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FILIAL THERAPY WITH CHILDREN WITH SPECTRUM  
PERVASIVE DEVELOPMENTAL DISORDERS

DISSERTATION

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

For the Degree of

DOCTOR OF PHILOSOPHY

By

Dean R. Beckloff, M.Ed.

Denton, Texas

December, 1997

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This investigation was concerned with determining the effectiveness of filial therapy as a method of intervention for families of children with pervasive developmental disorders. The goals of filial therapy are to enhance the filial (parent/child) relationship, reduce behavioral or emotional symptoms of the child, increase child confidence, and improve the quality of the parents' child-rearing skills. Using a competence-oriented psychoeducational framework, professionally trained therapists teach parents to conduct specialized play sessions with their children, supervise parents during these play sessions, and help them eventually integrate the play sessions and parenting skills at home. Specifically, the purpose of this study was to determine if filial therapy is effective in: 1) increasing the parents' empathic behavior and acceptance with their children, 2) reducing the number of problems experienced by the parents with their children, 3) decreasing sociability difficulties in the child, and, 4) reducing the parents' stress related to parenting.

The experimental group parents, consisting of 12 volunteer parents, received 10 weekly 2-hour filial therapy training sessions and participated in weekly 30-minute play sessions with one of their children. The control group, consisting of 11 volunteer parents, received no treatment during the ten weeks.

All of the parents completed three instruments, the Porter Parental Acceptance Scale, the Parenting Stress Index, and the Child Behavior Checklist.

Analysis of Covariance revealed that the parents in the experimental group significantly increased their attitude for "Recognition of the Child's Need for Autonomy and Independence," and showed a highly suggestive positive trend on the overall attitude of acceptance with their child. Other variables revealed slightly positive trends in the areas of aggressive problems, externalizing problems, and one subtest in the internalizing area, depressive/anxiety symptoms, although none of these were at statistically significant ranges. A possible reason for the lack of significance in the overall reduction of problems may be due to the short length of the study period.

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## TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION .....	1
Statement of the Problem	
Literature Review	
Pervasive Developmental Disorder	
PDD Spectrum	
Asperger's Disorder	
Hyperlexia	
Play in Children With PDDs	
Treatment Of Children With PDDs	
Rationale For Utilizing Filial Therapy With PDD Children	
Filial Therapy	
Summary	
II. PROCEDURES .....	37
Hypotheses	
Definition of Terms	
Instrumentation	
Participants	
Collection of Data	
Procedures	
Facilitator	
Analysis of Data	
III. RESULTS AND DISCUSSION.....	63
Results	

Discussion  
Parental Acceptance  
Problematic Behaviors of Children with PDD  
Parental Stress  
Implications  
Recommendations

APPENDIX A .....	98
APPENDIX B .....	101
APPENDIX C .....	119
APPENDIX D .....	121
APPENDIX E .....	127
APPENDIX F .....	136
REFERENCES .....	140

## CHAPTER I

### INTRODUCTION

Pervasive developmental disorders (PDDs) are a spectrum of disorders characterized by several key features and symptoms, although there is no universal consensus regarding which symptoms are essential for a diagnosis (McCallon, 1988). PDDs encompass all disorders in which there is qualitative impairment in the development of (1) reciprocal social interaction, (2) communication (verbal and nonverbal) and (3) imaginative activity or play (Bishop, 1989). The child may tend to avoid physical contact, and toddlers seem to form stronger attachments to objects than to people. Slight rearrangement of the objects in the physical surroundings may produce an extreme reaction. Children with PDDs respond to aural sensations in unpredictable ways, ranging from seeming indifference to intense emotion. Hyperactivity may be common in the young child, and temper tantrums may occur if the child feels confused or prevented from the pursuit of some activity.

PDDs can occur in less severe and prototypical forms, and indeed, represent a spectrum of autistic disorders with ranges of impairment displayed in the major symptom domains. The manifestations are most severe and therefore, easiest to recognize when the IQ is below 60. Recognition of this disorder, for children with IQ's above 60, is much more difficult where the symptoms are typically milder. However, even the mildest cases are usually

associated with a severe social disability. Failure to recognize a PDD as the cause of these problems places a severe burden on the child and the parents, and deprives the child of appropriate treatment (Menshew & Payton, 1988).

For the parent of a child with a PDD, the situation is at once disturbing, distressing, and at times destabilizing, both internally for the parent, and for the family situation as well. For most parents, the crowning effect is guilt for not having the resources necessary to cope with the situation and solve it. Negative feelings about parenting capability and self-blame for the disorder clearly compound the perplexity of the problem for these parents (Moes, 1995; Schopler, 1995; Powers, 1989).

PDDs are usually accompanied by severe and pervasive impairments in several areas of development, usually evident in the first years of life, and are often associated with mental retardation. Development is not merely delayed, but distinctly deviant. PDDs are defined by three particular areas: (a) qualitative impairments in reciprocal social skills; (b) impairments in communication and imaginative activity; and (c) stereotyped behavior with restricted repertoire of activities and interests (American Psychiatric Association, Diagnostic and statistical manual of mental disorders, fourth edition, 1994). Despite encountering difficulties in classification and diagnosis, many clinicians concur that the prominent characteristics along this autistic spectrum include impairment of social and communicative behaviors, with autism being the earliest and most severe form along such a spectrum. For this reason, the term autism is commonly used when referring to the spectrum of disorders, and this



spectrum is sometimes noted as the autistic spectrum (Pope, 1993).

The DSM-IV (1994) fourth edition lists several PDDs: autistic disorder, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder-not otherwise specified (PDD-NOS). Autistic disorder is the best-known of the disorders, and has an estimated incidence of 3-5 per 10,000 persons. Males predominate by a ratio of 3:1 to 4:1, and all socioeconomic classes are effected. Persons with autistic disorder are characterized by impaired social interaction, communication impairment, and restricted range of interests. Other symptoms such as an uneven cognitive profile and isolated cognitive strengths are often evident.

Rett's disorder is a progressive neurological disorder of females that develops after a period of normal functioning after birth. Rett's disorder is much less common than autistic disorder, and the characteristic feature is a loss of social, language, neurological, and motor capacities beginning at 5-48 months. This loss is persistent and progressive, and the disorder is typically associated with severe or profound mental retardation (DSM-IV, 4th Ed., 1994).

Childhood disintegrative disorder is characterized by marked regression in multiple areas of functioning following at least two years of apparently normal development. The social and communicative deficits and behavioral features of autistic disorder are typically observed (DSM-IV, 4th Ed., 1994).

Asperger's disorder is characterized by severe and sustained impairment in social interaction, with restricted, repetitive patterns of behavior, interests, and activities, and may have a later onset than autistic disorder. There are no

clinically significant delays in language development, cognitive development, and self-help skills (DSM-IV, 4th Ed., 1994).

PDD-NOS is a diagnosis reserved for atypical or sub-threshold presentations of PDDs. There may be mild mental retardation at times, but these persons may also have a mental capacity in the normal ranges. The course in adulthood is usually stable and the outcome is fair to good (DSM-IV, 4th Ed., 1994).

A variety of treatments have been utilized in mitigating the autistic symptoms of these children. Many of these treatments have been behavioral methodologies, and have focused on learning and changing behavior through manipulation of rewards and punishments. As more understanding of the etiology of the disorders have come to the forefront, different forms of intervention have been utilized, including the use of play interventions. Some researchers have suggested that interventions which use (a) toys, (b) free choice in selection of play materials, (c) use of communication with an adult in a therapeutic setting, and (d) the use of relationship dynamics show great promise in accomplishing many goals of treatment for children with PDDs. These types of interventions have had a significant effect in helping the child with a PDD to acquire less rigid play behaviors, greater imaginative play behavior, increased communication, and more appropriate social skills (Campbell, Schopler, Cueva, & Hallin, 1996; Lord, Bristol, & Schopler, 1993; Rogers & Lewis, 1989; Kupperman & Bligh, 1995).

Some more recent interventions have focused on training the parent to

interact with the child in prescribed ways within the context of play to enhance the growth of the child. Several researchers have suggested research is needed to determine the efficacy of using parents in play treatment interventions (Greenspan, 1992; Wieder, 1992; Shanok, 1992; Kalmanson, 1992; Stahmer, 1995; Thorp, Stahmer, & Schreibman, 1995; Wolfberg & Schuler, 1993; Goldstein, Kaczmarek, Pennington, & Shafer, 1992; Rogers & Lewis, 1989; Pope, 1993). Filial therapy, which trains parents to use basic child-centered play therapy skills in special play sessions with their own children, has been shown to be effective with a variety of populations. Positive outcomes have been found in self esteem enhancement of parents and children, stronger relationships between parent and child, increased parental acceptance of their children, reduction of parental stress, and improved communication between parents and children (Porter, 1954; Guerney, 1964; Bratton, 1993; Glass, 1986; Lebovitz, 1982; Lobaugh, 1991; Sensue, 1981; Sywulak, 1977).

The goals of filial therapy are to enhance the filial (parent/child) relationship, reduce behavioral or emotional symptoms of the child, increase child competence and confidence, and improve the quality of the parents' child-rearing skills (Guerney, 1983). Using a competence-oriented psychoeducational framework, professionally trained therapists teach parents to conduct specialized play sessions with their children, supervise parents during these play sessions, and help them eventually integrate the play sessions and parenting skills at home (Van Fleet, 1994).

Guerney (1983) contends that most of the important components of

successful parenting can be acquired while learning play therapy skills. While the parent is providing treatment for the child, the parent is also enhancing the parent-child relationship. The play session serves as a learning laboratory, "bringing into focus, in the context of the child's play and in the parent's responses to the child, the salient issues in the respective dynamics of the parent and child and in their relationship" (Guernsey, 1983, p. 28).

#### Statement of the Problem

This investigation was concerned with determining the effectiveness of filial therapy as a method of intervention for families of children with pervasive developmental disorders. Specifically, this study was designed to: (a) determine the effectiveness of filial therapy in increasing the parents' empathic understanding and acceptance of their children; (b) determine the effectiveness of filial therapy in reducing the number of problems experienced by the parent with their child; (c) determine the effectiveness of filial therapy in decreasing sociability difficulties in the child, specifically withdrawal symptoms, social problems, and aggressive behaviors; (d) determine the effectiveness of filial therapy in reducing the parents' stress related to parenting; and (e) determine the effectiveness of filial therapy in reducing child stressors as measured by the parent, specifically the child's demandingness, moodiness, and adaptability problems.

#### Literature Review

##### Pervasive Developmental Disorder

Kanner first reported the syndrome of disorders referred to as pervasive

developmental disorders in 1943 (Menshew & Payton, 1988; Gillberg, 1992; Kanner, 1972), stating that the condition was markedly and uniquely different from anything reported so far. He noted the following characteristics:

- Inability to relate to people, including members of the child's own family, from the beginning of life.
- Failure to develop speech or abnormal, largely non-communicative use of language in those who did speak. Pronoun reversal was observed in all children who could speak, and echolalia, obsessive questioning and ritualistic use of language was also present.
- Abnormal responses to environmental objects and events, such as food, loud noises and moving objects.
- Good cognitive potential with excellent rote memory and normal performance on the non-verbal board test.
- Normal physical status with good fine muscle coordination (Kanner, 1972; Bishop, 1989).

The condition became known as autism, and was considered to be early forms of childhood schizophrenia. Children with autism were thought to be the offspring of highly organized, professional parents who exhibited cold, rationalistic methods of parenting. The popularity of psychogenic theories began to fade in the late 1960's with the findings of studies documenting that parents of autistic children did not differ in personality from parents with normal children. Autism was accorded separate status from childhood schizophrenia in

1980 in the Diagnostic and Statistical Manual of Mental Disorders (DSM). At that time, the first of many neurobiologic studies appeared supporting a neurologic origin for autism. Presently, research seems to support a disorder of forebrain development at the microscopic level, rather than “refrigerator parents” (Menshew & Payton, 1988; Gillberg, 1992).

It is estimated that approximately 40 percent of children with a PDD have IQ's below 50, and 70 percent have IQ's below 70 (McMillon, 1988). While most children with a PDD are retarded to some degree, a small subgroup is not. Apparently this was the group initially identified by Kanner. The presence of unusual peak skills appear to exist in an identifiable subgroup of higher functioning autistic children. Although higher functioning autistic children have greater mental capabilities, they have marked impairment in the development of social relationships and imaginative play and show some type of stereotyped, ritualistic, or compulsive behavior (McMillon, 1988). There are approximately 4-5 children with PDD in every 10,000 children, and most of these children are mentally retarded (Yirmiya & Sigman, 1991). Only 5% to 30% of these children function at normal intelligence levels.

Menshew and Payton (1988) identified three core symptoms in PDDs: (1) a social deficit of the autistic type; (2) delayed and disordered development of propositional language (vocabulary and word order in sentences, according to the rules of grammar), disturbances in prosodic language and in the use of eye contact, facial expression, and gesture for communication; and (3) a restricted range of activities and interests. Basic elements of the social deficit seem to be

a reduced inclination to interact with other people, an impairment in awareness of the feelings and thoughts of other people, an inability to modulate one's interactions in response to the social context, and a tendency to emphasize trivial details.

Language development is typically delayed in children with a PDD (Menshew & Payton, 1988), or may begin on schedule and then undergo a regression. When speech has been developed, there are abnormalities in social speech, first manifested by the lack of an inclination to speak. Once talking, the child 'talks over' everyone, saying whatever comes to mind. The child may interrupt constantly, pay little if any attention to what other people are talking about, and may appear to talk at people rather than to them. Abnormalities in prosody (referring to the meaning given to speech by its melody) are typically in evidence. The child may have unusual intonations early on, have a monotone voice, and have difficulty modulating voice loudness. Typically, the autistic child who cannot speak does not point, gesture, or pantomime to indicate his or her needs. Facial expression and gestures are typically absent or extremely limited in many autistic individuals.

The child with a PDD also exhibits a markedly restricted range of interests, with a tendency to focus on a single interest and to amass a detailed fund of knowledge related to that interest. There is often resistance to change, and insistence on adhering to routines and rituals. The child has an interest in the parts of objects, often in the smell, taste, and texture of objects. Abnormal toy play, which is also included in this category, probably reflects the child's lack

of appreciation of the symbolic meaning of toys, which is a prerequisite for their appropriate use (Menshew & Payton, 1988).

Goodman (1989) argued that autism involves multiple functional deficits due to multiple coexistent neurological deficits. There appears to be two distinct constellations of functional impairments: deficits in mechanical language skills, and deficits in social relatedness, play, and nonverbal communication. Asperger's disorder is an example of the latter.

There is some evidence that autism and autistic-like conditions are on the rise, according to Gillberg, Steffenburg, and Schaumann (1991). They found that prevalence rates in 1988 increased twofold from previous years in western Sweden. Reasons for this rise are speculative, from better detection of the syndromes, to the understanding of autism as a spectrum of disorders (Gillberg, 1992).

### PDD Spectrum

PDDs represent a spectrum of autistic disorders, with ranges of impairment displayed in the autistic symptom domains. The manifestations of autistic symptoms are most severe and therefore, easiest to recognize when the IQ is below 60. Recognition of this spectrum of disorders, for those individuals with IQ's above 60, is much more difficult where the symptoms are typically milder. However, even the mildest cases of PDDs are usually associated with a severe social disability (Menshew & Payton, 1988).

Gillberg (1992) has argued that evidence supports the belief that autism is not a discrete disease entity with one etiology, but rather is one of several



syndromes on a spectrum of autism and autistic-like conditions. The basis of this spectrum is a triad of social, communication and imagination impairments. If Asperger's disorder is included in this spectrum, as well as other conditions that contain autistic features (such as obsessive compulsive personality disorder, Tourette syndrome and anorexia nervosa), then population prevalence would be considerably higher than presently believed. According to Gillberg (1992), Asperger's disorder is most often conceptualized as a variant of high-functioning autism. High-functioning autism has generally been defined in terms of a Full Scale IQ of 70 or more. This group constitutes 25% to 30% of the autistic spectrum (Menshew, Goldstein, & Siegel, 1995).

Szatmari (1992) reviewed the literature regarding the spectrum of PDD and included previous terms such as atypical autism, autistic-like, Asperger syndrome, autistic tendencies, and so forth. Szatmari's study distinguished three subgroups of autistic spectrum disorders from autism: a low-functioning atypical group; a high-functioning atypical group, and Asperger syndrome. Mayes, Volkmar, Hooks, & Cicchetti (1993), found differences between autism and pervasive developmental disorder-not otherwise specified (PDD-NOS). They described the PDD-NOS diagnosis as a subthreshold syndrome for autistic related features, but note that it is essentially 'not' autism. They were able to clinically differentiate between autism, PDD-NOS, and other language disorders. The syndrome of autism was more clearly related to PDD-NOS than to language disorders, in areas such as difficulties with social relatedness and more need for routines and order. Ehlers and Gillberg (1993) reported that

prevalence figures of autism spectrum problems may be a more common condition in the normal school population than previous studies have suggested.

PDDs associated with severe mental retardation carry a negative prognosis in respect to psychosocial adaptation (Gillberg, 1992). PDDs associated with mild mental retardation or near average intelligence levels have a much more variable prognosis. In the very high functioning group of individuals with PDDs, the overall prognosis is much better. Oddities of social style, communication and interests are likely to remain, but the majority of individuals from this group hold down jobs and a large proportion marry and have children. There is evidence that symptom aggravation may occur in adolescence with some individuals diagnosed with a PDD, with clear evidence of deterioration during this developmental period. The prognosis is poor when this deterioration occurs, with growth and development severely retarded. These individuals may never be able to regain even preadolescent levels of proficiency in language, communication and social functioning (Gillberg, 1992; Frea, 1995).

Menshew, Goldstein, Taylor, and Siegel (1994) studied academic achievement performance and found that individuals with higher functioning autism performed significantly less well than controls on comprehension tasks. A comparison deficit did not exist on mechanical reading, spelling, and computational tasks. In a study of speech and language differences, Menshew, Goldstein, and Siegel (1995) found that the division between intact and

deficient language abilities conforms to a dissociation between basic mechanical or procedural skills and comprehension or interpretive abilities. Higher functioning PDD children tend to score higher on Performance IQ tests than on Verbal IQ tests, and generally show a 'scatter' of strengths and weaknesses on their IQ profiles. They tend to perform best on nonsocial subscales and least well on subtests that require social understanding. Along the spectrum of PDD, there is an impaired ability to form representations and to engage in symbolic activities. Deficits are in such areas as symbolic play, recognition of emotions, and metarepresentational ability (Yirmiya & Sigman, 1991).

#### Asperger's Disorder

Asperger's disorder is a relatively new diagnostic category, having only been in use for approximately the past fifteen years. Although a group of children with this clinical picture were originally described in the 1940's by the Viennese pediatrician, Hans Asperger (Klin, 1994), the term has become more widely applied only during the past several years. Asperger's disorder represents that portion of the PDD continuum which is characterized by higher cognitive abilities (at least normal IQ by definition, and sometimes ranging up into the very superior range) and by more normal language function compared to other disorders along the spectrum (Bauer, 1995).

There has been some controversy over the usage and inclusion of Asperger's disorder in the spectrum of PDDs (Gillberg, 1992, Rickaby, Carruthers, & Mitchell, 1991, Ghaziuddin, Leininger, & Tsai, 1995). However,

the DSM-IV (DSM-IV, 4th Ed., 1994) has included Asperger's within the spectrum of PDDs, and it is primarily differentiated by two criteria: there is no clinically significant general delay in language, and there is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior, and curiosity about the environment in childhood. Some of the similarities between Asperger's disorder and other forms of PDDs include (a) social isolation, egocentricity and lack of empathy, (b) problems with the way language is used, including long-winded pedantic speech, (c) impaired nonverbal aspects of communication, (d) lack of flexible imaginative play, and (e) behavior problems such as negativism and aggressiveness to people (Wing, 1991, Klin, 1994; Davies, Bishop, Manstead, & Tantam, 1994; Szatmari, 1991).

Unlike other forms of the PDD spectrum, expressive language at the formal level is usually better developed in Asperger's disorder (Gillberg, 1992; Jones & Kerwin, 1990). Asperger's disorder seems to show considerable overlap with semantic-pragmatic disorder. Semantic and pragmatic problems are quite common in these children with deficits in attention, motor control and perception. These children often show marked autistic-type symptoms, such as social impairments, and restricted-stereotyped-repetitive-obsessive behavior patterns of a milder variant. Semantic-pragmatic language disorder in PDDs suggests a dissociation between intact lexical, phonological, and syntactic aspects of language, and comprehension, judgment, and effectiveness in the use of language to communicate (Menshew, Goldstein, & Siegel, 1995).

Children with Asperger's disorder may exhibit delayed motor milestones and present with motoric clumsiness. They may have a history of delayed acquisition of motor skills, and are often visibly awkward, exhibiting rigid gait patterns, poor manipulative skills and significant deficits in visual-motor coordination (Klin, 1994; Szatmari, Bartolucci, & Bremner, 1989). Children with Asperger's disorder, unlike other forms of PDD, present with an awareness of others. However, their approach to others tends to be inappropriate and sometimes malicious. They are socially inept but often socially interested, articulate yet strangely ineloquent, and generally tend to be specialists in unusual fields (Frith, 1991; Ryan, 1992).

### Hyperlexia

Hyperlexia is a sub-genre of the PDD spectrum, which refers to children who present with highly developed word recognition skills but exhibit little or no comprehension of the words recognized. These children exhibit many of the features of children in the high functioning range of the PDD spectrum. They appear to be displaying a type of savant skill in word recognition and decoding ability, and many of them exhibit the skills from very early years. Many of the behavioral and emotional problems exhibited are typical of children with autistic spectrum disorders. There is some controversy about whether to describe these children as having a unique diagnosis, or to include them in the PDD spectrum, and currently, they are often included (Patti & Lupinetti, 1993; Kupperman, Bligh, & Barouski, 1995; Kupperman & Bligh, 1995; Sharp, 1992).

### Play in Children With PDDs

Children with PDDs, wherever they may present on the spectrum including Asperger's syndrome, appear to demonstrate impairment in the area of social/play (Goodman, 1989; Wolfberg & Schuler, 1993; Rogers & Lewis, 1989; Stahmer, 1995). These children may have innate deficits in the expression and comprehension of nonverbal communication mediated by gesture, facial expression, and voice tone. This results in an inability to form normal empathic links, both with others and in self.

This social/play impairment appears to affect all individuals with PDDs regardless of the intellectual capacity or language development. Even where these are normal, the social interactions are generally so gauche that individuals with PDDs end up alienating others (Goodman, 1989; Wolfberg & Schuler, 1993; Thorp, Stahmer, & Schreibman, 1995). They cannot participate in the normal give-and-take of ordinary social interactions, and have particular difficulty deciphering social and emotional cues in other people's behavior. The odd and awkward manner in which children with PDD play is frequently misinterpreted by other children, resulting in their social exclusion (Wolfberg & Schuler, 1993; Thorp, Stahmer, & Schreibman, 1995). Play may be obsessional, mechanical, and repetitive, with a marked absence of both cooperative play and of innovative pretend play. Unusual preoccupations are characteristically pursued single-mindedly to the detriment of other activities. Children with PDDs tend to engage in higher rates of manipulative forms of play (Wolfberg & Schuler, 1993).

Jarrold, Boucher, and Smith (1993) reviewed the literature concerning play in children with PDDs and found evidence for an impairment in spontaneous symbolic play. However, researchers who have studied elicited and instructed play have reported that PDD children may have a capacity for symbolic play that they do not spontaneously exhibit. Ungerer and Sigman (as cited in Jarrold, Boucher, & Smith, 1993) found that a structured play situation produced more sophisticated and diverse symbolic play than was produced spontaneously. They proposed that previous studies may have failed to tap the full potential of the PDD child's capacities for play. Jarrold, Boucher, and Smith (1993) suggested that the more developmentally delayed child with autism may have less capacity for symbolic play, and those more developmentally advanced with normal or high scores on intelligence tests may be able to form quite complex symbolic concepts. Sigman and Ungerer (as cited in Jarrold, Boucher, & Smith, 1993) reported that the more verbally adept individuals with PDDs benefitted from simply structuring the play situation, which allowed for symbolic representational play to occur.

#### Treatment Of Children With PDDs

Treatment of children with PDDs generally tends to focus on acquisition of basic skills in social interaction as well as in other areas of adaptive functioning. Supportive psychotherapy focused on problems of empathy, social difficulties, and depressive symptoms is helpful (Klin, 1994). Communication skills training and early speech and language intervention seems to be important for children in the PDD spectrum. Increased awareness that learning

to communicate will have positive effects in other areas has resulted in more emphasis being placed on methods to increase spontaneous language (Szatmari, 1991; Campbell, Schopler, Cueva, & Hallin, 1996). Medication may be useful for treating a number of accessory symptoms, such as short attention span, depression, anxiety, and obsessive-compulsive symptoms (Szatmari, 1991). There are a number of behavioral interventions used in the treatment of PDD individuals, including intensive behavior therapy. These generally incorporate the use of environmental manipulation to strengthen adaptive behaviors or eliminate maladaptive ones (Campbell, Schopler, Cueva, & Hallin, 1996).

Recent studies utilizing play as a treatment modality for the symptoms of PDDs are of special interest because they relate to the treatment proposed by this study. Greenspan (1992) utilized play interventions to help PDD children make developmental progress and reported remarkable growth in their ability to relate to others with warmth, pleasure, and empathy. He recommended a program that included interactive play therapy involving the child and parents, speech therapy, occupational therapy, and parent counseling. Greenspan advocated using play as a way to pull the child into spontaneous joyful relationship patterns that remediate the child's difficulty. A key is to make any of the child's behaviors a form of communication. Interaction between caregiver and child is promoted in order to establish a pleasurable sense of attention and engagement. All emotions are welcomed, and strong feelings of anger and frustration are responded to as forms of communication. In Greenspan's



approach, the relationship becomes the focal point of the intervention. Through the play therapy sessions, the child's isolating behavior is responded to, imitated, and given new communicative meanings if possible. Following the child's lead and supporting the child's spontaneity, internal motivation, and affective expression in free and unstructured play are the vehicles for accomplishing the task of communication. As these communications are accomplished, the child's perseverative behavior decreases and attention improves. These treatment interventions have as their basis (a) following the child's lead, (b) use of play as a means of interaction, and (c) exploring the meaning of the child's behavior (Greenspan, 1992; Kalmanson, 1992; Wieder, 1992; Shanok, 1992).

Stahmer (1995) investigated the effectiveness of a behavioral approach to teaching symbolic play to children with PDD. After specific symbolic play training, all of the children learned to perform complex and creative symbolic play actions. In most cases, the children generalized their play to new toys and other partners. Their interactional skills also improved with the training. Thorp, Stahmer, and Schreibman (1995) reported similar results utilizing sociodramatic play training with PDD children. They found that social skills improved as a result of the play interventions, and were maintained over time. There was also an increase in spontaneous speech which the authors hypothesized was due to the experimenter's verbalizations about the intentions and actions of the child during the play period.

Wolfberg and Schuler (1993) studied the effects of play by integrated

groups of children paired with PDD children. They found (a) decreases in isolate play and collateral gains in social forms of play, (b) decreases in stereotyped object play and gains in functional object play, (c) generalizations to other contexts, and (d) accompanying language gains.

Goldstein, Kaczmarek, Pennington, & Shafer (1992) investigated the effects of peer-mediated intervention, which entailed attending to, commenting on, and acknowledging the behavior of preschoolers with PDDs. They found that improved rates of social interaction during play were clearly associated with the peer intervention.

Rogers and Lewis (1989) studied the effectiveness of a day treatment model for children with PDDs. Strategies included (a) the use of positively charged affective experiences to aid the development of close interpersonal relationships, (b) use of play in all its interpersonal, cognitive, and structural variety, and (c) a pragmatics-based language therapy model. The children demonstrated significant treatment effects in a number of areas. Play skills increased significantly in symbolic complexity, and there was significant reduction of autistic symptomology. The authors hypothesized that these changes were attributable to the establishment of a relationship between adult and child through (1) careful attention to the child's verbal and nonverbal communications, (2) reactive and reciprocal interactions with the children, (3) emphasis on the child's positive affective experiences, and (4) use of play as a major interpersonal and learning medium.

Pope (1993) reported that play therapy can be usefully employed in the

treatment of higher functioning PDD children, and suggested that identifications with the therapist may be a way to help these children learn appropriate expression and interpretation of affect. The treatment employed by Pope involved facilitating social interaction for the child with PDD by imitating behavior. Imitating the child places the child in the position of initiating a social interaction and piques the child's interest in shared communication and mutuality.

#### Rationale for Utilizing Filial Therapy With PDD Children

Research findings have demonstrated the effectiveness of utilizing play in treating children with a PDD. Interventions which use (a) toys, (b) free choice in selection of play materials, (c) use of communication with an adult in a therapeutic setting, and (d) the use of relationship dynamics show great promise in accomplishing many goals of treatment for children with a PDD. These types of interventions have had a significant effect in helping children with a PDD to acquire less rigid play behaviors, greater imaginative play behavior, increased communication, and more appropriate social skills (Campbell, Schopler, Cueva, & Hallin, 1996; Lord, Bristol, & Schopler, 1993; Rogers & Lewis, 1989; Kupperman & Bligh, 1995).

Some of the research interventions which have used play with PDD children have included parents in those treatments. Parents have been trained to interact with their child within the context of play in prescribed ways to enhance the growth of the child. Researchers have been encouraged with the results of this area of intervention, and have suggested that this is an area

where further research is needed to determine the efficacy of using parents in play treatment interventions (Greenspan,1992; Wieder, 1992; Shanok, 1992; Kalmanson, 1992; Stahmer,1995; Thorp, Stahmer, & Schreibman, 1995;Wolfberg & Schuler, 1993; Goldstein, Kaczmarek, Pennington, & Shafer, 1992; Rogers & Lewis, 1989; Pope, 1993).

Filial therapy appears to meet many of the recommendations made by researchers for treating children with PDD. The particular skills taught in the filial approach which are aligned closely with what researchers advocate include:

- training in responding verbally to the child's play, sometimes called 'tracking.' The parent is taught to respond to the play behavior, and all behavior of the child as a form of communication. In play therapy, play is regarded as a form of communication by the child.
- training in responding to the affective dimensions of the child's play behavior, the child's language, and the child's non-verbal behaviors. Parents are trained in how to respond to the various avenues of affective communication.
- training in giving the child the lead and allowing the child to play in an atmosphere of free choice, which facilitates expression of internal experiences through play.
- training in how to set limits in an atmosphere that encourages the child and helps the child to see that the parent is

- understanding the internal expressions of the child.
- training in how to keep the sessions firmly positive and encouraging to the child, with a strong component of self esteem building.
- training in fostering an atmosphere of unconditional acceptance created by the parent. Relationship dynamics are taught in the parent sessions, and the parent is given supervised training in fostering the relational aspects between parent and child in special play sessions (Landreth, 1991).

### Filial Therapy

Guerney was one of the first to advocate utilization of the parent within the therapeutic process of play therapy, and coined the term 'filial therapy' (Guerney, 1964). It was a radical departure at the time from traditional child psychotherapy, in that it employed parents of the child patients as therapists for their own children (Guerney, 1976). Guerney's efforts were based on several clinical issues:

- a. the exclusion of parents from the therapy process tended to develop defensiveness and resistance on the part of parents to therapeutic measures taken for the child;
- b. parents are in a position to have a unique impact on their own children, which should be utilized in the treatment of those children;
- c. the role of parents ought to be as an active ally and worker, rather than

passive observer or co-client;

d. the limited number of professional therapists for children could be better utilized if they acted as supervisors and consultants to primary therapists, such as parents or others within the environment of the child (Guerney, 1964).

While the approach proposed by Guerney was new, there were precursors to using parents in the therapeutic process. One of the earliest prototypes of this method was discussed by Freud (1909) in his "Analysis of a Phobia of a Five-Year-Old Boy" - or "Little Hans." Here Freud gave play treatment recommendations to the boy's father, who in turn carried out the treatment at home. Freud asserted that "the special knowledge by means of which he (the father) was able to interpret the remarks made by his . . . son was indispensable" (p. 149).

Guerney (1964) cites the work of Dorothy Baruch (1949) as being an important influence to the development of filial therapy. Baruch suggested that play sessions at home offered a way of fostering good parent-child relationships, modeled after the Rogerian tradition. These play sessions differed from filial therapy in that they were for relatively normal children, as opposed to children who were emotionally disturbed in the clinical sense (Guerney, 1964).

Natalie Rogers Fuchs (1957), the daughter of Carl Rogers, wrote in a series of letters to her father about her young daughter's emotional distress. With encouragement by her father, Fuchs conducted home play therapy sessions with her daughter modeled after Virginia Axline's approach and was

able to achieve remarkable results in dealing with a toilet-training problem.

Moustakas (1959) suggested that 'play therapy' sessions could be conducted in the home by parents of relatively normal children, and he described the very positive experiences of some mothers and children in such 'relationship therapy.' According to Moustakas, relationally oriented play with children can be emotionally therapeutic for the child, given an open, caring environment in which to play out emotional struggles.

These early experiences of parents conducting special play sessions at home differed from filial therapy in that parents did not receive regularly scheduled training and supervision from a specially trained professional and did not have the opportunity to discuss their experiences in a support group format (Landreth, 1991). Guerney's filial therapy approach incorporated these dynamic and didactic elements that set it apart, and brought to the forefront an elegant form of therapeutic intervention that was child-centered and yet family focused.

Filial therapy offers a therapeutic modality in a uniquely twofold way: (a) the model employs play therapy as the intervention with the child, and (b) the therapeutic delivery is administered by the parent rather than a professional therapist. In filial therapy, the parents are taught specific child-centered play therapy skills by a professional therapist, and the parent in turn utilizes the training in implementing therapeutic play sessions at home (Guerney, 1976; Guerney, 1983; Landreth, 1991). In filial therapy the major therapeutic strategy is to teach parents to conduct special play sessions modeled after play therapy

as practiced by Axline (1947) and other Rogerian child therapists, such as Moustakas (1959). The training is usually given in weekly group meetings. Combining a support group format with didactic instruction provides a dynamic process that sets filial therapy training apart from other parent training programs, the majority of which are exclusively educational in nature.

Once parents have completed the initial training period, they conduct regularly scheduled special play sessions in their homes with their children while receiving supervision from a therapist and support in the filial group meetings. Parents learn to convey acceptance, empathy, and encouragement to their children as well as to master the skills of effective limit setting. According to Landreth (1991): "This new creative dynamic of empathic responding by parents becomes the creative process through which change occurs within the parent and child and between parent and child" (p. 339).

Unlike more behaviorally oriented therapies, this child-centered play therapy is not directed toward a specific problem, but is generic in nature. That is, it is aimed at improving self-esteem and the feelings underlying inappropriate behaviors. Feelings such as frustration, anger, performance anxiety, separation anxiety, or concerns about personal safety which manifest in maladaptive behaviors or emotions can be addressed through encouraging the child to play them out in the safe, interpersonal atmosphere of a play session in the presence of a warm, caring adult (L. Guerney, 1983).

Filial therapy is a relationship-based approach. The parent-child relationship is the catalyst for reorganization and growth in both parent and



child. Filial therapy is a process-oriented approach, promoting change through the process of parent and child interacting with each other in an accepting fashion for a limited period of time. Filial therapy is a developmental approach, utilizing methods appropriate for the particular developmental stages of the child, parent, and family. In particular, filial therapy acknowledges that play is the primary way in which children express themselves, grow and develop, are socialized, and improve their interpersonal skills (Ginsberg, 1989).

The Guerney's filial therapy model, and a ten-week model developed by Landreth (1991) have proven effective with a number of different populations. Research by Andronico, Fidler, Guerney, and Guerney (1967) supported the efficacy of filial therapy in reducing emotional and behavioral symptoms, increasing harmony between parents and children, and improving academic performance. They also reported on the advantages of utilizing the didactic and dynamic elements of the method, citing that it appeared to enable the parents to enter into more emotionally and dynamically significant areas. The blending of the didactic and dynamic elements seemed to enhance and provide an opportunity for parents to discuss their feelings in the group sessions.

Guerney and Stover (1971) studied the effects of filial therapy on a group of 51 mothers and confirmed the positive outcomes of filial therapy. All children demonstrated at least some improvement, and 78% of the mothers reported that their children were either much improved or very much improved. Significant improvement on psychosocial adjustment and on symptomatology of the children was indicated on a variety of measures completed by parents and by

clinicians. This study also demonstrated that the filial training made a significant positive difference in the way mothers behave in relation to their children in an observed behavioral interaction.

To control for potential differences between troubled families who seek professional help and those that do not, Sywulak (1977) designed a filial therapy study in which the treatment group served as their own control group. Thirteen mother-father pairs and six single mothers were represented, with nineteen children included in the study. The results showed a significant improvement by the experimental group in child adjustment as well as in parental acceptance. Marked improvement in parental acceptance was also noted at the end of two months of training in addition to improvement in some aspects of child adjustment. The changes were discovered to continue throughout the four months of treatment. Other findings demonstrated that withdrawn children evidenced faster changes than aggressive children, and that the parents exhibited the capacity and the willingness to employ filial skills.

In a three-year follow-up of the Sywulak study, Sensue (1981) found even higher scores at the end of six months, and no significant losses 2 to 3 years later. At the time of follow-up, children who had formerly been diagnosed as maladjusted were determined to be as well adjusted as a control group of children who had never been diagnosed. Both parents and children maintained that the filial training had resulted in positive change in the family.

Wall (1979) conducted a study that examined 3 variations of play therapy conducted by (a) graduate therapist trainees, (b) non-trained parents, and (c)

parents directed and observed by therapist trainees. Parents who were guided by the trainees significantly improved their skills in empathic communication with their children. The findings indicated that the children's ability to express negative feelings and their perception that their parents were more accepting of these negative feelings led to increased adjustment. Wall reported that acceptance of negative feelings by a parent might have a more powerful effect on the children than acceptance of the feelings by a therapist.

Payton (1980) compared the effects of parents trained in filial therapy and paraprofessionals trained in play therapy interventions with a control group. He found that parents trained in filial therapy were significantly more effective with their children than paraprofessionals. The parents showed significant improvement in child-rearing attitudes, and results indicated significant improvement in the personality adjustment of the children.

Lebovitz (1982) compared the effectiveness of a filial therapy group, a group conducting supervised play sessions, and a group receiving no treatment. Within the filial group Lebovitz reported (a) significant decreases in children's aggression, withdrawal, and dependence, (b) significant increases by mothers in communicating acceptance of children's feelings, (c) more involvement with children than was evidenced in the supervised play sessions, and (d) more allowing of self-direction than mothers in the no treatment group. Children in both treatment groups experienced a decrease in problem behaviors and parents in both groups reported they became more accepting of their children. Similar results were not found in the group that did not receive

treatment.

Glass (1986) compared a group of parents who received the Landreth (1991) 10-week filial therapy training with a control group who received no filial therapy training and found significant results in favor of the filial group. The parents in the filial therapy group reported an increase of unconditional love for their child, a decreased level of conflict between parent and child, and an increase of their understanding of the meaning of their child's play. Further results, although not statistically significant, revealed greater parental acceptance of the child and increased self esteem for the parent and the child.

Packer (1990) conducted a case study using filial therapy with a single family. The parents and teachers reported marked improvement in the child's gaining control over negative feelings, the child showed improved self-confidence, and the child became more independent. The parents reported feeling more relaxed and competent as parents and empowered in their role as parents.

Glazer-Waldman (1991), utilizing the Landreth (1991) 10-week filial therapy group model, studied the impact of participation in filial therapy on families with chronically ill children. She found that filial therapy training had a positive impact on parents of these children. Parents demonstrated a better ability to judge their child's level of anxiety. Qualitative reporting of outcomes indicated that the parents felt that their relationship had been improved with their chronically ill child.

Lobaugh (1991) studied the effectiveness of the Landreth (1991) 10-

week filial therapy model with incarcerated fathers at a federal correctional institute. Sixteen incarcerated fathers met once each week for 10 weeks in two-hour parent group sessions and also spent 30 minutes each week with one of their own children in a special play time. A group of 16 incarcerated fathers served as the control group. The fathers who received the training showed significant gains over fathers in the control group. The results revealed (a) significant increases in parental acceptance, (b) significant increases in child self-esteem, (c) significant decreases in parental stress, and (d) significant reduction of problematic behaviors by the child, as perceived by the parent.

Lahti (1992) examined Landreth's (1991) 10-week filial therapy model process using ethnographic methodology to provide an in-depth understanding of the process and effects on the parent, child, and the parent/child relationship. Lahti's findings revealed (a) the play sessions facilitated change by utilizing the parent in a therapeutic role, which appeared to reduce the parent's anxiety level about learning, (b) changes in parents including increases in confidence and feelings of personal power, reduction in degree of parental control, and increased awareness of both adults' and children's needs, (c) closer parent/child and marital relationships characterized by increased communication and less friction, and (d) the children's changes included increased and enhanced communication, increased responsibility for actions, decreased withdrawn and aggressive behavior, and increased feelings of happiness.

Bratton (1993) conducted a study of the effectiveness of filial therapy with

single parents and their children, utilizing the Landreth (1991) 10-week filial therapy group model. She compared the results of the experimental group (20 mothers/2 fathers; 10 girls/12 boys), with a control group (19 mothers/2 fathers; 9 girls/12 boys) and found that filial therapy is an effective intervention for strengthening and enhancing the parent-child relationship in single parent families. Specifically, parents in the experimental group (a) significantly increased their level of empathy towards their children, (b) significantly increased their attitude of acceptance toward their children, (c) significantly reduced their level of stress related to parenting, and (d) reported significantly fewer problems with their children's behavior.

Bavin-Hoffman (1994) conducted a three year follow-up qualitative study of families who had undergone filial therapy utilizing the Landreth (1991) 10-week filial therapy group model. She found that there were three consistent themes reported by the families: (a) improved parent/child communication, (b) improved partner communication, and (c) improved child behavior. Fathers primarily reported increased self-control in the child, while mothers reported primarily decreased aggression in the child.

Harris (1995) studied the effectiveness of filial therapy with incarcerated mothers, utilizing the Landreth (1991) 10-week filial therapy model condensed to twice weekly training sessions for a 5 week period. She found significant improvement in parental empathy and acceptance in the parent-child interaction and relationship. There was also a reduction in the number of reported child problems, and a positive trend in lowered stress related to

parenting.

Chau (1996) investigated the effectiveness of Landreth's (1991) 10-week filial therapy training model with Chinese families who had immigrated to the United States. Compared to a control group, the parents who received filial therapy training evidenced a significant increase in their level of empathic interactions with their children, a significant increase in their attitude of acceptance toward their children, and a significant reduction in their level of stress related to parenting. With such a significant degree of improvement, Chau found it to be a compatible approach to utilize with Chinese families and suggested it could help in fostering their adjustment to the United States.

Glover (1996) studied the effectiveness of Landreth's (1991) 10-week filial therapy training model with Native American parents and their children on the Flathead Reservation in Montana. Compared to a control group, parents who received filial therapy significantly increased their level of empathy in interactions with their children. The children significantly improved their desirable play behavior with their parents. Positive trends were also indicated in greater parental acceptance, lowered parenting stress, and improved children's self-concept.

Yuen (1997) studied the effectiveness of Landreth's (1991) 10-week filial therapy training model with Immigrant Chinese parents in Canada. Compared to a control group, parents who received filial therapy significantly increased their empathic behavior with their children, significantly increased the parents' acceptance level towards their children, significantly reduced the parents' stress

related to parenting, significantly reduced the parents' perceived number of problem behaviors in their children, and significantly enhanced the self-concept of the immigrant Chinese children. Yuan concluded that the study supported the use of filial therapy for promoting parent-child relationships in Chinese families.

Kale (1997) studied the effectiveness of Landreth's (1991) 10-week filial therapy training model with parents of children with learning disabilities.

Compared to a control group, parents who received filial therapy significantly increased their acceptance level towards their children, significantly reduced the parents' stress related to parenting, significantly reduced the parents' perception of problems related to attention, and indicated positive trends in reducing problematic behavior problems overall in the parents' perceptions.

### Summary

Children with a PDD present with limited imaginative play experiences, heightened emotional reactivity, rigid behavior with restricted repertoire of activities and interests, social problems with or without aggressive behavior, and difficulty in engaging relationally with others. Therapeutic interventions that utilize play as a modality show great promise in reducing these symptoms related to PDDs, and increase the likelihood of healthy growth and development. Researchers suggest that play with these children:

- increases creative play experiences with less rigid play behaviors and greater imaginative play behavior;
- seems to reduce their emotional reactivity;
- results in a sense of personal self control and choice, which brings



about lessened anxiety and greater interaction with the child's environments;

- fosters language and meaning of human communication;
- fosters more appropriate social skills;
- reduces obsessional types of play, and allows the child to learn how to interact with the child's environment (Kanner, 1972; Bishop, 1989; Bruckheim, 1994; Menshew & Payton, 1988; Mayes, Volkmar, Hooks, & Cicchetti, 1993; Gillberg, 1992; Frea, 1995; Landreth, 1991; Greenspan, 1992; Wieder, 1992; Shanok, 1992; Pope, 1993).

Filial therapy shows promise in fostering improvements in these areas. Filial therapy as a therapeutic approach with families having a child with a PDD is deserving of research since: (a) play as a treatment modality is indicated in the research literature with children having PDDs; (b) parents have been successfully utilized in various ways as a part of the treatment team with this population; and (c) filial therapy is a treatment for children that utilizes play as the modality and the parent as the therapeutic agent (Landreth, 1991; Greenspan, 1992). The need for involving parents has been addressed by Landreth (1991): "...the skills of professionals ...must be brought out of hiding...and must be given away through training to parents who are in the best position to profoundly impact the lives of future adults" (p. 336). However, there is still a paucity of research on the use of play in ameliorating the negative experiences between parent and the child with a PDD in the current literature.

To date, there is no research that utilized filial therapy as a treatment method with this population of families. A reasonable assumption is that there is a need for research into this area using filial therapy as the treatment modality, in order to determine the outcomes of such an approach with families having children with PDDs.

## CHAPTER II

### PROCEDURES

The purpose of this study was to determine if filial therapy is effective in: 1) increasing the parents' empathic behavior and acceptance with their children; 2) reducing the number of problems experienced by the parents with their children; 3) decreasing sociability difficulties in the child; 4) reducing the parents' stress related to parenting; and, 5) reducing child stressors as measured by the parent. This chapter will address hypotheses, definition of terms, instrumentation, participants, collection of data, procedures, facilitator qualifications, and analysis of data.

A pretest-posttest control group design (Campbell & Stanley, 1963) was utilized in this study to measure the effectiveness of filial therapy with families having children with PDDs. Volunteer participants that met specified criteria were selected to participate in the study. These participants were then assigned to either a control group or an experimental group, with only the experimental group receiving treatment.

The effectiveness of filial therapy in increasing the parents' empathic behavior and acceptance with their children was measured using the Porter Parental Acceptance Scale (Porter, 1954). Specific attitudes that the Porter Parental Acceptance Scale assesses 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 needs for autonomy and independence; and (d) feeling of unconditional love for the child.

The effectiveness of filial therapy in reducing the number of problems experienced by the parents with their children, was measured by the Child Behavior Checklist (Achenbach, 1991). Specific components used to assess this was the total score, the externalizing behavior score, and internalizing behavior score.

The effectiveness of filial therapy in decreasing sociability difficulties in the child was measured by the Child Behavior Checklist (Achenbach, 1991). The specific subscales used to measure this component were the withdrawal symptoms score, social problems score, and aggressive behaviors score.

The effectiveness of filial therapy in reducing the parents' stress related to parenting was measured by the Parenting Stress Index (Abidin, 1990). Here, the parent domain score and the child domain score was used, as well as the total score, to assess the reduction in parental stress. The parent domain measures stress related to parents' perceptions of their skills as a parent and their style of parenting. The child domain reveals the stress parents feel related to their children's behavior, moods, and personalities.

The effectiveness of filial therapy in reducing child stressors as measured by the parent were measured with the Parenting Stress Index (Abidin, 1990). Specific components used to assess this was the subscales measuring child demandingness, moodiness, and adaptability.

## Hypotheses

To carry out the purposes of this study, the following hypotheses were formulated:

1. The experimental parent group will attain a significantly higher mean total score on the Porter Parental Acceptance Scale (PPAS) posttest than will the control parent group.
  - a. The experimental parent group will attain a significantly higher mean score on the Respect for the Child's Feelings and Right to Express Them subscale of the PPAS posttest than will the control parent group.
  - b. The experimental parent group will attain a significantly higher mean score on the Appreciation of the Child's Unique Makeup subscale of the PPAS posttest than will the control parent group.
  - c. The experimental parent group will attain a significantly higher mean score on the Recognition of the Child's Need for Autonomy and Independence subscale of the PPAS posttest than will the control parent group.
  - d. The experimental parent group will attain a significantly higher mean score on the Unconditional Love subscale of the PPAS posttest than will the control parent group.
2. The experimental parent group will attain a significantly lower mean total score on the Child Behavior Checklist (CBCL) posttest than will the control parent group.

- a. The experimental parent group will attain a significantly lower mean score on the Externalizing Problems subscale of the CBCL posttest than will the control parent group.
  - b. The experimental parent group will attain a significantly lower mean score on the Internalizing Problems subscale of the CBCL posttest than will the control parent group.
  - c. The experimental parent group will attain a significantly lower mean score on the Withdrawal subscale of the CBCL posttest than will the control parent group.
  - d. The experimental parent group will attain a significantly lower mean score on the Social Problems subscale of the CBCL posttest than will the control parent group.
  - e. The experimental parent group will attain a significantly lower mean score on the Aggressive Problems subscale of the CBCL posttest than will the control parent group.
3. The experimental parent group will attain a significantly lower mean total score on the Parenting Stress Index (PSI) posttest than will the control parent group.
- a. The experimental parent group will attain a significantly lower mean score on the parent domain of the PSI posttest 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 posttest than will the

- control parent group.
- c. The experimental parent group will attain a significantly lower mean score on the Adaptability subscale of the child domain of the PSI posttest than will the control parent group.
  - d. The experimental parent group will attain a significantly lower mean score on the Demanding subscale of the child domain of the PSI posttest than will the control parent group.
  - e. The experimental parent group will attain a significantly lower mean score on the Mood subscale of the child domain of the PSI posttest than will the control parent group.

#### Definition of Terms

Filial therapy is defined as a unique approach used by professionals to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision. Parents are taught basic child-centered play therapy skills including responsive listening, recognizing children's emotional needs, therapeutic limit setting, building children's self esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment which enhances the parent-child relationship, thus facilitating personal growth and change for child and parent. (G. L. Landreth, personal communication, June 27, 1995)

Play therapy is defined as "a dynamic interpersonal relationship between

a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, behaviors, and experiences) through play, the child's natural medium of communication or expression" (Landreth, 1991, p. 14).

Parental acceptance was defined as the parent's ability to recognize and approve of the child regardless of appearance, abilities, feelings, or behavior. For the purpose of this study, parental acceptance was operationally defined as the parent's scores on the Porter Parental Acceptance Scale (Porter, 1954).

Respect for the child's feelings and right to express them was defined as the parent's willingness to allow the child to express feelings, and still show acceptance for the child in the face of the expression of those feelings. For the purpose of this study, this construct was operationally defined as the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Appreciation for the child's unique make-up is the parents' attitude of appreciating and showing pleasure in the child's uniqueness. For the purpose of this study, appreciation for the child's unique make-up was operationally defined as the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Recognition of the child's need for autonomy and independence is the parents' understanding of their child's need to differentiate and separate from their parents in order to achieve their own identities. For the purpose of this study, recognition of the child's need for autonomy and independence was



operationally defined as the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Unconditional love means a parent shows love toward a child without setting conditions or standards on the child's behavior in order to receive that love. For the purpose of this study, unconditional love was operationally defined as the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Child Mood refers to children whose affective functioning shows evidence of dysfunction, with a picture of an unhappy, depressed child who frequently cries and does not display signs of happiness. For the purpose of this study, child mood was operationally defined as the parents' scores on this subscale of the Parenting Stress Index (Abidin, 1990).

Adaptability refers to children who exhibit behavioral characteristics associated with: (a) perseveration and inability to change from one task to another without emotional upset; (b) overreactive to changes in sensory stimulation; (c) avoidance of strangers; (d) overreactive to changes in routines; and (e) the child is difficult to calm once upset. For the purpose of this study, adaptability was operationally defined as the parents' scores on this subscale of the Parenting Stress Index (Abidin, 1990).

Child Demandingness is descriptive of when the parent experiences the child as placing many demands upon him or her. The demands may come from a diversity of sources such as crying, physically hanging on the parent, frequent requests for help, or a high frequency of minor problem behaviors. For the

purpose of this study, child demandingness was operationally defined as the parents' scores on this subscale of the Parenting Stress Index (Abidin, 1990).

Parental stress describes the degree of stress in the parent-child system perceived by the parent. For the purpose of this study, parental stress was operationally defined as the parents' scores on the Parenting Stress Index (Abidin, 1990).

Pervasive Developmental Disorder (PDD) refers to a diverse group of disorders of neurobiologic origin. Development is not merely delayed, but distinctly deviant, and is usually evident in the first years of life. Although often associated with mental retardation, this is not a defining diagnostic characteristic, and there are those who operate in the average to above average ranges of intellectual functioning. The defining characteristics of these disorders are (a) qualitative impairments in reciprocal social skills, (b) impairments in communication and imaginative activity, and (c) stereotyped behavior with restricted repertoire of activities and interests (DSM-IV, 4th Ed., 1994).

High Functioning refers to those individuals who have been diagnosed with a PDD, but operate at normal to above average ranges of intelligence. The typical impairments are in evidence, but some areas may be at subthreshold levels of impairment (Gillberg, 1992; Szatmari, 1992).

Externalizing Problems refers to the problems that children exhibit related to behaviors that can be generated outwardly towards the environment, such as arguing and demanding attention. For the purpose of this study,

externalizing problems was operationally defined as the problems making up the subscales for aggressive behavior and delinquent behavior for the 4-18 profile Child Behavior Checklist, and the subscales for aggressive behavior and destructive behavior for the 2-3 profile Child Behavior Checklist (Achenbach, 1991).

Internalizing Problems refers to the problems that children exhibit related to behaviors that can be generated inwardly towards self, such as sadness and fearfulness. For the purpose of this study, internalizing problems was operationally defined as the problems making up the subscales for anxious/depressed, withdrawn, and somatic complaints for the 4-18 profile Child Behavior Checklist, and the subscales for anxious/depressed and withdrawn for the 2-3 profile Child Behavior Checklist (Achenbach, 1991).

Withdrawn refers to withdrawal behaviors exhibited by children, as characterized by behaviors such as avoiding eye contact, secretive, sad, and underactive. For the purpose of this study, withdrawn was operationally defined as the parents' scores on this subscale of the Child Behavior Checklist (Achenbach, 1991).

Social Problems refers to socially problematic behaviors exhibited by children, as characterized by behaviors such as not getting along with others, not liked by peers, and getting teased by peers. For the purpose of this study, social problems was operationally defined as the parents' scores on this subscale of the Child Behavior Checklist (Achenbach, 1991).

Aggressive Behavior refers to problems with aggressive behaviors

towards others, as characterized by behaviors such as arguing, meanness, destroying others' things, and temper outbursts. For the purpose of this study, aggressive behavior was operationally defined as the parents' scores on this subscale of the Child Behavior Checklist (Achenbach, 1991).

### Instrumentation

#### Porter Parental Acceptance Scale (PPAS)

The PPAS was developed by Porter (1954), and is designed to measure parental acceptance of children. The scale is a 40 item self-report inventory designed to measure parental acceptance as revealed in the behavior and feelings parents express toward, with, or about their child. The scale involves four dimensions of acceptance: (a) respect for the child's feelings and right to express them; (b) appreciation of the child's uniqueness; (c) recognition of the child's need for independence and autonomy; and (d) unconditional love.

Each question has five responses ranging from low to high acceptance. There are two dimensions of acceptance: (a) how the parent feels in a specific situation, and (b) what the parent will do in a specific situation. The PPAS may be scored to yield four subscale scores and one total scale score.

A split-half reliability correlation of .76 raised by the Spearman Brown Prophecy formula to .86 was reported. Further research reported a split-half reliability coefficient of .66 which was raised to a total reliability coefficient of .80 by utilizing the Spearman Brown Prophecy formula. Both of the studies' reported coefficients are significant beyond the .01 level (Porter, 1954).

The validity of the instrument was investigated by using five expert

judges to rank the responses on a continuum of one representing low acceptance to five representing high acceptance. On all items there was agreement among at least three out of the five judges. The findings suggest that the PPAS is a valid measure of parental acceptance as operationally defined by Porter (1954). The validity and internal consistency of the PPAS were further established by Burchinal, Hawkes, and Garner's study (1957) which was comprised of 256 children and their parents. Item analysis was used to establish the degree of internal consistency of the PPAS. The group with the highest quartile in total test scores was compared with the group with the lowest quartile, with respect to their mean scores on each item. In order to determine whether the item had discriminated between high and low scoring groups, the difference between means was tested for significance. Through analysis of both the fathers' and mothers' responses, the researchers found that 39 of the 40 items discriminated between high and low scorers. Thirty-five items had t values in excess of 3.46, the value needed for a probability level of .001. The finding suggested that the items were able to discriminate consistently between high and low scores.

The PPAS was used for this study because (a) parental acceptance is identified as one of the essential elements underlying the parent-child relationship (Porter, 1954); (b) the four dimensions of acceptance in PPAS are closely related to the objectives of filial therapy; (c) it has been used in several other studies concerning filial therapy; (d) parental acceptance is one of the areas that might be affected negatively when a child has a disability such as a

PDD; (d) it is easy to administer and relatively easy to complete in a short period of time.

#### Child Behavior Checklist (CBCL)

The CBCL was developed by Achenbach and Edelbrock (1986). The purpose of the CBCL is to record in a standardized format the behaviors and competencies of children as reported by their parents. In the current study, the 1991 profile (Achenbach, 1991) was used. The CBCL is normed for 4-11 year old children, and for 12-18 year old adolescents. For the children under age four included in the study, the downward extension of this instrument for 2-3 year olds was utilized. The CBCL contains 120 items and requires about 15 to 20 minutes to complete. In this study, the scores for the Total Score, the Externalizing Behavior Problem Scale, the Internalizing Behavior Problem Scale, and the subscales of Aggressive Problems, Withdrawn, and Social Problems, were used.

Reliability has been extensively established for the CBCL. As the syndrome scales were derived from principal components analyses of the correlations among items, internal consistency was built-in. Cronbach's alpha is .90 for Internalizing Behavior Problems and .93 for Externalizing Behavior Problems for girls age 4-11. For boys age 4-11, Cronbach's alpha is .89 for Internalizing Behavior Problems and .93 for Externalizing Behavior Problems. Cronbach's alpha represents the mean of the correlations between all possible sets of half the items comprising a scale.

Inter-interviewer reliability of item scores was established at .959 for the

problem items by comparing scores obtained by three interviewers on 241 matched triads of children. This indicates a very high inter-interviewer reliability in scores obtained for each item relative to scores obtained for each other item.

Test-retest reliability was established at .89 and .93 for Internalizing and Externalizing Behavior Problems respectively. However, among children receiving mental health services, long-term stability coefficients have been generally lower, with significant decreases in problem scores. Therefore, the long-term stability found in the longitudinal sample does not mean that the parents' CBCL ratings are insensitive to the effects of interventions with children.

Content validity is supported by the ability of nearly all CBCL items to discriminate significantly between demographically matched referred and non-referred children. Construct validity is supported by numerous correlates of CBCL scales, including significant associations with analogous scales on the Conners (1973) Parent Questionnaire and the Quay-Peterson (1983) Revised Behavior Problem Checklist. Criterion-related validity is supported by the ability of the CBCL's quantitative scale scores to discriminate between referred and non-referred children after demographic effects were partialled out. Clinical cutpoints on the scale scores were also shown to discriminate significantly between demographically matched referred and non-referred children.

The CBCL was selected for use in this study because: (a) scores for overall problem behaviors, internalizing problems, and externalizing problems can be derived, and these will be used to determine any decreases in overall

problems exhibited through the filial therapy treatment; (b) scores can be derived for the subscales for aggressive problems, withdrawal symptoms, and social problems, and these will be used to determine if the sociability problems that children with PDDs experience, might be reduced through the filial treatment; (c) this instrument has been used in numerous other studies concerning children and the problems they might exhibit, including studies concerning play therapy treatments; (d) the instrument is relatively easy to administer and score, and it takes a relatively short period of time to complete by the parents; and (e) the instrument contains some demographic information questions, making an additional long demographic questionnaire unnecessary.

#### Parenting Stress Index (PSI)

The PSI was developed by Abidin (1983) to measure the level of stress in the parent-child system. It is a 101 item self-report index and is separated into two domains: parent and child. The Parent Domain measures the parent's perceived level of Depression, Attachment, Role Restrictions, Competence, Social Isolation, Spouse Relations, And Health. The Child Domain indicates how a parent perceives the child in relation to levels of Adaptability, Acceptability, Demandingness, Mood, Distractibility, and Reinforcing Behavior for parents. An overall psychosocial stressors scale is also included in the measurement. There are five possible responses that range from strongly agree to strongly disagree for each item.

Alpha reliability coefficients were calculated on the total score and on each of the domains to determine internal consistency. The reliability



coefficients were based on responses of a sample of 2633. The reliability coefficients for the two domains and Total Stress Score are: Child Domain .90; Parent Domain .93; and Total Stress Score .95 (Hauenstein, Scarr, & Abidin, 1983). These findings indicate a high degree of internal consistency for the PSI. Zakreski (1983) used the test-retest method to determine a coefficient of reliability. This study produced coefficients of .77 for the child domain, .69 for the parent domain, and .88 for the total index.

The PSI was selected for use in this study because: (a) the child with a PDD can typically be a child that may have personality components that are highly stressful, and this measures the stress related to some of those components, (b) three components in particular are perhaps significantly related to the child with a PDD - Mood, Adaptability, and Demandingness, (c) the overall stress ranges for the dynamic parent-child relationship can be measured with this instrument, and if the filial therapy training is effective in enhancing the parent-child relationship, there should be a reduction in this stress range. (d) the subscales are perhaps closely related to the parent's ability to accept their child, (e) this instrument has been used in other studies of filial therapy training, and (f) the PSI is easy to administer, and can be completed in 20 minutes.

### Participants

Solicitation of parents with children who had a diagnosis of PDD was done by contacting several sources in a large urban metroplex:

- a. Physicians who had contact with PDD children and their parents,

including child specialists, pediatricians, behavioral pediatricians, child neurologists, child psychiatrists, and child training psychiatrists.

b. Psychologists, counselors, and other mental health professionals who had contact with these children and their parents.

c. School districts with special programs including early childhood programs, resource programs, special education programs, or other specialized programs specifically for children diagnosed with PDDs.

d. Private sources that had contact with these children including private schools, special education schools, speech and language centers, medical and psychological centers, medical hospitals for children, psychological or neuropsychological assessment centers, and the like.

After receiving permission to solicit this population, advertisement fliers were sent out to the targeted population. Parents who responded were contacted by the investigator and given more details about the parent training classes and the selection process.

Parents were selected to participate in the study based on the following criteria:

- a. Must be a parent at least 18 years old with either full or joint custody of their child;
- b. Must be able to speak, read, and write the English language;
- c. Must have a child who has been diagnosed with a PDD with relatively normal cognitive functioning. Diagnostic categories may include such terminology as high-functioning autism, PDD-NOS, high-functioning

PDD, atypical autism, Asperger's disorder, hyperlexia, PDD, or autistic.

d. Must be able to attend the 10 week filial therapy training at the scheduled times;

e. Must agree to participate in weekly 30-minute home play sessions with their child;

The investigator conferenced with each participant who met the requirements to: (a) explain the purpose and the requirements of the filial therapy training, (b) provide information about confidentiality, and (c) answer any questions the participants had before they signed the consent form (Appendix A). The parent was asked to indicate the child by name on the consent form. The investigator informed the parents that they would be arbitrarily scheduled to participate in either the first series (experimental group) or second series (control group) of filial therapy training sessions.

In the experimental phase, two filial groups were offered at one site, one meeting during the day with 4 participants, and one in the evening with 10 participants. Thus a total of fourteen parents were able to attend the first series of filial therapy training groups, and the rest were placed into the control group. Of those 14, two were dropped because of an inability to complete the tasks of the filial training, making 12 parents who completed the filial training in full. There were 14 parents in the control group, and of these 14, two were dropped because of a defensive, invalid scoring pattern. One was later dropped because the physician who diagnosed PDD had changed the diagnosis to Obsessive-Compulsive Disorder with a language disorder. Therefore, 11 parents were

retained for the control group. Thus 33 parents completed the present study, 12 in the experimental group and 11 in the control group.

The experimental group was comprised of 9 mothers and 3 fathers. Of these participants, there were three couples and six individual parents. There were 7 mothers and 4 fathers in the control group. Of these control parents, there were four couples and three individual parents. The parents in the experimental group ranged in age from 34 to 50 years of age, with a mean age of 38. The age range for the control group parents was 35 to 47 years of age, with a mean age of 39. The highest level of educational attainment for the experimental group parents was the following: 17% had completed at least some college, 33% had completed at least an undergraduate degree, and 50% had either worked on or completed graduate work. The highest level of educational attainment for the control group parents was the following: 9% had completed at least high school, 9% had completed at least some college, 37% had at least completed an undergraduate degree, and 45% had either worked on or completed graduate work. Of the experimental group, 8% were of hispanic heritage and 92% were caucasian. Of the control group, 18% were African American, and 82% were caucasian.

The children in both groups ranged from 3 to 10 years of age. The experimental group included 34% 3-year olds, 25% 5-year olds, 8% 6-year olds, 8% 7-year olds, and 25% 9-year olds. The control group included 9% 3-year olds, 18% 4-year olds, 18% 6 year olds, 18% 8-year olds, 9% 9-year olds, and 28% 10-year olds. The mean age of the children was 5.58 years for the

experimental group and 7.09 years for the control group.

Of the experimental group 50% were employed full-time, 16% were employed part-time, and 34% were full-time parents. Of the control group, 64% were employed full-time, and 36% were full-time parents.

#### Collection of Data

In the first session, parents were given some background information about the efficacy of play and what they would be looking forward to doing with their child. Prior to coming to the first training session, parents completed the Porter Parental Acceptance Scale and the Child Behavior Checklist. The Parenting Stress Index was completed in the first 15 minutes of the first training session. Directions were read aloud and participants were reminded to respond to all items in terms of interaction with their child with PDD.

One week following the completion of 10 weeks of filial therapy training, the posttest battery of instruments was administered to both the experimental and control groups. The control group parents were scheduled to begin filial therapy training as soon as they completed the posttesting requirements. The instruments were number coded to maintain confidentiality of the participants. The investigator kept a master list with subjects' names and respective codes in a locked file.

#### Procedures

The experimental group met for a two hour training session every week for ten consecutive weeks, for a total of 10 sessions. The training sessions followed the methodology outlined by Landreth (1991) for a ten week filial

therapy training group (Appendix B). Parents learned the skills through didactic instruction, demonstration, and role playing. They were then asked to practice these skills with their child in weekly 30-minute special play sessions.

The parents were given a list of toys to be used for the home play sessions. In addition, they videotaped a play session at home for viewing in one of the training sessions. Each of the parents was given feedback on their play session video tape about the skills they were learning. Other group members were encouraged to also provide feedback for the videotaped sessions. Thus parents were helped to learn from each other, fostering a sense of encouragement and support among the parents.

During the course of training, parents who missed a class were contacted immediately and scheduled for a make-up session prior to the next training session. Parents were also asked to make-up any missed home play sessions with their child.

### Training Session One

Parents introduced themselves, and described their families, particularly the child they would be working with in the filial sessions. The goals and objectives for the filial sessions was discussed, with a particular emphasis on the child with PDD. The facilitator emphasized the importance of parents' sensitivity and empathy to their children, and demonstrated the skills of reflective listening and tracking behavior through role-play with one of the parents. Their homework assignment was to notice some physical characteristic about their child they hadn't seen before.

### Training session Two

The homework assignment on noticing a physical characteristic about their child was discussed, then related to their job in filial therapy. The facilitator explained the basic principles, goals, and the process of play sessions (Appendix B) using the handout, "Filial Therapy Group." The toys to be used in the special play times were demonstrated, and parents were reminded that the toys were to be used only during the special play times. The group watched a video on children's emotions. The parents paired off and practiced reflective responding. The homework assignment was to read through the "Facilitating Reflective Communication" handout (Appendix B) and identify a place and time for the play sessions in their home. Additionally they were to identify emotions of anger, happiness, sadness, and surprise in the child of focus and make a reflective response (Appendix B).

### Training Session Three

Discussion of the reflective responses was conducted, and each parent reported on the time and place for their special play sessions. A video tape of a demonstration of empathic listening/filial therapy was shown of the facilitator and his daughter. The facilitator instructed the group using the handouts, "Eight Basic Principles of Play Therapy" (Appendix B), and "Basic Rules for Filial Therapy" (Appendix B) in preparation for their first play session at home. Basic limit setting was briefly discussed. The homework assignment was to begin their home play sessions.

#### Training Session Four

Each parent reported on their play session with their child and areas of difficulty they experienced, and suggestions were offered by the facilitator. The facilitator paid attention to the feelings and experiences of each parent, and encouraged support among the group members. The skills of limit setting were explored through the use of the handout, "Two Techniques of Discipline That Work" (Appendix B). Parents were also provided with the handout, "Training Manual for Parents," by Louise Guerney. The homework assignment for parents was to continue home play sessions and to notice one intense feeling in themselves. Two parents (in the smaller group, one parent) were selected to videotape their home play session for showing to the group the next week.

#### Training Session Five Through Ten

These sessions followed the same general format. The parents reported on their play sessions. A parent video tape was viewed and discussed each time. The facilitator gave suggestions and feedback, and encouraged the parents to also comment on the videotape, with especial emphasis on group support and encouragement. Group interaction concerning parent problems was facilitated, and the parents' feelings were focused on. Training and role playing of skills continued each session, and newly developed parental coping skills were identified to develop the parents sense of empowerment. Generalization of skills outside the play sessions were discussed.

#### Training Session Five

Parents reported on the intense feelings they experienced during the



week, and the importance of self awareness was emphasized. Parents practiced limit setting skills through role playing, and were given the handout "When Setting Limits Doesn't Work" (appendix B). Another handout on utilizing play to intervene with children with PDD was given to parents to read (Appendix B). The homework assignment was to practice giving one choice to their child this week, and to institute sandwich hugs.

#### Training Session Six

Parents debriefed and reported on their play session, and the homework assignments. The facilitator gave further instruction on dealing with some of the common problems in Filial Therapy when used with children with PDD. The parents were encouraged to continue their play sessions with a view of noticing the patterns of play that were emerging, as well as the differences between sessions.

#### Training Session Seven

The parents debriefed their sessions, along with the review of the videotapes. The skills of reflective listening, limit setting and giving choices were reviewed and practiced in role playing among the parents, and with the facilitator modeling responses. The homework assignments were to continue the play sessions, two parents were assigned to videotape their sessions, and the parents were asked to note the number of times they touch their child.

#### Training Session Eight

Parents debriefed their play sessions, discussed the number of times they touch their child, and the videotapes were reviewed for the group. The

parents' confidence in their newly learned skills became more evident as they participated more freely in critiquing each other's skills and offered suggestions as the videotapes were reviewed. The homework was to continue sessions, one or two were selected to videotape their sessions, and all were encouraged to write down any unanswered questions they might have.

#### Training Session Nine

The parents debriefed their play session, and the video tapes were reviewed by the group. Some of their parenting problems and their children's behavioral problems were discussed in the group. Parents practiced the skills of reflective listening, tracking, and esteem building, with a focus on building esteem. The homework assignment was to continue their play sessions.

#### Training Session Ten

Parents debriefed their play sessions, and the videotapes were reviewed by the group. The focus was on evaluating the parents' experience and sharing how the training and the play sessions had affected them. The parents evaluated the changes in themselves and their children and shared their perceptions of changes they noticed in other parents. Parents were encouraged to continue play sessions with their child of focus, and/or other children in the family. Making changes in format or toys in future play sessions was detailed and discussed.

#### Facilitator

The filial therapy training groups were facilitated by the investigator of this study. The investigator is a Licensed Professional Counselor in the state of

Texas, and is a doctoral student at the University of North Texas. He has completed an introduction to play therapy course, an advanced play therapy course, a filial therapy course, a doctoral level practicum in play therapy, a doctoral internship in play therapy and filial therapy, and an advanced play therapy supervision course. He has received supervision in play therapy and filial therapy in doctoral practicums and internships, and has provided play therapy supervision to master level students. In addition, the investigator has had several years of experience conducting play therapy and training parents in filial therapy. This experience includes working with children with PDDs, and training their parents in filial therapy.

#### Analysis of Data

Following the collection of the pretest and posttest data, the instruments were scored and double checked. The data from the two filial therapy training groups were pooled to form the experimental group. The resulting data was keyed into the computer and analyzed using SPSS, Inc (1990).

An analysis of covariance (ANCOVA) was computed to test the significance of the difference between the experimental group and the control group on the adjusted posttest means for each hypothesis. In each case, the posttest specified in each of the hypotheses was used as the dependent variable and the pretest as the covariant. ANCOVA was used to adjust the group means on the posttest on the basis of the pretest, thus statistically equating the control and experimental groups. The significance of difference between the means was tested at the .05 level of significance. On the basis of

the ANCOVA, the hypotheses were either retained or rejected.

## CHAPTER III

### RESULTS AND DISCUSSION

This chapter presents the results of the analysis of the data for each hypothesis tested in this study. Included also is a discussion of the results, implications, and recommendations for further 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 higher mean total score on the Porter Parental Acceptance Scale (PPAS) posttest than will the control parent group.

Table 1 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 2 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 1.

Mean total scores for the Porter Parental Acceptance Scale (PPAS)

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	145.7500	156.3333	141.4545	144.0909
<u>SD</u>	17.1683	15.1618	16.5491	18.3927
Total cases = 23				

Table 2.

Analysis of covariance data for the mean total scores for the (PPAS)

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	493.07	1	493.07	3.08
Covariates	2710.77	1	2710.77	16.94
Error	3200.80	20	160.04	
Total cases = 23				

In table 2, the F ratio for the main effects was significant to the .095 level indicating no significant difference in the experimental group parents' mean total scores for the Porter Parental Acceptance Scale (PPAS). On the basis of this data, hypothesis 1 was not retained.

Hypothesis 1.a

The experimental parent group will attain a significantly higher mean

score on the "Respect for the Child's Feelings and Right to Express Them" subscale of the PPAS posttest than will the control parent group.

Table 3 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 4 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 3.

Mean scores for the (PPAS) subscale: Respect for the Child's Feelings and Right to Express Them

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	33.8333	36.3333	35.0000	36.0000
<u>SD</u>	6.8202	7.1138	7.0569	6.8411
Total cases = 23				

Table 4.

Analysis of covariance data for the mean scores on the (PPAS) subscale: Respect for the Child's Feelings and Right to Express Them

Source of Variation	Sum of Squares	df	Mean	
			Square	F
Main effects	8.05	1	8.05	.33
Covariates	543.33	1	543.33	22.58

Error	481.33	20	24.07
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Total cases = 23

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In table 4, the  $F$  ratio for the main effects was significant to the .569 level indicating no significant difference in the experimental group parents' mean total scores for the (PPAS) subscale: Respect for the Child's Feelings and Right to Express Them. On the basis of this data, hypothesis 1.a was not retained.

#### Hypothesis 1.b

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

Table 5 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 6 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 5.

#### Mean scores for the (PPAS) subscale: Appreciation of the Child's Unique Makeup

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	36.5833	38.0000	33.0000	33.3636
<u>SD</u>	6.9079	8.4853	6.1806	6.6974

Total cases = 23

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Table 6.

Analysis of covariance data for the mean scores on the (PPAS) subscale:  
Appreciation of the Child's Unique Makeup

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	54.83	1	54.83	1.00
Covariates	142.90	1	142.90	2.60
Error	1097.64	20	54.88	
Total cases = 23				

In table 6, the  $F$  ratio for the main effects was significant to the .329 level indicating no significant difference in the experimental group parents' mean total scores for the (PPAS) subscale: Appreciation of the Child's Unique Makeup. On the basis of this data, hypothesis 1.b was not retained.

#### Hypothesis 1.c

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

Table 7 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 8 presents the analysis of covariance data, showing that there is a significant difference between the experimental and control groups' post-test mean scores.

Table 7.

Mean scores for the (PPAS) subscale: Recognition of the Child's Need for  
Autonomy and Independence

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	41.0000	45.3333	42.6364	41.6364
<u>SD</u>	2.8604	2.9949	3.5573	4.4107
<u>Total cases = 23</u>				

Table 8.

Analysis of covariance data for the mean scores on the (PPAS) subscale:  
Recognition of the Child's Need for Autonomy and Independence

Source of Variation	Sum of Squares	df	Mean	
			Square	<u>F</u>
Main effects	136.46	1	136.46	18.69 *
Covariates	147.21	1	147.21	20.17
Error	146.00	20	7.30	
<u>Total cases = 23</u>				
* $p < .05$				

In table 8, the F ratio for the main effects was significant to the  $< .001$  level indicating a significant difference in the experimental group parents' mean

total scores for the (PPAS) subscale: Recognition of the Child's Need for Autonomy and Independence. On the basis of this data, hypothesis 1.c was retained.

#### Hypothesis 1.d

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

Table 9 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 10 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 9.

#### Mean scores for the (PPAS) subscale: Unconditional Love

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
<b>Mean</b>	34.3333	36.6667	30.8182	33.0909
<b><u>SD</u></b>	6.6515	5.4828	8.4477	9.3963
<b>Total cases = 23</b>				

Table 10.

Analysis of covariance data for the mean scores on the (PPAS) subscale:

Unconditional Love

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	13.63	1	13.63	.33
Covariates	384.69	1	384.69	9.28
Error	828.89	20	41.44	

Total cases = 23

In table 10, the  $F$  ratio for the main effects was significant to the .573 level indicating no significant difference in the experimental group parents' mean total scores for the (PPAS) subscale: Unconditional Love. On the basis of this data, hypothesis 1.d was not retained.

Hypothesis 2

The experimental parent group will attain a significantly lower mean total score on the Child Behavior Checklist (CBCL) posttest than will the control parent group.

Table 11 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 12 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 11.

Mean scores for Total Behavior Problems for the Child Behavior Checklist

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	66.0000	64.7500	68.0909	67.0909
SD	8.7801	7.8755	8.0182	8.1296
Total cases = 23				

Table 12.

Analysis of covariance data for the mean scores for Total Behavior Problems for the Child Behavior Checklist

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	2.88	1	2.88	.13
Covariates	902.40	1	902.40	40.95
Error	440.76	20	22.04	
Total cases = 23				

In table 12, the F ratio for the main effects was significant to the .722 level indicating no significant difference in the experimental group parents' mean total scores for the Child Behavior Checklist (CBCL). On the basis of this data, hypothesis 2 was not retained.

### Hypothesis 2.a

The experimental parent group will attain a significantly lower mean score on the externalizing problems subscale of the CBCL posttest than will the control parent group.

Table 13 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 14 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 13.

#### Mean scores for the CBCL Subscale: Externalizing Problems

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	58.3333	56.3333	57.9091	57.7273
<u>SD</u>	10.3426	11.4838	10.2903	10.0707
Total cases = 23				

Table 14.

#### Analysis of covariance data for the mean scores for the CBCL Subscale: Externalizing Problems

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	18.46	1	18.46	.78
Covariates	1988.45	1	1988.45	83.48

Error	476.40	20	23.82
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Total cases = 23

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In table 14, the  $F$  ratio for the main effects was significant to the .389 level indicating no significant difference in the experimental group parents' mean scores on the externalizing problems subscale of the CBCL posttest. On the basis of this data, hypothesis 2.a was not retained.

#### Hypothesis 2.b

The experimental parent group will attain a significantly lower mean score on the internalizing problems subscale of the CBCL posttest than will the control parent group.

Table 15 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 16 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 15.

#### Mean scores for the CBCL Subscale: Internalizing Problems

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	63.6667	63.4167	58.9091	58.3636
<u>SD</u>	8.8763	6.9342	9.4600	8.7667
Total cases = 23				

Table 16.

Analysis of covariance data for the mean scores for the CBCL Subscale:

Internalizing Problems

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	19.48	1	19.48	.74
Covariates	769.18	1	769.18	29.12
Error	528.28	20	26.41	

Total cases = 23

In table 16, the  $F$  ratio for the main effects was significant to the .401 level indicating no significant difference in the experimental group parents' mean scores on the internalizing problems subscale of the CBCL posttest. On the basis of this data, hypothesis 2.b was not retained.

Hypothesis 2.c

The experimental parent group will attain a significantly lower mean score on the Withdrawal subscale of the CBCL posttest than will the control parent group.

Table 17 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 18 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.



Table 17.

Mean scores for the CBCL subscale: Withdrawal

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	66.0833	67.5000	62.7273	62.0000
<u>SD</u>	9.1100	9.1004	10.6779	7.4162
Total cases = 23				

Table 18.

Analysis of covariance data for the mean scores on the (CBCL) subscale:Withdrawal

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	77.03	1	77.03	1.74
Covariates	577.09	1	577.09	13.06
Error	883.91	20	44.20	
Total cases = 23				

In table 18, the F ratio for the main effects was significant to the .202 level indicating no significant difference in the experimental group parents' mean scores on the withdrawal subscale of the CBCL posttest. On the basis of this data, hypothesis 2.c was not retained.

Hypothesis 2.d

The experimental parent group will attain a significantly lower mean score on the Social Problems subscale of the CBCL posttest than will the control parent group.

Table 19 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 20 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 19.

Mean scores for the (CBCL) Subscale: Social Problems

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	66.7500	66.0000	65.8182	67.0909
<u>SD</u>	5.2030	8.4684	10.4002	10.0245
Total cases = 23				

Table 20.

Analysis of covariance data for the mean scores on the (CBCL) Subscale: Social Problems

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	17.77	1	17.77	.72

Covariates	1110.64	1	1110.64	44.84
Error	396.27	16	24.77	
<u>Total cases = 23</u>				

In table 20, the  $F$  ratio for the main effects was significant to the .409 level indicating no significant difference in the experimental group parents' mean scores on the social problems subscale of the CBCL posttest. On the basis of this data, hypothesis 2.d was not retained.

#### Hypothesis 2.e

The experimental parent group will attain a significantly lower mean score on the Aggressive Problems subscale of the CBCL posttest than will the control parent group.

Table 21 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 22 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 21.

#### Mean scores for the (CBCL) Subscale: Aggressive Problems

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	59.5000	58.7500	59.9091	60.6364
<u>SD</u>	10.0589	8.4652	10.3774	9.1353
<u>Total cases = 23</u>				

Table 22.

Analysis of covariance data for the mean scores on the (CBCL) Subscale:

Aggressive Problems

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	14.07	1	14.07	1.00
Covariates	1341.73	1	1341.73	95.47
Error	281.07	20	14.05	

Total cases = 23

In table 22, the F ratio for the main effects was significant to the .329 level indicating no significant decrease in the experimental group parents' mean scores on the aggressive problems subscale of the CBCL posttest. On the basis of this data, hypothesis 2.e was not retained.

Hypothesis 3

The experimental parent group will attain a significantly lower mean total score on the Parenting Stress Index (PSI) posttest than will the control parent group.

Table 23 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 24 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 23.

Mean total scores for the Parenting Stress Index (PSI)

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	279.1667	292.2500	281.8182	283.2727
<u>SD</u>	31.3828	35.4173	38.9790	40.3883
<u>Total cases = 23</u>				

Table 24.

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

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	762.32	1	762.32	2.58
Covariates	24200.04	1	24200.04	81.89
Error	5910.40	20	295.52	
<u>Total cases = 23</u>				

In table 24, the F ratio for the main effects was significant to the .124 level indicating no significant difference in the experimental group parents' mean total scores for the Parenting Stress Index (PSI). On the basis of this data, hypothesis 3 was not retained.

### Hypothesis 3.a

The experimental parent group will attain a significantly lower mean score on the parent domain of the PSI posttest than will the control parent group.

Table 25 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 26 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 25.

#### Mean scores for the (PSI) subscale: Parent Domain

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	137.9167	143.3333	128.6364	131.0909
<u>SD</u>	19.2612	21.6935	21.9876	23.4966
Total cases = 23				

Table 26.

#### Analysis of covariance data for the mean scores on the (PSI) subscale: Parent Domain

Source of Variation	Sum of Squares	df	Mean Square	<u>F</u>
Main effects	60.58	1	60.58	.49

Covariates	8208.53	1	8208.53	65.96
Error	2489.05	20	124.45	

Total cases = 23

In table 26, the  $F$  ratio for the main effects was significant to the .493 level indicating no significant difference in the experimental group parents' mean total scores for the (PSI) subscale: Parent Domain. On the basis of this data, hypothesis 3.a was not retained.

#### Hypothesis 3.b

The experimental parent group will attain a significantly lower mean score on the child domain of the PSI posttest than will the control parent group.

Table 27 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 28 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 27.

#### Mean scores for the (PSI) subscale: Child Domain

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	141.2500	148.9167	153.1818	152.1818
<u>SD</u>	18.7962	19.0810	21.7201	22.4402
<u>Total cases = 23</u>				

Table 28.

Analysis of covariance data for the mean scores on the (PSI) subscale: Child Domain

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	321.83	1	321.83	4.04
Covariates	7447.59	1	7447.59	93.51
Error	1592.96	20	79.65	

Total cases = 23

In table 28, the F ratio for the main effects was significant to the .058 level indicating no significant difference in the experimental group parents' mean total scores for the (PSI) subscale: Child Domain. On the basis of this data, hypothesis 3.b was rejected.

Hypothesis 3.c

The experimental parent group will attain a significantly lower mean score on the Adaptability subscale of the child domain of the PSI posttest than will the control parent group.

Table 29 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 30 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.



Table 29.

Mean scores for the (PSI) subscale: Adaptability

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	33.7500	36.2500	39.6364	39.2727
<u>SD</u>	5.4793	5.3279	5.8527	7.7471
Total cases = 23				

Table 30.

Analysis of covariance data for the mean scores on the (PSI) subscale:Adaptability

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	34.15	1	34.15	2.63
Covariates	653.03	1	653.03	50.35
Error	259.40	20	12.97	
Total cases = 23				

In table 30, the F ratio for the main effects was significant to the .120 level indicating no significant difference in the experimental group parents' mean total scores for the (PSI) subscale: Adaptability. On the basis of this data, hypothesis 3.c was not retained.

### Hypothesis 3.d

The experimental parent group will attain a significantly lower mean score on the Demanding subscale of the child domain of the PSI posttest than will the control parent group.

Table 31 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 32 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 31.

#### Mean scores for the (PSI) subscale: Demanding

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	28.5000	30.5833	29.1818	29.2727
<u>SD</u>	5.1962	4.7378	5.6359	5.4054
Total cases = 23				

Table 32.

#### Analysis of covariance data for the mean scores on the (PSI) subscale:

##### Demanding

Source of Variation	Sum of Squares	df	Mean Square	F
Main effects	19.25	1	19.25	2.20
Covariates	363.93	1	363.93	41.55

Error	175.17	20	8.76
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Total cases = 23

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In table 32, the  $F$  ratio for the main effects was significant to the .154 level indicating no significant difference in the experimental group parents' mean total scores for the (PSI) subscale: Demanding. On the basis of this data, hypothesis 3.d was not retained.

#### Hypothesis 3.e

The experimental parent group will attain a significantly lower mean score on the Mood subscale of the child domain of the PSI posttest than will the control parent group.

Table 33 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 34 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 33.

#### Mean scores for the (PSI) subscale: Mood

	<u>Experimental (n=12)</u>		<u>Control (n=11)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	13.0833	14.5833	15.0909	15.2727
<u>SD</u>	3.4499	3.6794	4.0609	3.3494

Total cases = 23

---

Table 34.

Analysis of covariance data for the mean scores on the (PSI) subscale: Mood

Source of Variation	Sum of Squares	df	Mean Square	F Ratio
Main effects	4.31	1	4.31	1.14
Covariates	185.32	1	185.32	48.91
Error	75.78	20	3.79	
Total cases = 23				

In table 34, the F ratio for the main effects was significant to the .299 level indicating no significant difference in the experimental group parents' mean total scores for the (PSI) subscale: Mood. On the basis of this data, hypothesis 3.e was not retained.

### Discussion

The results of this study along with parents' comments and the facilitator's observations provide information regarding filial therapy training as an intervention with the parents of children with PDD. An interpretation of the findings of this study is provided in the following section.

#### Parental Acceptance

As can be seen in Table 1 through Table 10, the members of the experimental group reported significant growth only on the subscale for "Recognition of the Child's Need for Autonomy and Independence," and showed a highly suggestive positive trend on the total score on the Porter

Parental Acceptance Scale (PPAS). All of the other subscales demonstrated a positive trend as well in the areas of “Respect for the Child’s Feelings and Right to Express Them,” “Appreciation of the Child’s Unique Makeup” and “Unconditional Love.” It might be conjectured that the one area that showed statistical significance may be the one area that is potentially most helpful to the parents of a child with PDD. The diagnosis of PDD is one that is often seen as debilitating, and many parents have obvious fears about what the future holds for their child. It is interesting to note that this area of granting autonomy and independence to the child, perhaps most at risk for the child with PDD, is the area that parents demonstrated the most growth. The experimental parents showed the most growth in being able to allow their child greater autonomy.

The significant increase reported on the PPAS may be attributed to the relationship of the variables tested to the training given in filial therapy. The specific play therapy skills that the parents were required to practice during training may be closely related to the variables assessed on the PPAS, those of ‘unconditional love,’ ‘appreciation of the child’s unique makeup,’ ‘respect for the child’s feelings and right to express them,’ and ‘recognition of the child’s need for autonomy and independence.’

The growth of these attitudinal changes was displayed in subtle ways throughout the sessions. The parents approached the first play session with a great deal of trepidation. They were concerned about a number of issues, many that proved to be unfounded, and some that were indeed well deserving of consideration. The youngest children exhibited much hyperactivity and

distractibility, and just getting them to focus for a few minutes became quite a task for the parents. Most of the parents were very pleased, however, that their child demonstrated a desire to play with the parent. Most of the children began to branch out and explore in their play as the parent followed the lead of the child and exhibited much acceptance and openness to the child. After 3 to 4 sessions, even the youngest children were demonstrating increased focus and attention and were able to engage with their parents for up to the 30 minutes required of each play session.

One father began the sessions having just discovered that their child was 'autistic.' This father had a great deal of sadness and hopelessness over his son's condition and felt there was little that could be done. His statements at first reflected this. He called his son autistic, stated that he could no longer engage with him since the autism had 'hit,' and was very pessimistic, especially when his son only stayed in the session for 4 to 5 minutes. Much encouragement was given during the sessions by the other group members, and he was encouraged to continue attempting to engage and follow the cues his son was able to give during the play sessions. Little by little, he began noticing his son's attempts to stay longer, to engage relationally, to stay within the boundaries, and to play with his father. The father began to recognize his son's attempts at language, and in later sessions the child was able to work up to 30 minutes per session. Much of the breakthrough appeared to occur as the father began accepting his son. By the end of the sessions the father was proud of the fact that he was able to engage with his son for the 30 minutes.

The results of the PPAS suggest that the ten week filial therapy training model is effective in increasing parental acceptance among parents of children with PDD.

#### Problematic Behaviors of Children with PDD

As indicated in Table 11 through Table 22, the children of the parents in the experimental group did experience a beginning reduction of behavior problems in several areas as measured by the Child Behavior Checklist (CBCL). However, the results were not significant at the .05 level. There was a slight reduction in the areas of aggressive problems and externalizing problems, although again not at statistically significant ranges. Scores on the internalizing behavior problems subtest did not show a reduction in problems, however, one subtest in this area, depressive/anxiety symptoms, did show a beginning reduction of symptoms, although again not at statistically significant ranges. A possible reason for the lack of significance in the overall reduction of problems may be due to the length of the study. Most of the children received only 6 or 7 sessions by the end of the study in this treatment. It may be conjectured that children with pervasive, multisystemic developmental problems may need more sessions to obtain significant growth, perhaps twice as many sessions as other children.

By the 3rd and 4th play session, parents in the experimental group were beginning to note behavioral changes in their children. An obvious change was the children's play behavior. One mother was afraid her child would simply draw and color the entire session, as was his usual preoccupation in play. He

did utilize this behavior, but as he became comfortable with the situation, he began playing with all of the toys and created scenarios with the toys. As he played, he first drew pictures about himself playing baseball with his brother, then played out that scenario with the toys. His mother reported that he refused to engage in any kind of ball playing, and typically engaged in socially ostracizing behavior when around ball playing. It became apparent that this child was playing out a scenario of something that he wished and yearned he could do, but had no way of communicating this to the family in his usual ways.

The parents were pleasantly surprised to watch the process of their children's play, sometimes in its complexity, sometimes in its relationship to what was going on in their child's world, and sometimes in just being able to utilize the play to gain relational engagement. Most of the parents reported giggles and happiness being displayed in the play sessions.

Several parents of younger children with pronounced language problems began reporting on more effective language communication. One mother reported that her son was largely non-verbal prior to the sessions, and that after their sessions had started, he was becoming a verbal child, making many attempts at language. Pronoun reversals began to be less typical. Many parents noted much greater eye contact in their communication with their child. The parents were beginning to 'hear' their child's attempts at words, and were excited that they were used in context with what was happening in the play session. It could be hypothesized that this was a result of two happenings: one, the parents were more attuned to their child's verbalizations and were hearing



their attempts for the first time, and two, the children in the stress-free environment of the play session were more willing to make attempts in the relational presence of their parents.

One mother noted growth with her child in that at first he wanted her to play with a puppet and make it talk. Then he moved to putting the puppet on his hand, and finally made the puppet talk himself. This mother also reported gaining insight into her child's lack of language progress - that he was nervous about talking and producing language - and this insight was helpful to her in understanding him better. Another mother noticed that her son was beginning to verbalize personal needs, something he had never done before. One mother noted that the speech therapist reported that for the first time, her son was making many attempts at reproducing speech and in fact had attempted 25 words.

Some other benefits from the play sessions: One mother commented that she felt she understood her child better, and that her daughter had begun to let her into her world. Another mother noted that her son was able to 'come out of' tantrums faster, and seemed to be able to converse more effectively with his mother and father. Most parents described more creative and imaginative play by their children. Many parents noted their children were more talkative and took more initiative in engaging conversationally. Many parents talked of greater eye contact with the parents. Some parents said that their child was not so overconsumed with just one toy. Obviously these aspects of functioning are not 'testable' in the classical sense, but perhaps further research in the use of

play with children with PDD will be helpful in substantiating and validating these observations by parents.

### Parental Stress

As can be seen in tables 23 through 34, the experimental group parents did not demonstrate lowered stress as measured through the Parenting Stress Index (PSI) on the various scales. This is quite a contrast to other studies using filial therapy which have demonstrated improvement with various populations including children with attentional problems, learning problems, and hyperactive children. A number of reasons may be suggested for this lack of improvement. The parents were only able to do 6 to 7 sessions on average during the scope of this training. For children who have pervasive or multisystem developmental differences of the magnitude of these children, this may not be long enough to begin seeing these types of changes. It may be conjectured that more sessions, perhaps twice as many, might be needed to see effects begin to take place.

The parents of these children were also undertaking this training at a difficult seasonal juncture. The children were coming to the end of the school year, and by this time many children were dealing with the stress of having been in school for an extended period. Most of these parents were also in the throes of taking their children to special schools and various special therapies. During one of the training sessions, the parents were asked to tell an intense feeling they had during the week. Most parents stated that the intense feeling was either exhaustion or feeling overwhelmed. Besides all of their other

activities, they were also engaged in coming to the filial therapy training and spending a session in play with their child. The play sessions ended about the time that school was coming to an end, and many of the children were in various therapies (speech and language, occupational, etc). By the time they were coming to an end with the training sessions, they were also coming to an end with many things, making those last weeks quite a crunch. The control parents were at a different seasonal juncture, however, as many of them finished their second set of assessments during mid-summer, after much of this seasonal distress was over and their children were able to take some break from all of these activities. Children with PDD are cited for being very susceptible to stressors. Perhaps the results of the PSI were suggestive of this aspect of susceptibility for the child with PDD.

Although there were no significant changes on the PSI, parents commented on changes in mood, demandingness and adaptability. Parents began learning that they could redirect their child's behavior, and in fact, several parents reported that their child was making transitions easier. One child was able to manage going to 'Pizza Planet' for the first time ever. Another mother reported that her child got on a horse for the first time in his life, and she was excited that he finally shook off some of his reactivity and was able to have some fun on the horse. Several other parents reported that their child was beginning to transition to various aspects of their lives without the reactivity that had been in place previously.

One boy, whose father was a physician, was petrified of anything

regarding medicine. In his play sessions, he first began playing out battles and lots of conflict, then he began asking his mother to play doctor with him briefly, then he would return to the conflictual play. As time progressed, he was able to more and more play out a theme of medicine and 'doctoring,' and actually used the play to allow his mother to establish contact with him. He began using the play as a way to receive nurturing attention from his mother as he received her medical attention.

At this juncture, the training did not reduce the stress levels in parents of children with PDD, as measured by the PSI. Perhaps further studies can substantiate this, or demonstrate that more sessions may be needed to help reduce stress in these areas.

#### Implications

Although the results of this study were not statistically significant, the parents' comments and facilitator's observations support the use of filial therapy training with the parents of children with PDD. These children are experiencing multiple and pervasive differences that impair various systems on a neurobiologic level, which then impairs a fundamental aspect of their life, that of relating to others. This study has been a beginning in demonstrating that methods which utilize a filial therapy approach can make a difference in the basic parent-child relationship, a core unit of relationship. Further research is necessary to determine if these areas are indeed significantly effected through statistical analysis.

This study did not take into consideration other confounding variables,

such as various therapies that were also being conducted at the same time. Speech and language therapies, occupational therapy, sensory integration therapy, special schools, and the like were also participated in by most of the children and their parents, to work on many of the difficulties that were assessed in the course of this study. It would have been quite difficult to exclude anyone from participating in this study in order to eliminate the effects from these various therapies and works. Most parents of children with PDD are going to be investigating and participating in several therapies in order to promote their child's growth and development. Perhaps a way of dealing with this difficulty is to assess for these areas as well in order to determine their effects on the children who are undergoing this filial therapy treatment.

As in other studies, the parents in this study reported more empathic responses emanating from the child, the child's play appeared to grow and develop in the context of the parent-child relationship, and the child's language development appeared to be facilitated. In this study it would be presumptuous to assume that the play sessions alone brought growth in these areas. Other therapies were also utilized to work on these problems. But perhaps the reports of the parents lend credence to the fact that the play sessions can facilitate these areas of functioning, perhaps working in concert with the other therapies to facilitate the growth of the child.

Finally, the parents appeared to enjoy facilitating the growth of their child. This particular diagnosis is a difficult one to accept by most parents. It also brings about much stress on the parent on just how to encourage the child's

development and growth. This therapy puts the parent in the seat of facilitating their own child's growth. It gives the parent something to do that is beneficial. Parents in this study were able to see their child's play expand and become more creative. They were able to see the child grow in relational expressiveness with the parent. This may not remove all the stressors that parents might have in taking care of a child with PDD, but it can help.

### Recommendations

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

1. Conduct a filial therapy group with parents of PDD children that would last longer than ten weeks, perhaps meeting every other week for a total of 15 play sessions to assess if there might be further growth in the areas that did not show statistical significance.
2. Conduct a filial therapy group with parents of children with PDD that would last 10 weeks with the parents conducting two (or more) play sessions per week, and assess for growth.
3. Further research in which filial therapy training groups begin the 10 weeks of training during the first month of the school year and offer follow-up/support meetings conducted every month thereafter until the end of the school year.
4. Further research in which teachers are trained in filial therapy principles concurrently with parents receiving filial therapy training.
5. Conduct a replication of this study using both the CBCL and the Filial Problems Checklist, and an assessment used for assessing the PDD symptomology as well.

6. Conduct a filial therapy study that would also assess changes in play, particularly studying what types of changes might occur. Some studies demonstrate that play in its varying expressiveness and symbolic richness can grow, and this would be an area of study to further research.
7. Conduct a filial therapy study that would also examine the role of language to determine if language development is indeed enhanced.
8. Assess the effects of individualized filial therapy training with parents of PDD children.
9. Investigate the effect of filial therapy training on the very young child diagnosed with PDD, in the age range of 2 to 3. The very young child with PDD has unique growth and developmental issues that might not be the same as the child of age 8. Thus, these issues might succinctly and appropriately be dealt with in a group made up of this age population only.

**APPENDIX A**  
**INFORMED CONSENT**



### Informed Consent

You are invited to participate in a study to determine the effectiveness of Filial Therapy training with parents of children with a pervasive developmental disorder. Filial Therapy is a family skills training program that focuses on enhancing the parent-child relationship. The training will consist of ten weekly sessions, lasting two hours per week. During the sessions, the group leader 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. You will be asked to share some insights, feelings, questions, and comments with the other group members during the sessions. You will also be asked to participate in 10 weekly 30-minute play sessions at home with your child practicing the techniques being taught in the training sessions. You will be asked to work with your child with pervasive developmental disorder (she or he should be between the ages of 2 and 10 years of age), during those special play sessions, during the course of this training.

The benefits of this training can be 1) a better relationship with your child, 2) a greater understanding of your child, 3) a better sense of your abilities as a parent, and 4) an improvement in your child's self-esteem, behavior, and emotional expression.

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 emotion. In fact, the training should help you deal with these situations more effectively. Your participation and your child's participation is completely voluntary. You may withdraw at any time without penalty or prejudice.

You will be asked to complete four questionnaires before, and three after the training. The information you provide when you answer the questionnaires will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of this material. Information obtained from the

questionnaires will be recorded with a code number. Only the investigator, Dean Beckloff, will have a list of participants' names. At the end of this study, the list of participants names will be destroyed.

If you are not selected to receive the training during this first training period, your name will be placed on a waiting list and you will be contacted regarding a second section of training which will be offered after the completion of the first 10-week section.

If you agree to participate, please sign this consent form. You are making a decision whether or not to participate in this study. You should sign only when you understand all the information presented on the front of this form and all your questions about the research have been answered to your satisfaction. For further information please contact Dean Beckloff at 972-238-5978 (work). Your signature indicates that you meet all the requirements for participation as explained by Dean Beckloff and have decided to participate, having read the information on this form.

\_\_\_\_\_  
Signature of Participant                      Age

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Child                                      Age

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

"This project has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (817) 565-3940."

**APPENDIX B**  
**FILIAL THERAPY SESSIONS**

FILIAL SESSION #1  
(Garry L. Landreth, 1983)

- 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 since 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. Group Introductions:
  - Describe entire family - help pick child of focus.
  - Tell concerns about this child (take notes).
  - Make generalizing comments to other parents..
  - "Anyone else felt angry with their child this week?"
- IV. Provide Basic Agenda:
  - One-half hour play sessions.
  - Everyone will be video-taped here at least once for replay.
  - (Bring your own tape to keep.)
  - We will see demonstrations before starting.
  - Patience is important in learning a new language.
- V. Show video tape of "Children's Emotions."
- VI. Reflective listening: A 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 positive.**

**RULE OF THUMB:** You can't give away what you do not possess.  
As significant caregivers 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 a child.

Homework:

- (1) Notice some physical characteristic about your child you haven't seen before.
- (2) Practice reflective listening this week (hand out 4 faces sheet).

THE FOUR BASIC FEELINGS  
(Garry L. Landreth, 1983)

1 _____	2 _____
3 _____ Reflective responses this week.	4 _____

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

FILIAL SESSION #2  
(Garry L. Landreth, 1983)

- I. Review homework:
  - (1) Physical Characteristic
  - (2) 4 Faces Sheet
  
- II. Handout: "Filial Therapy Group"
  - Go over entire sheet, especially list of toys.  
(Demonstration Box.)
  - The "how to" of play sessions.
  
- III. Show video tape of session or do live demonstration.
  
- IV. Have participants pair off and role play to practice reflective responding.

**RULE OF THUMB:** When a child is drowning, don't try to teach the child 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 -- report back next week.

**FILIAL THERAPY GROUP**  
(Garry L. Landreth, 1983)

Session #2 Handout A

Basic Principles of the Play Sessions

- (1) The child should be completely free to determine how the child will use the time. The child leads and the parent follows without making suggestions or asking questions.
- (2) The adult's major task is to empathize with the child, to understand the intent of the child's actions, and the child's 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 set are on time, not breaking specified toys, and not physically hurting the adult.

Goals of the Play Sessions

- (1) To help the child change perceptions of the adult's feelings, attitudes, and behavior.
- (2) To allow the child - through the medium of play - to communicate thought, needs, and feelings to the adult.
- (3) To help the child develop more positive feelings of self-respect, self-worth, confidence.

REMINDER

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

Toys for the Play Sessions

Creative: Play Doh, crayons (8 colors), paper, blunt scissors,  
 Nurturing: nursing bottle (plastic), doll, small blanket, tea set for two, doctor kit,  
 Aggressive: rubber knife, dart gun, toy soldiers (10-15), punching bag, 5' rope, toy snake  
 Dramatic: family of small dolls, doll house furniture, Lone Ranger type mask, hand puppet, plastic animals (2 domestic, 2 wild)  
 Other: small plastic car, Tinkertoys, ball (soft sponge type), bowling pins & ball

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 the child in a different, "special" way than you usually do.

Process

Let the child use the bathroom prior to the play sessions. 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 would like." Let the child lead from this point. Play actively with the child if the child requests your participation. Set limits only behaviors that make you feel uncomfortable. Track the child's behavior and feelings verbally. Do not identify toys by their normal names; call them "it", "that", etc. Give the child a five minute advance notice before terminating the session. Do not exceed the time limit by more than two or three minutes.

Session #2 Handout B

**FACILITATING REFLECTIVE COMMUNICATION**  
(Garry L. Landreth, 1983)

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!"  
Adult: \_\_\_\_\_  
\_\_\_\_\_
2. Jill: (Enters with C- test paper in hand) "I tried so hard, but it didn't do any good."  
Adult: \_\_\_\_\_  
\_\_\_\_\_
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)  
Adult: \_\_\_\_\_  
\_\_\_\_\_
4. John: (Undressing Barbie doll) "Wow!" Look at her butt!"  
Adult: \_\_\_\_\_  
\_\_\_\_\_
5. Carol: (Looking through the doorway to a dark room) "What's in there? Will you come with me?"  
Adult: \_\_\_\_\_  
\_\_\_\_\_
6. Charlie: (Showing you his torn, smudged painting from school) "Look! Isn't it neat! My teacher said I was a good artist!"  
Adult: \_\_\_\_\_  
\_\_\_\_\_



FILIAL SESSION #3  
(Garry L. Landreth, 1983)

I. Review homework:

(1) "Facilitating Reflective Communication" Handout

(2) Time and Place for Play Sessions

NAME	TIME	PLACE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(3) Toys

II. Handout in Class: "Basic Rules for Filial Therapy".  
Use to review rules for play sessions.

Basic Limits: Child's name

Reflect feeling ... "I know you'd like to shoot the gun at me . . .

Set limit .... but, I'm not for shooting.

Alternative...You can choose to shoot at that (point at something acceptable)."

III. Demonstration

IV. Arrange for a parent to do video-taping during the week.

First Volunteer: \_\_\_\_\_

**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.

Homework:

(1) Begin play sessions at home this week.

BASIC RULES FOR FILIAL THERAPY  
(Garry L. Landreth, 1983)

Session #3 Handout A

Don't

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 (These first 7 are taken from Guernsey, 1972)
8. Don't be passive, quiet.

Do

1. Do set the stage.
2. Do let the child lead.
3. Do track behavior.
4. Do reflect the child's feelings.
5. Do set limits.
6. Do salute the child's power and effort.
7. Do join in the play as a follower.
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 w/you."

[Guernsey, L. F. (1972). Play therapy: A training manual for parents. Mimeographed Report.]

## Session #3 Handout B

THE EIGHT BASIC PRINCIPLES  
(of Non-Directive Play Therapy)  
(Virginia M. Axline, 1969)

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 the child is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to the child in such a manner that the child gains insight into behavior.
5. The therapist maintains a deep respect for the child's ability to solve 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 the child's responsibility in the relationship.

[Axline, V. M. (1969). Play Therapy. New York: Ballantine Books. (pp. 72-73)]

FILIAL SESSION #4  
(Garry L. Landreth, 1983)

- I. Debriefing. How did the play sessions go?  
(Be aware of the 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.  
Second Volunteer: \_\_\_\_\_
- V. Show video tape from first volunteer.

**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 event in our child's life.

Homework:

- (1) Notice one intense feeling in yourself this week.

## TWO TECHNIQUES OF DISCIPLINE THAT WORK

(Garry L. Landreth, 1983)

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 \_\_\_\_\_", or ". . . but the cabinet door is not for kicking.", or ". . . but the answer is no."
    - (3) Provide an alternative -- "You can \_\_\_\_\_ if you'd like.", or "You can choose to \_\_\_\_\_."
  - 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 the child 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), that's enough."
    - (3) If you think the child 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  
(Garry L. Landreth, 1983)

- I. Debriefing, combined with report on one intense feeling they had. Focus on importance of awareness of themselves in the play sessions.
- II. Handout: "When Setting Limits Doesn't Work"
- III. Arrange next taping session.  
Taping Session: \_\_\_\_\_
- IV. Review video of play 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.

Homework:

- (1) Sandwich hugs - explain.
- (2) Continue play sessions.
- (3) Practice giving one choice.

FILIAL SESSION #6  
(Garry L. Landreth, 1983)

- I. Debriefing on play sessions and giving one choice.
- II. Handout: "Common Problems in Filial Therapy"
- III. Arrange next taping session.

Taping Session: \_\_\_\_\_

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

It's okay for the "baby brother" 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 \_\_\_\_\_.  
That is such an important quality, we're going to put this note up."

- (2) Continue play sessions -- notice patterns of play that are showing up.

COMMON PROBLEMS IN FILIAL THERAPY  
(Garry L. Landreth, 1983)

Session #6 Handout

1. Q: My child notices that I talk differently in the play sessions, and wants me to talk "normally". 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: I'm bored. What's the value of this?  
A: \_\_\_\_\_  
\_\_\_\_\_
4. Q: My child doesn't respond to my comments. How do I know I'm on target?  
A: \_\_\_\_\_  
\_\_\_\_\_
5. Q: When is it okay for me to ask questions, and when is it not okay?  
A: \_\_\_\_\_  
\_\_\_\_\_
6. Q: My child hates the play sessions. Should I discontinue them?  
A: \_\_\_\_\_  
\_\_\_\_\_
7. Q: My child wants the play time to be longer. Should I extend the session?  
A: \_\_\_\_\_  
\_\_\_\_\_



FILIAL SESSION #7  
(Garry L. Landreth, 1983)

- I. Debriefing on play sessions with focus on patterns.
- II. Review reflective listening, setting limits, giving choices, etc.
- III. Show video tape of session.
- IV. Arrange next taping session.

Taping Session: \_\_\_\_\_

**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.

FILIAL SESSION #8  
(Garry L. Landreth, 1983)

- I. Debriefing on play sessions and number of times they physically touched their child.
- II. Show video tape of session.
- III. Arrange next taping session.

Taping Session: \_\_\_\_\_

**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  
(Garry L. Landreth, 1983)

- I. Debriefing on play sessions. Give time for questions on various topics.
- II. Show video tape of session.
- III. Arrange last taping session.  
Taping Session: \_\_\_\_\_
- IV. Mention filial follow-up meetings.

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

Homework:

- (1) Continue play sessions.

FILIAL SESSION #10  
(Garry L. Landreth, 1983)

- I. Briefly debrief.
- II. Show last video taped session.
- III. Handout: "Rules of Thumb and Other Things to Remember"
- IV. Closing Procedures:  
Focus on looking at differences in child and adult – then and now.  
Encourage feedback within group on positive changes made.  
(Praise them, they may be scared about leaving the safety of the group!)
- V. Emphasize continued meetings.
- VI. 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."

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

Recommended Reading:

1. How to Really Love Your Child, Campbell.
2. Between Parent and Child, Ginott.
3. Liberated Parents, Liberated Children, Faber & Mazlish.
4. How to Talk So Kids Will Listen, & Listen So Kids Will Talk, Faber & Mazlish.

APPENDIX C  
SAMPLE FLIER

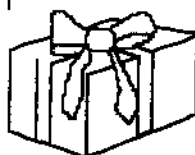
### An Invitation



**Let's  
Play!**

You are invited to participate in a study to determine the effectiveness of a form of therapy that uses **parents and play** (called Filial Therapy), with parents of children with a *Pervasive Developmental Disorder (PDD)*. Filial Therapy is a family skills training program that focuses on enhancing the parent-child relationship.

### The Benefits!



The benefits of this training can be 1) a better relationship with your child, 2) a greater understanding of your child, 3) a better sense of your abilities as a parent, and 4) an improvement in your child's self-esteem, behavior, emotional expression, and relationship skills. During the sessions, the group leader 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 - promote his or her growth and development - as well as strengthen your relationship with your child.

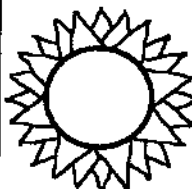
### The Requirements



First, you must have a child diagnosed with a PDD, of average (or above) intellectual ranges. Although the participants of this study will not be assessed a fee, your time and effort will be

needed. The training will consist of seven weekly sessions, lasting two hours per week, and then meet every other week for three more sessions. You will also be asked to participate in 12, once a week, 30-minute play sessions at home with your child practicing the techniques being taught in the training sessions. You will be asked to complete four questionnaires before and after the training.

### Confidentiality



Your participation and your child's participation is completely voluntary. The information you provide when you answer the questionnaires will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of this material.

### How To Enroll!



For further information please contact Dean Beckloff, M.Ed., Licensed Professional Counselor, at 972-238-5978. If unavailable, please leave a message and you will be contacted very shortly.

"This project has been reviewed and approved by the UNT (University of North Texas) Committee for the Protection of Human Subjects (817) 565-3940."

APPENDIX D  
DEMOGRAPHIC DATA SHEET





Date of Birth \_\_\_\_\_ Last year of education completed: \_\_\_\_\_  
 Occupation \_\_\_\_\_

**\* GENERAL INFORMATION \***

Child's Primary Household: Mother only \_\_\_ Father only \_\_\_ Natural parents \_\_\_ Natural mother and step-father \_\_\_ Natural father and step-mother \_\_\_ Blended family (both spouses with children) \_\_\_ Adoptive parents \_\_\_ Relatives \_\_\_ Foster family \_\_\_ Institution \_\_\_ Other \_\_\_\_\_

List by Household your child's current family, beginning with the oldest member and include the child:

**Primary Household**

Name	Age	Gender	Relationship to the child (include "step", "half", etc.)

**Second Household (If applicable)**

Name	Age	Gender	Relationship to the child (include "step", "half", etc.)

Currently involved in a custody dispute: no \_\_\_ yes \_\_\_ (If yes, explain) \_\_\_\_\_

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile		Frustrating		Friendly
1	2	3	4	5

\*\*\*\*\* CHILD'S HEALTH \*\*\*\*\*

Date of LAST complete physical: \_\_\_\_\_ Physical Disability: yes\_\_ no\_\_ (if yes, explain \_\_\_\_\_)  
 Chronic Illness: yes\_\_ no\_\_ (if yes, explain \_\_\_\_\_)

Check the following items for a diagnosis or medication your child has received:

Diagnosis	Current	Past	Date of Diagnosis	Name of medication	dosage
Depression	_____	_____	_____	_____	_____
ADHD Hyperactive	_____	_____	_____	_____	_____
ADHD Inattentive	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Bedwetting	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

If your child has been diagnosed, who gave the diagnosis? Pediatrician\_\_ Psychiatrist\_\_ School\_\_  
 Other \_\_\_\_\_

What other medication is your child currently taking? \_\_\_\_\_ Dosage \_\_\_\_\_

\* CHILD'S EXPERIENCES/HISTORY \*

*Family Problem History (Please check up to 10 items that currently apply your child. Circle the item that you see as the most significant issue in your child's life.)*

- Adjustment to life changes (changing schools, parent's divorcing, moving, etc.)
- Bed wetting and related problems/soiling
- Abuse (physical, emotional, sexual)
- Child's disruptive behavior (aggression, acting out, attention deficit, hyperactivity, annoying, repetitious, etc.)
- Child's inappropriate behavior
- Disturbing memories (past abuse, neglect or other traumatic experience)
- Drug or alcohol use (both legal and illegal drugs)
- Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
- Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
- Feeling angry or irritable
- Feeling guilty or shameful
- Feeling sadness depression or suicidal urges related to grief
- Feeling sadness, depression or suicidal urges NOT related to grief
- Gang related concerns (explain \_\_\_\_\_)
- Health concerns (physical complaints and/or medical problems)
- Illegal behaviors (runaway, stealing, repeated run-ins with the law, etc.)
- Learning/Academic difficulties
- Personal Growth (no specific problem)
- Parent-Child relationship (discipline, adoption, single parent, etc.)
- Family or Step-family relationship (not parent-child or partner)
- Non-family relationship (roommates, classmates, teachers, playmates, etc.)
- Sexual concerns (excessive masturbation, inappropriate acting out, inappropriate display of sexual knowledge)
- Sexual identity concern
- Sleep problem (nightmares, night-terror, sleeping too much or too little, etc.)
- Speech problem (not talking, stuttering, etc.)
- Unusual experiences (loss of periods of time, sensing unreal things, etc.)
- Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
- Vocational concerns
- Other (explain \_\_\_\_\_)

\*Remember to circle the most significant issue.

When did you first become concerned about your child and this issue? \_\_\_\_\_

How have you attempted before now to deal with your child's current issue? \_\_\_\_\_

Other Treatment your child has received: None \_\_\_ Individual counseling \_\_\_ Family counseling \_\_\_  
Hospitalization \_\_\_ Play Therapy \_\_\_ Other (explain) \_\_\_\_\_

Anything else you think we need to know: \_\_\_\_\_

What does the counselor most need to know in order to be helpful today? \_\_\_\_\_

Raised by (For each of the following items that apply, write in your child's approximate age at the time it occurred):  
Natural parents \_\_\_ Single natural parent \_\_\_ Grandparents \_\_\_ Adoptive parent(s) \_\_\_ Natural and  
step-parent \_\_\_ Foster parents \_\_\_ Institution \_\_\_ Relatives \_\_\_ Other \_\_\_\_\_

Stressors in the Family: Parents fighting frequently \_\_\_ Parents divorced \_\_\_ Financial problems \_\_\_  
Family member's disability or major accident or illness \_\_\_ Chronic illness of family member \_\_\_  
Moved a lot \_\_\_ Family member absent (explain) \_\_\_\_\_) Death of significant person \_\_\_  
Family member suicide (explain) \_\_\_\_\_ Other (explain) \_\_\_\_\_

Abused (check all that apply): Physically \_\_\_ Emotionally \_\_\_ Sexually \_\_\_

*Neglected* (check all that apply): Physically\_\_\_ Emotionally\_\_\_

*School Problems* (check all that apply): Academic problems\_\_\_ Severely teased\_\_\_ Discipline problems\_\_\_ Unpopular\_\_\_ Other (explain)\_\_\_\_\_

*Early Language/Speech Problems:* (explain)\_\_\_\_\_

*Emotional Concerns:* Emotional problems\_\_\_ Suicide attempts\_\_\_ Other (explain \_\_\_\_\_)

*Behavior Problems* (check all that apply): Misbehaved a lot\_\_\_ Trouble with the law\_\_\_ Involved with the juvenile system\_\_\_ Ran away\_\_\_ Impulsive\_\_\_ Alcohol and/or drug use\_\_\_ Hyperactive\_\_\_ Attention problems\_\_\_ Accident-prone\_\_\_ Frequent arguments\_\_\_ Taken advantage of\_\_\_ Temper outbursts\_\_\_ Slapping, hitting, shoving\_\_\_ Loner\_\_\_ Other\_\_\_\_\_

*Physical Problems* (check all that apply): Major illness\_\_\_ Major accident\_\_\_ Disability\_\_\_ Chronic illness\_\_\_ Hospitalization\_\_\_ Developmental delay(s)\_\_\_ Sleep problem\_\_\_ Bedwetting\_\_\_ Serious overeating or undereating\_\_\_ Neurological problems/exam\_\_\_ Other\_\_\_\_\_

*Trauma/Stressor on Child* (check all that apply): Child separated from parent (how long and when)\_\_\_\_\_ Death of a significant person\_\_\_ Death of a pet\_\_\_ Incarcerated family member\_\_\_ Sexual Assault\_\_\_ Victim of trauma (unusual, terrifying experience)\_\_\_ Medical\_\_\_ Natural Disaster\_\_\_ Other\_\_\_\_\_

**\*Please review all of your answers and circle, up to 10, indicating the most influential items.**

*Family Atmosphere* (circle the number that best describes how you think your child views the atmosphere in your home):

Very lenient 1 2 3 4 5 Very strict

Very non-religious 1 2 3 4 5 Very religious

Chaotic 1 2 3 4 5 Highly structured

Few expectations 1 2 3 4 5 High expectations

Inconsistent 1 2 3 4 5 Consistent

*Family Support System* (such as church, friends, relatives, school):

Hardly any support 1 2 3 4 5 Considerable support

*Child's use of Computer, VCR, and Television* (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 14+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 14+

**APPENDIX E**  
**ASSESSMENTS**

## PORTER PARENTAL ACCEPTANCE SCALE

We are seeking information about parent-child relationships. You can help us by filling out the following questionnaire frankly and carefully. Sincere and honest answers are requested so that valid data may be obtained.

The questionnaire does not call for any mark of identification. Your answers along with all others will be absolutely anonymous. Furthermore, all of the responses will be treated confidentially and will be used only for purposes of scientific research.

It is essential that all questions be answered. If you do not find an exact answer to a question, choose the answer that most closely describes your feelings or actions.

### GENERAL INFORMATION

1. Sex: Male \_\_\_ Female \_\_\_      2. Year of birth \_\_\_\_\_      3. Year of marriage \_\_\_\_\_
4. Living with spouse at present time.      Yes \_\_\_ No \_\_\_
5. Married more than once. Yes \_\_\_ No \_\_\_
6. If married more than once, was previous marriage ended because of:  
death \_\_\_ divorce \_\_\_ other \_\_\_ (Please state) \_\_\_\_\_
7. Draw a circle around the number of years of schooling you have completed.
 

1 2 3 4 5 6 7 8	1 2 3 4	1 2 3 4	1 2 3 4
Grade School	High School	College	Post Graduate
8. Religious Affiliation:  
 \_\_\_ Protestant      \_\_\_ Jewish      \_\_\_ None  
 \_\_\_ Catholic      \_\_\_ Other \_\_\_\_\_
9. Was your childhood and adolescence, for the most part, spent in:
 

___ open country or village under 1,000 ___ a town of 1,000 to 4,999 ___ a city of 5,000 to 9,999 ___ a city of 10,000 to 49,999 ___ a city of 50,000 to 99,999 ___ a city of 100,000 to 249,999 ___ a city of 250,000 or over	___ under \$15,000 ___ \$15,000 to \$24,999 ___ \$25,000 to \$34,999 ___ \$35,000 to \$49,999 ___ \$50,000 to \$74,999 ___ \$75,000 to \$99,999 ___ \$100,000 or more
--	---
10. Presently family income (annual)
11. Husband's occupation (Be specific such as computer specialist, CPA, salesperson, teacher, auto mechanic, lawyer, interior designer, etc.) \_\_\_\_\_
12. Wife's occupation (Be specific as illustrated above) \_\_\_\_\_

## 13. Ages of children (to nearest birthday)

Ages of boys \_\_\_\_\_

Ages of girls \_\_\_\_\_

While responding to the following questions please think of only one child. If you have a child in the age range of six to ten years, choose that one. If you have more than one child in that age range, choose the one nearest to ten. If your children are all younger than six years, choose the one nearest six. Place a circle around the age (in question 13 above) of the one which you will be thinking of while answering the following questions about your child. **BE SURE AND REFER ONLY TO THIS CHILD WHILE ANSWERING THE QUESTIONS.**

14. Is this child your: (circle one)      Biological child      Step child      Adopted child

### INFORMATION ABOUT YOUR CHILD

Many parents say that their feeling of affection for their child varies with his/her behavior and with circumstances. Please read each item carefully and place a check in the column which most nearly describes the degree of feeling of affection which you have for your child in that situation.

Check One Column For Each Item Below	Degree of Feeling of Affection				
	Much more than usual	A little more than usual	The same	A little less than usual	Much less than usual
1. When my child is obedient					
2. When my child is with me					
3. When my child misbehaves in front of special guests					
4. When my child expresses unsolicited affection. For example, "You're the nicest mommy (daddy) in the whole world."					
5. When my child is away from me					
6. When my child shows off in public					
7. When my child behaves according to my highest expectations					
8. When my child expresses angry and hateful things to me					
9. When my child does things I have hoped he/she would not do					
10. When we are doing things together.					

Listed below are several statements describing things which children do and say. Following each statement are five responses which suggest ways of feeling or courses of action.

Read each statement carefully and then place a circle around the letter in front of the one response which most nearly describes the feeling you usually have or the course of action you most generally take when your child says or does these things.

It is possible that you may find a few statements which describe a type of behavior which you have not yet experienced with your child. In such cases, mark the response which most nearly describes how you think you would feel or what you think you would do.

Be sure that you answer every statement and mark only one response for each statement.

\*\*\*\*\*

11. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
- feel annoyed.
  - want to know more about what excites my child.
  - feel like punishing my child.
  - feel that I will be glad when my child is past this stage.
  - feel like telling my child to stop.
12. When my child misbehaves while others in the group are behaving well, I:
- see to it that my child behaves as the others.
  - tell my child it is important to behave well when in a group.
  - let my child alone if the others are not disturbed by the behavior.
  - ask my child to suggest an alternate behavior.
  - help my child find an alternate behavior to enjoy while not disturbing the group.
13. When my child is unable to do something which I think is important for him/her, I:
- want to help my child find success in other things.
  - feel disappointed in my child.
  - wish my child could do it.
  - realize that my child can not do everything.
  - want to know more about the things my child can do.
14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
- realize that my child is growing up.
  - feel pleased to see my child's interests widening to other people.
  - feel resentful.
  - feel that my child doesn't appreciate what I have done for him/her.
  - wish that my child liked me more.



15. When my child is faced with two or more choices and has to choose only one, I:
- tell my child which choice to make and why.
  - think it through with my child.
  - point out the advantages and disadvantages of each, but let my child decide.
  - tell my child that I am sure he/she can make a wise choice, and help my child foresee the consequences.
  - make the decision for my child.
16. When my child makes decisions without consulting me, I:
- punish my child for not consulting me.
  - encourage my child to make many of his/her own decisions.
  - allow my child to make many of his/her own decisions.
  - suggest that we talk it over before he/she makes the decision.
  - tell my child that I must be consulted before any decisions are made.
17. When my child kicks, hits or knocks his/her things about, I:
- feel like telling my child to stop.
  - feel like punishing him/her.
  - am pleased that my child feels free to express himself/herself.
  - feel that I will be glad when my child is past this stage.
  - feel annoyed.
18. When my child is not interested in some of the usual activities of his/her age group, I:
- realize that each child is different.
  - wish that my child were interested in the same activities.
  - feel disappointed in my child.
  - want to help my child find ways to make the most of his/her interests.
  - want to know more about the activities in which my child is interested.
19. When my child acts silly and giggly, I:
- tell my child I know how he/she feels.
  - pay no attention to him/her.
  - tell my child that he/she shouldn't act that way.
  - make my child quit.
  - tell my child it is all right to feel that way, but help him/her find other ways of expressing himself/herself.
20. When my child prefers to do things with his/her friends rather than with the family, I:
- encourage my child to do things with his/her friends.
  - accept this as part of his/her growing up.
  - plan special activities so that my child will want to be with the family.
  - try to minimize his/her association with friends.
  - make my child stay with the family.

21. When my child disagrees with me about something which I think is important, I:
- feel like punishing him/her.
  - am pleased that my child feels free to express his/her thoughts and feelings.
  - feel like persuading my child that my way is best.
  - realize that my child has his/her own ideas.
  - feel annoyed.
22. When my child misbehaves while others in his/her group are behaving well, I:
- realize that my child does not always behave as others in his/her group.
  - feel embarrassed.
  - want to help my child find the best ways to express his/her feelings.
  - wish my child would behave like the others.
  - want to know more about his/her feelings.
23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
- give my child something quiet to do.
  - tell my child that I wish he/she would stop.
  - make my child be quiet.
  - let my child tell me about what is so exciting.
  - send my child somewhere else.
24. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
- try to minimize my child's association with that person.
  - let my child have such associations when I think he/she is ready for them.
  - do some special things for my child to remind him/her of how nice I am.
  - point out the weaknesses and faults of the other person(s).
  - encourage my child to create and maintain such associations.
25. When my child says angry and hateful things about me to my face, I:
- feel annoyed.
  - feel that I will be glad when my child is past this stage.
  - am pleased that my child feels free to express himself/herself.
  - feel like punishing my child.
  - feel like telling my child not to talk that way to me.
26. When my child shows a deep interest in something I don't think is important, I:
- realize that my child has interests of his/her own.
  - want to help my child find ways to make the most of this interest.
  - feel disappointed in my child.
  - want to know more about my child's interests.
  - wish my child were more interested in the things I think are important for him/her.

27. When my child is unable to do some things as well as others in his/her group, I:
- tell my child that he/she must try to do as well as the others.
  - encourage him/her to keep trying.
  - tell my child that no one can do everything well.
  - call attention to the things he/she does well.
  - help my child make the most of the activities which he/she can do well.
28. When my child wants to do something which I am sure will lead to disappointment for him/her, I:
- occasionally let my child carry such an activity to its conclusion.
  - don't let my child do it.
  - advise my child not to do it.
  - help my child with it in order to ease the disappointment.
  - point out what is likely to happen.
29. When my child acts silly and giggly, I:
- feel that I will be glad when he/she is past this stage.
  - am pleased that my child feels free to express himself/herself.
  - feel like punishing my child.
  - feel like telling him/her to stop.
  - feel annoyed.
30. When my child is faced with two or more choices and has to choose only one, I:
- feel that I should tell my child which choice to make and why.
  - feel that I should point out the advantages and disadvantages of each.
  - hope that I have prepared him/her to choose wisely.
  - want to encourage my child to make his/her own choices.
  - want to make the decision for my child.
31. When my child is unable to do something which I think is important for him/her, I:
- tell my child that he/she must do better.
  - help my child make the most of the things which he/she can do.
  - ask my child to tell me more about the things which he/she can do.
  - tell my child that no one can do everything.
  - encourage him/her to keep trying.
32. When my child disagrees with me about something which I think is important, I:
- tell my child he/she should not disagree with me.
  - make my child quit.
  - listen to my child's side of the issue and change my mind if that seems reasonable.
  - tell my child that maybe we can do it his/her way another time.
  - explain that I am doing what is best for him/her.

33. When my child is unable to do some things as well as others in his/her group, I:
- realize that my child can't do as well as others in everything.
  - wish that my child could do as well.
  - feel embarrassed.
  - want to help my child find success in the things he/she can do well.
  - want to know more about the things my child can do well.
34. When my child makes decisions without consulting me, I:
- hope that I have prepared my child adequately to make his/her decisions.
  - wish that my child would consult me.
  - feel disturbed.
  - want to restrict his/her freedom.
  - am pleased to see that as my child grows, I am needed less.
35. When my child says angry and hateful things about me to my face, I:
- tell my child that it is all right to feel that way, but help him/her find other ways to express himself/herself.
  - tell my child that I know how he/she feels.
  - pay no attention to him/her.
  - tell my child he/she shouldn't say such things to me.
  - make my child quit.
36. When my child kicks, hits and knocks his/her things about, I:
- make my child quit.
  - tell my child that it is all right to feel that way, but help him/her find others ways of expressing himself/herself.
  - tell my child he/she shouldn't do such things.
  - tell my child that I know how he/she feels.
  - pay no attention to him/her.
37. When my child prefers to do things with friends rather than with the family, I:
- wish my child would spend more time with us.
  - feel resentful.
  - am pleased to see my child's interests widening to other people.
  - feel my child doesn't appreciate us.
  - realize that he/she is growing up.
38. When my child wants to do something which I am sure will lead to disappointment, I:
- hope that I have prepared him/her to meet disappointment.
  - wish that my child did not have to experience unpleasant events.
  - want to keep my child from doing it.
  - realize that occasionally such an experience will be good for him/her.
  - want to postpone these experiences.

39. When my child is not interested in some of the usual activities of his/her age group, I:
- a. help my child realize that it's important to be interested in the same things as others in the group.
  - b. call attention to the activities in which he/she is interested.
  - c. tell my child that it is all right not to be interested in the same things as others in his/her group.
  - d. see to it that my child does the same things as others in his/her group.
  - e. help my child find ways of making the most of his/her interests.
40. When my child shows a deep interest in something I don't think is important, I:
- a. let my child go ahead with this interest.
  - b. ask my child to tell me more about this interest.
  - c. help my child find ways to make the most of this interest.
  - d. do everything I can to discourage my child's interest in it.
  - e. try to interest him/her in more worthwhile things.

**THANK YOU VERY MUCH FOR YOUR COOPERATION**

**APPENDIX F**

**LETTERS**



## University of North Texas

Sponsored Projects Administration  
November 5, 1996

Mr. Dean Beckloff  
635 Wentworth Dr.  
Richardson, TX 75081

Re Human Subjects Application No. 96-226

Dear Mr. Beckloff:

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 "Filial Therapy with Children With Spectrum Pervasive Developmental Disorders." 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.

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,

A handwritten signature in cursive script, appearing to read "Mark Elder".

Mark Elder  
Chairman  
Institutional Review Board

ME:em

cc IRB Members

BLAINE R. PORTER  
1675 PINE LANE  
PROVO, UTAH 84604-2163

January 22, 1997

Dean Beckloss  
635 Wentworth Drive  
Richardson, TX 75081

Dear Mr. Beckloss:

Thank you for your telephone call today. I am sorry if you have had difficulty reaching me. I am retired now. Until 3 months ago I still had an office on campus, but they are now remodeling and expanding that building, so temporarily I am without an office and telephone on campus. I do still have a mail box there.

I am pleased to learn of your interest in using my Parental Acceptance Scale. I hereby grant you permission to use it. For your convenience, I am enclosing a copy of the latest revision of the Scale, Instructions for Administering it and a Scoring Key.

If it proves to be of use to you in your research, I will appreciate your sending me a copy of the results of your study or at least a summary.

Best wishes to you in your research project.

Sincerely,



Blaine R. Porter

BRP\ms

Enclosures

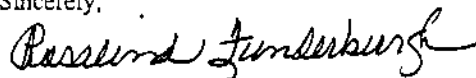


February 30, 1997

To Whom It May Concern:

With regard to the study that Dean Beckloff is conducting, it is with pleasure that I give my permission to solicit our parents who have a child with PDD, to participate in the filial therapy training. He may use brochures, fliers, or any such materials to solicit our parent population. I also give Dean Beckloff permission to use the site facilities to meet for the training in filial therapy.

Sincerely,



Rosalind Funderburgh

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