A COMPARISON OF SKILL LEVEL OF PARENTS TRAINED IN THE
LANDRETH FILIAL THERAPY MODEL AND GRADUATE STUDENTS TRAINED IN
PLAY THERAPY

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The purpose of this study was to determine if parents trained in the Landreth Filial Therapy Model could demonstrate child-centered play therapy skills as effectively as graduate play therapy students who completed an Introduction to Play Therapy course. The participants in both the parent group and the graduate student group were videotaped in play sessions with children pre- and post-training in order to measure change in adult empathic behavior as defined on the Measurement of Empathy in Adult-Child Interaction (MEACI). The specific skills measured in this study were (a) communicating acceptance to the child, (b) allowing the child to direct his or her own play during the play sessions, (c) demonstrating appropriate levels of involvement in the child's play, and (d) demonstrating empathic behavior toward the child.

The Landreth Filial Therapy Model is a training system that utilizes both didactic and dynamic means to train parents and other paraprofessionals to be therapeutic agents of change with children. Parents are taught child-centered play therapy skills to use in weekly home play sessions with their children in order to strengthen the emotional bond between parent and child.

The Introduction to Play Therapy course is a graduate-level counseling course at the University of North Texas taught by Dr. Garry Landreth. The course focuses on the philosophy, theory, and skills of child-centered play therapy. Students enrolled in this course typically plan to use play therapy in professional settings.
The filial-trained parent group \((n = 21)\) consisted of the experimental group of single parents from Bratton and Landreth’s (1995) study, *Filial Therapy with Single Parents, Effects of Parental Acceptance, Empathy and Stress*. The parents met for weekly 2-hour filial therapy sessions over the course of 10 weeks and conducted six or seven 30-minute play sessions at home with their child-of-focus.

The graduate student group \((n = 13)\) was enrolled in Dr. Landreth's Introduction to Play Therapy course during fall 2000. The class met over a course of a 15-week semester for three hours per week. During the course of the semester, the students completed two play therapy sessions outside of class and two supervised play therapy sessions during class time.

Analysis of covariance revealed that the play therapy-trained graduate students preformed at a statistically significant higher skill level than the filial-trained parents on Total Empathy scores and the Involvement subscale, but that there was no statistically significant difference between the groups' skill level on Communication of Acceptance to the child and Allowing the Child Self-Direction. Although the graduate students' mean post-training scores revealed a higher attainment of skill level, the parents made greater mean change of score on all measures except Involvement. The study supports the use of the Landreth Filial Therapy Model to train parents to use the child-centered play therapy skills, especially those of communicating acceptance and allowing self-direction.
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CHAPTER 1

INTRODUCTION

The mental health needs of children is an issue that has caught the attention of officials in the highest level of government. The challenges of our current managed health care system and lack of appropriate, affordable mental health resources for children are two major concerns in this new century (Ginsberg, 1995). Increases in cultural problems, such as abuse, neglect, and child violence that affect children further tax an already overloaded health care system (Friedman, 1997; Gullotta, Adams, & Montemayor, 1998).

Serious concerns about children being appropriately diagnosed and treated for emotional and behavioral problems were voiced at the recent government Conference on Children's Mental Health (U.S. Public Health Service, 2000). The outcome of the conference included the identification of several systems through which health care for children may be dispersed. Although schools, primary care professionals, the juvenile justice system, the child welfare system, and substance abuse treatment centers were cited as possible vehicles for delivery of child mental health, the family was recognized as a primary vehicle for treatment. Conference participants called for early intervention for children and cited studies that home and community based treatments compare favorably
to traditional mental health treatments including institutional care (U.S. Public Health Service, 2000).

The Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda (U.S. Public Health Service, 2000), published as a result of the Conference on Children's Mental Health, stated that home-and-community-based treatments fared positively because they are individualized, strength-based, less expensive, and easily transferable to real world situations where training likely occurs. One important goal generated from the conference to improve mental health care for children by means of home-and-community-based services was that of "engaging families in all aspects of service delivery" (U.S. Public Health Service, 2000, p. 12).

The Surgeon's General's report recognized that children are still in the process of development and acknowledged the need for proven interventions targeted specifically to the needs of children (U.S. Public Health Service, 2000). In order to treat children most effectively, those involved in their treatment must understand the distinct developmental needs of children and incorporate this understanding into treatment (Landreth, 2002). Children have limited ability to accurately articulate their understanding and life experiences because they have not fully developed the capability for abstract reasoning prior to age 11 (Piaget, 1952). Bratton and Ray concluded that, "The child's world is one of concrete realities; thus, children must be afforded a concrete means of expressing their perception of self, others, and the world" (2002, p. 369). While verbalizing thoughts, concepts, and experiences comes naturally to adults, playing as a means of self-expression comes naturally to children (Axline, 1947; Ginott, 1960; Landreth, 1983).
Play is the way in which children naturally and concretely communicate. Piaget (1962) stressed the importance of play in children's attempts to organize their experiences and bridge the gap between their concrete experiences and abstract thought processes. According to Landreth (2002), children play out their life experiences and their concepts of their inner worlds. Play facilitates language development, social skills development, decision-making skills, and cognitive development. Interpersonal relationships, sexual identity development, experimentation with adult roles, and understanding personal thoughts and feelings are also explored during child's play (Landreth, 1993).

Additionally, "Play promotes social interaction, provides opportunities for development of communication and motor skills, allows for movement between reality and fantasy, and permits the release of energy and emotion" (DelPo & Frick, 1988, p. 261).

It follows logically that play therapy is the developmentally sensitive approach to helping children with their problems (Guerney, 1976). Erikson (1940) observed that children process experiences by playing them out while adults process by talking them out. "Limiting the young child to strictly verbal communication is taking away his tools" (Nelson, 1967, p. 144). One purpose of play therapy is to provide a safe environment for children to be free to express their feelings because a child's play behavior may reveal deep emotions that cannot be expressed in acceptable outlets (Kawin, 1950). Axline (1950) emphasized the counselor-child relationship as one that provides a safe zone for the child. The child's therapeutic relationship with the therapist is also symbolic of relationships in the child's external world. Thus, through play therapy the therapist is allowed the opportunity to enter a child's world (Gil, 1991; Landreth, 2002).
Play therapy gives children a chance to gain a sense of control over their world (Bratton & Ray, 2002). Play therapy can be used for diagnostic understanding of a child, to establish a working relationship with a child, to break through a child's defenses, to provide opportunities for a child to verbalize thoughts and feelings, to release tension, and to strengthen a child for future life (Amster, 1943). Bettelheim contended that the child's play needed to be understood in order to understand the child because the child uses play to process difficult psychological issues (1987). In fact, "Play therapy has been in practice as the developmentally appropriate approach to child therapy for close to a century" (Bratton & Ray, 2000, p. 47). A thorough review of research literature resulted in the conclusion that play therapy has been proven effective with a variety of children's concerns (Ray, Bratton, Rhine, & Jones, 2001).

Filial therapy training is a well-researched method of treating children for emotional and behavioral difficulties that takes their developmental needs into consideration by utilizing play therapy methods and also enlists families, especially parents, as active therapeutic agents (Bratton, Ray, & Moffit, 1998). The purpose of filial therapy training is to train parents in basic child-centered play therapy skills in order that the parent may become a therapeutic agent in the child's life (Bratton & Landreth, 1995). Bernard Guerney developed filial therapy training to tap the previously neglected but potentially powerful resource of parents to work for the therapeutic benefit of their children (Guerney, 1964). Bernard Guerney's original filial therapy training model was conducted over the course of six to eighteen months (Guerney, B., Guerney, L., & Andronico, 1976). Landreth (2002) further contributed to the development of filial
therapy as a viable treatment modality by developing and researching a model that collapsed filial training into a 10-week format. He developed this intensive adaptation of Guerney’s model in response to the need for quality parent training that is an efficient use of parents’ time and financial resources. The curriculum and training format for Landreth’s 10-week filial model incorporates the child-centered play therapy procedures he developed to train graduate counseling students enrolled in a one-semester Introduction to Play Therapy course. Landreth’s passion for training parents in this method reflects the recent Surgeon General Report’s emphasis on utilizing parents proactively in raising emotionally and mentally healthy children:

The skills of those in the helping professions must be brought out of hiding from behind closed office doors, and must be given away through training to parents, who are in the best positions to profoundly impact the lives of future adults (Landreth, 2002, p. 366).

The body of research on filial therapy is impressive, with outcome studies on Landreth’s model of filial training accounting for the majority of the experimental research in this area. The findings overwhelmingly support the efficacy of this intervention for children exhibiting a variety of presenting concerns (Landreth, 2002). In a meta-analytic review of 94 play therapy outcome studies, Ray et al., (2001) cited a significantly higher effect size for play sessions conducted by filial-trained parents ($es = 1.15$) than for play sessions conducted by professionals ($es = .73$) and concluded that training parents in play therapy methods to use with their own children is highly effective and under-utilized.
One area of concern regarding the research supporting the efficacy of filial therapy is that the majority of measures used are parent-reports. For example, Bratton and Landreth (1995) speculated that a change in parental attitude toward their child, as a result of the filial training, may positively bias parents’ report on child behavior measures and called for further research to explore the factors that impact the efficacy of filial therapy. Although several filial therapy studies have used direct-observation measures to assess parents’ improvement of skill level after filial training, no study has investigated whether the skills of filial-trained parents are on par with those of mental health professionals with similar training. A review of literature revealed one study by Smith and Landreth (in press) that compared the effects of play therapy conducted by mental health professionals and paraprofessionals. However, this study did not measure the observed skill level between the groups. In light of the meta-analysis findings that filial-trained parents are significantly more effective than professional play therapists, an investigation of comparative play therapy skill level is clearly needed to shed more light on this issue. The question, then, is: following a similar play therapy skills training format, can parents trained in the Landreth Filial Therapy Model demonstrate child-centered play therapy skills as effectively as graduate students trained in child-centered play therapy skills?

Statement of the Problem

The problem with which this study was concerned was the ability of parents, as compared with graduate students, to learn specific child-centered play therapy skills. The purpose of this study was to compare the specific child-centered play therapy skills of
parents trained according to the Landreth Filial Therapy Model and graduate students
trained in a child-centered play therapy course. Specifically, the Measurement of
Empathy in Adult-Child Interactions was used to compare graduate students' and single
parents' child-centered play therapy skills with children in play sessions before and after
their respective training. Each group was rated pre-and post-training on their
demonstration of specific child-centered play therapy skills measured by the domains of
Total Empathy, Communication of Acceptance, Allowing the Child Self-direction, and
Involvement (Stover, Guerney, & O'Connell, 1971).

Synthesis of Related Literature

The review of literature follows the evolution of play therapy and filial therapy by
concentrating on (a) History and Development of Play Therapy, (b) Overview of the
Clinical Efficacy of Play Therapy, (c) History and Development of Filial Therapy, (d)
Filial Therapy Studies Using the Guerney Model and Other Models, and (e) Filial
Therapy Studies Using the Landreth Filial Therapy Model.

History and Development of Play Therapy

Prior to the 20th Century, children were considered smaller versions of adults.
Little was understood about children's cognitive development, emotional development, or
maladjusted behaviors (Gelfrand, Jensen, & Drew, 1997). Few people recognized the
importance of play in the development of children, but there were exceptions such as
Rousseau, who in the early 18th Century observed that children were not merely
miniature adults (Lebo, 1955). In *Emile*, published in 1762, Rousseau expressed his
belief that observing children's play was key to understanding them (Landreth, 1991). At
the turn of the 20th Century, Froebel (1903) attributed conscious and unconscious meaning to children's play (Landreth, 1991). As children's problems began gaining recognition early in the 20th Century, attempts to treat children's psychological difficulties as unique to children increased.

The first documented attempt to treat a child psychotherapeutically was Freud's (1909) case of 5-year-old "Little Hans." Freud's worked through "Little Han's" father to collect data, make a diagnosis, and treat the boy's phobic reactions (Landreth, 1991; Schaefer & O'Connor, 1983). This was the first case on record to link the etiology of a child's difficulty to an emotional cause.

The beginning of play therapy can be traced to efforts of professional psychotherapists to treat children psychoanalytically. Since that time, there have been four major phases of development in play therapy: Psychoanalytic Play Therapy, Release Play Therapy, Relationship Therapy, and Non-directive Play therapy. Each phase is characterized either by a shift in theoretical basis for play therapy or a change in therapeutic technique.

Hermine Hug-Hellmuth, who believed that adult psychoanalysis was not successful with children, used play in the therapy with children in 1919 (O'Connor, 1981). She included play materials in her therapy sessions with children in order to enhance the children's self-expression (Landreth, 1991). However, unlike Anna Freud and Melanie Klein, Hug-Hellmuth did not ascribe a specific theory to her approach. Klein (1955) utilized play to analyze children younger than age 6. Her approach to play therapy was psychoanalytical as was her interpretation of children's play. She considered a child's
play to be the child's expression of free association and the means of supplying the therapist access to the child's unconscious (Landreth, 1991). Klein stressed interpretation of the child's conscious and unconscious meanings and motivations in play. Anna Freud (1965), also psychoanalytical in her approach to play therapy, viewed play as the means for creating a therapeutic alliance between the child and therapist in order to access the child's inner life. Freud also modified her famous father's cognitive model for free association by encouraging children to experience at an affective level (Landreth, 1991).

Both Melanie Klein and Anna Freud used play therapy to help children uncover their past and gain insight in order to work through difficulties (Landreth, 1991; Shaefer & O'Connor, 1983). The work of Hermine Hug-Hellmuth, Melanie Klein, and Anna Freud became the catalyst for new methods for working with and treating children in the 20th Century.

The next major development in play therapy was originally called Release Play Therapy and later became known as Structured Play Therapy. David Levy (1939) developed this structured approach to play therapy to enable children to reenact anxiety-provoking situations. Release Play Therapy has a psychoanalytic framework including an emphasis on the cathartic value of play (Shaefer & O'Connor, 1983). The therapist serves as a director, using toys and shifting settings to recreate the child's experience in order for the child to release feelings associated with specific stressful event (Landreth, 1991).

Gove Hambidge (1955) emulated Levy's Release Play Therapy, but extended the therapist's role to be more directive, once the therapeutic relationship was established. Hambidge's Structured Play Therapy calls for the therapist to directly recreate the child's
traumatic event in the playroom in order that the child might abreact feelings about the trauma and recover from its effects (Schaefer, 1985).

The third major contribution in the field of play therapy, Relationship Play Therapy, evolved out of Otto Rank's (1936) work and shifted the focus from the psychoanalytic emphasis on transference and analyzing past events to the importance of the client-therapist relationship and the reality of the client's present life. Jesse Taft (1933), Frederick Allen (1934), and Clarke Moustakas (1959) applied Rank's philosophy to children in play therapy (O'Connor, 1991). "In relationship therapy, the primary emphasis is placed on the curative power of the emotional relationship between the therapist and the child" (Landreth, 1991, p. 31). One of the tenets of Relationship Play Therapy is the belief that children are capable of taking responsibility for their own growth process, therefore the approach of Taft, Allen, and Moustakas afforded children more freedom to choose play activities in the play room. As the child made decisions about play activities, the therapist was free to focus on material that was important to the child (Landreth, 1991).

Virginia Axline (1947) pioneered the fourth major development in play therapy by applying the theory and principles of Carl Rogers' (1942) non-directive adult therapy, also known as client-centered therapy and now called person-centered therapy, to play therapy with children. Axline believed that children have within themselves all the necessary components for changing and growing (Landreth, 1991). She defined non-directive play therapy as:

...a play experience that is therapeutic because it provides a secure
relationship between the child and the adult, so that the child has the
dominion and room to state himself in his own terms, exactly as he is
at that moment in his own way and in his own time (Axline, 1950, p.68).

Clark Moustakas (1959), Louise Guerney (1983) and Garry Landreth (2002) also
made significant contributions to client-centered play therapy (Ray, et al., 2001).
Moustakas (1959), a proponent of non-directive play therapy with children, emphasized
the therapeutic relationship and unconditional acceptance of children's feelings and
expressions in therapy. Moustakas encouraged parents to apply child therapy principles
and practices in play sessions at home. Guerney explained how the non-threatening
atmosphere of play therapy fosters bringing children's ordinarily hidden content to the
surface:

By associating play with psychological issues, the threat of being examined and
treated is enormously reduced, permitting the child to be unguarded in expression
of content and free and open to new relationships and behaviors. The interest of
the counselor in therapeutic play is in the child's verbal and nonverbal expressions
in relation to the counselor and in the objects present and in the resulting
opportunities for the child to develop self-understanding, self-acceptance, and

Garry Landreth (1991, 2002) has championed child-centered play therapy as a
philosophy and a complete therapeutic system. He coined the term child-centered play
therapy to better define his approach to client-centered play therapy. Landreth described
the child-centered philosophy as "...a way of living one's life in relationships with
children...a way of being based on a deep commitment to certain beliefs about children and their innate capacity for growth” (1991, p. 55). Those beliefs about children are reflected in the tenants of child-centered play therapy. The child-centered approach to play therapy "...is both a basic philosophy of the innate human capacity of the child to strive toward growth and maturity and an attitude of deep and abiding belief in the child's ability to be constructively self-directing" (Landreth, 2002, p. 65). In child-centered play therapy, the relationship between the child and the therapist is characterized by empathy, warmth, and permissive understanding on the part of the therapist. Within the context of a secure therapeutic relationship, the child feels accepted, respected, and understood and is free to experience and deal with personal feelings (Landreth, 2002).

The skills used by a competent child-centered play therapist in play sessions are the same skills that are taught in filial therapy training (Landreth, 2002). Skills necessary for the therapist to master include the communicating of caring acceptance of the child's feelings and behaviors, responding to the child therapeutically, returning responsibility to the child, tracking the child with appropriate verbal and nonverbal responses, and setting limits therapeutically (Landreth, 2002). A therapist's use of these child-centered play therapy skills fosters the therapeutic relationship between the child and the therapist by communicating to the therapist's sensitive understanding of the child.

Overview of the Clinical Efficacy of Play Therapy

Play therapy has been utilized with positive outcomes in the treatment of a variety of childhood problems, psychological and otherwise. The effectiveness of play therapy with children who have experienced trauma, abuse and neglect, emotional disturbance,
grief, low self-concept, aggression, chronic illness, and selective mutism is recorded in a comprehensive review of research and case studies published by Landreth, Hoymeyer, Glover, and Sweeney (1996). According to Landreth et al. (1996), other populations who have benefited from play therapy are children from divorced families, children with attachment difficulties, autism, blindness, and physical challenges.

Phillips and Landreth (1998) conducted a national survey \( (N=1166) \) and reported that play therapists throughout the United States rated play therapy effective as an intervention for children who had experienced problems in the areas of school and academic adjustment, acting out/impulse control, depression/withdrawal, phobias, physical/sexual abuse, and enuresis/encopresis. Although clinical studies are more often given credence over case studies, case studies lend credibility to the effectiveness of techniques and can motivate experimental research. Case studies have supported the effectiveness of play therapy with a number of presenting issues (Bratton, & Ray, 2000).

Meta-analysis of outcome research studies using play therapy supports the effectiveness of play therapy as a treatment modality. LeBlanc's (1998) meta-analysis of 42 outcome research studies yielded an average treatment effect of 0.66 standard deviations, comparable to that of non-play therapies. Ray, et al. (2001) conducted a meta-analysis on 94 experimental research studies. Play therapy was found to have positive outcomes for children's self-concept, locus of control, behavioral change, anxiety/fear, and cognitive ability. In addition, play therapy research in the area of social skills has also had a positive outcome. The overall effect size for the 94 studies was high \( (d = .80) \).
History and Development of Filial Therapy

Filial therapy as a therapeutic method was formally developed by Bernard Guerney in the 1960s to train parents to treat their own emotionally disturbed young children (Stover & Guerney, 1967). However, the first documented case of a parent participating in the treatment of his child was the case of "Little Hans" in 1909 (Freud, 1909). Rather than treating the 5-year-old boy directly, Freud instructed "Little Hans'" father to respond therapeutically to the boy during play sessions at home. Natalie Rogers Fuchs (1957) published an article about her experience of participating in regularly scheduled play therapy sessions with her daughter at home at the suggestion of her father, Carl Rogers. Ms. Rogers used Virginia Axline's (1947) model for client-centered play therapy to help her daughter overcome her anxiety regarding toilet training. Moustakas and Makowsky (1952) suggested applying client-centered training to parents when parents sought counseling because of concerns about their children. Later, Moustakas recommended that parents conduct play therapy sessions with their children at home (1959). Although he advocated home play therapy sessions, he did not develop a structure for training and supervising parents to facilitate the sessions.

Bernard Guerney initiated the development of filial therapy to teach parents to utilize professional therapeutic techniques with their children because he believed parents would be more effective than professionals in affecting positive change in their own children (Stover & Guerney, 1967). Guerney's wife, Louise Guerney, supported her husband's work and contributed significantly to the research and development of filial therapy, which they later identified as child relationship enhancement family therapy.
(CREFT) (Guerney, 1991). Guerney's (1964) rationale for assigning a therapeutic role to parents was based on his observation and understanding of the parent-child relationship. He observed that parents, rather than professional therapists, have more emotional significance to their children. He believed that anxieties learned in conjunction with parents could best be unlearned in similar conditions. He also noted that parents most effectively communicate to their own children the code of behavior expected of them (Stover & Guerney, 1967). Louise Guerney (1991) acknowledged that the new skills parents acquire in filial training would also be available and helpful in their role as parent. Bernard Guerney recognized that filial therapy is advantageous to the therapist as well. Filial therapy training is an efficient use of the therapist's time. Parental fears, rivalry, and insecurity, which can arise in reaction to a therapist-child alliance, are circumvented. Feelings of parental guilt and helplessness, common when parents have to seek expert help to deal with family problem, are reduced. Finally, possible problems resulting by the parents' failure to develop appropriate new responses to their child's recently acquired behavior patterns can be avoided (Stover and Guerney, 1967).

The original filial therapy training was conducted by a professional therapist with groups of 6 to 8 parents who met regularly, usually weekly, over the course of 6 to 18 months (Guerney, Guerney, & Andronico, 1976). The Guerney model combined didactic instruction in client-centered play therapy skills with modeling and supervision by the therapist. Parents were encouraged to create a pleasant, supportive child-centered environment for the play sessions. Child-centered play therapy skills were taught through
live demonstrations and parents were given opportunities to practice and role play each component (Guerney, 1997).

After a period of approximately 6 to 8 weeks of instruction, parents were encouraged to begin 30-minute weekly play sessions with their children at home. If desired, parents could work up to 45-minute sessions two or more times per week (Guerney & Stover, 1967). Specific goals of the play sessions were: (a) for the child to have the opportunity to change the child's perceptions or misunderstandings of the parent's attitude, feelings, and/or behavior; (b) for the medium of play to be a means for the child to communicate internalized conflicts and other needs, thoughts and feelings previously withheld from the parents and even outside of the child's own awareness; and (c) to increase self-respect, a sense of self-worth, and confidence in the child (Guerney, 1969). The parents' role in filial therapy is closely modeled after that of the child-centered play therapist. Guerney et.al., (1976) explained the basic skills necessary for the parents to develop as follows:

1. to be empathic with the child during the sessions--to make every effort to understand how the child is viewing himself and his world at the moment and what his feelings of the moment are;

2. to be fully understanding and accepting of the child--i.e., his feelings and thoughts, whatever their nature;

3. to leave the directions that the play sessions take (within certain clearly defined limits...) completely to the child;

4. most of all, to *convey* this understanding and acceptance to the child (p. 378).
Landreth (2002) modified filial therapy training to be more amenable to the time and financial constraints of parents and also encouraged training for all parents, not merely parents of children experiencing severe problems. The Landreth 10-Week Filial Therapy Model offers didactic training in a supportive small group atmosphere in 10 weekly 2-hour sessions. The first three sessions focus on instructing parents about the goals and objectives of filial therapy and preparing them to begin play therapy sessions with their children at home. Parents are trained to be sensitive to their children as well as to respond empathetically to them. They are given a list of materials necessary to conduct the special play times at home. At the end of the third session, parents are encouraged to begin weekly 30-minute play sessions with their children at home. The fourth through ninth sessions consist of further instruction on topics such as tracking, limit setting and choice-giving with the focus being on supervising parents' play sessions with their children. Parents are instructed to videotape their play sessions in order that the tapes may be reviewed during the group meetings. As each parent processes feelings about his or her play sessions, that parent is encouraged, and other parents learn from the experience. The final session consists of concluding and evaluating the training, but parents are encouraged to continue conducting weekly play sessions with their children (Landreth, 2002).

Filial Therapy Studies Using the Guerney Model and Other Models

There has been ongoing research on filial therapy with parents and other adaptations of filial therapy since the Guerneys developed it in the 1960s (Landreth,
This section will contain an overview of some of the research in the field.

Stover and Guerney (1967) conducted filial therapy training with mothers and observed changes in the mothers' communication with their children. After filial training, the mothers' reflective statements increased significantly and their directive statements decreased in their communication with their children. The mothers noticed positive changes in the parent-child relationship, the child's behavior, and the child's overall emotional development as recorded by the mothers' self-reports.

There was not a control group for the Stover and Guerney (1967) study, but Oxman (1972) utilized the Stover and Guerney (1967) data to create an experimental group and assembled a volunteer control group with similar demographic data. The treatment group reported a statistically significant improvement in their children's behavior as compared to the control group.

Stollack (1969) used Guerney's (1964) filial model to train twenty volunteer college students to conduct special play times with children who were referred through a clinic on campus. The students' ability to verbally reflect the content of the children's play and clarify the children's feelings improved significantly after completing the filial training. Stollack concluded that college students could be an untapped resource for working with children in play therapy.

Guerney and Stover (1971) studied the effects of filial therapy on 51 pairs of mothers and their children. The results were positive for both mothers and children. The mothers demonstrated significant increases in empathetic interactions with their children.
including reflecting their children's feelings, allowing their children self-direction, and
demonstrating appropriate levels of involvement in their child's affective expressions and
behaviors. The children demonstrated increased interactions with their mothers, increased
appropriate expressions of aggression, increased sharing behaviors and decreased
dependency on their mothers. Improvements in psychosocial adjustment and
symptomatology in all of the 51 children were reported by clinical assessments.

L Guerney (1975) conducted a follow up survey of the research participants from
the B. Guerney and Stover (1971) study. Thirty-two mothers reported continued
improvement in their child's behaviors, and 64% of those mothers believed that the
improvement was due to their own ability to better understand their child. Four mothers
reported regression in their child's behavior, and 1 mother reported that her child's
behavior had deteriorated. The mothers' overall evaluation of the filial therapy program
was positive. This follow up study confirms the longitudinal effectiveness of filial
therapy training three years later.

Boll (1972) adapted the Guerney model of filial therapy to study its effectiveness
with a group of parents and their mentally retarded children. The 21 mothers were
equally divided into three groups of 7: one group who received filial therapy training, a
second group who participated in filial therapy discussions, and a control group. Both the
group trained in filial therapy and the filial therapy discussion group reported
improvement in their children's socially acceptable behavior, with the group trained in
filial therapy reporting the most improvement. Boll suggested that the group dynamics
had an effect on the outcome of the study.
Filial therapy was found to be an effective intervention with foster parents, single parent families, and families with different socioeconomic status in a study by Ginsberg (1976). Each of these groups reported positive results after filial therapy training. Foster parents reported a reduction of stress as well as improved ability to forge a mutually satisfactory relationship with their foster children. Mothers in the low socioeconomic group reported that their children's school progress and sibling and peer interaction improved. L. Guerney and Gavigan (1981) reported in a later study that foster parents were more accepting of their foster children after participating in filial therapy training.

Sywulak (1977) conducted a filial therapy study in which participants served as both the control and treatment groups. Thirty-two parents (13 mother/father pairs and 6 single mothers) completed assessments 4 months prior to training, at a 2-month midpoint in training, and 4 months after the completion of training. Analysis of the parent assessments revealed a statistically significant improvement in child adjustment and parental acceptance of the child after 2 months of training. This improvement was maintained 4 months after training ended. Sywulak also reported that changes in withdrawn children occurred faster than changes in aggressive children.

Sensue (1981) conducted a 3-year follow up study of the Sywulak (1977) study. The positive results (improvement in child adjustment and parental acceptance) were confirmed after a 3-year period. The 25 parent participants and 16 child participants reported continued positive change as a result of filial therapy training. Children formerly diagnosed as maladjusted were reported to be as well adjusted as children who had not been diagnosed as maladjusted.
Filial Studies Using the Landreth Filial Therapy Model

There have been many studies using the Landreth Filial Therapy Model with a multitude of populations (Landreth, 2002). This section contains a review of those studies.

Glass (1986) studied 27 parents referred for clinical services. The treatment group consisting of 15 parents were trained in filial therapy using the Landreth Filial Therapy Model (Landreth, 2002). The other twelve parents were assigned to the control group. The group who receive treatment reported statistically significant increases in unconditional love for their children and in their level of understanding their children's play and statistically significant decreases in perceptions of perceived family conflict. Other positive trends reported by the participants of the treatment group included increased self-esteem for both parents and children and increased closeness between parents and children.

The efficacy of the Landreth Filial Therapy Model for families with chronically ill children has been the focus of studies by Glazer-Waldman, Zimmerman, Landreth, and Norton (1992) and Tew, Landreth, Joiner, and Solt (2002). Glazer-Waldman et al. (1992) studied 10 parents of chronically ill children ages 4 to 8. There was no control group in the study. Parents in the study reported a statistically significant decrease in the parents' awareness of their child's anxiety. This result could indicate an increase in parental understanding of children. Tew et al. (2002) studied 23 parents of hospitalized chronically ill children. The treatment group of 12 parents received filial therapy training using the Landreth Filial Therapy Model. Parents in the treatment group reported
statistically significant decreases in stress related to parenting and in their children's behavior problems including anxious and depressed behaviors. These parents also reported a statistically significant increase in acceptance of their children as compared to the control group.

Bratton and Landreth (1995) studied the effects of using the Landreth Filial Therapy Model to train single parents. Mothers and their children were directly observed in pre- and post-training play sessions by trained raters. Compared to the control group, the filial trained treatment group demonstrated statistically significant increase in empathetic interactions with their children. The mothers who received filial training also reported statistically significant improvement in parental acceptance of their children and statistically significant decreases in their own stress related to parenting and in their children's behavior problems.

The Landreth Filial Therapy Model has been used as an intervention with incarcerated parents and their children. Harris and Landreth (1997) utilized an accelerated version of the Landreth Filial Therapy Model by conducting training sessions twice per week for 5 weeks instead of the typical 10-week, once weekly format. In the study, 22 mothers incarcerated in a county jail and their children ages 3-10 were divided into an experimental group and a control group. The experimental group of mothers who received filial therapy training demonstrated statistically significant increases in their empathic interactions with their children and in their attitude of acceptance toward their children. The mothers in the treatment group also reported a statistically significant decrease in their children's problematic behaviors. Landreth and Lobaugh (1998) studied
32 fathers incarcerated in federal prison. Fathers in the group trained according to the Landreth Filial Therapy Model reported statistically significant increases in their acceptance of their children. These fathers also reported statistically significant decreases in their children's behavior problems and in their own stress related to parenting, as compared to the control group. The children in the treatment group demonstrated a statistically significant increase in self-esteem.

The effectiveness of the Landreth Model of Filial Therapy training with parents and children from different cultures has been the focus of several studies. Glover and Landreth (2000) studied 21 Native American parents and their children living on the Flathead Reservation in Montana. The 11 parents in the treatment group received training according to the Landreth Filial Therapy Model. After completing the training, the parents demonstrated a statistically significant increase in empathic behaviors toward their children and a statistically significant decrease in stress related to parenting. The children of the parents who received filial therapy training demonstrated a statistically significant increase in desirable play behaviors with their parents, as compared to the control group. Chau and Landreth (1997) studied the effects of using the Landreth Filial Therapy Model in an experimental-control design with Chinese immigrant parents and their children. Compared to the control group of parents, the parents in the experimental group reported statistically significant increases in levels of empathy toward their children and acceptance of their children as well as statistically significant decreases in their children's behavior problems and parental stress. An experimental design using the Landreth Filial Therapy Model as treatment was used in another study of Chinese
immigrant parents and their children by Yeun, Landreth, and Baggerly (2002). They compared an experimental group of 18 parents and their children to a control group of 17 parents and their children. Yeun et al. (2002) reported that statistically significant results were achieved by the parents in the experimental group on all measures including measures of increased parental empathy toward and acceptance of their children and decreased parental stress and perceived child problematic behaviors. Lee (2002) conducted an experimental study to determine the effectiveness of the Landreth Filial Therapy Model with immigrant Korean parents and their children. When compared to the control group, the experimental group of parents who received filial training demonstrated statistically significant positive changes including increased empathetic interactions with their children and attitude of acceptance toward their children. These parents also reported a statistically significant decrease in their level of stress related to parenting. The Lee (2002) study supports the use of the Landreth Filial Therapy Model for strengthening the parent-child relationship in immigrant Korean families.

Kale and Landreth (1999) studied parents of children who had difficulty learning by comparing an experimental group consisting of 11 parents who received filial therapy training according to the Landreth Filial Therapy Model and a control group of 11 parents. The parents in the experimental group had a statistically significant increase in their acceptance of their children and reported a statistically significant decrease in stress due to parenting.

The Landreth Filial Therapy Model has been used as treatment for children who have been affected by violence and/or abuse. Costas and Landreth (1999)
used the Landreth Filial Therapy Model as an intervention for non-offending parents and their children who had been sexually abused. The results indicated that filial therapy was a viable treatment for this population. The parents who received filial training showed statistically significant increases in their empathic interactions with their children and their acceptance of their children and reported a statistically significant decrease in parental stress. This group of parents also reported significant improvements in their children's problem behaviors, anxiety, emotional adjustment, and self-concept compared to a control group. Smith and Landreth (in press) used a modified version of the Landreth Filial Therapy Model as the experimental treatment in a comparison study of interventions for children who had witnessed domestic violence. Intensive filial therapy training with mothers of children who had witnessed domestic violence was compared with intensive individual play therapy (Kot, Landreth, & Giordano, 2001) and intensive sibling group play therapy (Tyndall-Lind, Landreth, & Giordano, 2001) with child witnesses of domestic violence. The children whose mothers received 12 Intensive Filial Therapy training sessions in 2 to 3 weeks had statistically significant increases in self-concept and statistically significant decreases in overall problem behaviors according to parent reports. The mothers in the filial therapy experimental group demonstrated a statistically significant increase in communication of empathy to their children as compared to a non-treatment comparison group. Intensive filial therapy was found to be as effective as treatments conducted by mental health professionals, intensive sibling group play therapy and intensive individual play therapy. Specifically, intensive filial therapy was shown to be effective as a means of helping parents relate to their children...
therapeutically, especially with the ability to convey empathy and acceptance to their children.

A number of researchers have studied the effects of using the Landreth Filial Therapy Model with paraprofessionals other than parents. Baggerly (1999) used the LFTM to train 5th grade students to facilitate play sessions with kindergarten students. Robinson (2001) also studied fifth grade students as facilitators of play sessions with kindergarten students and concluded that fifth grade students could successfully learn and utilize child-centered play therapy skills when trained in the LFTM. Rhine (2000) studied the efficacy of using the LFTM to train high school students to become therapeutic agents of change with pre-kindergarten and kindergarten students. Statistical analyses supported LFTM training for high school students. The students receiving filial training demonstrated a statistically significant increase in their empathic interactions with children and the experimental group of children receiving the play intervention experienced a significant reduction in problem behaviors. Jones (2001) studied the use of training high school students to be therapeutic agents of change for primary school students identified as having adjustment difficulties. In the experimental study the treatment group received a total of 24 weeks of filial therapy/play therapy training based on the Landreth Filial Therapy Model. The experimental group of high school students demonstrated statistically significant increases in empathetic interactions and communication of acceptance of the children's feelings and behaviors, willingness to follow the children's lead during play sessions, and involvement in the children's play.
Brown (2000) investigated the effectiveness of Child-Teacher Relationship Training adapted from the Landreth Filial Therapy Model of teaching child-centered play therapy skills to teacher-trainees. Statistical analyses comparing the pretest and posttest scores for the experimental group who received the Child-Teacher Relationship Training and the control group of teacher-trainees indicated that the experimental group demonstrated statistically significant increases in empathic interactions with children.

The use of the LFTM with another group of teachers was supported by a study of teachers of deaf and hard of hearing students by Smith (2002). The experimental group of teachers in this study was trained according to the LFTM to conduct child-centered play therapy sessions with their students. At the end of treatment the experimental group of teachers demonstrated statistically significant increases in attitude of acceptance of students and ability to allow students self-direction during play sessions. Problem behaviors from the children in the experimental group decreased at a statistically significant level.
CHAPTER 2

METHODS AND PROCEDURES

The purpose of this study was to determine if parents trained in the Landreth Filial Therapy Model (LFTM) (Landreth, 2002) could demonstrate specific child-centered play therapy skills as effectively as graduate counseling students who completed a semester-long Master's level play therapy course taught by Dr. Garry Landreth. The principles and procedures of the LFTM are based on those of Dr. Landreth's child-centered play therapy course. The methods and procedures used for this study will be discussed under these headings: definitions of terms, hypotheses, instrumentation, selection of subjects, collection of data, and analysis of data.

Definition of Terms

*Allowing the child self-direction* is the parent's behavioral willingness to follow the child's lead rather than exercise control over the child's behavior. For the purpose of this study, allowing the child self-direction was operationally defined as the parents' scores on the Allowing the Child Self-Direction subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, and O'Connell, 1971).

*Child-centered play therapy* is a complete therapeutic system based on a belief that children are the best resource about themselves, resilient, and able to appropriately direct their own growth and maturity process. Child-centered personality theory is based on Rogers (1951) three central constructs: the person, the phenomenal field, and the self.
The therapeutic relationship is the basis of providing the conditions necessary for the growth of the child. The attitudes of the play therapist that form the basis for the therapeutic relationship and which facilitate the release of the child's inner resources for growth are genuineness (being real), non-possessive warmth (warm caring and acceptance), and empathy (sensitive understanding) (Landreth, 2002). Selected toys are used in the play sessions, but the therapeutic relationship, not the toys, is the key to growth.

*Communication of acceptance* is the parents' or graduate students' verbal expression of acceptance or rejection of the child and represents the most significant element in the communication of empathy. For the purpose of this study, the communication of acceptance was defined as the parents' scores on the Communication of Acceptance subscale of the MEACI (Stover et al., 1971).

*Empathy* refers to adults' sensitive understanding and acceptance of the child's current feelings and the adults' ability to communicate this understanding to the child. For the purpose of this study, empathy was operationally defined as the Total Empathy scores on the MEACI (Stover et al., 1971).

*Filial therapy* was defined for the purpose of this study as "...a unique approach used by professionals trained in play therapy 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 in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills, including reflective listening, recognizing and responding to\]
children's feelings, 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 that enhances the parent-child relationship, thus facilitating personal growth and change for both child and parent" (Landreth, 2002, p.370).

*Filial-trained parents, or parent group* were custodial mothers or fathers, 18 years of age or older, who were divorced, separated, or never married and had a dependent child between the ages of 3 and 7 (Bratton, 1994). These parents were the experimental group in the Bratton and Landreth (1995) study who received filial training in the Landreth Filial Therapy Model.

*Graduate students, graduate student group, or play therapy-trained graduate students*, for the purpose of this study, were defined as Masters level Counseling students enrolled in a graduate-level Introduction to Play Therapy course at the University of North Texas taught by Dr. Garry Landreth.

*Introduction to Play Therapy course* was a one-semester, 3-credit hour, graduate-level counseling course designed and taught by Dr. Garry Landreth at the University of North Texas in Denton, Texas. The purpose of this 45-hour course is to teach the rationale for, tenets of, and skills of child-centered play therapy. It is both didactic and clinical in nature. Most students enrolled in this course intend to use play therapy in a professional clinical setting.

*Involvement* was defined in this study as the measure of the adult's attention to the child and participation in the child's activities. For the purpose of this study, involvement
is operationally defined as the adults' scores on the Involvement subscale of the MEACI (Stove, et al, 1971).

Landreth Filial Therapy Model (LFTM) is a filial therapy training course, usually 10 weeks in length, developed by Dr. Garry Landreth to train parents and other paraprofessionals to use child-centered play principles and procedures in play sessions with children (Landreth, 2002).

Play therapy, for the purpose of this study, was defined as "...a dynamic interpersonal relationship between a child ... and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child ... to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development" (Landreth, 2002, p. 16).

Hypotheses

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

1. There will be no significant difference in the mean post-test scores on the Communication of Acceptance subscale of the MEACI between the filial-trained single parents and the play therapy-trained graduate students, when compared to the mean pre-test scores.

2. There will be no significant difference in the mean posttest scores on the Allowing the Child Self-Direction subscale of the MEACI between the filial-trained parents and the play therapy-trained graduate students, when compared to the mean pre-test scores.
3. There will be no significant difference in the mean posttest scores on the Involvement subscale of the MEACI between the filial-trained single parents and the play therapy-trained graduate students, when compared to the mean pre-test scores.

4. There will be no significant difference on the mean posttest scores on the Total Empathy scale of the MEACI between the filial-trained parents and the play therapy-trained graduate students, when compared to the mean pre-test scores.

**Instrumentation**

The Measurement of Empathy in Adult-Child Interaction (MEACI) is a direct observational rating scale adapted by Bratton (1994) from the content of a scale developed by Stover et al. (1971) to operationally define empathy as related to parent-child interactions based on an earlier measure of empathy (B. Guerney, Stover, & DeMerritt, 1968). Bratton (1994) developed a training and administrative protocol for the Stover et al. (1971) empathy scale, including content and meaning of each subscale and the total score. The use of the MEACI has been applied to the measure of empathy in non-parent adult-child interactions as well. The MEACI, a direct observational scale, measures three specific behaviors identified as major indicators of empathy in adult-child interactions: (a) communication of acceptance; (b) allowing the child self-direction; and (c) involvement. The total combined scores of these three subscales provide a Total Empathy score.
The MEACI is a five-point bipolar scale used to rate the each of the three components of parental/adult empathic behavior every 3 minutes for six consecutive coding intervals. The scale ranges from the highest level of 1 to the lowest level of 5 with each point on the scale being followed by typical responses of parent/adult-child interactions obtained from codings of direct observations. The combination of the three subscales constitutes empathic behavior. Therefore, the highest level of empathy is evident when the parent/adult is: a) commenting frequently in an accepting manner on the child's expressions of feelings and/or behaviors, b) clearly demonstrating that the child is fully permitted to engage in self-directed activity, and c) attending fully to the child's behavior. The lowest level of empathic interaction is characterized by the adults'/parents' a) verbally rejecting or criticizing the child's feelings or behaviors, b) continually demanding, cajoling, and/or redirecting the child's activity, and c) exhibiting self-involved or preoccupied behavior or ignoring the child (Stover et al., 1971).

Reliability coefficients for the MEACI were established for each of the three subscales (Stover et al., 1971). After four training sessions of collaborative rating on half-hour play sessions, followed by discussion, six pairs of coders independently rated seven to ten parent-child play sessions of 20 minutes each.

The Communication of Acceptance subscale measures the parents' or adults' verbal expression of acceptance-rejection of the child's feelings and behaviors during spontaneous play sessions. The communication of acceptance is not only a necessary element in the communication of empathy, but also a vital condition for the optimal development of a child's self-worth. (Stover et al., 1971). Rogers (1951) considered this
dimension to be necessary for therapeutic personality change. This subscale contains a rating for the highest and lowest levels of communication of acceptance, with the Communication of Acceptance score being the mean of the two totals. The average reliability correlation coefficient for the Communication of Acceptance subscale was .92 (Stover et al., 1971).

A second dimension of empathy is measured on the Allowing the Child Self-Direction subscale. The parents'/adults' willingness to follow the child's lead rather than control the child's behavior is the focus of this facet of empathy. Allowing the child self-direction parallels the communication of acceptance (Stover et al., 1971). The reliability for the Allowing the Child Self-Direction was established at .89 (Stover et al., 1971).

The Involvement subscale is the measure of the parents'/adults' attention to and participation in the child's play. Although high scores on the Involvement subscale do not necessarily correlate with high levels of empathy, 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. Stover et al. (1971) reported reliability of the Involvement subscale as .89.

B. Guerney and Stover (1971) demonstrated construct validity for each subscale and the Total Empathy score of the MEACI in a study with a group of 51 mothers who participated in filial therapy training. The filial therapy training method was selected to demonstrate the validity of the scales because this method involves training parents in empathic skills very similar to the behaviors the scales are intended to measure. The parent' levels of empathic interactions with their children were measured at
three intervals: the pre-training play session, the first post-training play session, and the third post-training play session. Highly significant (.005) increases between the pre-training and first post-training play sessions were obtained on each subscale and for the Total Empathy score. The scales proved to be extremely sensitive measures of empathic behavior because significant increases (at the .01 level) occurred between the first and third post-training play sessions. Concurrent validity was established by demonstrating a .85 correlation at the .005 level between the Measurement of Empathy in Adult-Child Interaction and a previously developed empathy measure (Stover et al., 1971).

Selection of Subjects

A class of graduate students in a child-centered play therapy course was selected for the professional group in this study. The Introduction to Play Therapy course is taught three times each year, so a fall semester class was selected because it typically includes the most demographically diverse students of the three classes. A group of parents who had completed filial therapy training was needed for a comparison group. Studies using the Landreth Filial Therapy Model (LFTM) were examined, and the group from the Bratton and Landreth (1995) study that was similar to the age and ethnicity of the graduate students was chosen. However, if the parent group was to be a representative of parents who seek filial training, it could not be a perfectly matched with the graduate student group. One obvious difference between the groups was the level of education. The graduate students all had completed a Bachelors degree and had also completed a minimum of 12 hours in Counseling courses, including at least one basic counseling skills course, as prerequisites to Introduction to Play Therapy. A parent group with a
similarly high level of education would not be representative of the parents who typically seek help for their children, so there was not an attempt to match the education level of the groups. The parent group consisted parents of whom 75% had completed high school, 20% had completed an undergraduate degree, and 5% had completed a graduate degree.

The experimental group from Bratton and Landreth (1995) was a relatively close match in mean age of both adult and child participants to the play therapy-trained graduate student group. The parents in the parent group conducted filial therapy with their own children, while the children in the graduate student group were selected by the investigator to participate in the study. The mean age of the filial-trained parents was 28 years; the mean age of the play therapy-trained graduate students was 32 years. The age range of the filial-trained parents' children was 3 to 7 years, whereas the age range of the children who participated in the graduate students' play sessions was 3 to 8 years. These demographics, along with a close match in ethnicity (90% Caucasian, 5% Hispanic, and 5% Other in the parent group compared to 92% Caucasian and 8% Other in the graduate student group), made this group a desirable comparison group for this study.

Filial-trained Parents

The parent group in this study was the experimental group from a previous study of the efficacy of filial therapy for single parents (Bratton & Landreth, 1995), as previously described. Unlike parent groups from other filial therapy studies that focused on participants from a single ethnic background, specific occupation such at teaching, or limited age range, this group varied in age, ethnicity, education, and employment.
Besides the fact that the group consisted of single parents, the group was one of the more diverse samples of the population among the studies examined.

The selection process for the Bratton and Landreth (1995) study began with advertisements for "parent-child relationship enhancement classes for single parents" run in five area newspapers and two college campus newspapers. Fliers were posted at the two college campuses and at various community agencies serving families throughout the county and were also distributed through area day care centers and preschools. Parents who responded by the advertised deadline were contacted by the investigator and given more details about the parent training classes and the selection process. The classes were offered at no charge.

Parents were selected to participate in the study based on the following criteria:
a) must be a single parent, at least 18 years of age with either full or joint custody of their child, b) must have a child between the ages of 3 years and 7 years who is not currently in therapy, c) must have been a single parent for at least 6 months, d) must be able to speak, read, and write the English language, e) must not currently be in therapy, f) must not have taken a parenting class in the last 2 years, g) must be able to attend the ten weeks of filial therapy training at the scheduled times, h) must be able to attend a pre-training session to complete pretest instruments and be videotaped playing with their child, i) must agree to participate in weekly 30-minute home play sessions with their child, and j) must be willing to sign the consent to participate form (Bratton, 1994).

The investigator met with each participant who met the specified criteria to: a) explain the purpose and the requirements of the filial therapy training, b) provide
information about how confidentiality would be maintained, and c) answer any questions
the participants had before they signed the consent form (Appendix A). Each parent was
asked to select one of their children, between the ages of 3-7 years, as the "child of focus"
for the 10-week training period and indicate that child by name on the consent form. The
investigator informed the parents that after they attended the pre-training session, they
would be arbitrarily scheduled to participate in either the first series (experimental group)
or second series (control group) of filial therapy training classes.

All parents who met the criteria specified above (N=50) were scheduled to bring
their "child of focus" to a pre-training session to complete all pretest requirements. All
50 subjects completed the pre-training requirements and were include in the study.
Subjects were not matched on any demographic variable prior to group assignment. The
investigator randomly assigned parents to the experimental group (n=25) and the control
group (n=25). Over the course of the 10-week treatment period, three subjects from the
experimental group and four subjects from the control group dropped out of the
investigation. Thus 43 subjects completed the study, 22 in the experimental group and 21
in the control group (Bratton, 1994).

The experimental group, which became the filial-trained parent group for this
study, was comprised of 20 mothers and 2 fathers. The parents in the experimental group
ranged in age from 20 to 41 years of age, with a mean age of 28. The population in both
parent groups was approximately 90% Caucasian, 5% Hispanic, and 5% other. Of the
experimental group parents, 75% had completed high school, 20% had completed
college, and 5% had completed a postgraduate degree. There were 19 divorced or
separated parents and 3 mothers who had never married in the experimental group.

Forty-one percent of the parents in the experimental group were either part-time or full-time students and 59% were employed full-time. (Bratton, 1994).

The children in the experimental group ranged in age from 3 - 7 years and included 30% 3-year olds, 23% 4-year olds, 23% 5-year olds, 24% 6-year olds, and 14% 7-year olds. The mean age of the children was 4.45 years for the experimental group of parents (Bratton, 1994).

*Play Therapy-trained Graduate Students*

Graduate counseling students were selected from a graduate-level Introduction to Play Therapy course taught at the University of North Texas by Dr. Garry Landreth. The prerequisites for the course included the criteria that the students have completed a minimum of 12 hours of coursework in counseling, including at least one basic clinical course in the application of counseling skills. Students were eliminated from the study if they had received any previous play therapy training from Dr. Garry Landreth, completed any university course in play therapy, attended a play therapy workshop that lasted longer than one day, or had accumulated hours in a doctoral program.

Students were selected to participate if they met the aforementioned criteria and: (a) agreed to participate in the study; (b) agreed to conduct a pre-training and a post-training videotaped play session at the Child and Family Resource Clinic on the University of North Texas campus; (3) agreed to complete a demographics information form prior to participation; (4) agreed to sign the consent to participate form and the form granting consent to be videotaped.
The investigator met with the students who met the specified criteria (N=16) to:
(a) explain the purpose and requirements of the study, (b) provide information about how confidentiality would be maintained, and (c) answer any questions the participants had before they signed the consent form. The investigator assigned each student a time to conduct a pre-training play session. All 16 subjects completed the pre-training requirements. During the course of the study, three graduate play therapy student subjects dropped out of the investigation. Therefore, 13 graduate play therapy students completed the present study.

The graduate student group was comprised of 4 males and 9 females ranging in age from 26 to 53 years with a mean age of 32.6 years. The ethnicity of this group was approximately 92% Caucasian and 8% self-described "Other." One hundred percent of this group had completed a Bachelor's degree. Of the 13 participants, 54% were single (never married), 38% were currently married, and 8% were divorced. Three members, two men and one woman, had their own children. One of the three parents was divorced.

The children who participated in the play session for the graduate student group ranged in age from 3 to 8 years. Twenty-five percent were 3 years of age, 50% were 5 years of age, and 25% were 8 years of age. The mean age of the children in this study was 5.25 years.

Collection of Data

Filial-trained Parents

Pre-training sessions were scheduled the week before the filial therapy training classes started for the purpose of collecting data. The pre-training sessions were held at
the Child and Family Resource Clinic at the University of North Texas. The clinic has four play therapy rooms with two-way mirrors and videotaping equipment. Parents were scheduled for the pre-training in groups of four. During the pre-training session parents played with their child for 20 minutes in one of the playrooms. Doctoral research assistants supervised the data collection. Directions were read aloud and participants were reminded to respond to all items in terms of their interaction with their child of focus. The research assistants were available to answer any questions and to direct the parents and children to the playroom for videotaping. The parent and child were shown the playroom with the explanation, "this is a room where children and parents can play together. You may play with any or all the toys in lots of the ways you would like to." The research assistant then told the parent and child that she would knock on the door one minute before the end of the 20- minutes to signal that time was up (Bratton, 1994).

The post-training sessions followed the same procedures outlined in the pre-training sessions. The videotapes were number coded to maintain the confidentiality of the participants. The researcher kept a master list with the subjects' names and respective codes in a locked file.

Play Therapy-trained Graduate Students

For the purpose of collecting data, a pre-training session was held during the first week of the semester prior to instruction commencing in the Introduction to Play Therapy course taught by Dr. Garry Landreth. The pre-training session was held at the Child and Family Resource Clinic to accommodate the videotaping of the graduate play therapy students in a 20-minute pre-training play therapy session with a child between the ages of
3 and 8 years. Each graduate student-child pair was shown the playroom with the following explanation: "This is a room where children and grown-ups can play together. You may play with any or all of the toys in lots of the ways you would like to." The investigator then told the student and child that she would knock on the door one minute before the end of the 20-minutes to signal that the play time was almost over. The investigator and graduate assistants from the Child and Family Resource Clinic videotaped the play sessions. Demographic information was gathered from the students before or after their pre-training play session.

The investigator recruited children from parents who were personal acquaintances and volunteer graduate students. The parent must have expressed concern regarding the child's behavior in order for the child to participate. The parents whose children fit the criteria to participate were given both a written and an oral explanation of the study and were asked to sign a consent form and a consent-to-videotape form. The children also received an explanation of the study in language appropriate to their developmental level. At the end of the semester, 14 weeks after the first play therapy session and prior to final exams, the post-training play therapy session was conducted at the Child and Family Resource Clinic. The final play session followed the same procedures as the first play session.

The demographics forms and videotapes were number coded to maintain the confidentiality of the participants. The investigator has kept a master list with subjects' names and respective codes, along with the videotapes, in a locked file. The videotapes will be destroyed upon the completion of the study.
Treatment

*Filial-trained Parents*

The parent group was trained using the 10-week Landreth Filial Therapy Model (LFTM) (Landreth, 2002). The 25 parents in the experimental group were divided into three smaller filial therapy training groups to facilitate small group work as prescribed by Landreth (1991) and B. Guerney, L. Guerney, & Vogelsong (1980). Parents were assigned to one of the three groups according to (a) scheduling of work and school and (b) random assignment. Group A \( n = 6 \) met in the early afternoon, group B \( n = 9 \) met at night, and group C \( n = 10 \) met in the late afternoon. Each group met weekly for a 2-hour training session for ten consecutive weeks. Twenty-two parents in the group completed the study.

The filial therapy groups following the Landreth Filial Therapy Model (LFTM) were facilitated by Dr. Garry Landreth or Dr. Sue Bratton. The Landreth Filial Therapy Model (LFTM), containing both didactic and dynamic components, is designed to enhance the parent-child relationship by helping parents learn how to create an accepting environment in which their child will feel safe enough to express and explore thoughts and feelings. This concept of the accepting environment was modeled after the optimum child-centered play therapy environment recommended by Landreth (2002) and taught in his Introduction to Play Therapy course. The parents first learned these new skills through demonstration and role play, then practiced with their child of focus in weekly 30-minute special play sessions at home, and subsequently reported their experiences to their filial parent group. Parents were instructed in other child-centered play therapy
skills, mirroring skills taught by Dr. Landreth in his Introduction to Play Therapy course. These skills included reflective listening, reflection of feelings, and tracking responses as aspects of communication of empathy. Learning these skills required the parents to become more observant of their child, more understanding of the child's feelings, thoughts, and behaviors, and adept at communicating this understanding to the child. Other child-centered play therapy skills and topics, such as allowing the child freedom in the playroom, therapeutic limit setting, and solutions for typical problems in play therapy were included in the Landreth Filial Therapy Model training. Parents were supplied with a special toy kit to be used for the home play sessions. In addition, during the training period parents were scheduled on an individual basis to bring their child to the clinic for a videotaped play session that was critiqued during the following week's group training session. Parents received encouragement and support from the other group members as well as the facilitator throughout this process. The training sessions followed the methodology outlined by Landreth (1991) for a ten week filial therapy training group (Bratton, 1994).

*Play Therapy-trained Graduate Students*

Each play therapy-trained graduate student completed and passed the Introduction to Play Therapy course taught by the originator of the Landreth Filial Therapy Model, Dr. Garry Landreth. The course lasted 15 weeks with practice play sessions spread out throughout the semester. The students studied the main course textbook, *Play Therapy: The Art of Relationship* (Landreth, 1991), as well as other readings assigned by Dr. Landreth, and received instruction in a clinical component of the class. In addition to the
Clinical practice and readings, the students received instruction by lecture, videotapes, role-play, and live demonstration. The skills training for the students included instruction and practice in play sessions focusing on empathetic facilitative responses such as reflection of feelings and tracking responses, allowing the child to take the lead, therapeutic limit setting, and solving typical problems in play therapy. The students conducted two unsupervised play sessions outside of class and two supervised micro-practicum play sessions during class time. During the micro-practicums, each student conducted a play session lasting approximately 30 minutes and two 30-minute observations of other students conducting play sessions. Supervision sessions immediately followed each play/observation session. The students received feedback from trained play therapist supervisors as well as peers during small group supervision.

Analysis of Data

The pre-training and post-training videotapes of play sessions of the filial-trained parent group and the play therapy-trained graduates student group were collected, but not rated until completion of the study to insure that the raters did not know whether they were rating a pre-training or a post-training session. The Measurement of Empathy in Adult-Child Interaction (MEACI) was used to rate the videotapes of play sessions. Dr. Sue Bratton developed the training procedures for the raters of the MEACI. Doctoral students with advanced coursework and training in play therapy and filial therapy under the supervision of Dr. Bratton blind-scored the videotapes for the parent group and the graduate student group at the time of their respective studies. Inter-rater reliability for the raters was established for each group during two 2-hour training sessions. The use of
professional play therapists to blind-rate the participants in this study and the Bratton and Landreth (1995) study, rather than dependence on parent self-reports, lends credibility to the objectivity of the results. Dr. Sue Bratton developed the MEACI training procedures and trained all the raters for both studies, giving continuity to the rating system.

Training procedures followed the guidelines outlined by Stover et al. (1971) and included explanations, discussions, and collaborative rating sessions. Kendall's Tau was used to calculate inter-rater reliability. The inter-rater reliability for the raters of the play therapy-trained graduate students is shown in Table 1, while the inter-rater reliability for the raters of the filial-trained parents is shown in Table 2. High inter-rater reliability was established for both groups.

Table 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reliability Coefficient</td>
<td>Reliability Coefficient</td>
</tr>
<tr>
<td>Communication Of Acceptance</td>
<td>.948**</td>
<td>.998***</td>
</tr>
<tr>
<td>Allowing Self-Direction</td>
<td>.995**</td>
<td>.998***</td>
</tr>
<tr>
<td>Parental Involvement</td>
<td>.952*</td>
<td>.981***</td>
</tr>
<tr>
<td>Total Empathy</td>
<td>.950**</td>
<td>.997***</td>
</tr>
</tbody>
</table>

*p < .01; ** p ≤ .005; *** p ≤ .0001
Table 2
Inter-rater reliability coefficients of concordance for coding of the Measurement of Empathy in Adult-Child Interaction scales of the filial-trained parents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pre-test Reliability Coefficient</th>
<th>Post-test Reliability Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Of Acceptance</td>
<td>.975*</td>
<td>.957**</td>
</tr>
<tr>
<td>Allowing Self-Direction</td>
<td>.999**</td>
<td>.983**</td>
</tr>
<tr>
<td>Parental Involvement</td>
<td>.934**</td>
<td>.999**</td>
</tr>
<tr>
<td>Total Empathy</td>
<td>.952***</td>
<td>.989***</td>
</tr>
</tbody>
</table>

* p ≤ .01; ** p ≤ .005; *** p ≤ .0001

An analysis of covariance (ANCOVA) was computed to test the statistical significance of the difference between the filial-trained parents and the play therapy-trained graduate students on the adjusted posttest means for each hypothesis. SPSS for Windows was used to calculate the ANCOVA data. ANCOVA was used to adjust the within-group variance, using the mean pretest scores as the covariate and the posttest scores as the dependent variable, for the adjusted posttest means for each hypotheses for scores as measured by the Measurement of Empathy in Adult-Child Interaction (MEACI). ANCOVA was used to statistically equate the group of single parents trained according to the Landreth Filial Therapy Model and the group of graduate students trained in play therapy by adjusting the group means on each posttest on the basis of each
pretest. The level of significance was set at the .05 to test the significance of differences between means. Each hypothesis was retained or rejected on the basis of the ANCOVA.

Tests of between-subject effects were calculated to take into consideration the effects of sample size, effect size, and power and therefore reduce the risk of committing a Type I or Type II error (Cohen, 1992; Kirk, 1996; Rogers, Howard, & Vessy, 1993; Vacha-Haase & Nilsson, 1998). Cohen's $f$ was computed for the purpose of reporting statistical power analysis (Cohen, 1992; Kirk, 1996). For the purpose of this study, the effect sizes $\eta$ squared are as follows: small = .02; medium = .15; and large = .35 (Cohen, 1992).
CHAPTER 3
RESULTS AND DISCUSSION

This chapter presents the results of the statistical analysis of the data for each hypothesis tested in this study. A discussion of the possible meanings, limitations of the study, implications of the findings, and recommendations for future research are also covered.

Results

The results of this study are presented in the order in which the hypotheses were presented in chapter 2. Analyses of covariance (ANCOVAs) were performed on all hypotheses and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses. For the purpose of this study, Group 1 is the play therapy-trained graduate students and Group 2 is the filial-trained parents.

Hypothesis 1

There will be no significant difference in the mean posttest scores on the Communication of Acceptance subscale of the MEACI between the filial-trained parents and the play therapy-trained graduate students, when compared to the pretest scores.

Table 3 presents the mean pretest and posttest scores, standard deviations, and mean gains on the Communication of Acceptance subscale for both Group 1, the play therapy-trained graduate students and Group 2, filial-trained parents. Table 4 presents the analysis of covariate (ANCOVA) data containing the statistical significance of the
difference between the posttest scores of Group 1 and Group 2. Table 5 also includes data on the observed power and treatment effects.

Table 3

Mean scores of Group 1 (graduate play therapy students) and Group 2 (filial-trained parents) on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Communication of Acceptance

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (graduate students)</th>
<th>Group 2 (parents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>16.058</td>
<td>10.192</td>
</tr>
<tr>
<td>SD</td>
<td>5.000</td>
<td>1.114</td>
</tr>
<tr>
<td>Total Cases</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>

Note. A lower score = a higher skill level.

Table 4

Analysis of covariance data of Group 1 (graduate play therapy students) and Group 2 (filial-trained parents) on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Communication of Acceptance

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance</th>
<th>Observed Power</th>
<th>Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate</td>
<td>3.478</td>
<td>1</td>
<td>3.478</td>
<td>2.596</td>
<td>.117</td>
<td>.346</td>
<td>.075</td>
</tr>
<tr>
<td>Treatment effects</td>
<td>2.123</td>
<td>1</td>
<td>2.123</td>
<td>1.585</td>
<td>.217</td>
<td>.231</td>
<td>.047</td>
</tr>
<tr>
<td>Error</td>
<td>42.871</td>
<td>32</td>
<td>1.340</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrected Total</td>
<td>52.296</td>
<td>34</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows that the F ratio for the main effects was not significant at the .05 level, indicating that there was no significant difference between the graduate students' and the parents' ability to communicate acceptance as measured by the MEACI. On the basis of this data, hypothesis 1 was retained. The effect size for this analysis, according to Cohen's (1992) reference for effect size, is small (.047). Although there was no
statistically significant difference in the observed skill level of the groups, filial-trained parents improved more than the play therapy-trained graduate students on this subscale, as indicated by Table 3, however, the graduate students attained a higher skill level as indicated by the raw mean posttest scores.

*Hypothesis 2*

There will be no significant difference in the mean posttest scores on the Allowing the Child Self-Direction subscale of the MEACI between the filial-trained parents and the play therapy-trained graduate students, when compared to the mean pretest scores.

Table 5 presents the mean pretest and posttest scores, standard deviations, and mean gains for both Group 1, the play therapy-trained graduate students and Group 2, the filial-trained parents. Table 6 presents the analysis of covariate (ANCOVA) data containing the statistical significance of the difference between the posttest scores of Group 1 and Group 2. Table 6 also includes data on the observed power and treatment effects.

Table 5
Mean scores of Group 1 (graduate play therapy students) and Group 2 (filial-trained parents) on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Allowing the Child Self-Direction

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (graduate students)</th>
<th>Group 2 (parents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td><strong>Allowing the Child Self-Direction</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6
*Analysis of covariance data of Group 1 (graduate play therapy students) and Group 2 (filial-trained parents) on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Allowing the Child Self-Direction*

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance</th>
<th>Observed Power</th>
<th>Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate</td>
<td>19.261</td>
<td>1</td>
<td>19.261</td>
<td>3.282</td>
<td>.079</td>
<td>.420</td>
<td>.093</td>
</tr>
<tr>
<td>Treatment effects</td>
<td>6.269</td>
<td>1</td>
<td>6.269</td>
<td>1.068</td>
<td>.309</td>
<td>.171</td>
<td>.032</td>
</tr>
<tr>
<td>Error</td>
<td>412.167</td>
<td>32</td>
<td>12.880</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases</td>
<td>23939.625</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 6 shows that the F ratio for the main effects was not significant at the .05 level, indicating that there was no statistically significant difference in the play therapy-trained graduate students' behavioral willingness to allow the child self-direction as measured by the MEACI as compared to the filial-trained parents'. On the basis of this data, hypothesis 2 was retained. The effect size for this analysis, according to Cohen's (1992) reference for effect size, is small (.032). The raw mean gains of both groups, as shown on Table 5, improved after treatment with the parent group making the most gain in behavior congruent with allowing the child self-direction. However, the graduate students ended the study with the higher skill level of the two groups.

**Hypothesis 3**

Mean 17.192  7.039  10.15  21.73  8.591  13.14
SD 7.704  2.610  4.10  2.443
Total Cases 13  13  22  22
Note. A lower score = a higher skill level.
There will be no significant difference in the mean posttest scores on the Involvement subscale of the MEACI between the filial-trained parents and the play therapy-trained graduate students, when compared to the mean pre-test scores.

Table 7 presents the mean pretest and posttest scores, standard deviations, and mean gains for both Group 1, the play therapy-trained graduate students and Group 2, the filial-trained parents. Table 8 presents the analysis of covariate (ANCOVA) data containing the statistical significance of the difference between the posttest scores of Group 1 and Group 2. Table 8 also includes data on the observed power and treatment effects.

Table 7
Mean scores of Group 1 (graduate play therapy students) and Group 2 filial-trained parents) on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Involvement

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (graduate students)</th>
<th>Group 2 (parents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>12.577</td>
<td>6.231</td>
</tr>
<tr>
<td>SD</td>
<td>6.852</td>
<td>.388</td>
</tr>
<tr>
<td>Total Cases</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>

Note. A lower score = a higher skill level.

Table 8
Analysis of covariance data of Group 1 (graduate play therapy students) and Group 2 (filial-trained parents) on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Involvement

<table>
<thead>
<tr>
<th>Source of Variation of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance level</th>
<th>Observed Power</th>
<th>Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of Variation of Squares</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

53
Table 8 shows that the F ratio for the main effects was significant at the .02 level, indicating a significantly greater increase in the play therapy-trained graduate students' attention to and participation in the child's activity as measured by the MEACI than the filial-trained parents'. On the basis of this data, hypothesis 3 was rejected. According to Cohen's (1992) reference for effect size, there was a medium effect size for this subscale ($f = .162$). According to Table 7, both the parent group and the graduate student group improved on the Involvement subscale after their respective treatment.

**Hypothesis 4**

There will be no significant difference in the adjusted mean post-test scores on the Total Empathy score of the MEACI between the filial-trained single parents and the play therapy-trained graduate students, when compared to the adjusted pre-test scores.

Table 9 presents the mean pretest and posttest scores and standard deviations, as well as the mean gain scores for both groups in the study. Table 10 presents the ANCOVA data containing the statistical significance of the difference between the posttest scores of Group 1, the graduate students and Group 2, the parents. Table 10 also includes data on the observed power and treatment effects.

Table 9
Mean scores of Group 1 (graduate play therapy students) and Group 2 (filial-trained parents) on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Total Empathy

<table>
<thead>
<tr>
<th></th>
<th>Group 1 (graduate students)</th>
<th>Group 2 (parents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>45.83</td>
<td>23.43</td>
</tr>
<tr>
<td>SD</td>
<td>18.58</td>
<td>1.04</td>
</tr>
<tr>
<td>Total Cases</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>

Note. A lower mean score = a higher skill level.

Table 10
Analysis of covariance data of Group 1 (graduate play therapy students) and Group 2 (filial-trained parents) on the Measurement of Empathy in Adult-Child Interaction (MEACI) subscale: Total Empathy

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F Ratio</th>
<th>Significance</th>
<th>Observed Power</th>
<th>Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariate</td>
<td>.308</td>
<td>1</td>
<td>.308</td>
<td>.024</td>
<td>.878</td>
<td>.053</td>
<td>.001</td>
</tr>
<tr>
<td>Treatment effects</td>
<td>106.876</td>
<td>1</td>
<td>106.876</td>
<td>8.298</td>
<td>.007*</td>
<td>.798</td>
<td>.206</td>
</tr>
<tr>
<td>Error</td>
<td>412.167</td>
<td>32</td>
<td>12.880</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases</td>
<td>23939.625</td>
<td>35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* p < .01

Table 10 shows that the $F$ ratio for the main effects was statistically significant at the .01 level, indicating a significantly greater skill level rating of the play therapy-trained graduate students' ability to express empathy as measured by the MEACI as compared to the filial-trained parents'. On the basis of this data, hypothesis 4 was rejected. The effect size for this analysis, according to Cohen's (1992) reference for effect size, is medium (.206). Although the hypothesis was rejected, Table 9 indicates that both groups improved in their ability to demonstrate empathy after their respective treatments,
with the parent group demonstrating the higher mean gain, but the graduate students demonstrating a higher level of skill.

Discussion

This study compared specific child-centered play therapy (CCPT) skills of play therapy-trained graduate students trained in an Introduction to Play Therapy course and parents trained in the Landreth Filial Therapy Model (LFTM) (Landreth, 2002). Specifically, the study examined the CCPT skills related to empathy which has been recognized as an essential quality of a play therapist necessary to form the basis of therapeutic growth (Landreth, 2002). The group of graduate students, who were training to be professional play therapists, completed a 15-week, 45-hour graduate level play therapy course taught by Dr. Garry Landreth, also the developer of the Landreth Filial Training Model (LFTM). The graduate students also completed homework as well as four 30-minute play therapy sessions, two outside of class and two during class time. The parents were trained using the 10-week, 20-hour LFTM training (Landreth, 2002) and completed six to seven 30-minute play sessions with their children at home. Analysis of covariance revealed that the play therapy-trained graduate students demonstrated a statistically significant greater level of CCPT skills on the Total Empathy score as well as the Involvement subscale of the MEACI. There were no statistically significant difference between the mean posttest scores of the play therapy-trained graduate students and the filial-trained parents on the Communication of Acceptance and Allowing the Child Self-Direction subscales of the MEACI. The results of the study show that although the play therapy-trained graduate students demonstrated a higher overall skill level than
the filial-trained parents, the parents' skill level approximated that of the graduate
students' on Communication of Acceptance and Allowing the Child Self-Direction which
are vital components of empathic behavior. A discussion of each of the subscales and the
Total Empathy score of the MEACI follows.

Communication of Acceptance

Hypothesis 1, that there would be no statistically significant difference in the
mean posttest scores on the Communication of Acceptance subscale between the play
therapy-trained graduate students and the filial-trained parents, when compared to the
adjusted pre-test scores, was retained on the basis of the statistical analyses. There was no
statistically significant difference between the mean posttest scores of the graduate
students and parents on this subscale, indicating that the filial-trained parents learned to
utilize these CCPT skills at a similar level to the play therapy-trained graduate students.
The Communication of Acceptance, as defined on the MEACI, is the verbal expression
of acceptance or rejection of the child (Stover, et al., 1971) In fact, Stover, et al.
identified the verbal expression of acceptance as the major element of communication of
empathy. On this subscale, the highest rating (1) was given when the graduate student or
parent verbally conveyed acceptance of the child's feelings. At the other end of the
spectrum, the lowest rating, (5) was given when the adult was strongly critical, preaching,
or verbally rejecting of the child. The parents and graduate students received two ratings
per each 3-minute segment on this subscale. They received a score for the highest level of
response and a score for the lowest level of response. The average of these scores was
used for the Communication of Acceptance score.
While the play therapy-trained graduate students' raw mean posttest score reflected a higher skill level (lower score) than the filial-trained parents' mean posttest score, 10.19 and 11.05, respectively, the parents' mean gain score \((m = 7.75)\) evidenced greater change than that of the graduate students (5.87). The performance of the parents on this subscale is particularly noteworthy because the communication of acceptance does not generally occur in spontaneous interactions between parents and their children (Bratton & Landreth, 1995; Stover, et al., 1971). In the Bratton and Landreth (1995) study during the pretest play session, no parent in either the control group \((n = 21)\) or the experimental group \((n = 22)\) responded to the child with a reflection of the child's feeling, the primary indicator of communication of acceptance on the subscale. The parents' greater mean gain score was likely influenced by the fact that they began with a lower skill level (indicated by their mean pre-test score of 18.79) than the graduate students (whose mean pretest score was 16.06). This beginning differential is not surprising given that the graduate students had completely a minimum of 12 graduate hours in Counseling, including a course in basic counseling skills, and 100% reported prior exposure to play therapy. So, although the filial-trained parents started with less education, experienced less prior exposure to play therapy, and overcame a beginning skill deficit, they were able to learn the child-centered play therapy skills necessary to communicate acceptance almost as well as the play therapy-trained graduate students. This impressive finding supports using the Landreth Filial Therapy Model to train parents to use the CCPT skill of communicating acceptance to their children.

*Allowing the Child Self-Direction*
Hypothesis 2, which stated that there would be no statistically significant difference in the mean posttest scores on the Allowing the Child Self-Direction subscale of the MEACI between the play therapy-trained graduate students and the filial-trained parents when compared to the mean pretest scores, was retained on the basis of statistical analysis. These results indicate that the filial-trained parents were able to learn the child-centered play therapy (CCPT) skills included on this subscale on par with the play therapy-trained graduate students. Allowing the Child Self-Direction, an extension of the skill of communication of acceptance, encompasses the ability to follow the child's lead rather than to attempt to direct or control the child's behavior (Stover et al., 1971). A high rating (1) was given when the graduate student or parent willingly followed the child's lead, with or without verbal comment, during play sessions. At the other end of the spectrum, the lowest rating (5) was scored if the adult persuaded, demanded, interrupted, or insisted that the child do something a certain way. Although the graduate student group again demonstrated a higher level of skill in Allowing the Child Self-Direction than the filial-trained parents after completing training (posttest means $m = 7.04$ and $m = 8.59$, respectively), the parent group started at a lower skill level and made the greater mean gain. The filial-trained parents, whose mean pre-test score was 21.73, had a mean gain of $m = 13.14$ from the pretest to the posttest. This gain was 2.99 higher than that of the play therapy-trained graduate students, whose mean gain was $m = 10.15$ after starting with a mean pre-test score of 17.19. Both parents and graduate students made the greatest gains on this subscale, which likely reflects adults' (particularly parents') natural tendency to direct, instruct, or control children's behavior, thus suggesting greater room for growth.
These findings support the use of the Landreth Filial Therapy Model to train parents to allow their children to determine their own play and follow the child's lead when invited. This skill is also important in light of the person-centered foundation of child-centered play therapy (CCPT). The skills of allowing the child to determine the direction of play and following the child's lead are cornerstones of CCPT because these behaviors nurture the child's internal locus of control and internal valuing processes, while facilitating the child's self-directed play. This is the mean through which parents are taught to better understand their child's needs. In addition, parents' natural tendency to direct their child required most parents to unlearn old habits before they could apply the new skill, making the parents' gain in this skill all the more impressive.

**Involvement**

Hypothesis 3, which stated that there would be no statistically significant difference in the mean posttest scores on the Involvement subscale of the MEACI between the play therapy-trained graduate students and the filial-trained parents when compared to the pretest scores, was retained on the basis of statistical analysis. On the Involvement subscale of the MEACI, the play therapy-trained graduate students were rated higher than the filial-trained parents at a statistically significant level \( p < .02 \). The graduate students had a greater mean gain than the parents \( m = 6.346 \) compared to \( m = 5.368 \), respectively. The Involvement subscale measures the adult's ability to attend to and contribute appropriately to the child and the child's activity during the play session (Stover, et al., 1971). The highest rating (1) was given when the adult was fully physically and verbally observant of the child rather than of toys or their own activities in
the playroom. The lowest rating on this subscale (5) was scored for adult behavior that was totally self-involved and shut-off from the child for a prolonged period of time. (See Appendix C for complete explanation of rating scale.) Involvement can be positive or negative, therefore Involvement in and of itself does not constitute empathic behavior (Stover et al., 1971). For example, a parent could be directive and critical with a child, receiving a low score on Communication of Acceptance and Allowing the Child Self-Direction subscales, and receive a relatively high rating of 2 for demonstrating a high level of attention directed toward an activity that the parent directed the child to play. However, the highest levels of Total Empathy on the MEACI are recorded when the child-centered play therapy skills in Involvement combine with those of Communication of Acceptance and Allowing the Child Self-Direction.

There are several possible explanations for the greater success of the play therapy-trained graduate students on this subscale. One explanation is that the filial-trained parents had a shorter training time, 10 weeks, to learn and integrate the skills than the play therapy-trained graduate students, who benefited from 15 weeks of play therapy training. Thus, the parents may not have integrated the new skills to the degree that they came naturally at the end of 10 weeks. The greater focus of LFTM training is on verbal expression of acceptance and following the child's lead. Parents in filial therapy are often so intent on trying to internally process and use their new skills in their play sessions with their child, that thinking of how to respond initially distracts them from full involvement with their child (personal communication with Dr. Sue Bratton, March 12, 2003). Stover and Guerney (1967) noted that parents and therapists alike become less inhibited and
preoccupied with what not to do and more relaxed and focused on what to do the longer they are in filial/play therapy training. As previously mentioned, the graduate student group had the benefit of exposure to play therapy concepts prior to training. Their foreknowledge, especially if it included viewing videotapes of child-centered play therapy sessions, could give them an advantage by having observed play therapists in action. Although the filial-trained parents did not fare as well as the play therapy-trained graduate students on the Involvement subscale, the parents still improved in their ability to be involved with the child and the child's activity, as indicated by a respectable mean gain of $m = 5.37$.

*Total Empathy score on the Measurement of Empathy in Adult-Child Interaction (MEACI)*

The Measurement of Empathy in Adult-Child Interactions (MEACI) is designed to rate foundational child-centered play therapy skills used in the Communication of Acceptance, Allowing the Child Self-Direction, and Involvement as components of adult empathic behavior toward children in play sessions (Stover et al., 1971). The Total Empathy score provides a composite rating of the subscales.

According to the data from the Total Empathy score on the MEACI, the play therapy-trained graduate students demonstrated a statistically significant ($p < .01$ level) greater child-centered play therapy skill level than the filial-trained parents. The play therapy-trained graduate students also began at a higher skill level than the filial-trained parents, as reflected on their mean pretest Total Empathy scores of 45.83 and 55.02, respectively. In fact, the graduate students' pretest scores were lower (better) than those
of the parents on every subscale. This inequity could be a result of both the amount of formal education (a minimum of 12 graduate Counseling hours for the graduate students, who were also Counseling majors) and the exposure to play therapy that all 13 participants in the graduate student group reported prior to training. Quantity of training could be another factor in the post-training differences in skill level of the two groups. The play therapy-trained graduate students had the advantage of attending a three-hour course weekly for 15 weeks while the filial-trained parents had 20 total hours of training spread over 10 weeks plus an additional six or seven 30-minute home play sessions with their children. In spite of the advantages held by the play therapy-trained graduate students, the filial-trained parents demonstrated a larger mean gain on the Total Empathy score, indicative of greater change from pretest to posttest. The parent group's raw mean gain was 27.705, compared to the mean gain of the graduate student group, 22.442. In fact, the parents' mean gain on every measure except Involvement was greater than that of the graduate students. Although the parents had disadvantages in education and knowledge of play therapy at the onset of the study, the progress of the filial-trained parents in learning child-centered play therapy skills, especially Involvement, was encouraging and strongly supports using the Landreth Filial Therapy Model to train parents to be therapeutic agents in the lives of their children.

Limitations of the Study

The study had the following limitations:

1. The time between the collection of data from the two groups used in this study was approximately six years. However, raters for both studies were all trained and supervised
by Dr. Sue Bratton in order to assure consistency of training methods and the establishment of inter-rater reliability for this study.

2. This study relied on volunteer sampling from graduate students enrolled in an Introduction to Play Therapy course at the University of North Texas at Denton. Therefore, due to the nature and purpose of this study random selection was not possible.

3. The play therapy-trained graduate student group and the filial-trained single parent group in this study were qualitatively different. Due to the nature and purpose of this study, this difference was by design. An attempt was made to match the groups on as many demographics as possible.

4. The play therapy-trained graduate student group differed quantitatively from the filial-trained parent group. The adjusted mean pretest scores were used as covariates for each Analysis of covariate to equate the groups on each scale.

Implications of the Study

This study compared the child-centered play therapy skill level of parents trained in the Landreth Filial Therapy Model (LFTM) and graduate students trained in a graduate-level play therapy course taught by Dr. Garry Landreth. The findings indicate that the two groups finished their training with similar skill levels on the Communication of Acceptance subscale and the Allowing the Child Self-Direction subscale. It is significant that the skills measured in these two scales most closely mirror the skills that are emphasized most during the 10-week LFTM training. The mean posttest scores of the play therapy-trained graduate students were statistically significantly greater than the mean posttest scores of the filial-trained parents on the Involvement subscale ($p < .02$).
and the Total Empathy score ($p < .01$). Post-training mean scores revealed that the play therapy-trained graduate students demonstrated a higher attainment of skill level than the filial-trained parents on every behavior assessed on the Measurement of Empathy in Adult-Child Interaction (MEACI). The parent group in the study had previously proved that they could demonstrate these skills at a statistically significant level (at the $p < .001$ level on each subscale and the Total Empathy score) compared to a control group of parents (Bratton & Landreth, 1995). The Bratton and Landreth (1995) study, as well as 14 others that have been conducted using the LFTM, confirm its effectiveness for training parents to help their children after 10 weeks of training (or less in studies that utilized a compressed version of the LFTM). It is important to continue to train parents to learn child-centered play therapy skills because parents have greater influence on their children's lives than do professionals far beyond the 10 weeks of treatment and 30-minute play sessions during training (Bratton, 1994). Using parents rather than professionals to provide treatment not only addresses current concerns, but also gives parents the tools to help prevent future problems, therefore is preventative in nature.

The results of a meta-analysis of play therapy outcome research indicated that play therapy conducted by parents (filial therapy) is more effective than play therapy conducted by professionals (Bratton, Ray, Rhine, & Jones, 2001). The effect size for parent-only filial therapy studies, mostly based on the Landreth Filial Therapy Model, ($d = 1.15$) was significant at the .001 level when compared to the effect size of 70 play therapy studies ($d = .73$).
The results of this study, while supporting the notion that parents can learn child-centered play therapy skills, do not explain the meta-analysis results regarding filial therapy. Even if, as this study suggests, parents don't gain the skill level of professional play therapists after 10 weeks of filial therapy training, research has shown that they can still use the skills extremely effectively in the lives of their children, in fact, with greater impact than professionals. In light of the meta-analysis (Bratton, et al., 2001), the fact that the filial-trained parents did not achieve the same level of effectiveness as the play therapy-trained graduate students suggests that there must be a variable other than actual skill level that accounts for the effectiveness of filial therapy for children. Filial therapy proponents have proposed this method based on a belief in the importance of the parent-child relationship and the significance of the parent to the child (Bratton & Landreth, 1995; Guerney, 1969). This study supports this belief. Therefore, the parent's significance to the child could be that variable.

It is also possible and likely that filial therapy training impacts more than just a change in children's behavior as studies have shown. As parental attitudes change during the course of filial therapy, parents view their children differently. In the Bratton and Landreth (1995) study, the parents reported a sizable decrease in their children's problematic behavior after filial training. Bratton and Landreth suggested that perhaps the children's behavior had not changed as much as the parents' attitude toward their child. After 10 weeks of filial therapy, parents tend to see their children's behavior in a less negative light, and become more accepting of their child. The assessment from one parent from Bratton and Landreth's study sums up this point: "It's not so much that (child) has
changed...things don't bother me as much...I guess I'm the one who's changed" (1995, p.76).

The most important implication of this study is that parents learned the child-centered play therapy skills accounted for in the Communication of Acceptance and Allowing the Child Self-Direction subscales of the Measurement of Empathy in Adult-Child Interaction at a level close to that of graduate play therapy students. The skills measured on these subscales contribute greatly to empathic behavior. Parents' impact on the lives of their children is greater than that of professionals according to meta-analysis (Bratton, et al., 2001), therefore this finding strongly supports using the Landreth Filial Therapy Model to train parents to use child-centered play therapy skills.

Recommendations for Future Research

Based on the findings of this study, recommendations for further research fall into two major categories: filial therapy research and graduate training research. As a result of this study, the author recommends examining methods of helping to decrease the inhibition of parents' involvement and playfulness in filial therapy training. A study of child-centered skill level after 15 weeks of training compared to 10 weeks of training might shed light on the possible impact of the length of training that differed in this study. Due to the proven success that the Landreth Filial Therapy Model (LFTM) has already demonstrated with several populations, further study using the model to train paraprofessionals to use child-centered play therapy skills is recommended. Of particular interest would be examining the impact of the Landreth Filial Therapy Model on any population that plays a significant role in children's lives, such as child care providers,
teachers, residential treatment care givers, and foster parents. Additional studies investigating parents using child-centered play therapy skills with older children in activity therapy and with adolescents could examine whether or not the skills are beneficial for those populations. Play therapy and filial therapy emphasize relationship, so wherever relationships with children exist could be fertile ground for research.

Additional recommendations with regard to the training of professional play therapists were formulated as a result of this study. One recommendation would be a study comparing knowledge and skill level of graduate students training to be play therapists in didactic courses and in clinical courses. Another recommendation is for a study that compares the efficacy of the Landreth Filial Therapy Model with other filial therapy training models. Studying the impact of additional supervised clinical practice during the 15-week play therapy course on the skill level of graduate play therapists in training is recommended because the parents, who had more practice in actual play sessions with their children and subsequent group supervision, learned some of the child-centered play therapy skills as well as graduate-level students who began at a higher skill level. Finally, it would be interesting to compare the play therapy skill level of undergraduate play therapy students with the skill level of graduate play therapy students and paraprofessionals.

Conclusion

Part of the rationale for this study was the need for creative means of delivery of mental health services for children and the identification of families and home based
services as possible vehicles of delivery (U.S. Public Health Service, 2000). Furthermore, systems of treatment that recognize the unique developmental needs of children and early intervention were considered vital. The Landreth Filial Therapy Model (LFTM) was identified as a treatment mode that met those criteria. A comparison of the child-centered play therapy skill level of parents and a group of graduate students who were training to be professional play therapists was undertaken to examine whether parents could learn these skills as well as professionals-in-training in order to be viable providers of treatment for their children and explore what makes filial therapy effective. The dramatic results of the study indicate that the parents were able to demonstrate the skills of Communication of Acceptance and Allowing the Child Self-Direction at a level that was on par with the graduate students in spite of the fact that the parents had to make more improvement to catch up with the graduate students. Prior filial therapy research, much of that focusing on the LFTM, indicates that parents are effective in helping their children. It is clear from this study that filial-trained parents, particularly parents trained in the LFTM, are effective in the delivery system of mental health services, specifically child-centered play therapy skills for their children. This method also answers the need for proven methods of treating children at an early age and involving families identified by the Surgeon General (U.S. Public Health Service, 2000). Additionally, professionals have an ethical responsibility to use the most effective treatment for their clients. This study, along with the body of filial therapy research, provides a strong basis for recommending that all play therapists receive training in how to train parents in filial therapy in order to
provide the most effective treatment for their clients. The use of the Landreth Filial Therapy Model to train parents is strongly recommended, as is continued LFTM research.
Appendix A

Child and Adult Consent Forms
August 28, 2000

Dear Parents,

My name is Roseanne P. Elling and I am a doctoral student in the Department of Counselor Education. I am beginning a study for my dissertation, and I would like to ask for your support. I will be conducting a study in the play therapy rooms at the Child and Family Resource Clinic and the Counseling and Human Development Center at the University of North Texas. I will examine the use of a particular training model measuring its effects on counselors-in-training as they interact with children. I will be collecting data on the counselors and not on the children, but would like to respectfully request for your willingness for your child to participate in my study. The counselors-in-training will be video taped during special play times, and all tapes will be kept confidential. All attempts will be made to videotape only the counselor trainees. Your child will not be identified in the study, nor will any data be collected about your child.

The counselors-in-training will be University of North Texas students enrolled in a basic course in play therapy and will be videotaped at the beginning and end of the course. Your child would participate in one or two twenty-minute play therapy sessions. Again, no data will be collected on the child, only on the counseling students. All participants will be trained and supervised in their individual play sessions by Dr. Garry Landreth. Through the course of this study no overt risks to your child's physical or mental health will exist.

Your participation would be appreciated and very helpful as we examine the usefulness of training professional counselors in play therapy techniques to expand their ability to be effective helpers of children. Your participation is completely voluntary. I appreciate your support and willingness to participate in this study. Results of the study will be available at the termination of the study to all participants. Please feel free to call me with any questions at (940) 565-3864 or speak with Dr. Sue Bratton at 940-565-2066. This project has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940/565-3940).

Sincerely,

Roseanne P. Elling, M. Ed.
Doctoral Student
Department of Counselor Education

Please detach and return this bottom portion of the permission form to Roseanne P. Elling or Dr. Sue Bratton at The Child and Family Resource Clinic; P.O. Box 311337; University of North Texas; Denton, TX 76201. PLEASE RETAIN THE TOP PORTION FOR YOUR RECORDS.

Please indicate your willingness to have your child participate in the Doctoral Dissertation study under the direction of Roseanne P. Elling and supervised by major professors Dr. Garry Landreth and Dr. Sue Bratton described above.

◊ I do grant permission for my child ________________________ to participate in this project.

______________________________
Parent / Guardian’s Signature & Date

CHILD PERMISSION FORM FOR PARTICIPATION IN RESEARCH STUDY

The following will be read to the children whose parents grant permission for them to participate in the study. It will be read by the Principal Investigator of the study, Roseanne Elling, in the presence of at least
one witness. The children who choose to participate will agree verbally and/or in writing (if they are old enough to sign their names).

"My name is Roseanne Elling, and I am doing some work at my school, The University of North Texas, to help grown-ups learn more about working with children. I am asking some children to help me do this, and I would like to ask you to help. Your mom/dad/guardian has said I may ask if you would like to help.

"Before you decide if this is something you would like to help with, let me tell you more about what you would be doing. You would get to play in one of the special playrooms full of different kinds of toys at my school. While you are playing, a grown-up who is learning more about children would be in the playroom with you. The grown-up might be videotaped, but the person videotaping would try not to show you on tape. They would not be taping you, but the grown-up. After about twenty minutes of playing, you would get a break. Then you might get to play again with another grown-up in the playroom for about twenty minutes. Someone you know, your parent or friend, would bring you to my school and stay there the whole time you are there.

"You may ask me any questions you want about the helping me by playing in our playrooms. Do you have any questions?

"If you think of any more questions, your mom/dad/guardian has my phone numbers and may call me. Also, if you decide to help and then change your mind at any time, you will not have to help.

"Would you like to help me by visiting my school and playing in our playrooms?"

If the child agrees to participate, the witness, investigator, and if able, the child will sign below.

__________________________________
Signature of witness

Principal Investigator

_________________________      ________________________________      ______________________
Name of child                                 Signature of child                                         Date

__________________________________                                                         _______________________
Signature of witness                                                                                   Date
Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks, and discomforts of the study. It also describes the alternative treatments that are available to you and your right to withdraw from the study at any time. It is important for you to understand that no guarantees or assurances can be made as to the results of the study.

PURPOSE OF THE STUDY AND HOW LONG IT WILL LAST:
The purpose of this study is to determine whether or not a training model developed to train professionals is effective for training paraprofessionals. A play therapy training model will compare basic play therapy knowledge and skills of professional counselors-in-training with those of parents and teachers trained with a similar model. The duration of the study will be from August 28, 2000 through February 28, 2001. The subject participation will take place during the span of the fall 2000 semester, August 28, 2000-December 11, 2000.

DESCRIPTION OF THE STUDY INCLUDING THE PROCEDURES TO BE USED:
The study will involve a voluntary group of students from the EDSS 5700 Introduction to Play Therapy class taught by Dr. Garry Landreth. The students will participate in a pretest, treatment, and a posttest. The pretest will consist of being videotaped during a twenty-minute play therapy session and filling out a Play Therapy Assessment of Knowledge and Skills Survey before the semester class begins. The treatment is attending and fulfilling the requirements for Dr. Garry Landreth's fifteen week play therapy class, EDSS 5700. The posttest will require the students to be videotaped in another twenty-minute play therapy session and filling out another PTAKSS at the end of the semester. The pretest, treatment, and posttest will be administered during one semester, which consists of three hours per week for fifteen weeks. The videotapes will be reviewed by trained coders who will rate the students on the Measurement of Empathy in Adult-Child Interaction (MEACI). The videotaping will take place on campus in the playrooms at the Child and Family Resource Clinic and the Counseling and Human Development Center. The data gathered from the study will then be compared to data from two similar studies that examined Dr. Landreth's ten-week Filial Therapy training model for paraprofessional groups.

DESCRIPTION OF PROCEDURES/ELEMENTS THAT MAY RESULT IN DISCOMFORT OR INCONVENIENCE:
There will be little to no discomfort or inconvenience for the students in the experimental group in this study. Except for the initial videotaped session and PTAKSS, all of the requirements of this study are part of the normal curriculum for Dr. Landreth's EDSS 5700 class.

DESCRIPTION OF THE PROCEDURES/ELEMENTS THAT ARE ASSOCIATED WITH FORESEEABLE RISKS:
There are no identified foreseeable risks to this project.

BENEFITS TO THE SUBJECTS OR OTHERS:
The student-subjects will have the opportunity to contribute to research in their field of study. They will be a part of a study used to determine whether their base of knowledge can be applied to other populations. The students will also have the opportunity to become familiar with the play therapy facilities on campus.

CONFIDENTIALITY OF RESEARCH RECORDS:
All subjects will be identified by a non-sequential four-digit numeral during the course of this study. The correlating participant list will be kept in a locked storage file at all times. All videotapes and assessment instruments will also be kept in the locked storage file at all times. Only the Principal Investigator, Coders, and Key Faculty Member will see the videotapes. Coding will be done in complete privacy. Upon completion of the study, all videotapes will be destroyed.
RESEARCH CONSENT FORM - Page 2 of 2

Subject Name: ________________________________________ Date: _______________

Title of Study: Effectiveness of Play Therapy Training of Basic Play Therapy Skills With Professionals versus Paraprofessionals

Principal Investigator: _Roseanne P. Elling_______________________________________________________

Co-Investigators: __________________________________________________________________

REVIEW FOR PROTECTION OF PARTICIPANTS:

RESEARCH SUBJECTS’ RIGHTS: I have read or have had read to me all of the above. Roseanne P. Elling has explained the study to me and answered all of my questions. I have been told the risks or discomforts and possible benefits of the study. I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of rights to which I am entitled. Additionally, I understand that I am entitled to fully participate in EDSS 5700 whether or not I choose to participate in this study. I may withdraw at any time without penalty or loss of benefits to which I am entitled. The study personnel can stop my participation at any time if it appears to be harmful to me, if I fail to follow directions for participation in the study, if it is discovered that I do not meet the study requirements, or if the study is canceled.

In case there are problems or questions, I have been told I can contact Roseanne P. Elling at telephone numbers 972-716-0818 or 214-215-0250 or email address Roseanne2000@aol.com, Dr. Sue C. Bratton at telephone number 940-565-2066, or the UNT Institutional Review Board at telephone number 940-565-3940. I understand my rights as a research subject, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

_____________________________________                          __________________________________
Subject’s Signature                                                                     Date

_____________________________________                          ____________________________________
Signature of Witness                                                                  Date

For the Investigator or Designee:
I certify that I have reviewed the contents of this form with the person signing above, who, in my opinion, understood the explanation. I have explained the known benefits and risks of the research.

_____________________________________                         ____________________________________
Principal Investigator’s Signature                                             Date
Appendix B

Measurement of Empathy in Adult-Child Interaction
REFERENCES


