THE EFFICACY OF FILIAL THERAPY WITH FAMILIES
WITH CHRONICALLY ILL CHILDREN

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

Kristi L. Tew, B.S., M.S.
Denton, Texas
May, 1997

This study was designed to determine the effectiveness of Filial Therapy as a method of intervention with families with chronically ill children. Filial Therapy is an intervention that focuses on strengthening and enhancing the parent-child relationship. Parents are trained to become the agents of change for their children's behaviors by utilizing basic child-centered play therapy skills in weekly play sessions. The purpose of this study was to a) determine the effectiveness in decreasing parental stress, b) determine the effectiveness in increasing parental acceptance, and c) determine the effectiveness in decreasing problematic behaviors in the chronically ill child as assessed by their parents.

The twelve experimental group parents received ten weekly two-hour Filial Therapy training sessions and participated in thirty minute play sessions with their children. The control group, consisting of eleven volunteer parents of chronically ill children, received no treatment during the ten weeks. All of the parents completed three instruments: The Parenting Stress Index, The Porter Parental
Acceptance Scale, and The Child Behavior Checklist.

Analyses of Covariance revealed that the parents involved in the experimental group a) significantly decreased their parental stress, b) significantly increased their attitude of acceptance toward their children, and c) reported a significant decrease in problematic behaviors with their chronically ill children.

This study supports Filial Therapy as an effective intervention for strengthening and enhancing the parent-child relationship. There is vast potential for Filial Therapy as it promotes healthy parenting skills and provides group support to parents who are eager to receive assistance in this manner.
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CHAPTER I

INTRODUCTION

Medical expertise and technology have drastically decreased the mortality rates of infants, and the ability to sustain life while not necessarily restoring health. Correspondingly, there has been an increase in the prevalence of children with chronic illnesses. Today, many children who would have been considered terminal a few years ago are now learning to live with an illness of a chronic nature. It is estimated that there are between 7.5 to 10 million children with chronic illnesses; over one million of these children have a severe condition (Roland, 1993; Martin, Brady, & Kotarba, 1992; Lynch, Lewis, & Murphy, 1993). These conditions include: cystic fibrosis, juvenile onset diabetes, congenital heart disease, sickle cell anemia, spina bifida, hemophilia, severe asthma, cerebral palsy, and juvenile arthritis (Steinhausen & Schindler, 1981; Swift & Seidman, 1963).

The medical conditions faced by children with chronic illnesses alter the lives of the children and their families. Most research in this area relates to the extent to which chronic illnesses influence adjustment in the sick children. Given the potential obstacles created by these childhood
diseases, it is perhaps to be expected that some adverse repercussions would occur, and that those repercussions can result in deficits in intellectual, personal and social functioning. The bulk of the research suggests that deficits can occur in all these areas. Early literature on the psychological adjustment of children with chronic illnesses reported that these disorders predisposed children to psychological maladjustment and psychopathology. Current researchers have suggested that chronic illnesses place children at greater risk for emotional problems, though there is wide variation in individual functioning (Wallander, Varni, Babani, Banis, & Wilcox, 1989). The maladjustment can be represented in a wide variety of ways including lowered self-esteem, dependency, hyperactivity, depression, and concern with body image (Daltroy, Larson, Eaton, Partridge, Pless, Rogers, & Liang, 1992). Pless and Roghman (1971) found that the proportion of chronically ill children who were deemed maladapted was about twice that of physically healthy children. Other researchers show that one in five children with a chronic disorder also has emotional problems added to those of coping with the illness itself (Wallander, Varni, et. al, 1989). While there may be a greater risk for behavioral and social problems, only a small proportion of chronically ill children would be considered clinically maladjusted. At the very least, most researchers believe that the existence of a chronic illness increases the risk
for psychosocial maladjustment as compared with their healthy peers.

In addition to the child, it is unequivocal that the existence of a chronic illness places extra responsibilities and stress on the parents. Bolding and Llorens (1991) reported that mothers of disabled preschoolers spent one and one-half to two times as much time in physical care activities as mothers of non-disabled children. Parents of chronically ill children reported less intimacy, more parenting stress, more maternal depression, and increased strain on the parenting role because of the additional duties (Cappelli, 1990).

A sizable amount of literature (Wallander, Varni, Babani, Banis, & Wilcox, 1989; Grey, Genel, & Tamborlane, 1980; Patterson, McCubbin, & Warwick, 1990) suggests that there are some intervening variables that may help chronically ill children and their families deal with the psychosocial manifestations of the chronic illness in more adaptive means, including lower family conflict, higher organization, and lower parental depression. These variables have been found to predict greater self-esteem and better coping strategies in these children with chronic illnesses.

Since it is clear that parents of chronically ill children significantly affect these children's ability to cope with their illnesses, an enlightened mental health treatment would include parents as the therapeutic agents of
change for their children. In the 1960s, Dr. Louise Guerney and Dr. Bernard Guerney developed Filial Therapy which involves parents as the primary change agents for their children. Filial Therapy has been shown to be an effective intervention to resolve child-related problems and to encourage children's healthy psychosocial development. The Filial therapist trains parents to use child-centered play therapy skills in special play sessions with their children, and educates on parenting skills which facilitate more effective communication between parents and their children. This interaction not only decreases emotional or behavioral difficulties; it strengthens the parent-child and family relationships (VanFleet, 1994).

When parents accept their chronically ill children, foster self-responsibility in them, and strengthen communication with their children, problems will be minimized (Bolding & Llorens, 1991). Filial Therapy has been proven to improve these three areas of parent-child interaction. Empirical evidence and clinical results suggest that Filial Therapy is suitable for use with children with chronic illnesses. Through play sessions, Filial Therapy can provide children with an experience of control, when many areas of life might feel out of control. It can also provide parents with a means to improve the quality of family life (VanFleet, 1994).
Review of Literature

Chronic Illnesses

Advances in health practices and medical technology have dramatically changed many acute and life-threatening illnesses to chronic. There are growing numbers of children who are being diagnosed and treated for childhood chronic illnesses, estimated as high as fifteen percent of the pediatric population. The chronicity of these conditions places unique psychosocial demands and stress on the children and their family members (VanFleet, 1992).

Childhood Chronic Illnesses

The range of childhood disorders and their physical conditions is quite variable. Currently there are studies that are providing some validation for the concept of adjustment issues common to all chronic illnesses; though the physical disorders vary in their medical and physical consequences, they seem to produce similar general psychological consequences (Coupey & Cohen, 1984). This suggests that the general challenges faced by children with chronic illnesses may be quite similar, which argues for studying and treating the psychosocial implications of children with chronic illnesses as a group (Wallander, Varni, Babani, Banis, & Wilcox, 1988).
The majority of research suggests that children with a chronic illness constitute a population at risk for adjustment problems (Wallander, Varni, Babani, Banis, & Wilcox, 1988; Wallander, Varni, Babani, Banis, & Wilcox, 1989; Mattsson, 1972; Blum, 1992; Cadman, Boyle, Szatmari, & Offord, 1987; Holaday & Turner-Henson, 1993; Daniels, Moos, Billings, & Miller, 1987; Orr, Weller, Satterwhite, & Pless, 1984; Coupey & Cohen, 1984; Wolfish & McLean, 1974; Pless, 1984; Gortmaker & Sappenfield, 1984; Leventhal, 1984). Some studies show that children with chronic illnesses are not at greater risk for emotional problems. These studies found little or no greater risk for psychological maladjustment with some specific chronic physical disorders, such as cystic fibrosis or diabetes, compared to controls (Drotar, Doershuk, Stern, Boat, Boyer, & Matthews, 1981). Others suggest that the association between childhood illnesses and serious adjustment problems is significant, but less pronounced than some research indicates (Stein & Jessop, 1984; Tavormina, Kastner, Slater, and Watt, 1976).

Wallander, Varni, Babani, Banis, & Wilcox (1988) propose four reasons for the contrasting findings. First, determining the adjustment in children is an inexact science. Secondly, inconclusive findings could be a result of different perspectives, such as between parents, teachers, clinicians, and doctors. A third reason for the discrepant
findings is that the study which found no differences in adjustment for chronically ill children used small samples. A last reason to explain the various results is that the study which found no significant maladjustment focused on single disorders. Wallander, et. al. assert that different chronic illnesses vary in their medical and physical consequences, but they produce similar general psychosocial consequences. Coupey and Cohen (1984) add that "the burdens and stresses that chronic illnesses impose are common to virtually all disease" (p. 211).

Effects of a Chronic Illness on a Child

Physical

The chronicity of these conditions places unique physical demands and stress on these children. Depending on the condition, the demands can include pain, discomfort, loss of energy, physical restrictions, changes in outward appearance, and mood variations. "Some chronic illnesses may be characterized by a series of remissions and relapses, while others may result in progressive deterioration" (VanFleet, 1992, p. 88). The uncertainty and unpredictability of having a chronic illness adds to the stress for the individual.

In addition to the illness, these children must also endure the management of the disease. Treatments are often painful, invasive, frightening, and can have unpleasant
side-effects. After such treatments, children often exhibit persistent nightmares, fears, eating difficulties, sleep disturbances, and can exhibit other regressive behaviors (Wilkinson, 1978). All children experience pain, but due to cognitive developmental issues, younger children remain relatively unable to understand pain, and what they can do to cope with it. Children report a low rate of adaptive coping strategies while exhibiting a high rate of maladaptive thoughts, such as pain is a result of misdeeds (McGrath & Craig, 1989).

Developmental

"There is an expected course of normal development that may be seriously disrupted by a chronic disease or handicapping condition" (Magrab, 1984). For a child with an illness, many aspects of the developmental process may be thwarted because emotional needs such as independence, autonomy, self-respect, security, acceptance as an individual, and achievement may not be met due to the disruption the illness causes the child and the family. The amount of disruption depends upon: the age of onset, the severity of the condition, the severity of the treatment, and the degree of incapacitation (Rolland, 1993).

In dealing with children with chronic conditions, there are several different types of change occurring simultaneously. First there is the evolving development of
the child. Superimposed on this developmental progression is the change in the chronic condition as it follows its course. Third, there are the changes in the family as it develops through the family life cycle. Finally, there is the coping or adapting to the condition, almost as if the chronic illness represents a separate entity in the family (Stein & Jessop, 1984).

Most research conducted on chronically ill children focuses on their development through a cognitive model (Perrin & Gerrity, 1984; Bibace & Walsh, 1980; Young, McMurray, Rothery, & Emery, 1987; Berry, Hayford, Ross, Pachman, & Lavigne, 1993; Ungerer, Horgan, Chaitow, & Champion; Reissland, 1983; Perrin & Gerrity, 1981; Sayer, Willett & Perrin, 1993; Beales, Holt, Keen, & Mellor, 1983). These researchers show how a child with a disease is developmentally affected, using Piaget's developmental model. They suggest that the best predictor of a child's understanding of a illness is the child's level of cognitive development. Every child develops a coherent progressive understanding of the cause, prevention and treatment of his disease that parallels other areas of development. These concepts appear to be predictable and consistent. For an infant, the major emotional impact that a chronic illness can have is on the bonding and attachment process, which can be challenged with frequent hospitalizations and the discomfort of pain. The young
child tries to explain the illness, but lacks the comprehension. At this stage, phenomenalism and contagion explanations are linked in the child's mind with feelings of guilt, and viewing the disease as punishment. As the child rationally and logically develops, the child's perception of his illness becomes more important. Since mastery is the important issue for school-aged kids, the loss of control because of an illness may have an extensive impact on the development of self-worth. A primary task in the adolescent stage of life is to acquire a sense of self; illness imposes uncertainty and confusion on the achievement of this task. Instead of feeling independent and self-sufficient, adolescents with a disease frequently feel defeated by their declining strength and dependence on others (Daltroy, Larson, Eaton, Partridge, Pless, Rogers & Liang, 1992). Differences in conceptualization of medical concepts, illnesses, pain, and treatment seems to be closely tied to one's level of maturational cognitive understanding (Robinson, 1987; Redpath & Rogers, 1984; Brewster, 1982).

"Children with chronic illnesses have the same emotional needs as healthy children, but attainment of the major affective tasks of attachment, individuation, and mastery is more complex for them" (Brill, Cohen, Fauvre, Klein, Clark, & Garcia, 1987, p. 105). Stresses from the disease itself as well as the disruption in daily living
caused by the illness, can interfere or distort children's emotional development. At each age there are developmental tasks that may be encumbered as a result of a child's illness and or hospitalization.

As a summary of the developmental section, Table I shows the developmental issues and level of cognitive understanding of chronic illness in children based on information from Magrab (1984).

TABLE I

<table>
<thead>
<tr>
<th>Age</th>
<th>Psychological Issues</th>
<th>Illness Concept</th>
<th>Hospital Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>Importance of parent child bonding; fear of separation</td>
<td>•Generalized perception of pain &amp; discomfort</td>
<td>•Parent's presence &amp; reactions provide best support in handling fear, pain &amp; separation</td>
</tr>
<tr>
<td></td>
<td>•Need to be close as physically possible</td>
<td>•Perceptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>change by environmental response</td>
<td></td>
</tr>
<tr>
<td>Pre-School</td>
<td>Need to prepare for medical procedures, separation, etc.</td>
<td>•Illness seen as punishment for bad behavior</td>
<td>•Fears of mutilation rise &amp; treatment may be seen as punitive</td>
</tr>
<tr>
<td></td>
<td>•Regression possible</td>
<td>•Adults have magic powers to cure illness</td>
<td>•Death may not be permanent or may be confused with sleep</td>
</tr>
<tr>
<td></td>
<td>•Need to have sense of mastery</td>
<td>•Can begin to understand body processes</td>
<td>•Inadequacy feelings</td>
</tr>
<tr>
<td>School</td>
<td>Fear of loss of control</td>
<td>•Notions of self-causation</td>
<td>•Needs knowledge of disease &amp; ways to handle anxiety</td>
</tr>
<tr>
<td>Age</td>
<td>•Need for honest explanations</td>
<td>•Understanding can be contaminated with internalization</td>
<td>•May be rebellious</td>
</tr>
<tr>
<td></td>
<td>•Need to continue learning &amp; producing like others</td>
<td>•Focus on symptoms</td>
<td>•Separation from family &amp; friends may interfere with development</td>
</tr>
<tr>
<td></td>
<td>•Death becomes real &amp; final</td>
<td>•May deny or over-compensate in areas to show lack of illness</td>
<td>•Suicide as retaliatory reversible; high risk independent &amp; status threatened</td>
</tr>
</tbody>
</table>

Teen | Intense preoccupation with body changes & sexuality | Focus on symptoms | Conflicts over control are acute |
|     | Concerns about being different                                                        | •May deny or over-compensate in areas to show lack of illness | •Suicide as retaliatory reversible; high risk |
|     | Individuality issues                                                                  | •Conflicts over control are acute | •Independent & status threatened |
Psychological

The literature suggests that children with a chronic illness have more depression and other emotional problems, such as over-anxious, deep-seated dependence, and lack of self-confidence, than their peers without a chronic illness. It is also clear that a chronic illness does not uniformly negatively impact children (Skevington, 1993; Neuhaus, 1958). Sinnema (1992) and Blum (1992) report on four types of chronic illnesses which appear to have a greater risk for self-esteem and or emotional problems. First, conditions that are relatively invisible, such as cystic fibrosis, may cause ambiguity and ambivalence as many children try to conceal their condition. Second, having a disease characterized by instability, such as rheumatoid arthritis, often leads to uncertainty because of fluctuations between acute illness and periods of low or no disease activity. Third, children with progressively deteriorating diseases, such as congenital heart disease face uncertainty of their future (Glaser, Harrison, & Lynn, 1964). A fourth group includes cerebral palsy, described as physical disabilities with brain involvement; usually these children cannot conceal their illness, and can have poor self-images (Collings, 1990).

Stress is an important variable to address when working with chronically ill children as it can exacerbate many
diseases. A high frequency of stress has been consistently reported with chronically ill children compared to healthy controls and other groups of hospitalized children (Vandvik, Høyeraal & Fagertun, 1989; Cherry, 1989).

Cognitive

A lack of academic success and adaptation to the school environment can create even more stress for the chronically ill child. Children's school attendance may be interfered with, and their activities restricted because of a lack of mobility or hospitalizations. The prolonged disruption of a chronic illness in one's life experience may have a lasting effect on the cognitive development (Steinhauer, Mushin, & Rae-Grant, 1974).

The majority of children with chronic illnesses have normal intelligence. Despite this fact, most chronically ill children under-achieve and do more poorly academically than do their healthy peers (Weitzman, 1984). "Children with chronic illnesses...perform at a lower achievement level because of psychosocial problems, not cognitive or physical impairments" (Stein, 1989). Many times, these children have side effects from medications, limited energy, psychosocial maladjustment, as well as missing an excessive amount of school which may all contribute to their under-achievement in school. Underachieving can also be a result of over-protectiveness on the part of parents (Weitzman, 1984). Many
aspects of these illnesses and their treatments lead to under-achievement.

Social

Preliminary data based on long-term clinical observation suggests socialization may be a particular area of vulnerability for chronically ill children. Chronic illnesses in childhood present special problems for a child's socialization. Drotar (1981) reports

Some chronically ill children are stigmatized by their appearance, limitations in activity owing to their disease, and having to take medications in school. Further, hospitalization and physical treatments limit time and opportunities for socialization with physically healthy peers, and can contribute to social stress and/or isolation (p. 221).

The successes and failures of social relationships have a strong influence on the child's evolving sense of self. The presence of the illness and the treatments may thwart the development of trust and security, as well as decrease the opportunities to develop autonomy, identity, and self-esteem (VanFleet, 1992).

The Ontario Child Health Study of 3,294 children, from four to sixteen years of age, investigated the relationship between children with chronic illness and psychiatric and/or social adjustment problems. Cadman, Boyle, Szatmari, and Offord (1987) found that
children with both chronic illness and associated disability were at greater than threefold risk for psychiatric disorders and considerable risk for social adjustment problems. Children with chronic medical conditions, but no disabilities, were at considerably less risk: about a twofold increase in psychiatric disorders but little increased risk for social adjustment was observed (p. 805).

Holaday and Turner-Henson (1993) studied 365 chronically ill children's use of time outside of school. They found "a high percentage of the children (26%) could not name a close friend, and twenty-five percent admitted playing alone most of the time" (p. 30). While mothers perceive a deficiency in their child's social competence, the mothers usually report lesser involvement in activities, hobbies, and regular tasks, not in lacking peer relationships (Wallander, Varni, Babani, Banis, Wilcox, 1988).

**Effects of a Chronic Illness on Families**

A chronic disorder introduces a series of problems as well as a chronic level of strain inherent in the care of such a child (Wallander, Varni, Babani, & Wilcox, 1989). As a family makes a major adjustment in their expectations of having a normal child, they progress through several stages: initial shock, denial, sadness, anger, equilibrium and reorganization (Magrab, 1984). "Many if not most parents feel some sense of personal failure or question their own
adequacy in having produced a less than perfect child. Virtually every family member wonders what he or she might have done differently to prevent the child's condition" (Stein, 1989).

A qualitative study by Martin, Brady, and Kotarba (1992) obtained the perspectives of families with a chronically ill young child to discover the impact of the illness. They found the illness affected the families' daily lives to a tremendous extent. Areas of life that were affected include financial, medical, social, career, and family relationships.

The burden of a chronic illness can tax the financial resources of families. For most families, the expense of caring for their chronically ill child prove to be an additional source of pressure and anxiety. Doctor and hospital bills, medications, needed equipment, and so forth may necessitate having to seek another source of income. The cycle can be intense as parents come home to the demands of caring for their child (Steinhauer, Mushin, & Rae-Grant, 1974). Although additional income may be needed, the demands of caring for a chronically ill child often constrain employment of one of the parents. Much like the children, such families with a chronically ill child tend to be socially isolated.

A sizable amount of literature (Wallander, Varni, Babani, Banis, & Wilcox, 1989; Daniels, Moos, Billings, & Miller, 1987) suggests that there are intervening variables
that may help children and families deal with their chronic illness in more adaptive means. A child's response to his illness appears to be positively influenced by the characteristics of the family such as good problem solving abilities, an expressive family environment, lower parental depression, and lower family conflict. Eiser (1990) adds that emotional support, quality of the marital relationship, family income, religious beliefs, and satisfaction with medical care are other family characteristics that work towards "good coping". These variables have been found to predict greater self-esteem and better coping strategies in children with chronic illnesses.

**Effects on Parents**

At the time of diagnosis, most parents cycle through the grieving process as they mourn the loss of their desired normal child, including the stages of initial shock, denial, sadness, anger, and anxiety (Wood, Siegel, & Scott, 1991). Initially, parents experience high anxiety related to the possible outcomes of the disease. Closely associated with the first stage, disbelief of the diagnosis emanates, particularly if the obvious signs of the illness subside. In this stage, many parents seek other opinions to try to disprove the initial diagnosis. Often feelings of sadness, resentment, and self-blame emerge. When parents can realize and face these feelings, they are able to accept more of the
reality of the chronic illness and its impact on the family (Mattsson, 1972; Steinhauer, Mushin, & Rae-Grant, 1974).

When parents cannot accept the illness and are guilt-laden, they tend to cope by over-protecting and pampering their children. Often these parents become more indulgent and lenient on discipline. This reaction can predispose the ill child to emotional problems. Adler (1930) believed that neglect, organ inferiority (physical disability), and pampering were the roots of childhood neurosis, especially the comorbidity of combining the pampering with the existence of a chronic illness. Children's perception of overprotection by parents has been highly correlated with the following: lower levels of happiness, lower self-esteem, higher anxiety levels, lower perceived popularity, and greater self consciousness (Blum, 1992; Mattsson, 1972; Brantley, Stabler, & Whitt, 1981).

Parents of chronically ill children are faced with many decisions and problems. Two basic issues for parents are learning to deal with their child's health care, and coping with the inherent emotional stress (Pilon & Smith, 1985). It is clear that the existence of a sick child places extra responsibilities and stress on parents. Parents spend significantly more time in care-taking activities, and they also report less intimacy, more parenting stress, less social support, more maternal depression, and increased strain on the role of parenting because of the additional duties
Hobbs and Perrin point out that parents of children with long term illnesses had less agreement in areas of childhood management than parents of children with no such illness (1985). The demands of a chronic disease stress the parent's relationship and may disrupt the child rearing capacities.

Regarding the parental needs for those who have chronically ill children, Walker, Epstein, Taylor, Crocker, and Tuttle reported that until 1987 "only one study... reported on how parents perceive their own needs" (p. 196). To address this deficit, several studies have been conducted. The above researchers studied a sample of 910 parents in Massachusetts using questionnaires assessing their needs. Sixty-three percent of the parents indicated needing financial help; 49 percent rated parent support groups as very important, and 34 and 36 percent thought getting counseling for their child and siblings respectively was very important. According to Schulman (1976), couples who have lived through chronic illnesses in their children advise other couples to get involved in groups of similar people who can share and find help and strength from within the group.

Burks (1994) assessed the needs of parents who have a chronically ill child. She found eight needs: 1) support of spouse, 2) support of family, 3) support of friends, 4) support from other parents of chronically ill children, 5)
support of doctors, 6) medical information, 7) religious support, and 8) counseling. In finding a successful treatment program for families with a chronically ill child, these various needs should be addressed.

Other need assessment studies have been conducted. Terry (1987) identified two needs of parents with chronically ill children. First, the parents desired to have more information especially at the time of hospitalization. Second, parents wanted to feel important and useful to their child. Consistent with the above study, Algren (1985) reports using a Likert attitude scale with mothers of hospitalized children. He found 84 percent of the mothers had a positive attitude toward taking part in their children's hospital care, and the majority wanted to perform other nurturing types of care if allowed to do so by hospital staff. These studies indicate a willingness and desire for parents to be actively involved in the care of their hospitalized child. More than needs and willingness, a family-oriented supportive intervention can be a highly productive means of therapy. Other research points to the need of increasing the parental role during hospital stays because it appears to ease stress on the parent and the child, reduce the psychological trauma, and promote the parent-child relationship (Iscoe & Bordelon, 1985; Knox & Hays, 1983).
Mothers Specifically

There is evidence that mothers experience more stress than do fathers with regard to chronically ill children (Vandvik & Eekblad, 1991). Most of the care taking of chronically ill children is placed on their mothers. Anxieties, stresses, and depression are well documented in the literature by researchers, clinicians, and mothers themselves. As high as eighty percent of mothers described themselves as depressed, and over forty percent were taking antidepressant medication (Sabbeth, 1984).

Recent studies examining mothers and their chronically ill child have rendered some interesting findings. Several studies indicate mothers who begin to work part-time is significantly correlated with improved child functioning (Blum, 1992). Daltroy, Larson, Eaton, Partridge, Pless, Rogers and Liang (1992) discovered an phenomenon in that "better social competence was reported among children of mothers working part-time, compared with mothers working full time or not-at-all." This seems to further establish the need for children to have some time for self-reliance and underscores the impact that overprotectiveness can have on the child's social development.

Working with eighty mothers of hospitalized three to nine year-old children, Skipper and Leonard (1968) randomly assigned mothers and their children to treatment and control
groups. The researchers were able to decrease the stress in the children by affecting change in the mothers through affective and cognitive counseling as well as emotional support. Realizing the salient component between mothers and their hospitalized children, a changed level of stress for the mothers significantly decreased their children's stress level as measured by elevated pulse, blood pressure, temperature, and the length of recovery.

**Effects on Siblings**

Chronic illness is not only a psychosocial stressor for ill children, but also for their siblings. "Siblings have sometimes been referred to as 'the forgotten ones' and are, by many accounts, the most left out and neglected of all the family members during the course of a chronic illness" (Maden-Swain, Sexson, Brown, & Ragab, 1993). Frequently, the siblings of a sick child feel anxiety, jealousy, embarrassment, neglect, resentment, and guilt (Mattsson, 1972; Harris, Newcomb, & Gewanter, 1991; Jacobs, 1982; Sabbeth, 1984). Siblings may feel a loss of attention with overburdened parents, yet feel guilty for being jealous of the parental attention given to their sick sibling (Wolfish & McLean, 1974). They may also fear contracting the illness, and have anger toward the disease. Feeling guilty for being healthy and enjoying themselves is also common. With all of these various emotions, it is not surprising that
maladjustment, under achievement, and socialization problems are common among siblings of chronically ill children.

Few scientific research studies focusing on the siblings of children with chronic illnesses have been reported in the literature. The studies reported have statistically validated much of the qualitative research about siblings' feelings. The Madan-Swain, Sexson, Brown, and Ragab study found that these siblings perceived greater psychological distance from their parents as well as less family cohesion than did parents or the ill child (1993). Trieber, Mabe, and Wilson (1987) examined the psychological adjustment of children with sickle cell anemia and their siblings. The healthy sibling group had a significantly higher percentage of maladjustment than norms for their age and gender.

Brothers and sisters of a chronically ill child need information about the illness, as well as the knowledge that their emotional responses are normal. They need to experience and express their feelings without fear of criticism or rejection. When not allowed to verbalize their feelings, their feelings of resentment intensify. This hostility can be expressed covertly by withdrawal, depression, under achievement at school, behavior problems, or delinquency (Steinhauer, Mushin, & Rae-Grant, 1974).
Play and the Chronically Ill Child

Play is universal; it promotes growth and is therapeutic (Gladding, 1993). As with all children, the use of play can be an important variable in the life of a chronically ill child. Play can be powerful in helping children "gain perspective and in devising appropriate and creative strategies to address their concerns" (Gladding, p. 114). As most chronically ill children are hospitalized, play can help these children adjust more easily to the hospital environment (St. Albert & Daniewicz, 1958). "Playing out a fearful episode over which there can be no control can help a child feel in control" (Glazer & Landreth, 1993, p. 104). After years of research, Alger, Linn, & Beardslee (1985) believe play, specifically puppetry, serves as an effective, safe means to release emotions for this special population. It provides children in hospitals a means of focusing on the common feelings of separation, pain, and rage.

The Platt Report regarding the hospitalization of children instigated the use of many aspects of current hospitalizations of children, including the use of play (Noble, 1964). Play in the hospital has developed beyond the original role of recreation into an essential component as a means of normalizing the child's hospital experience (Committee on Hospital Care, 1985). Hall and Cleary (1988) stated
Play is now seen as the way par excellence of communicating with children, particularly those facing painful hospitalization experiences. For the individual, it covers self-discovery, reassurance against fear and anxiety, and increase in self-esteem through achievement and mastery. In the hospital, play comprises both the cognitive tasks of coming to terms with understanding the strange new environment and also the emotional tasks of coping with unpleasant and frightening procedures (p. 224).

Noble (1964) also emphasizes the need and value of play for hospitalized children, as she states, "the skilful [sic] provision of play can do much to help them cope with the tensions, frustrations and anxieties that are inevitable in this situation" (p. 1607). Furthermore, Noble suggested that play is the very essence of being for a child as it lays the foundation of mental health. In the hospital setting, Noble found through a series of experiments that children play more contentedly and for longer periods when an adult gave full-time attention to the children's play as compared to incidental adult attention and adults engaged in play. Other research with chronically ill children suggests that they may initiate and explore less, but with a therapist who will accept them, these children can play out their feelings of anger, disappointment, and sadness (Carmichael, 1992).
There are interesting dynamics and perceptions regarding the play of chronically ill children. Zimburean (1993) found that mothers with chronically ill children indicated the presence of a chronic illness negatively affected their children's play behavior, and it also negatively affected their own ability to play with their children. This research demonstrates the need for play therapy for chronically ill children as well as the need to training parents to play with their children. Others note the use of play between handicapped children and parents can help lessen the "parental side-effects" of guilt and anger over the birth of child with an illness or deformity (Hodapp & Goldfield, 1983).

Filial Therapy

Based on the belief that parents could act as the therapeutic agents with their children, Bernard and Louise Guerney developed filial therapy in the 1960s at Pennsylvania State University. Other names for this program (Guerney & Guerney, 1985) include Child Relationship Enhancement Family Therapy (CREFT), Child Relationship Enhancement (CRE), CPR (Child-Parent Relationship) for Parents (Landreth, 1991) and (PCRE) Parent-Child Relationship Enhancement (Coufal & Brock, 1984). Filial Therapy was designed for children ten years of age or younger who have mild to severe emotional and/or behavioral problems. The principles of Filial Therapy work on enhancing the relationship between the parent and child,
the most important part of the child's environment (Levant, 1983; VanFleet, 1994; Straughan, 1964).

Including the parent in the therapy process has several recognized benefits: 1) the parent is the most significant person in the child's life, 2) problems learned in the presence of the parent can be most effectively unlearned under similar conditions, 3) expectations can be realigned by the parent as well as being understood by the child, and 4) confidence in parenting is built. (Guerney, Guerney, & Andronico, 1966; Ginsberg, 1976). Moustakas (1975) believes that much of the difficulties in growing a relationship, such as the relationship between parents and their child, comes from being "stuck in a feeling of defeat or failure and remaining static comes from a lack of confidence" (p. 24). Furthermore, Filial Therapy can produce a reduction of the feelings of guilt and helplessness that often arise when parents are obligated to take their child to a therapist. Also of benefit, the parents develop appropriate new responses due to new behavioral patterns of their children (Stover & Guerney, 1967). Developing new, positive responses also directly results in an inhibition of inappropriate responses by parents (Straughan, 1964). "Training parents to help in the treatment of their children provides them with a sense of useful and active participation" (Andronico, Fidler, Guerney, & Guerney, 1967, p. 16).
This method of parent training involves teaching parents to utilize client-centered play therapy skills in thirty to forty-five minute play sessions with their children (Guerney & Guerney, 1985). Parents learn the elements of play therapy and develop skills in reflecting feelings, accepting their children's feelings, setting therapeutic limits, and following their children's lead. These elements of Filial Therapy are based on Virginia Axline's eight principles to guide the therapeutic process:

1) The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.

2) The therapist accepts the child exactly as he is.

3) The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4) The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.

5) The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6) The therapist does not attempt to direct the child's actions or conversations in any manner. The child leads the way; the therapist follows.

7) The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.

8) The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship (Axline, 1947, p. 73-74).

The basic tenants that parents must learn, according to Guerney, Guerney, & Andronico (1966), are: 1) to be empathic and make every effort to understand how the child views self and the world, 2) to be fully accepting of the child's feelings and thoughts, 3) to leave the direction of the play sessions to the child, and perhaps most importantly, 4) to convey this understanding and acceptance to the child. Parents are taught to respond empathically to the child's expression of feelings and content, which indicates interest and involvement with the child. Parents also receive instruction about eliminating the giving of advice, suggestions, directions, judgments or evaluations during their special play times (Guerney, 1978).

With acceptance and understanding, children can work through their various emotions by recognizing and accepting
their own feelings. Children are helped toward growth as they gain confidence in themselves, and learn through the parent-therapist's verbalizations about the play to evaluate and find constructive solutions to their problems. "Parental acceptance contributes to a child's self-acceptance, and such an atmosphere facilitates the development of a child's self-expression, confidence, and independence" (Ginsberg, Stutman, & Hummel, 1978, p. 155).

With a qualified therapist teaching parents the theory and techniques of play therapy, "the child will more readily display his emotions, share his world of dreams, and establish a greater degree of communication with the parent" (Ohlson, 1976, p. 167). Not only does play act as a mode of expression for children, but parents can use it as an effective technique to better understand their children, and their world of real and make-believe in which they live (Ohlson, 1974).

Parents are trained in groups of six to eight which meet weekly. The training process incorporates both didactic and dynamic elements. More specifically, Filial Therapy includes instruction, supervision, modeling, demonstration, individual practice, homework assignments, and the process of group therapy (Landreth, 1991). Filial Therapy emphasizes teaching, rather than fixing, as it builds on resources already existing in the parent-child relationship (Ginsberg, 1989). "Skills are operationalized as fully as possible and
presented in small, progressively more difficult steps" (Guerney, 1978, p. 193). Usually early sessions focus on skills training, the middle sessions focus on the play sessions conducted at home, and the last sessions focus on generalization of the experience to outside the realm of the special play time (Guerney, 1991). In the final phase of transfer and generalization, parents are encouraged to attempt to introduce the same elements of the special play times into real life (Guerney & Guerney, 1985).

Parents meet weekly to discuss parenting skills, their play sessions and to receive supervision from the therapist. With this educational model as a basis, the therapist acts as a trainer, mentor, and consultant to the parents (Ginsberg, 1976). The therapist, also called a therapeutic educator, needs to make sure the parents perceive that the therapist 1) understands their difficulties, problems, needs, and emotions, 2) invites and respects the parents' viewpoints, 3) does not give any indication of blame to the parents for their past relationships, and 4) views the parents as an important, indispensable ally in improving the well-being of their children (Guerney, Guerney, & Stover, 1972). The leader must be aware of the latent implications of parent's communications, and possess all of the skills and sensitivities demanded to enlist the parents into this special type parent training (Ginott, 1957).
Although Filial Therapy was originally designed as a long-term therapy, Landreth developed a ten-week model that has proven to be effective (Bratton, 1993; Glass, 1987; Glazer-Waldman, 1991; Lahti, 1992; Lobaugh, 1992; Harris, 1995; Chau, 1996; Glover, 1996). Landreth outlined the program in two hour sessions for ten weeks, see Appendix C for detailed description of the sessions (Landreth, 1991).

In summary, enhancement of the child-parent relationship and communication of acceptance of the child is the focus of this treatment. Also, learning good parenting skills and problem-solving techniques are included in the process. Further, it has been proven that parents absorb these skills into their permanent behavioral repertoire, so the gains experienced in therapy do not end when the treatment ceases.

Filial Therapy Research

Studies of Filial Therapy have concentrated on five broad areas: 1) determining the efficacy of the training procedures themselves, 2) measuring the changes that occurred in the parents, 3) ascertaining the effects of the parent training on the children, 4) discovering the long-term effects of Filial Therapy, and 5) assessing the efficacy of Filial Therapy with special populations. Filial Therapy has been proven effective to produce change, maintain change, and improve parenting attitudes and acceptance (Guerney, 1991).

The effectiveness of the Filial Therapy model has been documented by almost thirty years of research. The earliest
study demonstrated that with the training, mothers could learn to effectively use the following skills: empathetic listening, following the child's lead, structuring, and setting therapeutic limits with their behaviorally/emotionally disturbed children. Mothers in the experimental groups significantly increased in the use of all of the skills (Stover & Guerney, 1967).

Additionally, the rates for acceptance of the program and motivation for parents to continue the therapy appear to be very favorable to this approach. Previous counseling research has indicated 35 to 46 percent of clients initiated termination in child guidance centers; whereas, B. Guerney (1976) reports a nineteen percent client-initiated termination by parents involved in Filial Therapy. He also stated that this method of parent training is "equally effective across the range of the sample regardless of socio-economic status, degree or type of child's maladjustment,...and regardless of differences between mothers on numerous pre-treatment maternal attitude and personality variables" (Guerney, B., 1976, p. 35).

In 1971, Stover and B. Guerney provided additional evidence of Filial Therapy's effectiveness with severely emotionally disturbed children and their parents. Conducted at Rutgers University Psychological Clinic and Huntingdon Psychiatric Clinic, 51 child and mother dyads completed the 12 to 18 month training. Parents found Filial Therapy an
acceptable form of therapy, and they could effectively use the skills taught. From this study, the researchers found significant improvement on a variety of parent-rated measures of symptomatology and psychological adjustment as well as on two measures completed by the therapists. These children improved significantly from intake to termination. In this one-group pretest/posttest research design, all children were rated as having shown at least some improvement.

A methodological criticism of the above research is the lack of randomization or an alternative control group. As a partial response to this criticism, Oxman (1972) found empirical data supporting Filial Therapy using a matched pairs control group pretest-posttest design (Issac & Michael, 1990), and using the original Stover & Guerney experimental group. Control subjects were matched by age, geography, age of parent and child, size of family, education, and occupational levels. The mothers who completed the twelve month study indicated that Filial Therapy was effective in assisting them to bring about desired changes in their children. Oxman's results indicated that the treatment children significantly demonstrated improvements on both measures of symptomatology and maternal-child satisfaction as compared to the control group.

Additional information about the effectiveness of Filial Therapy was provided by Horner (1974), who found that there was a 59% reduction in symptoms for the sixty children who
participated in the six month study as reported by their parents on the Problem Checklist.

In 1975, the first follow-up data on Filial Therapy was obtained from parents by use of a questionnaire. There was an eighty-two percent rate of return of the questionnaires from the families who had participated in Filial Therapy one to three years prior. Of the forty-two parents who responded, thirty-two reported their children as having continued improvement since termination. Parents indicated an improvement in their ability to better relate to their children, and only three of the forty-two children who participated in the study were receiving psychological services after termination (Guerney, 1975).

Sywulak (1977) conducted research assessing both outcome and process by adding the following variables: condensing the length of treatment, including fathers, and exploring process variables. This major contribution to research on the Filial program utilized an own-control research design with nineteen families. The researcher used a four-month control period, followed by a two-month training period, and a two-month supervision of home play sessions period. The results of the Sywulak study showed significant improvement with respect to parental acceptance and perception of child adjustment relative to gains during the control period. To combat the limitation of Sywulak's own-group design project, Sensue (1981) replicated the study with a matched control group.
The results of the Sensue research project again indicated that parents with Filial training demonstrated significant improvement on parental acceptance and perceived child adjustment three years after treatment. These parents also presented a capacity and willingness to use the Filial skills with their children; this study indicated that a number of parents had continued to have special times with their children three years after completing the program (Guerney, 1983). Overall, parents and children involved in the treatment group reported that Filial Therapy was influential in promoting positive change within the family.

In order to examine the preventative nature of Filial Therapy, Payton (1980) studied 22 mothers from a Colorado community college and their children between the ages of four and ten. His results indicate parents who are trained in Filial Therapy are more effective agents of change than paraprofessionals. The children's personality adjustment significantly improved in the parent treatment group as compared to the control group.

Glass (1986) further assessed the efficacy of Filial Therapy with families and found a significant increase on all of the following variables due to the training: awareness, presence of unconditional love, parental understanding of the meaning of their child's play, and a decrease of conflict in the parent-child relationship. Parents showed more acceptance of their children, more respect for their
children's feelings, increased parental and child self-esteem, and a greater amount of closeness between the parent and child, though not statistically significant.

Filial Therapy has also been modified from working with groups to training a single set of parents to engage in play sessions in a clinic playroom (Stollak, 1981). Successes have also been shown with this method. Stollak found some differences in the play of children with mothers and with fathers. Fathers and sons typically play with the issues of nurturance, affection, and warmth. The child usually plays in fantasy the "provider-protector" role. The play between mothers and sons seems to focus on the struggle of limit-setting. Stollak believes that the way the parents act toward the child in the playroom reflects the parents' own personal conflicts. Thus, parents learn about themselves while they are learning ways of being sensitive, empathic, and caring with their child.

The Filial Therapy model has also been modified by Ginsberg, Stutman, and Hummel, who used a group of six children in play therapy with parent-therapists (1978). The group sessions were beneficial to four of the six children. Two withdrawn girls became more expressive; two aggressive boys began to fight less frequently. Interestingly, the mother of the two children, who did not change as a result of the play sessions, did not participate. This appears to
support the belief that there is a direct correlation between parental involvement and positive change in the children.

Bratton (1993) investigated the efficacy of Filial Therapy as a method of intervention with single parent families who were experiencing difficulties. The 22 experimental single parents significantly increased their attitude of acceptance and their empathic behavior toward their children when compared to the 21 single parents in the control group. Also, the parents who participated in the 10-week training significantly reduced their level of stress related to parenting, and indicated significantly fewer problems with their child's behavior.

Other studies conducted with special populations include Lobaugh (1991) and Harris (1995). Lobaugh studied incarcerated fathers and found significant decreases of parenting stress and increases of parental acceptance as a result of the Filial Therapy parenting training program. Harris conducted research with 22 incarcerated mothers; twelve received the Filial Therapy training in five weeks. She found a significant change in nine of thirteen areas including: 1) increases in the mothers' level of empathic interactions with their children, 2) increases in the mothers' attitude of acceptance toward their children, and 3) reductions in the number of reported problems in the children's behavior.
Filial training with parents of other cultures, such as American Indians (Glover, 1996) and Chinese (Chau, 1996) have proven the parenting skills and techniques of Filial Therapy successful cross-culturally. Conducting her study on an Indian reservation, Glover found that many of the Child-Centered skills were already a part of the traditional Indian culture. She did find significant differences in the interactions between the parents who received Filial Therapy training and the control group as assessed by pre and post video-taped play sessions and rated by play therapists. Chau conducted her research with thirty-four Chinese parents; eighteen were in a treatment group and sixteen in a control group. Her treatment was well received by this special population. She found a significant decrease of parental stress and increase of parental acceptance. As a result of the Filial training, the Chinese parents also experienced an increase of empathic responses and increases in their attitudes of acceptance of their children.

Filial Therapy has been applied successfully to children with a variety of problems and difficulties such as: children with stuttering problems (Andronico & Blake, 1971), social behavior of mentally retarded children (Boll, 1972), children with elimination problems (Fuch, 1957), adolescent issues (Guerney, Coufal, & Vogelsong, 1981), children with learning disabilities (Guerney, 1979), withdrawn children (Guerney & Flumen, 1970), children of divorce (Glazer-Waldman, 1992),
foster/adopted children (Ginsberg, 1989), and autistic children (Hornsby & Appelbaum, 1978).

In 1991, Glazer-Waldman investigated the impact of Filial Therapy on families with a chronically ill child. Using the Landreth (1991) model, she conducted ten weekly sessions. Five mothers, whose ages ranged from 29 to 36, completed the program. The children ranged in age from four to eight. She found that: 1) child anxiety as measured by the Child Anxiety Scale did not change, 2) parents were more accurate in their ability to judge the child's report of anxiety after the training, and 3) there was a trend, though not significant, toward increased parental acceptance of their children as measured by the Porter Parental Acceptance Scale. There were several positive outcomes noted: the parents indicated significant changes in their relationships with their children, and all participants reported that the sessions had become important to them (Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992).

Filial therapy offers a number of benefits to families with chronically ill children. It involves family members in a non-threatening, educationally oriented program which yields therapeutically beneficial outcomes. The ill child has an opportunity to express emotions and solve problems in a safe, accepting environment. Filial therapy can help all children in the family build a sense of mastery and confidence, and it allows control issues, so common in
families of chronically ill children, to be expressed and dealt with. The practical, flexible nature of the skills which the parents learn are particularly important in families where chronic illness adds to the complexities of parenting. Perhaps one of the greatest advantages of Filial Therapy for families of chronically ill children is that it emphasizes the parent-child bond and strengthens family cohesiveness, factors which related to individual children's adjustment to chronic illness (VanFleet, 1992).

The data being produced with the growing list of published and unpublished studies indicates that Filial Therapy produces beneficial results. Of particular interest are the effects of Filial Therapy with regard to the parents' stress, the chronically ill child's anxiety and depression, and the parents' level of acceptance with their chronically ill child.

Summary

There are an estimated 7.5 to 10 million children with chronic illnesses in the United States, over one million cases are severe. The physical, psychological, and social consequences of having a childhood chronic illness affect the children, their parents, and their siblings. Little research exists on the effects on parents, and even less with siblings. The need for research in the areas of psychological and social consequences of childhood chronic illnesses has been reported by the American Academy of
Pediatrics, by the U.S. Surgeon General, and by the Vanderbilt Study of Chronically Ill Children and Their Families (Holaday & Turner-Henson, 1993). Filial Therapy currently has been proven to be an effective intervention to resolve child-related problems and to encourage healthy child-parent interactions.

Statement of the Problem and Purpose of the Study

This study utilized Filial Therapy as the method of intervention with families with chronically ill children. Specifically, this study was designed to determine the efficacy of Filial Therapy with parents of chronically ill children with regard to the following: reducing parental stress, increasing parental acceptance, and decreasing emotional/behavior problems in the children.
CHAPTER II

METHODS AND PROCEDURES

Chronically ill children are increasingly being diagnosed and treated in the medical community, but far less research has been conducted to help the families deal with the socio-psychological issues surrounding the diagnosis and treatment of a chronic illness. These children with a chronic illness, as well as their siblings, appear to be at greater risk for developing some psychosocial problems. The parents are also affected, as many of them experience intense stress, marital difficulties, and other problems that can have detrimental effects on the parent-child relationship. This study investigated the effects of Filial Therapy on families with a chronically ill child.

Hypotheses

This research was based on the hypotheses listed below.

1. The experimental parent group will attain a significantly lower mean total score as measured by the Parenting Stress Index (PSI) than will the parents in the control group.

   a) The experimental parent group will attain a significantly lower mean score on the "Parent Domain" of the PSI post-test than will the control parent group.
b) The experimental parent group will attain a significantly lower mean score on the "Child Domain" of the PSI post-test than will the control parent group.

2. The experimental parent group will attain a significantly higher mean total score on the Porter Parental Acceptance Scale (PPAS) post-test than will the control group.
   a) The experimental parent group will attain a significantly higher mean total score on the Respect for the Child's Feelings and Right to Express Them subscale of the PPAS post-test than will the control parent group.
   b) The experimental parent group will attain a significantly higher mean total score on the Appreciation of the Child's Unique Makeup subscale of the PPAS post-test than will the control parent group.
   c) The experimental parent group will attain a significantly higher mean total score on the Recognition of the Child's Need for Autonomy and Independence subscale of the PPAS post-test than will the control parent group.
   d) The experimental parent group will attain a significantly higher mean total score on the Unconditional Love subscale of the PPAS post-test than will the control parent group.
3. There will be a significantly lower mean total score on the Child Behavior Checklist (CBCL) total behavior problems scale as compared to the control group for the siblings of the chronically ill children as assessed by their parents.

4. There will be a significantly lower mean total score on the CBCL anxiety/depression scale post-test scores as compared to the chronically ill children control group as assessed by their parents.

5. There will be a significantly lower mean total score on the CBCL total problem behaviors scale as compared to the chronically ill children control group as assessed by their parents.

Procedures

Definition of Terms

**Chronically Ill Children**- For this study, the following criteria will establish the operational definition of a chronically ill child. First, the child has a chronic illness, such as but not limited to: arthritis, cerebral palsy, chronic renal failure, cleft lip/palate, congenital heart disease, cystic fibrosis, diabetes mellitus, hemophilia, muscular dystrophy, severe asthma, sickle cell disease, spina bifida, or seizure disorders. Also, these children utilize more health-related professional services and a wider variety of services than other children (Gortmaker & Sappenfield, 1984).
**Filial Therapy** was defined in this study as the psychotherapeutic method of intervention developed by Bernard Guerney that trains parents...by utilizing a small group format in which parents are trained in the overall principles and methodology of client-centered play therapy...filial therapy is structured to enhance the relationship, in this case between the parent and child, with the parent serving as the therapeutic agent of change. Through didactic instruction, viewing of video-tapes, and role playing, parents' sensitivity to their children is enhanced, and parents learn how to create a nonjudgmental, understanding, and accepting environment during which children feel safe enough to explore other parts of themselves as persons and other ways of relating with their parents. The setting for this new kind of environment is a required thirty minute special play time (Landreth, 1991, p. 338-339).

**Parental Acceptance** describes the ability of parents to recognize and approve of their child without conditions. For the purpose of this study, parental acceptance was operationally defined as the parent's scores on the Porter Parental Acceptance Scale. The essential elements of parental acceptance are 1) the parent values the uniqueness of the child, 2) the parent recognizes the child's need to become an
autonomous individual, 3) the parent loves the child unconditionally, and 4) the parent regards the child as a person with feelings and respects the child's right to express those feelings (Porter, 1954).

Parental Stress is the stress a parent experiences which includes certain salient child characteristics, parent characteristics, and parental reactions to situations that are directly related to the role of being a parent. For this study, parental stress is operationally defined as the parent's scores on the Parenting Stress Index (Abidin, 1983). The child characteristics measured by the Parenting Stress Index include: distractibility/hyperactivity, adaptability, demandingness, and acceptability. The parent characteristics are: parenting competence, feelings of isolation, attachment to child, parental health, role restriction, parental depression, and relationship with spouse.

Subjects

Approval was obtained to conduct this research at the Children's Medical Center in Dallas through The University of Texas Southwestern Medical Center. Recruitment of subjects focused on announcements by child life specialists at the hospital, and through phone calls made by the researcher. Parents were selected to participate in the study based on the following criteria: a) must have a chronically ill child, b) the child must be between the ages of three and ten, and
c) must be able to read, speak and write in the English language. Parents involved in the experimental group also:
a) must be able to attend the ten sessions to complete the Filial Therapy training, and b) must agree to participate in weekly 30 minute home play sessions with their child.

Approval was obtained from the University of North Texas Institutional Review Board for the Protection of Human Subjects in Research (See Appendix A) and from Institutional Review Board at The University of Texas Southwestern Medical Center (See Appendix B). Recruitment of subjects followed ethical guidelines established by the American Counseling Association, and the guidelines established by the hospital. Volunteers signed an Informed Consent form, see Appendix C.

Twenty-eight parents volunteered for this study. Initially, thirteen parents were in the treatment group and fifteen parents in the control group. Twelve of the thirteen parents in the treatment group completed the course; eleven of the parents in the control group completed both the pre and post battery of test instruments. This study did not exclude any person on the basis of race, religion, age, or gender. Each of the treatment and control groups had three divorced individuals, with all other persons being married. There were nine females and two males in the control group, which consisted of nine Caucasians and two Hispanics. The treatment group included nine females and three males; the racial make-up of this group was comprised of one Hispanic
and eleven Caucasians. Participants in the treatment group completed at least eight of the ten sessions to be included in the final analysis of data. A video-tape of each two-hour session was made, and parents were given the opportunity to make-up any session missed by viewing the video-tape. Recruitment of parents for the control group focused on asking parents who brought their children to the hospital clinics to complete the test battery as well as the test battery that they would receive in the mail ten weeks later. Parents in the control group were offered Filial Therapy training facilitated by the Child Life Specialists after the completion of this study.

Facilitators

Two Filial Therapy training groups were facilitated by the investigator of this study while two masters-level Child-Life Specialists at Children's Medical Center of Dallas co-lead one additional group. The investigator is a Licensed Professional Counselor, a National Certified Counselor, and a doctoral candidate at the University of North Texas. She and the two co-leaders have all completed an Introduction to Play Therapy course and a Filial Therapy course. The investigator also completed a supervised play therapy practicum and supervised doctoral internship. During the co-leaders parent training groups, the investigator had weekly discussions with the co-leaders for consultation.
Instruments

Parenting Stress Index (PSI)

Since extremely high and low parenting stress is a predictor of greater disturbance in chronically ill children (Wells & Schwebel, 1987), stress reduction as well as engaging uninvolved parents is a goal when working with families with a chronically ill child. One measure that this study will include is the Parenting Stress Index, which measures the stress in the parent-child relationship (Abidin, 1983). Built into this scale are a Child Domain Score, Parent Domain score, a Total Stress Scores, and an optional Life Stress Score. The Child Domain contains forty-seven items which assess how parents perceive their child in the following areas: Adaptability, Acceptability, Demandingness, Mood, Distractibility/ Hyperactivity, and Parent Reinforcement. Subscales included in the fifty-four question Parent Domain include Depression, Attachment, Restriction of Role, Sense of Competence, Social Isolation, Relationship with Spouse, and Parent Health. The PSI is Likert-type scale, and scores are reported in raw score and percentile ranks for the Total Score, Child Domain, Parent Domain, and all of the subscales. The PSI was normed on 534 mainly Caucasian parents with an average age of 29.8 years (Gresham, 1989), and "is recommended for...use as a screening,
diagnostic, and research instrument for Caucasian parents of children below ten years of age" (Wantz, 1989, p. 271).

The PSI was selected for this study because 1) the literature describing families with a chronically ill child found stress to be prevalent, 2) the subscales are closely related to the parent's ability to accept their child, which as stated in the literature review is vital for the psychosocial development of the chronically ill child, and 3) this assessment has been used in other of filial therapy training, building the body of research using filial therapy.

"Adequate internal consistency and stability coefficients are reported" in the PSI manual (Wantz, p. 271). The reliability coefficients were based on the responses of 2633 people included in the sample. Alpha reliability coefficients are reported for the Total Stress Score of .95; and .93 and .89 for the Parent Domain and Child Domain respectively (Hauenstein, Scarr, & Abidin, 1986). In a series of four studies, the PSI established the stability over a one to three month period of .70 for the Child Domain, .80 for the Parent Domain, and .92 for the Total Stress score. Test-retest reliability coefficients are reported ranging from .55 to .82 for the Child Domain, from .69 to .91 for the Parent Domain, and from .69 to .96 for the Total Stress score (Gresham, 1989; Wantz, 1989). Zakreski also conducted a test-retest study to determine a coefficient of reliability; this study found coefficients of .78 for the
Child Domain, .69 for the Parent Domain, and .88 for the Total Stress Score. Crowley (1995) further analyzed the PSI, and the data from her study were consistent with the previously reported literature and in the manual; Crowley found internal consistency of the instrument to be .91, and the three-year test-retest reliability to be .73 for the Total Stress Score.

Evidence of content, concurrent, construct, discriminant, and factorial validity is provided in the manual (Abidin, 1983). All items of the instrument are directly related to one of the thirteen subscales, indicating its content validity. "Evidence of construct validity is demonstrated through significant correlations between the PSI Child Domain score and the Child Behavior Checklist and between the PSI Parent Domain Score and the State-Trait Anxiety Scale" (Wantz, 1989, p. 271). A discriminate validity study examined scores of mothers of special-needs children and non-special-needs children. The PSI was also found to be successful at discriminating between physically abusive and nonabusive mothers, amount of husband support, and between single and married mothers. The PSI reports three factor analyses which support the organization of the instrument, and concluded that the Domains are distinct scales (Abidin, 1983).
Porter Parental Acceptance Scale (PPAS)

The Porter Parental Acceptance Scale was developed by Porter (1954) for the purpose of measuring parental acceptance of children. He uses the following operational definition of parental acceptance: 1) values the uniqueness of the child, 2) recognizes the child's need to become an autonomous individual, 3) loves the child unconditionally, and 4) regards the child as a person with feelings and respects the child's right to express those feelings. The instrument consists of forty items in a Likert-type format, ranging from low to high acceptance. There are also two additional dimensions of acceptance measured in this instrument, that of how the parent feels in a specific situation, and what actions the parent would take in a specific situation.

The PPAS is included in this study for the value it can add to assessment of changes in the parent-child relationship because of the similarity between the dimensions of this instrument and the tenants of filial therapy. The researcher has approval to use this instrument, see Appendix D.

A split-half reliability correlation coefficient of .766 is reported by Porter (1954), and the coefficient was raised to .865 using the Spearman Brown Prophesy formula. Other research established the reliability for the PPAS at .666 raised by the Spearman Brown formula to .80 (Burchinal,
Hawkes, & Gardner, 1957). All coefficients are significant beyond the .01 level of significance (Porter, 1954; Burchinal, Hawkes, & Gardner, 1957).

Porter (1954) used a panel of five experts to investigate the validity of the instrument. The judges ranked the responses on a continuum of one representing low parental acceptance to five representing high parental acceptance. All items had at least three of five experts' agreement, with the greatest degree of distance of only two scale points which occurred on only 18.67 percent of the responses. Burchinal, Hawkes, and Gardner conducted a study using 256 parents and children to measure the instrument for item discrimination using item analysis (1957). All items, except for one, showed statistical significance in discriminating between high and low scoring fathers. The group with the highest quartile of the total test score was compared with the lowest quartile group with respect to their mean score on each item. The difference between the means was measured for significance. Thirty-five of the forty items had significant T scores over 3.46, the value needed for a significance at the .001 level. The findings suggest that the instrument is valid for measuring parental acceptance.

**Child Behavior Checklist (CBCL)**

The Child Behavior Checklist Home version is to be completed by parents. The CBCL obtains parents' reports of
children's competencies and problems. The 118 three-point Likert-type items cover internalizing and externalizing problems in eight cross-informant syndromes, and a total problem scales. The subscales for this instrument include Anxious/Depressed, Social Problems, Thought Problems, Somatic Complaints, Withdrawn, Attention Problems, Aggressiveness, and Delinquency. The CBCL Home Version was selected above the other forms of the CBCL based on clinical research finding that the parent information is most informative (Bird, Gould, Rubio-Stipec, Staghezza, & Canino, 1991).

The CBCL scales were developed through factor analytic studies, and based on parents' ratings of 4,455 clinically referred children. Norms were conducted on 2,368 non-referred children; scores are standardized separately for boy and girls at ages four to five, six to eleven, and twelve to sixteen. Scores for each of the subscales can be computed yielding T-scores and percentiles (Achenbach & Edelbrock, 1983).

Several forms of reliability are reported in the manual (Achenbach & Edelbrock, 1983). Individual item intraclass correlations coefficients were calculated to assess the test-retest reliability, interparent agreement, and inter-interview reliability of item scores; all coefficients were significant above .90. The test-retest reliability of mothers' ratings were .89. Other correlation studies report significantly reliable scores for test-retest reliability,
score stability, and mother-father agreement using the scale scores, total problems scores, and competence scores (Kelley, 1985).

Several studies support the construct validity of the CBCL instrument (Kelley, 1985). Tests of criterion-related validity also support the validity of the instrument. Using the 90th percentile of the behavior problems scores, the misclassification rate on the behavior problem scale was only 9.8 percent on predicting referred from non-referred children (Achenbach, & Edelbrock, 1983). Also important, the demographic variables such as race and socio-economic status account only for a relatively small proportion of score variances (Kelley, 1985).

Protocol for Intervention

Each Filial Therapy parent training took place in a conference room with two to eight parents at the Children's Medical Center in Dallas. In this study there were three groups. The researcher lead two groups; one with seven members and one with two members. The Child Life Specialists co-lead one group consisting of three members. Each group met once weekly for ten weeks for two hours each session, following the Landreth model (Landreth, 1991). This model of filial therapy was selected for this study because of the depth of coverage in a compacted number of session, as parents of chronically ill children have limited available
time for training. For specific information covered and for specific handouts given, see Appendix E.

Parents were given the test instruments during the first and last sessions, which slightly lengthened these two sessions. Childcare at the facility was provided.

Session # 1

Parents introduced themselves and briefly described the members of their families; facilitators gave explanations of filial therapy and discussed expectations. Then, informed consent forms were given to parents to be signed. Upon getting informed consent, parents were given the following instruments to complete: the Child Behavior Checklist, the Parenting Stress Index, the Porter Parental Acceptance Scale and an information/demographic form, see Appendix F. Information and ideas for the form were generated from several sources (Leventhal, 1984; Pless, 1984; Gortmaker & Sappenfield, 1984). Parents were introduced to the importance of emotions through the video segment from "Children's Emotions." The facilitator described the skills of reflective listening and tracking behavior and demonstrated these skills with one parent playing the role of a child. The homework assignment for the first session was to identify emotions of happiness, sadness, anger and surprise in their child of focus and make a reflective response, using a handout from Appendix E as the group's first homework assignment.
**Session # 2**

The therapist began the session by facilitating a discussion of the group’s week, and checking their homework assignment and having the parents focus on being specific. The facilitator eased into the basic principles of the play sessions, goals of the play sessions, and helped the parents set a day and time for the play sessions. The session ended by working on making facilitative reflective communication, by having the parents practice on each other.

**Session # 3**

The therapist began the session by facilitating a discussion of the group's week, and checking how reflective listening was going. The facilitator discussed the "do's and don'ts of filial therapy". Parents were given their filial therapy toy kits for their home play sessions with an explanation of the different kinds of toys. Parents were prepared for starting their first play session, and selected one parent to video-tape a play session to view at the next group. All parents began having their play sessions at home.

**Session # 4**

Parents discussed their week being very specific and identifying their feelings. The parents were debriefed on the play sessions, starting with the question, "Did the time go by fast or slow?" There was a lengthy discussion about limit setting and other discipline strategies that work. The
group viewed the first play session video-taped by one of the parents. The facilitator gave feedback to that parent, and arranged for the next parent to video-tape. The homework assignment was given.

**Session # 5**

The therapist discussed how play session were going, and discussed any problems the parents were having in the sessions. These discussions were used to help guide the teaching points, like their child's emotional tank, using 30 second bursts of attention, and the rules of thumb. The facilitator discussed what to do when limit setting does not work. The group viewed a parent's video-taped play session, and gave feedback, and arranged for next parent to video-tape. The homework assignment was given to the parents.

**Session # 6**

The therapist found out how play session were going, and discussed any problems the parents were having in the session, and discussed what the parents were learning through this process. Parents were grouped in pairs to continue to practice their reflective listening. A parent's video-taped play session was viewed, and arrangements for next video-taping were made. The homework assignment was given to the parents.
Session # 7
The therapist helped to debrief this week's play session, and helped parents begin to understand the possible meanings of their children's play during the discussions of the play session. The facilitator lead a discussion about praise versus encouragement, and gave the handout about "Learning to be Perfectionistic". A parent's video-taped play session was viewed and arrangements were made for taping of the next parent's play session. The parent's homework assignments were given.

Session # 8
The therapist began the session by facilitating a discussion of the group's play session this week, and checking their homework assignments. The group viewed a parent's video-taped play session and arranged for taping of the next play session. The parents began to think in terms of ending the training, and were told to bring any questions still needing answers to the next session.

Session # 9
The therapists facilitated the debrief of the play sessions. The group watched the video-taped play session, and gave feedback. The therapist answered questions and discussed the various topics brought by parents. The discussion then focused on how the parents had changed through this process.
Session # 10

In closing, the facilitator debriefed the parents about the whole process. The "rules of thumb and other things to remember" were discussed, paying particular attention to how their play sessions should continue and change. The therapist lead a discussion about the changes the parents and children have experienced. Encouragement was offered for parents to continue in the play sessions with their children. Parents completed the same instruments completed during the first session. Parents exchanged phone numbers to be able to stay in contact.

Statistical Analysis

With this special population, a control-group pretest-posttest design was utilized. The advantages for using this design include the pretest provided a comparison between the parental acceptance, parental perceptions, and parental stress by the same group of subjects before and after exposure to the treatment, as well as providing a control group with which to measure change. It also provided a control for selection and mortality variables, of the same subjects are assessed twice by the same instruments (Issac & Michael, 1990). For this type of study, an ANCOVA (Analysis of Covariance) was used to determine significant differences at the .05 level between and among the treatment and control groups.
CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of data for each hypothesis tested in this study. Also included is a discussion of the results, implications, and recommendations for future research.

Results

The results of this study are presented in the order the hypotheses were tested. Analyses of covariance were performed on all hypotheses and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses.

Hypothesis 1

The experimental parent group will attain a significantly lower mean total score as measured by the Parenting Stress Index (PSI) than will the parents in the control group.

Table 2 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 3 shows the analysis of covariance data, indicating that there is a significant difference between the experimental and control groups' post-test mean scores.
Table 2

Mean total scores for the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group n = 12</th>
<th>Control Group n = 11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>224.6667</td>
<td>205.25</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>31.7240</td>
<td>27.5457</td>
</tr>
</tbody>
</table>

Table 3

Analysis of Covariance data for the mean total scores on the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>2217.390</td>
<td>1</td>
<td>2217.390</td>
<td>6.641</td>
<td>.018</td>
</tr>
<tr>
<td>Covariates</td>
<td>9448.217</td>
<td>1</td>
<td>9448.217</td>
<td>28.296</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>21283.826</td>
<td>22</td>
<td>967.447</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3 shows the F ratio for the main effects was significant to the .018 level indicating a significant decrease in the experimental group's total stress scores on the Parenting Stress Index. On the basis of this data, hypothesis 1 was retained.

Hypothesis 1a

The experimental parent group will attain a significantly lower mean score on the "Parent Domain" of the PSI post-test than will the control group parents.

Table 4 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 5 shows the analysis of covariance data, indicating that there
is no significant difference between the experimental and control groups' post-test "Parent Domain" mean scores.

Table 4

Mean "Parent Domain" scores for the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>124.5</td>
<td>114.1667</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>20.5366</td>
<td>16.9173</td>
</tr>
</tbody>
</table>

Table 5

Analysis of Covariance data for the mean "Parent Domain" scores on the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>478.205</td>
<td>1</td>
<td>478.205</td>
<td>3.176</td>
<td>.090</td>
</tr>
<tr>
<td>Covariates</td>
<td>1831.325</td>
<td>1</td>
<td>1831.325</td>
<td>12.161</td>
<td>.002</td>
</tr>
<tr>
<td>Error</td>
<td>5864.609</td>
<td>22</td>
<td>266.573</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 5 presents the F ratio for the main effects and indicates no significant decrease in the experimental group's "Parent Domain" stress score on the Parenting Stress Index. On the basis of this data, hypothesis 1a was rejected at the .05 level of significance.

**Hypothesis 3**

The experimental parent group will attain a significantly lower mean score on the "Child Domain" of the PSI post-test than will the control parent group.
Table 6 displays the pre and post-test means and standard deviations for the experimental and control groups. Table 7 depicts the analysis of covariance data, indicating that there is a significant difference between the experimental and control groups' post-test "Child Domain" mean scores. Table 7 shows a significant decrease in the experimental group's "Child Domain" stress score on the Parenting Stress Index, indicated by the F ratio of 10.154 for the main effects at the .005 level. On the basis of this data, hypothesis 1b was retained.

Table 6

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>752.109</td>
<td>1</td>
<td>752.109</td>
<td>10.154</td>
<td>.005</td>
</tr>
<tr>
<td>Covariates</td>
<td>5043.113</td>
<td>1</td>
<td>5043.113</td>
<td>68.085</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>8112.957</td>
<td>22</td>
<td>368.771</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7

Mean "Child Domain" scores for the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>752.109</td>
<td>1</td>
<td>752.109</td>
<td>10.154</td>
<td>.005</td>
</tr>
<tr>
<td>Covariates</td>
<td>5043.113</td>
<td>1</td>
<td>5043.113</td>
<td>68.085</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>8112.957</td>
<td>22</td>
<td>368.771</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>752.109</td>
<td>1</td>
<td>752.109</td>
<td>10.154</td>
<td>.005</td>
</tr>
<tr>
<td>Covariates</td>
<td>5043.113</td>
<td>1</td>
<td>5043.113</td>
<td>68.085</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>8112.957</td>
<td>22</td>
<td>368.771</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7

<table>
<thead>
<tr>
<th>Source of Variation</th>
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<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>752.109</td>
<td>1</td>
<td>752.109</td>
<td>10.154</td>
<td>.005</td>
</tr>
<tr>
<td>Covariates</td>
<td>5043.113</td>
<td>1</td>
<td>5043.113</td>
<td>68.085</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>8112.957</td>
<td>22</td>
<td>368.771</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Hypothesis 2

The experimental parent group will attain a significantly lower mean total score on the Porter Parental Acceptance Scale following Filial training as compared to the control group.

The pre and post-test total means and standard deviations on the Porter Parental Acceptance Scale (PPAS) for the experimental and control groups are presented in Table 8. Table 9 depicts the analysis of covariance data, indicating that there is a significant difference between the experimental and control groups' post-test total mean scores.

Table 8

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n = 12$</td>
<td>$n = 11$</td>
</tr>
<tr>
<td>Pretest</td>
<td>142.0833</td>
<td>140.0000</td>
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<tr>
<td>Post-test</td>
<td>156.5833</td>
<td>141.2727</td>
</tr>
<tr>
<td>Mean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>11.8495</td>
<td>24.4800</td>
</tr>
<tr>
<td></td>
<td>11.2358</td>
<td>24.0117</td>
</tr>
</tbody>
</table>

Table 9

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>1065.375</td>
<td>1</td>
<td>1065.375</td>
<td>8.297</td>
<td>.009</td>
</tr>
<tr>
<td>Covariates</td>
<td>5289.043</td>
<td>1</td>
<td>5289.043</td>
<td>41.191</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>9202.435</td>
<td>22</td>
<td>418.292</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9 shows that the F ratio for the main effects was 8.297 indicating a significant increase at the .009 level for the parental acceptance on the Porter Parental Acceptance Scale. On the basis of this data, hypothesis 2 was retained.

**Hypothesis 2a**

The experimental parent group will attain a significantly higher mean total score on the "Respect for the Child's Feelings and Right to Express Them" subscale of the PPAS post-test than will the control parent group.

Table 10 displays the pre and post-test means and standard deviations for the experimental and control groups. Table 11 depicts the analysis of covariance data, indicating that there is a significant difference between the experimental and control groups' post-test scores. Table 11 shows a significant increase in the experimental group's score on the subscale of the PPAS, indicated by the F ratio of 8.50 for the main effects at the .009 level. On the basis of this data, hypothesis 2a was retained.

**Table 10**

| Mean "Respect for the Child's Feelings and Right to Express Them" scores on the PPAS |
|---|---|---|---|
| | Experimental Group | Control Group |
| | n = 12 | n = 11 |
| | Pretest | Post-test | Pretest | Post-test |
| **Mean** | 34.9167 | 41.2500 | 33.2727 | 34.9090 |
| **Standard Deviation** | 5.7076 | 4.6748 | 6.4679 | 6.2443 |
Table 11

Analysis of Covariance data for the mean "Respect" score on the Porter Parental Acceptance Scale (PPAS)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>161.04</td>
<td>1</td>
<td>161.04</td>
<td>8.50</td>
<td>.009</td>
</tr>
<tr>
<td>Covariates</td>
<td>312.26</td>
<td>1</td>
<td>312.26</td>
<td>16.48</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>921.91</td>
<td>22</td>
<td>41.91</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis 2b

The experimental parent group will attain a significantly higher mean total score on the "Appreciation of the Child's Unique Makeup" subscale of the PPAS post-test than will the control parent group.

Table 12 displays the pre and post-test means and standard deviations for the experimental and control groups. Table 13 depicts the analysis of covariance data, indicating the significance of difference between the experimental and control groups' post-test scores. Table 13 shows the F ratio for the main effects was not significant. On the basis of this data, hypothesis 2b was rejected.

Table 12

Mean "Appreciation of the Child's Unique Makeup" scores on the Porter Parental Acceptance Scale

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>32.25</td>
<td>34.1667</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>5.1821</td>
<td>3.3870</td>
</tr>
</tbody>
</table>
Table 13

Analysis of Covariance data for the mean "Appreciation of the Child's Unique Makeup" scores on the PPAS

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>3.41</td>
<td>1</td>
<td>3.41</td>
<td>.18</td>
<td>.680</td>
</tr>
<tr>
<td>Covariates</td>
<td>204.79</td>
<td>1</td>
<td>204.79</td>
<td>10.51</td>
<td>.004</td>
</tr>
<tr>
<td>Error</td>
<td>597.30</td>
<td>22</td>
<td>27.15</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis 2c

The experimental parent group will attain a significantly higher mean total score on the "Recognition for the Child's Need for Autonomy and Independence" subscale of the PPAS post-test than will the control parent group.

Table 14 displays the pre and post-test means and standard deviations for the experimental and control groups. Table 15 depicts the analysis of covariance data, indicating the significance of difference between the experimental and control groups' post-test scores. Table 15 shows the $F$ ratio for the main effects was significant at the .001 level. On the basis of this data, hypothesis 2c was retained.

Table 14

Mean "Recognition for the Child's Need for Autonomy and Independence" scores on the PPAS

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n = 12$</td>
<td>$n = 11$</td>
</tr>
<tr>
<td>Pretest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>38.8333</td>
<td>38.9090</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>4.2589</td>
<td>6.4308</td>
</tr>
</tbody>
</table>

|                |                    |               |
|                | 43.0000            | 38.1818       |
|                | 1.6329             | 5.8901        |
Table 15

Analysis of Covariance data on "Recognition for the Child's Need for Autonomy & Independence" scores on the PPAS

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>135.64</td>
<td>1</td>
<td>135.64</td>
<td>14.05</td>
<td>.001</td>
</tr>
<tr>
<td>Covariates</td>
<td>220.59</td>
<td>1</td>
<td>220.59</td>
<td>22.85</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>193.04</td>
<td>22</td>
<td>9.65</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis 2d

The experimental parent group will attain a significantly higher mean total score on the "Unconditional Love" subscale of the PPAS post-test than will the control parent group.

Table 16 shows the pre and post-test means and standard deviations for the experimental and control groups. Table 17 presents the analysis of covariance data, indicating the significance of difference between the experimental and control groups' post-test scores. Table 17 shows the F ratio for the main effects was not significant at the .05 level. On the basis of this data, hypothesis 2d was rejected.

Table 16

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 12</td>
<td>n = 11</td>
</tr>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>36.0833</td>
<td>38.1667</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>5.8943</td>
<td>7.0926</td>
</tr>
</tbody>
</table>
Table 17

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>52.11</td>
<td>1</td>
<td>52.11</td>
<td>1.28</td>
<td>.272</td>
</tr>
<tr>
<td>Covariates</td>
<td>764.97</td>
<td>1</td>
<td>764.97</td>
<td>18.73</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>816.88</td>
<td>22</td>
<td>40.84</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypothesis 3

There will be a significantly lower mean total score for the experimental group on the Child Behavior Checklist (CBCL) total behavior problems scale as compared to the control group for the siblings of the chronically ill children as assessed by their parents.

Due to an unforeseen inability to recruit families with siblings of chronically ill children between the ages of three and ten, the number of siblings on which parents completed the CBCL was not large enough to have the data analyzed. This problem will be discussed further in the discussion and recommendations.

Hypothesis 4

There will be a significantly lower mean total score for the experimental group on the CBCL anxiety/depression scale post-test scores following Filial Therapy as compared to the control for the chronically ill children as assessed by their parents.
Table 18 presents the pre and post-test means and standard deviations of the Anxiety/Depression subscale of the Child Behavior Checklist (CBCL) for experimental and control groups' post-test mean scores.

Table 18

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>3.1667</td>
<td>2.0000</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>1.4625</td>
<td>1.4142</td>
</tr>
</tbody>
</table>

Table 19

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>7.094</td>
<td>1</td>
<td>70.94</td>
<td>6.751</td>
<td>.017</td>
</tr>
<tr>
<td>Covariates</td>
<td>117.713</td>
<td>1</td>
<td>117.713</td>
<td>112.034</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>150.870</td>
<td>22</td>
<td>6.858</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 19 presents the analysis of covariance data. The F ratio for the main effects was 6.751 indicating a significant decrease at the .017 level for the anxiety and depression of the chronically ill children based on the Child Behavior Checklist. On the basis of this data, hypothesis 4 was retained.
Hypothesis 7

There will be a significantly lower mean total score of CBCL total problem behaviors scores for the experimental group as compared to the control for the chronically ill children as assessed by their parents.

Table 20 shows the pre and post-test means and standard deviations of the total problem behaviors of the Child Behavior Checklist (CBCL) for experimental and control groups' post-test mean scores.

Table 20

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n = 12</td>
<td>n = 11</td>
</tr>
<tr>
<td></td>
<td>Pretest</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>27.7500</td>
<td>15.0000</td>
</tr>
</tbody>
</table>

Table 21 presents the analysis of covariance data. The F ratio for the main effects was significant at the .002 level, indicating a significant decrease for total problem behaviors of the chronically ill children based on the Child Behavior Checklist as assessed by their parents. On the basis of this data, hypothesis 7 was retained.
Table 21

Analysis of Covariance data for the mean scores on the Anxiety/Depression subscale of the CBCL

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F ratio</th>
<th>Significance of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>1318.836</td>
<td>1</td>
<td>1318.836</td>
<td>12.501</td>
<td>.002</td>
</tr>
<tr>
<td>Covariates</td>
<td>3102.880</td>
<td>1</td>
<td>3102.880</td>
<td>29.411</td>
<td>.0001</td>
</tr>
<tr>
<td>Error</td>
<td>7053.652</td>
<td>22</td>
<td>320.621</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Discussion

The results of this study in conjunction with the parents' comments and the facilitators' observations support filial therapy training as an effective intervention with chronically ill children and their families. Of the eleven hypotheses, seven were retained; three were rejected; and one was unable to be statistically analyzed. The three hypotheses which were rejected at the .05 level, were significant at other levels. An interpretation of all scores is provided in the following sections.

Parental Stress

A review of the literature showed that many parents of chronically ill children feel added parenting stress because of the extra responsibilities placed on them by their child's condition. The stress in the parent-child relationship is an important factor when working with this population, as stress can exacerbate many conditions.
As indicated by the data presented in Table 2 through Table 7, parenting stress significantly decreased for parents in the experimental group. The overall total parenting stress scores and the scores of the "Child Domain" both were found to be significantly reduced following Filial Therapy training. Although the "Parent Domain" had positive change for the experimental group, it was not found to be significant at the .05 level.

A closer examination of the questions in the "Parent Domain" reveals that this assessment instrument may need to be normed specifically to this population if used with parents of chronically ill children. Many questions deal with the physical care of the child, financial obligations in caring for the child, responsibilities of taking care of the child's needs, which would be many of the common struggles of parents of chronically ill children. Parents of chronically ill children may answer certain questions differently than the parents without an ill child, such as "I often feel that my child's needs control my life," "When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent", or "I feel capable and on top of things when I am caring for my child." The experimental group included a set of problems which would not be common to families without sick children, such as a father who had to catheterize his five year old daughter throughout the day and night, a step mother who has
stayed at the hospital for at least one day every week for over six months, and a mother who has to take blood from her nine-year-old child bi-weekly for analysis. A typical parent might read one idea of “caring” into these questions, while a parent of a chronically ill child might have a different notion of what is included in the term “caring” for their child.

Another possibility for the lack of significant change in the "Parent Domain" might be explained by the fact that several questions in the PSI deal with the relationship with the spouse, such as "Since having my child, my spouse or significant other has not given me as much help and support as I expected." All of the parents involved in the study would be considered the primary care-takers of their sick children; most of the parents expressed some level of frustration that their spouses did not take a more prominent role in the care of their sick children. Tasks and certain dynamics of the parental relationships may not be changed with Filial Therapy training, but some of the overall parental stress certainly was decreased with the training.

Parental Acceptance

The data in Tables 8 through Table 17 shows that the experimental group made significant positive gains in their perceived acceptance of their children. The deviations of scores of each parent in the experimental group on each of the four subscales measured by the Porter Parental Acceptance
Scale as well as the total score deviations are displayed in Table 22. The positive numerals indicate positive gains in parental acceptance; the negative numbers denote decreases in parental acceptance. The four areas of parental acceptance measured in the PPAS are the following: respects child's right and need to express feelings, values the unique make-up of the child and fosters that uniqueness within the limits of healthy personal and social adjustment, recognizes the child's need to differentiate and separate from parents and become an autonomous individual, and loves the child unconditionally (Porter, 1954).

Table 22

<table>
<thead>
<tr>
<th>Experimental Participant</th>
<th>Respect Deviation</th>
<th>Uniqueness Deviation</th>
<th>Autonomy Deviation</th>
<th>Unconditional Deviation</th>
<th>Total Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>2</td>
<td>-1</td>
<td>6</td>
<td>10</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>3</td>
<td>-5</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>12</td>
<td>-6</td>
<td>3</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>-13</td>
<td>3</td>
<td>-4</td>
<td>-14</td>
</tr>
<tr>
<td>6</td>
<td>11</td>
<td>7</td>
<td>9</td>
<td>-18</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>9</td>
<td>5</td>
<td>12</td>
<td>32</td>
</tr>
<tr>
<td>8</td>
<td>18</td>
<td>1</td>
<td>-3</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
<td>14</td>
<td>6</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>10</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>10</td>
<td>17</td>
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<tr>
<td>11</td>
<td>7</td>
<td>-1</td>
<td>-2</td>
<td>-4</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>7</td>
<td>0</td>
<td>6</td>
<td>-1</td>
<td>12</td>
</tr>
<tr>
<td>Group Totals</td>
<td>76</td>
<td>23</td>
<td>50</td>
<td>25</td>
<td>174</td>
</tr>
</tbody>
</table>

As seen in Table 22, all but one of the participants in the experimental group remained the same or increased in parental acceptance following the ten week training course.
The one parent who produced negative gain scores had the highest scores of the group on the pre-test, and then average scores on the post-test. A possible explanation for this negative gain is that the parent gained insight into areas in which he was not as accepting as he thought he was ten weeks earlier.

Overall, parents in the experimental group made the largest parental acceptance gains in the subscale of "Respect for the Child's Feelings and Right to Express Them." The Filial Therapy training emphasized children's feelings from the first session and continued placing importance on recognizing and expressing feelings throughout the training. These findings suggest the Filial Therapy training succeeded in helping to create more parental acceptance.

**Siblings of Chronically Ill Children**

The parents of the three siblings of the sick children whose parents were in the experimental group expressed a great deal of concern about the problems with the siblings. The parents discussed how they believed that the siblings enjoyed and got more out of the play sessions than did the chronically ill children. Most of the hospitalized children had been exposed to play therapy in the hospital setting, but this was the first exposure the siblings received. The parents who also had sessions with the non-sick children stated that they were creating a special bond with these siblings which had not been present previously as the
siblings did not often get their parent's undivided attention.

Problematic Behaviors of the Chronically Ill Children

Parents reported feeling more in control of their children by listening and responding to their feelings, as they experienced less frustrations and manipulation in the parent-child relationship. Parents believed that there were fewer problematic behaviors in their children following the training as well as less anxious/depressed behaviors. Parents in the experimental group expressed that their role as a parent is more manageable and more fun with the thirty-minute play sessions.

Implications

The results of this study support the use of Filial Therapy with chronically ill children and their families. Participants learned the basic skills taught during the ten week course, as each were able to demonstrate these skills on at least a minimally effective level.

The parents and children involved found value in the experience as the parents reported a decrease in stress related to parenting, an increase of accepting attitudes toward their children, and a reduction in their children's behavior problems as well as their anxiety and depression. These results suggest that the parents of chronically ill children were able to adopt a more therapeutic role with their children during special play times.
These results showing significant changes have several implications for other parent training programs for families with hospitalized or sick children: a) the importance of the small support group format allowing for interaction between parents with similar experiences; b) the use of both didactic and dynamic training; c) the benefit of using professional trained in basic counseling skills to provide emotional support and to model the skills taught in the sessions; d) the advantage of having the practice sessions at home based on the learning taking place in the group sessions; and e) the absolute necessity for providing child care during the group training sessions.

Recommendations

Based on the results of this study, the following recommendations are offered:

1. The utilization of Filial Therapy training groups as a viable intervention for families with chronically ill children.

2. Conduct future research in which siblings of chronically ill children could be studied using Filial Therapy as a means for change.

3. Conduct a follow-up study with the participants of this study.
4. Conduct a similar study using a time series design where the participants are used both as the experimental and control group to alleviate contamination in the control group.

5. Conduct a longitudinal study to determine the long term effects of increasing acceptance of primary care givers.

6. Conduct future research to investigate the effectiveness of intensive Filial Therapy training to be used while the children are hospitalized over a period of 3 days to one week.

7. Conduct a future study to determine the efficacy of traditional play therapy in the hospitalized setting versus parents trained in Filial Therapy and utilized in the hospital.

Concluding Remarks

Filial Therapy is an effective intervention for families with chronically ill children. With families affected by chronic illness increasing dramatically, parents' need for training and support increases accordingly. These parents experience additional responsibilities and stress related to demands for caring for their ill child. Many children have to adjust to living with pain and painful procedures, which has the potential for negative psychological ramifications. Mental health professionals will be working with more and more families struggling with these difficulties. Filial
Therapy is one means to providing help to families with chronically ill children. The process can provide direction toward healthier parent-child relationships, which is essential to the future mental health of these and all children. There is vast potential for Filial Therapy as it promotes healthy parenting skills and provides group support to parents who are eager to receive assistance in this manner.
Ms. Kristi Lee Tew
RT 7 BOX 186F
Decatur, TX 76234

Re: Human Subjects Application No. 96-106

Dear Ms. Tew:

As permitted by federal law and regulations governing the use of human subjects in research projects (45 CFR 46), I have conducted an expedited review of your proposed project titled "Efficacy of Filial Therapy with Families with Chronically Ill Children." The risks inherent in this research are minimal, and the potential benefits to the subjects outweigh those risks. The submitted protocol and informed consent form are hereby approved for the use of human subjects on this project.

If the use of human subjects extends beyond 12 months from this date, U.S. Department of Health and Human Services regulations require that the project be re-reviewed yearly. In such a case, please submit annual progress reports to the UNT Institutional Review Board. Further, the UNT IRB must re-review this project prior to any modifications you make in the approved project. Please contact me if you wish to make such changes or need additional information.

If you have questions, please contact me.

Sincerely,

Mark Elder
Chairman
Institutional Review Board

cc. IRB Members
Institutional Review Board

August 9, 1996

Kristi Tew
Route 7, Box 186F
Decatur, Texas 76234

RE: IRB FILE # 0896 28000
Filial Therapy in Families with Chronically Ill Children

Dear Ms. Tew:

On August 9, 1996, the Institutional Review Board considered the above-referenced study and approved the protocol and consent form as enclosed. Please use this approved consent form and destroy all other drafts or undated copies. The annual review of this study is scheduled for August 1997.

University and Federal regulations require that written consent be obtained from all human subjects in your studies. The consent form should be kept on file for a period of three years past completion of the study. A copy of the consent form should be given to each participant in your study. Also, the University attorneys have asked us to remind investigators to put a copy of the consent form in the subject's medical record. Investigators should file the original, executed copy of the consent form with their records of the protocol.

The HHS regulations require you to submit annual and terminal progress reports to our Institutional Review Board and to receive continuing review of your activity annually by this Board. Please report to the Board any deaths or adverse reactions occurring during the study. It is required that you keep the IRB informed of such events in order to prevent sanctions being placed on the institution. Furthermore, if you require a modification contact me in order that appropriate review and approval can be made prior to implementing the change.

If you have any questions related to this protocol or to the Institutional Review Board please contact me at 648-2258 or Romelle Hase at 648-3060.

Sincerely,

Perrie M. Adams, Ph.D.
Associate Dean for Research
Chairman
Institutional Review Board

PMA/rh
Enclosure
THE UNIVERSITY OF TEXAS SOUTHWESTERN MEDICAL CENTER AT DALLAS
SUBJECT CONSENT TO PARTICIPATE IN RESEARCH

TITLE OF STUDY: Efficacy of Filial Therapy with Families with Chronically Ill Children

SPONSOR: University of North Texas, Department of Counselor Education

INVESTIGATOR: Kristi Lee Tew, M.S., LPC, NCC, Ph.D. Candidate
Home (817) 627-6583 Office (817) 565-0949

You are being asked to participate in a research study. Persons who participate in research are entitled to certain rights. These rights include but are not limited to the subject's right to:
1. Be informed of the nature and purpose of the research;
2. Be given an explanation of the procedures to be followed in the research, and any drug or device to be utilized;
3. Be given a description of any attendant discomforts and risks to be reasonably expected;
4. Be given a disclosure of any benefits to the subject to be reasonably expected, if applicable;
5. Be given a disclosure of any appropriate alternatives, drugs, or devices that might be advantageous to the subject, their relative risks and benefits;
6. Be informed of the alternatives of medical treatment, if any, available to the subject during or after the experiment if complications arise;
7. Be given an opportunity to ask any questions concerning the research and the procedures involved;
8. Be instructed that consent to participate in the research may be withdrawn at any time, and the subject may discontinue participation without prejudice;
9. Be given a copy of the signed and dated consent form;
10. And be given the opportunity to decide to consent or not to consent to participate in research without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.
You are invited to participate in a study to determine the effectiveness of Filial Therapy training with parents who have chronically ill children. A healthy parent child relationship is the foundation for a child's success in life and is built on an atmosphere of respect, acceptance, and understanding combined with consistent limits and discipline. You will be asked to complete three questionnaires before and after training. You will be asked to participate in eight thirty minute play sessions with your child.

**Purpose:** The purpose of this study is to determine if Filial Therapy is an effective intervention for parents with chronically ill children. Filial Therapy is a relationship enhancement training program. This study will include approximately thirty parents.

**What you will be asked to do if you participate:** During these sessions, Kristi Tew will be teaching you and other parents some techniques on how to interact with your child in ways that will enhance your child's self esteem as well as strengthen your relationship with your child. Also, you will be asked to participate in eight weekly 30-minute play sessions at home with your child practicing the techniques being taught in the training sessions. You will be asked to select one of your children (between the ages of 3 -11) to focus on during the ten weeks of training. It will take 2 hours per week for 10 weeks to participate in this study. Each two hour session will consist of didactic training, discussions, and rehearsal of skills learned. There will be one session per week for ten weeks.

**Experimental Procedures:** Specific parental attitudes concerning children will be measured by the Porter Parental Acceptance Scale. The attitudes include: a) respect for the child's feelings and right to express them; b) appreciation for the child's unique make-up; c) recognition of the child's need for autonomy and independence, and d) unconditional love for the child. The Parenting Stress Index will be used to measure the amount of stress parents perceive. You will also be asked to indicate those behaviors which you consider problematic for your child and rate the severity of each behavior on the Child Behavior Checklist.

**Possible Risks and Benefits:** There is no personal risk or discomfort directly involved with this study. You will be asked to give some of your time, and to be willing to explore some new ideas and feelings related to the parenting of your child. There may be times during the play sessions when your child could express sadness, anger, or frustration. While
these sessions cannot avoid these situations, neither will they increase the emotions. In fact, the training should help you deal with these situations more effectively. Your participation is completely voluntary. You will learn new skills to use with your children. The benefits of this training can be 1) a better relationship between you and your child, 2) a greater parental understanding of your child, 3) a better sense of parental abilities, 4) an improvement in the child's self-esteem, and 5) an improvement in the child's behavior. The children who share in the special play times with their parents will also benefit.

As an incentive for the program, participants will be supplied a special toy kit to be used for the home play sessions. This research may help to determine the best way to assist families who have a chronically ill child.

YOU ARE MAKING A DECISION WHETHER OR NOT TO PARTICIPATE IN THIS STUDY. YOU SHOULD NOT SIGN UNTIL YOU UNDERSTAND ALL THE INFORMATION PRESENTED IN THE PREVIOUS PAGES AND UNTIL ALL YOUR QUESTIONS ABOUT THE RESEARCH HAVE BEEN ANSWERED TO YOUR SATISFACTION. YOUR SIGNATURE INDICATES THAT YOU HAVE DECIDED TO PARTICIPATE HAVING READ (OR BEEN READ) THE INFORMATION PROVIDED ABOVE.

The following signatures should be obtained:

Printed name and signature of subject    Age    Date

Printed name and signature of witness

Signature of Investigator
March 22, 1996

Kristi Tew
Route 4 Box 983A
Decatur, TX 76234

Dear Kristi:

I am pleased to grant you permission to use my Parental Acceptance Scale. As I told you on the phone last evening, I have made some revisions from the original. This one is more up-to-date in gender use and there are some other changes that have refined it.

I hope that you find it useful. If you do use it, I would appreciate receiving a summary of your findings.

If you wish to contact me, I can be more quickly reached at my home. I am retired now and not in my office everyday. Also, we are sometimes away on trips. My home phone number is (801) 377-2411 and my home Fax number is (801) 375-5115.

Best wishes for your success in your research project.

Sincerely yours,

Blaine R. Porter

BRP/ms
FILIAL THERAPY TRAINING:
A TEN WEEK MODEL

SESSION OUTLINES AND HANDOUTS

Developed by Garry Landreth, Ed.D.

(Landreth, 1991)
SESSION #1

I. Introduce self, welcome group, give name tags and booklets to all members.

II. Overview of Filial Training:

- Play is the child's language
- Based on actions, not words.
- Way of preventing problems because adults become aware of child's needs.

"In ten weeks, you are going to be different, and your relationship with your child will be different."

Techniques from play therapy will:

- Return control to you.
- Provide closer, happier times with your child.
- Give key to your child's inner world.

III. Pass out information on the filial program and the informed consent forms

IV. Group Introductions:

- Describe entire family
- Tell concerns about this child
- Make generalizing comments to other Parents...

"Anyone else felt angry with their child this week?"

V. Provide Basic Agenda:

- One-half hour play sessions.
- Everyone will be video taped once for replay.
- We will see demonstrations before starting.
- Patience is important in learning a new language.
VI. Show video tape of "Children's Emotions"

VII. Reflective listening:

- Way of following, rather than leading.
- Don't ask questions.
- Reflect behaviors, patterns and feelings.
- Responses say:
  
  I am here; I hear you.
  I understand.
  I care.

Not:

  I always agree.
  I must make you happy.
  I will solve your problems.

- Keep focus on the positives.

RULE OF THUMB: You can't give away what you do not possess.

"As parents we may be coming to the sessions deeply aware of our failures. Yet we can't effectively enter this process by being impatient and unaccepting toward ourselves while trying to extend patience and acceptance to our child."

Homework:

(1) Notice some physical characteristic about your child you haven't seen before.

(2) Practice reflective listening this week; hand out- "The Four Basic Feelings"
THE FOUR BASIC FEELINGS

BRIEFLY DESCRIBE WHAT HAPPENED AND/OR WHAT YOUR CHILD SAID. THEN WRITE DOWN YOUR REFLECTION OF FEELING RESPONSE.

1. CHILD:
   PARENT:

2. CHILD:
   PARENT:

3. CHILD:
   PARENT:

4. CHILD:
   PARENT:
FILIAL SESSION #2

I. Review homework:  (1) Physical Characteristic  
                       (2) Four Basic Feelings

II. Handout: "Filial Therapy Parent Group"

III. Show video tape of session or do live demonstration.

IV. Tour of play room, have them pair off and role play to practice reflective responding.

RULE OF THUMB: When a child is drowning, don't try to teach him to swim.

If a child is feeling upset, that is not the moment to impart a rule or value.

Homework:

(1) "Facilitating Reflective Communication" handout.

(2) Pick spot and time for sessions on which to report back next week.
FILIAL THERAPY PARENT GROUP  
(Dr. Garry Landreth, Ed.D.)

Basic Principles of the Play Sessions

(1) The child should be completely free to determine how he will use the time. The child leads and the parent follows without making suggestions or asking questions.

(2) The parent’s major task is to empathize with the child, to understand the intent of his actions, and his thoughts and feelings.

(3) The parent’s next task is to communicate this understanding to the child by appropriate comments, particularly, whenever possible, by verbalizing the feelings that the child is actively experiencing.

(4) The parent is to be clear and firm about the few "limits" that are placed on the child. Limits to be set are time limits, not breaking specified toys, and not physically hurting the parent.

Goals of the Play Sessions

(1) To help the child change his perceptions of the parent's feelings, attitudes, and behavior.

(2) To allow the child - through the medium of play - to communicate thoughts, needs, and feelings to his parents.

(3) To help the child to develop more positive feelings of self respect, self worth, and confidence.

Reminder

These play sessions and the techniques you use are relatively meaningless if they are applied only mechanically and not as an attempt to be genuinely empathic and to truly understand your child.
Place for the Play Sessions

Whatever room you feel offers the fewest distractions to the child and the greatest freedom from worry about breaking things or making a mess. Set aside a regular time in advance. This time is to be undisturbed—no phone calls or interruptions by other children. You may wish to explain to your child that you are having these sessions because you are interested in learning how to play with them in a different, "special" way than you usually do.

Process

Let the child use the bathroom prior to the play session. Tell the child, "we will have thirty minutes of special play time and you may choose to play with the toys in many of the ways you like to." Let the child lead from this point. Play actively with the child if the child requests your participation. Set limits on behaviors that make you feel uncomfortable. Track his/her behavior and feelings verbally. Do not identify toys by their normal names; call them "it," "that," "her," "him," etc. Give the child a five minute advance notice before terminating the session. Do not exceed time limit by more than two to three minutes.
FACILITATING REFLECTIVE COMMUNICATION
(Dr. Garry Landreth, Ed.D.)

What response would you make to the following situations if you were practicing reflecting the child's feeling:

1. Joe: (With wrinkled brow, red face, and tears in his eyes) We lost. That team didn't play fair!
   Parent:

2. Jill: (Enters with C-test paper in hand) I tried so hard but it didn't do any good.
   Parent:

3. Janet: (Rummaging through her drawer wildly, looking for a particular sweater she wanted to wear to the party she had been looking forward to for a long time) I can never find anything I want. (Begins to cry)
   Parent:

4. John: (Undressing Barbie doll) Wow! Look at her butt!
   Parent:

5. Carol: (Looking through the doorway to a dark room) What's in there? Will you come with me?
   Parent:

6. Charlie: (Showing you his torn, smudged painting from school) Look, MOM! Isn't it neat! My teacher said I was a good artist!
   Parent:
FILIAL SESSION #3

I. Review homework:
   (1) Time and Place for Play Sessions
   (2) "Facilitating Reflective Communication" Handout

II. Handout in Class: "Basic Rules for Filial Therapy."
   Use to review rules for play session.
   Basic Limits: "I'm not for shooting."

III. Go over first parent tape, or another demonstration tape.

IV. Arrange for parent to do video taping this week.

RULE OF THUMB Be a thermostat, not a thermometer.

Reflecting feelings creates an environment that is comfortable and accepting, as opposed to merely reacting to feelings.

V. Handout Toy Kits
   Items included are: play doh, crayons, paper, tape, other craft items, nursing bottle, rubber knife, dart gun, handcuffs, baby doll, animal family, Lone Ranger type mask, piece of rope, toy car, doll house furniture, bop bag, bear puppet, toy soldiers, small building blocks, deck of cards, play money, plastic animals, plastic insects, and a medical kit with real latex gloves, a tongue blade, band-aids, a syringe, an operating mask, and other medical items. Feel free to discuss the addition of other items.

VI. Give Homework Assignment:
   Play sessions at home begin this week.
BASIC RULES FOR FILIAL THERAPY
(Dr. Garry Landreth, Ed.D.)

Don'ts
1. Don't criticize any behavior.
2. Don't praise the child.
3. Don't ask leading questions.
4. Don't allow interruptions of the session.
5. Don't give information or teach.
6. Don't preach.
7. Don't initiate new behavior.
8. Don't be passive, quiet.

Do
1. Do set the stage.
   "You can play with the toys in lots of the ways you'd like to"...
   "In here, that's up to you...you can decide...that can be whatever
   you want it to be"
2. Do let the child lead.
   "You want me to put that on"...(whisper technique)..."what should I say"...
   "show me what you want me to do"
3. Do track behavior.
   "You're filling that all the way to the top...You've decided
   you want to paint next...You've got 'em all lined up just how
   you want them"
4. Do reflect the child's feelings.
   "You like how you look in that"..."that kinda surprised you"...You really like how that feels on your hands...
   You really wish that we could play longer...You don't like the way that turned out"
5. Do set limits.
   "I know you'd like to play with the play dough on the
   floor, but it's not for putting on the floor...you can
   play with it on the tray"
6. Do salute the child's power and encourage effort.
   "You worked hard on that and you did it" or "you figured it out" or
   "You've got a plan for how you want to..." or "You know just how you want that" or "Sounds like you
   know lots about...
7. Do join in the play as a follower.
   "You want me to be the robber and I'm supposed to wear the black mask...Now I'm supposed to go to jail until
   you say I can get out"
8. Do be verbally active.
Check your responses to your children. Your responses should convey:

1. "You are not alone; I am here with you."
2. "I understand how you feel and I hear/see you."
3. "I care."

Your responses should not convey:

1. "I will solve your problems for you."
2. "I am responsible for making you happy."
3. "Because I understand you that means I automatically agree with you."
THE EIGHT BASIC PRINCIPLES OF NON-DIRECTIVE PLAY THERAPY

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.

2. The therapist accepts the child exactly as he is.

3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4. The therapist is alert to recognize the feelings the child is expressing and reflects those feeling back to him in such a manner that he gains insight into his behavior.

5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.

6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.

FILIAL SESSION #4

I. Debriefing. How did their play sessions go?  (Be aware of time -- keep group process moving)

II. As reporting is occurring, use their examples to illustrate rules of filial therapy. Also focus on how they were able to reflect on their child's feelings.

III. Handout: "Two Techniques of Discipline that Work"

Go over importance of using this as first step in discipline process.

IV. Arrange for next parent to video tape.

V. Show video from parent-child session.

RULE OF THUMB: Good things come in small packages.

We enter our child's world in little ways, not big ones. We can't expect to be part of only the big events in our child's life.

Homework: Notice one intense feeling in yourself this week.
1. Firm limit-setting
   A. Three steps:
      (1) Recognize the feeling- "I know you'd really like to..." or "I can tell you're really feeling..." etc.
      (2) Set the limit- "...but you may not ________...(because...)" or "but the answer is no" or "but the cabinet door is not for kicking."
      (3) Provide an alternative- "You can ____ if you'd like." or "What you can do is _______ ."
   B. After three-step process, DON'T discuss: "I can tell you'd like to discuss this some more, but I've already answered that question."
   C. If you're not prepared to answer the question (want to talk it over with someone, want to get more information, want to think about it),
      (1) "I can't answer that question now ... (because...)"I'll let you know (specific time)."
      (2) Nagging begins: "If you must have an answer now, the answer will have to be NO."
   D. If s(he) asks the same question again: Calmly- "I've already answered that question." Variations:
      (1) "Do you remember the answer I gave you a few minutes ago when you asked that same question?" (Child answers, "No, I don't remember") "Go sit down in a quiet place and think and I know you'll remember."
      (2) "I've answered that question once (twice) and that's enough."
      (3) If you think s(he) doesn't understand: "I've already answered that question. You must have some question about the answer."
   E. If you're undecided and open to persuasion: "I don't know...Let's sit down and discuss it."
2. Oreo Cookie Theory: Give the child a choice, providing acceptable choices commensurate with the child's ability to choose.
FILIAL SESSION #5

I. Debriefing, combined with report on one intense feeling they had. Focus on importance of awareness of themselves in the play session.

II. Handout: "When Setting Limits Doesn't Work"

"Enslaved Parent"

III. Set up next parent to bring in a video tape.

IV. Review video of parent-child session.

RULE OF THUMB: The most important thing may not be what you do, but what you do after what you have done.

It's not whether we make mistakes but how we handle our mistakes that counts.

V. Homework:

(1) Sandwich hugs - explain.

(2) Continue play sessions.

(3) Practice giving one choice.
WHEN SETTING LIMITS DOESN'T WORK...

You have been careful several times to 1) reflect the child's feelings, 2) set clear, fair limits, and 3) give the child an alternate way to express feelings. Now the child continues to deliberately disobey. What do you do?

1. **Look for natural causes for rebellion:** fatigue, sickness, hunger, extreme stress, abuse/neglect, etc. Take care of physical needs and crises before expecting cooperation.

2. **Remain in control, respecting yourself and the child:** you are not a failure if your child rebels, and your child is not bad. All kids need to "practice" rebelling.

3. **Set reasonable consequences for disobedience:** let the child choose to obey or disobey, but set a reasonable consequence for disobedience. Example: "If you choose to watch TV instead of going to bed, then you choose to give up TV all day tomorrow."

4. **Never tolerate violence:** physically restrain the child who becomes violent, without becoming aggressive yourself. Reflect the child's anger and loneliness; provide compassionate control and alternatives.

5. **If the child refuses to choose, you choose for him:** the child's refusal to choose is also a choice. Set the consequences. Example: "If you choose not to (choice A . . or B), then you have chosen for me to pick the one that is most convenient for me."

6. **ENFORCE THE CONSEQUENCES:** Don't draw your gun unless you intend to shoot. If you crumble under your child's anger or tears, you have abdicated your role as parent and lost your power. GET TOUGH; TRY AGAIN.

7. **Recognize signs of depression:** the chronically angry or rebellious child is in emotional trouble and may need professional help. Share your concern with the child. Example: "John, I've noticed that you seem to be angry and unhappy most of the time. I love you, and I'm worried about you. We're going to get help so we can all be happier."
FILIAL SESSION #6

I. Debriefing on play sessions and giving one choice.

II. Handout: "Common Problems in Filial Therapy"

III. Go over "When Setting Limits Doesn't Work" handout briefly.

IV. Arrange for next taping.

RULE OF THUMB: Grant in fantasy what you can't grant in reality.

It's okay for the "baby sister" doll to be thrown out a window in play time.

Homework:

(1) Write a note to your child of focus (as well as other children in the family) for three weeks, pointing out a positive character quality you appreciate. "I was just thinking about you and I think you are ____________." After your child has opened the note, say "That is such an important quality, we're going to put this note up." (where the child will see it every day).

(2) Continue play sessions -- notice patterns of play that are showing up.
COMMON PROBLEMS IN FILIAL THERAPY

1. Q: My child notices that I talk differently in the play sessions, and wants me to talk normal. What should I do? A:

2. Q: My child asks many questions during the play sessions and resents my not answering them. What should I do? A:

3. Q: My child just plays and has fun. What am I doing wrong? A:

4. Q: I'm bored. What is the value of this? A:

5. Q: My child doesn't respond to comments. Am I on target? A:

6. Q: When is it okay for me to ask questions? A:

7. Q: My child hates the play sessions. Should I stop them? A:

8. Q: My child wants the play time to be longer. Should I extend the session? A:
FILIAL SESSION #7

I. Debriefing On play sessions with focus on patterns.

II. Review "Common Problems in Filial Therapy."
   Use as chance to review reflective listening, setting limits, giving choices, etc.

III. Show video tape of session.

IV. Handout: "Learning to be Perfectionistic"
    Handout: "Praise versus Encouragement"

V. Arrange for taping of next parent.

RULE OF THUMB: Praise the effort, not the product.

Homework:

(1) Notice the number of times during the week you touch your child.

(2) Continue play sessions.
Although praise and encouragement both focus on positive behaviors and appear to be the same process, praise actually fosters dependence in children by teaching them to rely on an external source of control rather than on self control. Praise is an attempt to motivate children with external rewards. In effect, the parent who praises is saying, "If you do something I consider good, you will have the reward of being recognized and valued by me," Over-reliance on praise can produce crippling effects. Children come to believe that their worth depends upon the opinions of others. Praise employs words which place value judgments on children and focuses on external evaluation.

Examples: "You're such a good boy/girl." The child may wonder, "Am I accepted only when I'm good?"

"You got an A. That's great!" Are children to infer that they are worthwhile only when they make As?

"You did a good job." "I'm so proud of you." The message sent is that the parent's evaluation is more important than the child's.

Encouragement focuses on internal evaluation, and the contributions children make. Encouraging parents teach their children to accept their own inadequacies, to have confidence in themselves, and to feel useful through contribution. When comments about children's efforts are to be made, we must be careful not to place our value judgments on what they have done. Be alert to eliminate value laden words (good, great, excellent, etc.) from your vocabulary at these times. Instead, substitute words of encouragement which help children believe in themselves.

Encouraging Phrases that Demonstrate Acceptance:
"I like the way you tackle a problem."
"I'm glad you're pleased with it."
"It looks as if you enjoyed that."
"How do you feel about it?"

Encouraging Phrases that Show Confidence:
"I have confidence in your judgment:"
"You'll figure it out."
"That's a rough one, but I'm sure you'll figure it out."
"Knowing you, I'm sure you will do fine."
"You'll make it."
Encouraging Phrases that Focus on Contributions, Assets, and Appreciation:

"Thanks, that helped a lot."
"It was thoughtful of you to..."
"I need your help on..."
"You have skill in ______. Would you do that for the family?"

Encouraging Phrases that Recognize Effort and Improvement:

"It looks as if you really worked hard on that."
"Look at the progress you've made." (Be specific)
"You're improving in....... (Be specific)

In summary, encouragement is:

(1) valuing and accepting children as they are (not putting conditions on acceptance),

(2) pointing out the positive aspects of behavior,

(3) showing faith in children so that they can come to believe in themselves,

(4) recognizing effort and improvement (rather than requiring achievement), and

(5) showing appreciation for contributions.

FILIAL SESSION #8

I. Debriefing on play sessions and number of times they physically touched their child.

II. Go over handout on "Learning to be Perfectionistic"

III. Show video tape.

IV. Arrange for next parent.

RULE OF THUMB: If you draw your gun, shoot.

Idle threats harm your relationship with your child.

Homework:

(1) Continue play sessions.

(2) Write down any unanswered questions and bring next time.
FILIAL SESSION #9

I. Debriefing of play sessions. Give time for questions on various topics.

II. Show video tape.

III. Handout: "Explaining Death to Children"

IV. Arrange last taping session.

RULE OF THUMB: Don't answer questions that haven't been asked.
Look behind the question for the deeper question.

VI. Homework:
(1) Continue play sessions.
FILIAL SESSION #10

I. Briefly debrief.

II. Show last video tape.

III. Handout: "Rules of Thumb and Other Things to Remember"

IV. Closing Process:

   Focus on looking at differences in child and parent --
   then and now. Encourage feedback within group on
   positive changes made.

   (Praise them, they may be scared about leaving the
   safety of the group!)

RULE OF THUMB: If you can't say it in 10 words or less, don't
say it.

V. Encourage them to continue play sessions.

   "If you stop now, the message is that you were playing
   with your child because you had to, not because you
   wanted to."

VI. Have parents complete the test instruments as completed
    at the beginning of the filial training.

Recommended Reading

1. How to Really Love Your Child, Campbell.


3. Liberated Parents, Liberated Children, Fabert Mazlish
DEMOGRAPHIC INFORMATION

Name ___________________________ Marital Status ________

Address ____________________________________________

________________________________________ Telephone (___)__________

Children's Names and Ages __________________________________________

Which child has a chronic illness? _________________________________

What illness does he or she have? _________________________________

What are the physical effects of the illness on the child? _________________________________

How has the illness affected the child's performance at home, with peers, and at school? _________________________________

How have the siblings adjusted? _________________________________

What are your family's strengths? _________________________________

What are your family's weaknesses? _________________________________
REFERENCES


Carmichael, K. D. (May 1992). Play therapy with special populations. Presentation given at the University of Alabama for beginning play therapists. 31p. ED360577


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