

***Case Study 1: An Evidence Based Practice Report***

***Theme: Parent-led Interventions for Children with Special Educational Needs***

***Review Question: How effective is the parent-led group intervention filial therapy (also known as Child-Parent Relationship Therapy) in reducing problematic behaviour in children aged two to twelve years?***

**1. Summary**

Behavioural, Emotional and Social difficulties (BESDs) have been consistently associated with poor short and long-term academic, social and psychological outcomes for children and young people (, Kutash, Duchnowski, Epstein & Sumi, 2005; Reid, Gonzalez, Nordness, Trout & EpsteinF, 2004; Rowe, Maughan & Eley, 2006). Filial therapy, a parent-led non-directive play therapy originally developed in the 1960's, has been widely utilised with the aim of improving socio-emotional wellbeing and behavioural outcomes for children aged two to twelve years. Meta-analytic results which evaluated controlled studies published between 1953- 2000 demonstrated large positive effects of filial therapy on behavioural outcomes (Bratton, Ray, Rhine & Jones, 2005). The current review aimed to systematically review research published since this date to determine the effectiveness of the intervention in light of the current legislative and research context which recognises the importance of parental involvement in the planning and delivery of interventions. Seven studies met the inclusion criteria and were systematically reviewed using the Gough (2007) weight of evidence framework and promising effects were found. Implications of these findings in terms of the possible utility of filial therapy as a short-term preventative intervention for use with vulnerable groups at risk of developing BESDs were discussed in relation to the methodological rigour and relevance of the studies included in the review.

## **2. Introduction**

### **What is Filial Therapy?**

The filial therapy approach involves parents being trained in non-directive, child-centred play therapy skills by a play therapist in a group setting, following which parents implement play therapy with their child. The approach was initially developed by Bernard and Louise Guerney in the 1960s (Guerney Jr., 1964). Filial therapy is based on the belief that the emotional bond between parents and their children can be utilised to enable parents to become therapeutic agents in their children's lives through child-centred play therapy. The goals of filial therapy sessions are: (a) to help the child change his or her perceptions or misconceptions of the parent's feelings, attitudes and behaviour; (b) to allow the child to communicate thoughts, needs and feelings to his/her parents that he/she had previously kept from awareness through the medium of play and (c) to bring the child a greater feeling of self-respect, self-worth and confidence (Andronico & Guerney, 1967).

A meta-analysis, which included 98 controlled outcome play therapy studies conducted between 1953-2000 (of which 26 used filial therapy) found a large effect of filial therapy in reducing problematic behaviour in children (among other variables) (Bratton, Ray, Rhine & Jones, 2005). Since the meta-analysis, a number of controlled outcome studies have been published which have used filial therapy as an intervention to improve the social and emotional wellbeing and decrease problematic behaviour in children, many of which were described in the comprehensive literature review conducted by Baggerly, Ray and Bratton (2010).

### **Modes of delivery**

Building on the work of the Guerney's, Landreth developed a condensed, 10-session training format of filial therapy delivered to parents in a group in order to minimise time and financial constraints which were found to hinder parental participation (Landreth, 1991, 2002). This protocol was later developed into a manual format by Bratton, Landreth, Kellam & Blackard (2006) to enhance utility and replicability and to enable therapists with varying experience to successfully train and supervise parents in filial therapy. An individual version of filial therapy has also been developed by Vanfleet (1994) which has been applied to a group context.

Table 1: Overview of the core components of filial therapy

Session 1	Facilitator presents an overview of filial therapy/CRPT training objectives and essential concepts. Session includes group introductions, training in basic child-centred play therapy skills e.g. reflective responding and optional activities e.g. role play/worksheets/introduction of homework assignment to facilitate understanding of the session content.
Session 2	Informal sharing and review of homework (if issued). Tools are used to facilitate further understanding of the basic principles of play. Demonstration of how toys could be used in play sessions. Homework assignment is focused on parents finding a suitable place to play at home.
Session 3-10	Parents conduct weekly, thirty minute, at-home play sessions with their child using a special kit of specific toys recommended in the filial therapy/CPRT protocol. These sessions are videoed for fidelity and supervision purposes. Each week, parents are assigned to show segments of their videotaped sessions to the rest of the group and discussion is focused around this. In group sessions, parents are also taught more advanced child-centred play skills including choice-giving and therapeutic limit setting.

Parent-Child Play Session Component (session 3-10)

After learning the child-centred play therapy skills, parents partake in thirty minute play sessions with their children using a special kit of toys which are approved by a supervisor, which contain “real-life toys” e.g. baby doll, kitchen dishes, “acting out aggressive toys” e.g. small toys soldiers and toys for “creative, emotional expression” e.g. play dough, crayons. These play sessions take place at home (or another designated space e.g. room in a university building or school dependent on the context of the study) at a time where the play session will not be disturbed. One key feature of these play sessions is that they are child-led and the parent follows the child in play. It is important that the parent does not take the role of a “teacher” in solving problems in play. Another key feature is that the parent uses the skills learnt in the group sessions about child-centred play e.g. through using positive body language. A special toy that might be used by a two year old is play dough. The child may start to squash the play dough into a flat shape. In this situation the parent can join in with what their child is doing however they should not try and manipulate the play dough into a more meaningful shape or figure. A twelve year old may choose to select one of the “acting out aggressive toys” such as toy soldiers. They might choose to play with the soldiers aggressively and make “gun noises.” However, it is important that the parent does not this form of play as it could be a way of the child expressing their internal anger.

#### Basis of filial therapy in psychological theory

Filial therapy is largely based on Carl Roger's humanistic theory of personality development (1951, 1959) who theorised that a child's feeling of self-worth develops in early childhood from the interaction of the child with his caregivers and that this predicts the child's behaviour and responses to others. Filial therapy aims to develop the child-parent relationship through play, whereby the parent demonstrates empathy and unconditional positive regard towards their child, hence creating optimum conditions in which a child's feeling of self-worth can develop.

Axline (1947), who was instrumental in the development of play therapy, believed that psychodynamic mechanisms underlie the approach as children are able to create play which resembles the emotional experiences that they are struggling with internally but which they cannot express verbally. She believed that they therefore have the ability to solve their own emotional problems through this medium. This concept is in line with the core principles of filial therapy described by Guerney (1964).

Filial therapy may also be underpinned by the psychological constructs of attachment and attunement. Siegel and Hartzell (2004) discussed the essential role of the ability of parents to communicate empathy, understanding and acceptance in promoting an attuned parent-child relationship that is essential for the development of secure attachment. Filial therapy enhances attunement through teaching parents child-centred play therapy skills which encourage the caregivers to be emotionally responsive and consistent, communicated through non-verbal signals during play.

*Relevance to Educational Psychology (EP) Practice*

Behavioural, Emotional and Social Difficulties (BESDs) are consistently associated with negative outcomes (Reid, et al., 2004). Some researchers have indicated that students with BESDs experience less success at school than any other group (Wood & Cronin, 1999; Landrum, Tankersley & Kauffman, 2003; Wagner, Kutash, Duchnowski, Epstein & Sumi, 2005) as they are at risk of failing to meet expected levels of progress (Anderson, Kutash and Duchnowski, 2001) and having lower levels of academic attainment (Reid, Gonzalez, Nordness, Trout & Epstein, 2004). SEBDs are also associated with increased levels of depression and long-term psychological distress (Rowe, Maughan & Eley, 2006).

A broad scope of work within Educational Psychology therefore includes implementing support and interventions for children and young people with SEBDs (Miller and Black, 2001; King & Kellock, 2002; Lown, 2005) and EP's are expected to possess considerable expertise in this field (Rees, Farrell and Rees, 2003). It is therefore paramount that EPs are equipped with a firm knowledge base of evidence-based interventions that are effective in reducing problematic behaviour(s) and enhancing the social and emotional wellbeing of young people displaying SEBDs.

Recent developments in legislation have emphasised the need for parental involvement in interventions to support children with SEN, including children and young people with SEBDs (DfES/DOH, 2014). This is in line with research that has consistently demonstrated the positive impact of parental involvement on children's academic achievement and socio-emotional development (Jackson, Gyamfi, Brooks-Gunn & Blake, 1998; Lamy, 2003; Parker, Boak, Griffin, Ripple & Peay, 1999;

Samaras & Wilson, 1999). This need therefore calls for systematic review of the effectiveness of parent-led interventions which aim to improve BESDs.

### Review question

Despite positive meta-analytic results (Bratton, Ray, Rhine and Jones, 2005) the effectiveness of filial therapy has not been systematically evaluated since the year 2000. Therefore in light of the current context, the following question will be reviewed systematically:

How effective is the parent-led group intervention filial therapy (also known as Child-Parent Relationship Therapy) in reducing problematic behaviour in children aged two to twelve years?

### **3. Critical review of the evidence base**

In order to ensure that the studies included in the review were suitable for the purpose of the question, inclusion and exclusion criteria were devised. Table 2 presents these criteria, with a rationale for each criterion. This criteria was then used in the search process detailed in Figure 1. Studies that met the inclusion criteria are presented in Table 3 and those that were excluded on this basis after full text reading are presented in Table 7, Appendix B.

**Table 2: Inclusion and exclusion criteria for studies included in the review**

	<b>Inclusion</b>	<b>Exclusion</b>	<b>Rationale</b>
<b>1. Type of publication</b>	The study must be published in a peer reviewed journal	The study is not published in a peer reviewed journal	Studies published in peer reviewed journals have gone through a process of external moderation and therefore this ensures a

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				level of methodological rigour
<b>2. Language</b>	The study must be published in English	The study is published in a language other than English		There is a lack of translation resources available.
<b>3. Year of publication</b>	The study must be published after the year 2000	The study was published before or including the year 2000		A meta-analysis (Bratton, Ray and Rhine, 2005) included all controlled outcome studies (1953-2000) which used filial therapy.
<b>4. Type of study</b>	a) The study must contain primary, empirical data  b) The study contains quantitative data	a) The study does not contain primary, empirical data  b) The study contains solely qualitative data		a) This ensures that findings are original and that effect sizes can be generated for analysis and comparison.  b) This allows for greater statistical comparison of results to determine effectiveness of the intervention.
<b>5. Intervention</b>	a) The filial therapy program must be explicitly stated as the intervention used in the study.  b) Filial therapy must be implemented by parents/carers, following a period of training by a professional trained in filial therapy.	a) The study does not explicitly state filial therapy as the intervention being used.  b) Filial therapy is implemented by a group other than parents, e.g. teachers.		a) This ensures that results are representative of the intervention relevant to the review question.  b) This allows the effectiveness of the parent component to be determined.

<b>6. Participants</b>	Participants include parents/carers and children aged between 2-12 years	Participants do not include parents/carers and children aged between 2-12 years	Implementers have indicated that filial therapy is suitable for children from 3-12 years old. However, studies which include 2 year olds in the intervention group have also been included as this reflects the current climate emphasising early intervention. This is supported by statutory guidance in relation to the EYFS framework which includes a progress check at age 2 for Personal, Social and Emotional development (NCB, 2012).
<b>7. Design</b>	<p>a) The study uses a group design</p> <p>b) The study must have at least one control group (no-treatment) or comparison group</p>	<p>a) The study does not use a group design (e.g. single case studies)</p> <p>b) The study does not contain a control group or a comparison group</p>	<p>a) Analysis of studies which use a group design allows for greater generalizability of results.</p> <p>b) This allows a judgement on whether the intervention is more effective than no-treatment or a comparison intervention.</p>
<b>8. Dependent variable</b>	The study must include child behaviour as a dependent variable.	The study does not include child behaviour as a dependent variable.	This allows for analysis of the effectiveness of the intervention on child behaviour.

## Literature search

A final search of databases PSYCINFO, ERIC and PUBMED was conducted on 11/02/15. Two sets of search terms were used (owing to the different terms used to describe problematic behaviour) to obtain the relevant studies to the review:

- **SET ONE:** (Child-Parent Relationship Therapy[Title/Abstract]) OR filial therapy [Title/Abstract] AND behav\* problems[Title/Abstract]
- **SET TWO:** (Child-Parent Relationship Therapy[Title/Abstract]) OR Filial Therapy [Title/Abstract] AND Behav\* difficulties[Title/Abstract])

When the searches were conducted, additional limits were applied which related to the inclusion criteria, these included:

1. Published in a peer-reviewed journal (related to exclusion criteria 1)
2. Published between the years 2000-2015 (related to exclusion criteria 3)
3. Studies published in English only (related to exclusion criteria 2)

Figure 1: outlining database search process for SET ONE search terms

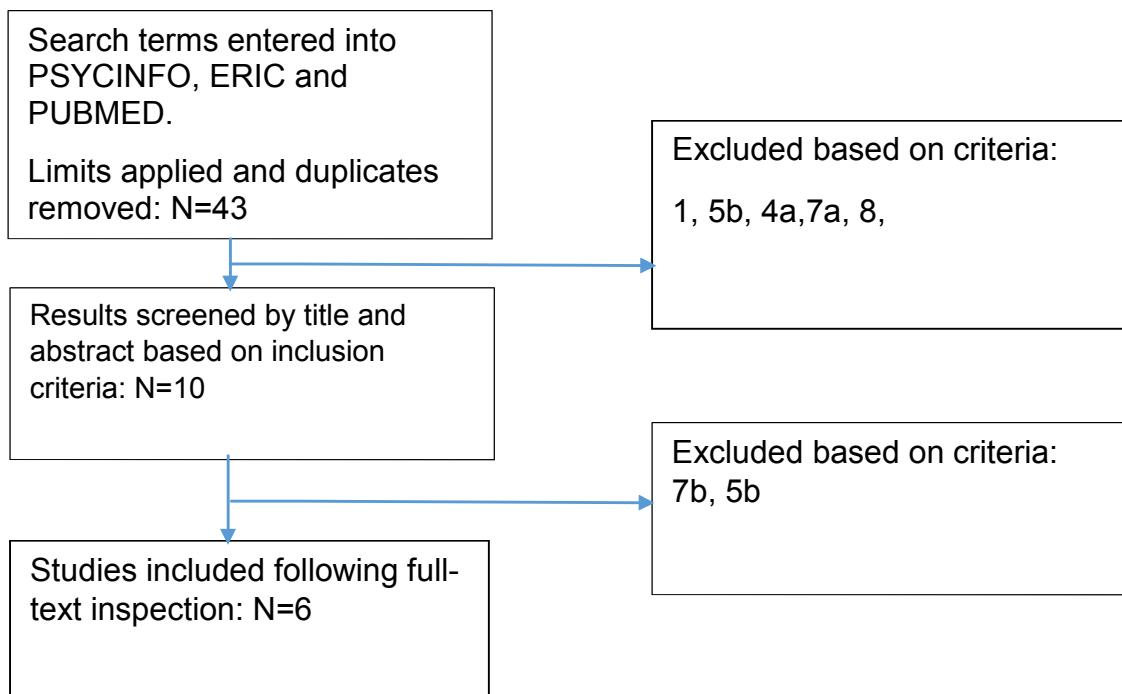
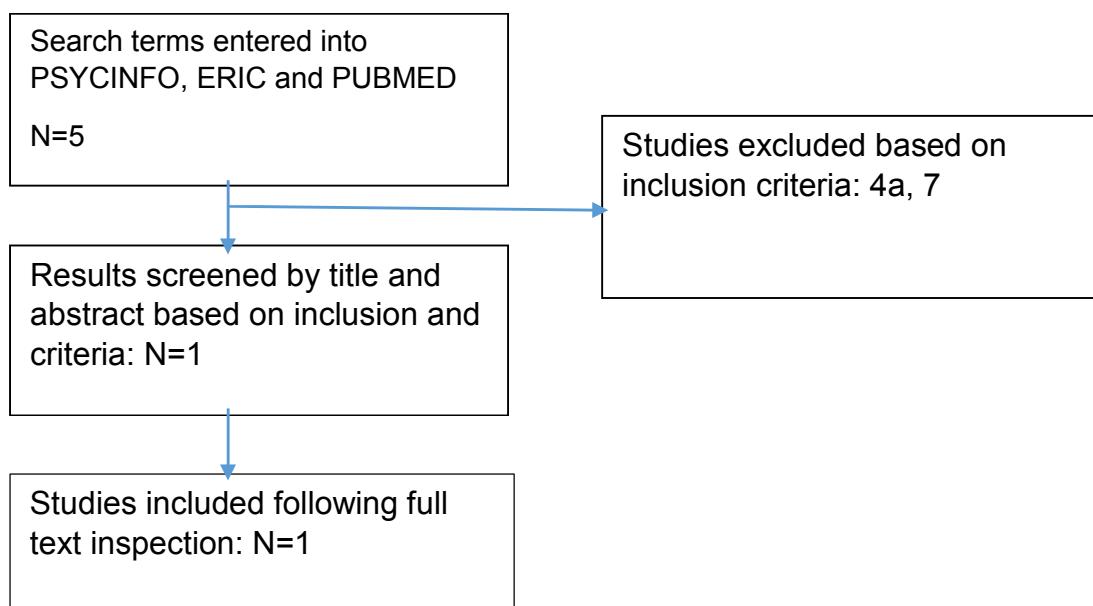


Figure 2: outlining database search process for SET TWO search termsTable 3: Studies included in review

<b>Study Code</b>	<b>Reference</b>
1	(Ceballos and Bratton(2010) Empowering Latino Families. <i>Psychology in the Schools</i> , 47(8),761-775
2	Yuen, T, Landreth, G, and Baggerly, J (2002) Filial therapy with Immigrant Chinese Families. <i>International Journal of Play Therapy</i> , 11(2), pp. 63- 90
3	Tew,K, Landreth, G, Joiner, K and Solt, M (2002) Filial Therapy with Parents of Chronically Ill Children, <i>International Journal of Play Therapy</i> , 11(1), pp. 79-100
4	Smith, N and Landreth, G (2003) Intensive Filial Therapy with Child Witnesses of Domestic Violence: A Comparison with Individual and Sibling Therapy, <i>International Journal of Play Therapy</i> , 12(1), pp. 67- 88
5	Carnes-Holt, K and Bratton, S.C (2014) The Efficacy of Child-Parent Relationship Therapy for Adopted Children with Attachment Disruptions, <i>Journal of Counseling &amp; Development</i> , 92, 328-337
6	Grkovic, J and Goetze, H (2008) Short-Term Filial Therapy with German Mothers: Findings from a Controlled Study, <i>International Journal of Play Therapy</i> , 17, No. 1, 39–51
7	Sheely-Moore, A.I and Bratton, S.C (2010) A Strengths-Based Parenting Intervention with Low-Income African American, <i>Professional School Counseling</i> , 13(3) pp. 175-183

### **Weight of Evidence (WoE)**

The Gough (2007) framework was used in order to appraise the quality and the relevance of the studies included in the review. Please see Appendix C for the criteria used, evidence, rationale and individual numerical ratings generated for each study. WoEA involved generic judgements about the coherence and integrity of the evidence being made. For this purpose the Kratochwill (2003) APA Taskforce coding protocol was used which allowed different features of the study to be coded systematically. Please see Appendix D for the coding protocols used to make WoEA ratings and numerical ratings for each study included in the review. Through using the Kratochwill coding protocols, it was possible to award each study a numerical rating for each of the key features outlined in Table 7 (Appendix C). A rating of 3 for each feature indicated that the evidence was 'strong', a rating of 2 indicated that it was 'promising', a rating of 1 indicated that it was 'weak' and a rating of 0 indicated that there was 'insufficient evidence' for a rating to be awarded. The ratings for each study for each key feature are presented in Table 8. This rating system then allowed mean rating to be calculated for each study. Studies received an overall WoEA rating of 3 if the mean fell between 2.5-3, 2 if the mean fell between 1.5-2.4, 1 if the mean fell between 0.5-1.4 and 0 if the mean fell between 0-0.4.

WoEB involved specific judgements about the appropriateness of the research designs in relation to the review question. WoEC involved specific judgements about the relevance of the focus of the evidence for the review question. The framework allowed the three sets of ratings to be averaged to form an overall assessment of the extent to which each study contributes to the review question (WoED).

Table 4: summary of WoE ratings (numerical ratings available in appendix C(iv))

<b>Authors</b>	<b>WoEA</b>	<b>WoEB</b>	<b>WoEC</b>	<b>WoED</b>
1.Ceballos and Bratton (2010)	Promising	Low	Medium	Medium
2.Yuen, Landreth & Baggerly (2002)	Weak	Medium	Medium	Medium
3.Tew, Landreth, Joiner & Solt (2002)	Promising	Low	Medium	Medium
4.Smith and Landreth (2003)	Promising	Medium	Medium	Medium
5.Carnes-Holt and Bratton (2014)	Promising	Medium	Medium	Medium
6.Grskovic and Goetze (2008)	Promising	Low	Low	Low
7.Sheely-Moore and Bratton (2010)	Promising	Low	High	Medium

### Critical review

#### **Participants**

Appendix A, Table 6 (Mapping the field) summarises participant characteristics for each of the studies included in the review. The ages of children who participated in the studies ranged from 2-12 years. There was a strong gender imbalance present in the studies, with 83% of the total parents who took part in the studies being female. A slight gender imbalance was also present in the five studies which reported the gender of the children who participated, however this was of an opposite nature, with 55% of the sample being boys. This imbalance may reflect research which suggests that boys are more likely to be identified as having BESD than girls (Lindsay, Panther & Strand, 2006) or it could have been due to the fact that the sample sizes were small, with a total of only 161 participants across all seven studies and only two

studies (Ceballos and Bratton, 2010 and Carnes-Holt and Bratton, 2014) fulfilling the WoEA criteria of having a sufficient sample size to yield statistical power.

The samples of the two studies which report the socio-economic status of participants consist of low-income parents (Ceballos and Bratton, 2010; Sheely-Moore and Bratton, 2010). Participants from a range of ethnic and cultural backgrounds (Mexican, South-American, Caucasian, Hispanic, African-American and Chinese) were represented in the studies. The diversity of the samples therefore indicate that the applicability of the intervention is not limited to one social or ethnic group. However, none of the studies were conducted in the United Kingdom.

Participants included were identified as belonging to a number of vulnerable groups. However only two of the studies (Sheely-Moore and Bratton, 2010; Carnes-Holt and Bratton, 2014) included children due to reported behavioural concerns, which was reflected in their WoEC ratings.

### ***Intervention***

Four different protocols were used to deliver filial therapy in the studies included in this review. The three studies that obtained a 'high' rating for WoEC (Ceballos and Bratton, 2010; Carnes-Holt and Bratton, 2014 and Sheely-Moore and Bratton, 2010) were those that used the Bratton, Landreth, Kellam & Blackard(2006) manualised protocol and which explicitly stated any modifications that were made to the protocol as these features were deemed to ensure the highest degree of replicability.

Fidelity in implementing the intervention was a key feature for WoEA. Three studies (Ceballos and Bratton, 2010; Carnes-Holt and Bratton, 2014 and Sheely-Moore and Bratton, 2010) met the sufficient fidelity checks to be awarded a 'strong evidence'

rating for this criteria on WoEA. The other four studies received a ‘promising evidence’ rating for this criteria.

Two of the studies which were rated as ‘high’ on WoEC (Ceballos and Bratton; 2010, and Carnes-Holt and Bratton, 2014) reported that the filial therapy intervention was delivered by a researcher trained in filial therapy/CPRT who received ongoing supervision from an expert in filial therapy. The remaining studies did not complete sufficient fidelity checks to fulfil this rating criteria and the Grskovic and Goetze (2008) study did not report the presence of either feature which amounted to a ‘low’ overall rating for WoEC.

The length and intensity of the intervention varied considerably between studies. Participants in five of the studies completed a minimum of 10, 2 hour sessions of filial therapy in addition to completing at-home play sessions and received a high rating for this criteria.

### ***Design***

Two studies in the review used a randomized control-group pretest-posttest design (Yuen, Landreth & Baggerly, 2002, Carnes-Holt and Bratton, 2014), one study used a randomized block control-group pretest-posttest design (Ceballos and Bratton, 2010) and four studies used a non-randomized control-group pretest-posttest design (Tew, Landreth, Joiner & Solt, 2002; Smith and Landreth, 2003; Grskovic and Goetze, 2008 and Sheely-Moore and Bratton, 2010). Studies that did not randomly allocate participants to conditions received a ‘low’ rating for this criteria for WoEB as this prevented group-equivalence being established.

Yuen, Landreth & Baggerly(2002) was the only study who tried to control for effects of prior or concurrent interventions. In order for participants to be included in the

study children must not have been receiving therapy at the time of the studies and parents must not have received a parenting class for two years prior to the study.

This was not a prerequisite of the other six studies included in the review, which effected their ratings for WoEB.

All of the studies in the review made an effort to control for the effects of time and repeated assessment through the use of wait-list control and/or comparison groups. However, only Smith and Landreth (2003) made an effort to identify the effectiveness of parental component of the intervention through including two active comparison groups in which play therapy was delivered by a therapist and a sibling in addition to a wait-list control group. Furthermore, as none of the studies included in the review included a follow-up procedure, it cannot be established whether the effects of the intervention were enduring, which lowered the WoEA ratings for all studies included.

Criticisms of the methodological relevance of the studies were reflected in the fact that only three of the studies in the review received a 'medium' rating and the remaining four studies received a 'low' rating for WoEB. This will therefore have a number of implications for the interpretation of the findings.

### **Measures**

In order to measure pre and post differences in child behaviour six studies used the Child-Behavioural Checklist Parent Report which was developed by Achenbach and Edlbrock (1983) and later revised by Achenbach (1991) and Achenbach and Rescorla (2000). This provides scores in the clinical, borderline and normal range for three domains: externalising, internalising and total behaviour problems. The studies used slightly different versions of the instrument and in all studies parent report was the only measure of behavioural change, which effected the WoEA ratings.

The measure has high reported reliability (ranging from  $r=.70\text{-}90$ ) and validity in differentiating between referred and non-referred children (Achenbach and Rescorla, 2000). The normative population for the CBCL was based on a diverse sample, including children referred for clinical and special education services across a number of settings. Children were residents of the US, Canada, Australia and Jamaica. This was reflected in the WOEA ratings for these studies. Furthermore, studies that reported pre and post differences for all three domains (externalising, internalising and total Problems) received a 'high' rating for WoEC.

Yuen, Landreth & Baggerly(2002) used the Filial Problem Checklist (FOC) developed by Horner (1974). The FOC is a self-report instrument which looks at child problem behaviour related to situations of parenting. However, despite the fact that the instrument was reported as being widely used in filial therapy research, no normative data concerning validity or reliability was available for this instrument. This contributed to a lower rating for WoEA.

A key requirement to receive a 'high' rating for WoEA was that measures are obtained from multiple methods and sources. All of the studies included in the review only used one instrument to measure behavioural change and parental views were the only source of information. This was therefore reflected in the WoEA ratings awarded for all of the studies included in the review.

### ***Findings***

In order to calculate mean pre-post differences in the treatment and control/comparison groups, the Morris (2007) effect size formula was used, due to the fact that pre and post means and standard deviations were included for the intervention and control group in all of the studies included in the review. Calculating

the effect size in parent reported behavioural change in the intervention group compared to the control group allows a standardised estimation of the effectiveness of the intervention to be generated. The findings are presented in table5. Cohen's D descriptors (Cohen, 1992) were used to judge whether the effect sizes were small (greater than or equal to 0.2), moderate (greater than or equal to 0.5) or large (greater than or equal to 0.8). Effect sizes below 0.2 were judged as 'not significant.'

Table 5: Summary of Morris (2007) effect sizes of intervention on behavioural outcomes

Author(s)	N	Measure	Outcome	Groups	Effect size	Descriptor (Cohen, 1992)	Overall WoE
<b>Ceballos and Bratton (2010)</b>	E: 24 C: 23	Parent report	Total behaviour problems	E/C	-2.03	Large	Medium
			Internalising behaviour problems	E/C	-1.86	Large	
			Externalising behaviour problems	E/C	-1.53	Large	
<b>Yuen, Landreth &amp; Baggerly (2002)</b>	E: 19 C: 17	Parent report	Total behaviour problems	E/C	-0.74	Moderate	Medium
<b>Tew, Landreth Joiner &amp; Solt (2002)</b>	E: 12 C: 12	Parent report	Total behaviour problems	E/C	-0.67	Moderate	Low
			Anxiety/Depression (internalising)	E/C	-0.21	Small	
<b>Smith &amp; Landreth (2003)</b>	E: 11 C: 11 Co1: 11 Co2: 10	Parent report	Total problem behaviour	E/C	-0.93	Large	Medium
				E/Co1	-0.45	Small	
				E/Co2	0.08	Not significant	
			Internalising Behaviour	E/C	-0.61	Moderate	
				E/Co1	-0.46	Small	
				E/Co2	0.01	Not significant	

			Externalising behaviour	E/C	-0.56	Moderate	
				E/Co1	-0.25	Small	
				E/Co2	-0.01	Not significant	
<b>Carnes-Holt &amp; Bratton (2014)</b>	E: 32 C: 29	Parent report	Total problem behaviour	E/C	-0.54	Moderate	Medium
	,		Externalising behaviour	E/C	-0.65	Moderate	
<b>Grskovic &amp; Goetze (2008)</b>	E: 15 C: 18	Parent report	Total problem behaviour	E/Co	-0.61	Moderate	Low
			Internalising	E/C	-0.56	Moderate	
			Externalising	E/C	-0.60	Moderate	
<b>Sheely-Moore &amp; Bratton (2010)</b>	E: 13 C: 10	Parent report	Total problem behaviour	E/C	-1.07	Large	Medium
			Externalising behaviour	E/C	-0.64	Moderate	
			Internalising behaviour	E/C	-0.48	Small	

E: Experimental (Intervention) group; C: Non treatment control group; Co1: Comparison group 1; Co2: Comparison group 2

It is evident from the fact that the effect sizes (ES's) across studies are negative (as shown in table 5), when the effects of filial therapy were compared to no-treatment controls,.that the filial therapy had the desired effect in terms of reducing problematic behaviour. However, in relation to the Smith and Landreth (2003) study, the only study to include both no-treatment and comparison groups, two positive effect sizes are shown, which were not significant. This indicates that filial therapy implemented by a parent and a sibling were equally effective in reducing total and internalising problematic behaviour. However, small significant negative effects were found when filial therapy was compared with play therapy implemented by a therapist, indicating that filial therapy was more effective when implemented by a parent than a therapist.

The ES's of the filial therapy intervention in reducing total behaviour varied between studies when compared with no-treatment controls. The three studies that reported a large effect (Ceballos and Bratton, 2010;Smith and Landreth, 2003 and Sheely-Moore and Bratton, 2010) each received an overall WoED rating of 'medium' indicating that although efforts had been taken to exercise methodological rigour, the fact that these studies failed to obtain a 'high' rating means that caution should be exercised when interpreting these findings. As studies included in the review did not include follow-up procedures, it cannot be established whether the effects were sustained. Furthermore, as behavioural change was measured solely by parent-report, it cannot be established whether the effects were transferrable across contexts or perspectives. The Ceballos & Bratton(2010) study received a 'low' rating for WoEB as the participants were receiving an additional intervention at the time of the study and participants were also randomly assigned to school site which meant that the effects could not be fully attributed to the intervention. Additionally, the Smith and Landreth (2003) study did not meet the required sample size needed to

generate statistical power. Given that small sample sizes tend to over-estimate effects sizes in populations (Grissom and Kim, 2012) it is possible that the effect may have been exaggerated. The remaining studies found a ‘moderate’ effect of the filial therapy intervention which, given the limitations, most notably in this case that many participants included in the studies were receiving additional interventions, is likely to be more representative of the effectiveness of the intervention overall.

Of the five studies which reported pre and post differences in internalising behaviour when filial therapy was compared with a no-treatment/ control, two small, two moderate and one a large effect were found. Interestingly, of the studies which reported differences in externalising behaviour, no small effects were found, with ES’s ranging from moderate to large. This indicates that filial therapy may be slightly more effective in reducing externalising behaviour. However, there is a difficulty with interpreting these differences for different dimensions as different studies reported different outcome effects. For example, Tew, Landreth, Joiner & Solt (2002) reported pre and post differences in total and internalising behaviour only but the Carnes-Holt and Bratton (2014) study reported differences in total and externalising behaviour only. The Carnes-Holt and Bratton (2014) study obtained higher rating for WoEB and participants in the Tew, Landreth, Joiner & Solt(2002) study received another intervention at the time of the study. Therefore, differences in effectiveness for different types of behaviour could reflect variation in methodology between studies rather than true differences.

## **Conclusions**

The aim of this review was to identify whether filial therapy is an effective intervention for reducing problematic behaviour for children aged 2-12 years. Findings indicate that filial therapy did have an effect of reducing problematic behaviour in participants who received filial therapy compared to participants who did not receive an intervention in all of the studies included in the review. These findings are promising as the samples included in the studies were ethnically and culturally diverse and many of the participants had experienced poverty, early attachment difficulties or trauma. A key strength that was identified through the reviewing process was that several studies used the manualised Bratton, Landreth, Kellam & Blackard (2006) protocol to deliver the intervention and took measures to ensure the fidelity of the delivery through videotaping play sessions where possible. This was reflected in the fact that six out of the seven studies received an overall 'medium' weight of evidence rating which indicates that the methodology and relevance was promising. Furthermore, findings indicate that filial therapy is more effective when delivered by parents than a play therapist, which supports the role of parents in implementing interventions. These findings support meta-analytic results which found positive effects of filial therapy on behavioural outcome (Bratton, Ray, Rhine & Jones, 2005).

However, despite these promising findings, the studies included in the review were limited in a number of key areas. Firstly, as a follow-up condition was not included in any of the studies reviewed, it could not be established whether the positive effects of the intervention were sustained. Secondly, as the only formal measure of behaviour change was through parent report, it could not be established whether the behaviour change was generalised across contexts. Furthermore, the fact that the

parents were the ‘intervenors’ in this study and were also the sole raters of behavioural change could have led to inaccurate reporting of change in problematic behaviour compared to if an objective observer had rated behaviour change from baseline. As this intervention required a significant time commitment it is possible that parents felt heavily invested in the intervention and expected to see a change in their children’s behaviour. This could consequently have led parents to report greater reductions in problematic behaviour than an objective observer would have.

Additionally, levels of baseline behaviour could have been inaccurately measured by the parents. Many of the parents were considered as vulnerable due to factors such as low socio-economic status. Emotional factors associated with this could have therefore led to an over or under representation of their children’s behavioural difficulties. Therefore, due to these factors, the results could lack the reliability that could have been obtained if multiple perspectives of baseline behaviour and change were considered. Thirdly, in a number of the studies the children were receiving interventions in addition to play therapy, participants were not randomly assigned to interventions and limited measures were taken to establish group equivalence. Therefore it cannot be firmly established whether the positive effects were due to the filial therapy intervention or other factors. Fourthly, only two out of the seven studies included children due to reported behavioural concerns, with other studies adopting a preventative approach, and therefore the generalizability of the effectiveness of the program as a targeted intervention to reduce BESDs is therefore limited. Finally, six of the seven studies included in the review were published by the same research team. These researchers have a large vested interest in the intervention and have published numerous profitable resources and books promoting its use. These

studies therefore lack the objectivity that could only have been achieved if the studies were conducted by researchers with no vested interest in the intervention.

### ***Recommendations***

Given the promising findings of the filial therapy intervention, it is recommended that the intervention could be used with children from 2-12 years as a preventative, short-term measure for groups at risk of developing BESDs. This recommendation is based on the fact that findings have indicated positive results with ethnically and culturally diverse, vulnerable groups. These findings are in line with research and legislation which has emphasised the fundamental importance of parental involvement in programmes which aim to develop the emotional, social and behavioural competencies of children and young people (DfES/DOH, 2014).

However, interventions should be exercised with caution and sensitivity as studies that met the inclusion criteria for this review have not yet been conducted in the United Kingdom.

Current limitations of the research prevent filial therapy as being recommended as a long-term, targeted intervention for children with BESD. However, there is a scope for future research to be conducted in this area. It is recommended that future research should include follow-up procedures in order to establish whether effects of the intervention are sustained. It would also be helpful if studies included children with clinical levels of BESD in order to establish whether filial therapy could be used as a targeted intervention for this population. It would also be useful if studies were conducted using larger samples to ensure that the effect sizes are sustained when there is a sufficient number of participants to generate statistical power. It would also be recommended that future research could also assess behavioural change as a

result of the filial therapy intervention from different perspectives, to combat the issue of parent interveners being the sole raters of behaviour change in all studies included in the review, to enhance reliability and credibility of the evidence evaluating effectiveness. Future research could also compare filial therapy with comparison groups in order to identify which components of the intervention are active agents in facilitating change.

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## **Appendices**

- Appendix A: 'Mapping the field' table
- Appendix B: Excluded studies (that did not meet the inclusion criteria following full-text reading)
- Appendix C:
  - i) WoEA (Methodological quality) summary table (with rationale for excluding sections of the Kratochwill (2003) coding protocol)
  - ii) WoEB (Methodological relevance) rationale and summary table
  - iii) WoEC (Review relevance) rationale and summary table
  - iv) WoED (Overall rating) summary table
- Appendix D: Coding Protocols

Appendix A: Table 6: 'Mapping the field'

Author	N	Study design	Age, gender, presenting difficulties of participants	Parent led therapeutic method	Therapist support	Outcome
<b>1.Ceballo s and Bratton (2010)</b>	48 E: 24 C: 24	Experimental group design with random allocation of participants by school site to either the filial therapy intervention group or the wait-list control group	The ages of children in the sample ranged from 3-5 years (with a mean age of 4.12 years for the experimental group and 4.42 for the control group). The sample consisted of 27 boys (13 in the experimental group and 14 in the control) and 21 girls (11 in the experimental, 10 in the control.) There were 47 mothers (23 in E, 24 in C) and 1 father (1 in	Parents conducted 7 weekly, 30 minute play sessions with their child during the last 7 weeks of the program. Parents also completed at-home practice sessions which were videotaped for supervision purposes.	Parents who participated in the filial therapy program received CPRT training in child-centred play therapy skills and supervision throughout the 11 week training program in which they were train. The training program followed the Bratton, Landreth, Kellam & Blackard (2006) protocol. Materials to support training and specific toys, recording equipment and a room in the	There were statistically significant interaction effect of time (pretest, posttest) x group membership (experimental, control) for Internalising Problems, Externalising Problems and Total Problems at the p<0.01 level.

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			E, 0 in C) in the sample.		child's school were also provided.
			The sample consisted of low-income Latino parents and children living in the US.		
<b>2.Yuen, Landreth and Baggerly (2002)</b>	35 E: 19 C: 17	Experimental, group design with random allocation of participants to either the filial therapy intervention or the wait-list control group	The ages of children in the sample ranged from 3-10 years (with a mean age of 5.9 in the experimental and 6.8 in the control group). There were 19 boys (9 in the experimental, 10 in the control) and 16 girls (9 in the experimental, 7 in the control.) 26 mothers (15 in E, 11 in C) and 10 fathers (4 in E, 6 in C) participated.	Each week parents participated in a 20-minute videotaped play session before and after the training in a play room with toys and materials recommended by Landreth (1991). Parents also completed at-home, 30 minute practice sessions with their child which were videotaped for	Parents participated in 10 weeks of filial therapy training (2 hour sessions) in accordance with the Landreth (1991) protocol. Parents received training by a doctoral candidate who was trained in filial therapy in child-centred play therapy skills and received supervision. Parents were also provided with resources related to the filial therapy protocol. Cantonese

			The sample consisted of immigrant Chinese parents and children living in Canada.	supervision purposes.	translation was also provided to parents.	
<b>3.Tew, Landreth and Joiner (2002)</b>	N=23 E: 12 C: 11	A non-randomized block, group design in which participants were non-randomly assigned to the experimental and no-treatment control group.	<p>The age of children ranged from 3-10 years, the average age was not specified. There were 18 mothers (9 in the experimental, 9 in the control) and 5 fathers (3 in the experimental, 2 in the control). 18 mothers and 5 fathers took part in total. The gender of the children was not specified.</p> <p>The sample consisted of chronically ill children and their parents in the US.</p>	<p>Parents completed weekly 30-minute, at-home practice sessions outside of the training, of which one was recorded and they were required to share their experiences with the training group.</p>	<p>Parents received training in child-centred play therapy skills in line with the Landreth (1991) 10-week filial therapy protocol. Training was administered in small groups by three researchers who were trained in filial therapy.</p> <p>Resources were provided in line with the protocol. A conference room was provided in the Children's Medical Centre.</p>	<p>Children in the filial therapy experimental group scored significantly lower than children in the control group on Total Behaviour Problems and the Anxiety/Depression Subscale. This was significant at the p&lt;0.05 level.</p>

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<b>4. Smith and Landreth (2003)</b>	N=22 E: 11 C (No-treatment): 11 Individual therapist assigned to the experimental, no-comparison and comparison group: 11 Intensive sibling group play therapy group: 10	The age of children ranged from 4-10 years with an average age of 6.1 years. There were 11 girls (4 in the experimental, 7 in the control) and 11 boys (7 in the experimental, 4 in the control). There were 12 girls and 10 boys assigned to the comparison groups. There was a total of 23 girls and 20 boys across groups. 22 (11 in E, 11 in C) mothers and 0 fathers took part in the study.  The sample comprised of mothers who had	Parents participated in play sessions with their children following the training sessions which ranged between 30 to 40 minutes in length. Segments of these play sessions were captured by the facilitator using video.	Participants were trained in child-centred play therapy skills and received supervision in accordance with the Landreth (2002) protocol which was collapsed into 12 one and a half hour sessions over a course of 2 to 3 weeks which was provided by a doctoral candidate who was trained in filial therapy. Participants were provided with a playroom and play session kit which was equipped with play materials outlined in the protocol. The facilitator also provided live	Children in the filial therapy experimental group demonstrated significant improvement as compared to children in the non-treatment comparison group for Internalising Problem Behaviour, Externalising Problem Behaviour and Total Problem Behaviour, which was significant at the p<0.05 level. However, there were no significant differences between the experimental group and the intensive individual play therapy comparison group or the intensive sibling play therapy comparison group for Internalising,
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			been victims of domestic violence and children who had witnessed domestic violence. The ethnicity of the sample was mixed and the study took place in the US.		demonstration, supervision and encouragement to the mother during the play sessions.	Externalising or Total Problems.
<b>5.Carnes-Holt and Bratton (2014)</b>	N=32 E: 32 C: 39 Rando mised control led pilot study	A pilot study with a randomized control group design.	The age of the children ranged from 2-10 years, with an average age of 5.8 for E and 5.6 for C. Gender of the children was not specified. 39 mothers (19 in E, 20 in C) and 22 (13 in E, 9 in C) fathers took part.  The sample consisted of adoptive children and their parents.	Parents participated in seven, weekly 30-minute play sessions with their adoptive child. 20-minute recorded play sessions with their adoptive child after they had received initial training.	Participants were trained in child-centred play therapy skills in accordance with the Bratton, Landreth, Kellam & Blackard (2006) protocol. Facilitators supervised and supported parents as they facilitated weekly 30 minute play sessions with their child.  Researchers also supported and encouraged parents as they shared their parenting struggles	There was a statistically significant interaction effect of Time (pretest vs posttest) x Group (Experimental vs control) for Total Behavioural Problems and Externalising Behaviour Problems at the p<0.01 level.

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			The study took place in the US.		with their adoptive children in group sessions.
<b>6.Grskovi c and Goetze (2008)</b>	N=33 E: 15 C: 18	A pre-posttest non-randomised, controlled, group design was used. Participants were non-randomly allocated to the filial therapy experimental group or the no-treatment control group.	<p>The age of the children ranged from 4-12 years.</p> <p>The sample consisted of 18 boys (6 in E, 12 in C) and 15 girls (9 in E, 6 in C). 33 mothers and 0 fathers took part (15 in E, 18 in C).</p> <p>The sample consisted of German children and mothers who were experiencing physical/psychological stress.</p>	<p>Parents participated in at least five play sessions with their children over the course 2 weeks. These were videotaped for supervision purposes. At the end of each play session, parents completed a reflection form and recorded the sequence of play, play themes, difficult issues and their affective responses. Three times a week mothers met to discuss their reflections, showed</p>	<p>Parents received two 90 minute sessions in which mothers were trained in basic child-centred play therapy skills in accordance with the VanFleet (1994) protocol. Therapists also provided at least two individual feedback sessions in which mothers were given evaluative feedback and reminders for improvement.</p> <p>There was a statistically significant interaction effect of Time (pre-test vs post-test) x Group (Experimental vs Control) for Internalising Behavioural Problems and Total Behavioural Problems. However, no statistically significant effect was reported for Externalising Behavioural Problems.</p>

				videotaped extracts to the group and participated in discussion in regards to this.		
<b>Sheely-Moore and Bratton (2010)</b>	N= 23 E: 13 C: 10	A pre-posttest, partially randomised, controlled group design was used. During the randomisation process it was noticed that 4 participants were unable to attend the treatment group due to work commitments and therefore they were non-randomly assigned to the control group.	The children's age range was not specified but the mean age for the E group was 4.4 years and for the C was 4.0 years. 13 boys (6 in E, 7 in C) and 10 girls (7 in E, 3 in C) took part. 21 mothers (12 in E, 9 in C) and 2 fathers (1 in E, 1 in C) took part. The sample consisted of African American, low-income parents and children presenting	Parents conducted seven 30-minute at home-play sessions with their children which were videoed for supervision purposes. Parents were provided with a kit of special toys as recommended in the Bratton, Landreth, Kellam & Blackard(2006) protocol.	Parents received 3 sessions of training on child-centred play therapy skills which was consistent with the Bratton, Landreth, Kellam & Blackard(2006) protocol through role play and hand-outs. Session 4-11 consisted of a supervisory component in which parents were assigned to show the group segments of their at-home play sessions and focused supervision	Statistically significant differences were found between groups for Total Behavioural Problems, after controlling for family structure. This was significant at the p<0.05 level. Statistically significant differences were not reported for Internalising Behaviour or Externalising Behaviour.

with behavioural concerns.	was provided by therapists.
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Appendix B: Table 7: Studies excluded through exclusion criteria following full-text reading

Name of study	Type of Study (design, N and variables measured)	Reason for exclusion
Topman, Wampler, Titrus & Rolling (2011) Predicting Parent and Child Outcomes of a Filial Therapy Program. <i>International Journal of Play Therapy</i> , 20(2), p.79-93	Included a pre-post study design. N=27 Analysed change from pre-post in Severity of child Total Behavioural Problems (Eyberg Child Behaviour Inventory, Eyberg & Pincus, 1999).	No control group included. This study therefore does not meet the inclusion criteria 7b.
Dillman Taylor, Purswell, Lindo, Jayne and Fernando (2011) The Impact of Child Parent Relationship Therapy on Child Behavior and Parent-Child Relationships: An Examination of Parental Divorce. <i>International Journal of Play Therapy</i> , 20(3), p.124-137	Included a pre-post study design (Mixed-methodological approach) N= 3 Outcome measures of CPRT included: Internalising Behaviour Problems, Externalising Behaviour Problems and Total Behavioural Problems as measured by the Child-Behaviour Checklist (CBCL).	No control group included. Although the study reports that quantitative assessments were carried out, no empirical data is included in the paper. This therefore does not meet the inclusion criteria 7b.
Draper, K.D, Siegek, C.S, White, J, Solis, C.M and Mishna, F (2009) Preschoolers, Parents and Teachers (PPT): A Preventative Intervention with an at risk Population. <i>International Journal of Group Psychotherapy</i> , 59(2), p.221-242	Included a randomised-controlled block design in which participants were randomly allocated to the intervention (filial therapy and kinder therapy) group or a wait-list control group by classroom. 28 children were assigned to the intervention condition and 32 were assigned to the control condition. The	Study was excluded as the intervention involves both a parent (filial therapy) and teacher (kinder therapy) strand. This therefore does not meet the inclusion criteria 5b.

Behaviour Assessment System for Children- Teacher Rating Scale (BAS-TRS, Reynolds & Kamphaus, 1992) was used to measure both problematic and social competencies exhibited by children in school settings.

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*Appendix C:Weight of Evidence*

Each of the studies including in the review were rated systematically for methodological quality (Weight of Evidence A), Methodological Relevance (Weight of Evidence B) and Relevance to the Review Question (Weight of Evidence C). A numerical rating was issued for each of these ratings for each study and these ratings were averaged to establish an overall rating (Weight of Evidence D).

i) Weight of Evidence A (WoEA): Methodological Quality

To establish the methodological quality of studies included in the review, the Kratochwill (2003) coding protocol for group based design was used. Studies were given numerical ratings for nine key features which indicate methodological quality. A numerical rating of 3 (Strong), 2 (promising), 1 (weak) or 0 (no/limited evidence) was issued for each criteria. Descriptors and criteria for each rating are summarised in the table below.

Table 7: Summary of WoEA features

<b>Key feature</b>	<b>Summary of criteria for Strong (3), Promising (2) or Weak (1) evidence</b>
Measurement	<ul style="list-style-type: none"><li>• Strong: Studies must report the type of reliability statistic used and measures must have a reliability coefficient of .85 or higher. Data must have been collected from multiple methods and sources.</li><li>• Promising: Measures must have a reliability coefficient of .75 or higher. Data must be collected from either multiple methods or multiple sources.</li><li>• Weak: Measures must have a reliability coefficient of at least .50. Multiple methods/sources not a criteria for this rating.</li></ul>

Comparison group	<ul style="list-style-type: none"> <li>• Strong: Studies must use at least one “active” comparison group. Group equivalence must be established (through random assignment), evidence that change agents were counterbalanced must have been provided and low attrition at post must be reported.</li> <li>• Promising: at least a “no intervention” comparison group must be used. At least two of the following must be present: (1) counterbalancing of change agents, (2) group equivalence established or (3) equivalent mortality with low attrition.</li> <li>• Weak: studies must use a comparison group and at least one of the following (1) counterbalancing of change agents, (2) group equivalence established or (3) equivalent mortality with low attrition.</li> </ul>
Statistical significance of primary outcomes	<ul style="list-style-type: none"> <li>• Strong: an appropriate statistical analysis must have been conducted including appropriate units of analysis, familywise/experiment wise error rate controlled and a sufficiently large N. Significant outcomes for 75% of outcomes.</li> <li>• Medium: an appropriate statistical analysis must have been conducted, including appropriate units of analysis, familywise error controlled and a sufficiently large N. Significant outcomes for 50% to 74% of outcomes.</li> </ul>

	<ul style="list-style-type: none"> <li>Weak: an appropriate statistical analysis must have been conducted, including appropriate unit of analysis, familywise error. Significant primary outcomes for between 25% and 49% of primary outcomes.</li> </ul>
Educational/clinical significance	<ul style="list-style-type: none"> <li>Strong: a study must provide evidence in support of the clinical/educational significance for at least 3 or the 4 criteria listed (i.e. categorical diagnosis data, outcomes assessed via continuous variables, subjective evaluation, or social comparison) during either post or follow up phase.</li> <li>Promising: a study must provide evidence in support of the clinical/educational significant for at least 2 of the 4 criteria listed.</li> <li>Weak: a study must provide evidence in support of the clinical/educational significance for 1 of the 4 criteria listed.</li> </ul>
Identifiable components	<ul style="list-style-type: none"> <li>Strong: a study must (1) demonstrate strong evidence for significant primary outcomes, (2) use a design that allows for an analysis that identifies specific components and (3) the analysis must provide evidence that at least 50% of the intervention components were necessary to produce change in the primary outcomes.</li> </ul>

	<ul style="list-style-type: none"> <li>• Promising: a study must (1) demonstrate significant primary outcomes, (2) use a design that allows for an analysis which identifies specific components and (3) the analysis must provide evidence that at least 50% of the identified intervention components were necessary to produce change in the primary outcomes.</li> <li>• Weak: a study must (1) demonstrate weak evidence for significant primary outcomes, (2) use a design which identifies specific components and (3) the analysis must provide evidence that at least 25% of the identified intervention components were necessary to produce change.</li> </ul>
Implementation fidelity	<ul style="list-style-type: none"> <li>• Strong: information should be measured through at least two of the following: ongoing supervision/consultation, coding sessions or audio/video tapes and use of a manual.</li> <li>• Promising: information should be measured through at least one of the criteria and use of a manual.</li> <li>• Weak: the study must demonstrate evidence of acceptable adherence measured through at least one of the above criteria or use of a manual.</li> </ul>
Follow up assessment	<ul style="list-style-type: none"> <li>• Strong: the study must have conducted follow up assessment over multiple intervals with all participants that were included in the original sample.</li> </ul>

	<ul style="list-style-type: none"> <li>Promising: the study must have conducted follow up assessments at least once with the majority of participants that were included in the original sample.</li> <li>Weak: follow up conducted at least once with some participants from the original sample.</li> </ul>
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*Table 8: Summary of ratings awarded for each study for each key feature in WoEA*

WoE key feature	Ceballos & Bratton (2010)	Yuen, Landreth & Baggerly (2002)	Tew, Landreth, Joiner & Solt (2003)	Smith & Landreth (2003)	Carnes-Holt & Bratton (2014)	Grskovic & Goetze (2008)	Sheely-Moore & Bratton (2010)
Measurement	2	0	1	0	1	1	1
Comparison group	2	2	2	2	2	2	2
Statistical significance of primary outcomes	3	1	1	1	3	1	1
Educational/Clinical Significance	2	1	2	2	2	3	2
Identifiable components	2	2	2	2	2	2	2
Implementation fidelity	3	2	2	2	3	2	3

Follow up Assessment	0	0	0	0	0	0	0
Mean rating and rounded mean rating	2.0 (2)	1.14 (1)	1.42 (1)	1.28 (1)	1.85 (2)	1.57 (2)	1.57 (2)

*Table 9: Rationale for sections excluded from the Kratochwill (2003) protocol*

Feature excluded	Rationale
<b>B7) Qualitative research methods</b>	The review focused on quantitative data only as per inclusion criteria
<b>C4, C5) Significance of secondary outcomes</b>	The review question focused solely on child's behaviour outcome and therefore secondary outcomes were not included as a point of focus in the review
<b>C) Primary/secondary outcomes statistical significance tables</b>	The present study did not report the results found by the study authors as effect sizes were calculated using means and SD's. This table was therefore not a necessary requirement as additional tables 'mapping the field' and 'effect sizes' were created for the purpose of this review.
<b>G) Replication</b>	The intervention was not replicated within the same studies and therefore this section was not relevant to the studies included in the review.
<b>H) Site of Implementation</b>	Six of the seven studies were not completed at a school site. As this was a parent-led intervention and it was appropriate for the intervention to be conducted outside of the school site, to include this section would have given an unfair WoEA rating.

<b>Descriptive criteria : A-table</b>	This table was not required due to the fact that a 'mapping the field' table was created for the purpose of this review which included relevant participant characteristics.
<b>A4-Receptivity/acceptance by target population</b>	No formal information was available regarding the receptivity/acceptance by target population.

\*See Appendix D for the completed Kratochwill (2003) coding protocols used to generate WoEA ratings.

ii) *Weight of Evidence B (WoEB): Methodological Relevance*

To establish whether the methodological design of studies were suitable for evaluating the effectiveness of filial therapy (CPRT) in reducing problematic behaviours in children, a criteria for judging the Weight of Evidence of the study designs was established.

Rationale:

- The Randomised Control Trial (RCT) is considered to provide the most reliable evidence when evaluating the effectiveness of an intervention (Mulrow & Oxman, 1997, Sackett, Richardson, Rosenberg & Haynes, 1997). The RCT process aims to minimise the risk of confounding variables and therefore the findings are thought to be closer to the true effect compared to findings generated from other methods (Evans, 2003). Although the studies included in the review did not describe the use of 'RCT' studies which used a completely randomised control-group, pretest-posttest design, in which participants were randomly assigned to intervention and control/comparison groups will be rated as 'high.'
- Studies which use at least one active comparison group and a no-treatment control group will be rated as 'high' on methodological relevance. This allows a judgement on the effectiveness of the intervention in comparison to an alternative intervention as well as allowing a judgement about whether the effectiveness is greater than that caused by a placebo effect (Kratchowill, 2003).

- Studies in which participants were not exposed to another intervention at the time of the study were rated 'high' on methodological relevance. This eliminates the possibility that outcomes are due to the effects of another intervention.

Table 10: WoEB coding protocol

High=3	<ul style="list-style-type: none"> <li>• The study used a completely randomised control-group, pretest- posttest design, in which participants were randomly assigned to intervention and comparison/control conditions.</li> <li>• Used at least one active comparison group (who received an alternative intervention) and a no-treatment control group.</li> <li>• Participants were not exposed to another intervention at the time of the study.</li> </ul>
Medium=2	<ul style="list-style-type: none"> <li>• The study used a randomised block control-group, pre-test, post-test design (between-participants variation), in which participants were initially blocked, or matched on the basis of some pre-study variable(s) and then randomly assigned to experimental and comparison/control conditions.</li> <li>• The study used at least one active comparison (who received an alternative intervention).</li> <li>• Participants were exposed to another intervention at the time of the study however this intervention was not parent led and it was not aimed at improving behavioural outcomes.</li> </ul>
Low=1	<ul style="list-style-type: none"> <li>• The study used a non-randomised control group pretest-posttest design in which participants were non-randomly assigned to intervention and comparison/control conditions.</li> <li>• A no-treatment control group was used.</li> <li>• Participants were exposed to another intervention at the time of the study which was parent led and/or aimed at improving child behavioural outcomes.</li> </ul>
Unable to code=0	<ul style="list-style-type: none"> <li>• Insufficient information available to generate a numerical coding.</li> </ul>

*Table 11: WoEB coding protocol applied to individual studies*

Study	Evidence of fulfilment of WoEB criteria	WoEB rating
Ceballos and Bratton (2010)	<ul style="list-style-type: none"> <li>• Participants were randomly assigned by school site to the experimental (n=31) group or the control (n=31) group (2)</li> <li>• A no-treatment control group was used (1)</li> <li>• Participants were recruited from the HeadStart and Title 1 prekindergarten classes, which encourages parental involvement and aims to enhance children's physical and emotional wellbeing (1)</li> </ul>	1
Yuen, Landreth and Baggerly (2002)	<ul style="list-style-type: none"> <li>• Participants were randomly assigned to the experimental (n=18) group or the control (n=17) group (3)</li> <li>• A no-treatment control group was used (1)</li> <li>• Participants were only included if their child was not receiving therapy at the time of the study and parents had not taken a parenting class for at least two years prior to the study (3)</li> </ul>	2
Tew, Landreth, Joiner and Solt (2002)	<ul style="list-style-type: none"> <li>• Participants were placed in an experimental (12) and a control group (11). The authors recognise the absence of randomisation as a limitation of the study. (1)</li> <li>• A wait-list control group was used (1)</li> <li>• Participants consisted of parents of chronically ill children recruited from a children's medical centre. Although no details were described, it cannot be assumed that the children were not receiving another intervention through the medical centre (1)</li> </ul>	1
Smith and Landreth (2003)	<ul style="list-style-type: none"> <li>• Participants were assigned to an experimental (n=11) group, a no treatment control group (11), an individual therapy comparison (n=11) group and a sibling therapy comparison (n=10) group. Details were not given as to how participants were assigned to groups. (1)</li> </ul>	2

	<ul style="list-style-type: none"> <li>Two active comparison groups were included (intensive individual play therapy and sibling play therapy.) (3)</li> <li>Children who participated in all four groups received three to four educational and recreational group sessions per week provided by shelter staff to all children in residence. These sessions focused on family violence, awareness, sexual abuse prevention, feelings and self-esteem. (1)</li> </ul>	
Carnes-Holt and Bratton (2014)	<ul style="list-style-type: none"> <li>A randomised control group design was used (19 participants were allocated to the experimental group and 20 to the control group.) (3)</li> <li>A wait-list control group was used (1)</li> <li>It was not reported whether the adopted parents or children were receiving any other interventions at the time of the study and therefore this could not be assumed (1).</li> </ul>	<b>2</b>
Grskovic and Goetze (2008)	<ul style="list-style-type: none"> <li>Participants were assigned to an experimental (N=15) or a wait-list control (N=18) group. No details of randomisation were reported. (1)</li> <li>The control group in the study received group and individual therapies to enhance physical and psychological well-being (2)</li> <li>Participants were recruited from a 'Mother Child Cure Centre' which was a residential facility in which group and individual therapies were offered to enhance physical and psychological well-being. Therapy was offered by a team of medical doctors, psychologists, psychotherapists, and educators. (1)</li> </ul>	<b>1</b>
Sheely-Moore and Bratton (2010)	<ul style="list-style-type: none"> <li>Participants were initially randomly assigned to the experimental and control conditions, however during random assignment procedures it was noticed that 4 parents could not attend group meetings due to work commitments and were therefore placed into the control group (1)</li> <li>A wait list control group was used (1)</li> <li>Participants were recruited from a 'Head Start' schools which encourage parental involvement and aim to improve children's emotional wellbeing (1)</li> </ul>	<b>1</b>

iii) *Weight of Evidence C (WoEC): Relevance to Question*

Rationale for ratings

1. To receive a rating of ‘high’ the interveners must have used the Bratton, Landreth, Kellam and Blackard (2006) Child Parent Relationship Therapy (CPRT) treatment manual. This manual contains treatment outlines of sessions 1-10 and all corresponding parent handouts, homework, and parent worksheets, with sample answers. To fulfil this criteria, any adaptations made to the protocol must also have been clearly stated. If these two conditions are fulfilled this enhances the replicability of the intervention (Kratochwill, 2003).
2. The second criteria that studies need to fulfil to receive a rating of “high” is in relation to the behavioural outcomes reported. If the study reports pre and post differences for internalising, externalising and total behaviours then this will allow an informed recommendation about cases in which filial therapy would be appropriate.
3. The third criteria that would need to be fulfilled refers to the selection of participants. Studies which report that the children involved in the filial therapy intervention were selected due to behavioural concerns will be identified as the most relevant to the review question as this would allow generalizability of the effectiveness of the intervention for other children who are presenting with social, emotional or behavioural difficulties. This will also increase the ethical grounding of the studies as interventions which target an area of need would be of greater benefit to the participants.

4. The fourth criteria that studies need to fulfil to receive a rating of ‘high’ is in relation to the length of the intervention and sessions. The Bratton, Landreth, Kellam & Blackard (2006) manual states that the protocol has been designed to cover sessions for this length of time. Although the authors state that the protocol can be used flexibly with clinical judgment and shortened where appropriate, the intervention can only be fully replicable if the length of the intervention is equal, at least 75% if a shortened version is used or a longer version is used (Kratochwill, 2003). Therefore, for the highest rating, the study will be of the same length as that stated in the protocol, for a medium rating, the study will be  $\geq 75\%$  of the length stated in the protocol and for the lowest rating, the intervention will be  $<75\%$  the length stated in the protocol. Additionally, parents must practice at-home practice sections as this is a criteria of the Bratton, Landreth, Kellam & Blackard (2006) protocol.
5. The final criteria relates to the acceptable adherence of the intervention. For a “high” rating, the interveners must be trained in filial therapy, receive ongoing supervision from an expert in CRPT/filial therapy and the sessions must have been videotaped for supervision purposes. If this criteria can be fulfilled then it could be established that the intervention delivered in the study is consistent with the intervention developer’s manual or protocol (Kratochwill, 2003).

Table 12: WoEC coding protocol

<b>High=3</b>	<ul style="list-style-type: none"> <li>The study used the Bratton, Landreth, Kellam &amp; Blackard (2006) manual to deliver the filial therapy intervention. Any adaptations to the protocol were clearly stated.</li> <li>The authors report pre and post-test differences in internalising, externalising and total behaviour outcomes.</li> <li>The children who participated in the intervention were identified due to concerns with their behaviour.</li> <li>Participants in the treatment group completed a minimum of 10, 2 hours sessions of filial therapy and completed at-home practice play sessions with their children which were videotaped.</li> <li>The interveners were trained in filial therapy and received supervision from an expert in CPRT/filial therapy.</li> </ul>
<b>Medium=2</b>	<ul style="list-style-type: none"> <li>The study used either the Landreth (1991) 10-session protocol to deliver the filial therapy intervention. Any adaptations made to the protocol were clearly stated.</li> <li>The authors report pre and post-test differences in either internalising OR externalising behaviour AND total behaviour.</li> <li>The children who took part in the intervention were identified due to the fact they belonged to a risk group for developing social, emotional or behavioural difficulties.</li> <li>Participants in the treatment group completed a minimum of 8, 2 hour sessions of filial therapy and all parents completed additional home-play sessions with their children.</li> <li>The interveners were trained in filial therapy.</li> </ul>
<b>Low=1</b>	<ul style="list-style-type: none"> <li>The protocol used in the study could be inferred but was not explicitly stated. Adaptations to the protocol were not clearly stated.</li> <li>The authors report pre and post-test differences in total behaviour only.</li> </ul>

	<ul style="list-style-type: none"> <li>• A rationale for the inclusion of children to the intervention in relation to social, emotional or behavioural outcomes was not explicitly stated.</li> <li>• Participants in the treatment group completed less than 8, 2 hour sessions of filial therapy sessions and it was not explicitly stated whether parents completed at-home practice sessions.</li> <li>• It was not explicitly stated whether the interveners were trained in CPRT/filial therapy and supervision procedures were not outlined.</li> </ul>
<b>Unable to code=0</b>	Studies do not meet the categorisation for a categorisation of low.

*Table 13: WoEC protocol applied to studies included in the review*

Name of study	Evidence of fulfilment of WoEC criteria	Overall numerical rating
Ceballos and Bratton (2010)	<ul style="list-style-type: none"> <li>• The CPRT manualised protocol was used and adaptations were clearly stated- modifications to the program included translation into Spanish, accommodation for sessions to take place in the school were described and it was stated that “The CRPT leader remained flexible with the session agendas outlined in the CPRT protocol to allot time for group members to discuss culturally relevant issues.” (3)</li> <li>• Pre and post differences were reported for Internalising, Externalising and Total problems (3)</li> <li>• Qualifying parents reported borderline to clinical levels of child behaviour concerns based on ratings on the CBCL (3)</li> </ul>	3

	<ul style="list-style-type: none"> <li>• All groups met weekly for 2 hours at their child's school for 11 weeks. Play sessions were conducted at home or within the school setting by all parents in the treatment group (3)</li> <li>• Groups were led by a "bilingual, Latina immigrant doctoral-level counselling student who was trained and experienced in providing CPRT. CPRT sessions were videotaped and supervised by an expert in CPRT protocol (3)"</li> </ul>	
Yuen, Landreth and Baggerly (2002)	<ul style="list-style-type: none"> <li>• The Landreth (1991) 10-week filial therapy training protocol was used by interveners to deliver the intervention. Modifications in terms of the conduction of training sessions in Cantonese and translation of materials into Chinese were detailed (2)</li> <li>• The authors reported pre and post differences in total behaviour (1)</li> <li>• Parents of the children who participated in the study were immigrant Chinese parents who were identified as being at risk of social isolation, emotional disturbance and psychological conflicts (Esquivel &amp; Keitel, 1990, Jung, 1984, Nann, 1982, Yao, 1985) and were identified by authors as a group requiring support. (2)</li> <li>• Participants completed 10, 2 hour filial therapy sessions which were videotaped for supervision purposes and parents videotaped practice play sessions with their children (3)</li> <li>• Sessions were facilitated by a doctoral candidate at the University of North Texas with a bachelors and masters degree in counselling. He had conducted various play and filial therapy courses. No details were given in regards to supervision or additional characteristics. (2)</li> </ul>	2
Tew, Landreth, Joiner and Solt (2002)	<ul style="list-style-type: none"> <li>• The Landreth (1991) 10-session filial therapy training protocol was used. The modification of the therapy taking place in a hospital facilities was stated however no detail was provided in regards to additional modifications to the protocol (1)</li> </ul>	2

	<ul style="list-style-type: none"> <li>• Pre and post differences were reported for total problems (1)</li> <li>• The children who participated in the intervention were chronically ill and the authors provided a rationale that chronically ill children are able to communicate their fears and frustrations concerning illness-related issues through play (1)</li> <li>• Participants completed 10, 2 hour training sessions (3)</li> <li>• One group of parents were led by a doctoral candidate who was a Licensed Professional Counselor and another group was co-led by two master's degree Child Life specialists. The three leaders had completed an Introduction to Play Therapy Course, a Filial Therapy Course and a supervised Play Therapy Practicum. The three leaders met weekly for consultation purposes. No supervision was detailed. (2)</li> </ul>	
Smith and Landreth (2003)	<ul style="list-style-type: none"> <li>• The Landreth (2002) 10-week filial therapy training model was used. Adaptations including the fact that the model was collapsed into 12 one and a half sessions over a course of 2-3 weeks and other modifications used to accommodate the mother's high levels of stress and depression were clearly stated (2)</li> <li>• Pre and post behavioural differences were reported for internalising, externalising and total behaviour (3)</li> <li>• The authors present a rationale for including children who have witnessed domestic violence in the intervention and behavioural problems that could result from this traumatic exposure (2)</li> <li>• Participants received 12 one and a half hour sessions which included mother-child play sessions (2)</li> <li>• The filial therapy training was provided by a doctoral candidate whose training included an introductory and an advanced course in play therapy and filial</li> </ul>	2

	therapy. No details of additional intervener characteristics, training or supervision were provided. (2)	
Carnes-Holt and Bratton (2014)	<ul style="list-style-type: none"> <li>The Bratton, Landreth, Kellam &amp; Blackard(2006) manualised protocol was used. Specific instructions given to parents were detailed and it appears as though the program was strictly adhered to (each parent and child were provided with a room equipped with toys recommended by the protocol.) (3)</li> <li>Pre and post differences in behavioural outcomes were reported for Externalising problems and total problems (2)</li> <li>Children participated in the study due to concerns with attachment-related difficulties and concerns about their behaviour (3)</li> <li>All participants completed 10, 2 hour sessions of play therapy and participated in at home play sessions (3)</li> <li>The groups were led by a licensed professional counsellor-supervisor and registered play-therapist supervisor with extensive training in play therapy, co-leaders were experienced in play therapy and the CPRT protocol (3)</li> </ul>	3
Grskovic and Goetze (2008)	<ul style="list-style-type: none"> <li>A brief form of the VanFleet filial therapy training approach was used. Specific modifications were not specified. (1)</li> <li>Pre and post differences were reported for Internalising, Externalising and Total Behaviour (3)</li> <li>Mothers of children who participated were referred to the Mother Child Cure Program due to “parental stress” but no rationale in terms of behavioural risk for children was reported (1)</li> <li>Participants received 8, 90 minute sessions of filial therapy. Additional at-home play sessions were not documented (1)</li> <li>Details were not provided about the intervener or whether training and/or supervision was given (0)</li> </ul>	1

Sheely-Moore and Bratton (2010)	<ul style="list-style-type: none"> <li>• The Bratton, Landreth, Kellam &amp; Blackard(2006) manualised protocol was used to deliver the filial therapy training. The procedures followed were described in detail. Modifications including providing participants with an evening meal and including an extra session were detailed (3)</li> <li>• Pre and post differences in internalising, externalising and total behavioural outcomes were reported (3)</li> <li>• All children scored in the borderline or clinical range on at least one syndrome scale on the Child-Behaviour Checklist Parent Version (CBCL)(Achenbach &amp; Rescorla, 2000)(3)</li> <li>• Participants received 11, 2 hours sessions of filial therapy training and parents completed practice at-home play sessions with their parents which were videoed (3)</li> <li>• CRPT training and supervision were provided by an advanced doctoral counselling student and masters level counsellor with extensive training in filial therapy. No details were stated in regards to supervision arrangements for interveners. (2)</li> </ul>	3
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(iv) Overall Weight of Evidence (WoED)

WoED involved averaging the three scores obtained from WoEA, WoEB and WoEC. An average rating of 1.0 to 1.6 was judged as 'low', a rating of 1.7 to 2.3 was judged as 'medium' and a rating of 2.5 to 3 was judged as 'high.'

Table 13:

Authors	WoEA (methodological Quality)	WoEB descriptor (methodological relevance)	WoEC (relevance to review question)	WoED (overall WoE)
1.Ceballos and Bratton (2010)	2 (promising)	1 (low)	2 (medium)	1.7 (medium)
2.Yuen, Landreth & Baggerly (2002)	1 (weak)	2 (medium)	2 (medium)	1.7 (medium)
3.Tew, Landreth, Joiner & Solt(2002)	1 (low)	1 (low)	2 (medium)	1.3 (low)
4.Smith and Landreth (2003)	1 (low)	2 (medium)	2 (medium)	1.7 (medium)
5.Carnes-Holt and Bratton (2014)	2 (promising)	2 (medium)	2 (medium)	2.0 (medium)
6.Grskovic and Goetze (2008)	2 (promising)	1 (low)	1 (low)	1.3 (low)
7.Sheely-Moore and Bratton (2010)	2 (promising)	1 (low)	3 (high)	2.0 (medium)

Appendix D-Kratochwill coding protocols (used to generate WoEA ratings)

**Coding Protocol: Group-Based Design**

- Domain:
- School- and community-based intervention programs for social and behavioral problems
  - Academic intervention programs
  - Family and parent intervention programs
  - School-wide and classroom-based programs
  - Comprehensive and coordinated school health services

Name of Coder(s):\_\_\_\_\_

Date: 12/01/14

M / D / Y

Full Study Reference in APA format: Ceballos, P.L and Bratton, S.C (2010) Empowering Latino Families. Psychology in the Schools.

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Intervention Name (description from study): Bratton, Landreth, Kellam & Blackard(2006) Child-parent relationship therapy

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Study ID Number (Unique Identifier): 1

Type of Publication: (Check one)

- Book/Monograph
- Journal article
- Book chapter
- Other (specify): \_\_\_\_\_

## Doctorate in Child and Educational Psychology

### I. General Characteristics

#### A. General Design Characteristics

A1. Random assignment designs (if random assignment design, select one of the following)

- A1.1  Completely randomized design
- A1.2  Randomized block design (between-subjects variation)
- A1.3  Randomized block design (within-subjects variation)
- A1.4  Randomized hierarchical design

A2. Nonrandomized designs (if nonrandom assignment design, select one of the following)

- A2.1  Nonrandomized design
- A2.2  Nonrandomized block design (between-participants variation)
- A2.3  Nonrandomized block design (within-participants variation)
- A2.4  Nonrandomized hierarchical design
- A2.5  Optional coding of Quasi-experimental designs (see Appendix C)

A3. Overall confidence of judgment on how participants were assigned (select one of the following)

- A3.1  Very low (little basis)
- A3.2  Low (guess)
- A3.3  Moderate (weak inference)
- A3.4  High (strong inference)
- A3.5  Very high (explicitly stated)
- 
- A3.6  N/A
- A3.7  Unknown/unable to code

#### B. Statistical Treatment/Data Analysis (answer B1 through B6)

B1. Appropriate unit of analysis

■ yes	no
<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/> yes	<input type="checkbox"/> no
<input checked="" type="checkbox"/> yes	<input type="checkbox"/> no

N/A

B2. Familywise error rate controlled

B3. Sufficiently large  $N$

Statistical Test: ANOVA  
level: 2

ES: Large  
N required: 26 x 2=52

B4. Total size of sample (start of the study):  $\frac{62}{N}$

B5. Intervention group sample size:  $\frac{31}{N}$

B6. Control group sample size:  $\frac{31}{N}$

**For studies using qualitative research methods, code B7 and B8**

B7. Coding

B7.1 Coding scheme linked to study's theoretical-empirical basis (select one)  yes  no

B7.2 Procedures for ensuring consistency of coding are used (select one)  yes  no

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Describe procedures: \_\_\_\_\_

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B7.3 Progression from abstract concepts to empirical exemplars is clearly articulated (select one)  yes  no

B8. Interactive process followed (select one)  yes  no

Describe process: \_\_\_\_\_

**C. Type of Program** (select one)

C1.  Universal prevention program

C2.  Selective prevention program C3.

Targeted prevention program C4.

Intervention/Treatment

C5.  Unknown

**D. Stage of the Program** (select one)

D1.  Model/demonstration programs

D2.  Early stage programs

D3.  Established/institutionalized programs

D4.  Unknown

**E. Concurrent or Historical Intervention Exposure** (select one)

E1.  Current exposure

E2.  Prior exposure

E3.  Unknown

## II. Key Features for Coding Studies and Rating Level of Evidence/ Support

(3=Strong Evidence    2=Promising Evidence    1=Weak Evidence    0=No Evidence)

### A. Measurement (answer A1 through A4)

A1. Use of outcome measures that produce reliable scores for the majority of primary outcomes. The table for Primary/Secondary Outcomes Statistically Significant allows for listing separate outcomes and will facilitate decision making regarding measurement (select one of the following)

- A1.1  Yes
- A1.2  No
- A1.3  Unknown/unable to code

A2. Multi-method (select one of the following)

- A2.1  Yes
- A2.2  No
- A2.3  N/A
- A2.4  Unknown/unable to code

A3. Multi-source (select one of the following)

- A3.1  Yes
- A3.2  No
- A3.3  N/A
- A3.4  Unknown/unable to code

A4. Validity of measures reported (select one of the following)

- A5.1  Yes validated with specific target group
- A5.2  In part, validated for general population only
- A5.3  No
- A5.4  Unknown/unable to code

**Rating for Measurement** (select 0, 1, 2, or 3):     3     2     1     0

### B. Comparison Group

B1. Type of Comparison Group (select one of the following)

- B1.1  Typical contact
- B1.2  Typical contact (other) specify: No differential relevance between experimental and control
- B1.3  Attention placebo
- B1.4  Intervention elements placebo
- B1.5  Alternative intervention
- B1.6  PharmacotherapyB1.1
- B1.7  No intervention
- B1.8  Wait list/delayed intervention
- 
- B1.9  Minimal contact
- B1.10  Unable to identify comparison group

**Rating for Comparison Group** (select 0, 1, 2, or 3):     3     2     1     0

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B2. Overall confidence rating in judgment of type of comparison group (select one of the following)

- B2.1  Very low (little basis)
- B2.2  Low (guess)
- B2.3  Moderate (weak inference)
- B2.4  High (strong inference)
- 
- B2.5  Very high (explicitly stated)
- B2.6 Unknown/Unable to code

B3. Counterbalancing of Change Agents (answer B3.1 to B3.3)

- B3.1  By change agent
- B3.2  Statistical
- B3.3  Other

B4. Group Equivalence Established (select one of the following)

- B4.1  Random assignment
- B4.2  Posthoc matched set
- B4.3  Statistical matching
- B4.4  Post hoc test for group equivalence

B5. Equivalent Mortality (answer B5.1 through B5.3)

- B5.1  Low Attrition (less than 20% for Post)
- B5.2  Low Attrition (less than 30% for follow-up)
- B5.3  Intent to intervene analysis carried out

Findings 7/21 dropped out of both groups, more than 20% attrition

## C. Primary/Secondary Outcomes Are Statistically Significant

C1. Evidence of appropriate statistical analysis for **primary outcomes** (answer C1.1 through C1.3)

- C1.1  Appropriate unit of analysis (rate from previous code)
- C1.2  Familywise/experimentwise error rate controlled when applicable (rate from previous code)
- C1.3  Sufficiently large N (rate from previous code)

C2. Percentage of **primary outcomes** that are significant (select one of the following)

- C2.1  Significant primary outcomes for at least 75% of the total primary outcome measures for each key construct
- C2.2  Significant primary outcomes for between 50% and 74% of the total primary outcome measures for each key construct
- C2.3  Significant primary outcomes for between 25% and 49% of the total primary outcome measures for any key construct

**Rating for Primary Outcomes Statistically Significant** (select 0, 1, 2, or 3):  3  2  1  0

C3. Evidence of appropriate statistical analysis for **secondary outcomes** (answer C3.1 through C3.3)

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C3.1  Appropriate unit of analysis

C3.2  Familywise/experimentwise error rate controlled when applicable (rate from previous code)

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C3.3  Sufficiently large  $N$  (rate from previous code)

C4. Percentage of ~~secondary outcomes~~ that are significant (select one of the following)

C4.1  Significant secondary outcomes for at least 75% of the total secondary outcome measures for each key construct

C4.2  Significant secondary outcomes for between 50% and 74% of the total secondary outcome measures for each key construct

C4.3  Significant secondary outcomes for between 25% and 49% of the total secondary outcome measures for any key construct

~~Rating for Secondary Outcomes Statistically Significant (select 0, 1, 2, or 3):~~  3  2  1  0

C5. Overall Summary of Questions Investigated

C5.1 Main effect analyses conducted (select one)  yes  no

C5.2 Moderator effect analyses conducted (select one)  yes  no

Specify results: \_\_\_\_\_

C5.3. Mediator

analyses conducted (select one) yes no

Specify results: \_\_\_\_\_

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C. Primary/Secondary Outcomes Statistically Significant (only list  $p \leq .05$ )

(list primary outcomes first in alphabetical order, followed by secondary outcomes in alphabetical order)

Outcomes	Primary vs. Secondary	Who Changed	What Changed	Source	Treatment Information	Outcome Measure Used	Reliability	ES	(1-)
Outcome #1:	<input checked="" type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input checked="" type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input checked="" type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input checked="" type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other <input type="checkbox"/> Unknown	CPRT training and supervision (2 hours per week for 11 weeks), Landreth and Bratton (2006)	Child Behaviour Check-list (CBCL-Spanish version, Achenbach and Rescorla, 2000).	Mean test-retest reliability established at ( $r=0.87$ ).		( $\geq .80$ )
Outcome #2	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input checked="" type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input checked="" type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input checked="" type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other <input type="checkbox"/> Unknown	CPRT training and supervision (2 hours per week for 11 weeks, Landreth and Bratton, 2006).	Parenting Stress Index: Parental Manual (Abidin, 1995)	For total stress, coefficients for test-retest reliability ranged from 0.65-0.96.		( $\geq .80$ )
Outcome #3:	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other <input type="checkbox"/> Unknown					
Outcome #4:	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other <input type="checkbox"/> Unknown					
Outcome #5:	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other <input type="checkbox"/> Unknown					

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Null Findings/Negative Outcomes Associated with the Intervention (listed alphabetically by outcome)

Outcomes	Primary vs. Secondary	Who Was Targeted for Change	What Was Targeted for Change	Source	Note null/negative outcomes	Outcome Measure Used	Reliability	ES
Outcome #1:	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other Unknown				
Outcome #2	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other Unknown				
Outcome #3:	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other Unknown				
Outcome #4:	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other Unknown				
Outcome #5:	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Unknown	<input type="checkbox"/> Child <input type="checkbox"/> Teacher <input type="checkbox"/> Parent/sign. Adult <input type="checkbox"/> Ecology <input type="checkbox"/> Other Unknown	<input type="checkbox"/> Behavior <input type="checkbox"/> Attitude <input type="checkbox"/> Knowledge <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Self Report <input type="checkbox"/> Parent Report <input type="checkbox"/> Teacher Report <input type="checkbox"/> Observation <input type="checkbox"/> Test <input type="checkbox"/> Other Unknown				

Type of Data Effect Size is Based On	Confidence Rating in ES Computation
(check all that apply) <input checked="" type="checkbox"/> Means and SDs <input checked="" type="checkbox"/> t - value or F - value <input type="checkbox"/> Chi-square ( $df = 1$ ) <input type="checkbox"/> Frequencies or proportions (dichotomous) <input type="checkbox"/> Frequencies or proportions (polytomous) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	(select one of the following) <input type="checkbox"/> Highly estimated (e.g., only have N p value) <input type="checkbox"/> Moderate estimation (e.g., have complex but complete statistics) <input type="checkbox"/> Some estimation (e.g., unconventional statistics that require conversion) <input type="checkbox"/> Slight estimation (e.g., use significance testing statistics rather than descriptives) <input checked="" type="checkbox"/> No estimation (e.g., all descriptive data is present)

**D. Educational/Clinical Significance**

Outcome Variables:	Pretest	Posttest	Follow Up
<b>D1. Categorical Diagnosis Data</b>	Diagnostic information regarding inclusion into the study presented: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	Positive change in diagnostic criteria from pre to posttest: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Positive change in diagnostic criteria from posttest to follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
<b>D2. Outcome Assessed via continuous Variables</b>		Positive change in percentage of participants showing clinical improvement from pre to posttest: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Positive change in percentage of participants showing clinical improvement from posttest to follow up: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
<b>D3. Subjective Evaluation:</b> The importance of behavior change is evaluated by individuals in direct contact with the participant.	Importance of behavior change is evaluated: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Importance of behavior change from pre to posttest is evaluated positively by individuals in direct contact with the participant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Importance of behavior change from posttest to follow up is evaluated positively by individuals in direct contact with the participant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown
<b>D4. Social Comparison:</b> Behavior of participant at pre, post, and follow up is compared to normative data (e.g., a typical peer).	Participant's behavior is compared to normative data <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Participant's behavior has improved from pre to posttest when compared to normative data: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Participant's behavior has improved from posttest to follow up when compared to normative data: <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Unknown

**Rating for Educational/Clinical Significance** (select 0, 1, 2, or 3):  3  2  1  0

**E. Identifiable Components (answer E1 through E7)**

- E1. Evidence for primary outcomes (rate from previous code):  3  2  1  0  
E2. Design allows for analysis of identifiable components (select one)  yes  no

E3. Total number of components:

N

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E4. Number of components linked to primary outcomes:

N

Additional criteria to code descriptively:

E5. Clear documentation of essential components (select one)  yes  no

E6. Procedures for adapting the intervention are described in detail (select one)  yes  no

E7. Contextual features of the intervention are documented (select one)  yes  no

**Rating for Identifiable Components** (select 0, 1, 2, or 3):  3  2  1  0

## F. Implementation Fidelity

F1. Evidence of Acceptable Adherence (answer F1.1 through F1.3)

F1.1  Ongoing supervision/consultation

F1.2  Coding intervention sessions/lessons or procedures

F1.3  Audio/video tape implementation (select F1.3.1 or F1.3.2):

F1.3.1  Entire intervention

F1.3.2  Part of intervention

F2. Manualization (select all that apply)

F2.1  Written material involving a detailed account of the exact procedures and the sequence in which they are to be used

F2.2  Formal training session that includes a detailed account of the exact procedures and the sequence in which they are to be used

F2.3  Written material involving an overview of broad principles and a description of the intervention phases

F2.4  Formal or informal training session involving an overview of broad principles and a description of the intervention phases

F3. Adaptation procedures are specified (select one)  yes  no  unknown

**Rating for Implementation Fidelity** (select 0, 1, 2, or 3):  3  2  1  0

## G. Replication (answer G1, G2, G3, and G4)

G1.  Same Intervention

G2.  Same Target Problem

G3.  Independent evaluation

~~Rating for Replication~~ (select 0, 1, 2, or 3):  ~~3  2  1  0~~

## H. Site of Implementation

H1. School (if school is the site, select one of the following options)

H1.1  Public

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- H1.2  Private
- H1.3  Charter
- H1.4  University Affiliated
- H1.5  Alternative
- H1.6  Not specified/unknown

~~H2. Non School Site (if it is a non school site, select one of the following options)~~

- H2.1  Home Some parents conducted additional play sessions at home.
- H2.2  University Clinic
- H2.3  Summer Program
- H2.4  Outpatient Hospital
- H2.5  Partial inpatient/day Intervention Program
- H2.6  Inpatient Hospital
- H2.7  Private Practice
- H2.8  Mental Health Center
- H2.9  Residential Treatment Facility
- H2.10  Other (specify): \_\_\_\_\_
- H2.11 Unknown/insufficient information provided

**Rating for Site of Implementation** (select 0, 1, 2, or 3):  3  2  1  0

### I. Follow Up Assessment

- Timing of follow up assessment: specify\_\_\_\_\_
- Number of participants included in the follow up assessment: specify\_\_\_\_\_
- Consistency of assessment method used: specify\_\_\_\_\_

**Rating for Follow Up Assessment** (select 0, 1, 2, or 3):  3  2  1  0

### III. Other Descriptive or Supplemental Criteria to Consider

#### A. External Validity Indicators

A1. Sampling procedures described in detail  yes  no

Specify rationale for selection: \_\_\_\_\_  
Young, Latino children at risk for socioemotional problems and academic failure.

Specify rationale for sample size: \_\_\_\_\_  
Sample consisted of parents who expressed concern and met screening procedure.

A1.1 Inclusion/exclusion criteria specified  yes  no

A1.2 Inclusion/exclusion criteria similar to school practice  yes  no

A1.3 Specified criteria related to concern  yes  no

#### A2. Participant Characteristics Specified for Treatment and Control Group

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Participants from Treatment Group	Grade/age	Gender	Ethnicity or Multi-ethnic	Ethnic Identity	Race(s)	Acculturation	Pri - mary Lan - guage	SES	Family Structure	Locale	Disability	Functional Descriptors
<input checked="" type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other	Average age: 4.12	Male: 13 Female: 11	Latino	85% Mexican 15% Latinos not born in Mexico	Mezti so	Yes	Span ish	Below US poverty level	Both biological parents: 21. Biological mother: 3	Suburban	None reported	Borderline to clinical levels of child behaviour concerns
<input checked="" type="checkbox"/> Child/Student <input checked="" type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other	Average age: 30	Male: 1 Female: 23				Yes						Concern about child's behaviour
<input type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other												
<input type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other												

Participants from Control Group	Grade/age	Gender	Ethnicity or Multi-ethnic	Ethnic Identity	Race(s)	Acculturation	Pri - mary Lan - guage	SES	Family Structure	Locale	Disability	Functional Descriptors
<input checked="" type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other	Average age: 4.42	Male: 13 Female: 11	Latino	85% Mexican 15% Latinos not born in Mexico	Mezti so	Yes	Span ish	Below US poverty level	Both biological parents: 20. Biological mother: 3, + stepfather: 1	Suburban	None reported	Borderline to clinical levels of child behaviour concerns.
<input type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other	Average age: 29	Male: 0 Female: 24				Yes						Concern about child's behaviour
<input type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other												
<input type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other												

A3. Details are provided regarding variables that:

A3.1 Have differential relevance for intended outcomes  yes  no

Specify: \_\_\_\_\_

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A3.2 Have relevance to inclusion criteria  yes  no

No differential relevance between experimental and control  
Specify: \_\_\_\_\_

A4. Receptivity/acceptance by target participant population (treatment group)

Participants from Treatment Group	Results (What person reported to have gained from participation in program)	General Rating
<input type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other		<input type="checkbox"/> Participants reported benefiting overall from the intervention  <input type="checkbox"/> Participants reported not benefiting overall from the intervention
<input type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other		<input type="checkbox"/> Participants reported benefiting overall from the intervention  <input type="checkbox"/> Participants reported not benefiting overall from the intervention
<input type="checkbox"/> Child/Student <input type="checkbox"/> Parent/caregiver <input type="checkbox"/> Teacher <input type="checkbox"/> School <input type="checkbox"/> Other		<input type="checkbox"/> Participants reported benefiting overall from the intervention  <input type="checkbox"/> Participants reported not benefiting overall from the intervention

A5. Generalization of Effects:

A5.1 Generalization over time

A5.1.1 Evidence is provided regarding the sustainability of outcomes after intervention is terminated  yes  no

Specify: \_\_\_\_\_

A5.1.2 Procedures for maintaining outcomes are specified  yes  no

Specify: \_\_\_\_\_

A5.2 Generalization across settings

A5.2.1 Evidence is provided regarding the extent to which outcomes are manifested in contexts that are different from the intervention context  yes  no

Specify: \_\_\_\_\_

A5.2.2 Documentation of efforts to ensure application of intervention to other settings  
yes  no

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Specify: \_\_\_\_\_

A5.2.3 Impact on implementers or context is sustained  yes  no

Specify: \_\_\_\_\_

A5.3 Generalization across persons

Evidence is provided regarding the degree to which outcomes are manifested with participants who are different than the original group of participants for with the intervention was evaluated

yes  no

Specify: \_\_\_\_\_

**B. Length of Intervention** (select B1 or B2)

B1.  Unknown/insufficient information provided

B2.  Information provided (if information is provided, specify one of the following:)

B2.1 weeks 11  
\_\_\_\_\_  
N

B2.2 months     
\_\_\_\_\_  
N

B2.3 years     
\_\_\_\_\_  
N

B2.4 other     
\_\_\_\_\_  
N

**C. Intensity/dosage of Intervention** (select C1 or C2)

C1.  Unknown/insufficient information provided

C2.  Information provided (if information is provided, specify both of the following:)

C2.1 length of intervention session 2 hrs  
\_\_\_\_\_  
N

C2.2 frequency of intervention session     
\_\_\_\_\_  
N

**D. Dosage Response** (select D1 or D2)

D1.  Unknown/insufficient information provided

D2.  Information provided (if information is provided, answer D2.1)

D2.1 Describe positive outcomes associated with higher dosage: \_\_\_\_\_

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### E. Program Implementer (select all that apply)

- E1.  Research Staff
- E2.  School Specialty Staff
- E3.  Teachers
- E4.  Educational Assistants
- E5.  Parents
- E6.  College Students
- E7.  Peers
- E8.  Other
- E9.  Unknown/insufficient information provided

### F. Characteristics of the Intervener

- F1.  Highly similar to target participants on key variables (e.g., race, gender, SES)
- F2.  Somewhat similar to target participants on key variables
- F3.  Different from target participants on key variables

### G. Intervention Style or Orientation (select all that apply)

- G1.  Behavioral
- G2.  Cognitive-behavioral
- G3.  Experiential
- G4.  Humanistic/interpersonal
- G5.  Psychodynamic/insight oriented
- G6.  other (specify): \_\_\_\_\_
- G7.  Unknown/insufficient information provided

### H. Cost Analysis Data (select G1 or G2)

- H1.  Unknown/insufficient information provided
- H2.  Information provided (if information is provided, answer H2.1)

H2.1 Estimated Cost of Implementation: \_\_\_\_\_

### I. Training and Support Resources (select all that apply)

- I1.  Simple orientation given to change agents
- I2.  Training workshops conducted

# of Workshops provided 11

Average length of training 2 hours

Who conducted training (select all that apply)

- I2.1  Project Director
- I2.2  Graduate/project assistants

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I2.3  Other (please specify):  
I2.3  Unknown

- I3.  Ongoing technical support
- I4.  Program materials obtained
- I5.  Special Facilities    Video equipment
- I6.  Other (specify): \_\_\_\_\_

**J. Feasibility**

J1. Level of difficulty in training intervention agents (select one of the following)

- J1.1  High
- J1.2  Moderate
- J1.3  Low
- J1.4  Unknown

J2. Cost to train intervention agents (specify if known): \_\_\_\_\_

J3. Rating of cost to train intervention agents (select one of the following)

- J3.1  High
- J3.2  Moderate
- J3.3  Low
- J3.4  Unknown

## Summary of Evidence for Group-Based Design Studies

Indicator	Overall Evidence Rating NNR = No numerical rating or 0 - 3	Description of Evidence Strong Promising Weak No/limited evidence or Descriptive ratings
<b>General Characteristics</b>		
General Design Characteristics	<b>NNR</b>	
Statistical Treatment	<b>NNR</b>	
Type of Program	<b>NNR</b>	
Stage of Program	<b>NNR</b>	
Concurrent/Historical Intervention Exposure	<b>NNR</b>	
<b>Key Features</b>		
Measurement	2	Promising Evidence
Comparison Group	2	Promising Evidence
Primary Outcomes are Statistically Significant	3	Strong Evidence
Educational/clinical significance	2	Promising Evidence
Identifiable Components	2	Promising Evidence
Implementation Fidelity	3	Strong Evidence
Replication		
Site of Implementation		
Follow Up Assessment Conducted	0	No Evidence

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<b>Descriptive or Supplemental Criteria</b>		
External validity indicators	NNR	
Length of Intervention	NNR	
Intensity/dosage	NNR	
Dosage Response	NNR	
Program Implementer	NNR	
Characteristics of the Intervener	NNR	
Intervention Style/Orientation	NNR	
Cost Analysis Data Provided	NNR	
Training and Support Resources	NNR	
Feasibility	NNR	

Average WOE1 rating: 2

