictorial Scale of Perceived Competence and Social Acceptance for Young Children (PCSA).

Quantitative Research

Four phenomenological studies attempted to discover overarching themes in the parents’ experience of filial therapy. Three of the studies focused on parents’ impressions in regards to the structure of the training and the impact of the treatment on the child’s behavior and the parent-child relationship (Winek, Johnson, Krepps, Lambert-Shute, Shaw, & Wiley, 2003; Sannanjanavancih, 2010; Kinsworthy & Garza, 2010). These studies were interested in hearing about both the challenges and successes as parents perceived them. One of those studies also probed how the filial treatment corresponded to participants’ parenting values.

Winek et al. (2003), in a fourth study, tracked a mother’s experience throughout her treatment phase and sought to discover “moments of movement” in the parent-child relationship, in terms of both positive and negative movement (p. 92). This research was interested in the ‘how’ of filial therapy; particularly in elements which inhibited or facilitated progress for the family.

Methodology

Filial Therapy

The experiments cited in the articles regarding filial therapy employed control groups, some of which received treatment after the study was completed. Generally, the studies of filial therapy employed Landreth’s 10-week training model and incorporated random assignment to experimental and control groups. One study controlled the assignment by matching participants across ethnicity and level of education. The model was applied with a variety of populations, including Chinese parents (Yuen-Fan Chau & Landreth, 1997), single parents (Bratton &
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Landreth, 1995), sexually abused children and their nonoffending parents (Costas & Landreth, 1999), incarcerated fathers (Landreth & Lobaugh, 1998), low-income Latino families (Ceballos & Bratton, 2010), Korean immigrant parents (Lee & Landreth, 2003), and Native American families (Glover & Landreth, 2008). Many of these groups were considered at-risk for a variety of reasons, including poverty (Glover & Landreth, 2008; Ceballos & Bratton, 2010), education level, multiple diagnoses/comorbid conditions, trauma (Landreth & Lobaugh, 1998; Costas & Landreth, 1999), cultural factors (Yuen–Fan Chau & Landreth, 1997; Lee & Landreth, 2003; Glover & Landreth, 2008; Ceballos & Bratton, 2010), and special stressors such as divorce (Bratton & Landreth, 1995), alcoholism or adult mental health issues (Glover & Landreth, 2008).

Numbers of participants ranged from eleven to thirty-one parent-child dyads and tended to reflect a wide range of income levels and family types. Child participants were generally between three and ten years old. The setting of the therapy varied, from prisons to clinics to in-school settings; and modifications were made to the training in order to meet the needs of various groups, such as language translation of materials (Ceballos & Bratton, 2010; Timmer et al., 2005) or the provision of free play equipment for families’ home play practice sessions (Ceballos & Bratton, 2010).

Several of the studies employed tight controls. Lee and Landreth (2003) incorporated video-tapes of every session which were reviewed and rated for the variables being tested. In several studies, tapes were blind rated (Yuen-Fan Chau & Landreth, 1997; Lee & Landreth, 2003) and in one case the interrater reliability was determined at above .95 (Bratton & Landreth, 1995).

Parent-Child Interaction Therapy

Several studies (McCabe & Yeh, 2009; Timmer, Zebell, et al., 2010; Chaffin et al., 2004; Nixon et al., 2003) compared groups of participants involved in different sorts of therapy. For
example, groups were trained using modified or enhanced varieties of PCIT and compared to
groups who were trained only in traditional PCIT skills. One of these studies provided adjunct
in-home services to families receiving treatment in a clinic (Timmer, Zebell et al., 2010).
Another study applied cultural modifications, such as additional time built in to sessions to allow
the development of rapport with families whose culture valued solidarity (McCabe et al., 2009).
Another provided families with videotapes in lieu of some of the in vivo sessions with a therapist
(Nixon et al., 2003). Or participants in traditional PCIT were compared to others who received a
“treatment as usual” approach. Most studies involved families in individual treatment. Some
incorporated a group format (McCabe et al., 2009).

Several studies (Capage, Bennett, & McNeil, 2001; Timmer et al., 2005; Timmer, Ware
et al., 2010) compared two groups experiencing the same treatment but differing on a particular
variable such as ethnicity (Capage et al., 2001), maltreatment history (Timmer et al., 2005), or
exposure to interparental violence (Timmer, Ware, et al., 2010). Two studies incorporated a
waitlist (untreated) control group (Matos et al., 2009; Nixon et al., 2003) and three studies
utilized a unique approach such as comparing drop-outs with completers (Boggs, Eyberg,
Edwards, Rayfield, Jacobs, Bagner, & Hood, 2004), testing the efficacy of in-home PCIT
without coaching equipment (Ware, McNeil, Masse, & Stevens, 2008), the comparison of three-
to six-year follow-up results with post-treatment results (Hood & Eyberg, 2003), and the effects
over time of PCIT for children with extreme behavior disorders (Eyberg et al., 2001). Groups
were largely randomly assigned. However, in one study, participants were matched on age and
referral location (Capage et al., 2001).

The usefulness of Parent-Child Interaction Therapy was tested with a variety of
demographics, including children diagnosed with behavior disorder diagnoses such as
Oppositional defiant disorder (ODD), Conduct disorder (CD), and Attention-deficit hyperactivity
disorder (ADHD) (Boggs et al., 2004; Eyberg et al., 2001; Matos et al., 2009; Schuhmann et al., 1998). A high number of boy participants was reported (Boggs et al., 2004; Nixon et al., 2003; Timmer, Ware, et al., 2010; Schuhmann et al., 1998). Most studies kept age limits to children below eight years old but one study incorporated children up to age 12 and found positive results for that sample (Chaffin et al., 2004). An ethnically diverse sample tended to be represented (Eyberg et al., 2001; Timmer, Ware, et al., 2010; Chaffin et al., 2004; Timmer, Zebell, et al., 2010) along with varied income level (Eyberg et al., 2001).

Participants in various studies were considered at risk (Timmer et al., 2005) of abuse or neglect (Timmer, Ware, et al., 2010), or parental substance abuse (Chaffin et al., 2004). Families were often clinic- or county-referred for the studies (Capage et al., 2001; Timmer, Ware, et al., 2010; Timmer et al., 2005; Chaffin et al., 2004); one of these studies (Chaffin et al., 2004) required parents to pass a test of motivation to participate. Several of the studies used samples of 100 or more participants (Chaffin et al., 2004; Timmer et al., 2005; Timmer, Ware, et al., 2010).

The program was modified for language groups (Matos et al., 2009), and tested in a variety of locations, including Hong Kong (Leung et al., 2009). The number of sessions also varied. The majority of the studies utilized a straight PCIT approach in which participants must achieve a level of mastery before moving on in the program. Matos et al. (2009) limited the number of sessions allowed.

Researchers tended to be highly trained (such as doctorate students) and bilingual where necessary. There were controls provided for reliability, including the use of independent observers to code videotapes to check adherence (Chaffin et al., 2004), monitors who accompanied sessions to check reliability of coding, and blind coders of pre-and post-test material (McCabe & Yeh, 2009). Generally, reliability was established at above 90%.
Quantitative Research

Participants in the phenomenological research included Latino parents for two studies (Garza et al., 2009; Sanganjanavanich et al., 2010), a mix of Latino and other families who had a history of domestic violence for a third study (Kinsworthy & Garza, 2010), and a single case Caucasian mother for the fourth study (Winek et al., 2003). All four phenomenological studies utilized an interview format to gather data. For three of the articles, one-time interviews were held post-treatment (Garza et al., 2009; Sanganjanavanich et al., 2010; Kinsworthy & Garza, 2010) and attempted to probe parents’ experience overall. Two of those used group interviews; one used individual interviews (Sangganjanavanich et al., 2010). In one case, the Colaizzi method was utilized to organize the findings (Garza et al., 2007).

In the fourth study, the interviews were conducted after each treatment session and highlighted the in-session experience of the family (Winek et al., 2003). The study utilized a single case design modeled after that described in multiple studies cited in the article.

Findings

Filial Therapy

Researchers generally conclude that filial therapy is either an effective or promising intervention for a variety of cultural groups such as Latino, Korean, and Chinese families; and for single parents, incarcerated fathers, and families who have experienced sexual abuse. One exception was the Glover and Landreth (2008) study on Native American families which concluded that although this population experienced gains, it did not do as well as other groups using this model of parent-child training.

Across a variety of populations, filial therapy affected significant gains in parent empathy and acceptance (Yuen-Fan Chau et al., 1997; Landreth & Lobaugh, 1998; Bratton & Landreth, 1995; Costas & Landreth, 1999; Lee & Landreth, 2003). Data was calculated based on both
parent report and, in some cases, observation ratings by trained professionals. Lee and Landreth (2003) videotaped sessions and determined that parents’ empathic behavior with their children was significantly improved. Most studies reported significantly reduced parental stress (Yuen-Fan Chau et al., 1997; Bratton & Landreth, 1995; Costas & Landreth, 1999; Lee & Landreth, 2003). Ceballos and Bratton (2010) reported that participating parents’ stress levels dropped almost 70 points, as measured on the Parenting Stress Index, whereas the stress levels of non-participants increased by 6 points. The Glover and Landreth (2000) study of Native American families determined that although parent empathy was significantly increased, parent stress was not more significantly affected in the experimental group than in the control group.

Measures of child behavior and self-concept, on the other hand, showed mixed results. Child behavior as perceived by parents was significantly reduced in three studies (Landreth & Lobaugh, 1998; Ceballos & Bratton, 2010; Bratton & Landreth, 1995). Bratton and Landreth (1995) found that parents in the experimental group reported an improvement of an average 18 points on the Filial Problem Checklist post-intervention, as opposed to the parents in the control group who reported an increase in problem behaviors on the FPC. Similarly, Landreth and Lobaugh (1998) reported that the parents who participated in filial therapy gained an average of 18 points on the FPC; this was 11 points more than parents in the control sample. In one study, results in this domain were not significant (Costas & Landreth, 1999).

Four of the studies attempted to rate children’s internal change. They were unable to significantly quantify improved self-concept or self-esteem but two of them noted positive trends in that direction (Landreth & Lobaugh, 1998; Glover & Landreth, 2008). Ceballos and Bratton (2010) attempted to measure both inward and outward change in children, found that children’s internalized reactions were significantly improved, right along with externalized behavior. The study reported that 17 of the 20 children who had demonstrated clinical or borderline levels of
internalized problems, and 15 of the 17 children who had been determined to function in the clinical or borderline range of externalizing problems, improved to normal levels by the end of the study. Results of all of these studies were primarily based on parent report.

**Parent-Child Interaction Therapy**

The data generally supported PCIT as an effective intervention for a variety of populations. Many studies reported strong treatment effects, in terms of improved child behavior and parent stress levels (Timmer et al., 2005; Hood & Eyberg, 2003; Leung et al., 2009; Matos et al., 2009; Boggs et al., 2004). Children diagnosed with ADHD were reported to show significantly less defiance and impulsivity (Matos et al., 2009) both at post-treatment and in a follow-up. Families in Hong Kong made significant gains for the variables studied (child behavior and parental stress) in spite of the fact that the intervention group started lower than the comparison group on both measures. These effects were maintained at a three- to six-month follow-up (Leung, 2009).

In studies which compared treatment groups who had received different forms of treatment, the unaltered version of PCIT tended to yield better results than even enhanced forms. For example, a program which supplemented PCIT with individual therapeutic services for parents achieved no greater gains than a PCIT-only program (Chaffin et al., 2004). Latino parents who received culturally-appropriate instruction did not outperform families in the standard PCIT group (McCabe & Yeh, 2009) and families who received additional in-home coaching did not achieve stronger results than families who did not receive the additional service (Timmer, Zebell, et al., 2010). There also was no difference found in likelihood to remain in treatment (Timmer, Zebell, et al., 2010). Families in these studies tended to significantly outperform families involved in community programs or on wait-lists (McCabe & Yeh, 2009; Chaffin et al., 2004). The study which tested the usefulness of video-taped instruction by the
therapist in lieu of some of the in-person modeling showed surprising results: Parents who received less one-on-one attention from the therapist differed on only one measure of success (Nixon et al., 2003) and six months later, there were no significant differences found between the two groups on measures of observed parent behavior.

An in-home study discovered that PCIT administered without coaching equipment (including the headsets and one-way mirror typically used for in vivo coaching) showed promising results (Ware et al., 2008). In two studies which compared groups receiving the same treatment, there was no significant difference found in either treatment results or drop-out rates. African-American and Caucasian families performed the same (Capage et al., 2001) and children who had been exposed to inter-parental violence did not differ at post-treatment from children who had been exposed to inter-parental violence (Timmer, Ware, et al., 2010).

Several studies looked at long-term treatment results discovered that participants maintained growth over time on several variables (Boggs et al., 2004; Eyberg et al., 2001; Hood & Eyberg, 2003; Schuhmann et al., 1998), including three of the studies focused on children with behavior disorder diagnoses. Ten to thirty months post-treatment, parental stress and child behavior remained low for families with kids from one study who had been diagnosed (pre-treatment) with ODD, CD, or ADHD (Boggs et al., 2004) and was still significantly different for treatment completers than for families who had dropped out of the study. In that same study, at follow-up, there was half as much diagnosable ODD and ADHD in treatment completers as in drop-outs (Boggs et al., 2004).

A second article, which addressed participants’ growth four months after treatment, found that all gains were maintained and that the study’s child participants (who had dropped from clinical to normal behavior levels through the course of treatment) continued to be in the normal range at follow-up (Schuhmann et al., 1998). Researchers generally conclude that filial
therapy is either an effective or a promising intervention for a variety of groups, including Latino, Korean, Chinese families; and for single parents, incarcerated fathers, and families who have experienced sexual abuse. One exception was the Glover and Landreth (2008) study on Native American families which concluded that although this population experienced gains, it did not do as well as other populations using this model of parent-child training.

Eyberg et al. (2001) worked with children with diagnoses of ODD, CD, and ADHD, and found that two years after treatment was completed, seven of thirteen children remained free of the diagnoses with which they had begun treatment (compared to at post-treatment, when 11 of 13 children were considered no longer diagnosable). The same study showed that after two years, post-treatment gains were maintained on indicators of parental stress and child behavior. Hood and Eyberg’s investigation (2003), which did not focus on children with diagnosable disorders, looked at treatment completers three to six years later and still found that treatment effects remained significant. In this study, researchers were surprised to find that some child behaviors even appeared to improve with time. This effect was attributed to a “reinforcing spiral” (p. 427) of positive child and parent behavior. Schuhmann et al. (1998) alluded to the same phenomenon when it hypothesized that treatment effects may increase over time.

In a single-case study with a foster family, one unexpected result was that the foster child moved from an extremely low score on a vocabulary assessment (PPVT) to well into the normal range after PCIT training. The researchers concluded from these findings that research is called for to evaluate this potentially powerful intervention for foster parent-foster child dyads (Timmer et al., 2006).

**Quantitative Research**

Qualitative research results cannot be, and are not intended to be, generalized to the larger public. However, they do lend add to the pool of data to inform practice and can provide
information for practitioners which otherwise would not have been discovered. By directly quoting participants the articles have the affect of helping the reader get into the parents’ world and see with their eyes. An example of where a parent’s own words seem to convey the effect more successfully than a researcher’s words could comes from Winek et al.’s (2003) article about Latino parents which quotes one parent as saying, “There are parents who want better for their families. I think because we have been through this class we are feeling very affected, we are definitely connected to our children. We see that change is possible” (p. 223-224).

Phenomenological research can also lead us in new directions. Winek et al. (2003) probed the experience of one mother-child dyad, with some surprising results. First, researchers discovered that, at least in this case, parent and researcher observations were very similar, leading the authors to posit that parents may be “informed consumers” (p. 100). They also discovered that there were far more potential parental behaviors than child behaviors which limited growth of the relationship. In two interesting examples, the parent’s self-calming behaviors were beneficial for the relationship while the parent’s self-criticizing statements were found to constrain the relationship. Phenomenological researchers condensed participants’ answers to interview questions in search of themes which described their experience of filial therapy.

Parents shared about challenges they ran into, particularly as they started the training. In one of the articles which focused on Spanish-speaking mothers, logistical issues were mentioned, such as finding time to do the assigned at-home play sessions or getting daycare for their non-involved children. Those women also talked about the difficulty when the language of the filial program didn’t translate well into Spanish (Sangganjanavanich et al., 2010).

Generally, the participants appreciated the group format of filial therapy, having liked that there were other parents with similar struggles to talk with and receive support from
Parents, even those who had felt skeptical at the beginning of the process, reported that they would recommend the treatment to other parents. In one case, the interviewees showed strong conviction that filial therapy should be offered to the larger community, including their friends and neighbors (Garza et al., 2009, p. ?). Parents in Sangganjanavanich et al.’s (2010) study stated that they would like the chance for extended family to be more involved.

Reports of changes in child behavior were mixed. Not in every case did parents perceive improvement (Sangganjanavanich et al., 2010). Parents talked primarily about changes in themselves; in their perceptions of and responses to their children’s behavior (Garza et al., 2009; Kinsworthy & Garza, 2010). Parents stated that they felt closer to their children and more effective as parents as a result of the training. One parent said, “I don’t yell or become frustrated with him easily. I don’t see him as rebellious like I used to. I feel like we understand each other more…” (Garza et al., p. 224). Parents also talked about the effect of their diminished stress level as a result of their participation in the study. A parent stated, “Once the stress level went down, I could communicate with her effectively and I started noticing all these awesome things” (Kinsworthy & Garza, 2010, p. 427).

One qualitative article reported a list of so-called facilitative and inhibitive behaviors on the part of both child and parent during treatment sessions. These were defined based on parent and therapist report, as well as researcher observation (Winek et al., 2003). Thirty categories were determined including, for example, “Asking for help” (a facilitative child behavior) and “Anticipating child’s next behavior” (an inhibiting adult behavior).
Limitations and Directions for Further Study

*Filial and PCIT Therapies*

There were a number of limitations cited in individual studies, as well as patterns of limitations noted in the research as a whole. By and large, sample sizes were relatively small, hindering the generalizability of the data. The call was made for larger, more controlled studies to be performed to validate findings which could only be considered “preliminary” because of limited data (Capage et al., 2001), small sample size (Eyberg et al., 2001; McCabe & Yeh, 2009; Ware et al., 2008), absence of a control group (Eyberg et al., 2001; Boggs et al., 2004), or issues with recruitment (Ware et al., 2008). Researchers ran into complicated human realities such as attrition and cost to expand the study controls (Matos et al., 2009). In one case, it was posited that higher attendance by participants would have further affected treatment change (Glover & Landreth, 2008).

Some investigations made modifications to the traditional filial or PCIT training programs (Chaffin et al., 2004; McCabe & Yeh, 2009; Nixon et al., 2003; Chaffin et al., 2004; Matos et al., 2009; Ware et al., 2008; Timmer, Zebell, et al., 2010), either for treatment or control groups. In other cases, researchers wondered whether modifications of the training program would have yielded greater results. For example, Glover and Landreth’s (2008) study of Native American families using filial therapy suggested that the involvement of extended family in the therapy sessions could have increased participant motivation and comfort in the process, leading to a lower attrition rate and greater change of parent and child behavior. Researchers questioned whether a longer treatment period would have further affected the data (Lee & Landreth, 2003). In another case, it was discovered that changes in child behavior could spike at different points (Ware et al., 2008). One could hypothesize that with longer treatment, more change may be evident for some children/families.
By and large, parents reported feeling better about themselves as parents as a result of their participation in the studies (Yuen-Fan Chau & Landreth, 1997; Lee & Landreth, 2003) and several of the articles provided rationales for the match of filial or PCIT skills with cultural values of various groups (Lee & Landreth, 2003; Yuen-Fan Chau & Landreth, 1997; Glover & Landreth, 2008). However, a conversation about the possible presence of cultural bias in some of the research could be relevant. For example, articles sometimes focused on how parents from various cultural groups struggled to meet the demands for mastery on certain skills which conflicted with their cultural beliefs (Glover & Landreth, 2008; Leung et al., 2009). For According to Glover and Landreth (2008) Korean parents were reported to have difficulty expressing their feelings and encouraging their children’s expression of feelings, and were considered to have been successful in treatment after they showed they could demonstrate those skills.

Yuen-Fan Chau and Landreth (1997), in writing about immigrant families to the U.S., stated that “generally, Chinese parents tend to try to control their children in many ways and give a lot of suggestions” (p. 86). The article takes the philosophy that child autonomy is a quality to be desired, and gauges part of the treatment effectiveness on Chinese immigrant parents ability to unlearn a culturally accepted practice. Further research on the effects of filial and PCIT therapies on family dynamics and cultural identity over time for these families may be useful.

The research as a whole could use more measures of observed behavior, as opposed to self-reported information. In several cases, parents’ reports conflicted with other sources. For example, Chaffin et al. (2004) reported that parent and teacher reports on child behavior did not highly correlate. (Name? x2) concluded that parent report may not be reliable (McCabe & Yeh, 2009; Timmer et al., 2005; Timmer et al., 2006) based on inconsistencies within parent reports and the researchers’ observation that parents working with Child Protection services may have a
tendency to under-report problems for a variety of reasons (McCabe & Yeh, 2009; Timmer et al., 2005).

In Timmer et al.’s investigation (2005), parents of maltreated children gave more glowing reports of their children at the beginning of treatment than parents of non-maltreated children, resulting in fewer gains overall for the first group. In another single case study, researchers used a technique (“Faking Good” and “Defensive Responding” scores) to determine the reliability of the foster mother’s reports on her own level of stress related to parenting, and concluded that she likely had under-reported her distress (Timmer et al., 2006). This indicates that while parent perception can be a powerful factor in mediating parents’ stress and level of satisfaction, it is not necessarily a valid interpretation of real change although the result of real behavior change is what filial and Parent-Child Interaction therapies promote.

Several studies (Matos et al., 2009; McCabe & Yeh, 2009; Timmer et al., 2005) recommended that a vaster range of sources of information could help validate results, including more objective measures of child behavior. For example, teacher reports are recommended (Ceballos & Bratton, 2010; Matos et al., 2009) along with reports from fathers (Matos et al., 2009). Reliable measures of children’s internal experience as a result of participation in the trainings are also recommended. However, experiments which attempted to study children’s perceptions encountered difficulties (Ceballos and Bratton, 2010). Costas & Landreth (1999) scores for children’s level of anxiety, self-esteem, and emotional disturbance did not show significant change over time. They hypothesized that the seven-week term of the study was not enough time to affect such deep inner change, in particular in working with children who had experienced severe trauma, such as sexual abuse. They also found that the sample size needed to be larger.
As a whole, there appears to be a need for longer-term study of the effects of these programs. Even articles which reported on long-term effects recommended even longer-term research on the maintenance of treatment results (Eyberg et al., 2001). Other recommendations for further study included more research on the efficacy of in-home treatment (Ware et al., 2008), PCIT for older children (Chaffin et al., 2004), and the use of PCIT for families who with to opt out of using medication for ADHD (Eyberg et al., 2001). Two sets of researchers suggest further study on attrition and how to retain participation (Boggs et al., 2004; Glover & Landreth, 2008). Boggs et al. (2004) found that 71% of drop-out families ended up seeking other interventions (and were not successful in general).

One article talked about the need for more process research to learn more about what exactly is causing the change; for example, to discover how parents learn to be more tolerant of their children (Timmer, Zebell, et al., 2010). Perhaps more research on girls and on internalized (versus externalized) behavior change would also be in order, based on the fact that much of the aforementioned research involved high percentages of boy participants (Timmer, Ware, et al., 2010; Boggs et al., 2004; Nixon et al., 2003; Schuhmann et al., 1998).

**Qualitative Investigations**

Qualitative research, by its nature, is not generalizable to the population at large. It also does not have the same controls that quantitative research needs to employ. Researchers in most of the phenomenological articles discussed the challenge of keeping their own biases in check, and the methods they used to control for that (Sangganjanavanich et al., 2010; Kinsworthy & Garza, 2010; Garza et al., 2009). Another limitation listed in one of the articles was the fact that because participation in this type of research is voluntary, the parents who decide to get involved may represent the group most positively affected (Garza et al., 2009). In other words, we may
not be hearing from the segment of the sample who did not have as good an experience. It may be useful, in terms of future research, to assess data from those parents as well.

Clinical Implications

The findings of the aforementioned research as a whole suggest a number of clinical implications. By and large, studies determined that parent-child relationship programs are transferable across a wide variety of populations, (including from highly educated to uneducated), and settings (including from prisons (Landreth & Lobaugh, 1998) to schools (Ceballos & Bratton, 2010)). One small study found that a streamlined PCIT format was effective. It is suggested that this is good news for families in communities where there is little funding or access to therapeutic resources (Nixon et al., 2003). The results also suggest that parenting skills, which are not necessarily acquired automatically, can be taught and retained over time by parents who find themselves in many different life situations. Several of the studies report even higher results than earlier studies (Bratton & Landreth, 1995), including those conducted by pioneers such as Guerney himself (Landreth & Lobaugh, 1998) suggesting that filial and PCIT therapies transfer well across time as well.

Studies tended to utilize manualized programs for parent-child training. It was discovered that these programs, as written, effected positive change. In the cases where the programs were modified (intensified in some way) and hypothesized to yield greater results, this was not often the case (Timmer, Zebell, et al., 2010; Chaffin et al., 2004). In these cases, it could be argued that “Less is more.” It was also reported, by one large study, that therapist expertise was not a relevant factor in determining treatment success (Chaffin et al., 2004). It could be supposed, based on the aforementioned data, that the filial and PCIT programs themselves are the strongest factor in determining success. In a field in which short-term cost-
Filial and PCIT Therapies effective therapies are in demand, this could have important implications. For example, as compared to other therapies which would require longer training time for practitioners and/or a greater degree of expertise, PCIT’s and filial therapy’s prescribed programs may be a welcome treatment option.

Some research conducted with various cultural groups concluded that cultural modifications could be helpful. Recommended modifications included additional time to build rapport with families and the inclusion of extended family members in the therapy process (Matos et al., 2009; Glover & Landreth, 2008). Others indicated that modifications were unnecessary for treatment effectiveness (McCabe & Yeh, 2009). Generally, immigrant parents reported positive results and research tended to support the hypothesis that these forms of therapy are a good fit with various cultural groups. Filial therapy was found to be effective with Latino (Garza et al., 2009; Ceballos & Bratton, 2010) and Korean immigrant families (Lee & Landreth, 2003), as well as Chinese families (Yuen-Fan Chau & Landreth, 1997), and with somewhat less success, Native American families (Glover & Landreth, 2008). Parent-child interaction therapy was found to be effective with populations representing a diverse range of ethnic backgrounds including Latino (McCabe & Yeh, 2009) and African-American participants (Capage et al., 2001). It would appear that parent-child relationship therapies are an effective intervention with ethnically diverse populations.

Some findings encourage practitioners to check their own biases. For example, findings overall seemed to challenge the common belief that some populations are more likely than others to drop out of treatment (Timmer et al., 200; Timmer, Ware, et al., 2010).

The results indicate that practitioners should use caution in interpreting parent-reported data. The data from the research showing parental attitude change appears more robust at this point than the data showing real behavior change (although significant change in child behavior
has been evidenced in numerous studies). In part, this is due to a lack of sufficient data from multiple sources (such as teachers) to verify movement on the part of children.

On the other hand, the data finds that parents’ internal changes can have a significant impact on the parent-child behavior (regardless of whether the child’s behavior is actually impacted). The qualitative research, for instance, seems to bear out this finding. Parents who were interviewed seemed to talk more about their own shift in perception when asked how their family lives had changed after participating in filial therapy (Garza et al., 2009; Sangganjanavanich et al., 2010; Kinsworthy & Garza, 2010; Winek et al., 2003). They also referenced how their internal movement bore out in their interactions with their children (for example, less spanking) (Kinsworthy & Garza, 2010). Winek et al., (2003) found that parents had more avenues to positively affect their relationship with their child than the children themselves had. The research seems to show that working with parents is an effective route to support families with challenging children. Parents also tended to respond positively to the group format of filial therapy (Kinsworthy & Garza, 2010).

A Comparison to Adlerian Play Therapy

Parent-child relationship and filial therapies share some similarities with Adlerian play therapy, as it is described by Kottman and Warlick (1989). In all three philosophies, play is viewed as a powerful modality, with the adult-child relationship acting as an agent for change in a family. In the case of Adlerian practice, it is the therapist developing a relationship with the child client (Kottman & Warlick, 1989). Parents may be invited into the playroom, and may even be encouraged to engage in filial techniques at home, but it is primarily the job of the therapist to effect change. In Adlerian play therapy, the therapist employs many of the same techniques as those utilized in the studies reviewed for this article. These include tracking child
behavior and reflecting child emotion during play in order to show the child that they are worthy of adult attention.

Another commonality found between PCIT, filial, and Adlerian play therapies is the balance of child-directedness and adult-directedness during the play. Adlerian play therapy encourages adult use of limit-setting. It also keeps question-asking to a minimum and allows that children have the right not to answer any question asked of them. Adlerian therapy tends to be very respectful of the client, as is evidenced in this approach in which both parent and child are allowed to honor their own needs.

Related Concepts in Adlerian Practice

Many of the components of PCIT and filial therapies are reflected in Adlerian concepts dating back to the 1960’s and beyond. Adlerian theory appears to support many of the tenets of parent-child relationship training models. Rudolf Dreikurs, in his 1964 comprehensive text on Adlerian parenting, wrote about the modern influences on parent-child relations which cause children to retaliate against parental control. In his view, children are one of the last groups to be liberated by democracy. Dreikurs (1964) stresses the parental role as that of a guide for children learning to live as responsible citizens in a free society. As he puts it, with greater freedom comes greater responsibility; therefore, a democratic parenting style falls in the middle of a spectrum between the over-directive authoritarian style and the under-directive permissive style.

This sentiment is reinforced in the filial and PCIT formats, which stress that parents should make no effort to control their children, but should be available to them - in an instructive capacity in the case of PCIT, and in a supportive capacity in the case of filial therapy (Bratton et al., 2006). Landreth and Bratton (Bratton et al., 2006), two filial therapists who developed the CPRT model describe punishment as an ineffective practice. Parents can no longer force
Filial and PCIT therapists believe that the child-parent relationship is the most powerful vehicle to affect change for a struggling family. Dreikurs (1964) similarly suggests that most family problems can be boiled down to relationship problems and that this is a critical area of focus for most families. Dreikurs shows his support for parent-child play when he recommends to parents that they build playtime with their kids into their daily routine. He states that having fun together, among other things, is a great diffuser of conflict. Dreikurs writes that this process takes tremendous time and practice; he acknowledges that change in the relationship is difficult to achieve.

In the new order, Dreikurs would have parents treat children as equals; as fellow human beings deserving of the same respect shown to any adult. Dreikurs would, no doubt, have supported the concept of child-directed play (as espoused by the two forms of therapy reviewed for this article). In the Adlerian view, parents ought to view their children’s behavior as goal-directed (Ansbacher & Ansbacher, 1956). It is not the child who is ‘bad’, but the behavior which can cause difficulties. Fortunately, children can be stimulated toward more useful behavior. The filial view, too, is that children are naturally programmed to grow in a positive direction; and that when parents communicate confidence in them, their kids will spontaneously improve. One way parents can convey this confidence is by respecting their children’s decisions during play sessions, by declining to ‘fix’ their mistakes (Bratton et al., 2006).

A respect for order is a quality found in a democratic family, says Dreikurs (1964). He posits that structure, with clear unchangeable boundaries, is something all human beings yearn for and is important for children’s well-being. Limit-setting is a focus of both filial and PCIT therapies. Dreikurs suggests that families teach children to focus on the needs of the particular
situation in which they find themselves. In this way, behavior is determined more by outside circumstances than by the parents’ whims, an approach which is more likely to gain compliance. Bratton et al. (2006) suggest that parents take care to set limits only when they teach responsibility. This sentiment is communicated by Dreikurs who says that parents’ requests must always be reasonable. Bratton et al. also recommend a parental stance of non-judgment and unconditional acceptance of the child. Their suggestion that we “look through the child’s eyes” brings to mind the Adlerian concept of social interest (Ansbacher & Ansbacher, 1956).

Conclusion

Parenting is a challenging journey for which many caregivers feel unprepared when they first embark upon it. Many parents need support and yearn for guidance on how to positively and successfully raise their children in a time when families face numerous challenges. Research suggests that two parent-child relationship training programs, called filial therapy and Parent-Child Interaction Therapy, can be appropriate interventions for families needing extra support. These models show the ability to transcend many differences between groups of people (both cultural and otherwise) to activate the restorative potential of the parent-child bond. They appear to be effective with a wide range of family types and under multiple circumstances.

Studies seem to support the notion that a strong bond between caregiver and child is indeed a healing medium. It would seem that there is hope, even for families and children who have come to critical levels of impairment. According to research, it would seem that there are certain steps, which most anyone can master, that can not only restore both children’s sense of being cared for, and their ability to respect limits. In addition, these steps can successfully be taught to parents individually, or to groups; and in multiple settings – from clinics to homes, to even schools and prisons. The programs also appear to be versatile in their form of presentation
– from more scripted transmissions to many modified versions; and have been effectively taught by people with varied levels of qualifications.
References


