SECOND EDITION

ROUTLEDGE

CHILD-PARENT RELATIONSHIP THERAPY (CPRT):

AN EVIDENCE-BASED 10-SESSION FILIAL THERAPY MODEL

Garry L. Landreth and Sue C. Bratton

This is a true second edition, with six new chapters! The applications for working with toddlers and tweens are specific, detailed, and wonderful. The discussion of how neuroscience aligns with CPRT is insightful. An exploration of CPRT research, along with the evidence-based designation, adds informative value. Other additions for using CPRT with adoptive families, teachers, and discussion of cultural issues round out the core chapters for the 10-session model! It is a treat to read and experience!

—Linda E. Homeyer, PhD, LPC-S, RPT-S,
distinguished professor emerita at Texas State University
and director emerita at the Association for Play Therapy

In their new edition, Landreth and Bratton build on their groundbreaking original CPRT treatment approach to provide an updated and expanded model that is practical, evidence-based, and applied to parents of toddlers through preadolescents as well as adoptive families and other systemic partners. Additionally, the authors have integrated interpersonal neurobiology and recent treatment research to provide rationale that makes a difference for child-parent relationships.

—Dee C. Ray, PhD, LPC-S, NCC, RPT-S,
distinguished teaching professor and director of the
Center for Play Therapy, University of North Texas

CPRT has been empirically demonstrated to improve child-parent relationships and child behaviors. This protocol for therapists provides the essentials needed to implement the program successfully. The notebook for parents expands on the principles, allowing parents to apply them to home situations. These resources enable users to experience the full value of CPRT.

—Louise Guerney, PhD, RPT-S,
professor emerita at Penn State University,
co-developer of Filial Therapy, and faculty
member of the National Institute of
Relationship Enhancement (NIRE)


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Child-Parent Relationship Therapy (CPRT)

Child-Parent Relationship Therapy (CPRT), grounded in the attitudes and principles of Child-Centered Play Therapy (CCPT), is based on the belief that a parent acting as an agent for change in place of a play therapist has potential for significant and lasting therapeutic gains. This newly expanded and revised edition of *Child-Parent Relationship Therapy (CPRT)* describes training objectives, essential skills and concepts taught in each session, as well as the format for supervising parents' play sessions. Transcripts of actual sessions demonstrate process and content in the 10 CPRT training sessions. Research demonstrating the effectiveness of CPRT on child and parent outcomes is presented in support of CPRT's designation as an evidence-based treatment model.

This second edition is updated to include six new chapters exploring the topics of cultural considerations for working with ethnically and racially diverse families, neuroscience support for CPRT, and adaptions for specific populations including parents of toddlers, parents of preadolescents, adoptive families, and the teacher/student relationship. The authors' expertise and experience results in a book that is essential reading for both students and professionals. By using this text and the accompanying treatment manual, filial therapists will have a complete package for training parents in the CPRT model.

Garry L. Landreth, EdD, LPC, RPT-S, is regents professor emeritus, department of counseling and higher education, and founder and director emeritus, Center for Play Therapy at the University of North Texas.

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Child-Parent Relationship Therapy (CPRT)

An Evidence-Based 10-Session Filial Therapy Model

2nd Edition

Garry L. Landreth
and Sue C. Bratton

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PREFACE

This book is about changing the mental health structure of families, communities, and ultimately society, by changing the nature of relationships in families through a process of helping parents become therapeutic agents in their children's lives. From ongoing research, we now know that in a matter of a few weeks, parents are quite capable of learning and incorporating into their relationships with their children and spouses therapeutic skills once thought to require years of graduate education and training.

What we have written in this book about Child-Parent Relationship Therapy (CPRT): An Evidence-Based 10-Session Filial Therapy Model is an extension of our experiences with children in play therapy as they expressed themselves through the process of play in the safety of a caring relationship that released their inner dynamic potential that had been previously unknown to significant adults in their lives. We have long held a deep and abiding belief in the ability of parents to establish the same kind of therapeutic relationship with their own children by learning and incorporating

the basic attitudes and skills of Child-Centered Play Therapy in special play relationships, referred to as filial therapy.

We believe the mental health of future adult populations lies squarely on the shoulders of mental health procedures that empower parents to become therapeutic agents with their own children. We must not wait until children become adults to attempt to impact their mental health, for by then a lifetime of less than the best has been lived out. That is not a very progressive or satisfying way for a society to go about the experience of living life. Mental health professionals must actively engage in the process of giving their skills away to families—that is the future.

We are indebted to the many parents who have shared their lives with us in our CPRT groups. From those parents, we have learned how to be more facilitative in our roles as filial therapists and how to use ourselves more fully in developing relationships with parents in our CPRT training groups. From parents, we have learned what works and what does not work very well in the training process. In general, parents have helped to perfect the 10-session filial therapy model into a dynamic, therapeutic, and educational process that changes lives.

The intent of this text is to provide the essential structure, skills, materials, and resources needed to learn how to effectively conduct CPRT training. To that end, some of the unique features of this book are:

- Specific instructions for implementing the group process and teaching components of the 10-session CPRT model.
- Detailed instructions for structuring the 10 sessions of CPRT training.
- Insights of filial therapists in training about difficult dimensions to pay attention to in facilitating a CPRT group.
- Transcripts of the interactions in 10 CPRT sessions for one group of parents afford an opportunity to experience the filial therapy training process.
- One mother's personal struggles are highlighted in each of the filial therapy training transcripts, revealing her development of insight and the dynamic changes in her attitude and behavior.
- Transcripts of parent-child play sessions provide insight into how parents apply the skills learned.

- Answers to questions parents ask about CPRT training.
- Suggested solutions to problems that arise in CPRT training.
- Application of the 10-session CPRT model in various settings is explained.
- Four-year and 13-year follow-up interviews provide an unusual opportunity to evaluate the continuing and long-range effects of the 10-session CPRT model.
- A review of research on the 10-session CPRT model, which is helpful in justifying CPRT to individuals and insurance panels who make decisions regarding children's mental health care.

Since the publication of the first edition of the CPRT text, important happenings include the national recognition of CPRT as an evidence-based practice by the National Registry of Evidence-based Programs and Practices (NREPP) and by the California Evidence-Based Clearinghouse (CEBC) for Child Welfare. Specific to helping adoptive families, the Donaldson Adoption Institute released a report in 2014 in which CPRT was evaluated as the parent-child intervention that demonstrated the most robust research support for this population of parents and children. We have continued to experience the exciting life-changing impact of CPRT on families in ways that have increased the depth of our understanding and expanded our perception of CPRT's potential. The result has been the addition of six new chapters to this second edition authored by experienced CPRT therapists with expertise in their topic areas:

- Neuroscience and CPRT
- Adapting CPRT for Parents of Toddlers
- Adapting CPRT for Parents of Preadolescents
- Adapting CPRT for Adoptive Families
- Adapting CPRT for Teachers
- Culturally Responsive CPRT

READERS' NOTE

To conduct CPRT, therapists will need to purchase this book's companion, *Child-Parent Relationship Therapy (CPRT) Treatment Manual: An Evidence-Based 10-Session Filial Therapy Model, 2nd Edition* (2019) published by Routledge. The treatment manual

contains treatment outlines, a therapist study guide, parent handouts, CPRT resources, and supplemental training materials needed for conducting the 10-session training model. The *CPRT Treatment Manual, 2nd Edition* is also accompanied by a Companion Website allowing the therapist to print the therapist notebook, parent notebook, and all additional material needed.

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The rewarding shared opportunity with our spouses, Monica and David, to be parents is the most significant experience in which we have invested our lives. Our children, Kimberly, Karla and Craig (G.L.L.) and Lauren (S.C.B.), have made the journey through parenting a wonderful experience as we have struggled to live out the principles of Child-Parent Relationship Therapy on a daily basis with them. They have reaffirmed our faith in the process. This book is dedicated to Monica and David, our children, and our grandchildren. Without their inspiration, love, and encouragement, this book would not have been possible.

We would also like to acknowledge the contributions of our graduate students whose enthusiasm about CPRT and its positive impact on families has been a significant factor in writing this book. We are especially grateful to our many doctoral students who have contributed to the research on the effectiveness of this model. A special thanks to our contributing authors, Mary Morrison Bennett, Kara Carnes-Holt, Peggy Ceballos, Wendy Pretz

Helker, Yung-Wei Lin, Kristin Meany-Walen, Raissa Miller, Yumiko Ogawa, Kristie Opiola, Angela Sheely-Moore, and Alyssa Swan, whose experience and expertise in their topic areas provide a significant addition to the second edition. We are also indebted to Lauren Dimon, Alyssa Swan, and Rinda Thomas-Stein for assistance in preparing and editing the manuscript. Finally, we wish to acknowledge and thank Theresa Kellam and Sandy Blackard for their inspiration, contributions, and feedback throughout the process of writing the first edition of this book.

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CHAPTER 1

HISTORY, DEVELOPMENT, AND OBJECTIVES OF CHILD-PARENT RELATIONSHIP THERAPY (CPRT): A 10-SESSION FILIAL THERAPY MODEL

In *Play Therapy: The Art of the Relationship*, Landreth (2012) stated that if the mental health of future adult populations is to be significantly impacted in positive ways, greater effort must be made to substantially improve the mental health of all children. His position was that the skills of those in the mental health professions must be given away through training to parents, who are in the best position to profoundly impact the lives of future adults. Therapists helping parents to become therapeutic agents in their children's lives is the most efficient way to significantly improve the mental health of adult populations of the future. CPRT is grounded in child-centered/person-centered theory and consistent with the principles of child development and attachment theory.

Child-Centered Play Therapy

CPRT/filial therapy applies the constructs and skills of Child-Centered Play Therapy (CCPT) to parent and child relationships in a manner similar to the relationship between a play therapist and a child. As in CCPT, the parent is taught to facilitate a permissive and growth-producing atmosphere in which the child can reach her full potential. Child-Centered Play Therapy is based upon the theoretical constructs of nondirective therapy developed by Carl Rogers (1942) and further developed and expanded by Rogers (1951) as client-centered therapy. CCPT is grounded in a belief in the innate human capacity of the child to strive toward growth and maturity and an attitude of deep and abiding belief in the child's ability to be constructively self-directing. Rogers (1986) summarized the essence of the approach:

> The person-centered approach, then, is primarily a way of being that finds its expression in attitudes and behaviors that create a growth-producing climate. It is a basic philosophy rather than simply a technique or a method. When this philosophy is lived, it helps the person expand the development of his or her own capacities. When it is lived, it also stimulates constructive change in others. It empowers the individual, and when this personal power is sensed, experience shows that it tends to be used for personal and social transformation. (p. 199)

It is this *formative tendency* that all persons—indeed, all of nature—possess that forms the foundation for the child-centered approach to working with children (Rogers, 1951).

These constructs were applied to working with children through play therapy by Virginia Axline (1969), a student and colleague of Rogers. She successfully applied nondirective (client-centered) therapy principles (i.e., belief in the individual's capacity for self-direction) to children in nondirective play therapy. Her approach was later referred to as client-centered play therapy and then as Child-Centered Play Therapy. Axline (1950) summarized her concept of play therapy:

> A play experience is therapeutic because it provides a secure relationship between the child and the adult, so

> that the child has the freedom and room to state himself in his own terms, exactly as he is at that moment in his own way and in his own time. (p. 68)

The child-centered approach to play therapy, like client-centered therapy with adults, is based upon a process of **being with children** as opposed to a procedure of application. It is not so much a process of reparation as it is a process of becoming. Thus, **the focus is on the child, not the problem.** The child-centered play therapist makes no effort to control or change the child, based on the theory that the child's behavior is at all times internally motivated toward self-realization, positive growth, improvement, independence, maturity, and enhancement of self. The child's behavior in this process is goal directed in an effort to satisfy personal needs, as experienced in the unique phenomenal field that for that child constitutes reality. A fundamental rule of thumb in Child-Centered Play Therapy is that the child's perception of reality is what must be understood if the child and behaviors exhibited by the child are to be understood (Landreth, 2012). (*This concept that the child's phenomenal field constitutes reality for the child is central to Child-Parent Relationship Therapy and is the basis for the structure of much of the training.* ***Rule of Thumb: Look through the child's eyes.*** *The parent is to avoid judging or evaluating even the simplest of the child's behaviors, e.g., painting or stacking blocks, and works hard to try to understand the internal frame of reference of the child.*)

In Child-Centered Play Therapy, it is the relationship that is the agent of change. Child-Centered Play Therapy is an experience for children in which the therapeutic process emerges from a shared living relationship developed based on the therapist's consistently conveyed acceptance of children and confidence in their ability to be of help to themselves, thus freeing children to risk using their own strengths. Virginia Axline (1969) concisely clarified the fundamental principles that provide guidelines for establishing and maintaining a therapeutic relationship and making contact with the inner person of the child in the play therapy experience. Landreth (2012, p. 80) revised and extended Axline's eight basic principles as follows:

- The therapist is genuinely interested in the child and develops a warm, caring relationship.

- The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.
- The therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express self completely.
- The therapist is always sensitive to the child's feelings and gently reflects those feelings in such a manner that the child develops self-understanding.
- The therapist believes deeply in the child's capacity to act responsibly, unwaveringly respects the child's ability to solve personal problems, and allows the child to do so.
- The therapist trusts the child's inner direction, allows the child to lead in all areas of the relationship, and resists any urge to direct the child's play or conversation.
- The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry things along.
- The therapist establishes only those therapeutic limits that help the child accept personal and appropriate relationship responsibility.

These principles all point to the development and maintenance of a strong therapeutic relationship. Moustakas (1959) further emphasized the therapeutic value of children experiencing this kind of relationship: "Through the process of self-expression and exploration within a significant relationship, through realization of the value within, the child comes to be a positive, self-determining, and self-actualizing individual" (p. 5).

Filial Therapy: A Radical Approach

The development of filial therapy was an evolutionary process for Bernard Guerney (1964), a child-centered play therapist who ascribed to the theoretical principles of client-centered therapy as conceptualized by Carl Rogers and the play therapy principles of Virginia Axline. Early in his professional career, in the l950s and early 1960s, Guerney (personal communication, October 22, 1992) viewed parents as potential effectual allies in the treatment of their children and began to contemplate the need to involve parents more directly in the therapeutic process. Guerney's first step in the

process of involving parents in the therapeutic process of helping their children was to include parents in the playroom as observers, followed by discussions with parents to explain what they had witnessed in the play sessions. His next step in the evolutionary process was to give parents more of a role in the therapeutic process.

These successful experiences led him to conceptualize a training program in which parents would be trained in basic Child-Centered Play Therapy skills to become the therapeutic agent in their children's lives, based on the view that play is the primary way children express themselves and work through issues. Guerney's premise for his innovative approach was that children's problems are often the product of parental lack of parenting knowledge and skill. Furthermore, he proposed that children's problematic behaviors that were influenced by parental attitudes could be more effectively ameliorated under similar conditions. This was a revolutionary idea, because a prevailing attitude in the mental health field in the l950s and early l960s was that children's problems are usually a product of the pathology of the parents. This shift from viewing the parents as pathological to being the primary therapeutic agent of change in their child's life was a radical departure for the time.

In 1964, Bernard Guerney published the first article, "Filial Therapy: Description and Rationale," explaining the principles and results of filial therapy. In that article, he described the importance of parents as key to the filial therapy approach:

> The parent-child relationship is nearly always the most significant one in a child's life. Therefore, if a child were provided the experiences of expression, insight, and adult acceptance in the presence of such powerful people as parents, every bit of success the parent achieves in carrying out the therapeutic role should be many more times more powerful than that of a therapist doing the same thing . . . a relatively small amount of affection, attention, interest, and so on, from the parent can be expected to be more therapeutic than a larger amount from a therapist. (p. 309)

Because the parent potentially has more emotional significance to the child than does the therapist, the objective of this

approach is to help the parent become the primary change agent in the child's life by using the naturally existing bond between parent and child; thus, the term *filial therapy* was coined by the Guerneys. (Louise Guerney participated with her husband in the early research and development of filial therapy at Rutgers University and has continued as one of the leading proponents of this innovative approach to helping children and families.) Stover and Guerney (1967) proposed further advantages of using filial therapy over play therapy. Utilizing parents as the agent of change would empower parents, reducing feelings of guilt and helplessness parents may experience when dependent upon a professional to help their child. Additionally, as parents learn more effective ways of interacting with their child, there is greater potential for long-lasting change as parents continue to utilize these acquired skills and attitudes throughout their child's life.

The next step in development of this revolutionary approach was the establishment of a sound research program to verify the effectiveness of this program of parent training. The Guerneys' early research results on filial therapy were highly encouraging and provided a strong foundation for the research that followed (Chapter 26 provides an overview of their groundbreaking research).

In the initial stages of development, the Guerneys (personal communication, March 8, 1995) conceptualized filial therapy as a structured treatment program for children with emotional problems and accepted only couples for filial therapy training. Using a small group format, parents were trained in basic Child-Centered Play Therapy principles and skills. Husbands and wives were not placed in the same groups, though, because there were concerns about marital issues dominating the training sessions. Experience and success with their model quickly resulted in a shift in attitude, and they found that when couples were allowed in the same group, they could deal with some marital issues appropriately.

Another important learning was that filial therapy groups composed of parents whose children all had similar personality dynamics, such as acting-out behaviors, were not very effective because the parents had similar dynamics of their own, and they reinforced each other's negative behaviors because they had difficulty viewing each other's children from a different perspective as parents who have children with other kinds of problems might do. This same concern does not apply to groups composed of parents

whose children have a similar issue that has nothing to do with dynamics: children with learning disabilities, children with chronic diabetes, etc. These children share a common problem, but they are different in terms of their personality and dynamics. Heterogeneous groups are preferred.

Originally, the Guerneys met with filial groups for 2 hours once a week for about a year. Their experience and success led them to streamline training procedures so that groups now meet 2 hours once a week for about 5 to 6 months. Research on these shorter groups has produced comparable results to those of the longer groups. Ginsberg (1997) and VanFleet (1994), both protégés of the Guerneys, have successfully adapted the Guerneys' model for use with individual parents.

Development of the Child-Parent Relationship Therapy (CPRT) 10-Session Filial Therapy Model

I (first author) have, throughout my professional career as a high school counselor, university professor, and consultant, been involved in working with parents through counseling and training experiences. For many of my early years as an assistant professor teaching play therapy and carrying play therapy cases, I was involved in teaching parents "Lessons from Play Therapy for Parents" but without any emphasis on having playtimes. I had an intensifying belief that if what I did in the playroom was helpful to children, then parents could develop those same kinds of attitudes and learn to utilize those same kinds of skills with their children. Play therapists should be giving their skills away to parents and teachers. We should not hide our skills behind the door of the playroom. When I read the Guerneys' work in filial therapy, I immediately resonated to this dynamic structure of training and supervising parents that incorporated the facets of teaching, supervision, play therapy, and group process, dimensions that are exciting to me and have occupied my professional focus. Here was a model that allowed me to meld my fascination with group process, my passion for play therapy, and my love of teaching. Filial therapy was a natural fit.

Long-term therapy has always been a problematic concern for me, as I believe we do not fully comprehend the potential of the human organism for growth and change. My doctoral dissertation focused on the effects of collapsing the time between group counseling sessions in time-limited settings. Therefore, I was naturally attracted to the possibility of reducing the number of filial therapy training sessions from what was at that time typically a year of training. I had already learned from my counseling experiences—with parents in the Albuquerque, New Mexico, public schools and parents who brought their children for counseling and play therapy sessions at the University of New Mexico counseling clinic where I was a graduate assistant and intern—that it was very difficult for parents to stay committed for long periods of time. I had similar experiences with parents in the Pupil Appraisal Center (later named the Child and Family Resource Clinic), which employed a multidisciplinary approach to children with learning problems and that I helped found in 1967 at the University of North Texas. In public schools, the typical semester of 15 to 17 weeks is a natural break, and many parents have difficulty carrying through with a commitment beyond that time frame. Therefore, my first filial therapy groups were structured around a 15-week model.

Although these experiences were rewarding, maintaining consistent attendance at training sessions in the last four or five sessions was very difficult; I began to experiment with 12 sessions, but still had problems with dropouts. A 3-month commitment seemed to parents to be much too long, so I decided to try 10 sessions and had immediate attendance success. During these early experiences with filial therapy, I was encouraged to find Arthur Kraft's (1973) book, which provided a case description of his use of 10 sessions of filial therapy training.

The immediate problem confronting me in developing my 10-session model was how to efficiently cover all the material and training experiences I thought necessary in only 10 2-hour sessions. The training content, method, and style of presentation, as well as the sequence of training in the 10-session model, was greatly influenced by my years of experience teaching master's- and doctoral-level courses in Child-Centered Play Therapy and by my experiences in play therapy in the Pupil Appraisal Center at the University of North Texas, where I joined the faculty as an assistant professor in 1966.

The process element, that is, the involvement of parents in the learning process, facilitation of interaction within the group, utilization of a therapeutic modality, and general emphasis on group process, in the 10-session model was an outgrowth of my experiences in teaching master's- and doctoral-level courses in group counseling. In the early years of developing the 10-session model, I trained a multitude of filial therapy groups primarily in off-campus settings in my role as a consulting supervisor in private counseling agencies in the late 1970s. Refinement of the 10-session model was a function of my experiences in these settings. Because the term *filial therapy* was not familiar to parents, in the late 1980s I began to market my approach to parents as Child-Parent-Relationship (C-P-R) Training. Later, after successful experiences with filial therapy in these private counseling agencies, I began to teach graduate courses in filial therapy in my department on the University of North Texas campus. Further refinement of the 10-session structure led to formally naming the model Child-Parent Relationship Therapy (CPRT) to distinguish it from other filial therapy models. The resulting structure of the 10-session CPRT training model is described in detail in later chapters.

The second task was to verify the effectiveness of the 10-session CPRT model through rigorous research. Beginning with Bratton and Landreth's (1995) investigation of the effects of CPRT with single parents reporting child behavior problems, the CPRT filial therapy model has been researched in 32 outcome studies representing a wide range of child and parent populations. Of these, 22 studies are controlled outcome studies published in peer-reviewed journals. Many of the studies used the rigorous dimension of blinded rater analysis of video-recordings of parent and child play sessions to evaluate parents' demonstrated ability to apply the empathic skills of Child-Centered Play Therapy. Chapter 26 provides the reader with summary findings for published controlled outcome studies conducted on this model.

Definition of CPRT/Filial Therapy

Since the use of filial therapy is rapidly becoming an accepted practice in the mental health field, it seems important to provide a

definition that identifies and standardizes the practice of filial therapy. In the CPRT model, *filial therapy is defined as*

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

Objectives of CPRT

The focus of CPRT is on the importance of the relationship between the parent and child and on the inner person of the child, what the child is capable of becoming. This relationship is viewed as the vehicle for the process of change. Therefore, the objective is to help the parent relate to the child in ways that will release the child's inner directional, constructive, forward-moving, creative, self-healing power. As in Child-Centered Play Therapy, **CPRT is not focused on solving specific problems** or a "quick fix," but rather is structured to enhance the relationship—in this case between the parent and child, with the parent serving as the therapeutic agent of change.

The overall aim of CPRT is to enhance and strengthen the parent-child relationship through improved family interactions and problem-solving strategies and through increased feelings of familial affection, warmth, and trust. CPRT offers significant benefits for both children and parents. Therapeutic goals for children are similar to those for children in play therapy, including a reduction of symptoms, development of coping strategies, and an increase in positive feelings of self-worth and confidence. Broad therapeutic

goals for parents include a greater understanding and acceptance of the child's emotional world, the development of more realistic and tolerant perceptions and attitudes toward both self and child, the development of more effective parenting skills based on developmentally appropriate strategies, and last, but not least, to help parents recapture the joy in parenting.

Specific play session objectives include helping parents (a) understand and accept their child, (b) develop sensitivity to their child's feelings, (c) learn how to encourage their child's self-direction, self-responsibility, and self-reliance, (d) gain insight into self in relation to the child, (e) change their perception of their child, and (f) learn Child-Centered Play Therapy principles and skills. Through didactic instruction, demonstration play sessions with children, viewing of video-recordings, role-playing, and supervision of parents' play sessions, parents' sensitivity to their children is enhanced, and parents learn how to create a nonjudgmental, understanding, and accepting environment in which children feel safe enough to explore other parts of themselves as persons and other ways of relating to their parents.

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CHAPTER 2

NEUROSCIENCE AND CPRT

Raissa M. Miller

Child-Parent Relationship Therapy (CPRT) is a well-established approach to working with families (Cornett & Bratton, 2013; Landreth & Bratton, 2019). The many chapters in this text and accompanying manual provide ample evidence of the efficacy of CPRT with a wide range of populations and presenting issues. Although CPRT was developed long before neuroscience terminology and conceptualizations began to enter into counseling, the approach is consistent with a number of findings from developmental, affective, and relational neuroscience fields. Examining links between neuroscience and CPRT can add further depth of understanding and credibility to the approach. Furthermore, relevant neuroscience principles can give counselors another language from which to connect and communicate with clients. Mental health professionals have reported a number of positive outcomes from learning neuroscience and integrating neuroscientific information into their work with clients, including increased empathy, renewed focus on the therapeutic relationship, and increased confidence as a counselor (Badenoch, 2008; Cozolino, 2010; Miller & Barrio Minton, 2016).

The field of neuroscience is still in its relative infancy, and counselors must use caution interpreting and relating such findings

to counseling. Individuals are unique, and brain structures and functions are infinitely complex (Perry, 2009). It is for this reason that this chapter will primarily focus on broad meta-concepts within neurobiology that are well established and broadly supported, including the nature of brain development and neuroanatomy of emotion and memory. I will also briefly discuss neuroscience principles of learning as they relate to the structure and implementation of CPRT.

Nature of Brain Development

Hierarchical Progression

The brain develops sequentially, beginning with lower, more primitive regions (e.g., brain stem and diencephalon) and progressing to higher, more advanced regions (e.g., limbic and cortical areas) (Gaskill & Perry, 2014; Siegel, 2012). Lower brain structures primarily develop in utero and are responsible for regulating core body functions, such as heart rate, sleep/wake cycles, temperature, respiration, and so forth (Siegel, 2012). These structures also play an important role in survival responses and physiological regulation. The loosely defined limbic region develops next, forming primarily from birth to age 5. Siegel (2012) noted that this part of the brain permits "the integration of a wide range of basic mental processes, such as the appraisal of meaning, the processing of social signals, and the activation of emotion" (p. 18). Integration of memory and the attachment system, largely mediated in the hippocampus and amygdala, are believed to originate from this central brain region. The thalamus and hypothalamus are also in the limbic region, serving as information links between the body proper and the brain (Sprenger, 2008).

The cerebral cortex is the last developing region of the brain (Perry, 2009). The brain structures in this "higher" part of the brain begin developing in early childhood but do not fully form and integrate with other regions until early adulthood (Siegel, 2012). The cortex is believed to be responsible for more complex executive functioning (e.g., working memory, attention and focus, planning, and response flexibility), abstract reasoning, problem solving, and inhibition of subcortical impulses.

The hierarchical nature of brain development has a number of implications for child and family therapy. Perhaps most importantly, interventions should match and appropriately scaffold children's cognitive, affective, and behavioral capacities (Perry, 2009). Perry (2009) developed a neurosequential developmental model of therapeutics, in which he suggests a sequence of therapeutic interventions based on children's developmental capabilities and domains of functionality. Perry noted that play therapy approaches are most useful in supporting the development of the limbic system, fostering secure attachments and emotional regulation. The limbic system is the dominant brain region throughout much of early childhood. Therapeutic interventions that primarily rely on verbal dialogue (e.g., cognitive, behavioral, and psychodynamic approaches) are often less effective with young children because they rely heavily on a part of the brain that is not fully developed or integrated, the cortex.

Child-Parent Relationship Therapy includes a number of principles and practices that demonstrate neurodevelopmental sensitivity. Perhaps most significantly, the approach helps parents learn principles of play therapy and engage children in relational connection rather than verbal discussions. This emphasis on relationship is well matched to the part of the brain that is dominant in early to mid-childhood, the limbic system. Neurodevelopmental sensitivity is also reflected in at least two Rules of Thumb: Big choices for big kids, little choices for little kids and If you can't say it in 10 words or less, don't say it. These Rules of Thumb honor the still developing nature of the cortex by not overwhelming children with too many words (i.e., language-based communication) and not expecting children to process too many pieces of information at once.

Neuroplasticity

The brain changes in response to experience throughout the lifespan (Kleim & Jones, 2008; Perry, 2009; Siegel, 2012). Cozolino and Sprokay (2006) defined neural plasticity as "the ability of neurons to change their structure and relationships to one another in an experience-dependent manner according to environmental demands" (p. 12). Put most simply, neuroplasticity is the way the brain learns (Sprenger, 2008). Neurons and neural pathways that

are regularly activated will strengthen and become more automatic and efficient, whereas neurons and neural pathways that are less used will eventually weaken and die (i.e., apoptosis, pruning). Siegel (2012) referred to this process as "use it or lose it." Although individuals are born with certain genetic predispositions and potentialities, experiences influence which genes are turned off or on (i.e., epigenetics). Experiences early in life disproportionally impact specific regions and resulting functions of the developing brain. Negative early experiences can significantly impact the integrative fibers of the brain, deeply impacting stress response systems and self-regulation capacities (Andersen et al., 2008).

The concept of neuroplasticity has significant implications for work with parents. Relationships with caregivers are some of the first experiences humans encounter and are thus central to brain development. The types of experiences parents facilitate, and the frequency of those experiences, will directly impact their children's genetic expression and developing neural structures. Most parents want their children to develop characteristics of self-reliance, compassion, resilience, flexibility, emotion regulation, and so forth. However, many parents do not know the optimal ways to promote neural learning in these areas.

CPRT both enhances and utilizes the brain's natural capacity for neuroplasticity. As noted above, healthy relationships, a key focus in CPRT, support the brain's capacity to learn. Porges (2009) noted that when individuals have a neuroception of safety, their social engagement system is turned on, fostering calm bodily (e.g., slow heart rate, reduced inflammation, and low levels of stress response hormones, such as cortisol) and behavioral (e.g., improved listening, expressions of empathy, and other prosocial interactions) states. When children feel the safety of connection with a trusted caregiver, their parasympathetic nervous systems are more dominant, allowing higher cortical areas of the brain (e.g., prefrontal cortex) to more fully engage and mid-brain structures responsible for memory consolidation (e.g., substantia nigra/ventral tegmental area and the hippocampus) to translate learning into long-term memory storage (Gruber, Gelman, & Ranganath, 2014).

Furthermore, connection is one of seven essential mental hygiene practices that support neuroplasticity and optimal mental functioning throughout the lifespan (Rock, Siegel, Poelmans, & Payne, 2012). The other six essential practices include sufficient

sleep, regular exercise, focus time, time-in, playtime, and downtime. According to Rock et al. (2012), connection is the sense of "feeling felt" and being seen and known by another person. The "Be-With" Attitudes in CPRT (e.g., I am here, I hear you, I understand, I care) provide the kind of presence and acceptance necessary for neuroplasticity-enhancing connection. Similar to Porges's polyvagal theory described above, these experiences foster a sense of openness and curiosity, promoting embodied learning.

CPRT also teaches parents how to facilitate experiences with their children that allow them to learn and *practice* critical skills. The practice component is essential for promoting neuroplasticity. Children are allowed to explore and struggle with developing responsibility, self-efficacy, and self-control. For example, parents learn how to return responsibility to the child. The Rule of Thumb: Don't do for the child what the child can do for him- or herself illustrates this point. Parents' responses, such as "*that is something you can do*" or "*we can work on that problem together*" allow the child to gain a felt sense of overcoming a challenge and of achievement.

Parents are also taught the difference between praise versus encouragement. CPRT emphasizes "encouraging the effort rather than praising the product" so that children can engage in self-appraisal and move towards looking inside themselves for evaluating worth. I can almost see the neurons firing as children experience the feeling of being prized for their efforts and being allowed to determine the value of their products. Neural connections link the positive sensations of creativity and mastery with the sense of being cherished and accepted.

Finally, the CPRT process of limit setting provides an opportunity for children to bring themselves under control and to gain a sense of safety (e.g., "where there are no limits, there is no security"). Through an accepting yet firm response to certain behaviors (e.g., "*I know you really want to hit me with the sword, but I am not for hitting. You can choose to hit the bop bag or the floor*"), children are allowed the time and space to regulate their impulses. They are able to experience what it feels like in their bodies to want to do something but choose not to do it. They learn other acceptable outlets for particular desires.

The repetition of these internalized felt sense experiences build neural nets of positive feelings, thoughts, and behaviors. The

more these experiences occur, the stronger and more automatic they will become in the brain. Although the neural connections will not be fully myelinated until adolescence and early adulthood, a strong foundation is laid that will guide future development of these capacities.

Neuroanatomy of Memory and Emotion

Implicit Memory

Within neuroscience, memory is often referred to as explicit (declarative) or implicit (non-declarative) (Kandel, 2009; Siegel, 2012). Explicit memories are episodic (e.g., remembering a specific event, such as eating strawberry ice cream on your eighth birthday) or factual (e.g., remembering a specific piece of knowledge, such as recalling an article that recommended children sleep 10–12 hours a night). Implicit memories do not carry with them a conscious sense of remembering. Rather, they are interwoven in the mind and body in such a way that they filter the outside world and influence perceptions, emotions, behavioral impulses, and bodily sensations. Implicit memories are the only kinds of memories individuals can form until about 18 months of age and remain primary throughout much of early childhood. Implicit memories play a critical role in the brain's job of anticipating, predicting, and reacting to environmental stimuli in an efficient and effective manner.

The attachment system, and the styles individuals develop to meet attachment needs, are considered a type of implicit memory (Badenoch & Cox, 2010; Schore, 2012; Siegel, 2012). Siegel (2012) defined the attachment system as an "inborn system in the brain that evolves in ways that influence and organize motivational, emotional, and memory processes with respect to significant caregiving figures" (p. 91). Broadly speaking, individuals develop attachment styles along a continuum of secure to insecure. The more secure individuals are, the more likely they are able to rely on significant relational figures to help regulate stress. They are also more likely to be curious about the world around them and seek out novelty and growth. Secure individuals have an internalized sense of "I am worthy and loveable. Although people are not perfect, I can

usually trust others to help me when needed. The world is full of interesting people, places, and things and I want to go out and explore it." Individuals who have more insecure attachments tend to struggle with self-regulation and have more negative views of self, others, and the world.

Implicit memories, especially mental models of attachment, can play an important role in work with parents (Siegel & Hartzell, 2003). All individuals carry with them implicit memories of their own childhoods and ways of being and relating in the context of family relationships. Badenoch and Cox (2010) noted that implicit memories can tell "us about our value and what we can expect in relationships" (p. 466). Sometimes implicit memories filter present moment experience in a negative way and begin to interfere with the parent-child relationship. Implicit memories may inhibit parents' abilities to be emotionally present for their children and to respond in empathic and intentional ways. Recognizing when reactions or responses are the result of implicit biases versus present moment realities is often the first step in creating more choice and change (Siegel & Hartzell, 2003). Although neuroscience research regarding implicit memories is still emerging, one of the best known ways to integrate and transform problematic implicit memories is through disconfirming relational experiences and mindfulness-based exercises that promote greater bodily awareness and acceptance of present moment experiences (Badenoch, 2008; Siegel, 2012). CPRT can help facilitate both new relational experiences and mindful parenting practices.

A relevant CPRT Rule of Thumb to the concept of implicit memory is You can't give away that which you don't possess. Parents can only provide as much emotional presence and acceptance as they are willing to experience and develop within themselves. These abilities are often linked to implicit attachment styles (Schore, 2012). The nature of instruction and group process in CPRT increases the likelihood that implicit memories will be triggered, and thus identified and worked through. Parents are often unaware of the roots of their emotional reactions to their children or even their children's emotional reactions to them and others. In my experience facilitating CPRT groups, discussions related to implicit memories have helped parents decrease self-blame and begin to transform implicit memories into more coherent and integrated ways of being. Badenoch and Cox (2010) noted that "when

implicit neural networks are activated in group, the group, supported by the therapist, can amplify the sense of attunement and, consequently, potentiate the possible repair" (p. 468). The group can serve as a source of regulation and act as disconfirming experiences that can help transform automatic reacting into reflective responding.

Parents are also taught in CPRT that "what's most important may not be what you do, but what you do after what you have done." This concept aligns with the implicit attachment notion of repair (Siegel & Hartzell, 2003; Siegel, 2012) and can help parents foster a secure attachment with their children. Parents do not have to respond perfectly to their children all the time to promote secure attachment. In fact, parents who foster both secure and insecure attachments only "get it right" about one third of the time (Badenoch, 2008). The difference between the two parenting styles is that parents who foster secure attachments recognize when they have "gotten it wrong" and loop back around to try it again (i.e., repair). This process of rupture and repair is believed to build resilience in the brain. Parents learn this important brain-building skill in CPRT.

Emotions

Understanding the role emotions play in brain functioning is essential to work with parents and children. In recent decades, significant emphasis in mental health treatment has been on cognitive theories of change. According to many of these models, emotional and behavioral change results from identifying and disputing maladaptive thoughts (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). These models do not necessarily reflect how our brains and bodies are designed to respond, especially when individuals perceive threat or are under high levels of stress (Field, Beeson, & Jones, 2015; Gaskill & Perry, 2014; Siegel & Hartzell, 2003). Scholars have used a number of terms to describe the way the brain processes and responds to such stimuli (e.g., low road/high road, fast thinking/slow thinking, and bottom-up/top-down). Individuals who have underdeveloped higher cortical brain structures (e.g., children, individuals who have unresolved traumas) are more likely to rely on bottom-up processing that is quick, largely automatic, and non-conscious. Such processing is motivated by

primitive emotional states and activates physiological responding that assists with survival (Panksepp & Biven, 2012).

The cortex, dominant in self-reflection, perspective taking, and thinking about long-term consequences, is largely bypassed in bottom-up processing (Field et al., 2015; Gaskill & Perry, 2014). The ability to learn new information, problem solve, and express empathy is temporarily impaired in such instances. Gaskill and Perry (2014) noted that "reflection on behavior is impossible for the child in an alarm state, and cognitive strategies to modify behavior (even if previously internalized and mastered) cannot be recruited in an efficient way because the cortex is relatively inaccessible under threat" (p. 185). Age, life history, and current stressors all impact whether a person operates out of bottom-up or top-down processing. In general, emotional regulation through more top-down neural processing is a skill initially learned in early childhood through relationships with caregivers and then refined throughout the lifespan.

Play has an important role in the development of emotional regulation (Kestly, 2016; Pankseep, 2009). The Broca's area of the brain, dominate in language development, grows throughout childhood, allowing children to become increasingly capable of verbal expression (Sprenger, 2008). Despite this development, however, play continues to be the most appropriate means of communicating emotional information. Through play, children are allowed to express their inner lives and learn the boundaries of their emotional expression. Play within the context of safe, connected relationships is believed to activate aspects of the parasympathetic and sympathetic nervous systems that allow processing of real-life scenarios and struggles (Kestly, 2016). Perry, Hogan, and Marlin (2000) also noted that play tends to mirror other aspects of physical, cognitive, and social-emotional development. In this manner, playing with a child can provide a window into their neural developmental functioning.

The CPRT approach is consistent with neurobiological understandings of emotions. Parents are taught that play is a more natural way for children to communicate emotions. Parents are provided with the instructions and support for setting up special playtimes that allow that natural communication to occur. Parents are also taught skills to help respond and cope with emotions outside of the special playtime. One of the first skills taught to parents in

CPRT is reflective responding. CPRT facilitators support parents in being able to understand and communicate that understanding to their children. This skill alone can help soothe emotional overwhelm. Siegel (2012) refers to the phrase "name it to tame it" when talking about the effect identifying and labeling emotions has on calming the nervous system.

The CPRT Rule of Thumb: When a child is drowning, don't try to teach her to swim is an excellent example of the approach honoring emotions. Parents are taught that moments of emotional overwhelm (e.g., tantrums, meltdowns) are not times to teach lessons or have children reflect on their behavior. Rather, parents are encouraged to find ways to connect with and soothe the child. Siegel and Hartzell (2003) referred to these incidences as "limbic override" and noted the importance of connection before correction.

Neuroscience of Adult Learning

One of the most exciting findings to come out of neuroscience fields in the last few decades is the notion that the brain can change throughout the lifespan (i.e., adult brain plasticity). Although learning does not occur as easily or efficiently as it does in early childhood and adolescence, counselors can join with parents to create real structural changes (Bavelier, Levi, Li, Dan, & Hensch, 2010). Cozolino and Sprokay (2006) outlined five principles of adult learning that enhance neuroplasticity (p. 12):

1. A safe and trusting relationship with an attuned other
2. Maintenance of a moderate level of arousal
3. Activation of both thinking and feeling
4. A language of self-reflection
5. Co-construction of a narrative that reflects a positive and optimistic self

The first principle, creating a safe and trusting relationship with an attuned other, relates to the social nature of the brain (Cozolino & Sprokay, 2006; Sprenger, 2008). Sprenger (2008) noted that "brains learn best with other brains" (p. 3). As has already been noted in earlier sections, plasticity is enhanced within the contexts of safe relationships. The brain's sympathetic nervous

system, which focuses more on here-and-now survival, is able to relax, allowing parts of the brain responsible for long-term learning and planning to take the lead.

The second principle, maintenance of a moderate level of arousal, reflects research on the role of motivation, rewards, and stress on learning (Cozolino & Sprokay, 2006; Gruber et al., 2014). Neural activity in largely automatic areas of the brain, including the amygdala, hippocampus, and the orbitofrontal cortex, play an important role in translating new information into long-term memory storage (Gruber et al., 2014; Siegel, 2012). Too little arousal, and the brain perceives the information as unimportant for storing. Too much arousal, and the brain is inhibited by other stress response functions in the brain, and memories can become largely implicit and fragmented (Elzinga, Bakker, & Bremner, 2005). Arousal can be regulated through a balance of challenge and support and making sure the information is meaningful and relevant to the learner.

The third principle, activation of both thinking and feeling, reflects the increased understanding of the role emotions play in cognitive learning (Immordino-Yang & Damasio, 2007; Rose, Gilbert, & Smith, 2013; Siegel, 2012; Sprenger, 2008). Emotional centers of the brain play an important role in filtering incoming information for memory salience, as well as in generalizing skills learned in an academic setting to real-life situations. Executive functioning relies heavily on the connection between the orbitofrontal and ventromedial prefrontal cortex and the emotion-producing limbic region (Cozolino & Sprokay, 2006). The Latin root of the word e-mot-ion is e (prefix)-mot (move). Without integration of these brain regions, individuals fail to adequately apply judgment and take appropriate action (i.e., move). Increasingly, state-dependence is emphasized in teaching and learning (Jovasevic et al., 2015). State-dependent learning generally refers to the notion that individuals' memory retrieval is enhanced when the context of learning and the context of application match. For example, parents learning to reflect their child's feelings should practice that skill under circumstances similar to those with which they will actually be reflecting the child's feelings. Ways to promote state-dependent learning include role-plays, true-to-life application exercises, and in vivo experimentation that activate both thinking and feeling.

The final two principles, a language of self-reflection and co-construction of a positive and optimistic self-narrative, also

relate to research on how information is organized and stored in the brain for later retrieval (Cozolino & Sprokay, 2006). Cozolino and Sprokay (2006) noted that "because narratives require the participation of multiple memory networks, these stories serve as ways of enhancing memory through linked associations" (p. 16). Information learned through rote memorization relies heavily on prefrontal cortex functioning, an area of the brain most susceptible to suboptimal functioning when under stress (e.g., insufficient sleep, hunger, emotional overwhelm). Information learned through embodied experiences and incorporated into the narrative of the self, however, is believed to be stored in subcortical, as well as cortical, parts of the brain and is more resilient to stress and overwhelm. The tone and focus of self-reflections (e.g., focus on strengths versus focus on deficits) are also critical in the neuroscience of adult learning. The stories individuals tell themselves about their adequacy and competence as a parent have important implications for behavior. Positive self-narratives beget more positive parenting behaviors.

The CPRT process aligns quite nicely with these neuroscience-informed principles of adult learning. The approach is designed as a group experience, allowing for the development of safe, supportive relationships and as a place to acknowledge emotions and rewrite parenting self-narratives. Counselors facilitating CPRT acknowledge strengths (e.g., positive parenting behaviors, successes) and empower parents through active affirmation. This idea is particularly illustrated in the Rule of Thumb: It is difficult to believe in yourself if no one believes in you. Parents' struggles are normalized within the group, and they are able to both give and receive support, enhancing relevance and meaning.

Furthermore, in CPRT counselors utilize a number of strategies that evoke thinking and feeling, as well as further foster development of positive self-narratives. The CPRT Treatment Manual, 2nd Edition, includes a number of stories and analogies (e.g., the struggle to become a butterfly, oxygen mask on an airplane), and participants are encouraged to share examples and areas of concern. Throughout the group experience, participants engage in state-dependent learning through conducting their own play sessions, engaging in role-plays (e.g., practice limit setting, choice giving, self-esteem-building responses), and completing homework assignments (e.g., Feeling Responses, skill tracking, Sandwich Hug/Kiss, positive character quality notes).

Conclusion

Neuroscience research is increasingly relevant in counseling. Some scholars have referred to neuroscience as the fifth force in the counseling profession (McHenry, Sikorski, & McHenry, 2014). Fortunately, this shift in the field does not necessarily mean counselors have to completely rethink their approaches. As has been presented in this chapter, much of what counselors already do align with neuroscience principles. CPRT is a good example of this notion. CPRT is consistent with principles of brain development, neuroanatomy of emotions and memory, and neuroscience of adult learning.

As counselors learn more about neuroscience principles that underlie their work, they can begin sharing this knowledge with clients. Excellent resources exist for counselors interested in sharing neuroscience principles with parents, including an article I wrote in a recent edition of *The Journal of Mental Health Counseling* (Miller, 2016), as well as multiple texts by Dan Siegel and various co-authors (for a complete list of books, visit www.drdansiegel.com). Additional information to share can be found through reputable online websites (e.g., Center on the Developing Child at developingchild.harvard.edu).

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CHAPTER 3

UNIQUE FEATURES OF CPRT

There are many significant and dynamic features of CPRT that set this model apart from other parent training programs. The following parent-child dimensions and training dimensions make CPRT a unique form of parent training.

Parent-Child Dimensions

Parent-Child Relationship

The primary focus of CPRT is on enhancing and strengthening the parent-child relationship by equipping parents with basic Child-Centered Play Therapy skills that have been proven to be necessary and effective dimensions in facilitating the development of secure attachment relationships. Most other parent training programs focus primarily on teaching specific techniques or problem-solving skills to be utilized in the correction or extinguishing of specific child-related behaviors. CPRT is based on the rationale that the relationship between parent and child is the essential and curative

therapeutic dimension for improving and correcting children's problems and preventing the development of future problems.

Communication Is Play Based

Unlike other parent training models that rely on verbal skills stressing family discussions or parent-child discussions to resolve problems, **CPRT and other forms of filial therapy rely on the child's natural means of communication—play—as the primary medium for communicating the child's feelings, needs, wants, wishes, fantasies, experiences, and thoughts.** In filial therapy, play is the communication medium for understanding the child and building the parent-child relationship. Children are comfortable with the medium of play and can, therefore, more easily lead the play experience/relationship to focus on dimensions important to them. The child's communication through play is, thus, less restricted.

Symbolic Expression

Since play is the child's natural medium of expression and CPRT is play based, it is the only parent training model that allows children to express their emotions fully through the safety of symbolic expression and within the context of child-directed play. Toys are not merely used as a way to get the child to talk or to provide parents a means to apply discipline strategies. Parents are taught that children's play behavior has meaning, and demonstrations with toys are used to convey examples of how a child's self-directed play with the selected toys may relate to events, fears, etc., in the child's life. Parents are taught to be sensitive to possible meanings in their child's play. However, they are not expected to figure out or understand symbolic meaning in a child's play, only to be sensitive to the importance of the play and the therapeutic value of play. The important factor is that the child has an opportunity to play out potentially significant messages. The playing out is more important than whether or not the parent understands the symbolic meaning.

Child Takes the Lead

In the special playtimes, the child is allowed to lead. The parent does not initiate topics of conversation, content of play, or how the time will be spent or offer suggestions for solutions to problems. The child leads throughout the 30-minute special playtime, and the parent follows. The focus of the time together is determined

by the child, regardless of previous child behaviors that may concern the parent. In most other parent training programs, content and direction of parent-child interactions are determined by the parent. Allowing the child to lead provides the child with opportunities to experience what responsibility feels like.

Acceptance Rather Than Correction

In CPRT, there is no emphasis on correcting a child's behavior. The focus of the training is on developing skills to be utilized during a special 30-minute playtime. For 30 minutes, the parent is to be accepting of the child and the child's decisions within appropriate boundaries or limits. The child is allowed to make decisions related to the playtime, what the child will play with, how the child will play, etc., and the parent accepts those decisions. The parent does not correct the child, except in situations where limits are needed, does not wish the child were different, and allows the child to make mistakes without interfering or offering suggestions. For 30 minutes, the child is in charge and is accepted as she is.

Training Dimensions

Group Process/Group Therapy

The process or group therapy component of CPRT is unique and vital to the success of CPRT, because parents often have strong reactions to their children and feelings about themselves and their family members that they need to process in order to be fully present and emotionally available to learn what is being taught in the CPRT training sessions. This process is described in the following self-critique of a graduate student in a supervised filial therapy practicum experience.

> I recognized that Ashley and her husband had an argument on the way to the filial session, and it was obvious that she was going to have a hard time listening until she was able to process how she was feeling right then; so I put my training agenda aside to help her process her feelings. I learned that this kind of flexibility is crucial to filial training. Taking the time to allow Ashley to express her feelings and be heard before I asked her to listen to my training points facilitated the development of rapport

> and trust in our relationship in addition to clearing her system so she could listen. Allowing her to explore her feelings facilitated not only the expression of her feelings but also a greater awareness of her own needs. I believe this will help her to have more effective play sessions with her son because she will better understand the power and process of reflection which I modeled. On a personal note, once again I learned the power of reflection. I did not try to help her come to a resolution in her argument with her husband, but I simply reflected and followed her lead. My reflections facilitated some interesting insights. At the end of the session, she reported feeling much better.

Parents' strong reactions to their children and feelings about themselves and their family members also need to be processed in CPRT training so parents can be fully present and emotionally available to their children as is called for in the special play sessions. One mother described the necessity of processing as "I grew up in a highly dysfunctional family, and I'm experiencing some really strong gut reaction feelings about my parents that are probably preventing me from hearing the emotional messages communicated by my child in our playtimes." The didactic/therapeutic dimensions of filial therapy training sessions and the processing of the parents' special play sessions with their children often reminds parents of emotional wounds and issues with their own parents that have been pushed aside over the years. These issues are explored in the context of their interference with the parents' role of relating to their children as therapeutic agents of change, not in the context of "There is something wrong with you that you need to change," or as personality issues that need to be corrected. Therefore, this component of filial therapy is referred to as group process or as a group therapy type component.

Parents are not in CPRT to receive group therapy. They need training and development of relationship skills. But they also need to develop insight into personal issues that interfere with their relating to their children as change agents, and the processing of personal issues facilitates the inner growth required to enable parents to incorporate the new skills and apply the new behaviors required.

During a CPRT training session focused on developing the skill of reflecting children's feelings, Angela seemed particularly resistant and adamantly questioned the importance of reflecting her child's feelings. In a later training session, she shared:

> I've been thinking about reflecting a child's feelings, and I now understand why it is important. As a child, I would tell my mom I didn't want to stay home with my father when she went out shopping. My mom ignored my pleadings, and my father sexually abused me. I grew up not trusting my feelings and not trusting myself because my mother didn't listen to my feelings. I now realize that when you validate children's feelings, you teach them to trust themselves.

Processing her childhood experience and current feelings in the filial group freed Angela to identify, emotionally relate to, and validate her child's feelings. Angela's sharing her insight also reinforced the leader's emphasis on the importance of reflecting children's feelings and provided added impetus for the other parents to invest energy in validating their children's feelings.

Hearing other parents' experiences breaks down barriers of defensiveness and isolation. Therefore, the leader is active in facilitating interaction among parents and helping them to feel included in the group. The power of the group was summed up by Emily in the last training session as she described what had impacted her in the CPRT training:

> Dr. Landreth could sit there and tell us all day that there are other parents like us who are struggling, to try to make us feel better, but knowing that there are other people we can see, hear, and touch makes a big difference. It helped me so much to hear you-all describe your problems and struggles with your children.

The critical importance of the group process/group therapy component of filial therapy was supported in Eardley's (1978) research. A model of filial therapy structured exclusively around didactic training components coupled with the utilization of demonstrations and required parent-child play sessions with supervision feedback was found to be less effective than a model of filial therapy incorporating a combination of didactic training components and group process components. The effectiveness of filial therapy training is dependent on parents actively processing personal issues related to themselves, their children, the play sessions, and their family.

Future Focused

CPRT training is future focused. Most other parent training models are grounded in past relationships and happenings with an emphasis on correcting the way the child has been. CPRT is focused on what the child is capable of being or becoming, not what the child has done. Therefore, minimal time is spent on parents recounting their children's behaviors. Responding to children based on past behaviors restricts children to continue to be the way they have been.

If significant adults in children's lives perceive them as being incapable of change, then children are bound to their past. It is not possible for a child to become what the child is capable of becoming until a significant adult in the child's life believes the child is capable and responds to the child as though the child were capable. CPRT is based on a belief in the child's capacity for positive self-directed change and, therefore, focuses on the child's potential rather than the child's problem.

Experientially Based

CPRT is primarily experientially based, relying on the principle of learning by doing. Most other parent training models use a lecture–discussion format to teach principles and procedures considered to be important. The experiential approach engages parents more quickly, maintains a high level of parent interest and involvement, and provides opportunities for the trainer to supervise the development of skills. The experiential approach also engages or draws out parents who are hesitant, quiet, or somewhat reserved about talking in a group. This process can be seen in the following description in a filial therapist's report.

> Maria has really surprised me. At first, she was quiet and did not participate in the group discussion. She seemed to become more comfortable in the third session, and then really seemed to explode with excitement once she began the play sessions with Adam. Wow, the excitement and enjoyment she had was exciting to me! She was faithful in bringing her video-recording each week. On the video-recording, it was evident that she understood the skills we taught and was applying them. In fact,

> I was surprised at the pace at which she really learned the skills. By the fifth training session, Maria began to share her feelings about the playtimes and began asking how she should respond in specific situations outside the play session.
>
> She also began sharing what she was learning with her husband and even video-recorded him in a play session with Adam, then brought the video, with her husband's permission, for us to view. As we viewed the video of his play session, Maria pointed out how he should have responded and in general took on the supervisor role. She reported that the play sessions were fun for her and for Adam, that Adam was treating his sister better and was much more obedient and cooperative at home. Adam's teacher reported that his behavior in the classroom was much more positive, he was more socially interactive and more cooperative at school.

Practicing new skills in a role-playing format in the training sessions prior to implementation of the special play sessions increases the confidence level of parents and helps ensure the new skills will be used correctly in parent-child interactions in the required at-home special play sessions. One filial therapist observed:

> It is not enough for a parent to tell you she understands limit setting. I am sure Margaret did understand. However, it is different when the parent is put in the position of actually setting a limit without having had enough rote memorization of how to state the limit. Margaret did set a limit in her play session, but it was set in the way that she would have done it in the past because she couldn't remember how to actually state the limit in the new way. I can really see the value of role-playing and how beneficial it is to practice in a group where a parent can observe others doing it, too.

The most dynamic part of experiential learning occurs in the required parent-child special playtimes as parents implement their new role of therapeutic agent with their child. These special play

sessions are usually times of exciting discovery for parents about themselves and their children and are often reinforcing times for parents as they successfully implement new skills.

The experiential approach of role-playing during training sessions and then having special play sessions that are viewed by other parents in the group allows parents to engage in the process of giving supportive feedback and encouragement. Peer group support is more powerful in influencing parental behavior than comments made by the CPRT trainer. These dimensions are vital in building parents' confidence in trying new ways of responding to their children.

Building a Relationship Rather Than Correcting a Problem

The focus of CPRT training is on equipping parents with the skills necessary to develop a therapeutic relationship with their children. There is no emphasis on correcting a specific problem a child may have. The rationale for this approach to parent training is that improving the parent's relationship with a child will positively impact the underlying causes of the problematic behavior, which will in turn result in positive changes in the behavior of concern. The person of the child and the parent's relationship with the child is always more important than the problem the child may have. Therefore, CPRT training sessions focus on developing therapeutic relationship skills rather than on techniques or methodology for correcting problems.

Changing the Child's Perception

A central objective of CPRT training is to change the child's perception of the parent and the parent-child relationship rather than to change the child's behavior. Behavior is viewed as a function of perception. Therefore, a change in perception will result in a change in behavior. In CPRT, parents learn how to establish an understanding, accepting, and empathic play session environment in which the parent comes to be viewed by the child as an ally, because for 30 minutes the parent gives up any attempt to correct or change the child. Parents learn how to look through their child's eyes, to assume their child's perceptual frame of reference.