FILIAL THERAPY WITH SINGLE PARENTS

DISSERTATION

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

For the degree of

DOCTOR OF PHILOSOPHY

BY

Sue Carlton Bratton, B.S., M.Ed.
Denton, Texas
August, 1993
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This study was designed to determine the effectiveness of filial therapy as a method of intervention for single parents and their children. Filial therapy is an intervention that focuses on strengthening and enhancing the parent-child relationship. Parents are trained to become a constructive force for change in their children's behaviors and attitudes by utilizing basic child-centered play therapy skills in weekly play sessions with their children. The purpose of this study was (a) to determine the effectiveness of filial therapy in increasing single parents' empathic behavior with their children; (b) to determine the effectiveness of filial therapy in increasing single parents' attitude of acceptance toward their children; and (c) to determine the effectiveness of filial therapy in reducing single parents' stress related to parenting.

The experimental group parents, consisting of 22 volunteer single 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 21 volunteer single 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 Filial Problems Checklist. The parents were also videotaped playing with their child before and after the training as a means of measuring empathic behavior in parent-child interactions.

Analyses of Covariance revealed that the single parents in the experimental group (a) significantly increased their level of empathy in their interactions with 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.

This study supports filial therapy as an effective intervention for strengthening and enhancing the parent-child relationship in single parent families. Filial therapy training offers significant possibilities for promoting the well-being of single parents and their children by equipping parents with healthy parenting skills, while providing them with the emotional support they need.
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CHAPTER I

INTRODUCTION

In the last three decades family life in the United States has changed dramatically. The divorce rate has escalated and the number of families with two working parents has increased, resulting in significant changes in the structure of families (Hamner & Turner, 1990).

These factors have been associated with increasing levels of stress in family members, as they adapt to changing roles (Arendell, 1986; Demo & Acock, 1988; Hamner & Turner, 1990; Hodges, Tierkey, & Buchsbaum, 1984; Wattenburg & Reinhart, 1979; Woody, Colley, Schlegelmilch, Maginn, & Balsanek, 1984). High levels of stress in parents can impact their ability to make positive contributions to their children's development. These changes in family life and the resulting effects may, in part, explain the growing demand over the last three decades for mental health services, particularly for children and families.

The critical need for mental health services for children and families and a lack of sufficient numbers of professionals to perform these services has been amply documented (Albee, 1969; Albee & Joffe, 1977; Donovan & McIntyre, 1990; Felner & Abner, 1983; Ginsberg, Weisberg, &
Cowen, 1985; Hankerson, 1983; Kazdan, 1993; Matarazzo, 1971; Miller, 1969; Parder, 1983; U.S. Congress, 1986, 1991). This problem is compounded by the limited number of professionals willing to provide services for families in the lower income brackets.

The results of the 1983 American Psychological Association (APA) Human Resources Survey indicated the existence of a shortage of professionals, particularly in disciplines related to children (VandenBos & Stapp, 1983). Indeed, recent epidemiological studies indicated that from 17% to 22% of youth under 18 years of age suffer developmental, emotional, or behavioral problems and that the vast majority do not receive the services they need (Costello, 1989; Institute of Medicine, 1989; Zill & Schoenborn, 1990). In the United States alone, this means that from 12 to 14 million of the 63 million children suffer from mental health problems.

Moreover, many of the problems identified in childhood often have life-long consequences (Robins & Rutter, 1990). Thus, the continuity of dysfunction across the lifespan heightens the significance of early intervention, not only to reduce the suffering of children, but also to prevent or attenuate dysfunction in adulthood (Kazdin, 1993). In addressing the importance of positively impacting the mental health of future adults, Landreth (1991) advocated the need for a greater effort to improve the mental health of all
children, not just those experiencing emotional or behavioral problems. Over two decades ago, Hobbs (1964) stressed that the only way to make substantial changes in the mental health of American society is to devote at least 75 percent of mental health resources toward helping children. Thus, providing preventative treatment for children and their families may well be our best hope to impact this country's growing mental health needs (Felner & Abner, 1983; Kazdin, 1993; Maddux, Roberts, & Wright, 1986; Papp, Silverstein, & Carter, 1976).

In response to the increasing demand for mental health services, some professionals have advocated the development of new and innovative treatment methodologies that will allow helping professionals to effectively assist greater numbers of children and their families (Bijou, 1984; Christenson, Miller, & Munoz, 1978; B. Guerney, L. Guerney, & Stollak, 1971-72; L. Guerney, 1983a; L. Guerney & B. Guerney, 1989; Hornsby & Appelbaum, 1978; Knitzer, 1984; Lindsley, 1978; Moustakas, 1975; Ohlson, 1976; Shah, 1969). Included in these proposed treatments are the following interrelated suppositions: (a) primary prevention, focusing on identifying those populations most at risk and providing treatment at an early age; (b) extending psychological services to include educational programs by encouraging mental health professionals to utilize their expertise in teaching and training paraprofessionals; and (c) utilizing
support services provided by significant individuals in a person's life.

Educational training programs based on psychotherapeutic models such as person-centered, behavioral, and Adlerian have been effective in training paraprofessionals to become highly effective agents of change (Campbell & Sutton, 1983; Dangel & Polster, 1984; Esters & Levant, 1983; Eyberg, 1988; Ginott, 1972; Lifur-Bennett, 1982; Nystul, 1987; Overman, 1974; Schultz, Nystul, & Law, 1980; Wahler, Winkel, Peterson, & Morrison, 1965). In some cases parents, teachers, and other paraprofessionals have proven to be as effective as professionals in the treatment of children's emotional and behavioral problems (Bonnard, 1950; Forehand, Wells, & Griest, 1980; B. Guerney, Coufal, & Vogelsong, 1976; L. Guerney, 1978; Hattie, Sharpley, & Rogers, 1984; Hawkins, Peterson, Schweid, & Bijou, 1966; Hornsby & Appelbaum, 1978; Lindsley, 1978; Pisterman, 1989; Straughan, 1974).

In the 1960's Bernard and Louise Guerney began developing treatment methodologies that would allow parents to create a therapeutic family system. Such a system would (a) utilize parents as psychotherapeutic agents to help their children overcome problems that had already developed; (b) help to prevent children's future problems through healthy parent-child interactions; and (c) enhance parents' relationships with their children (Guerney & Guerney, 1989).
Parent training programs that utilize proven counseling methods give parents the opportunity to become effective agents of change. By utilizing the naturally existing emotional bond between the child and parent, all that is required of the professional is teaching parents basic psychotherapeutic techniques (Authier, Gustafson, B. Guerney, & Kasdorf, 1975).

Training parents to be effective therapeutic agents with their own children is in keeping with the counsel of former APA President George Miller (1969):

...the secrets of our trade need not be reserved for highly trained specialists. Psychological facts should be passed out freely to all who need and can use them...our scientific results will have to be instilled in the public consciousness in a practical and usable form so that what we know can be applied by ordinary people. (p. 1070)

Landreth (1991) also addressed the need for mental health professionals to give their skills away: "...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). Thus the possibility of providing effective and efficient psychological services to children through the training of their parents becomes an important area of investigation.
Filial therapy, developed by Bernard Guerney (1964), is one intervention that helps children by teaching their parents psychological principles and training them as therapeutic agents. 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. Through the filial therapy training sessions parents learn to become a constructive force for change in their children's behaviors and attitudes by utilizing basic child-centered play therapy principles in special weekly play sessions with their children (B. Guerney, 1982). 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).

The rationale underlying this approach is that if the parent could be taught to execute the essentials of the role usually taken by the play therapist, the parent could conceivably be more effective. This rationale rests on the assumptions that (a) the parent has more emotional significance to the child than does the therapist; (b) any anxieties learned or influenced by parental attitudes could
be more effectively extinguished under similar conditions; and (c) interpersonal misperceptions could be corrected by the parent establishing clearly what is, and what is not, appropriate behavior according to place, time, and circumstance (B. Guerney, L. Guerney, & Andronico, 1966; Nickerson, 1973; Nickerson, 1980; Ohlson, 1974).

Furthermore, filial therapy also allows for a more parsimonious utilization of professional therapists' time by extending portions of their role to the parent with the further advantages of: (a) avoiding fears and rivalry which often develop in the parent when the child's dependency on the parent decreases and affection for the therapist increases; (b) reducing feelings of guilt and helplessness the parent may develop when dependent upon a professional for problem resolution; and (c) avoiding the problems that otherwise could be aroused when the parent fails to develop appropriate new responses to the child's new behavioral patterns (Stover & B. Guerney, 1967).

Unlike traditional psychotherapy, filial therapy is not an artificial situation occupying only a small portion of the child's life. According to Fidler, B. Guerney, Andronico, and L. Guerney (1969), the child in play therapy learns to accommodate to a new set of standards and a different way of communicating, analogous to adjusting to a new culture. The child is then faced with working with this new cultural framework within the old cultural framework at
Filial therapy, by involving both parent and child, may help minimize the distress and confusion involved in applying a new cultural framework within the old one (L. Guerney, 1976a).

In addition to these reported advantages over other forms of child therapy, filial therapy is well-suited as a preventive method (Authier et al., 1975; B. Guerney et al., 1971), since filial therapy skills can be presented in the framework of education and enhancement, as well as in the context of treatment. B. Guerney (1977) and L. Guerney (1980) advocated a psychoeducational skill training approach, utilizing basic filial therapy skills in a more structured format, as a preventive measure for parents and their children. These highly structured skill training courses are supervised by professionals, yet carried out by trained paraprofessionals, thereby freeing more of the professional's time for program development and evaluation (L. Guerney, 1976c). Such training may benefit vulnerable, high-risk groups within the community who have not been labeled mentally ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and to enhance their level of positive mental health (Goldstone, 1977; Kazdin, 1993), thereby encompassing the aim of prevention (Kessler & Albee, 1977).

Filial therapy training has been used successfully with various populations in diverse settings including private
counseling facilities and agencies, hospitals, prisons, homes, and schools (Andronico & B. Guerney, 1967; Bach, 1968; Bowling, 1989; Glazer-Waldman, 1991; B. Guerney et al., 1976; L. Guerney, 1976b; L. Guerney & Gavigan, 1981 Lobaugh, 1991; Stollak, 1975a; Stollak, 1975b; Tidler, B. Guerney, Andronico, & L. Guerney, 1969). Although the effectiveness of filial therapy has been documented, there has been little reported use of this approach as a primary preventive measure with those families identified "at risk" and those families with special parenting needs (Payton, 1980). One such family situation that has been shown to be at risk for optimal parenting is single parents (Riccuiti, 1980).

Single parents and their children comprise a rapidly growing population whose needs have been insufficiently recognized and poorly served. The single parent family is the fastest growing family form in the United States. Currently over 8.5 million families with children under 18 years of age are maintained by single parents. Single parents are not a homogeneous group...they exist in all social classes, in all racial and ethnic groups, and in all age groups from 15 to 50. Divorces, separations, desertions, out-of-wedlock births, single parent adoptions, incarcerations, hospitalizations, military duties, and out-of-state employments result in single parenthood (Hamner & Turner, 1990).
The stress related to single parenting and related problems of role overload, social isolation, emotional and psychological problems, economic difficulties, time shortages, childcare, and lack of support in parenting have been documented in the literature (Cunningham & Brown, 1984; Fine, Donnelly, & Voydanoff, 1986; Green, 1981; Hetherington, Cox, & Cox, 1976; Weiss, 1979; White & Bloom, 1981). Single parents, particularly divorced parents during the first two years following separation, feel overwhelmed by the practical and emotional demands of single parenting (Amato, 1993; Arendell, 1986, Hetherington, Cox, & Cox, 1977).

The quality of single parents' relationships with their children has been found to strongly correlate with the children's well-being (Hess & Camara, 1979; Peterson & Zill, 1986; Pett, 1982; Wallerstein & Kelly, 1980; Wallerstein, 1983). A multitude of factors associated with single parenting have been identified that make it especially difficult to maintain (and in some cases, to establish) a healthy parent-child relationship. Although research has established that the parent-child relationship is essential to children's future mental health, investigations into improving the quality of parent-child relationships in single parent families is limited.

The style of parenting of custodial parents has been reported to be related to the child's adjustment to
separation and divorce, and to the parent's adjustment as well (Johnson, 1986). Of concern, however, is Wallerstein and Kelly's (1980) observation that parenting competence often declines after marital separation as a result of the adult's emotional turmoil. Poor parenting skills can lead to a coercive cycle of parent-child relations. Limited parental effectiveness can result in an increase in the child's behavior problems which in turn increases the anxiety and depression of the parent who is already feeling overwhelmed (Hetherington et al., 1977; Peterson & Cleminshaw, 1980).

Despite the consistent observations about single parents' need for support and the difficulties facing these parents and their children, the literature on educational programs for single parents remains surprisingly sparse. Johnson (1986), emphasizing the need for prevention and intervention, called for services that focus on improving parental well-being and parent-child relationships. Since filial therapy training fulfills the dual function of prevention and intervention, it would seem to be an appropriate choice for providing needed support and training for single parent families.

Statement of the Problem

The problem with which this investigation was concerned was that of determining the effectiveness of filial therapy
as a method of prevention and intervention for single parents and their children. Specifically, this study was designed to: (a) to determine the effectiveness of filial therapy in increasing single parents' empathic behavior with their children; (b) to determine the effectiveness of filial therapy in increasing single parents' attitude of acceptance toward their children; and (c) to determine the effectiveness of filial therapy in reducing single parents' stress related to parenting.

Synthesis of Related Literature

The following review is a synthesis of theoretical constructs and research related to three major areas: (a) the variable of parental acceptance as it relates to the parent-child relationship and to the development of self-esteem in the child; (b) the use of filial therapy and its significance as an area of study; and (c) the impact of single parenthood.

Parental Acceptance

According to Axline (1969), acceptance is a feeling that is within the experiencing individual. Axline (1971) contended that acceptance grows out of genuine, sincere interest in the other person and a sensitivity to the rights and capacities of the other person to be an individual and to be able to assume responsibility for self.

Coopersmith (1967) defined parental acceptance as
parents' love and approval of their child regardless of the child's appearance, abilities, and performance. This unconditional acceptance is expressed by a sensitivity to a child's needs and desires, a concern for the child's interests, and the expression of affection and approval. Perkins (1974) stated that children who live in an atmosphere of acceptance learn that they can depend upon others for support and help. Such children gain a certainty of their own worth and thus are freed from their own anxiety. They are able to express affection for others and to work to progress toward growth and maturity. In short, their interactions with others confirm and reinforce their conception of their own value, thereby providing themselves with a firm feeling of security.

Porter (1954b) identified parental acceptance as one of the essential elements underlying the whole structure of the parent-child relationship. For the purpose of measuring this elusive construct, Porter (1954a) developed the first operational definition of parental acceptance:

Parental acceptance may be defined as feelings and behavior on the part of the parents which are characterized by unconditional love for the child, a recognition of the child as a person with feelings who has a right and a need to express those feelings, a value for the unique make-up of the child, and a recognition of the child's need
to differentiate and separate himself from his parents in order that he may become an autonomous individual. (p. 177)

According to Coopersmith (1967) the most important contribution to the development of self-esteem is the amount of respectful, accepting, and empathic treatment received from significant others. Eisman (1981) and Cox (1970) found that the self-concept of the child was highly correlated to parental acceptance or rejection.

Kagen and Moss (1962) reported parental rejection to be related to aggressive behavior in children. Medennus (1965) linked parental rejection to manifested signs of maladjustment in children. Hurley (1967) related parental rejection to lower scores on intelligence tests. Ausbel (1954) found that children who perceive their parents as rejecting were less independent and less able to postpone immediate gratification.

Burchinal, Hawkes, and Gardner (1957) studied the relationship between parental acceptance and adjustment of children and found a significant correlation between two of the 10 variables measured. The correlations indicated: (a) fathers who scored higher on a parental acceptance measure had children who scored lower on a social maladjustment scale and (b) mothers who scored higher on parental acceptance had children who scored lower on a personal inferiority measure. In a study by Baumrind
(1967), self-controlled, self-reliant, explorative, and content pre-school children were found to have parents who manifested positive behavior and who were more consistent, more loving, and more secure in child-rearing methods. These parents were also more likely to have given a reason with a directive, communicated more closely with their children, enforced directives, and did not over-protect or over-restrict their children.

Rohner, Chaille, and Rohner (1980) studied the relationship between locus of control and perceived parental acceptance. They found that the belief that one has control over events and actions in one's life increased significantly with children's perceptions of increased parental acceptance.

**Filial Therapy**

Traditionally, society has focused little attention on the training of parents. Most of the preparation for parenting comes from one's experiences as a child which leaves many parents ill-equipped to carry out this primary task of life (Giveans, 1988; Lobaugh, 1991; Wolfe, Edwards, Manion, & Koverola, 1988). Filial therapy, which trains parents to be sensitive to and accepting of children's feelings during special play sessions, is one way to teach new patterns of relating while enhancing existing skills (Lobaugh, 1991).

Although programs to train parents to be more effective
in parent-child relationships are not new, training based on the child's natural tendency to play is a relatively new and innovative concept. Bettelheim (1987) considered play to be the child's natural medium of communication. Landreth (Personal Communication, February, 1989) suggested that if parents wanted to understand their children, they should observe their children's play. Young children express their thoughts and feelings primarily through play (Axline, 1969; Hayakawa, 1967; Landreth, 1978; Moustakas, 1973; Strom, 1975). Self-directed play also provides the child with opportunities to practice and master new skills as well as allowing the child the time and freedom for introspection and development of an inner life (Lobaugh, 1991).

Precedents for training parents to be therapeutic agents in their children's lives can be traced to the early 1900's when Freud effectively utilized the father of a phobic five-year-old in the treatment of the child by instructing the father in how to respond. He contended that the father's special knowledge by which he was able to interpret his son's remarks was indispensable and that only the father could have persuaded the child to make such changes (Freud, 1959).

Baruch (1949) and Jacobs (1949) advocated home play sessions for the purpose of fostering more effective parent-child relationships. Fuchs (1957), on the advice and encouragement of her father, Carl Rogers, employed regularly
scheduled play times with her child based on play therapy procedures suggested in Axline's (1969, 1950) writings. Fuchs described significant results in helping her daughter overcome emotional reactions related to a toilet-training problem. Not only was the problem resolved, but Fuchs also reported positive changes within herself. Moustakas (1959) encouraged parents to use play therapy sessions at home with their children, and provided one of the earliest detailed descriptions of these special home play sessions:

Play therapy in the home...is a way through which the child opens himself to emotional expression and in this process releases tensions and repressed feelings...He learns to count on regular meetings with the parent...in which he is the center of the experience. A variety of play materials are made available to him...The parent does not tell him what to do, but sits nearby...showing interest and regard...In the play therapy relationship...the child finds that his parent really cares, wants to understand, and accepts him as he is. (pp. 275-277)

These early experiences of parents conducting special home play sessions differed from filial therapy in that the parents (a) did not receive regularly scheduled systematic training and supervision from a specially trained professional and (b) did not have the opportunity to discuss
their experiences with other parents in a support group format (Landreth, 1991). The term "filial therapy" was coined by Bernard Guerney in the early 1960's to describe the psychotherapeutic method he developed that extends specific client-centered play therapy approaches to parents, with the belief that they can be positive agents of change with their own children (B. Guerney, 1964).

Although filial therapy originated in 1964, there has been limited research focusing on this particular intervention. The literature on filial therapy reveals fewer than two dozen scientific investigations. The remainder of the published reports are descriptions of the use of filial therapy in clinics and agencies or variations and extensions of the method.

Stover and B. Guerney (1967) investigated the feasibility of training mothers in filial therapy techniques and reported a significant increase in the use of reflective statements by the mothers and a sharp decrease in directive-type statements, as measured by direct observation. According to the parents' self-reports, the children in the experimental group were exhibiting significantly fewer problematic behaviors at the end of treatment.

Since the Stover and B. Guerney (1967) study did not utilize a control group, Oxman (1971) matched the parents in their study with volunteer parents on several variables:
age of parents and children, size of family, geographical location, and social economic status. The findings showed that the control group did not exhibit the kinds of changes demonstrated by the experimental group in the original study.

A later study by B. Guerney and Stover (1971) of a group of 51 mothers and their children substantiated their earlier findings, that mothers could learn to reflect feelings, allow children self-direction, and demonstrate involvement in the emotional behaviors and expressions of their children. Significant improvement on psychosocial adjustment and on symptomatology of the children was indicated on a variety of measures completed by parents and by clinicians. All of the 51 children were rated by the clinicians as showing some improvement and 28 were rated as very much improved. No child remained the same or became worse. As a result of the play sessions, the children showed increased engagement with mothers in activities, worked out their feelings of aggression, learned to deal more realistically with their mothers in sharing and conversing, and decreased their dependence while increasing their leadership abilities.

The participants in the B. Guerney and Stover (1971) study were surveyed one to three years after treatment by L. Guerney (1975). The responses to the questionnaire indicated that (a) only one of the 42 children who had
participated in the play sessions required further treatment; (b) 32 of the 42 respondents claimed the children were evidencing continued improvement, four stated their children were the same, four stated that their children had regressed in adjustment, and one indicated the child's condition had worsened; (c) 64 percent of the parents stated the children's continuing improvement was related to their improved ability to relate to the children; and (d) the parents gave an overall positive evaluation of the filial therapy training. The results of this follow-up data suggest that filial therapy is effective with parents and children, and that the results of the training may endure as long as three years later.

In order to control for potential differences between subjects who seek treatment and those who do not, Sywulak (1977) utilized a design in which subjects served as their own control group. The results showed a significant improvement 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, that fathers detected change in adjustment later than did mothers, and that 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 of treatment and no significant losses two to three 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. Furthermore, both parents and children maintained that the filial training had resulted in positive change within the family.

Wall (1979) examined three variations of play therapy conducted by: (a) graduate therapist trainees; 00 non-trained parents; and (c) parents directed and observed by therapist trainees. Parents who were guided by the trainees improved their skills in empathic communication with their children. The findings indicated that the children's expression of negative feelings and their increased perception of negative attitudes in their families led to improved adjustment. The researcher concluded 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.

In a similar investigation, 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 the author reported:
(a) a significant decrease in children's aggression, withdrawal, and dependence; (b) a significant increase 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 other group. Children in both treatment groups experienced a decrease in problem behaviors and parents in these groups reported they became more accepting of their children. Similar results were not found in the group that did not receive treatment.

Payton (1980) demonstrated that parents trained in filial therapy can be more effective in impacting their children's personality adjustment than paraprofessionals. Parents in the filial therapy training group also showed significant improvement in child-rearing attitudes.

Children who received play therapy sessions with their parents in addition to sessions with a therapist were studied by Kezur (1980). The nature of mother-child communications and the effects of these communication patterns on the mother-child relationship were studied. The data revealed the following conclusions: (a) effective communication skills, based on therapeutic principles, were developed by the mothers; (b) the children expressing anger towards the mother in the therapist play sessions became more open with their mothers in the parent play sessions; (c) mothers developed new awarenesses in communication;
(d) mothers who developed self awareness changed in positive
directions with their children; (e) mothers who learned to
honor their own needs were better able to meet the needs of
their children; (f) new communication skills were developed
by mothers who accepted joint responsibility for the
problems with their children; (g) the greatest gain in new
communication skills were made by those mothers who opened
themselves to a relationship with the researcher;
(h) positive changes developed in the mother-child
relationship as both gained in self-esteem; (i) mothers who
were open to viewing and commenting on themselves in
videotape replays gained more from the feedback; (j) as
mothers and children became more involved in the joint
sessions, there was an increase in closeness and effective
communication; and (k) in the pairs of mothers and children
where the most change occurred, the mothers tended to report
improvement in other relationships.

Dematatis (1981) compared traditional filial therapy
with an integrated filial therapy program that utilized
traditional filial therapy methodology with the inclusion of
affect simulation and videotape recall modeled after Kagan's
Interpersonal Process Recall (IPR) training. Parents in
both programs showed significant gains in parental
acceptance, affect sensitivity, allowance of self-direction,
and involvement.

Glass (1986) compared the effects of parents in filial
therapy training with a control group of parents and found significant differences, favoring those in the filial groups. The parents reported an increase in unconditional love for their children, a decreased level of conflict in the parent-child relationship, and an increase in their understanding of the meaning of their children's play. Further results, although not significant, revealed that filial therapy produced greater changes in: (a) parental acceptance; (b) respect for children's feelings and their right to be expressed; (c) recognition of children's need for autonomy and independence; (d) increased self-esteem of parents and children; (e) closeness between parent and child, without greatly altering the authority hierarchy; and (f) positively influencing the family environment.

The findings by Glass supported previous research indicating that: (a) filial therapy effects a positive change in the parent-child relationship; (b) children in filial therapy exhibit significant decreases in aggression; (c) children in play sessions with parents show significant differences in improved adjustment by expressing their negative attitudes; and (d) mothers in filial therapy allow their children more self-direction along with more demonstrated involvement (Lebovitz, 1982; Sensue, 1981; Sywulak, 1977; Wall, 1979).

The results of filial therapy with special populations of children and parents have been equally encouraging.
Gilmore (1971) found significant improvement in academic and social functioning among a group of children with learning disabilities. In addition, self-esteem and family interaction were improved. Boll (1972) reported that both a non-directive filial group and a directive filial group of parents of educable mentally retarded children resulted in more positive changes, as perceived by the parents, in socially adaptive behavior than did a control group. The findings additionally demonstrated that parents could be effective therapeutic agents even though more positive parental attitudes were not attained. Foster parents in L. Guerney and Gavigan's study (1981) demonstrated more acceptance of their foster children upon completion of filial therapy training.

Glazer-Waldman (1991) found that filial therapy training had a positive impact on parents of children with chronic illnesses. Parents demonstrated that they were better able to judge their child's level of anxiety after completing the filial training. Qualitative reports of outcomes indicated that the parents believed that the training had a positive impact on their relationship with their child. Andronico and Blake (1971) described a program of filial therapy as applied to children who stutter. They found that parents' previously misdirected energies could be channeled into a focus on the improvement of the relationship with the total child, thereby effectively
changing the family environment. This was followed by a reduction in the intensity and frequency of the stuttering.

The effectiveness of filial therapy with incarcerated fathers was investigated by Lobaugh (1991). After a 10 week filial therapy program held at a federal correctional institute, the fathers who received the training showed dramatic gains over the control group of fathers. The results further supported the use of filial therapy with a variety of populations and revealed the following conclusions: (a) significant increases in parental acceptance; (b) significant increases in child self-esteem; (c) significant decreases in parental stress; and d) significant reduction of child's problematic behaviors as perceived by the parent.

B. Guerney and Flumen (1970) reported a statistically significant correlation between teacher's therapeutic intervention and the degree of a child's improvement, as it relates to positive interaction in the classroom. When teachers used filial therapy concepts such as individual attention for specified lengths of time, and limit setting, the children's interaction with peers improved.

In a descriptive case study of the attitudinal and behavioral changes that occur in parents and children as a result of their involvement in the filial therapy process, Packer (1990) found that after 10 weeks of filial therapy training the parents perceived themselves as possessing
skills which could effect positive changes in the behavior of their child. Documented gains for the child included: (a) reduction in temper tantrums and greater ability to control escalating emotions and (b) acceptance of father as an authority figure in the presence of the mother.

Utilizing ethnographic methodology, Lahti (1992) examined and described the filial therapy process to provide an in-depth understanding of the process and effects on the parent, child, and parent/child relationship. The findings revealed (a) the essential nature of the training process focused on balancing a didactic component with a group counseling format, providing an atmosphere conducive to personal exploration along with teaching parenting skills; (b) the play sessions ostensibly facilitated change by utilizing the parent in a therapeutic role, which also appeared to reduce the parent's anxiety while learning; (c) changes in parents entailed increases in confidence and feelings of personal power, reduction in degree of parental control, and increased awareness of both adults' and children's needs; (d) closer parent/child and marital relationships were described and characterized by increased, enhanced communication, adoption of more realistic expectations, and less friction; and (e) the children's changes included increased and enhanced communication, increased responsibility for actions, decreased withdrawn and aggressive behavior, and increased feelings of
happiness.

Andronico, Fidler, & B. Guerney (1967) examined the relationship between the didactic and the dynamic elements in filial therapy. They concluded that combining these elements produced increased harmony between parents and children, improved academic performance, and reduction in physical and behavioral symptoms (Andronico & B. Guerney, 1969).

Certain therapist attitudes facilitative in training parents as therapeutic agents were studied by B. Guerney, L. Guerney, and Stover (1972). They discovered that although high motivation, cooperativeness, and good rapport between therapist and parent were not sufficient conditions to insure that parents would be effective therapeutic agents, they did seem to be necessary conditions. The authors concluded that therapists need to adopt attitudes which will help the parents perceive them as:
(a) understanding the parents' difficulties and feelings;
(b) soliciting and respecting the parents' viewpoints;
(c) not attaching blame; and (d) being an indispensable helpmate in solving the child's problems.

Stover and B. Guerney (1967) investigated the efficacy of the first phase of filial therapy and studied the variable of therapist-trainer's level of experience. The parent group led by the experienced therapist used reflective statements on an average of 95% of the observed
play sessions. The parent group led by the untrained therapist used reflective statements only 15% of the time.

Stover, B. Guerney, and O'Connell (1971) developed an observational rating scale to measure the level of parents' empathic responses during play sessions with their children. This rating scale was an adaptation of an earlier observational scale developed by B. Guerney, Stover, and DeMeritt, (1968). The researchers concluded that a high level of empathic behavior in parents was a decisive factor in the success of the filial therapy process and was of paramount importance for a significant change in the child's behavior. B. Guerney, Burton, Silverberg, & Shapiro (1965) also utilized live observations to code and analyze children's behavior during the filial therapy play sessions with their parents.

A variation on filial therapy which involved training parents to engage in play sessions with their child while in a group rather than alone was recommended by Ginsberg, Stutman, and Hummel (1978). The benefits were outlined as the following: (a) being in a group led to the fast and clear identification of the behavioral problems; (b) changes and benefits that accrued were readily generalized to the school situation; (c) there were frequent opportunities for the parents to have regular interaction with their children; (d) group participation facilitated the interaction process; (e) participating in the group led to the children learning
more effective interpersonal skills while parents learned alternative ways of coping with the children's behavioral problems; (f) group participation facilitated increased interaction from withdrawn and shy children; and (g) parents gained from the effective modeling and encouragement offered by other parents.

Ginsberg (1976) examined the usefulness of filial therapy in a community mental health agency. He concluded that the model was a beneficial approach to a variety of problems and contexts within such a setting; i.e., with foster parents, with single-parent families, with two-parent families, with all socioeconomic groups, as an intensive treatment, and as a short-term treatment. He stated that filial therapy could be modified to the nature of the problem, as well as the demands of both the clinic and the family, and could be incorporated with other treatment approaches.

Hornsby and Appelbaum (1978) and Stollak (1979, 1981) reported still other effective variations and extensions of filial therapy within a clinic. These included:

a) teaching single sets of parents to conduct play sessions within the clinic, with parents alternating weekly sessions with the child; (b) utilization of the "bug in the ear," a device placed in the parent's ear through which the therapist can communicate with the parent while the play session is being conducted behind a one-way mirror;
(c) parents, child, and therapist viewing and discussing the videotaped play sessions; (d) utilizing filial therapy with the child, parents, and therapist in the playroom together; and (e) teaching filial therapy to high school students, college undergraduates, prospective parents, existing and prospective nursery and elementary teachers, and divorced or separated parents. The authors concluded that the playroom encounter was a useful setting, in addition to being a provocative stimulus, for parents and other paraprofessionals to learn to alter their behavior with children in ways that acknowledge the needs, feelings, wishes, and thoughts of children (Stollak, 1968).

**Single Parents**

The increase in single parent families is a widespread social phenomenon the impact of which has only begun to be addressed by mental health researchers. Two factors have contributed to the rise in single parenthood: (a) the escalating divorce rate, with one of every two marriages ending in divorce and (b) the dramatic increase in the number of single mothers who never married (Norton & Glick, 1986). Research has focused primarily on the divorced/separated single parent, particularly divorced/separated single mothers. More than 80% of single parent households are maintained by single mothers, 64% of which are single as a result of divorce or separation (Hamner & Turner, 1990).

Separation and divorce lead to a new set of adjustments
for parents and children. The adult's emotional turmoil, increased responsibilities, and isolation along with the children's emotional reactions to the loss of one parent in the home suggests that the adjustment to the new family system is a difficult one (Amato, 1987; Isaacs, 1981; Tarshis, 1990; Thompson & Gongla, 1983).

The impressive consensus of research on the effects of divorce on children is that divorce results in negative stresses and long-term adjustment of children to continued changes in their environment (Hamner & Turner, 1990). The quality of the relationship between custodial mothers and their children often deteriorates following marital disruption (Amato, 1993; Hetherington et al., 1977; Peterson & Zill, 1986). Wallerstein & Kelly, (1980) and Hetherington et al. (1977) found that custodial parents communicated poorly with their children, were unaffectionate, and were generally too absorbed with their own problems to help their children. Changes in maternal control practices were also noted; mothers were restrictive and punishing, and made few maturity demands. Correspondingly, children, particularly boys, frequently refused to comply with their mothers' directives and displayed behavior problems. A recent meta-analysis of 92 studies of children confirmed these findings. Amato and Keith (1991a) revealed that parental divorce is associated with negative outcomes in the areas of academic achievement, child behavior, psychological adjustment, self-
esteem, and social relations.

Although the literature indicates that these negative outcomes tend to be temporary rather than long-term (Hetherington et al., 1977; Wallerstein & Kelly 1980; Weiss, 1979), children who are exposed to recurrent conflict or the chronic absence of emotional and behavioral support are at increased risk of psychological disorders (Garbarino, Guttman, & Seeley, 1986; Hart & Brassard, 1987). In a recent meta-analysis of 33 studies, Amato & Keith (1991b) found that adults who experienced parental divorce as children, compared with those from continuously intact families of origin, have poorer psychological adjustment, lower socioeconomic attainment, and greater marital instability. The cumulative picture that emerges from the literature suggests that parental divorce (or some factor associated with it) is associated with lowered well-being among children.

Other investigators have explored characteristics of single parents that can mediate post-divorce child adjustment. Parent adjustment, parent availability, parenting style, and the parent-child relationship were found to be factors related to children's post-divorce adjustment (Hess & Camara, 1979; Peterson & Zill, 1986; Stolberg & Anker, 1983). Stolberg & Ullman (1984) discussed specific parenting dimensions that were associated with children's adjustment to the loss of another parent in the
home. They included physical and emotional availability of the parent, external controls or limits provided by the parent, and problem-solving skills.

Thus, good parenting skills are needed at a time when parents are most likely to feel vulnerable, overwhelmed, and emotionally unavailable. Research has repeatedly underscored the need for social supports for single parents (Kurdek & Berg, 1983; McLanahan, Wedemeyer, & Adelberg, 1981; Tarshis, 1990). The availability of social supports indirectly affect parenting because they provide emotional support, validation, tangible resources, and information that can help single parents be more effective parents.

Single parents and their children constitute a rapidly growing population whose needs have been insufficiently recognized and poorly served, particularly related to mental health services. Clearly, the issues related to single parenting are complex and single parents are not a homogeneous group. Research studies need to focus on prevention and intervention strategies that will give hope for a positive outcome for both single parents and their children. Innovative programs that strengthen the single parent's interest in and skills for promoting healthy parent-child interactions and at the same time provide emotional support for the single parent should be a high priority for mental health professionals (Warren, Grew, Konanc, Ilgen, & Amara, 1982).
Summary

Research indicates that single parents, as a group, are at risk for optimal parenting and that early intervention and prevention strategies are needed to prevent future mental health problems for their children (Hamner & Turner, 1990). However, a shortage of mental health professionals who work with children and families makes it impossible to provide direct services for all who would benefit from them (VandenBos & Stapp, 1988). Recognizing this situation, authorities in the mental health field have recommended the use of parents as therapists for their own children (B. Guerney, 1964; Kraft, 1973; Landreth, 1991; Moustakas, 1975).

Filial therapy is a method by which both parents and children can receive help and move toward healthier relationships. The nature of the child-parent relationship is of primary importance to the present and future mental health of children. Filial therapy offers significant possibilities for promoting the well-being of children of single parent families by equipping their parents with healthy parenting skills. Therefore, therapists training single parents to become therapeutic agents in their children's lives would seem to be the most efficient and perhaps the most effective way to significantly improve the future mental health of these children and ultimately our society (Landreth, 1991).
CHAPTER II

PROCEDURES

A pretest-posttest control group design (Campbell & Stanley, 1963) was utilized in this study to measure the effectiveness of filial therapy with single parents and their children. Volunteer subjects that met the specified criteria were selected to participate in the study and then randomly assigned to a control group and an experimental group, with only the experimental group receiving treatment.

Distinctive parenting behaviors observable in parent-child interactions were coded and analyzed using the Measurement of Empathy in Adult-Child Interactions, a direct observational scale (Stover, B. Guerney, & O'Connell, 1971). The behaviors measured include: (a) communication of acceptance; (b) allowing the child self-direction; and (c) parent involvement with the child.

Specific parental attitudes concerning children were measured by the Porter Parental Acceptance Scale (Porter, 1954a). These attitudes include: (a) respect for the child's feelings and right to express them; (b) appreciation for the child's unique make-up; (c) recognition of the child's needs for autonomy and independence, and (d) feeling of unconditional love for the child.
The Parenting Stress Index (Abidin, 1983) was used to measure the amount of stress parents perceive in two main categories: the parent domain and the child domain. 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. Parents were also asked to indicate those behaviors that they consider problematic for their child and rate the severity of each on The Filial Problems Checklist.

Definitions

Filial therapy was defined in this study as the psychotherapeutic method developed by Bernard Guerney in the early 1960's that trains parents... by utilizing a small group format in which parents are trained in the overall principles and methodology of client-centered play therapy. As in client-centered play therapy, filial therapy is structured to enhance the relationship, in this case between the parent and child, with the parent serving as the therapeutic agent of change. Through didactic instruction, viewing of video tapes, and role playing, parents' sensitivity to their children is enhanced, and parents learn how to create a nonjudgemental, understanding, and
accepting environment during which children feel safe enough to explore other parts of themselves as persons and other ways of relating with their parents. The setting for this new kind of environment is a required thirty minute special play time. (Landreth, 1991)

Play Therapy is a therapeutic approach for children ages two to eleven that utilizes selected play materials. The dynamic interpersonal relationship between the child and the trained therapist allows the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play (Axline, 1969; L. Guerney, 1983b; Landreth, 1991; Moustakas, 1973).

Single parent was defined in this study as a custodial mother or custodial father, 18 years of age or older, who was divorced, separated, or never married with a dependent child between the ages of 3 years and 7 years.

Parental acceptance means the ability of the parent to recognize and approve of the child regardless of appearance, abilities, or behavior. This unconditional acceptance is an essential element underlying the entire structure of the parent-child relationship. For the purpose of this study, parental acceptance was operationally defined as the parents' scores on the total Porter Parental Acceptance Scale (Porter, 1954a).
Respect for the child's feelings and right to express them, as understood in this study, means the parents' willingness to allow the child to express feelings and still show positive regard for the child. For the purpose of this study, respect for the child's feelings and right to express them was operationally defined as the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954a).

Appreciation for the child's unique make-up means that a parent values and shows 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' score on this subscale of the Porter Parental Acceptance Scale (Porter, 1954a).

Recognition of the child's need for autonomy and independence, as understood in this study, means the parent's understanding of children's need to differentiate and separate from their parents in order to mature in a healthy manner. For the purpose of this study, recognition of the child's need for independence and autonomy was operationally defined by the parents' scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954a).

Unconditional love is the love a parent shows toward a child without placing conditions or minimum 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, 1954a).

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, 1983).

Empathy refers to parents' sensitivity to their
children's current feelings and parents' ability to verbally
communicate this understanding to the child. For the
purpose of this study, empathy was operationally defined as
the parents' total scores on the Measurement of Empathy in
Adult-Child Interaction (Stover et al., 1971).

Communication of acceptance as understood in this study
involves the parent's verbal expression of acceptance-
rejection of the child. For the purpose of this study,
communication of acceptance was operationally defined by the
parents' scores on this subscale of the Measurement of
Empathy in Adult-Child Interaction (Stover et al., 1971).

Allowing the child self-direction is the behavioral
willingness on the part of the parent to follow the child's
lead rather than attempt to control the child's behavior.
For the purpose of this study, allowing the child self-
direction was operationally defined as the parents' scores
on this subscale of the Measurement of Empathy in Adult-
Child Interaction (Stover et al., 1971).

**Involvement** is described in this study as a measure of the parent's attention to and participation in the child's activities. For the purpose of this study, involvement was operationally defined by the parents' scores on this subscale of the Measurement of Empathy in Adult-Child Interaction (Stover et al., 1971).

**Hypotheses**

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

1. The experimental parent group will attain a significantly lower mean total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the control parent group.
   a) The experimental parent group will attain a significantly lower mean score on the Communication of Acceptance subscale of the MEACI posttest than will the control parent group.
   b) The experimental parent group will attain a significantly lower mean score on the Allowing the Child Self-Direction subscale of the MEACI posttest than will the control parent group.
   c) The experimental parent group will attain a significantly lower mean score on the
Involvement subscale of the MEACI posttest than will the control parent group.

2. The experimental parent group will attain a significantly higher mean total score on the Porter Parental Acceptance Scale (PPAS) 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.
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.

4. The experimental parent group will attain a significantly lower mean score on the Filial Problem Checklist (FPC) posttest than will the control parent group.

Instrumentation

The Measurement of Empathy in Adult-Child Interaction was developed by Stover, B. Guerney, and O'Connell (1971) to operationally define empathy as related to parent-child interactions (Unpublished: received permission to use by personal communication with B. Guerney, The Pennsylvania State University, April 12, 1992). This direct observational scale measures three specific parental behaviors identified as major aspects of empathy in adult-child interactions: (a) communication of acceptance; (b) allowing the child self-direction; and (c) involvement. The
scale also provides a total empathy score. The Measurement of Empathy in Adult-Child Interaction is a revision of an earlier measure of empathy (B. Guerney, Stover, & DeMerritt, 1968).

The Communication of Acceptance subscale measures the parent's verbal expression of acceptance-rejection of the child's feelings and behavior during spontaneous play sessions. The dimension of acceptance (particularly parental acceptance) is viewed as a necessary condition for optimal development of the child's self-worth and the major element in the communication of empathy. In a preliminary study, Stover et al. (1971) found that this behavior did not generally occur in spontaneous interactions between parent and child. They hypothesized that the verbal expression of acceptance was an important variable in explaining exceptionally positive or healthy adult-child relationships.

Paralleling the specific verbal expression of acceptance is the behavioral willingness on the part of the parent to follow the child's lead rather than attempt to control the child's behavior. The Allowing the Child Self-Direction subscale measures this dimension of empathy.

The Involvement subscale measures the parent's attention to and participation in the child's activity. Stover et al. (1971) found that high scores on this dimension of parental behavior may or may not be related to high levels of empathy. That is, involvement may be
empathic or non-empathic, highly directive or appropriately supportive. However, parents who exhibited high levels of communication of acceptance and allowing the child self-direction also demonstrated high levels of involvement.

The Measurement of Empathy in Adult-Child Interaction was selected for this study because (a) the scoring is based on the coding of observed interactions between parent and child; (b) the three parenting behaviors measured by this instrument are closely associated with enhancing the parent-child relationship, a major objective of filial therapy; and (c) research has shown empathy to be a measure of success in learning a therapeutic role (Carkhuff, 1969; Stover & B. Guerney, 1967), another major objective of filial therapy.

A five-point bipolar scale is used to rate the three dimensions of parental behavior every three minutes for six consecutive coding intervals. The scale ranges from a high rating of one to a low rating of five. Each point on the scale is followed by typical responses obtained from codings of the direct observations of parent-child interactions (Appendix C). Considering all the subscales together as components of empathic behavior, the highest levels of empathy are evident when the parent (a) is attending fully to the child's behavior; (b) is commenting frequently on the child's expression of feeling or behavior in a genuinely accepting manner; and (c) is clearly demonstrating that the child is fully permitted to engage in self-directed
activity. The lowest level of empathic communication would be one where the parent is (a) self-involved, preoccupied, or shut-off from the child who must repeat or prompt to get a response from the parent; (b) verbally critical and rejecting the feelings or behavior of the child; and (c) cajoling, demanding, and re-directing the child's activity (Stover et al., 1971).

Reliability coefficients were established for each of the three subscales. After four training sessions of collaborative rating on half hour play sessions, followed by discussion, six pairs of coders independently rated seven to ten parent-child play sessions of 20 minutes each. The average reliability correlation coefficient for the Communication of Acceptance subscale was .92. The Allowing the Child Self-Direction subscale had a median correlation coefficient of .89 and the Parental Involvement subscale had an average coefficient of .89 (Stover et al., 1971).

Construct validity for each subscale and the total empathy score was demonstrated in a study with a group of 51 mothers who participated in filial therapy training (B. Guerney & Stover, 1971). The filial therapy training method was utilized to demonstrate the validity of the scales because this method involves training parents in empathic skills closely related to the behaviors the scales are intended to measure. The parents' levels of empathic interactions with their children were measured three times:
the pretraining play session, the first posttraining play session, and the third posttraining play session. Highly significant (.0005) increases between the pretraining and first posttraining play sessions were obtained on each subscale and for the total empathy score. Significant increases (.01) between the first and third posttraining play session demonstrated that the scales are extremely sensitive measures of the empathic behaviors. Concurrent validity was established by demonstrating a .85 correlation at the .005 level between the Measurement of Empathy in Adult-Child Interaction and a previously developed empathy measure (Stover et al., 1971).

The Porter Parental Acceptance Scale (PPAS) developed by Porter (1954b) 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 (Appendix D). The scale measures four variables: (a) respect for the child's feelings and right to express them; (b) appreciation of the child's unique make-up; (c) recognition of the child's need for autonomy and independence; and (d) unconditional love. The PPAS was selected for this study because these four variables are closely associated with the training objectives of filial therapy and this instrument has been used in other studies on filial therapy training. The PPAS is easy to administer and takes approximately 20 minutes to complete.
Each item on the instrument has five multiple choice responses ranging from low to high acceptance. Incorporated into the scale are two dimensions of acceptance: (a) how the parent feels in a specific situation and (b) what the parent will do (their manifested behavior) in a specific situation. The instrument may be scored to yield one total scale score and four subscale scores.

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

Porter (1954b) investigated the validity of the instrument 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 greatest disagreement among the judges was by a distance of two scale points and occurred less than twenty percent of the time. These findings suggest that the PPAS is a valid measure of parental acceptance as operationally defined by Porter (1954a).

Burchinal, Hawkes, and Garner (1957) utilized an item analysis to study the internal consistency of the PPAS. By
analyzing both fathers' and mothers' responses, the researchers found that 39 of the 40 items discriminated between high and low scorers. The value of 3.46 needed for a probability level of .001 was exceeded by 35 items in the mothers' responses and 33 items in the fathers' responses. Thus the findings from this study indicate that the PPAS is internally consistent at the .001 level of probability.

The Parenting Stress Index (PSI) developed by Abidin (1983) is a 101 item self-report index designed to measure the level of stress in the parent-child system. The items are separated into two domains, the child domain and the parent domain. The parent characteristics measured by the PSI include parent's sense of competence, parent attachment, restrictions imposed by parental role, parent's feeling of social isolation, parent depression, relationship with spouse, and parental health. The child characteristics measured include child's acceptability to the parent, child demandingness, child mood, child distractibility, child adaptability, and child's reinforcement of parent.

The PSI was selected for use in this study because a) the characteristics addressed in each of the subscales are closely related to parents' ability to accept their child, (b) single parenting is associated with higher levels of parenting stress, (c) if filial therapy training is effective in enhancing the parent-child relationship, there should be a reduction in perceived parental stress, and (d)
this instrument has been used in other studies that measure the effectiveness of filial therapy training. The PSI is easy to administer, requires few directions, and can be completed in 20 minutes. Each item on the scale has five possible responses that range on a continuum from strongly agree to strongly disagree.

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. Alpha reliability coefficients were calculated on the total score and on each of the domains to determine internal consistency. The coefficient reported for the child domain was .89 and the coefficient for the parent domain was .93 with a total reliability coefficient of .95. These findings indicate a high degree of internal consistency for the PSI (Hauenstein, Scarr, & Abidin, 1986).

The Filial Problem Checklist (FPC) developed by Horner in 1974 has been used extensively by the Individual and Family Consultation Center at Pennsylvania State University in research related to filial therapy (Unpublished: received permission to use by personal communication with L. Guerney, The Pennsylvania State University, March 25, 1992). This self-report instrument lists 108 possible problem situations (Appendix E). Parents are instructed to consider each situation with one specific child in mind and to mark any of
the items that are currently problematic for their family with a 1, 2, or 3. A one means that a situation is true for the child, but not considered a problem. A two means that a situation is considered a moderate problem for the child. A three means that a situation is a severe problem for the child. The FPC is easy to administer and understand and takes about 15 minutes to complete. Normative statistics concerning validity or reliability are not available on this instrument. The Filial Problem Checklist was used as a means to compare results obtained by other studies on the effectiveness of filial therapy training.

Selection of Subjects

Advertisements stating the beginning of "parent-child relationship enhancement classes for single parents" were run in five area newspapers and two college campus newspapers. Fliers were posted at the two college campuses and at various community agencies serving families throughout the county. Fliers were also sent home through area daycares and preschools. Parents who responded by the advertised deadline were contacted by the investigator and given more details about the parent training classes and the selection process. The classes were offered free of charge.

Parents were selected to participate in the study based on the following criteria: (a) must be a single parent, at least 18 years of age with either full or joint custody of
their child; (b) must have a child between the ages of 3 years and 7 years who is not currently in therapy; (c) must have been a single parent for at least six months; (d) must be able to speak, read, and write the English language; (e) must not be currently in therapy; (f) must not have taken a parenting class in the last two years; (g) must be able to attend the ten weeks of filial therapy training at the scheduled times; (h) must be able to attend a pretraining session to complete pretest instruments and be videotaped playing with their child; (i) must agree to participate in weekly 30-minute home play sessions with their child; and (j) must be willing to sign the consent to participate form.

The investigator met with each participant who met the specified criteria to: (a) explain the purpose and the requirements of the filial therapy training; (b) provide information about how confidentiality would be maintained; and (c) answer any questions the participants had before they signed the consent form (Appendix A). Each parent was asked to select only one of their children, between the ages of 3–7 years, as the "child of focus" for the ten week training period and indicate that child by name on the consent form. The investigator informed the parents that after they attended the pretraining session, they would be arbitrarily scheduled to participate in either the first series (experimental group) or second series (control group) of filial therapy training classes.
All parents who met the criteria specified above (N=50) were scheduled to bring their "child of focus" to a pretraining session to complete all pretest requirements. All 50 subjects completed the pretraining requirements and were included in the study. Subjects were not matched on any demographic variable prior to group assignment. The investigator randomly assigned parents to the experimental group (n=25) and the control group (n=25). Over the course of the ten week treatment period, three subjects from the experimental group and four subjects from the control group dropped out of the investigation. Thus 43 subjects completed the present study, 22 in the experimental group and 21 in the control group.

The experimental group was comprised of 20 mothers and 2 fathers. There were 19 mothers and 2 fathers in the control group. The parents in the experimental group ranged in age from 20 to 41 years of age, with a mean age of 28. The age range for the control group parents was 19 to 47 years of age, with a mean age of 30. The population in both parent groups was approximately 90% caucasian, 5% hispanic, and 5% other. Of the experimental group parents, 75% had completed high school, 20% had completed college, and 5% had completed a postgraduate degree. The control group parents' level of education was approximately the same, with the exception of one mother who was presently attending high school.
There were 10 girls and 12 boys in the experimental group and 9 girls and 12 boys in the control group. The children in both groups ranged in ages from 3 to 7 years. The experimental group included 30% 3-year olds, 23% 4-year olds, 23% 5-year olds, 13% 6-year olds, and 11% 7-year olds. The control group included 24% 3-year olds, 19% 4-year olds, 19% 5-year olds, 24% 6-year olds, and 14% 7-year olds. The mean age of the children was 4.45 years for the experimental group and 4.85 years for the control group. Both groups were comprised primarily of divorced or separated parents. There were 19 divorced or separated parents in the experimental group and 3 mothers who had never married. The control group contained 2 mothers who had never married and 19 divorced or separated parents. 41% of the parents in the experimental group were either part-time or full-time students and 59% were employed full-time. 35% of the control group parents were part-time or full-time students and 65% were employed full time. Demographically, the experimental and control groups were similar in all areas, with the greatest variance between the groups being a 6% difference in student/employed status.

Collection of Data

Pretraining sessions were scheduled the week before the filial therapy training classes started for the purpose of collecting data. The sessions were held at the Child and
Family Resource Clinic at the University of North Texas. The clinic has four specially equipped play therapy rooms with two-way mirrors and videotaping equipment. Parents were scheduled for the pretraining in groups of four. During the pretraining session parents completed the (a) Porter Parental Acceptance Scale; (b) Parenting Stress Index; and (c) Filial Problem Checklist and then were videotaped playing with their child for 20 minutes in one of the playrooms. Childcare was provided for the children while their parents were completing the questionnaires. Doctoral research assistants supervised the data collection. Directions were read aloud and participants were reminded to respond to all items in terms of their interaction with their child of focus. The research assistants were available to answer any questions and to direct the parents and children to the playroom for videotaping as the parents completed the questionnaires. The parent and child were shown the playroom with the explanation, "this is a room where children and parents can play together. You may play with the toys in lots of the ways you would like to." The research assistant then told the parent and child that she would knock on the door one minute before the end of the 20 minutes to signal that time was up.

One week following the completion of the ten weekly filial therapy training sessions, the posttest battery of instruments was administered to both the experimental and
control groups. The posttraining sessions followed the same procedures outlined in the pretraining sessions. The control group parents were scheduled to begin filial therapy training as soon as they completed the posttesting requirements.

The instruments and videotapes were number coded to maintain the confidentiality of the participants. The researcher kept a master list with subjects' names and respective codes in a locked file.

Treatment

The 25 parents in the experimental group were divided into three smaller filial therapy training groups to facilitate small group work as prescribed by Landreth (1991) and B. Guerney, L. Guerney, & Vogelsong (1980). Parents were assigned to one of the three groups according to (a) scheduling of work and school and (b) random assignment. Group A (n=6) met in the early afternoon, group B (n=9) met at night, and group C (n=10) met in the late afternoon. Each group met weekly for a two hour training session for ten consecutive weeks. Childcare was provided.

The filial therapy training model, utilizing both didactic and dynamic components, was designed to enhance the parent-child relationship by helping parents learn how to create an accepting environment in which their children will feel safe enough to express and explore thoughts and
feelings. The parents learned these new skills through demonstration and role play and then were required to practice with their child of focus in weekly 30-minute special play sessions and report their experiences to the group. Parents were supplied with a special toy kit (description included in the filial handouts in Appendix (b) to be used for the home play sessions. In addition, during the training period parents were scheduled on an individual basis to bring their child to the clinic for a videotaped play session that was critiqued during the following week's group training session. Parents received encouragement and support from the other group members as well as the facilitator throughout this process. The training sessions followed the methodology outlined by Landreth (1991) for a ten week filial therapy training group (session outlines and handouts are included in Appendix B): Training Session One

Parents introduced themselves and described their families, particularly the child of focus. Parents were asked what they hoped to gain from this experience for themselves as well as for their child. Goals of the filial therapy training were explained and the facilitator gave an overview of the training sessions. The facilitator highlighted the goal of parents developing sensitivity to their children and responding with empathy and showed a videotape to demonstrate the skills of reflective listening
and tracking behavior. The facilitator further illustrated these skills through role-play with one of the parents playing as a child, and then encouraged the parents to practice empathic responses in a similar role-play situation. Through the use of a video tape, the parents were introduced to the facial expressions of children's emotions. The parents were asked to identify four different emotions in their children and make a reflective response for each emotion as their homework for the week (handout in Appendix B).

Training Session Two

Session two began with a review of the parents' homework assignment on identifying and reflecting feelings. The facilitator demonstrated empathic responding with a volunteer from the group. The basic principles and guidelines of the 30 minute play sessions were explained, as presented in the "Filial Therapy Parent Group" handout (Appendix B). The facilitator displayed the toys to be used during the play times and discussed the rationale of selecting specific toys. The parents were reminded that to add to the specialness of their time with their children, the toys were for the play sessions only, and not for general use. The group watched a video of a parent-child play session and practiced making reflective responses, taking turns role playing the parent and child in pairs. Their homework consisted of reading through the
"Facilitating Reflective Communication" handout (Appendix B), and picking a specific time and location for the home play sessions.

**Training Session Three**

The session began with a discussion of the homework assignment on reflective communication followed by a report by each parent as to when and where they would have their special play time with their child. The facilitator talked the group through the handouts, "Eight Basic Principles of Play Therapy" (Appendix B), and "Basic Rules for Filial Therapy" (Appendix B) in preparation for the parents first home play session. The facilitator instructed the parents to tell their children that they were going to special classes to learn to play with them in some new ways. The homework assignment was to begin home play sessions.

**Training Session Four**

A discussion of the parents' initial home play sessions with their children began the fourth training session. The facilitator used examples from the parents' comments to reinforce the basic principles of filial therapy, to point out difficult situations, and to focus on how the parents felt during the sessions. Much of the training session consisted of the parents sharing certain happenings that occurred in the play session and seeking advice on how to handle those situations. One goal of the facilitator was to find something in each parent's sharing that could be
encouraged and supported. Parents were reminded that it was their responsibility to end the sessions even though children may want to continue playing. The introduction of limit-setting, as outlined on "Two Techniques of Discipline That Work" (Appendix B), generated much discussion among the parents about how these techniques could be applied in everyday interactions with their children as well as during the special play sessions. A short video of the use of limit setting in a play session was shown and the parents spent the rest of the time role playing situations where a limit needed to be set. Parents were instructed to continue the home play session and to notice one intense feeling in themselves. Two parents were scheduled to come to the clinic to be videotaped playing with their children in the playroom.

Training Sessions Five through Ten

The last five sessions all followed the same general format for the first half of the training session: each parent reported about his or her home play session of the previous week and videotaped play sessions of two of the parents were shown. Suggestions, encouragements, and instructions from the facilitator along with group interaction facilitated the learning of new skills in a supportive atmosphere. The continued focus was on the parents' feelings. The facilitator helped the parents to see that they were not alone in their childrearing
difficulties by commenting frequently on experiences shared by several parents. Parental coping skills were identified to help parents gain a sense of personal power. The facilitator also took several opportunities to generalize the skills being learned to other settings.

**Training Session Five**

The facilitator reviewed the limit setting steps and focused on giving choices as a method of increasing the child's sense of responsibility and as a means of discipline. This session also included several minutes of role playing. Homework for this session consisted of finding a situation where the parents could practice giving their children a choice. Parents were instructed to continue the home play sessions and arrangements were made for two more parents to come to the clinic for videotaping.

**Training Session Six**

The facilitator focused on children's aggression and how parents could cope with it. The handouts, "Some Thoughts on Aggression" and "When Setting Limits Doesn't Work" (Appendix B) were given to the parents and discussed. Parents were instructed to continue the home play sessions and arrangements were made for two more parents to come to the clinic for videotaping.

**Training Session Seven**

The facilitator discussed some common problems parents experience during the play session, as presented in the
handout, "Common Problems in Filial Therapy" (Appendix B). This discussion was used to review the skills of reflective listening, setting limits, and giving choices. The parents were asked to write a note to their children pointing out a positive characteristic that they appreciated in their children. Parents were instructed to continue the home play sessions and arrangements were made for two more parents to come to the clinic for videotaping.

Training Session Eight

Debriefing of the previous week's home play sessions continued with a focus on the parent's perceived changes in their own behavior as well as how they saw their children changing. The parents' confidence in their newly learned skills became more evident as they participated more freely in critiquing each other's skills and offering suggestions as the videotapes were reviewed. Parents were instructed to continue the home play sessions and arrangements were made for two more parents to come to the clinic for videotaping.

Training Session Nine

The parents were asked how they wanted their children to remember them. As they responded, the facilitator encouraged and reinforced their hopes through the examples of progress they had already shared. The remainder of the session was spent critiquing videotaped play sessions. Parents were instructed to continue the home play sessions and two parents were scheduled for videotaping at the clinic.
Training Session Ten

The final session was used primarily as a review of the previous classes, the parents offered their perspective on what was most important to them in the process, and what they hoped to continue to do with their children. The facilitator asked them to think back to the beginning of the sessions and consider the progress they and their children had made. The importance of continuing the play sessions was emphasized and the parents each signed a contract, making a commitment to continue the play sessions for "X" number of weeks. Parents discussed the possibility of follow-up sessions and a time was set to meet again in six weeks.

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. Parents who missed more than three training sessions (n=3) were dropped from the study.

Two of the filial therapy training groups were facilitated by the investigator of this study and one was facilitated by Garry Landreth. Garry Landreth received his doctorate in education from the University of New Mexico, is a licensed psychologist and licensed professional counselor in the state of Texas, and is currently a Regents professor of counselor education at the University of North Texas.
(UNT) and the Director of the Center for Play Therapy at UNT. Dr. Landreth is acknowledged nationally as an authority on play therapy and filial therapy. The investigator, also a licensed professional counselor in the state of Texas and formerly the Assistant Director of the Center for Play Therapy, is a doctoral student at UNT and has completed advanced course work and training in play therapy and filial therapy under the supervision of Dr. Landreth. The investigator also participated in one of Dr. Landreth's filial therapy training groups as a parent. Both facilitators have conducted numerous filial therapy training groups following the methodology outlined by Dr. Landreth (1991) for a ten week filial therapy training group and utilized the outlines and handouts found in Appendix B. The investigator also reviewed video tapes of Dr. Landreth leading a ten week filial therapy group to insure consistency in how information was presented to the parents in each of the three training groups.

Analysis of Data

Following the collection of the pretest and posttest data, the three self-report instruments were blind-scored by a research assistant and double checked by a second research assistant. The pre and posttraining video tapes of parent-child play were not rated until completion of the study to insure that the raters did not know whether they were rating
a pretraining or posttraining session. Four doctoral students with advanced course work and training in play therapy and filial therapy blind scored the videotapes over a two week period. Interrater reliability for the four raters was established during two 2-hour training sessions. Training included discussions and collaborative rating sessions following the procedures outlined by Stover et al. (1971). Interrater reliability was also checked midpoint of the scoring process and again at the end of the scoring as suggested in the Manual for Coders (Muehl, 1961). Kendall's Coefficient of Concordance W was used to calculate interrater reliability and the resulting reliability coefficients are presented in Table 1.

Table 1
Interrater reliability coefficients of concordance for coding of the Measurement of Empathy in Adult-Child Interactions scales

<table>
<thead>
<tr>
<th>Variables</th>
<th>I Pre-coding</th>
<th>II Pre-coding</th>
<th>III Midpoint</th>
<th>IV Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication of Acceptance</td>
<td>.999**</td>
<td>.975*</td>
<td>.999*</td>
<td>.957**</td>
</tr>
<tr>
<td>Allowing Self-Direction</td>
<td>.983**</td>
<td>.999**</td>
<td>.844*</td>
<td>.983**</td>
</tr>
<tr>
<td>Parental Involvement</td>
<td>.975**</td>
<td>.934**</td>
<td>.840*</td>
<td>.999**</td>
</tr>
<tr>
<td>Total Empathy</td>
<td>.960***</td>
<td>.952***</td>
<td>.967***</td>
<td>.989***</td>
</tr>
</tbody>
</table>
For the purpose of statistical analysis, data from the three filial therapy training groups was pooled to form the treatment group. The resulting data was keyed into the computer and analyzed by the researcher using SYSTAT: The System for Statistics (Wilkinson, 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 hypotheses. 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. Significance of difference between means was tested at the .05 level. 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 Measurement of Empathy in Adult-Child Interaction (MEACI) posttest than will the control parent group.

Table 2 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 3 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.
Table 2

Mean total scores for the Measurement of Empathy in Adult Child Interaction (MEACI)

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>7367.045</td>
<td>1</td>
<td>7367.045</td>
<td>242.379</td>
<td>.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>412.795</td>
<td>1</td>
<td>412.795</td>
<td>13.581</td>
<td>.001</td>
</tr>
<tr>
<td>Error</td>
<td>1215.788</td>
<td>40</td>
<td>30.395</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates an increase in empathic behavior.

Table 3

Analysis of covariance data for the mean total scores on the Measurement of Empathy in Adult Child Interaction (MEACI)

Table 3 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group parents' empathic interaction with their children during observed play sessions. On the basis of this data, hypothesis 1 was retained.

Hypothesis 1.a

The experimental parent group will attain a significantly higher mean score on the Communication of
Acceptance subscale of the MEACI posttest than will the control parent group.

Table 4 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 5 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

Table 4
Mean scores for the MEACI subscale: Communication of Acceptance

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>18.795</td>
<td>11.045</td>
</tr>
<tr>
<td>SD</td>
<td>1.881</td>
<td>1.224</td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates an increase in communication of acceptance.

Table 5
Analysis of covariance data for the mean scores for the MEACI subscale: Communication of Acceptance

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>640.440</td>
<td>1</td>
<td>640.440</td>
<td>199.445</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>3.510</td>
<td>1</td>
<td>3.510</td>
<td>1.093</td>
<td>0.302</td>
</tr>
<tr>
<td>Error</td>
<td>128.444</td>
<td>40</td>
<td>3.211</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group parents' verbal expression of acceptance of their children's feelings and behaviors during observed play sessions. On the basis of this data, hypothesis 1.a was retained.

Hypothesis 1.b

The experimental parent group will attain a significantly higher mean score on the Allowing the Child Self-Direction subscale of the MEACI posttest than will the control parent group.

Table 6 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 7 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

Table 6

Mean scores for the MEACI subscale: Allowing the Child Self-Direction

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>21.727</td>
<td>8.591</td>
</tr>
<tr>
<td>SD</td>
<td>4.096</td>
<td>2.443</td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates an increase in allowing the child self-direction.
Table 7

**Analysis of covariance data for the mean scores on the MEACI subscale: Allowing the Child Self-Direction**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>1587.877</td>
<td>1</td>
<td>1587.877</td>
<td>125.360</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>201.229</td>
<td>1</td>
<td>201.229</td>
<td>15.887</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>506.660</td>
<td>40</td>
<td>12.667</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 7 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group parents' behavioral willingness to allow the children self-direction during observed play sessions. On the basis of this data, hypothesis 1.b was retained.

**Hypothesis 1.c**

The experimental parent group will attain a significantly higher mean score on the Involvement subscale of the MEACI posttest than will the control parent group.

Table 8 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 9 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.
Table 8

Mean scores for the MEACI subscale: Involvement

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>13.045</td>
<td>7.682</td>
</tr>
<tr>
<td>SD</td>
<td>1.759</td>
<td>1.644</td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Note. A decrease in the mean score indicates an increase in involvement.

Table 9

Analysis of covariance data for the mean scores on the MEACI subscale: Involvement

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>273.708</td>
<td>1</td>
<td>273.708</td>
<td>115.863</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>32.088</td>
<td>1</td>
<td>32.088</td>
<td>13.583</td>
<td>0.001</td>
</tr>
<tr>
<td>Error</td>
<td>94.494</td>
<td>40</td>
<td>2.362</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 9 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group parents' attention to and participation in their children's play during observed play sessions. On the basis of this data, hypothesis 1.c was retained.

Hypothesis 2

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 10 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 11 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

**Table 10**

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

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest Posttest</td>
<td>Pretest Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>140.00 165.136 140.429 139.143</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>17.747 17.600 13.515 13.271</td>
<td></td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

**Table 11**

**Analysis of covariance data for the mean total scores on the Porter Parental Acceptance Scale (PPAS)**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>7426.071</td>
<td>1</td>
<td>7426.071</td>
<td>59.117</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>5002.540</td>
<td>1</td>
<td>5002.540</td>
<td>39.824</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>5024.622</td>
<td>40</td>
<td>125.616</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 11 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group parents' perceived acceptance of their children. On the basis of this data, hypothesis 2 was retained.

**Hypothesis 2.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 12 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 13 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

**Table 12**  
Mean scores for the PPAS subscale: Respect for the Child's Feelings and Right to Express Themselves

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>34.773</td>
<td>43.455</td>
</tr>
<tr>
<td>SD</td>
<td>6.775</td>
<td>6.061</td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>
Table 13
Analysis of covariance data for the mean scores on the PPAS subscale: Respect for the Child's Feelings and Right to Express Themselves

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>922.425</td>
<td>1</td>
<td>922.425</td>
<td>104.898</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>903.999</td>
<td>1</td>
<td>903.999</td>
<td>102.803</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>351.741</td>
<td>40</td>
<td>8.794</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 13 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group parents' respect for their children's feelings and their right to express them. On the basis of this data, hypothesis 2.a was retained.

Hypothesis 2.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 14 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 15 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.
Table 14

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

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>33.591</td>
<td>38.500</td>
</tr>
<tr>
<td>SD</td>
<td>6.960</td>
<td>5.002</td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Table 15

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

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>208.264</td>
<td>1</td>
<td>208.264</td>
<td>14.187</td>
<td>0.001</td>
</tr>
<tr>
<td>Covariates</td>
<td>528.856</td>
<td>1</td>
<td>528.856</td>
<td>36.025</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>587.215</td>
<td>40</td>
<td>14.680</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 15 shows the F ratio for the main effects was significant to the .001 level indicating a significant increase in the experimental group parents' appreciation for their children's uniqueness. On the basis of this data, hypothesis 2.b was retained.

Hypothesis 2.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 16 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 17 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

Table 16

Mean scores for the PPAS subscale: Recognition of the Child's Need for Autonomy

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>39.818</td>
<td>47.455</td>
</tr>
<tr>
<td>SD</td>
<td>4.182</td>
<td>4.306</td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Table 17

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

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>688.361</td>
<td>1</td>
<td>688.361</td>
<td>72.719</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>498.624</td>
<td>1</td>
<td>498.624</td>
<td>52.675</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>378.640</td>
<td>40</td>
<td>9.466</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 17 shows the F ratio for the main effects was significant to the <.001 level indicating a significant increase in the experimental group parents' recognition of their children's need for autonomy and independence. On the basis of this data, hypothesis 2.c was retained.
Hypothesis 2.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 18 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 19 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

Table 18

Mean scores for the PPAS subscale: Unconditional Love

<table>
<thead>
<tr>
<th>Source</th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>32.045</td>
<td>37.636</td>
</tr>
<tr>
<td>SD</td>
<td>7.730</td>
<td>7.365</td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Table 19

Analysis of covariance data for the mean scores on the PPAS subscale: Unconditional Love

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>416.093</td>
<td>1</td>
<td>416.093</td>
<td>19.850</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>1305.274</td>
<td>1</td>
<td>1305.274</td>
<td>62.268</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>838.483</td>
<td>40</td>
<td>20.962</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 19 shows the F ratio for the main effects was significant to the <.001 level indicating a significant
increase in the experimental group parents' unconditional love for their children. On the basis of this data, hypothesis 2.d was 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 20 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 21 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

**Table 20**

Mean total scores for the Parenting Stress Index (PSI)

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>272.682</td>
<td>242.409</td>
</tr>
<tr>
<td>SD</td>
<td>44.258</td>
<td>39.032</td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

**Table 21**

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

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>18477.769</td>
<td>1</td>
<td>18477.769</td>
<td>31.946</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>45654.717</td>
<td>1</td>
<td>45654.717</td>
<td>78.931</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>23136.411</td>
<td>40</td>
<td>578.410</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 21 shows the F ratio for the main effects was significant to the <.001 level indicating a significant decrease in the experimental group parents' perceived level of stress related to parenting. On the basis of this data, hypothesis 3 was 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 22 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 23 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

Table 22
Mean scores for the PSI subscale: Parent Domain

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>Posttest</td>
<td>Pretest</td>
</tr>
<tr>
<td>Mean</td>
<td>150.773</td>
<td>135.500</td>
</tr>
<tr>
<td>SD</td>
<td>25.740</td>
<td>22.726</td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>
Table 23

**Analysis of covariance data for the mean scores on the PSI subscale: Parent Domain**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>5169.418</td>
<td>1</td>
<td>5169.418</td>
<td>26.998</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>17703.478</td>
<td>1</td>
<td>17703.478</td>
<td>92.459</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>7658.974</td>
<td>40</td>
<td>191.474</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td></td>
<td>43</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 23 shows the F ratio for the main effects was significant to the <.001 level indicating a significant decrease in the experimental group parents' perceived level of stress related to their attitudes and perceptions of themselves as parents. On the basis of this data, hypothesis 3.a was 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 24 presents the pre and posttest means and standard deviations for the experimental and control groups. Table 25 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.
Table 24

Mean scores for the PSI subscale: Child Domain

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th>Control (n=21)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>121.864</td>
<td>104.182</td>
</tr>
<tr>
<td>SD</td>
<td>23.961</td>
<td>14.786</td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
</tr>
</tbody>
</table>

Table 25

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

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>5481.955</td>
<td>1</td>
<td>5481.955</td>
<td>59.795</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>8569.931</td>
<td>1</td>
<td>8569.931</td>
<td>93.478</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>3667.151</td>
<td>40</td>
<td>91.679</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 25 shows the F ratio for the main effects was significant to the <.001 level indicating a significant decrease in the experimental group parents' perceived level of stress related to their children's behavior. On the basis of this data, hypothesis 3.b was retained.

Hypothesis 4

The experimental parent group will attain a significantly lower mean score on the Filial Problem Checklist (FPC) posttest than will the control parent group.

Table 26 presents the pre and posttest means and standard deviations for the experimental and control groups.
Table 27 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

Table 26

Mean scores for the Filial Problem Checklist

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=22)</th>
<th></th>
<th>Control (n=21)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>34.500</td>
<td>16.818</td>
<td>40.571</td>
<td>60.762</td>
</tr>
<tr>
<td>SD</td>
<td>28.034</td>
<td>11.839</td>
<td>26.517</td>
<td>51.429</td>
</tr>
<tr>
<td>Total cases</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 27

Analysis of covariance data for the mean scores on the Filial Problem Checklist

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Sign. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main effects</td>
<td>15557.246</td>
<td>1</td>
<td>15557.246</td>
<td>21.158</td>
<td>0.000</td>
</tr>
<tr>
<td>Covariates</td>
<td>26431.285</td>
<td>1</td>
<td>26431.285</td>
<td>35.947</td>
<td>0.000</td>
</tr>
<tr>
<td>Error</td>
<td>29411.797</td>
<td>40</td>
<td>735.295</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases =</td>
<td>43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 27 shows the F ratio for the main effects was significant to the <.001 level indicating the experimental group parents perceived a significant reduction in the number of problems their children were experiencing. On the basis of this data, hypothesis 4 was retained.
Discussion

The results of this study strongly point to the effectiveness of filial therapy training with single parents. Significant results were found on each of the 13 hypotheses. The meaning of these results is discussed below.

Empathy in Parent-Child Interactions

As can be seen in Table 2 through Table 9, the experimental group parents showed significant increases ($p < .001$) in empathic behavior during observed play sessions with their children as measured by the three subscales of the Measurement of Adult-Child Interaction. The experimental group's posttest mean total score decreased a dramatic 28 points ($SD = 3.7$), while the control group's mean score increased 1 point ($SD = 8.1$). (Note: For this scale, a decrease in the mean score indicates an increase in the desired behavior). The experimental group demonstrated: (a) an increase in attending fully to the child; (b) an increase in following the child's lead rather than attempting to control the child's behavior; and (c) an increase in commenting on the child's expression of feeling or behavior in a genuinely accepting manner. The experimental group displayed the most dramatic increase in Communication of Acceptance, with a pretest to posttest mean score difference of 11 points ($SD = 1.2$). The control group showed a 2 point average decrease ($SD = 2.2$) in
Communication of Acceptance. The facilitators' observations and parents' comments also support these results. One parent who had difficulty accepting her child's "negative" feelings and aggressive behavior made the following comment in the eighth week of training:

"...last week when you were talking about how important it was to accept negative feelings as well as positive feelings...that really hit me...that I really don't do that. This week in the play session, I tried really hard to be more accepting of (the child's) anger and aggressive behavior toward me...it really made a difference...when I reflected how I thought he was feeling, his whole behavior changed...he became calmer and for the first time in our play sessions chose to paint. I felt calmer, too, and was able to relax and do more tracking and reflecting...

Stover, B. Guerney, & O'Connell (1971), authors of this instrument, stated that the verbal expression of acceptance was the major element in the communication of empathy. They found that this behavior did not generally occur in spontaneous interactions between parent and child. The present study confirmed this finding. A reflection of feeling response, the primary behavioral indicator of communication of acceptance on this scale, was not made by any parent in either the experimental or control group.
during the pretraining play sessions or by any of the control group parents during the posttraining play sessions.

These results are particularly of interest because they are based on direct observation of specific parenting behaviors by trained professionals rather than self-report instruments. The findings of this investigation support earlier studies in filial therapy that used direct observations to measure empathic behavior in parents as they interacted with their children in play sessions (B. Guerney, Burton, Silverberg, & Shapiro, 1965; B. Guerney & Stover, 1971; B. Guerney, Stover, & DeMeritt, 1968; Stover & B. Guerney, 1967; Stover et al., 1971). The results of the present study with single parents show gains similar to those reported by B. Guerney and Stover (1971) and Stover and B. Guerney (1967). Stover et al. (1971) found that a high level of empathic behavior in parents was a decisive factor in the success of the filial therapy training process and of paramount importance for a significant change in the child's behavior. These findings suggest that a ten week filial therapy parent training group is an effective treatment for increasing empathy in parent-child interactions. Various parent populations, including single parents, can benefit from this training.

Parental Acceptance

As can be seen in Table 10 through Table 19, the members of the experimental parent group demonstrated highly
significant \((p < .001)\) increases in their perceived acceptance of their children in all four subscales measured by the Porter Parental Acceptance Scale (PPAS), as well as in the total score. The parents reported a growth in unconditional love for their children and a similar growth in acceptance of their children's unique make-up. The parents reported even more dramatic increases in acceptance of their children's feelings and their right to express them and recognition of their children's need for autonomy and independence. The more dramatic increases in the last two subscales may be attributed to the fact that the behaviors they measure are more closely related to specific play therapy skills that the parents are required to practice during training. In the tenth week of training, several parents commented that they were much better listeners than when they started the training and as a result that they better understood how their children were feeling. One parent commented: "it's not that I love her more...I'm more understanding...I feel like we're closer...there's more of a bond..." The investigator's observations and the highly significant results on the MEACI subscales, Communication of Acceptance and Allowing the Child Self-Direction, also seem to support the findings.

The results on the PPAS support earlier studies in filial therapy (Dematatis, 1981; Glass, 1986; Glazer-Waldman, 1991; L. Guerney & Gavigan, 1981; Lebovitz, 1982;
Lobaugh, 1991; Sensue, 1981; Sywulak, 1977) in that parental acceptance, as measured by the Porter Parental Acceptance Scale, increased after treatment. The results in the present study with single parents show gains similar to Lobaugh (1991) and Sywlak (1977). Sensue (1981) conducted a follow-up to Sywlak's study and found significant increases in parental acceptance at six months and three years.

These findings suggest that a ten week filial therapy training group is an effective treatment for increasing parental acceptance in a various parent populations, including single parents.

**Parental Stress**

As can be seen in Table 20 through Table 25, the members of the experimental parent group showed highly significant ($p < .001$) decreases in their levels of stress related to parenting as measured by the Parenting Stress Index. The control group parents' mean level of stress increased noticeably over the period of ten weeks. This may be explained, in part, by the fact that several of the parents were college students and that the posttesting was done the week before final exams. However, the experimental parent group was comprised of approximately the same percentage of college students as the control group and posttesting was done at the same time.

The parents in the experimental group reported a significant decrease in their level of stress related to
their perception of themselves as parents and in their level of stress related to their children's behavior. These changes can be inferred to have been a result of the filial therapy training. Learning skills to enhance the parent-child relationship and participating in a 30-minutes per week special play time with their children, along with the support and encouragement from group members, significantly reduced the stress these single parents were experiencing at the beginning of the study. In the tenth week of training, several parents commented that they felt calmer, more confident, and more in control of themselves as parents. Learning how to give their children choices and set limits were most often cited as the skills that had been the most beneficial in helping the parents feel more in control and confident of themselves in their parenting role.

Single parenting is associated with high levels of stress and a need for support systems to alleviate some of that stress (Hamner & Turner, 1990; Woody, Colley, Schlegelmilch, Maginn, & Balsanek, 1984). The supportive group atmosphere of the filial training groups may be an important factor in explaining the significance of these findings. Both group facilitators observed a high level of cohesiveness between group members during the training sessions and several members reported developing friendships outside the training sessions. Members seemed to readily identify with each other's situations of being single and
overwhelmed with the responsibility. Several parents commented that it helped knowing that other parents were dealing with similar struggles and problems.

The findings in the present investigation are similar to those found by Lobaugh (1991) in a study on filial therapy with incarcerated fathers. He found significant decreases in the experimental group's mean scores on the total Parenting Stress Index and on the Parent Domain subscale. Although Lobaugh's experimental group's posttest mean scores on the Child Domain subscale did not decrease significantly, they did drop four points from pretest to posttest. These findings suggest that a ten week filial therapy parent training group is an effective treatment for decreasing parental stress.

Child's Problematic Behaviors as Perceived by the Parent

The number of problem behaviors identified on the Filial Problem Checklist by the parents in the experimental group was significantly reduced after training, dropping an average of 18 points. Previous investigators found similar reductions in the number of problem behaviors reported by parents who had completed filial therapy training (B. Guerney, 1976; B. Guerney & Stover, 1971; Lobaugh, 1991; Sywlak, 1977). The new parenting skills, along with an increased sense of competency as a parent and a more accepting view of their children may be important factors in explaining the significance of the experimental group
parents' scores on the posttest. In the tenth week of the training, the parents described their children as more secure, more independent, demonstrating more self-control, and more risk-taking. They also commented on how they now viewed their children's behavior as more "normal" than when they began the training. One parent commented, "it's not so much that (child) has changed...things don't bother me as much...I'm the one who's changed."

**Implications**

The results of this study along with the parents comments and the facilitators' observations support the value of filial therapy training for single parents. The parents' ability to demonstrate empathy in their interactions with their children increased dramatically and they reported significantly more accepting attitudes toward their children. The parents also reported a decrease in stress related to parenting and noted a marked reduction in their children's behavior problems.

These results suggest that the single parents in this study were able to adopt a more therapeutic role with their children during the special play sessions. The increased levels of empathy and acceptance that the parents demonstrated are the basic skills associated with learning a therapeutic role. The facilitator noted that while some parents more readily took to this new role, all the parents were able to demonstrate these skills on a least a minimally
effective level by the end of training. Although this study did not directly attempt to assess the impact of filial therapy training on the children's behaviors, the findings imply that the children in single parent families as well as their parents can benefit significantly from the filial therapy training.

The highly significant results have several additional implications for other parent training programs for single parents: (a) using a small support group format to allow for a high level of interaction between parents; (b) utilizing a balance of didactic and dynamic experiences; (c) using professionals trained in basic counseling skills to provide single parents with the emotional support they need and to model the reflective listening skills the parents are required to learn; (d) requiring a structured time outside of the training group where parents practice the skills they are learning (this seemed especially important for the parents in this group, as their lives seemed so chaotic and unstructured); (e) using videotaped sessions of parent-child interactions to provide an objective measure of the parents' skill levels and to allow the facilitator to offer encouragement and suggestions for improvements based on actual observations; and (f) providing childcare for single parents seems an absolute necessity.

Based on the parents' comments of wanting to continue the sessions, parenting groups for single parents may want
to consider a longer training period or periodic follow-up groups to provide the additional support single parents need.

**Recommendations**

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

1. The utilization of filial therapy training groups as a viable intervention for single parents and their children.

2. Further research in which the children's behavior is objectively measured by the investigator before and after the filial therapy training. This study would require the development of a direct observational rating scale similar to the one used to measure parents' behavior in this study.

3. Follow-up research with the subjects from this study in which half the subjects in the experimental group would receive follow-up training approximately every 6 weeks for one year and the other half would receive no additional training. Then measure both groups at the end of one year using the same instruments utilized in this study.

4. Further research in filial therapy with other populations identified "at risk" for optimal
parenting. Teenage parents are one such group that has not been studied using this approach.

5. Further research in filial therapy with single parent populations comparing the outcomes of different family structures, such as families headed by divorced mothers, divorced fathers, never married mothers, widowed parents, etc.

6. Further studies might examine the impact of the filial therapy training on children's adjustment to divorce. Such a study might compare three groups of children's adjustment to divorce: (a) only the custodial parent receive filial training; (b) only the non-custodial parent receive filial training; and (c) both the custodial and non-custodial parents receive filial therapy training.

7. Further research might investigate the significance of the support component and other experiential aspects of the filial training groups. One way to do this would be to compare parents in a filial training group with parents receiving individual filial training.

8. Further research might include the comparison of alternate treatment groups, such as comparing filial training for single parents with another parent education model for single parents.
9. Further research might investigate the effectiveness of intensive filial training, for example training small groups of parents over a period of 2-3 all-day training sessions.

Concluding Remarks

Filial therapy training is an effective intervention for single parents that has preventive, educational, and clinical implications. Single parent families form an increasing portion of the population with particular needs. This intervention can be applied in a variety of settings such as schools, community centers, churches, prisons, hospitals, and mental health clinics. Single parents have needs for both training and support in meeting the demands of single parenthood. The children of single parents often have the additional burden of having to adjust to the separation from the other parent. Communities have a responsibility to provide more services for these families, particularly in the area of mental health. However, a shortage of mental health professionals who work with parents and children makes it impossible to provide direct services to all these families who need it.

Filial therapy is one method by which both single parents and their children can receive help and move toward healthier relationships. A healthy parent-child relationship is essential to the present and future mental health of these children. Filial therapy training offers
significant possibilities for promoting the well-being of single parent families by equipping parents with healthy parenting skills, while providing them with the emotional support they need.
APPENDIX A

PARENTING CLASS/RESEARCH INFORMATION

AND CONSENT FORM
You are invited to participate in a study to determine the effectiveness of Filial Therapy training with single parents and their children. You will be asked to complete three questionnaires before and after the training. You will also be asked to participate in a 20-minute videotaped play session with your child before and after training.

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 these sessions Sue Bratton or Dr. Garry Landreth will be teaching you and other single parents some techniques on how to interact with your child in ways that will enhance your child’s self esteem as well as strengthen your relationship with your child. Also, you will be asked to share some insights, feelings, questions, and comments with the other participants in the group, during the sessions. You will also be asked to participate in eight weekly 30-minute play sessions at home with your child practicing the techniques being taught in the training sessions. You will be asked to select one of your children (between the ages of 3-7 years) to focus on during the 10 weeks of 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. In addition, you may keep the toy kit furnished to you for the training.

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.

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, Sue Bratton will have a list of participants’ names. At the conclusion of this study the list of participants names will be destroyed. The video taped play sessions of you and your child will be viewed only by graduate research assistants. The research assistants will have no knowledge of participants’ names and they will be made aware that the confidentiality of participants is to be maintained. The video tapes will be destroyed upon the completion of this study.

If you agree to participate, please fill out and sign the consent form on the back of this page. For further information please contact Sue Bratton 817-565-2063 (work) or 817-481-5391 (home). Thank you very much for your time, cooperation and your participation.

Sincerely,
Sue Bratton
You are making a decision whether or not to participate in this study. You should not sign until you understand all the information presented on the front of this form and until all your questions about the research have been answered to your satisfaction. Your signature indicates that you meet all the requirements for participation as explained by Sue Bratton and have decided to participate, having read the information on the front of this form.

________________________________________  Age  ______________________________________
Signature of Subject                      Date

________________________________________  Age  ______________________________________
Name of Child of Focus                    Date

________________________________________  ______________________________________
Signature of Witness                      Date

________________________________________  ______________________________________
Signature of Investigator                 Date
APPENDIX B
FILIAL THERAPY TRAINING
SESSION OUTLINES AND HANDOUTS
FILIAL SESSION #1

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

II. Overview of Filial Training:

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

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

   Techniques from play therapy will:
   Return control to you.
   Provide closer, happier times with your child.
   Give key to your child's inner world.

III. 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 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:

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 positive.

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

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

VII. Suggest "Listening" and "Self-Care" as reading this week.

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

Reflective responses this week.

1.

2.

3.

4.
FILIAL SESSION #2

I. Review homework: (1) Physical Characteristic
   (2) 4 Faces Sheet

II. Handout: "Filial Therapy Parent 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. Tour of play room, have them pair off and role play to practice
    reflective responding.

   RULE OF THUMB: When a child is drowning, don't try to teach him to swim.
   If a child is feeling upset, that is not the moment to
   impart a rule or value.

Homework:

(1) Buy toys for special play sessions.

(2) "Facilitating Reflective Communication" handout.

(3) Pick spot and time for sessions--report back next week.
FILIAL THERAPY PARENT GROUP
Dr. Garry L. Landreth

Basic Principles of the Play Sessions

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

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

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

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

Goals of the Play Sessions

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

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

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

Reminder

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

Toys for the Play Sessions

Play Doh, crayons (8 colors), paper, blunt scissors, nursing bottle (plastic), rubber knife, dart gun, a family of small dolls, toy soldiers (10-15 only), small plastic car, Lone Ranger type mask, Tinkertoys, a small cardboard box with rooms indicated by strips of tape, doll house furniture, doctor kit, a Bobo, and a piece or rope. A hand puppet toy would be a special asset. Feel free to discuss with us the addition of other items.
Place for the Play Sessions

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

Process

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

Toy Shops:

Constructive Playthings
11100 Harry Hines
Dallas 243-2353

Toys R Us

Many "Dime Stores" have soldiers, knife, dart gun, scissors, nursing bottle, car, doctor kit.
FACILITATING REFLECTIVE COMMUNICATION

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

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

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

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

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

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

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

I. Review homework:

   (1) Toys bought
   (2) "Facilitating Reflective Communication" Handout
   (3) Time and Place for Play Sessions

II. Handout in Class: "Basic Rules for Filial Therapy."

   Use to review rules for play session.

   Basic Limits: "I'm not for shooting."

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

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

   RULE OF THUMB: Be a thermostat, not a thermometer.

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

Homework:

   Play sessions at home begin this week.
BASIC RULES FOR FILIAL THERAPY

Don'ts

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

Do

1. Do set the stage.
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 with you."
THE EIGHT BASIC PRINCIPLES
(of Non-Directive Play Therapy)

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

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

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

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

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

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

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

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.
FILIAL SESSION #4

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

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

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

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

IV. Arrange for next parent to video tape.

V. Show video from parent-child session.

RULE OF THUMB: Good things come in small packages.

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

Homework: Notice one intense feeling in yourself this week.
1. **Firm limit-setting**

   A. **Three steps:**

   (1) **Recognize the feeling**—"I know you'd really like to . . .", or "I can tell you're really feeling . . .", etc.

   (2) **Set the limit**—". . .but you may not ________ . . .(because . . .)", or "but the answer is no" or "but the cabinet door is not for kicking."

   (3) **Provide an alternative**—"You can ______ if you'd like." Or "What you can do is ________ ."

   B. **After three-step process, DON'T discuss:** "I can tell you'd like to discuss this some more, but I've already answered that question."

   C. **If you're not prepared to answer the question** (want to talk it over with someone, want to get more information, want to think about it),

   (1) "I can't answer that question now . . .(because . . .)"
   "I'll let you know (specific time)."

   (2) **Nagging begins:** "If you must have an answer now, the answer will have to be NO."

   D. **If s(he) asks the same question again:** Calmly—"I've already answered that question." Variations:

   (1) "Do you remember the answer I gave you a few minutes ago when you asked that same question?" (Child answers, "No, I don't remember.") "Go sit down in a quiet place and think and I know you'll remember."

   (2) "I've answered that question once (twice) and that's enough."

   (3) If you think s(he) doesn't understand: "I've already answered that question. You must have some question about the answer."

   E. **If you're undecided and open to persuasion:** "I don't know . . .Let's sit down and discuss it."

2. **Oreo Cookie Theory:** Give the child a choice, providing acceptable choices commensurate with the child's ability to choose.
FILIAL SESSION #5

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

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

"Enslaved Parent"

III. Set up next parent to come in and tape.

IV. Review video of parent-child session.

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

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

Homework:

(1) Sandwich hugs - explain.

(2) Continue play sessions.

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

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

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

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

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

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

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

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

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

I. Debriefing on play sessions and giving one choice.

II. Handout: "Common Problems in Filial Therapy"

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

IV. Arrange for next taping.

V. Arrange for next taping.

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

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

Homework:

(1) Write a note to your child of focus (as well as other children in the family) for three weeks, pointing out a positive character quality you appreciate. "I was just thinking about you and I think you are __________. 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.
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: My child just plays and has fun. What am I doing wrong?
A: ____________________________________________

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

5. Q: My child doesn't respond to my comments. How do I know I'm on target?
A: ____________________________________________

6. Q: When is it okay for me to ask questions, and when is it not okay?
A: ____________________________________________

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

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

I. Debriefing on play sessions with focus on patterns.

II. Review "Common Problems in Filial Therapy."

   Use as chance to review reflective listening, setting limits, giving choices, etc.

III. Show video tape of session.

IV. Handout: "Learning to be Perfectionistic"

V. Arrange for taping of next parent.

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

Homework:

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

(2) Continue play sessions.
FILIAL SESSION #8

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

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

III. Handout: "Are You Listening to Your Child" excerpt

IV. Show video tape.

V. Arrange for next parent.

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

Idle threats harm your relationship with your child.

Homework:

(1) Continue play sessions.

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

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

II. Show video tape.

III. Go over "Are You Listening to Your Child."

IV. Handout: "Explaining Death to Children"

V. Arrange last taping session.

VI. 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

I. Briefly debrief.

II. Show last video tape.

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

IV. Closing Process:

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

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

V. Emphasize monthly meetings.

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

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."

Recommended Reading

1. How to Really Love Your Child, Campbell.


RULES OF THUMB AND OTHER THINGS TO REMEMBER

Rules of Thumb

1. You can't give away what you do not possess.
   You can't extend patience and acceptance to your child if you can't first offer it to yourself.

2. When a child is drowning, don't try to teach him to swim.
   If a child is feeling upset, that is not the moment to impart a rule or value.

3. Be a thermostat, not a thermometer.
   Reflect rather than react. The child's feelings are not your feelings and needn't escalate with him/her.

4. Good things come in small packages.
   Don't wait for the big events in our child's life to enter their world. The little ways are always with us.

5. The most important thing may not be what you do, but what you do after what you have done.
   We are certain to make mistakes, but how we handle our mistakes will make all the difference.

6. Grant in fantasy what you can't grant in reality.
   In a play session it is okay to act out feelings and wishes that may require limits in reality.

7. Praise the effort, not the product.
   This circumvents feelings of failure and fear of rejection.

8. If you draw your gun, shoot.
   When you don't "follow through" you lose credibility and harm your relationship with your child.

9. Don't answer questions that haven't been asked.
   Look beyond the question for the deeper question.

10. If you can't say it in 10 words or less, don't say it.
Other Things to Remember

1. Reflective responses can diffuse anger.

2. What's important is not what a child knows, but what s(he) believes.

3. "We're about to institute a new and significant policy immediately effective within the confines of this domicile."

4. When you're just trying to solve the problem you lose sight of the child.

5. Give children credit for making decisions: "Oh, you've decided to do ________ ."

6. Today is enough. Don't push your child toward the future.

7. One of the best things we can communicate to our children is that they are competent. Tell a child he is capable and he will think he is capable. Tell him enough times he can't do it and sure enough, he can't.

8. Don't try to change everything at once.

9. In the play session, the parent is not the source of answers. Reflect questions back to child.

10. Free the child. With freedom comes responsibility.

11. Noticing the child is a powerful builder of self-esteem.

12. Support the child's intent even if you can't support his behavior.

13. When we are flexible in our stance we can handle anger much more easily. When we are rigid, we and the child can end up hurt. (Remember the stiff arm!)


15. Where there are no limits, there is no security.

16. In the play session, praise limits creativity and freedom.

17. In play, children express what their lives are like now, what their needs are, or how they wish things could be.

18. What a child doesn't do is as important as what he does do.
APPENDIX C

MEASUREMENT OF EMPATHY IN ADULT-CHILD INTERACTIONS

RATING FORM
Measurement of Empathy in Adult-Child Interaction

Rating Form

Rater's Initials __________ Videotape Code # ______

Communication of Acceptance: verbal expression of acceptance/rejection
1. **Verbally Conveys Acceptance of Feelings:** You're proud of...., You really like.... That made you angry....
2. **Verbally Recognizes & Accepts Behavior Only** (tracking, giving credit): You got it that time. You're hitting the.... You really stabbed...
3. Social or NO Conversation: Mothers aren't very good at that. These are nice toys,
4. Slight to Moderate Verbal Criticism: No, not that way. You'll have to be more careful. That's cheating. You'll ruin the paints
5. Strongly Critical/Preaching/Rejecting: You see, I told you to do it the other way, It's not nice to break..., How stupid! You're being nasty

Allowing the Child Self-Direction: behavioral willingness to follow the child's lead (rather than control child's behavior)
1. Follows Child's Lead (no verbal comment necessary): You'd like me to..., I'm supposed to..., Show me how you want me... (whisper technique)
2. Allows Child Option for Lead-Taking, but asks/volunteers info: gives praise: What shall we do?, "Good", You can shoot this. You did that right
3. Parent Takes Lead (teaching how to do): Are you sure that's how..., See if you can do..., Take your time and aim..., It might work better...
4. Directs or Instructs Child (initiates new activity): Put the doll away first, Why don't you..., Let's play..., Don't put the....
5. Persuades, Demands, Interrupts, Interferes, Insists: No, take this one; That's enough; I told you not to..., You've got to...

Involvement: Parent's attention to and participation in the child's activity (may not always contribute in a positive way)
1. Fully Observant (more attention to child than objects being used): involved verbally & with "eyes" & physically when invited by child
2. High Level of Attention (attention to activity rather than child): when parent more involved in game than attending to child's reactions/behaviors
3. Marginal Attention: no joint activity, adult involved in own activity to degree it interferes with attentiveness, occasionally comments on child's activity
4. Partially Withdrawn/Preoccupied: infrequently observes, but doesn't comment, fails to attend to child's needs, but responds when asked by child
5. Self-involved/Shut-off: child ignored for prolonged period, child must repeat or prompt to get a response

DIRECTIONS FOR SCORING: A rating is made every 3 minute interval for 6 intervals (scoring is retrospective)
(Highest score = 1; Lowest score = 5)

<table>
<thead>
<tr>
<th>Communication of Acceptance:</th>
<th>SCORE</th>
</tr>
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<tbody>
<tr>
<td>Score Highest Level</td>
<td>= ___</td>
</tr>
<tr>
<td>Score Lowest Level</td>
<td>= ___</td>
</tr>
</tbody>
</table>

Avg Total

Comments:

<table>
<thead>
<tr>
<th>Allowing Self-Direction:</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score Lowest Level</td>
<td>___</td>
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</table>

Comments:

<table>
<thead>
<tr>
<th>Involvement:</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score Lowest Level</td>
<td>___</td>
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</tbody>
</table>

Comments:

Empathy Score = Grand Total = ___

(This form was developed by the investigator, following an example given by Stover, B. Guernsey, and O'Counsell, 1971)
APPENDIX D

PORTER PARENTAL ACCEPTANCE SCALE
PORTER PARENTAL ACCEPTANCE SCALE

We are trying to learn more about parent-child relationships. Please assist us by filling out this questionnaire as frankly and as carefully as possible. Your answers will be absolutely confidential. You have been asked to focus on only one child during this parenting class... please think only of that child as you answer these questions. Please answer all questions. If you cannot give an exact answer, answer the best you can.

INFORMATION ABOUT YOUR CHILD

Many parents say that their feeling of affection toward or for their child varies with his behavior and with circumstances. Will you 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.

<table>
<thead>
<tr>
<th>Degree of Feeling of Affection</th>
<th>Much more than usual</th>
<th>A little more than usual</th>
<th>The same</th>
<th>A little less than usual</th>
<th>Much less than usual</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Check One Column For Each Item Below</th>
<th>Much more than usual</th>
<th>A little more than usual</th>
<th>The same</th>
<th>A little less than usual</th>
<th>Much less than usual</th>
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</thead>
<tbody>
<tr>
<td>1. When he is obedient</td>
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<td>2. When he is with me</td>
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<td>3. When he misbehaves in front of special guests</td>
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<td>4. When he expresses unsolicited affection. &quot;You're the nicest mommy (daddy) in the whole world.&quot;</td>
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<td>5. When he is away from me</td>
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<td>6. When he shows off in public</td>
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<td>7. When he behaves according to my highest expectations</td>
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<td>8. When he expresses angry and hateful things to me</td>
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<tr>
<td>9. When he does things I have hoped he would not do</td>
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<tr>
<td>10. When we are doing things together</td>
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(Unpublished: Received permission to use from Dr. Blaine Porter, Brigham Young University)
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 number 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.

(41-43)

11. When my child is shouting and dancing with excitement at a time when I want peace and quiet, it:

1. Makes me feel annoyed
2. Makes me want to know more about what excites him
3. Makes me feel like punishing him
4. Makes me feel that I will be glad when he is past this stage
5. Makes me feel like telling him to stop

12. When my child misbehaves while others in the group he is with are behaving well, I:

1. See to it that he behaves as the others
2. Tell him it is important to behave well when he is in a group
3. Let him alone if he isn't disturbing the others too much
4. Ask him to tell me what he would like to do
5. Help him find some activity that he can enjoy and at the same time not disturb the group

13. When my child is unable to do something which I think is important for him, it:

1. Makes me want to help him find success in the things he can do
2. Makes me feel disappointed in him
3. Makes me wish he could do it
4. Makes me realize that he can't do everything
5. Makes me want to know more about the things he can do
14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, it:
   1. Makes me realize that he is growing up
   2. Pleases me to see his interest widening to other people
   3. Makes me feel resentful
   4. Makes me feel that he doesn't appreciate what I have done for him
   5. Makes me wish he liked me more

15. When my child is faced with two or more choices and has to choose only one, I:
   1. Tell him which choice to make and why
   2. Think it through with him
   3. Point out the advantages and disadvantages of each, but let him decide for himself
   4. Tell him that I am sure he can make a wise choice and help him foresee the consequences
   5. Make the decision for him

16. When my child makes decisions without consulting me, I:
   1. Punish him for not consulting me
   2. Encourage him to make his own decisions if he can foresee the consequences
   3. Allow him to make many of his own decisions
   4. Suggest that we talk it over before he makes his decision
   5. Tell him he must consult me first before making a decision

17. When my child kicks, hits or knocks his things about, it:
   1. Makes me feel like telling him to stop
   2. Makes me feel like punishing him
   3. Pleases me that he feels free to express himself
   4. Makes me feel that I will be glad when he is past this stage
   5. Makes me feel annoyed

18. When my child is not interested in some of the usual activities of his age group, it:
   1. Makes me realize that each child is different
   2. Makes me wish he were interested in the same activities
   3. Makes me feel disappointed in him
   4. Makes me want to help him find ways to make the most of his interests
   5. Makes me want to know more about the activities in which he is interested
19. When my child acts silly and giggle, I:

1. Tell him I know how he feels
2. Pay no attention to him
3. Tell him he shouldn't act that way
4. Make him quit
5. Tell him it is all right to feel that way, but help him find other ways of expressing himself

20. When my child prefers to do things with his friends rather than with his family, I:

1. Encourage him to do things with his friends
2. Accept this as part of growing up
3. Plan special activities so that he will want to be with his family
4. Try to minimize his association with his friends
5. Make him stay with his family

21. When my child disagrees with me about something which I think is important, it:

1. Makes me feel like punishing him
2. Please me that he feels free to express himself
3. Makes me feel like persuading him that I am right
4. Makes me realize he has ideas of his own
5. Makes me feel annoyed

22. When my child misbehaves while others in the group he is with are behaving well, it:

1. Makes me realize that he does not always behave as others in his group
2. Makes me feel embarrassed
3. Makes me want to help him find the best ways to express his feelings
4. Makes me wish he would behave like the others
5. Makes me want to know more about his feelings

23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:

1. Give him something quiet to do
2. Tell him that I wish he would stop
3. Make him be quiet
4. Let him tell me about what excites him
5. Send him somewhere else
24. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:

1. Try to minimize his association with that person
2. Let him have such associations when I think he is ready for them
3. Do some special things for him to remind him of how nice I am
4. Point out the weaknesses and faults of that other person
5. Encourage him to create and maintain such associations

25. When my child says angry and hateful things about me to my face, it:

1. Makes me feel annoyed
2. Makes me feel that I will be glad when he is past this stage
3. Pleases me that he feels free to express himself
4. Makes me feel like punishing him
5. Makes me feel like telling him not to talk that way to me

26. When my child shows a deep interest in something I don't think is important, it:

1. Makes me realize he has interests of his own
2. Makes me want to help him find ways to make the most of this interest
3. Makes me feel disappointed in him
4. Makes me want to know more about his interests
5. Makes me wish he were more interested in the things I think are important for him

27. When my child is unable to do some things as well as others in his group, I:

1. Tell him he must try to do as well as the others
2. Encourage him to keep trying
3. Tell him that no one can do everything well
4. Call his attention to the things he does well
5. Help him make the most of the activities which he can do

28. When my child wants to do something which I am sure will lead to disappointment for him, I:

1. Occasionally let him carry such an activity to its conclusion
2. Don't let him do it
3. Advise him not to do it
4. Help him with it in order to ease the disappointment
5. Point out what is likely to happen
29. When my child acts silly and giggly, it:

1. Makes me feel that I will be glad when he is past this stage
2. Pleases me that he feels free to express himself
3. Makes me feel like punishing him
4. Makes me feel like telling him to stop
5. Makes me feel annoyed

30. When my child is faced with two or more choices and has to choose only one, it:

1. Makes me feel that I should tell him which choice to make and why
2. Makes me feel that I should point out the advantages and disadvantages
3. Makes me hope that I have prepared him to choose wisely
4. Makes me want to encourage him to make his own choice
5. Makes me want to make the decision for him

31. When my child is unable to do something which I think is important for him, I:

1. Tell him he must do better
2. Help him make the most of the things which he can do
3. Ask him to tell me more about the things which he can do
4. Tell him that no one can do everything
5. Encourage him to keep trying

32. When my child disagrees with me about something which I think is important, I:

1. Tell him he shouldn’t disagree with me
2. Make him quit
3. Listen to his side of the problem and change my mind if I am wrong
4. Tell him maybe we can do it his way another time
5. Explain that I am doing what is best for him

33. When my child is unable to do some things as well as others in his group, it:

1. Makes me realize that he can’t be best in everything
2. Makes me wish he could do well
3. Makes me feel embarrassed
4. Makes me want to help him find success in the things he can do
5. Makes me want to know more about the things he can do well
34. When my child makes decisions without consulting me, it:

1. Makes me hope that I have prepared him adequately to make his decisions
2. Makes me wish he would consult with me
3. Makes me feel disturbed
4. Makes me want to restrict his freedom
5. Pleases me to see that as he grows he needs me less

35. When my child says angry and hateful things about me to my face, I:

1. Tell him it's all right to feel that way, but help him find other ways of expressing himself
2. Tell him I know how he feels
3. Pay no attention to him
4. Tell him he shouldn't say such things to me
5. Make him quit

36. When my child kicks, hits, and knocks things about, I:

1. Make him quit
2. Tell him it's all right to feel that way, but help him find other ways of expressing himself
3. Tell him he shouldn't do such things
4. Tell him I know how he feels
5. Pay no attention to him

37. When my child prefers to do things with friends rather than with his family, it:

1. Makes me wish he would spend more time with us
2. Makes me feel resentful
3. Pleases me to see his interests widening to other people
4. Makes me feel he doesn't appreciate us
5. Makes me realize that he is growing up

38. When my child wants to do something which I am sure will lead to disappointment for him, it:

1. Makes me hope that I have prepared him to meet disappointment
2. Makes wish he didn't have to meet unpleasant experiences
3. Makes me want to keep him from doing it
4. Makes me realize that occasionally such experiences will be good for him
5. Makes me want to postpone these experiences
39. When my child is not interested in some of the usual activities of his age group, I:

1. Try to help him realize that it is important to be interested in the same things as others in his group
2. Call his attention to the activities in which he is interested
3. Tell him it is alright if he isn't interested in the same things
4. See to it that he does the same things as others in his group
5. Help him find ways of making the most of his interests

40. When my child shows a deep interest in something I don't think is important, I:

1. Let him go ahead with his interest
2. Ask him to tell me more about this interest
3. Help him find ways to make the most of this interest
4. Do everything I can to discourage his interest in it
5. Try to interest him in more worthwhile things

THANK YOU VERY MUCH FOR YOUR COOPERATION
Dear Sue,

Enclosed with my compliments is a copy of my PORTER PARENTAL ACCEPTANCE SCALE, instructions for administering it and a scoring key. I also grant you permission to use this in your study if you find that it will be of use to you. Additional copies of the instrument can be supplied to you at twenty cents each.

If you do use the instrument in your study, I will appreciate it very much if you will send me a copy of your findings or at least a summary of your report.

Best wishes for success in your research study.

Sincerely,

[Signature]
Blaine R. Porter

Sue Bratton
Center for Play Therapy
University of Northern Texas
Counselor Education Department
P.O. Box 13857
Denton, Texas 76203-3857

Enclosures
APPENDIX E

FILIAL PROBLEM CHECKLIST
INSTRUCTIONS

The following list describes a wide variety of problems children often have. Please underline any item which you feel applies to your own child. Then, to the right of each item you underline, indicate how serious a problem you feel this is by placing a 1, 2, or 3 in the blank provided:

A 1 means "This item is true for my child, but is not really a problem.

A 2 means "This item is true for my child, and it is a mild problem."

A 3 means "This item is true for my child, and it is a severe problem."

EXAMPLE

If you underlined item 20, and you did not think it was really a problem, then you would place a 1 in the blank to the right, like this:

20) Bites nails 1

Or, if you underlined the same item, but felt it was a serious problem, then you would place a 3 in the blank to the right, like this:

20) Bites nails 3

If you have any problems completing this list, please do not hesitate to call for assistance.
A 1 means "This item is true for my child, but is not really a problem.
A 2 means "This item is true for my child, and it is a mild problem."
A 3 means "This item is true for my child, and it is a severe problem."

(5-24)

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1. Eats too little</td>
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<tr>
<td>2. Not eating the right food</td>
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<td>3. Wets bed at night</td>
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<td>4. Gets lower grades in school than should</td>
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<tr>
<td>5. Does not talk plainly, poor pronunciation</td>
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<td></td>
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<tr>
<td>6. Shy with other children</td>
<td></td>
<td></td>
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<tr>
<td>7. Too few friends</td>
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<td></td>
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<td>8. Feels inferior to other children</td>
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<td>9. Picked on by children</td>
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<td>10. Has no self-confidence</td>
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<tr>
<td>11. Nervous, tense</td>
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<td></td>
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<tr>
<td>12. Sad, unhappy too often</td>
<td></td>
<td></td>
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<tr>
<td>13. Cries too easily</td>
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<td></td>
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<td>14. Feels helpless</td>
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<td></td>
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<td>15. Blames self too much</td>
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<tr>
<td>16. Gets into trouble</td>
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<td></td>
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<td>17. Destroys property of others</td>
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<td>18. Steals</td>
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<td>19. Lies</td>
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<tr>
<td>20. Bites nails</td>
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(25-43)

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<thead>
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<tbody>
<tr>
<td>21. Picks nose</td>
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<tr>
<td>22. Always late, dawdles</td>
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<tr>
<td>23. Difficulty falling asleep or sleeping</td>
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<td>24. Troubled restless sleep</td>
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<td>25. Slow in reading</td>
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<td>26. Cannot keep mind on studies</td>
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<td>27. Does not pay attention to teacher</td>
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<td>28. Restless in class</td>
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<td>29. Headaches for no physical reason</td>
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<td>30. Stomach cramps, aches</td>
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<td>31. Feels different from other children</td>
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<tr>
<td>32. Easily led</td>
<td></td>
<td></td>
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<td>33. Left out by children of own age</td>
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<td>34. Never chosen as a leader</td>
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<td>35. Is self-conscious about own body</td>
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<tr>
<td>36. &quot;Big-shot&quot;</td>
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<td>37. Gets angry too easily</td>
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<td></td>
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<tr>
<td>38. Fear of darkness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Panics when afraid</td>
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</tbody>
</table>
A 1 means "This item is true for my child, but is not really a problem."

A 2 means "This item is true for my child, and it is a mild problem."

A 3 means "This item is true for my child, and it is a severe problem."

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
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<tbody>
<tr>
<td>40.</td>
<td>Too easily discouraged</td>
</tr>
<tr>
<td>41.</td>
<td>Breaks promises</td>
</tr>
<tr>
<td>42.</td>
<td>Thumb sucking</td>
</tr>
<tr>
<td>43.</td>
<td>Bad table manners</td>
</tr>
<tr>
<td>44.</td>
<td>Untidy</td>
</tr>
<tr>
<td>45.</td>
<td>Has bad dreams</td>
</tr>
<tr>
<td>46.</td>
<td>Afraid to speak up in class</td>
</tr>
<tr>
<td>47.</td>
<td>Fights too much with children</td>
</tr>
<tr>
<td>48.</td>
<td>Blows his or her top</td>
</tr>
<tr>
<td>49.</td>
<td>Sulks, pouts</td>
</tr>
<tr>
<td>50.</td>
<td>Gripes too much</td>
</tr>
<tr>
<td>51.</td>
<td>Fear-ridden child</td>
</tr>
<tr>
<td>52.</td>
<td>Unusual fears</td>
</tr>
<tr>
<td>53.</td>
<td>Does not do chores</td>
</tr>
<tr>
<td>54.</td>
<td>Takes advantage of people</td>
</tr>
<tr>
<td>55.</td>
<td>Disobeys parents</td>
</tr>
<tr>
<td>56.</td>
<td>Not close to parents</td>
</tr>
<tr>
<td>57.</td>
<td>Scratches self a lot</td>
</tr>
<tr>
<td>58.</td>
<td>Swears, uses dirty language</td>
</tr>
<tr>
<td>59.</td>
<td>Unable to keep to a time schedule</td>
</tr>
<tr>
<td>60.</td>
<td>Uses hands in poorly coordinated way</td>
</tr>
<tr>
<td>61.</td>
<td>Restless, can't stay in one place</td>
</tr>
<tr>
<td>62.</td>
<td>Non-athletic</td>
</tr>
<tr>
<td>63.</td>
<td>Does not like to go to school</td>
</tr>
<tr>
<td>64.</td>
<td>Does not spend enough time in study</td>
</tr>
<tr>
<td>65.</td>
<td>Not interested in books</td>
</tr>
<tr>
<td>66.</td>
<td>Always wants revenge</td>
</tr>
<tr>
<td>67.</td>
<td>Irritable child</td>
</tr>
<tr>
<td>68.</td>
<td>Teases excessively</td>
</tr>
<tr>
<td>69.</td>
<td>Daydreams a lot</td>
</tr>
<tr>
<td>70.</td>
<td>Gets too excited</td>
</tr>
<tr>
<td>71.</td>
<td>Does not try to correct bad habits</td>
</tr>
<tr>
<td>72.</td>
<td>Too stubborn with parents</td>
</tr>
<tr>
<td>73.</td>
<td>Continued demanding of gifts, new things</td>
</tr>
<tr>
<td>74.</td>
<td>Wants too much attention from parents</td>
</tr>
<tr>
<td>75.</td>
<td>Careless in own appearance</td>
</tr>
<tr>
<td>76.</td>
<td>Careless with clothes &amp; belongings</td>
</tr>
<tr>
<td>77.</td>
<td>Selfish, won't share</td>
</tr>
<tr>
<td>78.</td>
<td>Does not complete work</td>
</tr>
<tr>
<td>79.</td>
<td>Poor memory</td>
</tr>
<tr>
<td>A 1 means</td>
<td>A 2 means</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>&quot;This item is true for my child, but is not really a problem.&quot;</td>
<td>&quot;This item is true for my child, and it is a mild problem.&quot;</td>
</tr>
</tbody>
</table>

80. Unsure of self in school | 97. Gets people angry, provokes |
81. Has had a number of accidents | 98. Loses own possessions frequently |
82. Plays too much with younger children | 99. Gets completely out of control |
83. Bossy with brothers and/or sisters | 100. Oversensitive to criticism from parents |
84. Jealous of brothers and/or sisters | 101. Behind other children on dressing |
85. Preoccupied with own thoughts | 102. Feels bad about own physical appearance |
86. Loses temper | 103. Elimination problems (e.g. diarrhea, constipation, gas, holds urine, etc.) |
87. Is erratic, unpredictable | 104. Dangerous habits (describe) |
88. No control over emotions | 105. Sex-related problems (e.g. "peeps", exposes self, etc.) |
89. Fights back, talks back to elders. | 106. Physical tension problems (e.g. hives, ulcers, colitis, sweats, nausea, dizziness, etc.) |
90. Too dependent upon Mother, Father | 107. Excessively passive, meek |
91. Inconsiderate of parents | 108. Body movement problems (e.g. clumsy in using legs, jerky movements, lazy, apathetic, has no energy, head banging, paralyzed, moves too slowly, has twitches, rocks all the time, etc.) |
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