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FILIAL THERAPY WITH NATIVE AMERICANS
ON THE FLATHEAD RESERVATION

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

Geraldine J. Glover, B.A., B.S., M.A.

Denton, Texas

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This study was designed to determine the effectiveness of the 10-week filial therapy model as an intervention for Native American parents and their children residing on the Flathead Reservation in Montana. Filial therapy is an approach used by play therapists to train parents to be therapeutic agents with their own children. Parents are taught basic child-centered play therapy skills and practice those skills during weekly play sessions with their children. The purpose of this study was to determine if filial therapy is effective in: 1) increasing parental acceptance of Native Americans residing on the Flathead Reservation of their children; 2) reducing the stress level of those parents; 3) improving empathic behaviors of those parents toward their children; 4) changing the play behaviors of children with their parents who participated in the training; and, 5) enhancing the self-concept of those children.

The experimental group parents (N=11) 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 (N=10) received no treatment during the 10 weeks. All adult participants completed the Porter Parental Acceptance Scale and the Parenting Stress Index. Child participants completed

the Joseph Pre-school and Primary Self Concept Screening Test. Parent and child participants were videotaped playing together in 20-minute videotaped play sessions before and after the training to measure empathic behavior in parent-child interactions and desirable play behaviors in children.

Analyses of Covariance revealed that the Native American parents in the experimental group significantly increased their level of empathy in their interactions with their children. Experimental group children significantly increased their level of desirable play behaviors with their parents. Although parental acceptance, parental stress, and children's self concept did not improve significantly, all measures indicated positive trends. In addition, this study gives rise to questions regarding the suitability of current self concept measurement instruments for Native American children and possible cultural differences in parent stress and parental acceptance.

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CHAPTER I

INTRODUCTION

According to 1990 census figures 1.75 million people in the United States consider themselves to be members of, or closely affiliated with, one of the more than 500 different Native American tribes (Census of Population (1990 CP-3-7), 1994). The Native American population has increased dramatically during the last two decades, but Native Americans continue to represent less than one percent of the total United States population. One half of the Native American population is under eighteen years of age as compared to 26% for the population in general (Census of Population [1990 CP-2-1], 1994; Census of Population [1990 CP-3-7], 1994).

Nearly three times as many Native American families live in poverty as compared to the national average. Poverty places families under great stress and shapes their behavior, attitudes, and expectations, forcing them to devote an inordinate amount of time and energy to the tasks of day-to-day survival (Horejsi, Craig, & Pablo, 1992). Unemployment for Native Americans is twice the national average. Although the number of high school graduates has increased significantly since 1960, 33% of Native Americans continue to drop out as compared to the national average of 25%.

The birth rate among young Native American women between the ages of 15 and 24 is 1.7 times greater than the national average. Native American people die at a very young age; more than one-third of all deaths are of individuals under age 45 which is three times the rate of the general population (Campbell, 1989).

In addition to the lowest average socioeconomic status, Native Americans have very high rates of alcoholism. Three Feathers Associates (1989) estimated that 95% of all Native Americans are affected directly or indirectly by alcoholism. Native Americans also have higher incidents of mental illness and higher rates of suicide than any other ethnic group residing in the United States today (Epperley, 1991).

Depression appears to be the emotional problem that occurs most frequently (Indian Health Service, 1990). The severity of mental health problems in Native American children and adolescents is illustrated by the situation in one state where only 7% of the children are Native American, but 45% of the children served by the state psychiatric adolescent unit and 65% of the children in residential placement for mental health problems are Native Americans (Indian Health Services, 1990). In a multicultural study conducted by Abbott and Meredith (1985), Native American parents reported the lowest overall levels of family satisfaction and had the lowest overall scores on two measures of family strength.

Dr. Karl Menninger's 1977 speech to the Navajo Nation Health

Symposium (as cited in Burgess, 1980) described the interference endured by the Native American family. The primary source of the disruption came from the practice of sending Native American children away from home to boarding schools to be educated in the ways of the dominant culture.

The family is the most wonderful educational and character shaping institution of human life...It is similar everywhere in the world because it is biologically the same. It is the unit of human social life. In most cultures, the family structure...is not interfered with or impaired by design; accidentally sometimes, by death or disaster or war...but not by human intention. In the case of the American Indians, however, it has been interfered with, purposely-with good intention, no doubt, but we psychiatrists think wrongly and harmfully, however well intentioned. (p. 71)

A report from the Oakland Urban Indian Center (as cited in National Indian Child Abuse and Neglect Resource Center, 1980) specifies factors involved in Indian child abuse which include a special form of immaturity and associated dependency among Native American parents that has been precipitated from the boarding school era. This is mitigated by the rising number of teenage pregnancies, a tragically low self-esteem, and a sense of incompetence resulting from a feeling of racial inferiority imposed by the dominant culture over the past centuries. Additional factors include difficulty in adjusting to the demands of the dominant culture which is seen as being both

exclusive and requiring assimilation, social isolation from the extended family or any other support community to assist in child rearing, lack of parenting skills, fear of spoiling the child, strong belief in the values of corporal punishment, and difficulty in coming to accept responsibility for their own lives.

In A National Plan for Native American Mental Health Services, (1990) the Indian Health Service recognized that the incidence and prevalence of mental health problems and family disruption is high, in part due to the conflicts between traditional and Western pressures. At the time the plan was drafted, few mental health staff were trained to provide treatment for children and preventative efforts within the existing mental health programs were minimal. The National Plan also provided a mission statement for Native American mental health:

The mission of the mental health system for Native Americans is 1) to ensure that mental health services are available to all Native American persons who need them, are appropriate to the nature and severity of their mental health needs, are of high quality, and are sensitive and responsive to the cultural values of the individual, family, and community and 2) to promote the mental health of individuals, families, and communities. (p. 3)

While Native Americans suffer from the same types of mental disorders as other Americans, the prevalence and severity of these disorders appear to be greater, the availability of services lower, the cultural relevance of treatment

plans more challenging, and the social context more disintegrated than in almost any other segment of American society. Failure to address these issues will result in more severe emotional problems for future generations of individuals, families, and communities (Indian Health Services, 1990).

Hobbs (1969) promoted the concept that early intervention was the key to substantial changes in the adult population. Thus a greater emphasis in professional training on the problems of children, on childhood disorders and early indicators of later difficulties, and especially on normal growth patterns of development was seen as a more effective deployment of the limited resources of highly trained people. As advocated by professionals for the general population, providing preventative treatment for children and their families may also be the key to impacting the growing mental health needs of the Native American (Felner & Abner, 1983; Kazdin, 1993; Maddux, Roberts, & Wright, 1986).

In the 1960's Bernard and Louise Guerney began developing treatment methodologies that would assist parents in creating a stronger, more therapeutic relationship with their children. Parent training programs that utilize proven counseling methods give parents the opportunity to become effective agents of change. By utilizing the emotional bond which naturally exists between the parent and child, professionals can further empower parents by teaching them basic psychotherapeutic techniques (Authier, Gustafson, B. Guerney, & Kasdorf, 1975). 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 and behaviorally oriented. 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).

The rationale for using filial therapy with Native American parents is based on the apparent congruence between filial therapy and traditional Native American values such as a deep respect for individuals, including children. Filial therapy is intended to allow the child to communicate thoughts, needs, and feelings to the parent and to bring the child a greater feeling of self-respect, self-worth, and confidence (B. Guerney, 1964). Filial therapy has been found to be effective in increasing the self-esteem level of parents (Glass, 1986/1987). Filial therapy has also been found to be effective in increasing parental acceptance their children (Bratton, 1993/1994; Glass, 1986/1987; Lebovitz, 1982/1983; Lobaugh, 1991/1992; Sensue, 1981; Sywulak, 1977/1978). Acceptance by parents has in turn been linked to higher levels of self-esteem in children (Porter, 1954). Increased self-esteem in both parents and children provides confidence, energy, and optimism to master life's tasks. Filial therapy has also been found to be effective in reducing parental stress and improving communication between parents and between parents and children. Filial therapy has been effectively used with parents of emotionally disturbed children

(Sensue, 1981; Sywulak, 1977/1978), parents of children with mild to moderate emotional and behavioral difficulties (Glass, 1986/1987; Lebovitz, 1982/1983; Oxman, 1972/1973; Payton, 1980/1981), teachers of withdrawn children, (B. Guernsey, & Flumen, 1970), parents of learning disabled children (L. Guernsey, 1983), parents of children with stuttering problems (Andronico & Blake, 1971), parents of chronically ill children (Glazer-Waldman, 1991; Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992), single parents (Bratton, 1993/1994), incarcerated fathers (Lobaugh, 1991/1992), and incarcerated mothers (Harris, 1995). In addition, subjects from qualitative studies have reported improved communication, greater feelings of parental competence, and improvements in behavior of the children involved (Bavin-Hoffman, 1994; Lahti, 1992/1993; Packer, 1990). (Appendix A)

Statement of the Problem

The problem with which this investigation was concerned was that of determining the effectiveness of filial therapy in increasing parents' levels of acceptance of their children, facilitating parents' empathic responsiveness, and reducing parental stress in a particular group of Native American parents (i.e., Native Americans residing on the Flathead Reservation in Montana). In addition, this investigation attempted to determine whether filial therapy was effective in enhancing certain desirable play behaviors of children whose parents participated in filial therapy training.

Review of the Literature

The following review is a synthesis of historical literature and research related to six major areas: (1) the Native American family and education; (2) parent education; (3) Native American parent education; (4) filial therapy; (5) traditional Native American parenting and filial therapy; and, (6) self-esteem of Native Americans.

Native American Families and Education

Interference with the Native American family has generally occurred through the education system. Efforts to educate focused on "civilizing" and assimilating Native Americans into White society (Reyhner, 1994). The early missionaries and politicians of the late eighteenth and early nineteenth centuries dealt with the original inhabitants as groups devoid of culture and religion. These Europeans did not consider the possibility that they were facing comprehensive cultures; consequently, they attempted to impose their own cultures and religions on the people they called Indians (Noley, 1992).

In 1817, Puyshmataha, a leader of the Choctaw Nation, came to the conclusion that the most effective method of dealing with the European-Americans was to send Choctaw children to schools so that they could learn the ways of their adversaries. After about a decade, the Choctaw had schools of their own, taught by Choctaw teachers in the Choctaw language. The Choctaws and the missionaries modeled two contemporary educational phenomena, bilingual instruction and Indian control, and took this method with them when they were moved to Oklahoma. The Choctaws had schools before Oklahoma

became a state and even sent 40 Indian students to college in the "states" on scholarship (Noley, 1992).

Off reservation boarding schools, which were established in the United States in the late 1800's, exhibited their greatest growth in the 1920's. The schools were highly authoritative and were run in strict military fashion (National Indian Child Abuse and Neglect Resource Center, 1980). The Canadian Indians suffered a similar fate. Although treaties that had been signed in the 1870's promised schools on the reservations, the government placed emphasis on residential institutions in order to remove the children from the "retrograde" influence of their parents (Miller, 1987). According to Horejsi et al. (1992), those parents who spent much of their childhood in boarding schools were deprived of an opportunity to experience family life. They reached adulthood without a clear concept of parenting behavior and family functioning. The boarding school effectively destroyed the intergenerational transmission of family and parenting knowledge. Boarding schools also introduced new and dysfunctional behaviors, such as the use of severe corporal punishment and sexual abuse.

In the 1930's an attitude of tolerance and a desire to understand the Indian population resulted in an attempt to bring an understanding of Indian cultures to the government schools. Bilingual education, recognition of the importance of family, and other ideas began to find their ways into the schools operated by the Bureau of Indian Affairs (BIA). Unfortunately the onset of World War II ended the activities designed to be more culturally appropriate for Native

American students. Noley (1992) surmised that the post-war conservatism of Congress was not friendly to diversity in America. World War II and the Korean Conflict exposed large numbers of Native American people to life off the reservation and out of the rural areas where they mostly lived prior to the wars. The G.I. Bill and the BIA's Relocation Program for Job Training moved significant numbers of Native Americans to large urban areas away from the support of the extended family system and the Indian community.

The Indian Education Act of 1972 followed the publication of a widely publicized government study, *Indian Education: A National Tragedy - A National Challenge*, popularly known as the Kennedy report. The Act was intended to encourage the public schools to become more involved in the provision of activities designed to meet the unique and culturally specific educational needs of Native American children. In 1975 the United States Congress passed the Indian Self-Determination and Education Assistance Act that actually permitted Native American nations to control their own schools. Still, many Native American students either dropped out or were pushed out of schools that were not culturally sensitive in their approach to academic, social, cultural, and spiritual development. Significantly more Native American students were successful in schools that respected and supported the students' language and culture (Reyhner, 1994).

In summary, two models of Native American education were evolved in the nineteenth century: the boarding schools developed by non-Indians and the

academies and neighborhood schools which allowed dignity and diversity developed by the Choctaws and Cherokees. It is ironic that the one that prevailed for Native Americans was the non-Indian model and the one that prevailed for all other Americans was the Indian model (Noley, 1992; National Indian Child Abuse and Neglect Resource Center, 1980). The current trends in Native American education, however, are more positive. Those who were targeted by the government and the missionaries to conform were able to master the basics of the white society and economy, although at great pain and cost. Now they emerge as a new generation of leaders, schooled in residential institutions, but devoted to the preservation of their people as Native Americans (Miller, 1987).

Parent Education

Education, which did so much to disrupt the Native American family, may be the means to restore it. Organized parent education came about as an answer to the loss of the informal socialization process which had been practiced in all eras and across cultures (Brock, Oertwein, & Coufal, 1993). Most people who become parents take the role seriously and want to be successful at it and most seek some kind of guidance in fulfilling this role (Brock et al., 1993). In times of rapid social change, parents may face new circumstances and challenges that require that they reexamine their basic parental functions and assume new and different roles (Brock et al., 1993). Harmin and Brim (1980) have identified several social factors that contribute to

the contemporary need for parent education:

The process of family nuclearization, erosion of community, role differentiation and specialization, geographical distancing of family generations, and the increased entry into the labor force, have created a new reality in which parents no longer benefit from traditional structure in their parenting roles. (p. 14)

Increasing incidence of divorce and remarriage, child abuse and neglect, spouse abuse, runaways, emotional disturbance, and high incidence of teenage pregnancy have also been identified as current indicators of the need for parent education (Hicks & Williams, 1981). These same factors have contributed to the disruption of Native American families and their traditional ways of parenting.

Currently, parent education is both preventive and remedial. Preventive programs are generally presented in an educational format based on the assumptions that 1) increased knowledge and skill are catalysts for change, 2) people wish to grow in positive and healthy ways, 3) growth is enhanced by clearly stated goals and objectives, and 4) optimum growth occurs when consumers select goals appropriate to their own perceived needs (Brock et al., 1993).

In a survey of parent training literature conducted by Brock et al. (1993), three themes about parent-child relationships emerged: nurturance, structuring, and patterns of interaction. Nurturance involves behaviors such as warmth, support, the recognition of each child as an individual, developmentally

appropriate expectations, and responsiveness to child-initiated interactions. Research cited in the survey reported the effects of nurturing parental behaviors to be increased sharing and comforting (Bradley, Caldwell, & Rock, 1988; Bryant & Crockenberg, 1980), fewer behavioral problems (Pettit & Bates, 1989), expression of positive emotions (Malatesta, Grigoryev, Lamb, Albin, & Culver, 1986), increased intellectual ability (Clarke-Stewart, 1977; Morrow & Wilson, 1961), and the development of social competence (Rollins & Thomas, 1975; Staub, 1979).

Structuring, the second theme in parent-child relationships, involves making and enforcing rules and includes limit setting, control, behavioral expectations, and follow-through. Support from the literature is not as prevalent as for nurturance and the difference appears to lie in how structure is maintained and communicated. Baumrind's (1967) model of authoritative parenting has been cited as the best method of structuring in parent-child interaction. Authoritative parents used inductive child guidance methods but they also expected compliance with their expectations. These parents valued both self-will and conformity and encouraged verbal give and take. Children whose parents fit the authoritative style were self-reliant, self-controlled, explorative, and contented.

The third theme in parent-child interactions involves the patterns of interaction which develop between the parent and child. Bell and Harper (1977) found that some physiological characteristics of a child substantially influenced

parent-child interaction. In addition Bell and Harper identified child behavior patterns which evoked different parental responses. These findings provide support for the concept that not only does parent behavior effect child behavior, but also that child behavior influences parent behavior.

In general, parent training programs incorporate one or all of these themes in an effort to help adults become better parents. According to Brock et al. (1993) parents often enroll in programs because of difficulties with their children. In addition, sometimes when professionals confront childrearing practices and beliefs of non-Anglo parents that seem strange to them, their response is to urge that the parents attend a 'remedial' parent education program. The programs are usually modeled on the dominant culture ideal and are justified as scientifically based (Sprott, 1994). In the dominant culture, control must be present for good parenting to take place. Any pattern that is perceived as not controlling children in the manner deemed appropriate is construed as too permissive (Sprott, 1994). In contrast, Becker (1964) observed that warm permissive parents appeared to have more cooperative, creative, less hostile children than warm restrictive parents. Lewis (1981) demonstrated in a reinterpretation of Baumrind's data that optimal child competence could be explained more in terms of the child's willingness to obey rather than as a function of the exercise of parental control. A training program for non-Anglo parents would seem to be more effective if the cultural style of parenting is respected and supported rather than rejected in favor of dominant culture

values.

Native American Parent Education

In 1982, Kellogg, under the direction of the National American Indian Court Judges Association, conducted a survey to identify parenting and skills development programs and materials that have been implemented in Native American communities. The most commonly mentioned motivations for introducing parenting programs included: A basic lack of solid parenting skills; a relative absence of preventive services in the community; a desire to encourage parents to address the needs of their children early in life and to be more attentive to the different stages of their child's development; a way to promote better communication between parents and children who are experiencing problems; helping parents instill a greater sense of discipline, order, and structure in both their children and themselves; and, a means of providing a source of support and information to young, often single, parents who experience particular difficulty in maintaining their families.

Eighteen programs in thirteen states were evaluated to determine what works with Native American parenting programs. Many of the programs used were a modification of either Systematic Training for Effective Parenting (STEP) or Parent Effectiveness Training (PET). All sites expressed a desire for more culturally relevant materials. The incorporation of tribal elders and tribal members as trainers was highly recommended. Much interest was noted in making comparisons between traditional and modern values. The need for basic

skills and support was identified, as well as the desire for ways to develop positive parent-child interactions, communication skills, confidence, and the ability to provide for the development of their children.

In 1986, the program Positive Indian Parenting was introduced to meet the specific needs of Native American parents. The primary philosophy of the program is that the family is the basis of the tribal society and the most important unit in the Native American culture. The program emphasizes that there is a wide variety of child rearing standards and styles among Native American parents due to tribal identity, degree of assimilation, and many other factors. However, many tribes share common beliefs about children and the responsibilities of parenting. The focus of Positive Indian Parenting is on the parent rather than the child, beginning with discussions of traditional Native American parenting in which nurturing, respect, and understanding of the child is paramount. Attention is drawn to the importance of both verbal and nonverbal communication. Storytelling is incorporated into most of the lessons. Parents are encouraged to take part in the ceremonial life of the community and reestablish the traditional extended family concept.

An extensive review of the literature produced no other published training program for Native American parents. Research on the effectiveness of training programs for Native American parents was also lacking.

Filial Therapy

Filial therapy is another program which focuses on the parent-child

relationship by attending to the parent side of the relationship. Filial therapy was developed in the 1960's by Dr. Bernard Guerney as an alternative method for treating young children with behavioral and emotional problems. Landreth (1991) expanded on this concept emphasizing that even parents whose children are not suffering from adjustment problems can benefit from learning how to relate more effectively to their children. Filial literally means "of or pertaining to sons and daughters". The Guerneys relabeled filial to be called Child Relationship Enhancement Family Therapy (CREFT) in 1985 to more clearly describe the concept, but the term filial therapy continues to be widely used (L. Guerney, & B. Guerney, 1985). In filial therapy the major therapeutic strategy is to teach parents to conduct special play sessions modeled after play therapy as practiced by Axline (1969) and other Rogerian child therapists, such as Dorfman (1958), Ginott (1965), and Moustakas (1959). Using a small group format, filial therapy is presented to parents through didactic instruction, viewing video tapes, and role-playing.

Unlike more behaviorally oriented therapies, this model of play therapy is not directed toward specific problems, but is generic in nature. That is, it is aimed at improving self-esteem and the feelings underlying inappropriate behaviors. Feelings such as frustration, anger, performance anxiety, separation anxiety, fear of abandonment, or concerns about personal safety which manifest in inappropriate and maladaptive behaviors can be addressed through encouraging the child to play them out in the safe, interpersonal atmosphere of a

play session and in the presence of a warm, caring adult (L. Guernsey, 1983). Once parents have completed the initial training period, they conduct regularly scheduled special play sessions in their homes with their children while receiving supervision from a therapist and support through the filial therapy group meetings.

The concept of parents working directly with their children to alleviate mental health types of problems was not new. Freud's (1959) case study of "Little Hans" described treatment of a five year-old boy through his father. Freud was convinced that no one could have made the necessary impact except the father who had special knowledge and a special relationship established with his son. Jacobs (1949) proposed the handling of developmental difficulties in children under the age of five through their mothers by providing the mothers with specific knowledge about ego development upon which they could base their interactions with their children. Bonnard (1950) detailed a case history of a child who was treated for obsessional neurosis through the mother. Moustakas and Makowsky (1952) identified the importance of being more than simply a listener to the difficulties a parent might bring regarding their child. In each of these examples of parent as therapist, the parent met individually with a therapist to talk about the presenting problem and to receive feedback from the therapist. The parent took this information home and carried out the treatment. Filial therapy expands this concept by focusing on the development of the parent-child relationship through special structured play sessions and provides

for direct supervision and feedback for the parent as they learn and practice the techniques of child-centered play therapy.

Although trained paraprofessional helpers have been shown to be at least as effective as professionals (Hattie, Sharpley, & Rogers, 1984), Payton's (1980/1981) study further refined this concept. Payton's study compared parents who had received filial therapy training with parents whose children were seen in special play sessions conducted by paraprofessionals and parents whose children participated in no play sessions. Parents who were directly involved as the change agent in the process of treating their children showed a significantly more improved attitude toward parenting than parents whose children were seen by paraprofessionals. Parents also reported greater confidence in facilitating personality adjustments in their children.

With young children living in the home, the primary source of difficulties can presumably be traced directly or indirectly to interpersonal relationships within the family (B. Guernsey, 1964; B. Guernsey, L. Guernsey, & Andronico, 1966). In filial therapy, the parent's intimate involvement in the specific plan to help the child mobilizes the parent's motivation to be helped and perhaps more important to be of help. This alleviates the problem of rivalry between parent and therapist, reduces feelings of helplessness for the parent, and makes the parent an ally in the treatment rather than a rival (B. Guernsey, et al., 1966). With few exceptions, parents of nonpsychotic, young, emotionally troubled children, given a very clearly defined role for a clearly limited period of time, and

given corrective feedback by the therapist and by other parents attempting to learn the same thing, can learn that role with the child reasonably successfully (B. Guerney, 1964). By attentively observing the child with the child's needs uppermost in mind, and with the child's increased freedom to express self during the sessions, the parent is in a position of greater understanding of the child and can develop more realistic expectations and attitudes (B. Guerney, 1964).

Filial therapy adopts an educational model rather than a sickness-health model and assumes that family dysfunction is due to inadequate learning and habit formation rather than sickness or maladjustment (Ginsberg, 1989). Filial therapy is a relationship-based, process-oriented, developmental approach. The parent-child relationship is the vehicle for change in both parent and child. Change is promoted through the process of parent and child interacting with each other in a nonjudgmental and accepting fashion for a limited period of time. Appropriate methods are utilized for the particular developmental stage of the child, parent, and family. In particular, filial therapy acknowledges that play is the primary way in which children express themselves, grow and develop, are socialized, and improve their interpersonal skills.

Both the Guerneys' model and a shorter ten-week model developed by Landreth (1991) have been proven effective with a number of different populations. Over a dozen research studies have been conducted since the Guerneys' first conception of this relationship enhancement intervention in the 1960's. One of the earliest studies was compiled by Oxman (1972/1973). After

a twelve-month treatment period, 51 mothers, whose children had been diagnosed as emotionally maladjusted, reported a decrease in the number of problem behaviors displayed by their children. These mothers also described their perception of their children as being closer to their perception of an ideal child. Both results were significant as compared to a control group of 71 mothers, whose children displayed normal behavior with typical childhood problems, who did not participate in the training.

Sywulak (1977/1978) conducted a study in which the participants served as their own controls during a 4-month waiting period. Participants in the study were interested families who had referred themselves or had been referred to the Individual and Family Consultation Center of Penn State University. The group included 13 mother/father pairs and 6 single mothers. The study included process data as well as pre and post data in that the participants were asked to complete measurement instruments four months prior to training, immediately prior to training, at a two-month midpoint during training, and finally after four months of training. Significant gains in parental acceptance were reported at the two-month midpoint rating. That increase was maintained after four months of training. Both the Filial Problem Checklist and the Wichita Parent Check List showed significant decreases in reported child problem behaviors after two months of training. That decrease was maintained after four months of training.

Later research (Sensue, 1981) determined that the gains made by the participants in the Sywulak (1977/1978) study were maintained after both a three

month and a six month follow-up. In addition, a comparison group of parents matched for age, gender, socioeconomic status (SES), and education whose children were considered to have normal behavior with typical childhood problems reported problem behaviors which were not significantly different from those reported by the parents who participated in the filial therapy training.

Payton (1980/1981) conducted a study in which both parents and paraprofessionals who received 12 weeks of filial therapy training were compared to a control group who did not receive training. Those parents trained in filial therapy showed significantly higher scores on the Herford Parental Attitude Survey Form than either the paraprofessional or the control groups. Parents trained in filial therapy also reported a significant improvement in their children's behaviors as compared to either the paraprofessional or the control group. No change was reported in the children's self-concept for any of the groups.

Lebovitz (1982/1983) contrasted a group of mothers who had received filial therapy training with a group of mothers who conducted supervised play sessions with their children. Classmates of children in both of these treatment groups were evaluated by their teachers as a further comparison. This study consisted of a 10-week treatment program with a follow-up evaluation 2 months later. Mothers' filial therapy skills were measured and change was assessed by parent, teachers, and independent observers. In both filial therapy and play session group programs, children demonstrated proportionately fewer problem

behaviors in the classroom than did a sampling of their classmates; however, this was not maintained at the two-month follow-up. The filial therapy group exhibited a proportionately greater decrease in problem behaviors than did the other groups. Process research revealed that filial therapy group mothers communicated more acceptance of their children's feelings, allowed their children more self-direction and demonstrated more involvement with their children than did mothers in the play session group. Children in the filial therapy group exhibited a greater decrease in dependence than did children in the play session group. Parents in each group reported that they became more accepting of their children.

Glass (1986/1987) found that filial therapy significantly increased the parents' feelings of unconditional love for their children and significantly decreased the parents' perception of expressed conflict in their family. In addition to the statistically significant results, there were some important trends which were mentioned as directional conclusions. Filial therapy may be an effective treatment for increasing parents' acceptance of their children, may be a somewhat effective treatment for increasing self-esteem, yet more effective in increasing parents' self-esteem than children's' self-esteem, may be effective treatment for increasing closeness of the parent-child relationship without altering the authority hierarchy, may influence the family environment, especially in the areas of expressiveness, conflict, independence, intellectual-cultural orientation, and control, and may be an effective treatment for increasing

parents' understanding of the meaning of their children's play.

Findings in a case study conducted by Packer (1990) showed 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 in the process of filial therapy were reduction in temper tantrums and a growing ability to control escalation of rising emotions in both the home and the child care setting, and acceptance of the father as an authority figure in the presence of the mother.

Although Glazer-Waldman (1991) found no significant difference between pre-test and post-test measures of acceptance and anxiety for parents of chronically ill children, all five parents in the study reported positive change in themselves and positive change in their children. A comparison of scores on the measures of anxiety found parents' perceptions of their children's anxiety to be more closely matched to children's anxiety scores on the post-test.

Lobaugh (1991/1992) conducted a study to determine the effectiveness of a 10-week filial therapy model on increasing incarcerated fathers' acceptance of their children and reducing the stress they experienced as parents. The fathers in the filial therapy group significantly increased their acceptance of their children on all four subscales of the Porter Parental Acceptance Scale and significantly reduced their stress as a result of the training. They reported significantly fewer problems in the post-test checklist. In addition, the children of the experimental group parents significantly increased their self concepts as a

result of the training.

Utilizing ethnographic methodology, Lahti (1992/1993) revealed that 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. The findings revealed an interrelatedness between the beneficial and the motivational components. The play sessions facilitated change by permitting parents to be agents of change for short periods, which appeared to reduce the parents' anxiety while learning. Parents reported gaining objectivity, feedback from others, and stimulation to refine skills through reviewing video-taped sessions. Changes in parents included increased confidence and feelings of personal power, reduction in the degree of parental control and responsibility, and increased awareness of personal and children's needs. Closer parent-child and marital relationships were described and characterized by increased and enhanced communication, more realistic expectations, and less friction. The children's changes included increased and enhanced communication, increased responsibility for actions, decreased withdrawn and aggressive behavior, and increased feelings of happiness.

Bavin-Hoffman (1994) examined the audio-taped interviews of 20 married couples who had participated in the 10-week model of filial therapy training. Data collected in a phenomenological manner revealed the recurring themes of improved communication and behavior. Parents reported increased unity,

parental confidence, understanding of play, and acceptance of their children.

In research involving single parents in a 10-week model of filial therapy training, Bratton (1993/1994) measured significant increases in single parents' empathy toward their children, acceptance, allowing self-direction, and involvement. Significant increases in respect for a child's feelings, a child's unique make-up, a child's need for autonomy, and unconditional love were also measured. Overall parental stress decreased significantly as well as perceived problems of child behaviors.

Harris (1995) found a significant change in 9 of 13 hypotheses tested for a group of incarcerated mothers who followed a condensed version of the 10-week filial training model. Parents met twice weekly for a period of five weeks. Significant increase was measured in the level of mothers' empathic interactions with their children, a significant increase in mothers' attitude of acceptance toward their children, and mothers reported a significant reduction in the number of problems with their children's behavior.

In addition other studies have yielded positive results in training teachers of withdrawn children, (B. Guernsey, & Flumen, 1970), parents of learning disabled children (L. Guernsey, 1983), and parents of children with stuttering problems (Andronico & Blake, 1971).

Traditional Native American Parenting and Filial Therapy

Although researchers have measured significant differences in parenting attitudes and skills across varying cultures and levels of socioeconomic status

(Clark, 1981; Dembo, Sweitzer, & Lauritzen, 1985; Fantini & Cárdenas, 1980; Strom, Griswold, & Slaughter, 1981), people from diverse cultures describe strong, healthy families in a similar fashion. Abbott and Meredith (1985) surveyed five distinct ethnic groups to identify traits desired in strong, healthy families. Native American parents agreed with parents from other groups that the top four characteristics included being affirming and supportive, communicating and listening well, being trusting and trustworthy, and teaching a sense of right and wrong behavior. Respect for the privacy of family members, spending time together, and sharing responsibility for family welfare were also important to all five groups.

Filial therapy training specifically targets the development of these traits identified as important for strong, healthy families. Parents are taught techniques which promote a caring and supportive relationship between parent and child. The training emphasizes the importance of communication and teaches parents how to practice reflective listening. The consistency in the special play sessions helps to build a sense of trust between parent and child. Parents are taught about child development so that they can adjust their expectations appropriately. In addition, limit-setting is explained and practiced.

The extended family plays a significant role in Native American life. This kinship system combines relatives of either or both parents' families, and often non-related friends, in a network of responsibility and interdependency (Harrison, Wilson, Pine, Chan, & Buriel, 1990; Red Horse, 1980). Child rearing

practices among Native Americans have been closely related to the extended family concept and in that respect have depended on more than just the parents of the children in the role of parenting. For some, the extended family has become a thing of the past, and consequently some Native American parents have found it more and more difficult to be "good parents" (National Indian Child Abuse and Neglect Resource Center, 1980). Bronfenbrenner (1977) suggested that successful parenting and competent child behavior may be best achieved with the revitalization of systematic support by community, family, friendship, and neighborhood networks. Sharing responsibility for the well-being of children is a positive feature of the extended family concept (Harrison, Wilson, Pine, Chan, and Buriel, 1990; Red Horse, 1980). The philosophy supporting filial therapy does not challenge this traditional Native American value. The filial therapy support group provides a familiar medium for parents to share their experiences and perceptions and provides the added benefit of building "cultural relevance" into the educational process (Kellogg, 1982).

Gfellner (1990) found that Native American parents demonstrated a more liberal child rearing ideology in comparison with white parents. The dominant culture often perceives this attitude as a lack of parental concern about the child's behavior. The act of disparaging childrearing preferences of a cultural group strikes at the group's sense of esteem and indirectly challenges their right to exist, because a society perpetuates itself by the way it socializes its children (Sprott, 1994). What appears to be excessive permissiveness or indulgence, in

fact, may be a healthier and more effective way to promote the development of children (Burgess, 1980). Rohner, Chaille, and Rohner (1980) found that children raised in a warm, accepting, and nurturing environment exhibited more positive social skills. Children's internal locus of control increased significantly with their perceptions of increased parental acceptance. Cox (1970) found that the self-concept of a child was highly related to parental acceptance or rejection. Filial therapy supports Native American parents in providing a nonjudgmental, understanding, and accepting environment to foster the positive development of their children.

In filial therapy, parents are required to follow certain rules while conducting their special play sessions with their children. Parents are instructed not to criticize behavior, not to praise, not to offer information or teach, and not to initiate new activities. Many of the rules as presented by B. Guerney, L. Guerney, and Stover (1972) have counterparts in traditional Native American practices. For example, in Native American tradition, crafts, such as baskets, rugs, and pottery, are made with purposeful imperfections, as a lesson to children that no one is perfect (Menninger, as cited in Burgess, 1980). Native American children do not expect praise for doing what is required of them. Parents occasionally praise children for doing well, indicating approval through a smile or pleasant tone of voice, or a friendly pat (Burgess, 1980). During twelve years of working with Eskimo families in Alaska, Briggs (as cited in Sprott, 1994) found that children are not prevented from making mistakes unless the mistake

might be life-threatening. A traditional Native American value is independence. Children are given abundant opportunities to make choices without coercion with the understanding that to make a decision for a child is to make the child weak (Brendtro & Brokenleg, 1993).

Respect for others is a prominent traditional Native American value. Parents are urged to teach by example, to treat all people politely and nicely, to accept and appreciate differences in people, to show concern for others' feelings, to help others express their feelings, and to show confidence in each other. The National Indian Child Abuse and Neglect Resource Center (1981) issued the following statement:

Native American people have traditionally held a great respect for all peoples. We have a tradition of respect in our culture and in our spirituality. We respect the earth, elders, children, animals, all of life. We have lost some of this respect along with our languages and many of our customs. But it is not too late to maintain those which are left and to use traditional concepts of respect in raising children. (p. 6)

As in filial therapy, social control of children is minimal and applied subtly. In the collective, cooperative, and noncompetitive Native American society, the family, and through it the tribe, becomes the primary social and educational organization (Burgess, 1980). For Native Americans, warnings about the consequences of bad behavior are presented in community terms identifying how others might view the behavior. Rarely is a threat of physical punishment

made. Unlike filial therapy though, shame, otherwise known as embarrassment, is a common disciplinary tool with Native Americans.

The dominant culture often shows concern about the relative freedom a Native American child is given and what seems to be a lack of parental concern about the child's behavior. Although this may appear as excessive permissiveness or indulgence, in fact, it is often a different and perhaps more effective way of allowing children to develop in a healthy way. Discipline may be administered in other ways and in other forms not noticeable to outsiders. Native American children are not punished often, nor are they in continual fear of punishment. Hoffman (1977) notes that there are only three ways of disciplining children: 1) power assertion, 2) love withdrawal, and 3) inductive discipline (e.g. learning how your behavior affects others). Native Americans have practiced inductive discipline for thousands of years.

Menninger (as cited in Burgess, 1980) listed practices valued in most societies but believed to occur more frequently in the Native American community:

- Children, from birth, are regarded as important units of the family and heirs to its concerns and belongings. Children are considered...by Native Americans...as more important than material possessions.
 - Songs and lullabies sung to children by the parents and grandparents carry messages of hope and aspiration, the appreciation of beauty, sharing, and physical strength (so as to be of service to each other)
-

- Families engage only in those social activities which include their children; if the children cannot go, no one goes.
 - Native American children are seldom, if ever, struck by an adult; not parent, uncles, aunts...no adults. This custom has enormous implications which may indicate the superiority of Native American parenting to Anglo-American customs.
 - Considerable parental time and effort is devoted to making items for children to play with, or operate, or use when participating in popular activities and ceremonies (Ex. costumes for special dances, looms for weaving, tools for gardening, hunting, and fishing)
 - Respectfulness is taught by example as well as by precept. Respect is paid to a large number of worthy objects...parents, grandparents, members of the extended family, elderly people, various totem animals and objects, and various abstractions such as natural beauty and nature, dignity, and modesty.
 - Talking loudly, especially while correcting children, is highly disapproved of.
 - Spiritual qualities are taught and emphasized in special rituals and ceremonies.
 - Artifacts (baskets, rugs, pottery, etc.) are made with purposeful imperfections, as a lesson to children that no one is perfect; we all make mistakes, and hence, censure and punishment are very minimal.
-

-Competition is considered acceptable as long as the object is not to get the best of (hurt) someone.

-Children are taught that the land...and all that grow... are only lent to us for our care and sharing, not for exploitation. (p. 67)

Self-Esteem of Native Americans

Giveller (1983) described the process of developing self-esteem in the context of the parent-child relationship as one in which the parent accepts the child as a separate individual at the child's current level of functioning, while encouraging the child's becoming more mature. Coopersmith's (1967) foundations of self esteem have been compared by Brendtro and Brokenleg (1993) to Native American empowerment values. Significance is related to belonging, competence to mastery, power to independence, and virtue to generosity. In the spirit of belonging, treating others as kin forges powerful social bonds of community and relationships of respect. In the spirit of mastery, adults ensure that each child has some opportunity for success by giving even the smallest child important daily tasks to master. In the spirit of independence, children are given abundant opportunity to make choices without coercion with the understanding that to make a decision for a child is to make the child weak. In the spirit of generosity, children are shown that prestige is accorded those who give unreservedly, while accumulation of property for its own sake is disgraceful.

As Native American children mature, they are more knowledgeable about

categorizing self and others, but lean away from preferences for their ethnicity (Farris, Neuhring, Terry, Bilecky, & Vickers, 1980; Spencer & Markstrom-Adams, 1990). Native parents (as cited in Dawson, 1988) state simply the importance of self-esteem in their children: "If my children are proud, if my children have an identity, if my children know who they are and if they are proud to be who they are, they'll be able to encounter anything in life" (p. 48).

Native American children view themselves more negatively than their Anglo counterparts and the self-concept of Native American children is negatively correlated with chronological age and years of schooling (Lefley, 1974; Luftig, 1983). Soares and Soares (1969) found that despite living in poverty, disadvantaged children in elementary school did not necessarily suffer from lower self-esteem and a lower sense of self-worth. These findings could possibly suggest that simply being poor is not the dominant factor in the low self-esteem of Native American students. Typical methods for supporting increased self-esteem have proven to be ineffective for Native American children such as increasing popularity with children from the dominant culture or learning how to give self praise (Luftig, 1983). Luftig (1983) suggested that a truly pluralistic school environment would be the most effective in increasing the self-esteem of Native American students.

All too often, the school experience teaches Native American children that the dominant society does not understand and does not value their culture and traditions (Dawson, 1988; Horejsi et al., 1992). Parents can monitor and control

the assimilation processes that continue to occur in the schools to the detriment of individual self-esteem (Noley, 1992). Prevention and intervention efforts to enhance self-esteem among ethnic minorities should include child rearing support by way of teaching parenting skills that promote the parents' sense of ethnic pride (Spencer & Markstrom-Adams, 1990).

Positive self-esteem is a way of thinking about oneself as worthwhile. Positive self-esteem provides confidence, energy, and optimism to master life's tasks. This positive sense of self and confidence is important for parents as well as children. If parents feel more competent in their parenting they may be more able to be involved in their children's lives outside of the home. Native American parental involvement is critical to the future educational development of their children (Dawson, 1988).

Native American children must have the opportunity to grow into adulthood with the understanding that they are worthwhile individuals who are equal to all other Americans. They must believe that they are respected for their culture as they respect others for their individual worth. They must believe that they are valued in American society in general to the extent that they can achieve in any way they choose according to their individual talents (Noley, 1992).

Sandy Armstrong, Director of Education for the Fairbanks Native Association (as cited in Szasz, 1991) testified that "the number one barrier to learning is a lack of self-esteem. No matter what kind of problems a child has in

his or her background, the solutions begin with building self-esteem...this includes validating a child's culture" (p. 20).

Summary

The history of the Native American has resulted in families left highly disrupted and even disabled to such an extent that much of the positive traditional parenting skills have been forgotten (Burgess, 1980; National Indian Child Abuse and Neglect Resource Center, 1980). There are many social service providers working in Native American communities who are convinced of the critical importance of offering parent training (Kellogg, 1982). However, parent education programs are generally modeled on the dominant culture ideals and are justified as scientifically based from data gathered with measurement instruments normed on the dominant culture (Sprott, 1994). These programs tend to be oriented around problem behaviors and seldom focus on the parent-child relationship (Brock, Oertwein, & Coufal, 1993). Native Americans have voiced a desire to be involved in parent training which respects and promotes their cultural values (Kellogg, 1982). Filial therapy is a parenting approach which honors traditional Native American values (Brendtro & Brokenleg 1993; Burgess, 1980; Sprott, 1994). Native Americans know that their success depends on the positive self-concept of their children (Dawson, 1988). Filial therapy has been shown to be effective in increasing the self-esteem of parents and children (Glass, 1986/1987; Lobaugh, 1991/1992). Native Americans have been consistently denied the opportunity to solve their own

problems (Blanchard & Barsh, 1980). Filial therapy empowers parents by relying on them as the change agents in their children's lives (Payton, 1980/1981).

Filial therapy appears to be particularly suitable for promoting the well-being of Native American children and their parents. Training Native American parents to become therapeutic agents in their children's lives would seem to be an efficient and effective way to significantly improve the future mental health of these children and positively impact the Native American population.

CHAPTER II

METHODS AND PROCEDURES

The purpose of this study was to determine if filial therapy is effective in:

- 1) increasing the acceptance level of Native American parents residing on the Flathead Reservation of their children; 2) reducing the stress level of those Native American parents; 3) improving empathic behaviors of those Native American parents toward their children; 4) changing the play behaviors of children with their parents who participated in the training; and, 5) enhancing the self-concept of children whose parents participated in the training. This chapter will address definition of terms, hypotheses, instrumentation, selection of subjects, collection of data, the ten-week training model, the facilitator, and statistical analysis.

Definition of Terms

Filial therapy was defined as follows:

Filial therapy is a unique approach used by play therapists to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision. Parents are taught basic child-centered play

therapy skills including responsive listening, recognizing children's emotional needs, therapeutic limit setting, building children's self esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment which enhances the parent-child relationship, thus facilitating personal growth and change for child and parent. (G. L. Landreth, personal communication, June 27, 1995)

Play Therapy is defined by Landreth (1991) as

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

Parent and/or Parenting includes any significant care giver, not necessarily biological or adoptive parent, and the functions performed by such a care giver.

Native American Parent was defined in this study as an enrolled member of a federally recognized Indian Tribe residing on the Flathead Reservation in northwestern Montana who is a significant care giver of a child between the ages of 3 years and 10 years.

Child was defined in this study as a child between the ages of 3 years and 10 years whose significant care giver was an enrolled member of a federally

recognized Indian Tribe residing on the Flathead Reservation in northwestern Montana.

Parental acceptance includes the feelings and behaviors 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 from the child's parents in order to become an autonomous individual (Porter, 1954). For the purpose of this study, parental acceptance was operationally defined as the parents' scores on the Porter Parental Acceptance Scale (PPAS)(Porter, 1954).

Respect for the child's feelings and right to express them, denotes 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 PPAS (Porter, 1954).

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 of the child's unique make-up was operationally defined as the parents' scores on this subscale of the PPAS (Porter, 1954).

Recognition for the child's need for autonomy and independence denotes the parents' 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 for the child's need for autonomy and independence was operationally defined as the parents' scores on this subscale of the PPAS (Porter, 1954).

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 PPAS (Porter, 1954).

Parental stress describes the degree of stress in the parent-child system as 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 their children. For the purpose of this study, empathy was operationally defined as the parents' total scores on the Measurement of Empathy in Adult-Child Interaction Rating Form (Stover, B. Guerney, & O'Connell, 1971).

Communication of acceptance, as understood in this study, involves the verbal expression of acceptance and/or rejection of the child. For the purpose of this study, communication of acceptance was operationally defined as the parents' scores on this subscale of the MEACIRE (Stover, et al., 1971).

Allowing the child self-direction is the behavioral willingness to follow the

child's lead rather than 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 MEACIRE (Stover, et al., 1971).

Involvement is described as the parent's attention to and participation in the child's activity even though it may not always be contributed in a positive way. For the purpose of this study, involvement was operationally defined as the parents' scores on this subscale of the MEACIRE (Stover, et al., 1971).

Play Behavior With Parent refers to children's level of comfort in play interactions with their parents. For the purpose of this study, play behavior with parent was operationally defined as the parents' total scores on the Children's Play Behavior With Parent (S. C. Bratton, personal communication, July, 1995).

Sustained Play indicates the length of time a child is fully engaged in play whether self or parent initiated. For the purpose of this study, sustained play was operationally defined as the child's score on this subscale of the CPBWPRE (S. C. Bratton, personal communication, July, 1995).

Self-Directiveness is a child's demonstrated ability to take responsibility and direct own activity. For the purpose of this study, self-directiveness was operationally defined as the child's score on this subscale of the CPBWPRE (S. C. Bratton, personal communication, July, 1995).

Parent/Child Connectedness is the degree of interaction between parent and child. For the purpose of this study, parent/child connectedness was operationally defined as the child's score on this subscale of the CPBWPRE (S.

C. Bratton, personal communication, July, 1995).

Self-concept is the internal measure of a child's worth. The child forms a sense of self based on outside experiences and inside perceptions. For the purpose of this study, self-concept was operationally defined as the children's total scores on the Joseph Pre-school and Primary Self Concept Screening Test (Joseph, 1979).

Hypotheses

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

1) The experimental group parents will attain a significantly higher mean total score on the Porter Parental Acceptance Scale (PPAS) post-test than will the control group parents.

1a) The experimental group parents will attain a significantly higher mean score on the "Respect for the Child's Feelings and Right to Express Them" subscale of the PPAS post-test than will the control group parents.

1b) The experimental group parents will attain a significantly higher mean score on the "Appreciation of the Child's Unique Makeup" subscale of the PPAS post-test than will the control group parents.

1c) The experimental group parents will attain a significantly higher mean score on the "Recognition of the Child's Need for Autonomy and Independence" subscale of the PPAS post-test than will the control group parents.

1d) The experimental group parents will attain a significantly higher mean

score on the "Unconditional Love" subscale of the PPAS post-test than will the control group parents.

2) The experimental group parents will attain a significantly lower mean total score on the Parenting Stress Index (PSI) post-test than will the control group parents.

2a) The experimental group parents will attain a significantly lower mean score on the "Parent Domain" of the PSI post-test than will the control group parents.

2b) The experimental group parents will attain a significantly lower mean score on the "Child Domain" of the PSI post-test than will the control group parents.

3) The experimental group parents will attain a significantly lower mean total score on the Measurement of Empathy in Adult-Child Interaction Rating Form (MEACIRE) post-test than will the control group parents.

3a) The experimental group parents will attain a significantly lower mean score on the "Communication of Acceptance" subscale of the MEACIRE post-test than will the control group parents.

3b) The experimental group parents will attain a significantly lower mean score on the "Allowing the Child Self-Direction" subscale of the MEACIRE post-test than will the control group parents.

3c) The experimental group parents will attain a significantly lower mean score on the "Involvement" subscale of the MEACIRE post-test than will the

control group parents.

4) The experimental group children will attain a significantly higher mean total score on the Children's Play Behavior With Parent Rating Form (CPBWPRF) post-test than will the control group children.

4a) The experimental group children will attain a significantly higher mean score on the "Sustained Play" subscale of the CPBWPRF post-test than will the control group children.

4b) The experimental group children will attain a significantly higher mean score on the "Child Self-Directiveness" subscale of the CPBWPRF post-test than will the control group children.

4c) The experimental group children will attain a significantly higher mean score on the "Parent/Child Connectedness" subscale of the CPBWPRF post-test than will the control group children.

5) The experimental group children will attain a significantly higher mean total score on the Joseph Pre-school and Primary Self Concept Screening Test (JPPCST) post-test than will the control group children.

Instrumentation

Porter Parental Acceptance Scale

The Porter Parental Acceptance Scale (PPAS) was developed by Porter (1954). The PPAS is a self-report inventory designed to measure parental acceptance as revealed in behavior and feelings toward, about, or with their child. Variables measured by the instrument are: 1) respect for the child's

feelings and right to express them, 2) appreciation of the child's unique make-up, 3) recognition of the child's need for autonomy and independence, and 4) unconditional love.

The instrument consists of 40 items, each with five multiple choice responses ranging from low to high acceptance. Two dimensions of acceptance are incorporated into the scale. The first reveals how the parent feels in a specific situation. The second reveals the parents' manifested behavior in a specific situation. The test may be scored to yield four subscale scores and one total score. Higher scores indicate higher levels of positive behavior in the total score and in each of the subscales.

Porter (1954) reported a split-half reliability correlation of .766 raised by the Spearman Brown Prophecy formula to .865. Later research reported a split-half reliability coefficient of .666 raised by the Spearman Brown formula to a total test reliability of .800. Both reported coefficients are significant beyond the .01 level (Burchinal, Hawkes, & Gardner, 1957).

Porter (1954) 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 degree of disagreement was by a distance of only two scale points which occurred in less than 20 percent of the responses suggesting that the operational definition of parental acceptance that Porter (1954) created is valid as measured by this

scale.

Internal consistency of the scale was investigated by Burchinal et al. (1957) using item analysis. All items discriminated between high and low scoring fathers with the exception of one item which failed to show significance. Analysis of mothers' responses yielded similar results. In fact 35 items in the mothers' responses and 33 in the fathers' responses were significant at the .001 level of probability clearly demonstrating that the items discriminated consistently between high and low scorers. The instrument was thus deemed to be internally consistent.

Parenting Stress Index

The Parenting Stress Index (PSI) was developed by Abidin (1983). This self-report inventory is a 101 item index designed to measure the level of stress in the parent-child system. The items are separated into two domains, the parent domain and the child domain. The parent characteristics measured by the PSI include parent's sense of competence, parent attachment, restriction imposed by the parental role, parent's feelings of social isolation, parent depression, relationship with spouse, and parental health. The child characteristics measured include the child's acceptability to the parent, the child's level of demandingness, the child's moodiness, the child's degree of distractibility, the child's adaptability, and the child's reinforcement of the parent. Higher scores indicate higher levels of stress and perceived negative behavior in the total score and in each of the subscales.

Zakreski (1983) used the test-retest method to determine a coefficient of reliability. This study produced coefficients of .778 for the child domain, .69 for the parent domain, and .88 for the total index. Alpha reliability coefficients were calculated on each 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, 1987).

Measurement of Empathy in Adult-Child Interaction

The Measurement of Empathy in Adult-Child Interaction Rating Form (MEACIRF) was created by Bratton (1993/1994) from a scale developed by Stover et al. (1971) to operationally define empathy as related to parent-child interactions. This direct observational scale measures three specific parental behaviors identified as major aspects of empathy in adult-child interactions including communication of acceptance, allowing the child self-direction, and involvement. The scale also provides a total empathy score. Lower scores indicate higher levels of positive behavior in the total score and in each of the subscales.

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 is viewed as a necessary condition for optimal development of the child's self-worth and the

major element in the communication of empathy (Stover et al., 1971).

The "Allowing the Child Self-Direction" subscale measures the verbal expression of acceptance and 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 "Involvement" subscale measures the parent's attention to and participation in the child's activity. Stover et al. (1971) found that parents who exhibited high levels of communication of acceptance and allowing the child self-direction also demonstrated high levels of involvement.

The MEACIRE is a five-point bipolar scale used to rate the three dimensions of parental behavior every 3 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. Considering the three subscales together as components of empathic behavior, the highest levels of empathy are evident when the parent is commenting frequently on the child's expression of feeling or behavior in a genuinely accepting manner; is clearly demonstrating that the child is fully permitted to engage in self-directed activity; and, is attending fully to the child's behavior. The lowest level of empathic communication would be one when the parent is verbally critical and rejecting of the feelings or behaviors of the child; cajoles, demands, and continually re-directs the child's activity; and, is self-involved, preoccupied, or shut-off from the

child.

Reliability coefficients were established for each of the three subscales. After four training sessions for collaborative rating on a half hour play session, followed by discussion, six pairs of coders independently rated 7 to 10 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. Guernsey, & Stover, 1971). The filial therapy training method was utilized to demonstrate the validity of the scales because this method involved training parent 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: 1) a pre-training play session; 2) the first post-training play session; and 3) the third post-training play session. Highly significant increases, at the .0005 level, between the pre-training and first post-training play session were obtained on each subscale and for the total empathy score. A significant increase, at the .01 level, between the first and third post-training play sessions 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 MEACI and a previously developed empathy measure for adult-child interaction (B. Guerney, Stover, & DeMeritt, 1968).

Children's Play Behavior With Parent Rating Form

The Children's Play Behavior With Parent Rating Form (CPBWPRF) was created by Bratton (1995) and modified for this study to operationally define children's play behavior as related to parent-child interactions during play sessions. No tests for reliability or validity have been conducted on this observational scale. The subscales were chosen for this scale specifically to measure behaviors which might change as a result of training parents in the filial therapy method. As this is a new and untried measure, it is being used strictly as a structured method to record data and determine change between pre and post observations.

The CPBWPRF is a five-point bipolar scale used to rate three dimensions of play behavior every three minutes for six consecutive coding intervals. The scale ranges from a high rating of five to a low rating of one. Each point on the scale is followed by typical responses obtained from codings of the direct observations of children's play behavior with a parent. This direct observational scale measures three specific child behaviors including the child's sustained play, self-directiveness, and parent-child connectedness. Considering the three subscales together as components of desirable play behavior, the highest level of desirable play behavior is evident when the child engages in sustained play

for at least 12 minutes during an 18-minute play session; goes about activities in a self-assured way; and, includes the parent in play. The least desirable play behavior would be when the child is unable to engage in sustained play for more than three minutes; is unable to proceed in play without parent permission and/or prompting; and, the child rejects the parent and/or is rejected by the parent. The three subscales are combined to provide a global "Play Behavior With Parent" score. Higher scores indicate higher levels of desirable play behavior in this global score and in each of these subscales. In addition a high score on the "Mood" scale acts as an additional reference for determining the comfort level of the child during the play session.

The "Sustained Play" subscale measures the time a child is fully engaged in play. The play may be momentarily interrupted, but the child must return to the same activity. Perry (1988/1989) found that maladjusted children in play therapy expressed significantly more play disruptions than did adjusted children. It is surmised that a child who feels safe and accepted will engage in sustained play. This subscale is included in the CPBWPRF as an indication of the child's comfort level. The expectation is that a child who feels safe and accepted will explore the new play situation, but will for at least a portion of the time engage in sustained play in the presence of the parent. For purposes of recording sustained play, any activity continued for at least 30 seconds is recorded on the observational scale for each interval. If play continues to the next interval, it is noted by a "+" in the next interval. At the end of the six observational intervals

the longest episode of sustained play is noted.

To determine scoring of sustained play, 34 play sessions were evaluated without regard to intervention, age, or gender. For each play session, the episodes of sustained play were ranked in descending order. The number of play episodes in a given 18-minute play session ranged from a high of 11 activities to a low of 1 activity, with the mode being 5 and the mean being 5.09. Upon further investigation it was determined that the relationship between the number of play episodes and the length of time of an individual play episode was inconsistent; i.e., a child could participate in up to seven different activities, but spend well over 15 minutes on one of those seven activities.

The longest play episode in a given 18-minute play session ranged from a high of 18 minutes to a low of 2.5 minutes, with the mean being 8.51 minutes. The longest play episode from each 18-minute session was noted. An analysis revealed only 1 episode of less than 3 minutes duration, 6 episodes clustering between 2 and 5 minutes, 13 episodes between 5 and 8 minutes, 8 episodes between 8 and 12 minutes, and 6 episodes of more than 12 minutes duration. This falls into a fairly normal curve skewed to the left. This would not be unexpected considering the premise that children who are comfortable in a situation will participate in uninterrupted play. These children all played in the presence of significant care givers with whom the children had an established relationship. Consequently, a score of five is applied for a single play episode of at least 12 minutes. A score of four is applied for a single play episode of at least

8 minutes. A score of three is applied for a single play episode of at least 5 minutes. A score of two is applied for a single play episode of at least 3 minutes. A score of one is applied for less than 2 minutes of sustained play.

The "Self-Directiveness" subscale measures the child's demonstrated ability to take responsibility and direct activity during the play session. The dimension of self-directiveness is viewed as a desirable component of play behavior of the adjusted child. Moustakas (1955) found adjusted children to be free and spontaneous in their play whereas maladjusted children often wanted to be told what to do and what not to do. It is surmised that a child who feels safe and accepted will make personal choices and direct the activity. This subscale is included in the CPBWPRE as an indication of the child's comfort level. The expectation is that a child who feels safe and accepted will explore the new play situation and choose activities without requiring parental assistance or prompting.

The "Parent-Child Connectedness" subscale measures the child's level of involvement with the parent. Filial therapy training is directed at enhancing the relationship between parent and child. The level of interactive flow between child and parent is rated to give a behavioral measure of relationship. This subscale is included in the CPBWPRE as an indication of the child's comfort level. The expectation is that a child who has a positive relationship with a parent will include the parent either verbally or non-verbally in the play.

The "Mood" scale is a subjective rating of the child's overall affective

representation during the 18-minute rating period. This scale has a narrow focus ranging from comfortable to uncomfortable. Extreme feelings of happiness and anxiety were generally not evident during the staged 18-minute play interactions between adults and children who had an established relationship. Low scores represent observations of discomfort, anxiety, discontent, being upset, or troubled. High scores represent observations of comfort, satisfaction, pleasure, and contentment.

Joseph Self Concept Screening Test

The Joseph Pre-school and Primary Self-Concept Screening Test (JPPSST) was originally developed by Joseph (1979) for pre-school children and later adapted for upper grade levels. Although norms have not been provided in the manual for children older than 9-11, the JPPSST may also be useful in identifying high risk subjects as old as 13 years of age. It is designed to measure the self concept of a child by using pictures to stimulate responses from the child. First, the child identifies the pictures as pictures of himself or herself (there are two sets of gender specific pictures). By using the child's descriptions of the activities and feelings surrounding the pictures of the self, the scorer is able to rate the child's self-esteem on a global index scale of zero to 30.

A test-retest sample to check the reliability of the JPPSST was taken producing a reliability coefficient of .87. A split-half test was given to determine internal consistency. The Kuder-Richardson 20 formula was used and estimated

the internal consistency in a range from .59 to .81 with a medium correlation of .73. An item analysis was also performed with item discrimination coefficients ranging from .30 to .70 as a function of the particular item and the age level of the sample. All items on the scale obtained correlation coefficients that significantly contribute to the overall test score performance.

Construct validity was addressed by correlating Global self concept score derived from two self concept rating scales that were completed by teachers. The correlation coefficient between the scores of the two tests equaled .51 which was significant at the .01 level of confidence.

Additional Instrumentation

Parent Sense of Competence Scale

The Parent Sense of Competence Scale (PSCS) was developed by Gibaud-Wallston and Wandersman (1978). This self-report inventory was designed to examine parents' sense of competence with regard to their children. The scale is made up of 17 items and is a specific measure of self-esteem in the parenting situation. The items are further divided into two subscales. The Skill/Knowledge subscale assesses parents' perceptions of the degree to which they have acquired the skill and understanding to be good parents. The Valuing/Comfort subscale assesses the degree to which the individual values parenthood and is comfortable in that role. Subjects rate each item on a 7-point Likert-type scale ranging from strongly agree (1) to strongly disagree (7). The mean score in each area provides an appraisal by the person of that person's

own functioning as a parent with regard to parental skill and knowledge, as well as comfort in being a parent. Alpha coefficients for the original sample of 132 mothers and fathers were .82 for Skill/Knowledge, .70 for Valuing/Comfort, and .83 for the total score (Gibaud-Wallston, & Wandersman, 1978). The standardizing procedures for this instrument were especially weak, consequently, the questions from this scale were used only as a means for collecting information to supplement the discussion.

Self-Perception Profile for Children and Pictorial Scale of Perceived Competence and Social Acceptance for Young Children

The Self-Perception Profile for Children (Harter, 1985) was devised in order to tap children's domain-specific judgments of their competence, self-adequacy and perception of their worth or esteem as a person. The present version of this instrument contains six separate subscales tapping five specific domains; scholastic competence, social acceptance, athletic competence, physical appearance, and behavior conduct. The sixth subscale provides a measure of global self-worth.

The internal consistency reliabilities for all six subscales, for each of four samples were based on Cronbach's Alpha and ranged from .71 for the Behavioral Conduct subscale to .86 for the Athletic Competence subscale. The target population for this instrument is third through sixth grades; however it can be employed with older subjects. Means are provided for populations up to eighth grade. For younger children the Pictorial Scale of Perceived Competence

and Social Acceptance for Young Children, (Harter, 1983) is a downward extension of the previous scale. The instrument contains four separate subscales tapping four specific domains; cognitive competence, peer acceptance, physical competence, and maternal acceptance. There is no global self-worth subscale as the authors contend that young children do not yet have a consolidated concept of their global self-worth as a person. Rating scales for both instruments are available for teachers which can be used with parents. The adult rates the child's actual behavior providing an independent judgment of the child's adequacy in each domain. This scale parallels the profiles for children and therefore can be compared directly to the children's scores. All of the scales utilize a four-point scale ranging from a high rating of four to a low rating of one.

For purposes of this investigation, these scales were used as an additional measure to the Joseph Pre-School & Primary Self-Concept Screening Test as neither test has been normed on the Native American population. An analysis of the subscales from each measure was undertaken and it was determined that the subscales for the older children's version; Scholastic Competence, Athletic Competence, and Social Acceptance closely resembled in content the Cognitive Competence, Physical Competence, and Peer Acceptance subscales respectively of the younger children's version.

Cross-Cultural Considerations

Cross cultural data for the PSI was gathered on African American and

Hispanic populations. Mean scores tended to be higher for both groups; however, mitigating factors such as poverty and low levels of education could not be ruled out.

J.D. Heberle, Ph.D. in clinical psychology and a tribal member of the Confederated Salish and Kootenai Tribes reviewed these instruments and provided a Native American viewpoint. Heberle commented that overall, the instrumentation would provide helpful information, but Native American parents' and children's scores may differ from norms depending on their level of acculturation (J. D. Heberle, personal communication, November 15, 1995). Scores on the PPAS may prove to be higher for less acculturated Native Americans. In regard to questions about acceptance of behavior, traditional people tend to think they should not make judgements about other's lives, even their young child's life as each person has their own path to walk. In regard to questions about a child's alliance with other adults, this is not only acceptable, but encouraged. The average Native American child has three primary caretakers before age 10: Grandmother for several years; mother for several years; and, aunts or mother's close women friends in early school years.

Both self-esteem scales include questions based on competition, best vs. worst. In a tribal society that is not an approved concept because all tribal members had to cooperate to ensure survival. Some of the children measured may never have thought in those terms. In addition, talking too much is considered a negative trait and scores may be low on such items.

The Harter scales for the youngest children have expectations which may not be met by the general Native American population. Many Native American children have no experience of books, puzzles, or paper work before they enter Head Start or kindergarten. Throughout childhood, children's closest friends often tend to be family members while outsiders are avoided or treated with shyness. At about the fourth grade, a cross-over effect in school appears. Native American children below that age do better than white peers because the materials have a visual spatial orientation. By the fourth grade, learning materials are primarily verbal and white children quickly outperform the Native American children. The results from these measures may not accurately represent the self-esteem of Native American children.

Selection of Subjects

Initially, three agencies were contacted to determine the feasibility of conducting this research project on the Flathead Reservation; the Salish and Kootenai College, the Confederated Salish and Kootenai Tribes Head Start Program, and Tribal Health and Human Services. Tribal Health and Human Services responded positively establishing Irene Lake, coordinator of the Protect Our Children Project as the designated tribal liaison between tribal members and the researcher conducting this study. In addition, Tribal Health and Human Services provided office space, phone, access to meeting space, babysitting, video equipment, and copying equipment. A letter of agreement with the Department of Health and Human Services is included as Appendix B.

Once the feasibility of the project had been established, the proposal was presented to the Tribal Council and permission was granted to conduct the research. A copy of the Tribal Council minutes as reported in the Charkoosta is attached as Appendix C.

To recruit participants for the study, the researcher met with currently existing parent support groups, advertised through the Tribal Health newsletter, and distributed flyers to the Head Start programs and at the annual Women's Conference. The researcher was also interviewed by the Tribal newspaper, the Charkoosta. Copies of marketing pieces are included as Appendix D. Names of all interested parents were collected along with phone numbers and addresses. Some of the parents who responded were non-tribal members. These parents were included in the training, but data was not collected on non-tribal participants. An assessment was made of the interested parents and it was determined that the best locations for groups were the communities of Arlee, St. Ignatius, and Ronan. A map of the Flathead Reservation is attached as Appendix E. Using convenience sampling by location, leaving all other factors random, parents from these communities were assigned to the experimental groups and all others were assigned to the wait list control group and would be offered training upon completion of the first series. Interested parents were contacted individually by the researcher and given more details about the parent training classes and the selection process. The classes were offered free of charge.

Thirty-two parents were selected to participate in the study based on the following criteria: (a) must be an enrolled member of a federally recognized Indian Tribe and reside on the Flathead Reservation; (b) must be the primary care giver of a child between the ages of 3 years and 10 years who is not currently in therapy; (c) must be able to speak, read, and write the English language; (d) must be able to attend the ten weeks of filial therapy training; (e) must be able to attend a pretraining session to complete pretest instruments and be videotaped playing with their child; (f) must be able to attend a post-training session to complete post-test instruments and be videotaped playing with their child; (g) must agree to participate in weekly 30-minute home play sessions with their child; and, (h) must be willing to sign the consent to participate form.

The investigator met with each parent participant who satisfied the specified criteria to explain the purpose and the requirements of the filial therapy training, provide information about how confidentiality would be maintained, and answer any questions the participants may have had before they signed the consent form (Appendix F). Each parent was asked to select only one child, between the ages of 3-10 years, as the "child of focus" for the ten week training period. The investigator informed the parents that they and their children would be scheduled to participate in either the first series (experimental group) or second series (control group) of filial training classes. Using convenience sampling, seventeen parents with their "child of focus" were placed in the experimental group and 15 parents with their "child of focus" were placed in the

wait list control group.

The investigator met with each child participant who had been selected as the "child of focus" to explain the data gathering procedure, provide information about how confidentiality would be maintained, and answer any questions the participants may have had before they signed the consent forms (Appendix F).

All parents who met the criteria specified above (N=32) were scheduled to bring their "child of focus" to a pretraining session to complete all pretest requirements. Twenty-five participants completed the pretraining requirements and were included in the study. Of the 25 who completed the pretraining requirements, 14 had been assigned to the experimental group and 11 to the control group under the convenience sampling method of assigning parents from the communities of Arlee, St. Ignatius, and Ronan to the experimental group and all other parents to the control group. Participants were not matched on any other demographic variable prior to group assignment. Although parents were not aware of their assignment to experimental or control groups at this point, the inconvenience of the times and/or locations of trainings may have precipitated this loss of participants at the beginning of the study. Over the course of the 10-week training period, three additional participants from the experimental group and two additional participants from the control group dropped out of the study. Consequently 21 participants completed the present study, 11 in the experimental group and 10 in the control group. Discussion of the attrition rate is more fully presented with the outline of the 10-week training model.

The population studied was comprised of Native Americans residing on the Flathead Reservation in northwestern Montana. All but two of the participants were enrolled members of the Confederated Salish and Kootenai Indian Tribes. One participant was an enrolled member of the Blackfeet tribe of Montana and one participant was an enrolled member of the Papago tribe of Arizona. According to 1990 census figures, approximately 4,400 Salish and Kootenai Indians live in the State of Montana (Census of Population (1990 CP-3-7), 1994). The median age of the population is 27 years. English is spoken by all members of the population. Between 65% and 75% of the population 25 years of age and over have graduated from high school. Between 24% and 30% of the population lives below poverty level.

The experimental group was comprised of nine mothers, one grandmother, and one step-mother. The control group was comprised of nine mothers and one grandmother. The parents in the experimental group ranged in age from 26 to 44 years of age, with a mean age of 37. The age range for the control group parents was 23 to 46 years of age, with a mean age of 32.7.

There were six boys and five girls in the experimental group. The age range was 3 to 10 years of age, with a mean age of 5.5 years. The experimental group included 36.4% 3 year-olds, 18.2% 5 year-olds, 18.2% 6 year-olds, 18.2% 8 year-olds, and 9% 10 year-olds. There were four boys and six girls in the control group. The age range was 3 to 9 years, with a mean age of 5.2 years. The control group included 30% 3 year-olds, 30% 4 year-olds, 10% 6 year-olds,

10% 7 year-olds, and 20% 9 year-olds.

Of the experimental group, 27.3% attended boarding school for some part of their education. Of the control group, 20% attended boarding school for some part of their education. All parents in the experimental group had completed high school, seven had completed some college, and three had earned Bachelor's Degrees. Of the control group, two parents had not completed high school, one parent had graduated from high school, and seven had gone on to complete some college. Although this group is older than the general Salish and Kootenai population and more educated, 28.6% live below poverty level reflecting the average for the general population. The income range for the experimental group was \$3,500 to \$36,000 annually with a mean of \$15,959. The income range for the control group was \$2,400 to \$47,000 annually with a mean of \$19,523. Of the experimental group, 72.7% were employed. Of the control group, 60% were employed.

Of the experimental group, 73% were married or living with a partner. Of the control group, 50% were married or living with a partner. Experimental group participants described their family structures as 36.4% nuclear families consisting of parent(s) and child(ren), 54.5% extended families consisting of grandparent(s) and/or other relatives, and 9.1% multiple-families consisting of unrelated members. The experimental group households ranged in size from two to seven persons, with a mean of five persons. Control group participants described their family structures as 70% nuclear families and 30% extended

families. The control group households ranged in size from two to eight persons, with a mean of 4.4 persons.

Of the experimental group, 54.5% described either personal or a family member with problems related to alcohol and 36.4% indicated that a member of the household had been diagnosed with some other physical, mental, or health condition. Of the control group, 30% described either personal or a family member with problems related to alcohol and 30% indicated that a member of the household had been diagnosed with some other physical, mental, or health condition.

Table 1.

Demographic Information

	Exp	Control		Exp	Control
Cases	11	10	Mean #HH	4.9	4.4
Tribe	6=Salish	6=Salish	HH type	6 = Extend	3 = Extend
	2=Kootenai	2=Kootenai		4= Nuclear	7= Nuclear
	2=Both	1=Both		1= Multiple	
	1=Papago	1=Blackfeet			
Status	5=Married	5=Married	Income	2 < 5,000	2 < 5,000
		1=Widow		2 = 5k-12k	2 = 5k-12k
	4=Divorce	1=Divorce		2 =12k-15k	1 =12k-15k
		1= Sep		4 =15k-25k	2 =15k-25k
	2 =No Mrg	2 =No Mrg		1 > 25,000	3 > 25,000
Education	1 = HSch	2<12th grd	Age Adult	37	32.7
	7= College	1 = HSch	Age Child	5.5	5.2
	3 = B.A.	7= College	Gender	Boys = 6	Boys = 4
Employed	3 = NO	4 = NO		Girls = 5	Girls = 6
	7=Fulltime	5=Fulltime	Alc. Impact	54.5%	30%
	1= PT	1= PT	Disorders	36.4%	30%

Demographically, the experimental and control groups were different in several areas. The experimental group parents were slightly older, had more education, larger families, were more impacted by alcohol abuse and other handicapping conditions, and had lower income than the control group parents.

Collection of Data

Pre-training sessions were scheduled during the two weeks prior to the first series of filial therapy training classes for the purpose of collecting data. The sessions were held at the Alcohol and Substance Abuse Prevention building in St. Ignatius, Montana and at the Community Building in Elmo, Montana. Every effort was made to keep conditions as consistent as possible in each of these locations. Parents were individually scheduled for the Pre-training. During the Pre-training sessions parents completed the (a) Demographics form (Appendix G); (b) Porter Parental Acceptance Scale (Appendix I); and, (c) Parenting Stress Index. Child participants were interviewed for the purpose of completing two questionnaires before and after the training. Both parent and child participants were asked to participate together in a 20-minute videotaped play session before and after the training. A space was specially equipped with toys similar to those used in the filial kits for the actual parent training. A video camera, which was operated during the taping sessions by the investigator, was set up on a tripod in one corner of the area. Child care was provided for the children while their parents were completing the questionnaires. The researcher 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 parent and child were shown to the play space and told, "This is where you and your mom/dad will play for 20 minutes. You may play with the toys in many of the ways you would like. You may not leave this play area until the time is up and you may not go under the table. I will be video-taping you with this camera. Try to pretend I am not here and I will try to be very quiet so as not to disturb you. I will tell you when the time is up."

During the two weeks following the 10 weekly filial therapy training sessions, the post-test battery of instruments was administered to both the experimental and control groups. The Post-training sessions followed the same procedures outlined in the Pre-training sessions. Post-training sessions were conducted at the Alcohol and Substance Abuse Prevention building in St. Ignatius, at the Parent-Infant Stimulation Center in Elmo, at the 2nd Circle Lodge in Ronan, and at two private residences. Every effort was made to keep conditions as consistent as possible in each of these locations. The control group parents were given the opportunity to schedule individual filial therapy training at a time after they had completed the post-testing requirements. All participants received copies of the pre and post-training video-tapes upon completion of the post-testing requirements.

The information provided on questionnaires was kept confidential. Names of both parents and children will not be disclosed in any publication or discussion of this material. Information obtained from the questionnaires was

recorded with a code number. Only the investigator has the list of the participants' names. At the conclusion of this study, the list of participants' names was destroyed. The video-taped play sessions of participants were viewed only by graduate research assistants. The research assistants had no knowledge of participants' names and they were made aware that the confidentiality of participants is to be maintained.

Prior to the study, two participants (one experimental and one control) expressed personal reasons for not wishing to be video-taped. These participants completed all written measures of the pre and post-testing. The "child of focus" of one control group participant was video-taped and interviewed for the pre-test, but refused to cooperate for post-testing. Three participants (one experimental and two control group) did not return written measures. Four children (one experimental group and three control group) were unavailable for the interview section of the post-testing, but completed all other measures.

Ten-Week Training Model

The experimental group parents participated in a 10-week model of filial therapy training (Landreth, 1991) two hours each week (See Appendix J). The 14 parents in the experimental group were assigned to the three community groups. Child care was provided. One of the groups met in St. Ignatius on Thursday mornings (n=8). One of the groups met in Arlee (n=7) on Tuesday evenings and another met in Ronan (n=4) on Thursday evenings. At the beginning of the first 10-week series, 19 parents started; 14 enrolled tribal

members who met the qualifications for the study; one tribal member whose child was not age appropriate, but chose to do training; one spouse who chose not to be involved in the research; and, three non-tribal members. Data was not collected for the members that did not meet the requirements for the study. The attrition rate was 32% for the groups overall and 21% for experimental participants only. Reasons for attrition among experimental group participants included the following: One felt uncomfortable with the nondirective nature of the play sessions; one participant was experiencing marital difficulties and chose to focus time and attention on couple's counseling with her partner; and, one participant was jailed for a large portion of the training period and was unable to make up training sessions or special playtimes with his step-daughter.

The 10-Week Filial Therapy Training Model utilizes both didactic and dynamic components and 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 were taught 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 share their experiences with the group. The parents were supplied with a special toy kit (described in the filial therapy handouts in Appendix J). In addition, each participant was video-taped once during the 10-week training. If parents had access to a video camera, they taped themselves at home. If video equipment was not available to the parent, the investigator

arranged to video tape the participant either at home or at the Alcohol and Substance Abuse Prevention building. This tape was reviewed during a group so that the participants could receive feedback as well as the opportunity to observe other parents during their special playtimes. The training sessions followed the methodology outlined by Landreth (1991) for a 10-week filial therapy training group (session outlines and handouts are included in Appendix J).

Training Session One

Attendance for experimental group participants at training session one was 100%. During session one, parents were asked to introduce themselves, describe their families, and characterize their "child of focus". Goals and objectives of the training were explained. The facilitator described the skills of reflective listening and tracking behavior and illustrated these skills through role play with one of the parents playing the role of the child. Parents were encouraged to practice empathic responses and tracking behavior in a similar role play situation with each other. Parents were introduced to the facial expressions of children through still photos of young children expressing various emotions. The homework assignment for the first session was to identify emotions of anger, happiness, sadness, and surprise in their child of focus and make a reflective response. (Handout in Appendix J) Responses were to be written down for reporting to the group.

Training Session Two

Attendance for experimental group participants at training session two was 57%. Each time a participant missed a session, every effort was made by the researcher to arrange a make-up session. Session two began with a review of homework assignments. One parent shared an experience with one of her older children in which she reflected the child's facial expression of being upset and her daughter responded with an immediate "That's obvious". The parent commented that at least she knew she was on the right track. Empathic responding was elaborated on and the facilitator demonstrated empathic responding with a volunteer followed by viewing of a video tape of the facilitator in a play session with a child. Parents were given the opportunity to role play with selected toys in pairs, taking turns being the parent and the child. Parents were given a list of toys (play dough, crayons, paper, blunt scissors, nursing bottle, baby doll, rubber knife, dart gun, doll family, toy soldiers, car, Lone Ranger type mask, Tinkertoys, doctor kit, Band-Aids, play money, rope, transparent tape, bop bag, bowling pins, ball, and cardboard box to be used as doll house and container for toys). The facilitator demonstrated each toy and explained the toy's purpose in the special sessions. The homework assignment was to select a time and an uninterrupted place in the home suitable for the play sessions.

Training Session Three

Attendance for experimental group participants at training session three

was 86%. During session three, the parents were asked to report on arrangements for their sessions. One parent expressed frustration with the necessity of setting a consistent time for play sessions. The facilitator reiterated the importance of developing trust through consistency with children in order to enhance the parent-child relationship. Play therapy skills were taught through role playing with toys. A second video tape was shown of the facilitator with a child in a play session. Parents were given filial kits as described in session two. The homework assignment was to help the child make a "Play Session - Do Not Disturb" sign to hang on the door and to have the first of their weekly play sessions. Parents were given a list of play time rules (see Appendix J). One parent was asked to volunteer to be video taped either at home or at the training site for demonstration purposes at the next group meeting.

Training Session Four

Attendance for experimental group participants at training session four was 71%. During session four, the parents were asked to report on their first play sessions. Areas of difficulty were discussed with suggestions offered by the facilitator. Parents commented that they found actually doing the play session to be much more difficult than they had expected. One parent stated that she felt awkward and did not enjoy the play session because she was thinking about everything she was not supposed to do. Several parents mentioned that they found it most difficult not to ask questions. Two parents were pleased with themselves for using the phrases "Show me how..." and "You tell me."

One child had an especially difficult time at the end of the session when the parent said the time was up. The parent reported that the child called her names and cried for an hour after the session, refusing to play with any of his other toys. The parent commented that she "wanted to dial up your (facilitator's) house and let you listen." The parent who was video-taped for the session had a similar experience. The first parent seemed much relieved that her child was not the only one to throw a tantrum at the end of the first play session. Both of the children who had difficulty with the time limit were 3 year-olds. This gave the facilitator the opportunity to discuss development and to reassure both parents that once these young children had experienced the play sessions a few times, they would be less anxious about the time limit, knowing that they would be able to play again the following week. The facilitator also suggested using the 5-minute warning to help children prepare for the transition.

Parents reported that the children were all very excited about the play sessions and immediately understood the special nature of the play time. One 6 year-old boy reminded his mother not to be late getting home from work. Another 8 year-old boy commented during his first play session, "If this was the real world you wouldn't let me do this."

Training Sessions Five Through Nine

Sessions five through nine follow the same general format as session four. Brief reporting by the parents of their play sessions was interspersed with suggestions and instruction from the therapist along with group interaction on

common problems and attention to parents' feelings. A parent video tape was viewed and discussed during each session. Homework assignments in which responses were written to typical happenings in play sessions were critiqued. Training and role playing of play session principles and skills was continued each session.

Training Session Five

Attendance for experimental group participants at training session five was 50%. The parents who had the most difficulties with the time limit in the first session reported that things had gone much more smoothly and that the 5-minute warning had been very effective. Limit-setting was discussed using the handout "Two Techniques of Discipline that Work". The "sandwich hug" was demonstrated and parents were given homework assignments to complete prior to the next session.

Training Session Six

Attendance for experimental group participants at training session six was 50%. The handout "When Setting Limits Doesn't Work" was discussed. Parents were asked to write notes to all of their children following the format outlined in the manual for Session #6. Parents with several children shared the difficulties they were having with jealousy between siblings. Parents expressed frustration that they could only do play sessions with one child. The importance of focussing on one child during this training period was reiterated. One parent described the process her son went through during his play session as

especially revealing to her. Her son had come home from a difficult day at school and had immediately gone into his play session angrily attacking the punching bag. Within a few minutes the anger had dissipated and her son's behavior for the rest of the session was more "playful". The mother reported that her son never verbalized what had been bothering him, but that his mood was noticeably calmer after the play session.

Training Session Seven

Attendance for experimental group participants at training session seven was 64%. The facilitator reviewed reflective listening, setting limits, and giving choices. Parents shared progress with play sessions, commenting on the routines which their children have developed. Limit-setting has become almost non-existent as children seem to know the rules. Most of the parents reported feeling pretty good about their sessions.

Training Session Eight

Attendance for experimental group participants at training session eight was 50%. The amount of physical interaction between parents and children seemed to be more extensive for younger children and parents commented that they were more aware of this fact and planned to do things to increase physical contact with their older children. During the presentation of play sessions, one parent reported that she has made significant progress in not verbally praising her child.

Training Session Nine

Attendance for experimental group participants at training session nine was 57%. Some parents commented that they have begun to use some of the reflective listening and limit-setting skills outside of the play sessions and with their other children. After play session debriefing, the facilitator asked parents to write down questions to be discussed during the final training session.

Training Session Ten

Attendance for experimental group participants at training session 10 was 86%. During session 10, parents reported on their play sessions and a parent session was viewed. The facilitator shared notes of parents' original descriptions of their children as points of reference for parents to evaluate progress.

The last hour was spent with parents sharing their evaluation of the experience and how and if they and their children had changed. One parent whose son was eight, commented that the training reminded her of working with a very small child that is just developing. At that early stage you are more likely to get on the floor and play. This parent stated that she took more notice of her child. Most parents commented that as the play sessions progressed their children seemed more confident in the play sessions and chose what they wanted to do more quickly and specifically. Most parents reported feeling more comfortable in their role as play therapist.

Several parents commented on how the training had already generalized

to life outside of the play session. They had learned to reflect feelings and behaviors. One parent in particular noted that she thought she wasn't learning anything and then realized that she had begun to use "you choose" successfully in her interactions with her children. Several parents stated that their limit-setting skills had gotten better. The special play times were particularly enjoyable for one grandmother and her granddaughter. This parent explained that she enjoyed letting her guard down during the half hour of allowing her child to do what she chose. After the half an hour of this change in roles, the child was satisfied and ready to give it back that responsibility. One parent noticed that rather than saying "good job" all the time, she now focused more to tell her child exactly what the child had done well. Another parent especially enjoyed writing the notes and the response she received from her children when they received their weekly notes.

Suggestions for making the training process more attractive were made. Open-ended groups might be more appealing for people who were unable to commit to the entire 10-week period. Also, because of "word of mouth" many people hear about trainings after they have started and they would like to join. Conducting the training with the children available during the group time for practice would alleviate some of the difficulties of doing the play sessions at home. Most of the parents would like for their children's fathers to learn these same techniques for giving children positive attention.

Facilitators

The filial therapy training groups were facilitated by the investigator of this study. The investigator is a Licensed Professional Counselor in the state of Texas, a Nationally Certified Counselor, a Registered Play Therapist-Supervisor, and a doctoral candidate at the University of North Texas. She has completed an introduction to play therapy course, an advanced play therapy course, a filial therapy course, a doctoral level practicum in play therapy, and a doctoral internship in play therapy.

During the first series of filial therapy training classes, the investigator trained the coordinator of the Protect Our Children Project in filial therapy. Parents from the control group were offered filial therapy training facilitated by this person after the completion of the first series. The investigator was available to this person for consultation as necessary during the second series of classes.

Statistical Analyses

Following the collection of the pretest and post-test data, the three self-reports from the parents were blind-scored by the researcher and double-checked by a research assistant. The two self-reports from the children were blind-scored by the researcher and double-checked by a research assistant. The pre- and post-training video tapes of parent-child play sessions were rated upon completion of the study to insure that the raters did not know whether they were rating a pre-training or post-training session. Two doctoral students with

advanced course work and training in play therapy and filial therapy blind-scored the video tapes. Interrater reliability for the two raters was established during training sessions. Training included discussion and collaborative rating sessions following the procedures outlined by Stover et al. (1971). Interrater reliability was also checked at 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.

Table 2. Interrater reliability coefficients of concordance for coding of the Measurement of Empathy in Adult-Child Interactions scales

Variables	Training Sessions		
	I Pre-coding	II Midpoint	III Post
Communication of Acceptance	.9999**	.9999**	.9063**
Allowing Self-Direction	.9999***	.7083*****	.9091****
Parental Involvement	.9999***	.8889****	.9999***
Total Empathy	.9999*	.9579*	.9306**

* $p < .005$

** $p < .05$

*** $p < .10$

**** $p < .20$

***** $p < .50$

Table 3. Interrater reliability coefficients of concordance for coding of the Children's Play Behavior With Parent

Variables	Training Sessions		
	I Pre-coding	II Midpoint	III Post
Sustained Play	.9999***	.9999***	.9999***
Child's Self-Directiveness	.9583***	.5000****	.9999**
Parent/Child Connectedness	.9999**	.9500**	.9999**
Total Play Behavior With Parent	.9894*	.9198*	.9999*
Mood	.9999***	.5000****	.9999***

* $p < .05$
 ** $p < .10$

*** $p < .20$
 **** $p < .50$

For the purpose of statistical analysis, data from the three filial therapy training groups was pooled to form the experimental group. The resulting data was keyed into the computer and analyzed by the researcher using SPSS (1993).

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 post-test means for each hypotheses. In each case the post-test specified in each of the hypotheses was used as the dependent variable and the pretest as the covariate. ANCOVA was used to adjust the group means on the post-test on the basis of the pretest, thus statistically equating the control and experimental groups. Significance of difference between means was tested using .05 as the level of significance. On the basis of the ANCOVA, the hypotheses was 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. Findings are displayed graphically in Appendix M.

Hypothesis 1

The experimental group parents will attain a significantly higher mean total score on the Porter Parental Acceptance Scale (PPAS) post-test than will the control group parents.

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

Table 4.

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

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	138.9000	148.2000	141.6250	144.5000
<u>SD</u>	23.951	10.528	16.953	14.957
Total cases = 18				

Table 5.

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

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F
Main effects	105.962	1	105.962	1.340	.265
Covariates	1377.444	1	1377.444	17.419	.001
Error	2624.444	17	154.379		
Total cases = 18					

Table 5 shows the F ratio for the main effects was .265 indicating no significant increase in the experimental group parents' mean total scores for the Porter Parental Acceptance Scale (PPAS). On the basis of this data, hypothesis 1 was not retained.

Hypothesis 1.a

The experimental group parents will attain a significantly higher mean

score on the "Respect for the Child's Feelings and Right to Express Them" subscale of the PPAS post-test than will the control group parents.

Table 6 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 7 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 6.

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

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	35.8000	39.8000	35.8750	38.3750
<u>SD</u>	7.800	4.104	6.686	6.823
Total cases = 18				

Table 7.

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

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>E Ratio</u>	<u>Sign. of F</u>
Main effects	9.449	1	9.449	.458	.509
Covariates	167.792	1	167.792	8.127	.012
Error	486.500	17	28.618		
Total cases = 18					

Table 7 shows the E ratio for the main effects was .509 indicating no significant increase in the experimental group parents' mean total scores for the (PPAS) subscale: Respect for the Child's Feelings and Right to Express Them. On the basis of this data, hypothesis 1.a was not retained.

Hypothesis 1.b

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

Table 8 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 9 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 8.

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

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	32.3000	33.6000	34.8750	33.2500
<u>SD</u>	5.376	2.951	4.086	6.364
Total cases = 18				

Table 9.

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

Appreciation of the Child's Unique Makeup

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F
Main effects	4.843	1	4.843	.219	.646
Covariates	30.627	1	30.627	1.387	.257
Error	362.444	17	21.320		
Total cases = 18					

Table 9 shows the F ratio for the main effects was .646 indicating no significant increase in the experimental group parents' mean total scores for the (PPAS) subscale: Appreciation of the Child's Unique Makeup. On the basis of this data, hypothesis 1.b was not retained.

Hypothesis 1.c

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

Table 10 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 11 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 10.

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

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	40.2000	43.6000	40.1250	41.1250
<u>SD</u>	6.973	5.420	2.850	3.441
Total cases = 18				

Table 11.

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

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>E Ratio</u>	<u>Sign. of F</u>
Main effects	26.148	1	26.148	2.954	.106
Covariates	214.499	1	214.499	24.232	.000
Error	374.500	17	22.029		
Total cases = 18					

Table 11 shows the E ratio for the main effects was .106 indicating no significant increase in the experimental group parents' mean total scores for the (PPAS) subscale: Recognition of the Child's Need for Autonomy and Independence. On the basis of this data, hypothesis 1.c was not retained.

Hypothesis1.d

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

Table 12 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 13 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 12.

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

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	30.6000	31.2000	30.7500	31.7500
<u>SD</u>	9.935	7.193	10.025	8.844
Total cases = 18				

Table 13.

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

Unconditional Love

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F
Main effects	.966	1	.966	.028	.869
Covariates	497.917	1	497.917	14.497	.002
Error	1014.444	17	59.673		
Total cases = 18					

Table 13 shows the F ratio for the main effects was .869 indicating no significant increase in the experimental group parents' mean total scores for the (PPAS) subscale: Unconditional Love. On the basis of this data, hypothesis 1.d was not retained.

Hypothesis 2

The experimental group parents will attain a significantly lower mean total score on the Parenting Stress Index (PSI) post-test than will the control group parents.

Table 14 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 15 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 14.

Mean total scores for the Parenting Stress Index (PSI)

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	239.6000	227.6000	240.5000	222.1250
<u>SD</u>	34.066	29.156	29.130	26.101
Total cases = 18				

Table 15.

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

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F
Main effects	161.840	1	161.840	.400	.537
Covariates	6344.839	1	6344.839	15.668	.001
Error	12552.500	17	738.382		
Total cases = 18					

Table 15 shows the F ratio for the main effects was .537 indicating no significant increase in the experimental group parents' mean total scores for the Parenting Stress Index (PSI). On the basis of this data, hypothesis 2 was not retained.

Hypothesis 2.a

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

Table 16 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 17 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 16.

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

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	125.3000	123.4000	137.2500	125.7500
<u>SD</u>	20.833	16.821	20.218	18.561
Total cases = 18				

Table 17.

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

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>E Ratio</u>	<u>Sign. of F</u>
Main effects	125.108	1	125.108	.938	.348
Covariates	2956.796	1	2956.796	22.164	.000
Error	4982.444	17	293.085		
Total cases = 18					

Table 17 shows the E ratio for the main effects was .348 indicating no significant increase in the experimental group parents' mean total scores for the (PSI) subscale: Parent Domain. On the basis of this data, hypothesis 2.a was not retained.

Hypothesis 2.b

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

Table 18 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 19 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 18.

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

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	114.3000	104.2000	103.2500	96.3750
<u>SD</u>	15.464	14.965	11.016	12.351
Total cases = 18				

Table 19.

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

Child Domain

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>F Ratio</u>	<u>Sign. of F</u>
Main effects	5.452	1	5.452	.041	.843
Covariates	1077.806	1	1077.806	8.061	.012
Error	3355.611	17	197.389		
Total cases = 18					

Table 19 shows the E ratio for the main effects was .843 indicating no significant increase in the experimental group parents' mean total scores for the (PSI) subscale: Child Domain. On the basis of this data, hypothesis 2.b was not retained.

Hypothesis 3

The experimental group parents will attain a significantly lower mean total score on the Measurement of Empathy in Adult-Child Interaction Rating Form (MEACIRF) post-test than will the control group parents.

Table 20 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 21 presents the analysis of covariance data, showing that there is a significant difference between the experimental and control groups' post-test mean scores.

Table 20.

Mean total scores for the Measurement of Empathy in Adult-Child Interaction Rating Form (MEACIRF)

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	53.8000	29.1000	50.6250	50.1875
<u>SD</u>	6.667	6.145	4.650	8.154
Total cases = 18				

Table 21.

Analysis of covariance data for the mean total scores on the (MEACIRF)

Source of Variation	Sum of Squares	df	Mean Square	E Ratio	Sign. of F
Main effects	1618.416	1	1618.416	33.690	.000
Covariates	84.788	1	84.788	1.765	.204
Error	2781.736	17	163.632		
Total cases = 18					

Table 21 shows the E ratio for the main effects was .000 indicating a significant increase in the experimental group parents' empathic interactions with their children during observed play sessions. On the basis of this data, hypothesis 3 was retained.

Hypothesis 3.a

The experimental group parents will attain a significantly lower mean score on the "Communication of Acceptance" subscale of the MEACIRF post-test than will the control group parents.

Table 22 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 23 presents the analysis of covariance data, showing that there is a significant difference between the experimental and control groups' post-test mean scores.

Table 22.

Mean total scores for the (MEACIRF) subscale: Communication of Acceptance

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	18.2000	12.4000	18.0625	16.8125
<u>SD</u>	1.947	1.612	1.050	2.017
Total cases = 18				

Table 23.

Analysis of covariance data for the mean total scores on the (MEACIRF)subscale: Communication of Acceptance

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>E Ratio</u>	<u>Sign. of F</u>
Main effects	85.084	1	85.084	25.784	.000
Covariates	2.370	1	2.370	.718	.410
Error	138.403	17	8.141		
Total cases = 18					

Table 23 shows the E ratio for the main effects was .000 indicating significant increase in the experimental group parents' communication of acceptance of their children's feelings and behaviors during observed play sessions. On the basis of this data, hypothesis 3.a was retained.

Hypothesis 3.b

The experimental group parents will attain a significantly lower mean score on the "Allowing the Child Self-Direction" subscale of the MEACIRF post-test than will the control group parents.

Table 24 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 25 presents the analysis of covariance data, showing that there is a significant difference between the experimental and control groups' post-test mean scores.

Table 24.

Mean total scores for the (MEACIRF) subscale: Allowing the Child Self-Direction

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	21.1000	8.2000	18.0000	17.3750
<u>SD</u>	3.814	2.860	5.318	3.420
Total cases = 18				

Table 25.

Analysis of covariance data for the mean total scores on the (MEACIRF) subscale: Allowing the Child Self-Direction

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>F Ratio</u>	<u>Sign. of F</u>
Main effects	318.868	1	318.868	30.965	.000
Covariates	1.007	1	1.007	.098	.759
Error	529.611	17	31.154		
Total cases = 18					

Table 25 shows the F ratio for the main effects was .000 indicating a significant increase in the experimental group parents' acceptance and behavioral willingness to follow their children's lead rather than attempt to control their children's behavior. On the basis of this data, hypothesis 3.b was retained.

Hypothesis 3.c

The experimental group parents will attain a significantly lower mean score on the "Involvement" subscale of the MEACIRF post-test than will the control group parents.

Table 26 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 27 presents the analysis of covariance data, showing that there is a significant difference between the experimental and control groups' post-test mean scores.

Table 26.

Mean total scores for the (MEACIRF) subscale: Involvement

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	14.5000	8.5000	14.6250	16.000
<u>SD</u>	3.171	2.506	2.134	5.014
Total cases = 18				

Table 27.

Analysis of covariance data for the mean total scores on the (MEACIRF)

subscale: Involvement

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F
Main effects	249.688	1	249.688	16.112	.001
Covariates	.051	1	.051	.003	.955
Error	482.500	17	28.382		
Total cases = 18					

Table 27 shows the F ratio for the main effects was .001 indicating a significant increase in the experimental group parents' attention to and participation in their children's activity. On the basis of this data, hypothesis 3.c was retained.

Hypothesis 4

The experimental group children will attain a significantly higher mean total score on the Children's Play Behavior With Parent Rating Form (CPBWPRF) post-test than will the control group children.

Table 28 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 29 presents the analysis of covariance data, showing that there is a significant difference between the experimental and control groups' post-test mean scores.

Table 28.

Mean total scores for the Children's Play Behavior With Parent Rating Form (CPBWPRF)

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	9.8490	13.0830	10.1475	10.2500
<u>SD</u>	1.812	1.342	2.891	2.004
Total cases = 18				

Table 29.

Analysis of covariance data for the mean total scores on the (CPBWPRF)

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>E Ratio</u>	<u>Sign. of F</u>
Main effects	36.194	1	36.194	12.456	.003
Covariates	.727	1	.727	.250	.624
Error	79.984	17	4.705		
Total cases = 18					

Table 29 shows the E ratio for the main effects was .003 indicating a significant increase in the experimental group children's sustained play, self-directiveness, and connectedness with their parents. On the basis of this data, hypothesis 4 was retained.

Hypothesis 4.a

The experimental group children will attain a significantly higher mean score on the "Sustained Play" subscale of the CPBWPRE post-test than will the control group children.

Table 30 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 31 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 30.

Mean total scores for the (CPBWPRE) subscale: Sustained Play

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	3.1000	3.8000	3.0000	3.3750
<u>SD</u>	1.101	.919	1.195	1.061
Total cases = 18				

Table 31.

Analysis of covariance data for the mean total scores on the (CPBWPRE) subscale: Sustained Play

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>F Ratio</u>	<u>Sign. of F</u>
Main effects	.744	1	.744	.745	.402
Covariates	.490	1	.490	.490	.494
Error	16.278	17	.958		
Total cases = 18					

Table 31 shows the E ratio for the main effects was .402 indicating no significant increase in the experimental group children's mean total scores for the (CPBWPRF) subscale: Sustained Play. On the basis of this data, hypothesis 4.a was not retained.

Hypothesis 4.b

The experimental group children will attain a significantly higher mean score on the "Child Self-Directiveness" subscale of the CPBWPRF post-test than will the control group children.

Table 32 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 33 presents the analysis of covariance data, showing that there is a significant difference between the experimental and control groups' post-test mean scores.

Table 32.

Mean total scores for the (CPBWPRF) subscale: Child Self-Directiveness

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	3.3330	4.7160	3.4388	3.4575
<u>SD</u>	.732	.610	1.288	.723
Total cases = 18				

Table 33.

Analysis of covariance data for the mean total scores on the (CPBWPRF)
subscale: Child Self-Directiveness

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F
Main effects	6.865	1	6.865	15.301	.001
Covariates	.280	1	.280	.625	.442
Error	14.049	17	.862		
Total cases = 18					

Table 33 shows the F ratio for the main effects was .001 indicating a significant increase in the experimental group children's demonstrated ability to take responsibility and direct activity during the observed play sessions. On the basis of this data, hypothesis 4.b was retained.

Hypothesis 4.c

The experimental group children will attain a significantly higher mean score on the "Parent/Child Connectedness" subscale of the CPBWPRF post-test than will the control group children.

Table 34 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 35 presents the analysis of covariance data, showing that there is a significant difference between the experimental and control groups' post-test mean scores.

Table 34.

Mean total scores on the (CPBWPRF) subscale: Parent/Child Connectedness

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	Pretest	Post-test	Pretest	Post-test
Mean	3.4160	4.5670	3.7088	3.4175
<u>SD</u>	.851	.466	.829	.792
Total cases = 18				

Table 35.

Analysis of covariance data for the mean total scores on the (CPBWPRF)

subscale: Parent/Child Connectedness

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>E Ratio</u>	<u>Sign. of F</u>
Main effects	5.691	1	5.691	13.458	.002
Covariates	.000	1	.000	.002	.964
Error	12.216	17	.719		
Total cases = 18					

Table 35 shows the E ratio for the main effects was .002 indicating a significant increase in the experimental group children's interaction with their parents during the observed play sessions. On the basis of this data, hypothesis 5.c was retained.

Hypothesis 4.d

The experimental group children will attain a significantly higher mean score on the "Child's Mood" subscale of the CPBWPRE post-test than will the control group children.

Table 36 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 37 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 36.

Mean total scores on the Mood scale of the (CPBWPRE)

	<u>Experimental (n=10)</u>		<u>Control (n=8)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	3.5000	4.7000	3.8750	4.1250
<u>SD</u>	.850	.675	1.246	1.126
Total cases = 18				

Table 37.

Analysis of covariance data for the mean total scores on the Mood scale of the (CPBWPRE)

<u>Source of Variation</u>	<u>Sum of Squares</u>	<u>df</u>	<u>Mean Square</u>	<u>F Ratio</u>	<u>Sign. of F</u>
Main effects	1.379	1	1.379	1.595	.226
Covariates	.008	1	.008	.009	.924
Error	14.444	17	.850		
Total cases = 18					

Table 37 shows the E ratio for the main effects was .226 indicating no significant increase in the experimental group children's mean total scores on the Mood scale of the (CPBWPRF). On the basis of this data, hypothesis 4.d was not retained.

Hypothesis 5

The experimental group children will attain a significantly higher mean total score on the Joseph Pre-school and Primary Self Concept Screening Test (JPPCST) post-test than will the control group children.

Table 38 presents the pre and post-test means and standard deviations for the experimental and control groups. Table 39 presents the analysis of covariance data, showing that there is no significant difference between the experimental and control groups' post-test mean scores.

Table 38.

Mean total scores for the Joseph Pre-school and Primary Self Concept Screening Test (JPPCST)

	<u>Experimental (n=9)</u>		<u>Control (n=6)</u>	
	<u>Pretest</u>	<u>Post-test</u>	<u>Pretest</u>	<u>Post-test</u>
Mean	19.1111	20.7778	21.5000	21.3333
<u>SD</u>	5.533	6.924	5.958	8.140
Total cases = 15				

Table 39.

Analysis of covariance data for the mean total scores on the (JPPCST)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Sign. of F
Main effects	6.377	1	6.377	.173	.685
Covariates	272.431	1	272.431	7.389	.019
Error	716.000	14	51.143		
Total cases = 15					

Table 39 shows the F ratio for the main effects was .685 indicating no significant increase in the experimental group children's mean total scores for the Joseph Pre-school and Primary Self Concept Screening Test (JPPCST). On the basis of this data, hypothesis 5 was not retained.

Discussion

The results of this study along with parents' comments and the facilitator's observations provide information regarding filial therapy training as an intervention with Native American parents residing on the Flathead Reservation and also for future research studies with this or a similar population. Of the 18 separate parts listed as hypotheses, 7 were retained and 11 were rejected. However, all measures showed positive trends even though not at the .05 level of significance. An interpretation of all scores is provided in the following section.

Parental Acceptance

As can be seen in Table 4 through Table 13, the participants in the experimental group demonstrated positive gains in their perceived acceptance of their children in all four subscales measured by the Porter Parental Acceptance Scale (PPAS), as well as the total score; however, those gains were not significant at the .05 level. Two of the experimental group participants made significant increases of 37 and 41 points respectively. The remaining eight participants from the experimental group showed varying results from a decrease of 11 points to an increase of 9 points. The participant with the significant decrease had a post-test score which was 14 points lower than the pretest score on the "Unconditional Love" subscale. During the 10-week training series, this parent had frequently mentioned frustration with her daughter's regressive behavior when in the presence of her non-custodial father. Two participants from the control group made significant increases of 10 and 26 points respectively. The participant with the 10 point increase had been involved in a residential treatment program for several weeks during a portion of the study. No specific circumstance could be identified for the participant with the 26 point increase.

Overall, for the experimental group, the subscale "Respect for the Child's Feelings and Right to Express Them" showed the largest increase. The remaining three subscales showed minimal positive change. One factor contributing to the lack of significant change in these scores could be the

sporadic participation in the group meetings. According to Horejsi (1987), a Native American individual's first priority is to family and friends. This takes precedence over all other obligations including appointments, work, or school. Although participants received individual make-up sessions, they missed the impact of the group context for sharing parenting strategies, as well as the opportunity to support one another in the role of parent.

These findings suggest that a filial therapy training group might be an effective intervention for increasing parental acceptance in the Native American parents residing on the Flathead Reservation. However a different format may be more effective.

Parental Stress

As indicated by Table 14 through Table 19, the experimental group participants showed only minimal decrease in overall parent stress as measured by the Parent Stress Index. A closer examination of the individual scores revealed that seven participants of the experimental group were in the normal range, one participant ranked at a low level of stress, and only two showed high levels of stress. The control group's stress levels were roughly equivalent. On the post-test, seven participants in the experimental group showed lowered levels of stress. One participant moved from the high to the normal range and two moved from the normal to the low range. The remaining four participants showing lowered stress levels stayed within the same range as measured by the pretest. One participant did move from the normal to the high range.

Participants from the control group also showed lowered stress levels as measured by this instrument. One participant moved from the high range to the normal range. Three participants moved from the normal range to the low range.

Although positive change occurred in the experimental group, such change can not be inferred to have been a result of the filial therapy training, since the control group experienced a similar reduction in stress scores. The control group made greater reductions in stress in the parent domain, while the experimental group showed a reduction in stress in relation to the child domain. The greatest reduction was shown in the "Child Distractibility" subscale. The additional time spent with the child in the special play session may have helped parents adjust expectations for age-appropriate behavior. Increased stress for experimental group participants was most significant in the "Relationship with Spouse" subscale. During the 10-week filial therapy training series, one parent became divorced while another was considering separation.

In comparing this study to other studies of filial therapy training (Bratton, 1993/1994; Harris, 1995) both single parents and incarcerated mothers showed significantly higher levels of stress prior to training. With scores farther from the mean, the likelihood of more significant change is possible. Scores that begin in the normal range tend to remain in the normal range. In addition, lower levels of stress may be appropriate for a Native American population. Harmonious living is valued. Stress often occurs as a result of conflict with the environment. The Native American perspective advocates living as much as possible in the

present and adapting to rather than resisting change.

These findings suggest that a filial therapy training group might be an effective intervention for decreasing parental stress in various parent populations, including the Native American parents residing on the Flathead Reservation. However a different format may be more effective.

Empathy in Adult-Child Interactions

Table 20 through Table 27 show significant increases for the experimental group participants ($p < .001$) 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 post-test mean total score decreased 24.7 points, while the control group's mean score decreased by only .4375. For this scale, a decrease in the mean score indicates an increase in the desired behavior. The experimental group demonstrated increased skill in communicating acceptance, allowing the child self-direction, and being involved with the child during a special play session. The greatest improvement was noted in the area of allowing the child self-direction.

Although the previous measures of acceptance scores and stress scores did not improve as was predicted, the significant positive changes indicated by this observational measure do suggest that filial therapy parent training is an effective treatment for increasing empathy in parent-child interactions. The findings in this study support earlier studies in filial therapy that used this same observational measure of empathic behavior in parents as they interacted with

their children (Bratton, 1993/1994; Harris, 1995). A high level of empathic behavior in parents was found to be a critical component in the filial therapy training process (Stover et al., 1971).

These findings suggest that a filial therapy training group might be an effective intervention for increasing parental empathic behaviors in the Native American parents residing on the Flathead Reservation.

Children's Play Behaviors With Their Parents

Table 28 through Table 37 show significant increases for the experimental group children ($p < .01$) in desirable play behavior during observed play sessions with their parents as measured by the total score of the Children's Play Behavior With Parent Rating Form. The experimental group's post-test mean total score increased 3.234 points on a 15 point scale, while the control group's mean score increased by .1025. The experimental group children demonstrated significantly greater self-directiveness and connectedness with their parents. The experimental group children showed positive increases in sustained play although not at the .05 level of significance. The children's overall mood score also increased by 1.2 between the pretest and post-test; however this was not significant at the .05 level. The control group children's scores shifted less than .375 in either direction on all three subscales, as well as the total mean score. The overall mood score for the control group children increased by .25 between the pretest and post-test.

These findings suggest that a filial therapy training group might be an

effective intervention for increasing children's desirable play behaviors with their parents in the Native American population residing on the Flathead Reservation.

Children's Self-Concept

Table 38 and Table 39 show that although there was a positive increase in self-esteem of the children whose parents participated in filial therapy training as measured by the Joseph Pre-school and Primary Self Concept Screening Test, the results were not significant at the .05 level. An evaluation of the self concept scores revealed a markedly low self concept for the group of children in general. Since there was minimal change over the 10-week treatment period, the investigator looked at the pretest scores of the 19 children given the Joseph Screening Test to determine any pattern which might emerge.

The Joseph Self Concept Screening Test was normed on a group of 1,245 children residing in rural, suburban, and urban areas of Illinois (Joseph, 1979). Approximate 91 percent of the subjects were Caucasian. The remaining 9 percent consisted of African American, American Indian, Asian, Filipinos, and Mexican American. The minority children were in all cases attending integrated school systems. Although the author concluded that the sample selected appeared to generally reflect the demographic makeup of the United States as a whole and was highly generalizable to other populations, the negatively skewed results from this study raise questions about the validity of the instrument with the Native American population. The children had not been identified as "at risk" by their parents nor did the researcher observe behaviors that would indicate

such low scores.

According to the information given by Joseph (1979), 71 percent of the normed population fall into the "High Positive" to "Moderately Positive" categories of the scale. Of the 19 children measured in this study, only 32 percent are found in this range, while 63 percent are considered to have "Poor" or "High Risk Negative" self concepts. Five questions in particular seem to be consistently answered in the negative. Question number one asks children to decide whether they are more like the "clean" child or the "dirty" child. Cleanliness may not be as significant an issue for Native American children whose parents are not as concerned with a child's appearance and instead promote exploration of the natural environment. Question number four asks a child to identify the child their parent likes best. Competition is not highly valued in traditional Native American homes. Children may not understand the concept of being better liked than a sibling. Question number nine asks whether the child would like to be called by a different name. Traditionally raised children often have a nickname and a specially given "Indian" name, as well as their regular name. The idea of choosing only one name may be unusual. Question number 11 speaks to winning or losing a game. Once again, the concept of competition may not be fully accepted. Finally, question number 15 asks whether the child would like to live in a different place. Many Native American children enjoy camping with their families and say they would like to live in the woods. In addition, Native American children who are accustomed to the

extended family concept may feel they have more choices, but not that they necessarily dislike where they currently live.

As a comparison, the Harter self perception profiles were also administered to the children. Once again, there was no significant change between pretest and post-test for either the experimental or the control group although the experimental group's scores did increase slightly. The scores, however, tended to fall within the normal range, supporting the assumption that the previous instrument may not be appropriate for a Native American population. In the cognitive subscale 14 children scored in the midrange, 1 in the high range, and only 1 in the low range of perceived competence. In the peer subscale, 11 children scored in the midrange and 5 in the high range of social acceptance. In the physical subscale 8 children scored in the midrange, 5 in the high range and 3 in the low range of perceived competence.

Parental competence includes feeling capable of managing the requirements of child rearing. For the purpose of this study, the Parent Sense of Competence Scale (Gibaud-Wallston, and Wandersman, 1978) was used to gather information on participants' perceptions of their competence in parenting. They reported feeling slightly less frustrated and less manipulated by their child in the parenting role. In addition, participants reported that parenting was slightly more manageable.

Implications

The results of this research indicate that filial therapy training is an

effective method for enhancing empathic responsiveness in parents and increasing desirable play behaviors in children. Participants did learn the specific basic skills taught during the training sequence. All participants were able to demonstrate these skills on at least a minimally effective level by the end of training. All of the children displayed behavior which indicated a higher level of comfort and feeling of safety in the play session with their parents. It is significant that this research when compared with other populations studied is not as effective in increasing parental acceptance as measured by the Porter Parental Acceptance Scale and decreasing parental stress as measured by the Parent Stress Index. Further investigation into these measurement instruments with the Native American population may reveal cultural differences in these areas which are not affected as readily by parent training. The inconsistency in the self concept scales for the children points to another possible area of cultural difference requiring greater sensitivity in selecting measurement instruments for research with a Native American population.

As was reported earlier in this study, the attrition rate for participants in both the experimental and the control groups was high. Future researchers working with a Native American population need to be aware that initial enthusiasm for a project may subside. Family matters often take priority over previous commitments. A larger sample size than previously estimated may be required to meet the needs of a particular study.

The lack of significant change in the two self-report instruments indicates

that these participants did not benefit as much from the 10-week filial therapy training model as previous populations studied. The training did yield significantly positive results in some areas and positive trends in others supporting the possibility that a change in presentation may be more effective. A format more conducive to positive results with a Native American population might include longer training segments with fewer sessions, and providing for practice play sessions on site. Creating an atmosphere of a social event by providing food for all participants, babysitting and entertainment for the children, and transportation might make the training more attractive. Family groups could be encouraged to attend and include all children in the practice sessions. For example, if a single parent has three young children, a partner, sister or brother, or grandparent could be encouraged to participate also.

Recommendations

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

1. Design a filial therapy training model keeping in mind the Native American preferences of including the whole family in the experience, of less structure and more flexibility in regard to time, and incorporation of traditional teaching methods such as storytelling.
2. With a recent shift in providing home-based services for "at-risk" parents, design an individual filial therapy training model which could be implemented by paraprofessionals trained in filial therapy and supervised by

professional therapists.

3. Refine the Children's Play Behaviors With Parent Rating Form and conduct reliability and validity tests on the instrument.
4. Conduct comparative research with other minority populations.
5. Investigate the relationship between an adult allowing self-direction and a child's self-directiveness.
6. Conduct a longitudinal study to determine the long term effects of increasing empathic behaviors of primary care givers.
7. Conduct a follow-up study with the participants of this study.
8. Conduct a similar study using a time series design using the participants as their own controls to alleviate contamination in the control group.
9. Investigate self concept of Native American children from an internal vantage point using measurement instruments designed for this population.
10. Conduct a longitudinal investigation of Native American children's self concept over the ages of 3 to 12.

Concluding Remarks

The motivation behind this study was to test the hypothesis that the 10-week filial therapy training model would be an attractive parent training program for a Native American population because the skills promoted in filial therapy support traditional Native American parenting values. The dominant culture of the United States values competition, wealth, conformity, and power. Goals

such as these can cause stress, conflict, prejudice, and isolation. Traditional Native American values include cooperation, generosity, individuality, and community. Such values would seem to foster the growth and development of a healthy individual.

Native Americans draw strength from the extended family. Positively impacting the relationship between adults and children could serve to reinforce the extended family concept. Filial therapy training, with some modifications to meet the specific needs of Native Americans, could be an effective vehicle for reintroducing traditional parenting skills and supporting traditional values.

APPENDIX A
FILIAL THERAPY DISSERTATION STUDIES

Author/Date	Summary of Findings With Respect to Filial Therapy
Bratton/1994	Significant results: 13 of 13 measures
Glass/1987	Significant results: 2 of 28 measures Positive trends: 16 of 28 measures
Glazer-Waldman/1991	Parents reported positive change personally and in children
Harris/1995	Significant results: 9 of 13 measures Positive trends: 4 of 13 measures
Lebovitz/1983	Significant results: 8 of 16 measures Study includes process research
Lobaugh/1992	Significant results: 8 of 9 measures Positive trends: 9 of 9 measures
Oxman/1973	Significant results: 2 of 2 measures
Payton/1981	Significant results: 2 of 3 measures
Sensue/1981	Significant results: 4 of 4 measures Measures at 6 month and 3 year follow-up
Sywulak/1978	Significant results: 3 of 4 measures
	Qualitative Studies
Bavin-Hoffman/1994	Parents reported positive change personally and in children
Lahti/1993	Parents reported positive change personally and in children
Packer/1990	Parents reported positive change personally and in children

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
Glass/1987 Volunteer parents (recruited through a counseling center) <u>Experimental Parents</u> 15 parents <u>Experimental Children</u> Children aged 5-10 <u>Control Parents</u> 12 parents <u>Control Children</u> Children aged 5-10	<u>Parent Measures</u> Porter Parental Acceptance Scale Acceptance Exp > Con Respect Feeling Exp > Con Uniqueness Exp > Con Autonomy Exp > Con Unconditional Love Exp > Con (S) Coopersmith Inventory Self-Esteem Exp > Con Madanes Family Hierarchy Test Hierarchy no change either group Closeness Exp > Con Family Environment Scale Cohesion Con > Exp Expressiveness Exp > Con Decrease Conflict Exp > Con (S) Independence Exp > Con Achievement Con > Exp Intell/Cultural Exp > Con Active no change either group Moral/religious Con > Exp Organization Exp > Con Reduced Control Exp > Con	Exp = Filial group (10-week Filial model) Con = Wait-list control
	<u>Child measures</u> Primary Self-Concept Inventory Self-Concept Con > Exp Madanes Family Hierarchy Test Hierarchy no change either group Closeness Con > Exp Family Environment Scale Cohesion Con > Exp Expressiveness Exp > Con Decrease Conflict Con > Exp Independence Con > Exp Achievement Con > Exp Intell/Cultural Exp > Con Active Con > Exp Moral/religious Exp > Con Organization Con > Exp Reduced Control Con > Exp	Methodological Problems
		Volunteer population

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
Glazer- Waldman/1991 Parents of chronically ill children <u>Parents</u> 5 mothers Mean age - 33.5 4 Caucasian 1 African American Education all H.S. graduates 1 some college 3 College graduates <u>Children</u> 5 children Mean age - 6.83 4 Caucasian 1 African American	<u>Parent Measures</u> Interview 4 of 5 parents reported significant changes in children. 5 of 5 parents reported positive changes in self. Porter Parental Acceptance Scale No significant difference pre & post Spielberger's State-Trait Anxiety Inventory No significant difference pre & post <u>Child measure</u> Child Anxiety Scale No significant difference pre & post	Filial group (10-week Filial model) No control
		Methodological Problems
	<u>Comparison Parent/Child</u> Parent's scores more closely matched child's scores on level of anxiety at post-test.	Small "N" S's not randomly assigned No control

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
<p>Harris/1995 Incarcerated Mothers <u>Experimental Parents</u> 12 mothers <u>Control Parents</u> 10 mothers</p> <p><u>Demographic Data</u> Mean age - 32 50% Caucasian 40% African-American 5% Hispanic 5% Native American</p> <p>Education 9th grade - 1 yr college</p> <p>Annual Income 41% <\$ 5,000 9% < 10,000 5% < 20,000 5% < 30,000 5% < 40,000 36% did not respond</p> <p>14% rcv SSI 27% rcv AFDC</p> <p>23% married 9% common law marriage 9% separated 14% divorced 41% single</p> <p>Children 47% girls 53% boys Mean age - 5</p>	<p><u>Parent Measures</u> Measurement of Empathy in Child-Adult Interaction</p> <p>Empathy Exp > Con (S) Acceptance Exp > Con (S) Self-direction Exp > Con (S) Involvement Exp > Con (S)</p> <p>Porter Parental Acceptance Scale</p> <p>Acceptance Exp > Con (S) Respect Feeling Exp > Con (S) Uniqueness Exp > Con (S) Autonomy Exp > Con (S) Unconditionl Love Exp > Con</p> <p>Parenting Stress Index</p> <p>Overall Stress Exp < Con Parent Domain Exp < Con Child Domain Exp < Con</p> <p>Filial Problem Checklist Perceived Prob. Exp < Con (S)</p>	<p>Exp = Filial group (10-week Filial model condensed to twice weekly for a 5 week period)</p> <p>Con = Wait-list control</p> <p>Methodological Problems</p> <p>Volunteer population</p> <p>Small n</p>

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
Lebovitz/1983 Parents of children displaying mild to moderate emotional or behavioral difficulties - Elementary Schools, Galveston, TX. <u>Filial Parents</u> 10 mothers <u>Filial Children</u> 10 children Aged 6-10 <u>Play Session Parents</u> 10 mothers <u>Play Session Children</u> 10 children Aged 6-10 Groups were comparable in terms of age, sex, parents' marital status, SES, and ethnicity.	<u>Parent Measures</u> Porter Parental Acceptance Scale Mothers Acceptance Fil = Play Both groups Post > Pre (S) Fathers (nonparticipant) Acceptance Fil = Play Both groups Post > Pre (S) <u>Child Measures</u> Behavior Problem Checklist Mother rating Emotional adj. Fil = Play Both groups Post > Pre (S) Father rating Emotional adj. Fil = Play Both groups Post > Pre (S) Teacher rating Emotional adj. Fil = Play Both groups Post > Pre (S) Video tape ratings Aggression Fil < Play (S) Dependence Fil < Play (S) Withdrawal Fil < Play (S) Positive Behavior Fil = Play Negative Behavior Fil = Play Physically Close Fil = Play <u>Process Analysis</u> Week 1 and Week 7 Aggression Fil = Play Dependence Fil = Play Withdrawal Fil = Play Week 10 Aggression Fil = Play Dependence Fil < Play (S) Withdrawal Fil = Play Mothers progressively increased Involvement Fil > Play (S) Allow Self-direct Fil > Play (S) Acceptance Fil > Play (S)	Fil = Filial group (10 week training) Play = supervised mother-child play session group
		Methodological Problems
		Small N
		Low power of statistical analysis
		No control group

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
Lobaugh/1992 Incarcerated Fathers <u>Experimental Parents</u> 16 fathers 52% Caucasian 30% Hispanic 18% African American Education 31% not H.S. graduate 37% H.S. graduate 32% advanced degree <u>Control Parents</u> 16 fathers Matched with experimental group by age of child, race, and educational level.	<u>Parent Measures</u> Porter Parental Acceptance Scale Acceptance Exp > Con (S) Respect Feeling Exp > Con (S) Uniqueness Exp > Con (S) Autonomy Exp > Con (S) Unconditionl Love Exp > Con (S) Parenting Stress Index Overall Stress Exp < Con (S) Parent Domain Exp < Con (S) Child Domain Exp < Con Filial Problem Checklist Perceived Prob. Exp < Con (S)	Exp = Filial group (10-week model) Con = Wait-list control group
	<u>Child measure</u> Joseph Pre-school and Primary Self-Concept Scale Self-concept Exp > Con (S)	Methodological Problems
		Control group procedure lacked specificity.

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
<p>Oxman/1973 Parents of children diagnosed as "emotionally maladjusted" seeking help at Rutgers Clinic.</p> <p><u>Experimental Parents</u> 51 mothers age - middle 30's Education All fathers H.S. graduates 50% fathers college graduates Occupation Mothers-homemaker Fathers=semi-skilled to major professional</p> <p><u>Experimental Children</u> Children aged 4-8 Emotionally maladjusted</p> <p><u>Control Parents</u> Volunteer in exchange for free babysitting. 77 mothers age range 30-40</p> <p><u>Control Children</u> Children aged 4-8 Normal behavior with typical childhood problems.</p>	<p><u>Parent Measures</u> Filial Problem Checklist Perceived Prob. Exp < Con (S)</p> <p>Interpersonal Checklist Real child=Ideal Exp > Con (S)</p> <p>Correlation between number of problems identified by mothers and discrepancy between real and ideal child. Significant for both experimental and control groups.</p>	<p>Exp = Filial group 12-month treatment period</p> <p>Con = volunteer control group</p>
		Methodological Problems
		<p>Validity of instruments</p> <p>Self-report</p>

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
<p>Payton/1981 Parents who were students at NW Community College, Steamboat Springs, Colorado.</p> <p><u>Experimental</u> 8 mother/child pairs Mean age of children = 6.3 years</p> <p><u>Comparison</u> 7 mother/child pairs Mean age of children = 7.6 years children seen by paraprofessionals</p> <p><u>Control</u> 7 mother/child pairs Mean age of children = 7.9 years</p>	<p><u>Parent Measures</u> Herford Parental Attitude Survey Form Improve attitude Fil > Con (S) Para = Con Fil > Para (S)</p> <p><u>Child Measures</u> Piers Harris Children's Self-Concept Scale Self-concept Fil = Con Para = Con Fil = Para</p> <p>Child Behavior Rating Scale Behavior Improve Fil > Con (S) Para > Con Fil > Para</p>	<p>Fil = Filial training (2 hrs. weekly for 12 weeks)</p> <p>Para = Paraprofessionals trained in Filial (2 hrs. weekly for 12 weeks) and conducting play sessions with children.</p> <p>Con - No treatment control group.</p> <p><u>Methodological Problems</u></p> <p>Subjects may have been sensitized to self-concept scale used in both pre- and post-test.</p> <p>Scale may have lacked sensitivity</p> <p>Small N</p> <p>Self-report</p>

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
Sensue/1981 Follow-up of Sywulak study. <u>Experimental Parents</u> 15 mothers Mean age 41 10 fathers Mean age 41 24 Married 2 Divorced Income: 10,000-25,000 Education: < H.S. graduate - post-graduate degree <u>Experimental Children</u> 11 boys Age range 6-14 5 girls Age range 5-13 <u>Comparison Parents</u> 15 mothers Mean age 35 9 fathers Mean age 35 Income: 7,000-25,000 Education: < H.S. graduate - post-graduate degree <u>Comparison Children</u> Matched with experimental children for age and gender. Normal behavior w/typical childhood problems.	<u>Parent Measures</u> Porter Parental Acceptance Scale 6 Month follow-up Post > Pre (S) 3 Year follow-up Post > Pre (S) Filial Problem Checklist 6 Month follow-up Post < Pre (S) 3 Year follow-up Post < Pre (S) # Problems Fil = Comp Wichita Parent Check List 6 Month follow-up Post < Pre (S) 3 Year follow-up Post < Pre (S) # Problems Fil = Comp Des Moines Parent Rating Scale 6 Month follow-up Post < Pre (S) 3 Year follow-up Post < Pre (S) # Problems Fil = Comp No significant difference between 6 month and 3 year follow-ups.	Fil = Filial group (Had participated in 6-9 month Filial program, meeting weekly for 2 hrs.) Comp = Non- clinical comparison group w/no Filial or parent education (Recruited by experimental families and matched for age, gender, SES, and education.) Methodological Problems Volunteer population

Author/Date Population	Dependent Measures Results (S = Significant)	Independent Variables
Sywulak/1978 Interested families from Individual and Family Consultation Center of Penn State University. <u>Experimental Parents</u> 19 mothers Mean age 34 13 fathers Mean age 38 13 mother/father 2 mothers only 4 divorced mothers Income: 4,000-25,000 Education: < H.S. graduate - post-graduate degree	<u>Parent Measures</u> Porter Parental Acceptance Scale 4 Month wait O1 = O2 2 months training O3 > O2 (S) 4 months training O4 > O2 (S) Comparative gains O3-O2 > O4-O3 <u>Filial Problem Checklist</u> 4 Month wait O1 = O2 2 months training O3 < O2 (S) 4 months training O4 < O2 (S) Between 2-4 mos O4 = O3 <u>Wichita Parent Check List</u> 4 Month wait O1 = O2 2 months training O3 < O2 4 months training O4 < O2 (S) Between 2-4 mos O4 = O3	O1 = 4 months prior to training O2 = Pre-test O3 = 2 months of training O4 = 4 months of training
<u>Experimental Children</u> 14 boys Age range 3-10 5 girls Age range 3-9 Subjects served as own controls during 4-month waiting period.	<u>Des Moines Parent Rating Scale</u> 4 Month wait O1 = O2 2 months training O3 = O2 4 months training O4 = O2	<u>Methodological Problems</u> Only 4 months of a typically 6 month or longer treatment program. Lack of girls in study. Small N

Author/Date Population	Qualitative Study	
<p>Bavin-Hoffman/1994 Parents who had participated in Filial training (10-week model) 1991-1994 north central Texas.</p> <p>20 married couples</p> <p>Fathers 1 stepfather 1 Hispanic 1 "Other" 18 Caucasian Education All some post-H.S. 25% Grad. degree Age range 32-52</p> <p>Mothers 1 stepmother 10 Caucasian Education All some post-H.S. 15% Grad. degrees Age range 29-47</p> <p>Children 26 Children Aged 3-11 15 boys 11 girls 10 eldest children 4 only children</p>	<p>Audio-taped interviews using an interview guide to insure same procedure for each interview.</p> <p>Data collected in a phenomenological manner looking for recurring themes and patterns.</p> <p>1. How has your family changed since you participated in a Filial therapy experience? 2. How has your relationship changed with your partner during, and after you participated in a Filial therapy experience?</p> <p>Themes: Improved parent/child comm. 13 fathers 16 mothers</p> <p>Improved partner communication: 14 fathers 16 mothers</p> <p>Improved child behavior: 15 fathers 18 mothers (Fathers primarily noted increased self-control, while mothers noted decreased aggression.)</p> <p>Reported: Increased unity between parents. Increased parental confidence. Increased understanding of play. Increased acceptance of child. Fathers can be trained to be therapeutic agents with Filial. Follow up with refresher classes.</p>	<p></p> <p>Methodological Problems</p> <p>Volunteer sample</p> <p>Small N</p> <p>Not randomly assigned</p>

Author/Date Population	Ethnographic Research	
<p>Lahti/1993 Two volunteer families <u>Parents</u> 1 father 2 mothers all Caucasian Upper-middle income</p> <p><u>Children</u> 1 boy aged 7 1 boy aged 9 1 girl aged 9</p>	<p>Essential nature of training process focused on balancing a didactic component with the group counseling format.</p> <p>Beneficial components: group counseling, classes, educational information, teaching methods & techniques, enhanced confidence, increased personal power, & play sessions</p> <p>Parents reported gains: objectivity increased awareness of needs closer relationships enhanced communication realistic expectations less friction</p> <p>Observed gains in children: enhanced communication increased responsibility for actions decreased withdrawal or aggression increased feelings of happiness</p>	<p>Filial group (10-week model)</p> <p>No Control</p> <p>Methodological Problems</p> <p>No control</p>

Author/Date Population	Case Study	
<p>Packer/1990 One family from rural central Pennsylvania.</p> <p><u>Parents</u> Father age 29 Mother age 28 Unmarried European American Lower Middle Class</p> <p><u>Child</u> Girl age 4½</p>	<p>Four months of observation</p> <ol style="list-style-type: none"> 1) Field notes 2) Video tapes 3) Telephone interview weekly parent 4) Telephone interviews weekly teacher 5) Informal interview w/child 6) Interviews w/Filial therapist <p><u>Initially</u> Parents and teachers report tantrums, uncooperative behavior, and acting out inappropriately to get attention.</p> <p><u>After Filial Training</u> Parents report marked improvement in child's gaining control over feelings, beginning to show self-confidence, more independent, and asks for less assistance.</p> <p>Teachers report marked improvement in child's gaining control over feelings, beginning to show self-confidence, willingness to try activities, and efforts at self-direction.</p> <p>Parents reported feeling more relaxed and competent as parents and feeling empowered.</p>	<p></p> <p>Methodological Problems</p>

APPENDIX B
LETTER OF AGREEMENT FROM THE CONFEDERATED SALISH
AND KOOTENAI TRIBES OF THE FLATHEAD NATION

THE CONFEDERATED SALISH AND KOOTENAI TRIBES
OF THE FLATHEAD NATION

P.O. Box 278
Pablo, Montana 59855
(406) 675-2700
FAX (406) 675-2806

Joseph E. Dupuis - Executive Secretary
Vern L. Clairmont - Executive Treasurer
Bernice Hewankom - Sergeant-at-Arms

TRIBAL COUNCIL MEMBERS:
Michael T. "Mickey" Pablo - Chairman
Rhonda R. Swaney - Vice Chairwoman
Carole McCrea - Secretary
Lloyd Irvine - Treasurer
Louis Adams
Eimer "Sonny" Morgeau Jr.
Henry "Hank" Baylor
D. Fred Malt
Donald "Donny" Dupuis
Mary Lefthand

April 10, 1995

Faculty Advisory Committee
University of North Texas
Department of Counseling, Development, and Higher Education
P.O. Box 13857
Denton, Tx 76203

To the Committee:

This letter is in support of Geradine (Geni) Glover conducting research as part of a dissertation study with enrolled members of the Confederated Salish and Kootenai Tribes who volunteer to participate. It is our understanding that the study will be limited to parent education which teaches parents a structure for special play times with their children. The purpose of these special play sessions is to enhance parent-child relationships.

Access to Tribal members will be arranged through Irene Lake, Coordinator of the Protect Our Children Project. In addition, we will be able to provide minimal office space, access to phone and copying equipment and meeting space for groups at various locations on the Reservation.

Sincerely,

Thomas Bearhead Swaney
Community Services Division Department Head

APPENDIX C

MINUTES FROM TRIBAL COUNCIL GRANTING PERMISSION FOR STUDY

**TRIBAL COUNCIL MEETING MINUTES
OF THE CONFEDERATED SALISH AND KOOTENAI TRIBES
OF THE FLATHEAD INDIAN NATION, MT.**

Volume 95 Number 81 Held: September 01, 1995
Council Chambers, Pablo, Mt. Approved: September 19, 1995

MEMBERS PRESENT: Michael Pablo, Chairman; Rhonda Swaney, Vice-Chair; Carole McCrea; Lloyd Irvine; Sonny Moriceau; Fred Matt; Donald Dupuis; Louie Adams; Mary Lefthand.

MEMBERS ABSENT: Hank Baylor (Indian Agricultural Council).

OTHERS PRESENT: Joseph E. Dupuis, Executive Secretary; Bernice Hewankorn, Sergeant at Arms; Tari Shaw, Executive Aide.

Meeting called to order at 9:05 a.m.

Roll called by Joe Dupuis, Executive Secretary. Quorum established.

The meeting was opened with a prayer by Fred Matt.

The Tribal Council Meeting Minutes for August 29, 1995, were presented for approval.

Irene Lake, Tribal Health & Human Services Department, introduced Gerri Glover, University of North Texas, who is working on a Play Therapy project for parents and children. Ms. Glover requested authorization to conduct a research

project for ten (10) weeks, utilizing the data from Tribal Health & Human Services.

MOTION by Fred Matt to authorize Gerri Glover to utilize THHS data to complete her research project. Seconded by Lloyd Irvine. Carried, unanimous (9 present); Michael Pablo out of the room.

APPENDIX D
MARKETING SAMPLES

*****THHS INTERDEPARTMENTAL NEWS LETTER*****
SEPTEMBER, 1995

PARENT TRAINING GROUP

Geri Glover will be doing a research on "Parent Training with Native Americans" from the University of Texas and will be on Staff at the Community Enrichment Program. Geri will be working closely with Irene Lake, "Protect our Children Program." She will be starting "Groups" targeting parents or significant care givers that have children between ages 3-10 years old. These "Groups" will be geared to help parents to communicate with their children. Geri is very flexible as to times and size of groups. She is in the process in identifying parents and will take referrals or self referral.

If you know of any parents or significant care givers with children between ages 3-10 that may want to learn how to better communicate with their children please call at 745-4363 or Ext. 425 or Ext. 427.

Geri plans to start the "Groups" the end of September and go to December, 1995.

Geri will schedule an inservice training regarding her program and services. This inservice is open to all THHS employees to be held September 8, Friday, at 10 a.m. in the THHS Nursing Conference Room. Everyone is welcome to attend.

Families needed for new study

Training can help strengthen family bonds, researcher says

ST. IGNATIUS — Indian parents interested in learning how to forge stronger bonds with their children through interpretation of the latter's "play language" are invited to participate in a new ten-week study involving a method called "filial therapy training."

Doctoral candidate Geri Glover, a University of North Texas student with ties to the Flathead Reservation, is recruiting parents — especially fathers — interested in learning how to interact with their offspring through play.

"Children speak a special language, one that we adults have often forgotten: play," she said. "Through play, children can tell us if they are happy or sad, angry or scared. Filial therapy training offers a unique opportunity to learn how to interact with children through play."

The training should result in increased self-esteem, and decreased stress levels, for parents and youngsters alike, she said in

a presentation to the Tribal Council Tuesday.

Plans call for small groups of about eight-to-ten parents and other caretakers to meet for two hours a week to learn how to better understand the world of children, and to help remedy current behavioral problems as well as prevent future ones. The age range for youngsters is three to ten.

Training tools — otherwise known as toys — will be provided for the participants' use. There's no charge for participation, which Glover likens to "your best investment in your child's and your family's happiness."

Glover, who holds baccalaureate degrees in liberal arts and education, and a master's in school counseling, has been studying kids for ten years, she said. Her work experience in the education and counseling fields has included posts in Texas, North Carolina, and New Mexico.

Although children are a popular study focus, little attention has been paid to Native Ameri-

can youngsters, she said. Her interest in the Salish-Kootenai Tribes comes partially from the fact that her father, Gene, is enrolled here, she noted.

She plans to begin her work in Mission in the next week or two. The Protect Our Indian Children program there has donated a desk and telephone privileges to the effort.

To sign up as a participant, or for more information, call Glover or POIC director Irene Lake at 745-4363.

FILIAL TRAINING ENHANCING PARENT CHILD RELATIONSHIPS

ATTENTION: *Parents or Significant Care-Providers of a Child age 3-10*

FREE TRAINING !!!

Children speak a special language, one that we adults have often forgotten: *PLAY*. Through play, children tell us if they are happy or sad, angry or scared. Adults can relearn this language to clearly communicate with their own children.

Filial Training offers a unique opportunity to learn how to interact with children through play. Small groups of parents and significant care-providers meet for two hours per week for ten weeks to learn how to better understand the world of children and to help remedy current behavioral problems as well as prevent future ones.

Groups will begin the last week of September and run for 10 weeks. Afternoon and evening groups will be available at several locations on the reservation. Toys will be furnished for participants' use and the training itself will be provided at no cost. Filial Training could be your best investment in your child's and your family's happiness.

Geri Glover will be leading the first series of groups and is working in conjunction with the PROTECT OUR CHILDREN PROJECT. She is a doctoral candidate from the University of North Texas conducting research on parenting among Native Americans. She has a Masters degree in Counseling, is a Nationally Certified Counselor, a Licensed Professional Counselor, and a Play Therapist.

**INFORMATION
MEETING!**

Nurses' Conference Room
THHS

FRIDAY, Sept. 8th

10:00 a.m.

For information, contact Geri Glover, Irene Lake, or Dana Tenas at 745-4363 no later than
SEPTEMBER 19TH.

APPENDIX E

MAP OF THE FLATHEAD RESERVATION

Contemporary Montana Indian Reservations

1. Flathead Reservation
2. Blackfeet Reservation
3. Rocky Boys Reservation
4. Ft. Belknap Reservation
5. Crow Reservation
6. Northern Cheyenne Reservation

Flathead Indian Reservation

Facts on File Publications (1984).

APPENDIX F
PARENTING CLASS INFORMATION AND CONSENT FORMS

PARENTING CLASS INFORMATION

You are invited to participate in a study to determine the effectiveness of Filial Therapy training with Native Americans. You will be asked to complete three questionnaires before and after the training. Your child will be interviewed to complete one questionnaire before and after 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 the sessions, the group leader will be teaching you and other parents some techniques on how to interact with your child in ways that will enhance your child's self-esteem as well as strengthen your relationship with your child. You will be asked to share some insights, feelings, questions, and comments with the other participants in the group, during the sessions. You will also be asked to participate in seven 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 3-9 years) to focus on during the 10 weeks of 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 voluntarily. You may withdraw at any time without penalty or prejudice.

The information you provide when you answer the questionnaire 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, Geri Glover, 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 completion of this study.

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

If you agree to participate, please fill out and sign this consent form. For further information, please contact, Geri Glover at (406) 745-4363.

PARENTING CLASS Informed Consent

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

Signature of Participant	Age	Date
Name of Child of Focus	Age	
Child's Legal Guardian (If different than Participant)		Date
Signature of Witness		Date
Signature of Investigator		Date

This project has been reviewed and approved by the University of North Texas Institutional Review Board for the protection of human subjects (817)565-3940.

CHILD'S FORM
Informed Consent

I understand that I am going to be part of a project with an adult who takes care of me (mom, dad, or another significant caregiver). Geri Glover has told me about the things that will happen at the beginning and the end of the project. I will look at some pictures and Geri will ask me to choose which one is most like me. I will also be video-taped playing with this adult for 20 minutes each time. The adult will be taking some classes to learn how to play with me in some new ways. For seven weeks, I will have special play sessions with this adult in my home for 30 minutes once each week. I understand that I can stop taking part in this project at any time I choose.

My "mark" means that I understand what Geri Glover has explained to me and that I am willing to be part of this project.

Signature of Child

Date

Name of Child Age

Signature of Witness

Date

Signature of Investigator

Date

This project has been reviewed and approved by the University of North Texas Institutional Review Board for the protection of human subjects (817)565-3940.

APPENDIX G
DEMOGRAPHICS DATA FORM

GENERAL INFORMATION

1. Tribal affiliation/ethnic origin: Salish ____ Kootenai ____ Other ____
(You may choose any or all to describe your ancestry. Indicate % in each category.)
2. Enrolled member of Salish or Kootenai Tribe: YES NO
Identified child enrolled member of Salish or Kootenai Tribe: YES NO
3. Marital Status: Now married ____ Separated ____ Widowed ____
 Never married ____ Divorced ____
4. How much school have you completed? _____
Did you attend boarding school for any part of your education? _____

If yes, describe: _____
5. Are you currently working outside the home? ____ Hours per week: ____
Occupation/type of work: _____
6. Do any other adults in your household work outside the home? _____
7. Occupation(s)/type of work: _____
8. Which best describes your household?
Nuclear Family ____ Extended Family ____ Multiple-family ____
[parent(s) and child(ren)] [grandparent(s)/other relations] [unrelated members]
9. Total number of persons in household: _____

	Sex	Age	Relationship
Self	_____	_____	_____
Identified Child	_____	_____	_____
Other(s)	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
10. What is your total household income per month? _____
11. Do any adults in your household have problems with alcohol or substance abuse? _____
12. Have any of the adults in your household been diagnosed with any type of physical, mental, or health condition? _____
If yes, please describe: _____

APPENDIX H
LETTER OF PERMISSION TO USE
PORTER PARENTAL ACCEPTANCE SCALE

BRIGHAM YOUNG
UNIVERSITY

BLAINE R. PORTER
UNIVERSITY PROFESSOR

THE GLORY OF GOD
IS INTELLIGENCE

September 13, 1995

Ms. Geri Glover
1129 Somers Stage
Kalispell, MT 59901

Dear Ms. Glover:

I was pleased to have the opportunity to speak with you on the phone the other day. I am happy to know of your interest in my Parental Acceptance Scale and to have you use it.

It was interesting to see how nearly the changes you made corresponded with the ones that I have made. Thank you for your interest in improving it.

Enclosed is a copy of my revision of the last 30 items. I hope that the Scale proves to be useful to you. I will appreciate it if you will send me at least a summary of the findings of your research.

Best wishes for your success.

Sincerely yours,

Blaine R. Porter

BRP/ms

4505-H011

BRIGHAM YOUNG UNIVERSITY

APPENDIX I
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 training...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 feelings of affection toward or for their child varies with the child's behavior and with circumstances. Please read each item carefully and place a check in the column which most nearly describes the degree of feeling of affection which you have for your child in that situation.

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

(Unpublished: Permission to use received 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

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

- a. feel annoyed.
- b. want to know more about what excites my child.
- c. feel like punishing my child.
- d. feel that I will be glad when my child is past this stage.
- e. feel like telling my child to stop.

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

- a. see to it that my child behaves as the others.
- b. tell my child it is important to behave well when in a group.
- c. let my child alone if the others are not disturbed by the behavior.
- d. ask my child to suggest an alternate behavior.
- e. help my child find an alternate behavior to enjoy while not disturbing the group.

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

- a. want to help my child find success in other things.
- b. feel disappointed in my child.
- c. wish my child could do it.
- d. realize that my child can not do everything.
- e. want to know more about the things my child can do.

14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:

- a. realize that my child is growing up.
- b. am pleased to see my child's interests widening to other people.
- c. feel resentful.
- d. feel that my child doesn't appreciate what I have done for him/her.
- e. wish my child liked me more.

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

- a. tell my child which choice to make and why.
- b. think it through with my child.
- c. point out the advantages and disadvantages of each, but let my child decide.
- d. tell my child that I am sure he/she can make a wise choice and help my child foresee the consequences.
- e. make the decision for my child.

16. When my child makes decisions without consulting me, I:

- a. punish my child for not consulting me.
- b. encourage my child to make many of his/her own decisions.
- c. allow my child to make many of his/her own decisions.
- d. suggest that we talk it over before he/she makes the decision.
- e. tell my child he/she must consult me first before making a decision.

17. When my child kicks, hits, or knocks his/her things about, I:

- a. feel like telling my child to stop.
- b. feel like punishing him/her.
- c. am pleased that my child feels free to express himself/herself.
- d. feel that I will be glad when my child is past this stage.
- e. feel annoyed.

18. When my child is not interested in some of the usual activities of his/her age group, I:

- a. realize that each child is different.
- b. wish my child were interested in the same activities.
- c. feel disappointed in my child.
- d. want to help my child find ways to make the most of his/her interests.
- e. want to know more about the activities in which my child is interested.

19. When my child acts silly and giggly, I:

- a. tell my child I know how he/she feels.
- b. pay no attention to him/her.
- c. tell my child he/she shouldn't act that way.
- d. make my child quit.
- e. tell my child it is all right to feel that way, but help him/her find other ways of expression.

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

- a. encourage my child to do things with his/her friends.
- b. accept this as part of his/her growing up.
- c. plan special activities so that my child will want to be with the family.
- d. try to minimize his/her associations friends.
- e. make my child stay with the family.

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

- a. feel like punishing him/her.
- b. am pleased that my child feels free to express his/her thoughts and feelings.
- c. feel like persuading my child that my way is best.
- d. realize my child has ideas of his/her own.
- e. feel annoyed.

22. When my child misbehaves while others in his/her group are behaving well, I:

- a. realize that my child does not always behave as others in his/her group.
- b. feel embarrassed.
- c. want to help my child find the best ways to express his/her feelings.
- d. wish my child would behave like the others.
- e. want to know more about his/her feelings.

23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
- a. give my child something quiet to do.
 - b. tell my child that I wish he/she would stop.
 - c. make my child be quiet.
 - d. let my child tell me about what is so exciting.
 - e. send my child somewhere else.
24. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
- a. try to minimize my child's association with that person.
 - b. let my child have such associations when I think he/she is ready for them.
 - c. do some special things for my child to remind him/her of how nice I am.
 - d. point out the weaknesses and faults of the other person(s).
 - e. encourage my child to create and maintain such associations.
25. When my child says angry and hateful things about me to my face, I:
- a. feel annoyed.
 - b. feel that I will be glad when my child is past this stage.
 - c. am pleased that my child feels free to express himself/herself.
 - d. feel like punishing my child.
 - e. feel like telling my child not to talk that way to me.
26. When my child shows a deep interest in something I don't think is important, I:
- a. realize my child has interests of his/her own.
 - b. want to help my child find ways to make the most of this interest.
 - c. feel disappointed in my child.
 - d. want to know more about my child's interests.
 - e. wish my child were more interested in the things I think are important for him/her.
27. When my child is unable to do some things as well as others in his/her group, I:
- a. tell my child he/she must try to do as well as the others.
 - b. encourage him/her to keep trying.
 - c. tell my child that no one can do everything well.
 - d. call attention to the things he/she does well.
 - e. help my child make the most of the activities which he/she can do well.
28. When my child wants to do something which I am sure will lead to disappointment for him/her, I:
- a. occasionally let my child carry such an activity to its conclusion.
 - b. don't let my child do it.
 - c. advise my child not to do it.
 - d. help my child with it in order to ease the disappointment.
 - e. point out what is likely to happen.
29. When my child acts silly and giggly, I:
- a. feel that I will be glad when he/she is past this stage.
 - b. am pleased that my child feels free to express himself/herself.
 - c. feel like punishing my child.
 - d. feel like telling him/her to stop.
 - e. feel annoyed.

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

- a. feel that I should tell my child which choice to make and why.
- b. feel that I should point out the advantages and disadvantages of each.
- c. hope that I have prepared him/her to choose wisely.
- d. want to encourage my child to make his/her own choices.
- e. want to make the decision for my child.

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

- a. tell my child he/she must do better.
- b. help my child make the most of the things which he/she can do.
- c. ask my child to tell me more about the things which he/she can do.
- d. tell my child that no one can do everything.
- e. encourage him/her to keep trying.

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

- a. tell my child he/she should not disagree with me.
- b. make my child quit.
- c. listen to my child's side of the issue and change my mind if that seems reasonable.
- d. tell my child maybe we can do it his/her way another time.
- e. explain that I am doing what is best for him/her.

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

- a. realize that my child can't do as well as others in everything.
- b. wish that my child could do as well.
- c. feel embarrassed.
- d. want to help my child find success in the things he/she can do well.
- e. want to know more about the things my child can do well.

34. When my child makes decisions without consulting me, I:

- a. hope that I have prepared my child adequately to make his/her decisions.
- b. wish that my child would consult me.
- c. feel disturbed.
- d. want to restrict his/her freedom.
- e. am pleased to see that as my child grows, I am needed less.

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

- a. tell my child it is all right to feel that way, but help him/her find other ways to express himself/herself.
- b. tell my child I know how he/she feels.
- c. pay no attention to him/her.
- d. tell my child he/she shouldn't say such things to me.
- e. make my child quit.

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

- a. make my child quit.
- b. tell my child it's alright to feel that way, but help him/her find other ways of expressing him/herself.
- c. tell my child he/she shouldn't do such things.
- d. tell my child I know how he/she feels.
- e. pay no attention to him/her.

37. When my child prefers to do things with friends rather than with the family, I:
- a. wish my child would spend more time with us.
 - b. feel resentful.
 - c. am pleased to see my child's interests widening to other people.
 - d. feel my child doesn't appreciate us.
 - e. realize that he/she is growing up.
38. When my child wants to do something which I am sure will lead to disappointment, I:
- a. hope that I have prepared him/her to meet disappointment.
 - b. wish that my child did not have to experience unpleasant events.
 - c. want to keep my child from doing it.
 - d. realize that occasionally such an experience will be good for him/her.
 - e. want to postpone these experiences.
39. When my child is not interested in some of the usual activities of his/her age group, I:
- a. help my child realize that it's important to be interested in the same things as others in the group.
 - b. call attention to the activities in which he/she is interested.
 - c. tell my child it is all right not to be interested in the same things as others in his/her group.
 - d. see to it that my child does the same things as others in his/her group.
 - e. help my child find ways of making the most of his/her interests.
40. When my child shows a deep interest in something I don't think is important, I:
- a. let my child go ahead this interest.
 - b. ask my child to tell me more about this interest.
 - c. help my child find ways to make the most of this interest.
 - d. do everything I can to discourage my child's interest in it.
 - e. try to interest him/her in more worthwhile things.

THANK YOU VERY MUCH FOR YOUR COOPERATION

APPENDIX J

FILIAL THERAPY TRAINING SESSION OUTLINES AND HANDOUTS

FACILITATOR'S COPY

FILIAL SESSION #1

(Garry L. Landreth, 1983)

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

II. Overview of Filial Training:

Play is the child's language.

Based on actions, not words.

Way of preventing problems since adults become aware of child's needs.

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

Techniques from play therapy will: Return control to you.

Provide closer, happier times with your child.

Give key to your child's inner world.

III. Group Introductions:

Describe entire family - help pick child of focus.

Tell concerns about this child (take notes).

Make generalizing comments to other parents..

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

IV. Provide Basic Agenda:

One-half hour play sessions.

Everyone will be video-taped here at least once for replay.

(Bring your own tape to keep.)

We will see demonstrations before starting.

Patience is important in learning a new language.

V. Show video tape of "Children's Emotions."

VI. Reflective listening: A way of following, rather than leading.

Don't ask questions.

Reflect behaviors, patterns and feelings.

Responses say:

I am here; I hear you.

I understand.

I care.

Not:

I always agree.

I must make you happy.

I will solve your problems.

Keep focus on the positive.

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

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

Homework:

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

(2) Practice reflective listening this week (hand out 4 faces sheet).

[illegible]

THE FOUR BASIC FEELINGS

(Garry L. Landreth, 1983)

1 _____	2 _____
3 _____	4 _____

Reflective responses this week.

1. _____

2. _____

3. _____

4. _____

FILIAL SESSION #2

(Garry L. Landreth, 1983)

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

- II. Handout: "Filial Therapy Group"
 - Go over entire sheet, especially list of toys.
(Demonstration Box.)
 - The "how to" of play sessions.

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

- IV. Have participants pair off and role play to practice reflective responding.

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

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

Homework:

- (1) "Facilitating Reflective Communication" handout.
 - (2) Pick spot and time for sessions -- report back next week.
-

FILIAL THERAPY GROUP

(Garry L. Landreth, 1983)

Basic Principles of the Play Sessions

- (1) The child should be completely free to determine how the child will use the time. The child leads and the parent follows without making suggestions or asking questions.
- (2) The adult's major task is to empathize with the child, to understand the intent of the child's actions, and the child's thoughts and feelings.
- (3) The parent's next task is to communicate this understanding to the child by appropriate comments, particularly, whenever possible, by verbalizing the feelings that the child is actively experiencing.
- (4) The parent is to be clear and firm about the few "limits" that are placed on the child. Limits set are on time, not breaking specified toys, and not physically hurting the adult.

Goals of the Play Sessions

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

REMINDER

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

Toys for the Play Sessions

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

Place for the Play Sessions

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

Process

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

FACILITATING REFLECTIVE COMMUNICATION

(Garry L. Landreth, 1983)

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

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

Adult: _____

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

Adult: _____

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

Adult: _____

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

Adult: _____

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

Adult: _____

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

Adult: _____

FILIAL SESSION #3

(Garry L. Landreth, 1983)

I. Review homework:

(1) "Facilitating Reflective Communication" Handout

(2) Time and Place for Play Sessions

NAME

TIME

PLACE

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(3) Toys

II. Handout in Class: "Basic Rules for Filial Therapy".
Use to review rules for play sessions.**Basic Limits:** Child's name

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

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

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

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

First Volunteer: _____

RULE OF THUMB: Be a thermostat, not a thermometer.Reflecting feelings creates an environment that is comfortable and accepting, as opposed to merely reacting to feelings.**Homework:**

(1) Begin play sessions at home this week.

BASIC RULES FOR FILIAL THERAPY

(Garry L. Landreth, 1983)

Don't

1. Don't criticize any behavior.
2. Don't praise the child.
3. Don't ask leading questions.
4. Don't allow interruptions of the session.
5. Don't give information or teach.
6. Don't preach
7. Don't initiate new behavior (These first 7 are taken from Guernsey, 1972)
8. Don't be passive, quiet.

Do

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

Check your responses to your children. Your responses should convey:

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

Your responses should not convey:

1. "I will solve your problems for you."
2. "I am responsible for making you happy."
3. "Because I understand you, that means I automatically agree w/you."

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

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as the child is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to the child in such a manner that the child gains insight into behavior.
5. The therapist maintains a deep respect for the child's ability to solve problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of the child's responsibility in the relationship.

FILIAL SESSION #4

(Garry L. Landreth, 1983)

- I. Debriefing. How did the play sessions go?
(Be aware of the time -- keep group process moving!)
- II. As reporting is occurring, use their examples to illustrate rules of filial therapy. Also, focus on how they were able to reflect on their child's feelings.
- III. Handout: "Two Techniques of Discipline that Work".

Go over importance of using this as first step in discipline process.
- IV. Arrange for next parent to video tape.

Second Volunteer: _____
- V. Show video tape from first volunteer.

RULE OF THUMB: Good things come in small packages.

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

Homework:

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

TWO TECHNIQUES OF DISCIPLINE THAT WORK

(Garry L. Landreth, 1983)

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

FILIAL SESSION #5

(Garry L. Landreth, 1983)

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

Taping Session: _____

- IV. Review video of play session.

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

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

Homework:

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

WHEN "SETTING THE LIMIT" DOESN'T WORK . . .

(Garry L. Landreth, 1983)

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

1. Look for natural causes for rebellion: Fatigue, sickness, hunger, extreme stress, abuse/neglect, etc. Take care of physical needs and crises before expecting cooperation.
2. Remain in control, respecting yourself and the child: You are not a failure if your child rebels, and your child is not bad. All kids need to "practice" rebelling.
3. Set reasonable consequences for disobedience: Let the child choose to obey or disobey, but set a reasonable consequence for disobedience. Example: "If you choose to watch TV instead of going to bed, then you choose to give up TV all day tomorrow."
4. Never tolerate violence: Physically restrain the child who becomes violent, without becoming aggressive yourself. Reflect the child's anger and loneliness. Provide compassionate control and alternatives.
5. If the child refuses to choose, you choose for the child: The child's refusal to choose is also a choice. Set the consequences. Example: "If yo 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, yo have abdicated your role as adult 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 concerns 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

(Garry L. Landreth, 1983)

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

Taping Session: _____

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

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

Homework:

- (1) Write a note to your child of focus (as well as other children in the family) for three weeks, pointing out a positive character quality you appreciate.

"I was just thinking about you and I think you are _____.
That is such an important quality, we're going to put this note up."

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

COMMON PROBLEMS IN FILIAL THERAPY

(Garry L. Landreth, 1983)

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

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

3. Q: I'm bored. What's the value of this?
A: _____

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

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

6. Q: My child hates the play sessions. Should I discontinue them?
A: _____

7. Q: My child wants the play time to be longer. Should I extend the session?
A: _____

FILIAL SESSION #7

(Garry L. Landreth, 1983)

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

Taping Session: _____

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

Homework:

- (1) Notice the number of times during the week you touch your child.
 - (2) Continue play sessions.
-

FILIAL SESSION #8

(Garry L. Landreth, 1983)

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

Taping Session: _____

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

Idle threats harm your relationship with your child.

Homework:

- (1) Continue play sessions.
- (2) Write down any unanswered questions and bring next time.

FILIAL SESSION #9

(Garry L. Landreth, 1983)

- I. Debriefing on play sessions. Give time for questions on various topics.
- II. Show video tape of session.
- III. Arrange last taping session.

Taping Session: _____

- IV. Mention filial follow-up meetings.

RULE OF THUMB: Don't answer questions that haven't been asked.

Look behind the question for the deeper question.

Homework:

- (1) Continue play sessions.

FILIAL SESSION #10

(Garry L. Landreth, 1983)

- I. Briefly debrief.
- II. Show last video taped session.
- III. Handout: "Rules of Thumb and Other Things to Remember"
- IV. Closing Procedures:

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

(Praise them, they may be scared about leaving the safety of the group!)
- V. Emphasize continued meetings.
- VI. Encourage them to continue play sessions.

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

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

Recommended Reading:

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

RULES OF THUMB AND OTHER THINGS TO REMEMBER

(Garry L. Landreth, 1983)

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 the child 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 the child.
 4. Good things come in small packages.

Don't wait for the big events in your child's life to enter the child's 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 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.
-

Others Things to Remember

(Garry L. Landreth, 1983)

1. Reflective responses can diffuse anger.
 2. What's important is not what a child knows, but what a child 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 children they are capable and they will think they are capable. Tell children enough times they can't do it and sure enough, they can't.
 8. Don't try to change everything at once.
 9. In the play session, the adult is not the source of answers. Reflect questions back to the 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 the child's 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!)
 14. Questions imply non-understanding. Questions put people in their minds. Children live in their hearts.
 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 the child does.
-

APPENDIX K
MEASUREMENT OF EMPATHY IN ADULT-CHILD INTERACTION
RATING FORM

Measurement of Empathy in Adult-Child Interaction Rating Form

Rater's
Initials _____

Videotape
Code # _____

Communication of Acceptance: verbal expression of acceptance/rejection

5. Strongly Critical/Preaching/Rejecting: You see, I told you to do it the other way. It's not nice to feel/say... How stupid. You're being nasty.
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.
3. Social or NO Conversation: Grownups aren't very good at that. These are nice toys.
2. Verbally Recognizes & Accepts Behavior Only (tracking, giving credit): You got it that time. You're hitting the.. You really stabbed..
1. Verbally Conveys Acceptance of Feelings: You're proud of... You really like... That made you angry...

Allowing the Child Self-Direction: willingness to follow child's lead (rather than control child's behavior)

5. Persuades, Demands, Interrupts, Interferes, Insists: No, take this one. That's enough.. I told you not ... You've got to..
4. Directs or instructs Child (initiates new activity): Put the doll away first. Why don't you... Let's play... Don't put the...
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...
2. Allows Child Option for Lead-Taking, but asks/volunteers info: gives praise: What shall we do? Good. You can shoot this. You're right.
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 tech)

Involvement: Parent's attention to and participation in the child's activity (may not always contribute positively)

5. Self-involved/Shut-off: Child ignored for prolonged period. Child must repeat or prompt to get a response.
4. Partially Withdrawn/Preoccupied: Infrequently observes, but doesn't comment. Fails to attend to child's needs, but responds when child asks.
3. Marginal Attention: No joint activity, adult involved in own activity to degree interferes w/attentiveness. Occasionally comments on child activity.
2. High Level of Attention (attention to activity rather than child): Parent more involved in game than attending to child's reactions/behaviors.
1. Fully Observant (more attention to child than objects being used): Involved verbally & with "eyes" (& physically when invited by child).

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

Communication of Acceptance:

Score Lowest Level	<div style="display: flex; justify-content: space-between; padding: 2px 5px;"> </div>	=	
Score Highest Level	<div style="display: flex; justify-content: space-between; padding: 2px 5px;"> </div>	=	
			Avg Total

Allowing the Child Self-Direction:

Score Lowest Level	<div style="display: flex; justify-content: space-between; padding: 2px 5px;"> </div>	=	
			Total

Involvement:

Score Lowest Level	<div style="display: flex; justify-content: space-between; padding: 2px 5px;"> </div>	=	
			Total

Empathy Score = Grand Total = _____

adapted from Bratton (1993/1994) and Stover, B. Guernsey, & O'Connell (1971)

APPENDIX L
CHILDREN'S PLAY BEHAVIOR WITH PARENT RATING FORM

Children's Play Behavior With Parent Rating Form

 Rater's
Initials _____

 Videotape
Code # _____

Sustained Play: Indicate actual time child is fully engaged in play which continues for at least 30 seconds. May be interrupted but keeps coming back to same play.

5. Maximum: 1 activity of at least 12 minutes duration.
4. Primarily sustained: 1 activity of at least 8 minutes duration.
3. Midpoint: 1 activity of at least 5 minutes duration.
2. Occasionally sustained: 1 activity of at least 3 minutes duration.
1. Minimal: No activities of at least 3 minutes duration.

Child's Self-Directiveness: child's demonstrated ability to take responsibility, direct own activity.

5. Self-Directive: Assured way of going about activity. Takes responsibility to solve problems; may solicit help when realistic.
4. Primarily self-directive: 1-2 incidents of checking with or asking parent's help after attempting on own; interrupts play momentarily, but reassumes self-direction immediately.
3. Less self-directive than 4: 1-2 incidents of asking parent's permission or help without attempting on own; child stops own play and follows parent's suggestion (active compliance); appears distracted during play; goal is power/opposition.
2. Requires permission: Solicits permission or help (verbally or non-verbally) ideas, or instructions, and then proceeds with play; checks with parent regularly.
1. Insecure: Requires directional permission (yes, you can play/paint, etc.); seems to wait for direction (passive compliance).

Parent/Child Connectedness: Interactive flow between parent and child.

5. Connected: Child includes parent in play. Involved, comfortable verbal or non-verbal interaction between parent and child.
4. Primarily connected: Same as above, but intermittent; parent involved, but not really a part of the play/interaction.
3. Connection attempted: Child attempts to connect - parent ignores; parent directs child and child complies.
2. Non-connection: Child ignores parent/parent ignores child (different agendas); child attempts connection, parent rejects.
1. Rejection: Child rejects parent. Parent may or may not also reject child.

SCORE
Sustained Play:

Time	Activity	Time	Activity	Time	Activity	Time	Activity	Time	Activity	Time	Activity

TOTAL TIME OF LONGEST ACTIVITY: _____ =

Score

Child's Self-Directiveness:

--	--	--	--	--	--	--	--	--	--	--	--

Total

Average

Parent/Child Connectedness:

--	--	--	--	--	--	--	--	--	--	--	--

Total

Average

Child's Mood:

5	4	3	2	1	TOTAL
Comfortable	Calm	Unsure	Frustrated	Uncomfortable	
Satisfied	Compliant	Distracted	Annoyed	Anxious	
Pleased	Ambivalent	Confused		Discontent	
Content				Upset	
				Troubled	
				Distressed	

Scoring the Children's Play Behavior With Parent Rating Form

Sustained Play:

Using a stopwatch, time each activity engaged in by the child which lasts at least 30 seconds. Indicate the time and activity in the chart provided. If play continues to the next interval, it is noted by a "+" in the next interval.

(Example)

Time	Activity	Time	Activity
1'9"	Color	+2'	Doll
1'5"	Blocks		
54"	Doll		

Determine the longest episode of sustained play and indicate on the line provided.

Translate that time into a score according to the information provided.

5. Maximum: 1 activity of at least 12 minutes duration.
4. Primarily sustained: 1 activity of at least 8 minutes duration.
3. Midpoint: 1 activity of at least 5 minutes duration.
2. Occasionally sustained: 1 activity of at least 3 minutes duration.
1. Minimal: No activities of at least 3 minutes duration.

Child's Self-Directiveness:

A rating is made at each 3 minute interval for 6 intervals (scoring is retrospective).

Lowest score = 1; Highest score = 5. The scores should be judged as though on a continuum.

5. Self-assured way of going about activity.
4. Primarily self-directive.
3. Less self-directive than 4.
2. Requires permission.
1. Insecure.

Parent/Child Connectedness:

A rating is made at each 3 minute interval for 6 intervals (scoring is retrospective).

Lowest score = 1; Highest score = 5. The scores should be judged as though on a continuum.

5. Child includes parent in play.
4. Primarily connected.
3. Connection attempted.
2. Non-connection.
1. Rejection.

Play Behavior With Parent:

The is a global score arrived at by summing the scores from the three subscales. The global score can range from a minimum of 3 to a maximum of 15.

Child's Mood:

Taking into consideration the entire 18-minute play session, estimate the child's overall mood, rating it on a continuum from 1 to 5, 1 being the most negative mood and 5 being the most positive.

APPENDIX M
GRAPHIC DISPLAY OF DATA

Figure 1 presents the pre and post-test means for the experimental and control groups for the total score on the Porter Parental Acceptance Scale.

Figure 1

Figure 2

Figure 2 presents the pre and post-test means for the experimental and control groups for the subscales "Respect for the Child's Feelings and Right to Express Them" and "Appreciation of the Child's Uniqueness".

Figure 3

Figure 3 presents the pre and post-test means for the experimental and control groups for the subscales "Recognizes Autonomy and Independence" and "Unconditional Love".

Figure 4 presents the pre and post-test means for the experimental and control groups for the total score on the Parent Stress Index.

Figure 4

Figure 5 presents the pre and post-test means for the experimental and control groups for the "Parent Domain" and the "Child Domain" of the Parent Stress Index.

Figure 5

Figure 6 presents the pre and post-test means for the experimental and control groups for the total score on the Measurement of Empathy In Adult-Child Interaction Rating Form. (A decrease in score indicates an increase in desired behavior.)

Figure 6

Figure 7 presents the pre and post-test means for the experimental and control groups for the three subscales of the Measurement of Empathy In Adult-Child Interaction Rating Form: "Communication of Acceptance"; "Allowing Self-Direction"; and, "Involvement".

Figure 7

Figure 8 presents the pre and post-test means for the experimental and control groups for the total score on the Children's Play Behavior With Parent Rating Form.

Figure 8

Figure 9

Figure 9 presents the pre and post-test means for the experimental and control groups for the subscales "Sustained Play", "Child's Self-Directiveness", & "Parent/Child Connectedness" of the Children's Play Behavior With Parent observation instrument

Figure 10

Figure 10 presents the pre and post-test means for the experimental and control groups for the "Child's Mood" scale of the Children's Play Behavior With Parent observation instrument.

Figure 11 presents the pre and post-test means for the experimental and control groups for the total score on the Joseph Pre-School and Primary Self-Concept Screening Test.

Figure 11

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