FILIAL THERAPY WITH ISRAELI PARENTS

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The purpose of this study was to determine the effectiveness of an intensive version of the Landreth (2002) 10-week filial therapy model as a method of intervention for children of Israeli parents living in Israel. This study was designed to determine the effectiveness of intensive filial therapy training in (a) reducing internalizing behavior problems of Israeli children; (b) reducing externalizing behavior problems of Israeli children; and (c) reducing overall behavior problems of Israeli children.

A second purpose of this study was to determine the effectiveness of intensive filial therapy training with Israeli parents in increasing the parents' (a) empathic responsiveness with their children; (b) communication of acceptance to their children; (c) allowance of self-direction by their children; (d) involvement in their children's play activities; (e) feelings of efficacy as parents; and (f) reduction of parental stress.

The experimental group consisted of fourteen Israeli children who their parents received nine intensive Filial Therapy training sessions within a five week period and had seven parent-child play sessions. The non-treatment comparison group consisted of thirteen Israeli children whose parents received no treatment. Parents in the study completed the Hebrew version of the Child Behavior Checklist, the Parenting Stress Index, and conducted pre-test and post-test play sessions for the Measurement of Empathy in Adult-Child Interaction.

Multivariate Analysis of Covariance revealed the children in the experimental group significantly reduced external behavior problems. The results also revealed the parents in the experimental group significantly reduced parental stress and significantly increased communication of empathy to their children.
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CHAPTER I
INTRODUCTION

Describing Israeli society in general and defining the typical Israeli family is difficult because Israel is so diverse and complex. Nevertheless, demographics and overall characteristics of Israel are useful in understanding the mainstream culture. Conducting an intervention with Israeli families requires a broader understanding of the diverse characteristics: the ways in which families differ in their countries of origin, their beliefs and values, and their parenting styles. Israel is an urban society: 90% of the Jewish population lives in cities, 24% of the labor force is employed in industry, and 70% are employed in services (Worldmark Encyclopedia of Cultures and Daily Life, 1998). The average standard of living does not fall below that of western countries like France or Italy. Given the extremely diverse population of Israel, it is difficult to define any standard Israeli ways of relating to one another. Native-born Israelis (Sabras), however, tend to be very straightforward, plain-talking people, even to the point of rudeness. They detest sentimentality of any kind and love a good argument. They are fierce and articulate; friendly and hospitable; self-confident; and ambitious and proud (Worldmark Encyclopedia of Cultures and Daily Life, 1998).

Understanding Israeli culture requires an understanding of the four types of Jews in Israel including ultra-Orthodox, national religious, traditional, and nonobservant. Each of these four types of Jews follows rabbinical law to a different degree and interprets religious and cultural tradition in a different way. The ultra Orthodox family segregates from other Israelis, sends their children to Orthodox schools, and dresses differently. National religious Jews follow rabbinical law closely and are very active in the public life of the state. The majority of Jewish Israelis are traditional Jews who follow rabbinical law to a lesser extent and treat men and women as equals. Nonobservant Jews have varying degrees of respect for religious ideas and are culturally more
similar to liberal Western individuals (Worldmark Encyclopedia of cultures and daily live, 1998).

The average Jewish family includes two parents and three children, and the children are generally cared for very well. Schooling in Israel is highly valued. Many two-and three-year-old Israelis attend preschool, which is neither mandatory nor free. Schooling is free and mandatory for children ages five to 16, and continues to be free, but not mandatory, until age 18 (Worldmark Encyclopedia of cultures and daily live, 1998). This unique weave of characteristics makes it difficult to define the typical Israeli family.

Families in Israel experience exceptional levels of stress related to the geopolitical realities, the cultural context, and the structure and traditions of everyday life. Sade-Kidron (1997) investigated the effects of chronic exposure to political events on the emotional adjustment of children living in different parts of Israel and found that children's emotional stress was higher when exposed to many kinds of political events ranging from easy, such as safety drills at school or safety checks in public places, to difficult, such as terrorist attacks or death of a family member as a result of political violence. This emotional distress was manifested in extreme feelings of fear, anxiety, and worries about threats.

Sade-Kidron (1997) hypothesized that children living in the West Bank would experience higher levels of overall emotional distress resulting from exposure to extremely high levels of difficult political events such as daily terror attacks, protection by soldiers, and death of family members and friends. However, no significant difference was found in overall emotional distress in children living in different parts of the country: most of the children included in the research study experienced a high level of emotional distress. These results signify that exposure to chronic political stress, either through first-hand exposure or through the media, affects dramatically the emotional health of children in Israel.

A recent research study conducted by Lauper (as cited by Eldar, 2003) during the wave of
terrorist attacks from May to June 2002 supports the assumption that stressful and fearful events in Israel affect children's emotional health even if they are not exposed directly to the events. Lauper found that of the 3000 children that participated in the study, 70% reported that the terrorist attacks had an impact on their lives. Approximately 43% of the children suffered from moderate to severe levels of post-traumatic stress disorder symptoms. The most severe symptoms were found among young children that were exposed to a high number of terrorist attacks. The highest rate of post-traumatic stress symptoms were found among children from religious schools in different parts of the country that experience higher levels of exposure to terrorist attacks. Lauper explained that many of these children have family members residing in areas that are exposed more to terrorist attacks, such as the West Bank and Jerusalem, and they experience more fear and worry in their lives.

A research study by Cohen, Slonim, Finzi, and Leichtentritt (2002) found that, in times of high stress and crisis, Israeli family members self-disclosed more, shared experiences and feelings, attended to the needs of others in the family, changed roles from providing support to being supported, and used humor and optimism. The results of this research support the assumption that families in Israel tend to deal with stress within the family. These results may indicate the possible flexibility of Israeli parents in adapting to a new parent training model. Utilizing interventions that teach parents therapeutic skills could increase the ability of the parents to help their children cope more effectively with the stressful circumstances in Israel.

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of Israeli parents in adapting to a new parent training model. Utilizing interventions that teach parents therapeutic skills could increase the ability of the parents to help their children cope more effectively with the stressful circumstances in Israel.

Living in a country with such high levels of stress magnifies the need for interventions that will help children and their parents cope with the stress they experience on a daily basis. By building on the emotional bond that naturally exists between the parent and child, mental health professionals can empower parents by teaching them basic psychotherapeutic skills (Smith, 2000). Filial therapy is an innovative parent training program developed by Bernard and Louise Guerney as an alternative method for treating young children with behavioral and emotional problems. Filial therapy is defined by Guerney (1980) as “. . . a behavioral method of intervening in the psycho-social development of children under eleven years of age, using the parents as agents of change. Individually or in groups of six to eight, parents are taught to conduct non-directive play therapy sessions with the instruction and supervision of professionals” (p. 227). Landreth (2002) added to this definition the importance of teaching parents to create a non-judgmental, understanding, and accepting environment that enhances the parent-child relationship.

Filial therapy has been effectively used with children presenting normal to severe behavioral and emotional problems and with families from very diverse backgrounds and stressful life circumstances: emotionally disturbed children (Sensue, 1981; Sywulak, 1979); parents of learning-disabled children (Guerney, 1979; Kale, 1997); parents of children with stuttering problems (Andronico & Blake, 1971); parents of chronically ill children (Glazer-Waldman, Zimmerman, Landreth, and Norton, 1992); single parents (Bratton and Landreth, 1995); teachers of withdrawn children (B. Guerney & Flumen, 1970); incarcerated fathers and their children (Landreth and Lobaugh, 1998); incarcerated mothers (Harris & Landreth, 1995);
parents of sexually abused children (Costas & Landreth, 1999); and parents of children from
diverse cultures (Chau & Landreth, 1997; Glover, 1997; Yeun, 1997).

Research studies on filial therapy have reported increases in parental levels of empathy
toward their children, greater parental acceptance, lower parental stress, and positive changes in
the family environment. Research studies on filial therapy have also reported significant changes
in children including positive improvements in children's adjustment, decreases in behavioral
problems, and improvement in self-concept (Bratton, 1995; Chau & Landreth, 1997; Glass, 1987;
Glover, 1997; Lebovitz, 1983; Landreth & Lobaugh, 1998; Sensue, 1981; Smith, 2000; Sywulak,
1979; Yeun, 1997).

Filial therapy can be viewed as a new kind of “creative dynamic” between parents and
children (Landreth, 2002). Filial therapy is based on the assumption that parents can learn and
effectively employ the therapeutic skills used by child-centered play therapists (Guerney, 1964).
The primary objectives of this training are to enhance the parent-child relationship, to assist
parents in acquiring play therapy skills for use in everyday life, and to help children reduce
problem behaviors and internal emotional distress (Guerney, 1967).

An intervention that focuses on strengthening the parent-child relationship in Israeli
families seems particularly appropriate in view of the political climate and stressful events
experienced by many in Israel. In such stressful life circumstances, it is important to strengthen
the family unit, to make the family relationship the anchor for children who do not have the
cognitive abilities to handle such extreme stress, and to help parents feel more competent in their
roll as parents.

Purpose of the Study

The purpose of this study was to determine the effectiveness of an intensive version of the
parents living in Israel. This study was designed to determine the effectiveness of intensive filial therapy training in (a) reducing internalizing behavior problems, such as withdrawal, somatic complaints, anxiety, and depression of Israeli children; (b) reducing externalizing behavior problems, such as aggression and delinquency, of Israeli children; and (c) reducing overall behavior problems, including internalizing and externalizing behavior problems, social problems, thought problems, and attention problems of Israeli children.

A second purpose of this study was to determine the effectiveness of intensive filial therapy training with Israeli parents in increasing the parents' (a) empathic responsiveness with their children; (b) communication of acceptance to their children; (c) allowance of self-direction by their children; (d) involvement in their children's play activities; (e) feelings of efficacy as parents; and (f) reduction of parental stress.

Literature Review

Characteristics of the Israeli Society

Israel's existential reality is often referred to in the literature when therapeutic issues and family interventions are examined (Halpern, 2001). Israel has struggled and continues to struggle with unusual circumstances and unique dynamics operating within the society that have a powerful impact on Israeli families. Historically, Israelis have lived with an unusually high stress level. The ecology of stress in Israel results from complex historical forces, geopolitical isolation, and armed conflict. The social and political forces which have contributed to this stress include the legacy of the Holocaust, the advent of several wars during one generation, the Arab-Israeli conflict, and the challenge of absorption of waves of Diaspora Jews (Good & Ben-David, 1995).

Holocaust survivors and their families. It has been 58 years since the end of World War II, yet Holocaust survivors, their children, and their grandchildren continue to experience its devastation (Good & Ben-David, 1995). Three generations of Holocaust survivors often need
help because of the multigenerational transmission of the unresolved issues of anger, guilt, grief, loss, abandonment, and a host of powerful emotions (Felsen & Erlich, as cited in Good & Ben-David, 1995; Danieli, 1987).

_The effects of the war on families._ The birth of the state of Israel was marked by the Independence War (1948) and in the nearly five decades that have followed, there have been four other major wars between Israel and its neighbors. For the Israeli people, the impact of a war is immediate because of the geographic proximity of the battlefront as well as the high probability of having family members or friends on active duty. The emotional toll has ranged from combat fatigue to rehabilitation problems to changed dynamics centered on the experience of war (Lavee & Ben-David, 1993; Rabin & Nardi as cited in Good & Ben-David, 1995). Loss and bereavement are common features of Israeli life. Whether the loss is from the holocaust, from war, or from political terrorism, there is hardly a family in Israel that is not plagued by it (Good & Ben-David, 1995). The presence of post-traumatic stress disorder symptoms in family members, especially the husband, affects the entire family unit and the secondary traumatization of wives has been found, at times, to lead to severe marital distress (Solomon as cited in Halpern, 2001).

_The impact of the Arab-Israeli conflict._ The Arab-Israeli conflict has taken a major toll on the lives of Israelis. Terrorism, as an outgrowth of hostility between the Jews and Arabs dating back to the post-World War II period, has long been a fact of life for the average Israeli. Israeli families live in a constant state of vigilance because of the prospect of real and perceived dangers lurking just around the corner (Good & Ben-David, 1995, p. 357). As reported by the Israeli police, during 2002, there were 1,781 terrorist attacks in Israel. Four hundred fifty-six citizens were killed and 2,343 citizens were wounded in the attacks (Ben-Ami, 2003). The dynamic of the conflict reveals a spillover into everyday life, especially in its centrality to the individual lives of Israelis and Palestinians, which involves a tremendous emotional response and concerns about
existence and survival. The implications of this unresolved conflict continue to increase the atmosphere of stress even in the absence of overtly belligerent conditions (Rouhana and Bar-Tal as cited in Halpern, 2001).

The effects of absorption of immigration. In the past 10 years, Israeli society has faced a unique challenge. The primary population growth of the country of Israel has occurred through absorption of immigrants, who outnumber native-born Sabras (Halpern, 2001). Immigrants from all over the world have moved to Israel and have caused a major change in the face of the society. Between 1980 and 1993, a massive wave of approximately 200,000 immigrants from the former Soviet Union and Eastern Europe and about 55,000 immigrants from Ethiopia moved to Israel (Good & Ben-David, 1995).

Good and Ben-David (1995) maintained that in a pluralistic society, such as Israel, a conflict in values is expected and inevitable. The gathering of Jews from distant and diverse cultures has formed Israel. Since the most recent influx of immigrants has been from non-western cultures, a clash in values is expected.

Individual families and the larger society have dealt with enormous economic and social problems involving the absorption of more than half a million immigrants into a society of five and a half million in five years. Israeli families, living in hard economic conditions, have questioned the wisdom of admitting such large numbers of immigrants, as unemployment and rising crime have mad them uneasy. As a result, the new immigrants have faced an undercurrent of hostility as the nation's economic resources are stretched (Good & Ben-David, 1995).

In the process of immigration, families have experienced great difficulties due to the abrupt changes involved in immigration. In a research study that explored family relations as related to the process of absorption, parents reported a loss in authority over their children, reflecting a breakdown in the intergenerational hierarchy that typified the family system in the
country of origin, which was partly eroded by the children's increased autonomy in the process of their integration into the Israeli youth culture (Sharlin & Elshanskaya as cited in Halpern, 2001). Sharlin and Elshanskaya (as cited in Halpern, 2001) hypothesized that the process of acculturation in the new environment by the young members of immigrant families increased the emotional distance between family members. The Family Interaction Pattern Model proposed by Kagitcibasi (1996) purports that these changes are part of broader changes that affect the family prototype around the world in which the family pattern involves material independence and emotional interdependence at the intergenerational level.

As a result of the societal and historical events, a common belief was that, as long as the country was preoccupied with issues of survival, Israeli society was somehow different and was, therefore, less vulnerable to the social problems found elsewhere. However, Israeli society has faced, at the same time, "common" social issues such as family violence, unemployment, immigration, divorce, drug use, rising crime, and delinquency (Good and Ben-David, 1995).

**Israeli Parenting**

Styles of parenting in Israel have been affected by the sociological and demographic developments related to immigration and the multicultural nature of the population (Ben-Israel, 2003). Historically, the small Jewish community that lived in Palestine before the twentieth century was a highly conservative and wholly religious society. Parenting followed the pattern which was laid down by religious prescriptions such as “honor your father and mother” and values that had been typical of Jewish communities for centuries. Families were large and mostly poor, but the most important goals were to keep the family together, guard it against modernization and secularization, invest all resources and authority in the education of the sons to help them become serious religious scholars, and prepare the girls for the role of mothers and housewives. Parenting styles were usually authoritarian in combination with warmth and caring.
Discipline was valued, but the norm was guidance rather than harshness. The goal of families was the assimilation of the love of learning and of a virtuous life. If, however, a son or daughter rebelled against accepted customs and beliefs, especially if the child abandoned religious observance, the child usually left the home and was mourned as if the child had died (Ben-Israel, 2003).

Israeli culture changed dramatically with the beginning of a new kind of immigration into Palestine in the twentieth century. The new immigrants, who called themselves pioneers had rebelled against traditional customs and adopted a new style of life and new goals for themselves and for their children. Alongside the traditional religious society, there grew a secular, farming, agricultural society of pioneers who saw themselves as revolutionizing the way of life for their people. They brought up their children to be hard-working, self-reliant, autonomous in their behavior, and independent in the choices they made. They believed that their children should feel free to pursue their own personal fulfillment, value freedom, strive for equality, and they placed society above everything else. Parenting among pioneering communities became strongly future-oriented, with parents working very hard and collectively devoting their best efforts to the raising of a new generation which would be almost like a new brand of humanity (Ben-Israel, 2003).

This style of upbringing, though prompted by high ideals, had a tremendous effect on the emotional health of the children. It created distance between the parent generation and the next generation. In the farming communes, called the Kibbutz, children were brought up by the community, or by the system, and not by their individual parents. Children lived together in homes for children and only saw their parents for a few hours after work. Some of the children brought up this way later complained that it did not satisfy their emotional needs. Although freedom was encouraged, it had its limits. Children who demonstrated from early childhood, or in adolescence, deviant characteristics antagonistic to the puritanical world view of the community
could undergo a very painful socialization process. Nevertheless, the “products” of this system were generally regarded as highly successful, and this created the dominant model for parenting in the community as a whole, affecting also families that did not live within the Kibbutz. A certain uniform goal was created for the whole community: to raise a new generation that would be modern, free, equal, active, socially responsible, and ready to sacrifice for the good of the community (Ben-Israel, 2003).

After the establishment of the state of Israel in the mid-twentieth century, the Kibbutz ideal remained dominant for a while, but conditions changed drastically. The waves of immigration from various parts of the world in the 1960's brought with them a multicultural presence. At first the ideal model of raising children continued to be both imposed by the educational system representing the dominant and local population and pursued by the immigrants themselves, who hoped their children would also become like the local brand of young men and women, the "sabras." In time, however, the process of achieving a melting pot was both abandoned and consciously rejected (Ben-Israel, 2003).

An important reason for abandoning the idea of creating a homogeneous society was the realization that it destroyed immigrant families by undermining the authority and even the self-respect of the patriarchal families in traditional families or by making the head of the family seem backward and primitive compared to his sons and daughters. The general trend in the world, especially since the 1970's, towards greater respect for ethnic traditions also caused second thoughts concerning the advantages and, indeed, the moral appropriateness of inducing drastic changes in the style of parenting among immigrant groups. The situation today is that of a highly differentiated society, with various approaches to parenting and education strongly characterizing the different groups. The widest gap between cultural groups is between the Jewish and Arab sectors. Although a part of the Arab minority in Israel has acculturated to the extent of allowing
their daughters to have educational opportunities, the general norm is still that of sharply
distinguishing between sons and daughters in all respects (Ben-Israel, 2003).

Within the Jewish Israeli community, too, variety is the rule. Orthodox, very religious
communities have their own educational system and, in their homes, they continue the pre-
modern styles of life, which have been practiced by their families for generations. Much love and
care is invested in the children, but great conformity is required and imposed. Children do not
have the option of becoming less religiously observant or free thinking and remain in the home.
The mothers, who are often the providers for the family (since the fathers often devote their time
to Torah study), do have a respected position in the family, but formally, it is a paternalistic
society in which young people are not even allowed to choose their wives and husbands (Ben-
Israel, 2003).

Even within the secular society there are great differences. Two groups of recent
immigrants stand out as retaining their old identities. The immigrants from Russia, for example,
believe that they come from a high culture that they want their children to retain rather than lose
by assimilating into Israeli society. Children are provided with extra schooling in addition to their
attendance at state schools so as to meet the high standards set for them by their parents, who
value education and professional success as well as the customary European values of
proficiency in art and music. Due to this intentional distancing from Israeli society, there is a high
percentage of school dropouts, juvenile delinquency, and maladjustment among Russian
immigrants (Ben-Israel, 2003).

Immigrants from Ethiopia constitute the group most widely separated from other groups
in Israel. Most of them came from villages where the structure of families and the style of life
were centuries behind what is commonly considered modern. Immigration to a totally different
country in every respect is, for most individuals, a traumatic experience. Some of the young
Ethiopian people who have acculturated are aware of the plight of their community and of the extent to which the cures for it depend on changing not only the prejudices of general society toward the Ethiopians but also the paternalistic and archaic family structure of the Ethiopians themselves. One apparent truth is that it is impossible to remain totally faithful to ethnic styles of life and at the same time integrate into the general society and win high positions within it. If parents encourage their children to remain more faithful to the old language than to master the new one, they cannot expect to make progress in the educational and professional systems (Ben-Israel, 2003).

Other immigrant societies have similar problems, mainly between traditional and modern styles of parenting. These problems are further complicated when there are also racial and religious differences and when the system of education is not made sufficiently uniform to overcome the cultural diversity of the next generation. Styles of parenting cannot be relied on to help in this process. On the contrary, parents tend to raise their children as they had been raised in their old countries, and that intensifies differentiation (Ben-Israel, 2003).

The style of parenting prevalent among most young and well-educated Israeli families today is characterized by openness to psychological analysis and prescription to the “right” way of bringing up children. The subject of parenting attracts a great deal of interest, and there exists a conscious effort to not repeat what many young people consider to have been their own parents' mistakes. Another strong tendency among young parents is the sharing of responsibility between father and mother for raising children with limited fixed ideas about the distribution of power. In numerous families, fathers and mothers share the rearing of children as they do other responsibilities (Ben-Israel, 2003).

Parenting also includes a great deal more play with the children than it did previously, even among progressive and modern parents. There is also a demonstrable shift from the notion
of “control” to the notion of warm support as the chief instrument to be used. In fact, it
sometimes seems that the desire to be entirely attuned to the child's emotional needs has driven
out all remnants of the traditional concepts of parenting which prevailed in traditional societies.
Judging by precedents in other fields, it is likely that this extreme reaction against restrictive
parenting will in time be moderated to produce a more balanced style, which is perhaps to be
expected in immigrant societies more than in homogenous ones (Ben-Israel, 2003).

Filial Therapy

Filial therapy is an intervention for parents developed in the 1960s by Bernard and Louise
Guerney as an alternative method for treating young children with behavioral and emotional
problems. Using a small group format, filial therapy is presented to parents through didactic
instruction, viewing videotapes, and role-playing (Guerney, 1964). The major therapeutic
strategy is to train parents to become the therapeutic agent in their children's lives by teaching the
parents to conduct special play sessions modeled after child-centered play therapy practiced by
parents have completed the initial training period, they conduct regularly scheduled, special play
sessions with their children while receiving supervision through the filial support group meetings.

Bernard and Louise Guerney were not the first to utilize a play time between a parent and
a child for therapeutic purposes. As early as 1909, Freud (1955) instructed the father of "Little
Hans" to conduct play times with his child. Freud successfully treated the young boy's phobias by
instructing the father regarding play times in the child's play at home. An early example of the
utilization of play therapy principles and skills was the case of Natalie Rogers Fuchs (1957). Her
daughter was having difficulty during toilet training. Fuchs was instructed by her father, Carl
Rogers, to have special play times with her daughter using specific toys, based on the writings of
Virginia Axline (1947). Fuchs' special play times with her daughter eventually resulted in an
Moustakas (1959) recommended that parents have play sessions with their children modeled after traditional play therapy. Moustakas stated that play therapy in the home enhances the relationship between children and their parents, helps children discover themselves, and teaches children to release tensions and express feelings by learning emotional expression.

Moustakas (1997) explained that, through their play, children invite their parents to visit their world and learn what is important to them. By playing with their children, parents have the opportunity to convey their valuing of their children, and their acceptance, support, and understanding of them. Recognition of the meaning of their children's play enhances the parent-child relationship.

Filial therapy is a parent training program focused on strengthening the parent-child relationship. Parents use child-centered play therapy skills to conduct weekly special play times with their child. It is within the special play time that the parent-child relationship is developed and strengthened and this unique relationship enables emotional expression, problem solving, and effective limit setting (Sweeney, Homeyer, & Pavlishina, 2000).

**Child-Centered Play Therapy**

Filial therapy is essentially the application of child-centered play therapy skills by parents. The child-centered approach is based on the nondirective counseling theory developed by Carl Rogers (1955) and applied to children by Axline (1947), Dorfman (1951), and Moustakas (1959). The child-centered approach makes no effort to control or change the child and is based on the theory that the child's behavior is at all times caused by the drive for complete self-realization (Landreth, 1993).

Play therapy is based on the belief that children do not communicate in the same way as adults. Adult communication requires both verbal abilities and abstract thinking skills, and
children often lack the cognitive and verbal capabilities to express themselves verbally (Landreth, 1993). According to Piaget (1962) the nature of adult verbal communication is complex, sophisticated, symbolic, and abstract. Verbal communication contradicts the operational nature of childhood, child's play and the concrete world of children. Play is the child's symbolic language of self-expression, a natural medium of communication, and concrete connection in coping with their world (Landreth, 2002). Children play out their experiences and feelings in a natural, dynamic, and self-healing process (Landreth, 1993).

In play therapy, children build up their confidence in dealing with their environment, and they experience all parts of the self because self-directed play is safe. Using selected toys, play provides a way for children to express their emotions and fears and helps them develop a capacity for synthesis of organization and affect (Landreth, 2002). Play therapy serves two major functions: aiding in the development of the therapist-child relationship and providing a vehicle for change (Russ, 1995).

In child-centered play therapy, the relationship is the key to growth (Landreth 2002). Moustakas (1959) described the relationship between the child and the therapist as unique and as the core of the therapy. He stated that the relationship must convey a deep belief in the child as a person and in the child's potential for growth; the parent must provide acceptance of the child exactly as the child is and must communicate respect for the child's values, ways, peculiarities, and playtime symbolism. The child-centered play therapist allows the child freedom to direct his or her personal growth. Without interpretation, evaluation, or labeling, the therapist creates limits within the playroom that compliment the development of a therapeutic relationship and help to make the experience a real life one (Landreth, 2002; Moustakas, 1959).

Axline (1969) described the role of the child-centered play therapist in eight basic principles that guide the therapist in all therapeutic contacts with a child: (1) the therapist must
develop a warm, friendly relationship with the child, and establish good rapport as soon as possible, (2) the therapist accepts the child exactly as he is, (3) the therapist establishes a feeling of permissiveness in the relationship, so the child feels free to express his feelings completely, (4) the therapist is alert to recognize the feelings the child is expressing and reflects the feelings back to him in such a manner that he gains insight into his behavior, (5) the therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so and gives the child responsibility to make choices and to institute change, (6) the therapist does not attempt to direct the child's actions or conversation in any manner allowing the child to lead the way, (7) the therapist does not attempt to hurry the therapy along because it is a gradual process and the therapist recognizes it as such, and (8) the therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship (p.73-74).

*Rationale for Filial Therapy*

The rationale underlying filial therapy training is based on the hypothesis that if parents can learn the role of therapist, they can be more effective than a professional because the parent naturally has more emotional significance in the life of the child (Sweeney, Homeyer, & Pavlishina, 2000). Parental involvement in a child's developmental process is a primary therapeutic agent that facilitates the parent's motivation and tends to eliminate the typical parental resistance that is encountered when the parent is not involved in the child's therapy. Training the parent as a therapeutic agent also diminishes the problems that otherwise are aroused when the parent does not develop appropriate responses to new child behavior patterns (Guerney, et. al. 1999; Landreth, 2002; Stover and Guerney, 1967; VanFleet, 2000). The attention by the parent to the child can prove to be therapeutic, even if for a short period of time, and the training of filial therapy can serve the parent long after formal therapy has ended (Guerney, 1969).
Guerney (1969) suggested that the primary source of maladjustment, for many children living with their families, could logically be traced to interpersonal relationships within the family. Filial therapy teaches parents new ways of interacting with their children, thus improving the parent-child relationship (Guerney, et. al. 1999; Landreth, 2002; VanFleet, 2000). The parent is the most emotionally significant adult in the child's life. The parent's focus on the child in the process of filial therapy encourages the child to unlearn anxieties learned by the parental influence and clarifies miscommunications by the parent (Guerney, et. al. 1999; Sweeney, 1997).

Filial therapy is based on the therapeutic nature of play and the parents' ability to learn to assume the therapeutic role required of them for a short period of time under special conditions (Johnson, 1995). The parent's new role permits a child to explore personal struggles by breaking previous patterns of parent-child interaction. It is expected that parents will generalize new patterns of interacting outside of the play sessions (Guerney, Guerney, & Andronico, 1966). According to Guerney (1964), the objective of the play sessions is to change the child's perceptions or misperceptions of the parent's feelings, attitudes, or behavior toward the child; allow the child to communicate thoughts, needs, and feelings to parents which have previously been kept from the parents; and bring the child a greater sense of self-respect, self-worth, and confidence.

Landreth (2002) suggested that filial therapy training enhances parents' sensitivity to their children as they learn how to create a non-judgmental, understanding, and accepting environment through which children are able to explore new aspects of self and new ways of relating to their parents. Filial therapy training typically takes place in a small group of six to eight parents. This small group format provides a supportive, encouraging learning environment for parents and ample time for each parent to receive encouragement and support from the instructor.

Van Fleet (1994) summarized the goals of filial therapy as a way to (a) eliminate
presenting problems at their source; (b) develop positive interactions between parents and their children; and (c) increase families' communication, coping, and problem solving skills so they are better able to handle future problems independently and successfully.

A few differences exist between filial therapy models. The Guerney (1964) model usually requires six months to a year of training. The first phase of the training includes several weeks to prepare parents before initiating parent-child play sessions. Landreth (2002) developed a filial therapy training model that collapses parent training into a 10-week parenting class that meets two hours each week and prepares parents to begin playtime sessions after the third training class.

Toys and materials. The filial therapist facilitates the child's expression of a wide range of feelings by providing carefully selected toys. Items likely to direct a child's play, such as books or electronic toys, are avoided. The availability of items such as a bop bag, dart gun, and dinosaur, convey a message to the child that anger and aggression are accepted. Inappropriate aggressive or harmful behaviors are redirected to acceptable outlets. Baby bottles, dolls, and kitchen food facilitate the expression of nurturance. A dollhouse and associated figures and furniture are often used in the expression of family issues (Landreth, 2002).

The play kit should include expressive media such as paint, crayons, markers, paper, and clay. These items encourage a variety of expression. The inclusion of a ring toss game, blocks, and play money can facilitate the expression of mastery, competition, and cooperation themes. Other recommended items are puppets, a baby bottle, container with water, small plastic soldiers, Play-Doh, and rope (Landreth, 2002).

Research on the Effectiveness of Filial Therapy

The efficacy of filial therapy has been verified with numerous research studies. Smith (2000) categorized empirical research on filial therapy into six areas of study: (1) effectiveness of parents as therapeutic agents of change with their children; (2) effectiveness of filial therapy with
children who have various types of emotional, symptomatic and behavioral problems; (3) effectiveness of methodology and integration of essential components of the model; (4) effectiveness in strengthening the parent-child relationship and effectiveness of parents as therapeutic agents of change versus professionals and paraprofessionals; (5) effectiveness with unique populations of families living with risk factors and extremely difficult life circumstances; and (6) effectiveness of filial therapy with culturally different populations.

Effectiveness of parents as therapeutic agents of change. Andronico and Guerney (1967) investigated the effectiveness of filial therapy in a school setting. They reported significant reduction in parental blame by the school for children's problems and positive increases in parental motivation to enter and maintain a commitment to children's therapeutic treatment. These results were believed to be related to the reduction of parents' feeling of helplessness to facilitate positive change in their children as a result of the filial training.

Stover and Guerney (1967) utilized filial therapy training with mothers and found a significant increase in the observed frequency of reflective statements and a decrease in directive statements. Positive change in the parent-child relationship and children's general emotional development was supported by self-report. Guerney and Stover (1971) investigated the effectiveness of filial therapy with 51 mothers and their children. The results of the study confirmed the findings from the earlier study. Significant increases were found in the mothers’ ability to apply the play therapy skills needed to appropriately reflect feelings, allow their children self-direction, and demonstrate appropriate involvement in their children's affective behavior and emotional expression. Clinical assessments revealed improvement in the psychosocial adjustment and symptomatology in all 51 children. The children also demonstrated significant increases in several areas including increased interaction with their mothers, appropriate expression of aggression, appropriate sharing behaviors, and decreased dependence.
Due to the absence of a control group in the Guerney and Stover (1971) study, Oxman (1972) used the parents from their study as an experimental group and matched them on demographic data with volunteer parents as a control group. Filial therapy mothers reported a significantly greater improvement in the behavior of their children than did the control group mothers.

Guerney (1975) conducted a longitudinal qualitative study of 42 participants in the Guerney and Stover (1971) study three years after treatment termination. He found significant longitudinal findings: only one of the 42 children required treatment after the filial training; 32 mothers reported continued improvement in their children, while four reported regression, and one reported deterioration; 64% of the mother's attributed the continued growth to their own ability to understand their child. In addition, the mothers reported an overall positive evaluation of the filial therapy training program. This follow up study confirms the effectiveness of filial therapy training as long as three years after completion of training.

In an attempt to control for potential differences between parents who seek professional help and those who do not, Sywulak (1977) utilized a design in which participants served as both the control and treatment group for a study of filial therapy. Thirteen mother/father pairs and six single mother participants completed assessments four months prior to training, at a two-month mid-point in training, and after four months of training. The study revealed significant improvement in child adjustment and parental acceptance after two months of training and this improvement was maintained after four months of training.

Sensue (1981) conducted a three-year follow-up study of the Sywulak (1977) study that found that filial therapy significantly increased parental acceptance and perceived child adjustment in the treatment group after four months of training. The positive results Sywulak reported were maintained three years later: parents reported maintaining positive change as a
result of filial therapy training and received significantly higher scores on acceptance of their children than did the parents in the control group. The children who were formerly diagnosed as maladjusted were as well adjusted as the control group children.

Glass (1986) investigated Landreth's (2002) 10-week filial therapy model and found that parents who received the training reported a significant increase in unconditional love for their children, an increase in their level of understanding of their children's play, and a decrease in the level of conflict as compared to a control group. Glass reported other positive changes: the parents scored significantly higher in parental acceptance, respect for children's feelings, recognition of children's need for autonomy, and closeness between parents and children.

_Filial therapy with various child problems._ Filial therapy research has been applied in various settings and with varied populations. Stollak (1969) trained college students to conduct special play times with children. Twenty volunteer college students received ten weeks of filial training and then conducted play times with children referred to an on campus clinic. No control group was used, and only children with severe mental retardation, severe emotional disturbance, or brain damage were excluded from the study. Stollak found that the undergraduate students made significant improvements in reflections of content and feelings as a result of the filial training.

Guerney and Flumen (1970) conducted filial therapy training with teachers of highly withdrawn children. All children in the experimental group showed a consistent pattern of increased assertiveness whereas the children in the comparison group did not show such a pattern. There was a significant correlation between the adequacy of the teacher to perform the therapeutic role and change in the child's academic performance.

Andronico and Black (1971) implemented filial therapy training with parents of children with stuttering problems and noted that a reduction in stuttering followed parents learning to
inhibit their tendency to interrupt or pressure the child, changing interaction patterns with the child, and refocusing energy on the parent-child relationship. Gilmor (1971) studied the effect of filial therapy on children with learning disabilities and discovered that children improved significantly in their academic and social functioning.

Boll (1972) examined the effectiveness of filial therapy training with a group of parents of mentally retarded children. He compared two experimental groups with a control group. One experimental group was trained in traditional filial therapy, the other experimental group was trained in filial therapy and given additional instruction on specific reinforcement and extinction techniques. Both groups trained in filial therapy reported improvement in their children's socially adaptive behavior, with the most change occurring in the traditionally trained group. The traditionally trained filial group reported greater satisfaction from the training, closer relationships with their children, and more consistent attendance in the meetings than did the other filial group.

Guerney (1979) studied the use of filial therapy with parents of children diagnosed with different disorders that were essentially organic in origin, including learning disabilities, hyperactivity syndrome, physical disabilities, and mild retardation. It is generally accepted that children with physical disorders are typically more vulnerable to a negative self-concept, dependency on parents, and a lack of self-control. The children who received filial therapy showed a significant increase in positive feelings about themselves and others, greater independence, and increased self-control.

Kale and Landreth (1999) researched the effects of the Landreth (2002) 10-week filial therapy training model and found that filial therapy training significantly increased parental acceptance and decreased parenting stress of parents of children experiencing learning difficulties as compared to a control group.
Filial therapy methodology. Wall (1979) examined the efficacy of play therapy provided by three groups: master-level trained play therapists, parents who received filial therapy training and conducted special play-times with their children and a control group with untrained parents. The purpose of this study was to assess the viability of parents trained as play therapists in comparison to graduate therapist trainees. Parents who received filial therapy training improved their ability in empathic communication with their children. Wall suggested that the parent's ability to accept negative feelings and respond empathetically might have a more powerful effect on the children than the same acceptance from a therapist.

Payton (1980) compared the effectiveness of filial therapy training on parents and paraprofessionals. Parents and paraprofessionals received filial therapy training for twelve weeks. Parents in filial therapy training reported significantly higher scores on parenting attitude and improvement in children's behaviors as compared to the paraprofessionals and the control group. Payton concluded that parents were more effective in affecting personality adjustment in their children's personality than paraprofessionals.

Kezur (1980) analyzed mother-child communication patterns before and after filial therapy training and examined the effects of those communication patterns on the mother-child relationship. The mothers in the experimental group received filial therapy training while their children were in play therapy sessions led by a trained therapist. The results of the study indicated improvement in parental communication skills and marked improvement in the self-esteem of the children and of their mothers. The children who expressed anger toward their mothers in their play therapy with a professional therapist become more open and communicative with their mothers in the parent-child play sessions. Mothers who learned to honor their own needs were found more able to meet the needs of their children, and the mother-child relationship became more positive as both gained in self-esteem. The mothers who took advantage of the
opportunity to review videotaped parent-child sessions and to receive feedback in class made the most gain in implementing the skills and in enhancing the parent-child relationship.

Dematatis (1981) conducted a study that compared the effectiveness of the traditional Guerney (1964) filial therapy model with a filial therapy training program combined with affect simulation and videotaped recall, modeled after Kagan's Interpersonal Process Recall (IPR) training (Kagan, 1990). Results indicated that the addition of affect simulation and IPR videotape recall did not increase the effectiveness of parents in eliciting or responding more therapeutically to their children than the parents receiving traditional filial training.

Lebovitz (1982) compared the effectiveness of filial therapy with a group of mothers receiving filial therapy training, a group of mothers receiving supervision of play sessions (without filial training), and a control group of mothers receiving no training. The mother's therapeutic skills were assessed and parents, teachers, and independent observers assessed change in children's behaviors. Assessments of children in both the filial group and the supervised play session's group revealed less behavioral problems as compared to the control group. The mothers in the filial therapy group reported a significant increase in communicating acceptance of feelings, in allowing the children more self direction, and in involvement with their children than did mothers in the supervised play session group or the control group. The mothers in the filial training group also reported greater decreases in children's problem behavior and in dependence on their parents than did the supervised play session group or the control group. Mothers in the control group reported the most problems and the least change.

Bavin-Hoffman (1994) examined the longitudinal effects of Landreth's (2002) 10-week filial therapy model on relationships in the families one to three years after filial therapy. Significant findings after participation in filial therapy training indicated that family functioning increased in the areas of improved parent-child communication, improved partner
communication, and improved child behavior, specifically including an increase in self-control and a decrease in aggression. Other findings suggested that as a result of the filial therapy training there was increased unity in parenting techniques, in child discipline, in values, and in the couple's relationship. This study points to the fact that when parents are more unified in parenting goals and discipline strategies, there is greater marital harmony and reduced parenting stress.

Brown (2000) investigated the effectiveness of a condensed version of the Landreth (2002) 10-week filial therapy training model in developing undergraduate teacher trainee awareness and use of relationship skills with children. This training resulted in statistically significant increased levels of empathy, acceptance, allowance of child self-direction, appropriate involvement with the child, play therapy skills, and play therapy knowledge as compared to a control group.

Smith (2002) studied the effectiveness of the Landreth (2002) 10-week filial therapy training model in increasing communication of empathy, attitude of acceptance, and allowance of self-direction among teachers of deaf-and-hard of hearing preschool students. The experimental group consisted of twelve teachers who received the filial training and conducted play sessions with their student of focus. The control group received no treatment. He found that the children in the experimental group significantly decreased overall behavior problems. Teachers in the experimental group increased communication of empathy with their students of focus, significantly increased their attitude of acceptance of their students, and significantly increased in their ability to allow the students appropriate self-direction.

change in the parent-child interaction. Parents refocused and normalized their attention on the child and not on the child's illness. Parents also reported being able to better assess their child's level of anxiety and match it to their own. They stressed the importance of positive interactions shared with their child during the play session in contrast to their former primary focus on the child's illness. Tew, Landreth, Joiner and Solt (2002) also used the Landreth (2002) 10-week filial therapy model in working with families with chronically ill children. They found filial therapy significantly strengthened and enhanced parent-child relationships, decreased parent stress, increased parental attitude of acceptance, and decreased problematic behaviors of chronically ill children as compared to a control group.

Landreth and Lobaugh (1998) studied the effectiveness of Landreth's (2002) 10-week filial therapy training model with incarcerated fathers. The fathers in the treatment group demonstrated significantly increased parental acceptance, appreciation of the child's unique makeup, recognition of the child's need for independence, and unconditional love, as well as significantly reduced parenting stress as compared with a control group of incarcerated fathers. They also reported significant positive change in the fathers' sense of competence and a new level of attachment to their children. Children in the treatment group demonstrated highly significant increases in their self-esteem and a decrease in problematic behavior as observed by the parent.

Bratton and Landreth (1995) examined the effectiveness of Landreth's (2002) 10-week filial therapy model with single parents. The mothers who received filial training showed significant increases in attitudes of acceptance toward their children, empathic behavior, and reported feeling more competent and effective as parents when compared to a control group. Parenting stress was significantly reduced in the treatment group as well, and parents reported significantly fewer problems with their children's behavior.

Harris and Landreth (1997) investigated the effectiveness of a condensed version of the
Landreth (2002) 10-week filial therapy-training model in prisons with incarcerated mothers. The mothers received filial therapy training twice a week for five weeks. Harris and Landreth reported significant positive increases in the mothers’ empathic interactions with their children, increases in attitudes of acceptance towards their children, and a reduction in the number of problems with their children's behavior in comparison to the control group.

Costas and Landreth (1999) investigated the effectiveness of the Landreth (2002) 10-week filial therapy training model as a method of intervention for non-offending parents and their children who had been sexually abused. The experimental group parents showed evidence of significantly increased level of empathy and acceptance toward their children, as well as reduction of parental stress as compared to the control group parents. At the completion of training, the experimental group’s parents rated their children's behavior within the normal range. Costas and Landreth noted that as a result of the training, the non-offending parents learned the importance of allowing their children to be self-directed. This is especially important because non-offending parents are often so overly protective that they inhibit the natural flow of their children's expression and play.

Smith (2000) conducted a comparative analysis of an intensive filial therapy model of the Landreth (2002) 10-week filial therapy model, intensive individual play therapy, and intensive group play therapy with children who had witnessed domestic violence. An experimental group of mothers received 12 intensive filial therapy-training sessions within a three-week period. Smith noted that filial therapy was as effective in reducing children's problematic behaviors as professional intensive individual play therapy and intensive sibling group play therapy. Intensive individual play therapy was more effective in improving children's self-concepts. The children in the filial therapy training group demonstrated significant increases in their self-esteem and decreases in their problematic behaviors. The mothers showed significant increases in conveying
empathy to their children, communicating acceptance of their children, and allowing their children self-direction as compared to the control group.

*Filial therapy with culturally different populations.* Although filial therapy was developed in the United States, Sweeney and Skurja (1999) stated that it should not be considered an American intervention. The population in the United States represents many different countries and cultures with varying degrees of acculturation that have served as a model laboratory for investigating the effectiveness of filial therapy as a cross cultural intervention.

Recent research studies have investigated the effectiveness of the Landreth (2002) 10-week filial therapy model with various cultures. In a quantitative study of Native Americans parents and their children, Glover and Landreth (2000) utilized the Landreth (2002) 10-week filial therapy model with parents on the Flathead Reservation in Montana and found significant positive results in increased level of parental empathy, parental acceptance, and reduction of parental stress as compared to a control group. Child participants experienced a significant increase in level of desirable play behaviors with parents and improvements of their self concepts.

Chau and Landreth (1997) examined the effectiveness of the Landreth (2002) 10-week filial therapy model with first generation Chinese immigrant parents and their children in the United States. All assessment instruments and filial therapy instruments were translated, and the training was conducted in Mandarin. They reported that the parents in the experimental group showed significant increases in the parent's empathic interactions, in full attendance to the child, in acceptance of expression of positive and negative feelings, in allowance of child self-direction, in implementation of therapeutic skills, in demonstration of unconditional love, and in recognition of their child's need for autonomy as compared to the control group. The parents in the experimental group also showed a highly significant decrease in their stress level related to
parenting as compared to the control group.

Yuen, Landreth and Baggerly (1997) utilized the Landreth (2002) 10-week filial therapy training model with Chinese immigrant parents in Canada. They found a significant increase in parental empathic behavior, acceptance of the child, and a significant decrease in level of stress related to parenting and in parental perceived problems in their children.

Jang (2000) studied the effectiveness of the Landreth (2002) 10-week model of filial therapy of enhancing the parent-child relationship of Korean parents in Korea. Although the training focused on the mother and a child of focus, Jang reported positive results of the filial training generalized to other relationships within the family. The qualitative results showed an increase in the mothers' level of sensitivity to the needs of their children, improved couple communication, improved relationships with other family members, and increased empathy and parental acceptance. The mothers also reported decreases in parental stress and in children's behavioral problems.

Lee (2002) investigated the effectiveness of the Landreth (2002) 10-week model of filial therapy in enhancing the parent-child relationship of immigrant Korean parents in the United States. The control group received no treatment. The results of the study confirmed the effectiveness of filial therapy training in increasing the parents’ levels of empathic interaction with their children, in increasing the parents’ attitudes of acceptance toward their children, and in reducing the parents’ levels of stress related to parenting.
CHAPTER II

METHODS AND PROCEDURES

The purpose of this study was to determine the effectiveness of filial therapy training with Israeli parents in Israel. This chapter presents the method and procedures for data collection in this study. Sections included are definition of terms, research hypotheses, methods, recruitment of subjects, procedures, analysis procedures, and limitations of the study.

Definition of Terms

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

Communication of Acceptance involved the verbal expression of acceptance and/or rejection of the child. For the purpose of this study, communication of acceptance was operationally defined as the parent's score on the Communication of Acceptance subscale of the MEACI (Stover, et al., 1971).

Empathy referred to parents' sensitivity to their children's current feelings and parents' ability to verbally communicate this understanding to the child. For the purpose of this study, empathy was operationally defined as the parents' scores on the total Empathy Scale of the MEACI (Stover, et al., 1971).

Externalizing Behavior Problems referred to behaviors which are outward manifestations of inner conflict. These behaviors can include aggression, hyperactivity, and conduct problems. For the purpose of this study, externalizing behavior problems was operationally defined as the score on the Externalizing Behaviors scale of the Child Behavior Checklist (CBCL) (Achenbach,
Filial Therapy was defined in 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. Parents are taught basic child-centered play therapy skills including responsive listening, recognizing children's emotional needs, therapeutic limit setting, building children's self esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent". (Landreth, 2002, p. 370).

Intensive Filial Therapy involved collapsing the time between parent training sessions to two sessions twice a week to provide maximum benefit to parents and children. For the purpose of this study, each parent participated in ten filial therapy training sessions (two hours in length) and seven parent-child play times within a five-week time period.

Internalizing Behavior Problems referred to behaviors that are directed inward, including withdrawal, anxiety, depression, and suicidal ideation. These behaviors are believed to be symptomatic of an attempt to cope emotionally resulting from an inability to express feelings. For the purpose of this study, internalizing behavior problems was operationally defined as the score on the Internalizing Behaviors scale of the CBCL (Achenbach, 1991).

Involvement was described as the parent’s attention to and participation in the child's activity even though their involvement may not always be considered positive. For the purpose of this study, involvement was operationally defined as the parent’s score on the Involvement subscale of the MEACI (Stover et al., 1971).

Israeli Parent was defined in this study as a parent, 18 years of age or older, living in
Israel with a child between the ages two to ten.

Parent-Child Relationship was the degree of interaction between parent and child.

Parental Stress described the degree of stress in the parent-child system as perceived by the parent. For the purpose of this study, parental stress was operationally defined as the parents' score on the Parenting Stress Index (Abidin, 1983).

Play Therapy 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 the child's natural medium of communication, play (Landreth, 2002).

Somatic Complaints referred to physical manifestations of emotional distress. For the purpose of this study, somatic complaints was operationally defined as the score on the Somatic Complaint subscale on the CBCL (Achenbach, 1991).

Withdrawn was defined as socially detached and unresponsive. For the purpose of this study, withdrawn was operationally defined as the score on the Withdrawn subscale of the CBCL (Achenbach, 1991).

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

1. The children of parents who receive intensive filial therapy training will attain a significantly lower mean score on the Total Behavior Problems scale of the Child Behavior Checklist (CBCL) post-test than will children of parents in the non-treatment comparison group.

2. The children of parents who receive intensive filial therapy training will attain a significantly lower mean score on the Internalizing Behaviors subscale of the CBCL post-test than will children of parents in the non-treatment comparison group.
3. The children of parents who receive intensive filial therapy training will attain a significantly lower mean score on the Externalizing Behaviors subscale of the CBCL post-test than will children of parents in the non-treatment comparison group.

4. Parents who receive intensive filial therapy training will attain a significantly lower mean total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) post-test than will parents in the non-treatment comparison group.

5. Parents who receive intensive filial therapy training will attain a significantly lower mean score on the Communication of Acceptance subscale of the MEACI post-test than will parents in the non-treatment comparison group.

6. Parents who receive intensive filial therapy training will attain a significantly lower mean score on the Allowing the Child Self-Direction subscale of the MEACI post-test than will parents in the non-treatment comparison group.

7. Parents who receive intensive filial therapy training will attain a significantly lower mean score on the Involvement subscale of the MEACI post-test than will parents in the non-treatment comparison group.

8. Parents who receive intensive filial therapy training will attain a significantly lower mean total score on the Parenting Stress Index (PSI) post-test than will parents in the non-treatment comparison group.

9. Parents who receive intensive filial therapy training will attain a significantly lower mean score on the "Parent Domain" of the PSI post-test than will parents in the non-treatment comparison group.

10. Parents who receive intensive filial therapy training will attain a significantly lower mean score on the "Child Domain" of the PSI post-test than will parents in the non-treatment comparison group.
Limitations of the Study

This study had the following limitations:

1. The subjects in the study were diverse in their ethnicity and in the length of time they had lived in Israel. This situation was due to the nature of Israel as an immigrant country. The level of assimilation to the Israeli culture varies.

2. This study relied on volunteer sampling. Due to the nature of the recruitment of the subjects, random selection was not possible.

3. The researcher scored the instruments after returning to the U.S.A. she encountered difficulties finding Hebrew speaking therapists to rate and score the MEACI. As a result of that, the raters for the MEACI were Hebrew speakers who completed the filial therapy training in the past with the researcher. They had one training session with the researcher to learn how to rate the MEACI.

4. Attrition raters was high in this study because of busy schedule of the raters. It forced the researcher to rate twelve pre- and post video tapes. The rating of twelve of the 54 tapes by the researcher is considered to be a limitation in this study.

5. The assumption of homogeneity of regression hyperplanes for Multivariate Analysis of Covariance (MANCOVA) was not met in all instances. The assumption was checked for each analysis by testing the interactions of all possible combinations of the respective covariates. In each of the analyses, at least one covariate combination interaction was found to be statistically significant, which violated the assumption of homogeneity of the regression hyperplanes.

6. Another assumption of MANCOVA deals with the homogeneity of variance/covariance matrices. Box’s M was used to test this assumption. The assumption was not met for the total score analysis (Box’s M=19.15, p=.01). That is, the variance/covariance matrices for the total scores proved to be statistically significantly different.
Instruments

*Child Behavior Checklist*

The Child Behavior Checklist (CBCL) is a well established, recognized instrument for the identification of behavioral and emotional difficulties in children ages 4 to 18. It consists of 120 items, requiring a fifth-grade reading level, and approximately 20 minutes to complete. It is a self-administered test that rates the existence of behavioral symptoms on a scale of zero to two, zero indicating the behavior is not true for the child and two indicating that the child often demonstrates that behavior. This checklist was designed to record, in a standardized format, behavioral symptoms and competencies of children as perceived by their parents or surrogates (Achenbach, 1991).

Internal consistency for the English version of the CBCL was demonstrated by the authors using Cronbach's alpha. For girls between the ages of 4 and 11, Cronbach's alpha is .90 for Internalizing behavior problems, and .93 for Externalizing behavior problems. For boys between the ages of 4 and 11, Cronbach's alpha is .89 for Internalizing behavior problems, and .93 for Externalizing behavior problems. Inter-interviewer reliability for the item scores in the norming sample was established at .959. Intraclass correlation from three matched samples of children showed a high level of reliability between raters, indicating that scores obtained for each item are relative to scores from each other item.

Cronbach’s alpha was used to determine internal consistency of the CBCL data at hand of this study. Table 1 presents those coefficients.
Table 1

Reliability of Child Behavior Checklist Scale and Subscales (N=27)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. items</td>
<td>Cronbach’s α</td>
</tr>
<tr>
<td>CBCL</td>
<td>103</td>
<td>.91</td>
</tr>
<tr>
<td>Internalizing</td>
<td>32</td>
<td>.81</td>
</tr>
<tr>
<td>Anxious</td>
<td>13</td>
<td>.66</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>8</td>
<td>.54</td>
</tr>
<tr>
<td>Somatic Complaints</td>
<td>11</td>
<td>.54</td>
</tr>
<tr>
<td>Externalizing</td>
<td>35</td>
<td>.80</td>
</tr>
<tr>
<td>Rule-Breaking Behavior</td>
<td>17</td>
<td>.39</td>
</tr>
<tr>
<td>Aggression</td>
<td>18</td>
<td>.79</td>
</tr>
<tr>
<td>Social Problems</td>
<td>11</td>
<td>.52</td>
</tr>
<tr>
<td>Thought Problems</td>
<td>15</td>
<td>.33</td>
</tr>
<tr>
<td>Attention Problems</td>
<td>10</td>
<td>.84</td>
</tr>
</tbody>
</table>

Test-retest reliability was established by the authors at .89 for Internalizing behavior problems and .93 for Externalizing Behavior Problems. Scaled scores were evaluated after two years to establish long-term stability, which was calculated to be .70 for Internalizing behaviors and .93 for External behavior. Scores were discovered to be lower for children receiving mental health treatment, indicating that the scale remains sensitive to minor changes as a result of intervention. Content validity of the CBCL has been established. All 120 items were associated with clinical status at the .01 level of significance. Criterion-related validity was supported by the ability to effectively distinguish between referred and non-referred children.

Similar data is not available on the revised and translated Hebrew version of the CBCL (Achenbach, 1991) which was used in this study. Specifically, this study focused primarily upon the Internalizing and Externalizing domain of the CBCL behavior scales. The parents were asked to complete the checklist because the CBCL requires the perception and judgment of a child’s behavior as viewed by the parent.
The Measurement of Empathy in Adult-Child Interaction (MEACI) was slightly modified by Bratton (1993) from a scale developed by Stover et al. (1971) to operationally define empathy as related to parent-child interactions. This direct observational scale measures three specific parental behaviors identified as major indicators of empathy in adult-child interactions. These include communication of acceptance, allowance of child self direction, and involvement. The scale also provides a total empathy score. Lower scores indicate higher levels of positive behavior in the total score and in each of the subscales.

The “Communication of Acceptance” subscale measures the adult's verbal expression of acceptance/rejection of the child's feelings and behaviors during the adult-child play sessions. The dimension of acceptance is viewed as a necessary condition for optimal development of the child's self-worth and the major element in the communication of empathy (Stover et al., 1971).

The “Allowing the Child Self-Direction” subscale measures the verbal expression of acceptance and the behavioral willingness on the part of the adult to follow the child's lead instead of attempting to direct the child's behavior during the play session.

The “Involvement” subscale measures the adult's attention to and participation in the child's play. Stover et al. (1971) found that parents, who exhibited a high level of acceptance and allowed the child self-direction, also demonstrated high levels of involvement.

The MEACI is a five-point, bipolar scale utilized to rate the three dimensions of adult-child interaction at three-minute intervals for six consecutive rating intervals (See Appendix C). The scale ranges from a high rating of one to a low rating of five. Each point on the scale is followed by typical responses obtained from coding the direct observations of parent-child interactions. Considering the three subscales together as components of empathic behavior, the highest level of empathy is evident when the adult is commenting frequently on the child's
expression of feeling or behavior in a genuinely accepting manner, is clearly demonstrating that the child is fully permitted to engage in self-directed activity, and is attending fully to the child's behavior. The lowest level of empathic communication occurs when the parent is verbally critical and rejecting of the feelings or behaviors of the child; cajoles, demands, and continually redirects the child's activity; and is self-involved, preoccupied, or shut-off from the child.

Reliability coefficients have been established for the three subscales (Stover et al., 1971). The average reliability correlation coefficient for the “Communication of Acceptance” subscale was .92. The “Allowing Child Self-Direction” subscale has a median correlation coefficient of .89, and the “Involvement” subscale has and average coefficient of .89 (Stover et al., 1971).

Cronbach’s alpha was used to determine internal consistency of the MEACI data at hand for this study. Table 2 presents those coefficients.

Table 2

<table>
<thead>
<tr>
<th>Scale</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. items</td>
<td>Cronbach’s α</td>
</tr>
<tr>
<td>MEACI</td>
<td>20</td>
<td>.90</td>
</tr>
<tr>
<td>Acceptance</td>
<td>10</td>
<td>.92</td>
</tr>
<tr>
<td>High</td>
<td>5</td>
<td>.84</td>
</tr>
<tr>
<td>Low</td>
<td>5</td>
<td>.86</td>
</tr>
<tr>
<td>Self-direction</td>
<td>5</td>
<td>.78</td>
</tr>
<tr>
<td>Involvement</td>
<td>5</td>
<td>.85</td>
</tr>
</tbody>
</table>

Six raters volunteered to score the MEACI. Inter-rater reliability was determined using Kendall’s $W$, a reliability coefficient used to measure consistency of scores.
Table 3

*Inter-rater reliability for Measurement of Empathy in Adult-Child Interaction (MEACI)*

<table>
<thead>
<tr>
<th>MEACI Scales/Subscales</th>
<th>Kendall’s $W$ Pre-coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>.92</td>
</tr>
<tr>
<td>High</td>
<td>.85</td>
</tr>
<tr>
<td>Low</td>
<td>.79</td>
</tr>
<tr>
<td>Self-direction</td>
<td>.83</td>
</tr>
<tr>
<td>Involvement</td>
<td>.62</td>
</tr>
</tbody>
</table>

Kendall's $W=.87$ demonstrated high agreement among the raters for the total MEACI during the pre-coding training session. The six trained raters were only able to rate 42 of the 54 pre- and-post video tapes of parent-child play sessions. The researcher rated the remaining twelve video tapes: seven pre video tapes and five post video tapes.

Construct validity for each subscale and the total empathy score was established (B. Guerney, & Stover, 1971). Highly significant increases, at the .005 level, were obtained on each subscale and for the total empathy score. A significant increase, at the .01 level, demonstrated that the scales are extremely sensitive measures of the empathic behaviors. Concurrent validity was established by demonstrating a .85 correlation at the .005 level between the MEACI and a previously developed empathy measure for adult-child interaction (B. Guerney, Stover, & DeMerrit, 1968).

The MEACI is considered appropriate for this study because it is the most appropriate measure for the assessment of empathy in adult-child interactions. The MEACI measures key issues in this study: the ability of Israeli parents to learn skills that facilitate the communication of acceptance and empathy, and the ability to allow the child self-direction. These areas are the key goals of filial therapy.
Parenting Stress Index

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

Zakreski (1983) used the test-retest method to determine a coefficient of reliability, which produced coefficients of .69 for the parent domain, .77 for the child domain, and .88 for the total index. Alpha reliability coefficients were calculated on each total score by the authors and on each of the domains to determine internal consistency. Alpha coefficients reported were .93 for the parent domain, .89 for the child domain, and .95 for the total instrument. These findings indicate a high degree of internal consistency for the English version of the PSI (Hauenstein, Scarr, & Abidin, 1987). Similar data is not available on the Hebrew version of the PSI which was used in this study.

Cronbach’s alpha was used to determine internal consistency of the PSI data at hand. Table 3 presents those coefficients.
### Table 4

**Reliability of PSI Scale and Subscales (N=27)**

<table>
<thead>
<tr>
<th>Scale</th>
<th>No. items</th>
<th>Pre-test Cronbach’s α</th>
<th>Post-test Cronbach’s α</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI</td>
<td>101</td>
<td>.94</td>
<td>.94</td>
</tr>
<tr>
<td>Child Domain</td>
<td>47</td>
<td>.89</td>
<td>.92</td>
</tr>
<tr>
<td>Distractibility</td>
<td>9</td>
<td>.72</td>
<td>.59</td>
</tr>
<tr>
<td>Reinforces Parents</td>
<td>6</td>
<td>.48</td>
<td>.32</td>
</tr>
<tr>
<td>Mood</td>
<td>5</td>
<td>.73</td>
<td>.77</td>
</tr>
<tr>
<td>Acceptability</td>
<td>7</td>
<td>.80</td>
<td>.80</td>
</tr>
<tr>
<td>Adaptability</td>
<td>11</td>
<td>.56</td>
<td>.67</td>
</tr>
<tr>
<td>Demandingness</td>
<td>9</td>
<td>.59</td>
<td>.76</td>
</tr>
<tr>
<td>Parent Domain</td>
<td>54</td>
<td>.88</td>
<td>.87</td>
</tr>
<tr>
<td>Competence</td>
<td>13</td>
<td>.67</td>
<td>.68</td>
</tr>
<tr>
<td>Attachment</td>
<td>7</td>
<td>.47</td>
<td>.48</td>
</tr>
<tr>
<td>Role-Restriction</td>
<td>7</td>
<td>.81</td>
<td>.89</td>
</tr>
<tr>
<td>Depression</td>
<td>9</td>
<td>.73</td>
<td>.64</td>
</tr>
<tr>
<td>Spouse</td>
<td>7</td>
<td>.58</td>
<td>.60</td>
</tr>
<tr>
<td>Isolation</td>
<td>6</td>
<td>.37</td>
<td>.42</td>
</tr>
<tr>
<td>Health</td>
<td>5</td>
<td>.49</td>
<td>.21</td>
</tr>
</tbody>
</table>

### Selection of Subjects

Volunteer subjects for the experimental groups were recruited from selected cities in Israel. Announcements stating the recruitment of parents to "parent-child relationship training classes" were made and fliers were posted in kindergarten classes, elementary schools and community centers in three cities in the south part of Israel by family members and friends of the researcher, since the researcher does not live in Israel. While in the United States, the researcher phoned parents who expressed an interest and gave them more details about the parent training classes. The classes were offered free of charge.

Volunteer subjects for the non-treatment comparison group were recruited from the same cities as the experimental group. Parents who could not participate in the filial classes because of job related constraints or because they could not find sitters for their children in the summer time,
volunteered to participate in the research as part of the non-treatment comparison group.

Parents in the experimental groups were selected to participate in this study based on the following eligibility criteria: (a) must be an Israeli resident, at least 18 years of age, with either full or joint custody of a child; (b) must select one *child of focus* between the ages of two and ten who has not received therapy and is not currently in therapy; (c) must be able to speak, read, and write the Hebrew language; (d) must agree to complete all filial training led by the researcher in the given time frame; (e) must be able to attend pre-and post-testing sessions to complete instruments and be videotaped playing with their child; (f) must agree to participate in seven parent-child play sessions, averaging 30 minutes in length; (g) must be willing to sign a consent to participate form; and (h) must not have taken a parenting class in the last two years.

The researcher contacted the parents who met the specified criteria and (a) explained the purpose and the requirements of the filial training; (b) provided information about how confidentiality would be maintained; and (c) answered any questions the participants had before they signed the consent form. The parents were asked to select only one of their children, between the ages of two to ten years, as the *child of focus*, and to indicate that child by name on the consent form. Children who were seven years or older were asked to sign an assent form. Parents were encouraged to choose the child who needed their help and attention the most. For the purpose of this study, the non-treatment comparison group was constituted of Israeli parents who did not receive filial therapy training. At the end of the research study, the non-treatment comparison group parents received three-hours of parenting training.

The experimental group was originally comprised of sixteen parents. Two parents were excluded from the study because of instruments not normed on the age group of their children. Lastly, thirteen mothers and one father participated in the experimental group. The non-treatment comparison group was originally comprised of seventeen parents. Four parents were excluded from
the study because of the same reasons as the experimental group. Lastly, thirteen mothers participated in the non-treatment comparison group. The parents in the experimental group ranged in age from 30 to 44 years of age, with a mean of 35.43 years. The age range for the non-treatment comparison group was 27 to 44 years of age, with a mean age of 34.69 years. Of the experimental group all the parents were married. Of the non-treatment comparison group twelve parents were married and one parent was divorced.

There were five boys and nine girls in the experimental group. The age range was four to eleven years of age, with a mean age of six years. The experimental group included three four years-olds, four five year-olds, four six year-olds, two eight year-olds, and one eleven year-old.

There were seven boys and six girls in the non-treatment comparison group. The age range was four to eight years of age, with a mean age of 5.92 years. The non-treatment comparison group included one four year-old, two five year-olds, eight six year-olds, one seven year-old, and one eight year-old.

All parents in the experimental group had completed high school, three had completed some college, 21% of the parents in the Experimental group, four had earned Bachelor's degree, 28.6% of the parents in the Experimental group, and two had earned Master's degree, 14.3% of the parents in the Experimental group. Of the non-treatment comparison group one parent had not completed high school, 7.7% of the non-treatment comparison group, twelve parents had completed high school, 46.2% of the non-treatment comparison group, five had completed some college, 38.5% of the non-treatment comparison group, and one had earned a Bachelor's degree, 7.7% of the non-treatment comparison group.

Of the experimental group seven parents reported a monthly income of $1000 to $2000 (50%), six parents reported an income of $2000 to $3000 (42.9%), and one parent reported an income of above $3000 (7.1%). Of the non-treatment comparison group two parents reported a
monthly income of $500 to $1000 (15.4%), nine parents reported an income of $1000 to $2000 (69.2%), and two parents reported an income of $2000 to $3000 (15.4%). Of the experimental group all the parents were employed. Of the non-treatment comparison group twelve were employed and one was a stay-home mom.

Collection of Data

A pre-test, post-test, and non-treatment comparison group design was used to carry out the objectives of this study. Pre-training sessions were scheduled one day before training began. All volunteer research participants were given a pre-test packet. The packet contained (a) the CBCL; (b) the PSI; (c) a demographic information form; and (e) a consent form. Each participant was assured of anonymity and was identified only by a self-assigned three-digit number. Directions to complete the assessments were given verbally, and participants were instructed to respond to all items. The participants were videotaped with a child in a room that contained specially selected toys and materials recommended by Landreth (2002). They were shown the room and were given the introductory explanation, "This is a room where you and your child can play together. You may play with the toys in lots of the ways you would like to. You will have 15 minutes for the playtime. I'll come and tell you at the end of 13 minutes, so you will know that you have 2 minutes before playtime will be over. Then I will come back to get you when your playtime is over." All assessments were conducted prior to the play times to prevent contamination of the participant's assessment responses to the playtime.

Confidentiality of the information provided on questionnaires and of the videotapes was ensured through use of the self-assigned code numbers. Only the researcher had the master list of the participants' names. Names of both parents and children will not be disclosed in any future publication or discussion of this material.

During the day following the last filial therapy training sessions, the post-test battery of
instruments was administered to research participants in both the treatment and comparison groups. The post-testing session's procedures were identical to the pre-testing sessions.

**Treatment**

Twenty-seven volunteer parents of children ages three to ten from two cities in Israel, Ofakim and Beer-Sheva, were selected. Parents were placed in two experiential groups. The experimental group parents participated in an intensive model of the Landreth (2002) 10-week filial therapy training model. One group had five members (three mothers and one couple), met twice a week for two hours from six thirty to eight thirty pm in Ofakim. The other group had twelve members (ten mothers and one couple), met twice a week for two hours from nine to eleven pm in Beer-Sheva. Both groups met for a total of nine sessions. Non-treatment comparison group parents received no treatment. Pre-and post-test play sessions were held prior to and after the training and were videotaped.

The experiential group children received 30-minute special play sessions twice a week from their parents for a total of seven play sessions during the training. Didactic instructions were blended with emotional support and empathic understanding. Demonstration videotapes of actual parent-child play sessions were included to serve as a model for participating parents.

At the end of the third training session, the parents conducted their first parent-child playtimes. Parents participating in the filial therapy training were asked to buy toys and materials consistent with those recommended by Landreth (2002). The parents told their children that the toys would be used only during *Special Play Times*, that is 30-minutes of uninterrupted playtimes using special toys and assimilating the skills learned in the filial training. The parents were asked to videotape a minimum of one play session at home for viewing in one of the training sessions. Each of the parents were given feedback on their play session videotape about the skills they learned in the training. Other group members were also encouraged to express their reactions to
the videotaped sessions.

The class followed the curriculum outlined by Landreth (2002) and the focus remained on (1) helping parents to better understand their child; (2) enhancing parenting skills and the parent-child relationship; (3) preparing parents to convey empathic understanding and parental acceptance to their child; and (4) allowing the child to be self-directive and self-responsible. Parents learned to use therapeutic limit setting based on a model of choice-giving and consequences designed to develop self-control within the child. All handouts and course material were translated to Hebrew by the researcher.

All the filial therapy training groups were facilitated by the investigator of this study. The investigator is a doctoral student in counseling at the University of North Texas with a master's degree in clinical-child psychology. She has completed an introduction to play therapy course, an advanced play therapy course, and a filial therapy course. In addition, she has received supervision of play therapy experiences in a master's degree practicum, an advanced doctoral practicum, and a doctoral internship. She has provided play therapy supervision for masters and doctoral students. She has also conducted filial therapy training with Israeli parents residing in North Texas.

Session by Session Outline of Landreth (2002) Filial Therapy Model

The following is the outline of the Landreth (2002) filial therapy training sessions utilized in this study. All of the curriculum in the outline was accomplished. However, instead of meeting once a week, the groups met twice a week, and the parents conducted the play session with their children twice a week for a total of seven sessions. All the handouts mentioned in the next section appear in Appendix D.

Training Session One

Parents introduced themselves, described their families, and identified concerns for their
children, most particularly their *child of focus*. Goals of the filial therapy training were explained, and the facilitator gave an overview of the training sessions. The importance of developing sensitivity to their children and responding with empathy was emphasized, and a videotape of a parent-child play time was shown to help the parents conceptualize what a parent-child play session might be like. Also, the videotape was instructional and demonstrated reflections of feelings and tracking behavior. The facilitator demonstrated tracking behavior and reflection of feelings through role-play with one of the parents, and then, all of the parents paired up and practiced the two skills, using toys provided for the exercise. The homework assignment was for parents to 1) review handouts, 2) practice reflecting feelings (sad, glad, mad and afraid) to their children and write down one example for each emotion on the "Reflection of Feelings" handout. The handout folder included the following: "Partners in Play", "Listening", "safe Person, safe Place, Safe Process."

*Training Session Two*

Session two began with a review of the parents' homework assignment on identifying and reflecting feelings. The facilitator demonstrated emphatic responding with a volunteer from the group. The basic guidelines and principles of the 30 minute play sessions were explained. The facilitator displayed the toys to be used during the play times and discussed the rationale for selecting specific toys; the parents discussed ways to purchase the toys at a low cost. The parents were reminded that the box of toys were for the play sessions only and not for general use. The facilitator reviewed the two beginning skills: 1) tracking behavior and 2) reflection of feelings and introduction to limit-setting, a three-step process developed by Landreth (2002). A videotape of a parent-child playtime demonstrating the skills was shown to the parents. Homework assignments included the following: 1) preparing the toy kit, 2) completing "Facilitating Reflective Communication" handout, 3) noticing a physical characteristic or trait
about their child they had never noticed before. The handout folder included the following:
"Child-Parent Relationship Training CPR for Parents", "Play Session Toy List."

Training Session Three

The session focused on preparing the parents for the first special playtime with their children. The session began with a discussion of the "Facilitating Reflective Communication" handout and of the toys the parents had purchased. The facilitator presented the basic procedures for the play time, talked the group through the handouts "Eight Basic Principles of Play Therapy", and the "Do's and Don'ts," and discussed different types of reflective responses. The parents practiced the basic skills of tracking behavior, reflecting feelings, and limit-setting. Homework assignments included the following: 1) give your child an appointment card, 2) conduct your first play session. The handout folder included the following: "Setting-Limits," "How are You Feeling Today?," "Notes From the Special Play Time".

Training Session Four

The session began with a report and a discussion of the parents' play sessions, focusing on how the parents felt during the sessions, the reaction of their children, and the difficult situation. Two videotapes of the parents conducting playtime were shown. The facilitator and the parents commented on the tapes. The facilitator's intention was to find something in each parent's sharing to affirm, encourage, and support. Setting limits was the next topic, and it met with excitement. The parents tried the limit-setting and choice-giving procedure prior to the meeting and were amazed to see how well it worked. The parents spent the rest of the time role-playing situations where a limit needed to be set. Homework assignment included the following: to fill up the handout setting the limits. The handout folder included the following: "Reinforce Child's Setting Limits," "Two Techniques of Discipline That Work."
Sessions Five through Nine. The following sessions followed the same general format: 1) parents reported on their homework assignments at the beginning of class; 2) discussed their most recent parent-child play session, generally viewing a brief segment of the videotaped session and receiving encouragement and suggestions from the facilitator and the other parents; 3) reviewed and expanded core skills, reinforced with additional handouts and supplementary articles to increase understanding, and mastery of the skills; 4) completed a brief role playing if needed, 5) focused on skills mastery in the play sessions with guidance for application outside of parent-child play sessions, and 6) discussed parents' concerns and parenting situations. The facilitator continued to affirm each parent's progress, target specific suggestions, and provide emotional support to each of the parents. Parental coping skills were identified to help mothers gain a sense of personal power.

Training Session Five

The class focused on issues of limit-setting and then discussed giving choices as a method of increasing the child's sense of responsibility and as a means of discipline. The session included several minutes of role playing. The group also discussed the handout: "Return Responsibility for Self-Confidence and Self Direction." Homework for this session consisted of finding a situation where the parents could practice giving their children a choice.

Training Session Six

The facilitator discussed with the parents children's aggression as presented in the handout "Some Thoughts on Aggression." The focus in the meeting was on expanding the concept of increasing children's positive self-concept through the parents' affirmation of their child's effort rather than judgmental praise of the child's product. The group read the handout "Praise Versus Encouragement". Homework assignment included the following: practice descriptively crediting their child's effort and identify appropriate choices to use when setting consequences for their
children's inappropriate choices.

**Training Session Seven**

The class focused on common problems that the parents were experiencing in the play sessions, as presented in the handout, "Common Problems in Filial Therapy". The facilitator asked the parents to write a note to their children pointing out a positive characteristic that they appreciate in their children.

**Training Session Eight**

Debriefing of the previous session's parent-child play sessions continued with a focus on the parents' perceived changes in their own behavior as their perception of their children's responses. The parents' confidence in their newly learned skills was evident and they were encouraged to speak more freely in critiquing each other's skill and offering suggestions as the videotapes were reviewed. The lesson also focused on identifying play themes as presented in the handouts: "Recognizing and Understanding Play Themes", and "Interpreting Play Themes". The handout folder included also the following: "Spanking".

**Training Session Nine**

The final session was used to review both the parents' and the children's progress as a result of the training. The parents were encouraged to offer their perspectives on what was most important to them, what they had gained, and what they hoped to retain from the training. The parents were encouraged to identify behavioral and attitudinal changes they had make within themselves during the course of training. The importance of continuing the lay sessions was emphasized.

**Non-Treatment Comparison Group**

Prior to training, parents who expressed an interest in joining the groups were given the course information. Parents who could not participate in the course were asked to participate in
the research by filling out the questionnaires and videotaping play sessions with their children. At the end of the five weeks period, they were invited to a one-time three-hour parenting workshop based on the filial therapy training.

Analysis of Data

For purposes of statistical analysis in the pre-test post-test control group design, data from the filial therapy training groups was pooled to form the treatment group. Following collection of the pre-test and post-test data, a multivariate analysis of covariance (MANCOVA) was computed to test the significance of the difference between the experimental group and the Non-treatment comparison group on the adjusted post-test means for each hypothesis. In each case the post-test specified that each hypothesis would be used as the dependent variable and the pre-test as the covariate. MANCOVA was used to adjust the group means on the post-test on the basis of the pre-test, thus, statistically equating the control and experimental groups. Effect size was measured by eta-squared.

Significant differences between means were tested at the .05 level. Duplicating Stevens (1992), the appropriateness of the use of covariance was determined by ensuring that there were no significant correlations among the dependent measures. The assumption of homogeneity of regression for the MANCOVAs was checked.
CHAPTER III
RESULTS AND DISCUSSION

This chapter presents the results of the data analysis for each hypothesis tested in this study. Included also is a discussion of the results, observations, implications, and recommendations for further research.

Results

Multivariate analyses of covariance (MANCOVA) were performed on all hypotheses, and a level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses.

Prior to analysis, data were screened and assumptions were checked. Box’s Test for the Equality of Covariance Matrices was used to check the homogeneity of variance-covariance matrices of the total scores of the CBCL, MEACI, and the PSI. Box’s $M$ was 19.15 ($p=.01$), indicating the heterogeneity of the variance-covariance matrices at the .05 level of significance. After adjusting post-test scores by the pre-test scores on the CBCL, MEACI, and PSI, the MANCOVA resulted in a statistically significant difference between the group means, Wilks’ lambda=$0.072$, $F(3, 20)=86.384$, $p<.001$, $\eta^2=0.928$. These results indicate that there existed a statistically significant difference between two or more of the adjusted post-test mean scores. Univariate results were examined for each test to determine the source of the statistically significant mean difference. The results of this study are presented in the order in which the hypotheses were tested.

Hypothesis One

The children of parents who receive intensive filial therapy training will attain a significantly lower mean score on the Total Behavior Problems scale of the Child Behavior Checklist (CBCL) post-test than will children of parents in the non-treatment comparison group.
Table 5 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison groups. Table 6 presents the results from the univariate analyses of covariance for the CBCL Total Behavior Problems score.

Table 5

*Total Mean scores for Total Behavior Problems on the Parent Form of the Child Behavior Checklist (CBCL)*

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=14)</th>
<th>Control (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>20.50</td>
<td>11.71</td>
</tr>
<tr>
<td>SD</td>
<td>13.71</td>
<td>10.77</td>
</tr>
</tbody>
</table>

Total cases =27

Table 6

*Analysis of Covariance for the Mean Total Behavior Problems Score on the Parent Form of the CBCL*

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBCL Pre-test</td>
<td>2067.69</td>
<td>1</td>
<td>2067.69</td>
<td>33.10</td>
<td>&lt;.001</td>
<td>.60</td>
</tr>
<tr>
<td>MEACI Pre-test</td>
<td>23.44</td>
<td>1</td>
<td>23.44</td>
<td>.38</td>
<td>.55</td>
<td>.02</td>
</tr>
<tr>
<td>PSI Pre-test</td>
<td>27.34</td>
<td>1</td>
<td>27.34</td>
<td>.44</td>
<td>.52</td>
<td>.02</td>
</tr>
<tr>
<td>Main effect</td>
<td>187.63</td>
<td>1</td>
<td>187.63</td>
<td>3.00</td>
<td>.10</td>
<td>.12</td>
</tr>
<tr>
<td>Error</td>
<td>1374.32</td>
<td>22</td>
<td>62.47</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases=27
Table 6 presents the univariate results for the CBCL total score. The F ratio for the main effect was .10, indicating no statistically significant decrease in the experimental group children's Total Behavior Problems as indicated on the Parent Form of the CBCL. The dependent variable variance accounted for by the main effect was 12\% (\eta^2=.12). This value indicates that the difference between the adjusted post-test total CBCL scores is of little practical significance. On the basis of this data hypothesis One was not retained.

**Hypothesis Two**

The children of parents who received intensive filial therapy training will attain a significantly lower mean score on the Internalizing Behaviors subscale of the CBCL post-test than will children of parents in the non-treatment comparison group.

Box’s Test for the Equality of Covariance Matrices was used to verify the homogeneity of variance-covariance matrices. Box’s $M$ was 6.33 ($p=.12$). Table 7 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison groups. Table 8 presents the results from the univariate analyses of covariance for the CBCL Internalizing Behavior Problems subscale scores.

Table 7

*Mean score for Internalizing Behavior Problems on the Parent Report Form of the CBCL*

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=14)</th>
<th>Control (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>6.29</td>
<td>4.00</td>
</tr>
<tr>
<td>SD</td>
<td>5.58</td>
<td>3.94</td>
</tr>
<tr>
<td>Total cases =27</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 8

*Analysis of Covariance for the Mean Total Behavior Problems Score on the Parent Form of the CBCL*

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal pre-test</td>
<td>110.48</td>
<td>1</td>
<td>110.48</td>
<td>21.24</td>
<td>&lt;.001</td>
<td>.48</td>
</tr>
<tr>
<td>External pre-test</td>
<td>20.56</td>
<td>1</td>
<td>20.56</td>
<td>3.95</td>
<td>.06</td>
<td>.15</td>
</tr>
<tr>
<td>Main effect</td>
<td>2.56</td>
<td>1</td>
<td>2.56</td>
<td>.49</td>
<td>.49</td>
<td>.021</td>
</tr>
<tr>
<td>Error</td>
<td>119.65</td>
<td>23</td>
<td>5.20</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases=27

Table 8 presents the univariate results for the internalizing Behavior Problems subscale on the parent form of the CBCL. The F ratio for the main effect was .49, indicating no statistically significant decrease in the experimental group children's internalizing Behavior Problems as indicated on the Parent Form of the CBCL. The dependent variable variance accounted for by the main effect was 2% (η²=.021). This value indicates that the difference between the adjusted post-test CBCL Internalizing Behavior Problems subscale scores is of little practical significance. On the basis of this data hypothesis two was not retained.

*Hypothesis Three*

The children of parents who receive intensive filial therapy training will attain a significantly lower mean score on the Externalizing Behaviors subscale of the CBCL posttest than will children of parents in the non-treatment comparison group.

Box’s Test for the Equality of Covariance Matrices was used to verify the homogeneity of
variance-covariance matrices. Box’s $M$ was 6.33 ($p=.12$). Table 9 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison groups. Table 10 presents the results from the univariate analyses of covariance for the CBCL Externalizing Behavior Problems score.

Table 9

*Mean score for Externalizing Behavior Problems on the Parent Report Form of the CBCL*

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal pre-test</td>
<td>4.23</td>
<td>1</td>
<td>4.23</td>
<td>.70</td>
<td>.41</td>
<td>.03</td>
</tr>
<tr>
<td>External pre-test</td>
<td>198.48</td>
<td>1</td>
<td>198.48</td>
<td>32.89</td>
<td>&lt;.001</td>
<td>.59</td>
</tr>
<tr>
<td>Main effect</td>
<td>28.21</td>
<td>1</td>
<td>28.21</td>
<td>4.67</td>
<td>.04</td>
<td>.17</td>
</tr>
<tr>
<td>Error</td>
<td>138.79</td>
<td>23</td>
<td>6.04</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases=27

Table 10 presents the univariate results for the Externalizing Behavior Problems subscale
on the parent form of the CBCL. The F ratio for the main effect was .04, indicating statistically significant decrease in the experimental group children's Externalizing Behavior Problems as indicated on the Parent Form of the CBCL. The dependent variable variance accounted for by the main effect was 17% ($\eta^2=.17$). This value indicates that the difference between the adjusted post-test CBCL Externalizing Behavior Problems subscale scores is of little practical significance. On the basis of the F ratio hypothesis Three was retained.

_Hypothesis Four_

Parents who receive intensive filial therapy training will attain a significantly lower mean total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) post-test than will parents in the non-treatment comparison group.

Table 11 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison non-treatment comparison groups. Table 12 presents the results from the univariate analyses of covariance for the total score for the Measurement of Empathy in Adult-Child Interaction (MEACI) rating form.

Table 11

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=14)</th>
<th>Control (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>44.54</td>
<td>20.80</td>
</tr>
<tr>
<td>SD</td>
<td>7.62</td>
<td>2.34</td>
</tr>
</tbody>
</table>

Total cases =27

Lower score indicates increase in empathy.
Table 12

*Analysis of Covariance for the Mean Total Scores on the MEACI*

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBCL Pre-test</td>
<td>2067.69</td>
<td>1</td>
<td>2067.69</td>
<td>33.10</td>
<td>&lt;.001</td>
<td>.60</td>
</tr>
<tr>
<td>MEACI Pre-test</td>
<td>23.44</td>
<td>1</td>
<td>23.44</td>
<td>.38</td>
<td>.55</td>
<td>.02</td>
</tr>
<tr>
<td>PSI Pre-test</td>
<td>27.34</td>
<td>1</td>
<td>27.34</td>
<td>.44</td>
<td>.52</td>
<td>.02</td>
</tr>
<tr>
<td>Main effect</td>
<td>3106.69</td>
<td>1</td>
<td>31.6.69</td>
<td>257.84</td>
<td>&lt;.001</td>
<td>.92</td>
</tr>
<tr>
<td>Error</td>
<td>265.071</td>
<td>22</td>
<td>12.05</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases=27

Table 12 presents the univariate results for the MEACI total scores. The F ratio for the main effect was <.001, indicating a statistically significant increase in the experimental group parents' empathic interactions with their children during observed play sessions. The dependent variable variance accounted for by the main effect was 92% (η²=.92). This value indicates that the difference between the adjusted post-test MEACI total scores is of very high practical significance. On the basis of this data hypothesis Four was retained.

*Hypothesis Five*

Parents who receive intensive filial therapy training will attain a significantly lower mean score on the Communication of Acceptance subscale of the MEACI post-test than will parents in the non-treatment comparison group.

Box’s Test for the Equality of Covariance Matrices was used to verify the homogeneity of variance-covariance matrices. Box’s $M$ was 14.08 ($p=.057$). Table 13 presents the pre-and post-
test means and standard deviations for the experimental and non-treatment comparison groups. Table 14 presents the results from the univariate analyses of covariance for the MEACI subscale Communication of Acceptance. Table 13

**Mean Scores for the Communication of Acceptance MEACI Subscale**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept pre-test</td>
<td>3.84</td>
<td>1</td>
<td>3.84</td>
<td>1.75</td>
<td>.20</td>
<td>.07</td>
</tr>
<tr>
<td>Direct pre-test</td>
<td>6.42</td>
<td>1</td>
<td>6.42</td>
<td>2.92</td>
<td>.10</td>
<td>.12</td>
</tr>
<tr>
<td>Involve pre-test</td>
<td>.46</td>
<td>1</td>
<td>.46</td>
<td>.21</td>
<td>.65</td>
<td>.01</td>
</tr>
<tr>
<td>Main effect</td>
<td>180.06</td>
<td>1</td>
<td>180.06</td>
<td>81.95</td>
<td>&lt;.001</td>
<td>.79</td>
</tr>
<tr>
<td>Error</td>
<td>48.34</td>
<td>22</td>
<td>2.19</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases = 27

Lower score indicates increase in communication of acceptance.

Table 14

**Analysis of Covariance for the Communication of Acceptance MEACI Subscale**

Table 14 presents the univariate results for the MEACI Communication of Acceptance subscale. The F ratio for the main effect was <.001, indicating a statistically significant increase
in the experimental group parents' communication of acceptance of their children's feelings and behaviors during observed play sessions. The dependent variable variance accounted for by the main effect was 79% ($\eta^2=.79$). This value indicates that the difference between the adjusted post-test MEACI Communication of Acceptance subscale scores is of very high practical significance. On the basis of this data hypothesis Five was retained.

Hypothesis Six

Parents who receive intensive filial therapy training will attain a significantly lower mean score on the Allowing the Child Self-Direction subscale of the MEACI post-test than will parents in the non-treatment comparison group.

Box’s Test for the Equality of Covariance Matrices was used to verify the homogeneity of variance-covariance matrices. Box’s $M$ was 14.08 ($p=.057$). Table 15 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison groups. Table 16 presents the results from the univariate analyses of covariance for the MEACI Subscale: Allowing the Child Self-Direction

Table 15

Mean Scores for the Allowing the Child Self-Direction MEACI Subscale

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=14)</th>
<th>Control (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>18.11</td>
<td>6.07</td>
</tr>
<tr>
<td>SD</td>
<td>2.76</td>
<td>1.21</td>
</tr>
</tbody>
</table>

Total cases =27

Lower score indicated increase in allowing the child self-direction.
Table 16

Analysis of Covariance for the Allowing the Child Self-Direction MEACI Subscale

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept pre-test</td>
<td>.27</td>
<td>1</td>
<td>.27</td>
<td>.09</td>
<td>.76</td>
<td>.004</td>
</tr>
<tr>
<td>Direct pre-test</td>
<td>16.39</td>
<td>1</td>
<td>16.39</td>
<td>5.69</td>
<td>.03</td>
<td>.21</td>
</tr>
<tr>
<td>Involve pre-test</td>
<td>.73</td>
<td>1</td>
<td>.73</td>
<td>.25</td>
<td>.62</td>
<td>.01</td>
</tr>
<tr>
<td>Main effect</td>
<td>638.84</td>
<td>1</td>
<td>638.84</td>
<td>221.67</td>
<td>&lt;.001</td>
<td>.91</td>
</tr>
<tr>
<td>Error</td>
<td>63.40</td>
<td>22</td>
<td>2.88</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases=27

Table 16 presents the univariate results for the MEACI Allowing the Child Self-Direction subscale. The F ratio for the main effect was <.001, indicating a statistically significant increase in the experimental group parents' acceptance and behavioral willingness to follow their children's lead rather than attempt to control their children's behaviors during observed play sessions. The dependent variable variance accounted for by the main effect was 91% (η²=.91). This value indicates that the difference between the adjusted post-test MEACI Communication of Acceptance subscale scores is of very high practical significance. On the basis of this data hypothesis Six was retained.

**Hypothesis Seven**

Parents who receive intensive filial therapy training will attain a significantly lower mean score on the Involvement subscale of the MEACI post-test than will parents in the non-treatment comparison group.
Box’s Test for the Equality of Covariance Matrices was used to verify the homogeneity of variance-covariance matrices. Box’s $M$ was 14.08 ($p=.057$). Table 17 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison groups. Table 18 presents the results from the univariate analyses of covariance for the MEACI Involvement subscale.

Table 17

*Mean Scores for the: Involvement MEACI Subscale*

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=14)</th>
<th>Control (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>11.93</td>
<td>5.86</td>
</tr>
<tr>
<td>SD</td>
<td>3.21</td>
<td>1.66</td>
</tr>
</tbody>
</table>

Total cases =27

Lower score indicates increase in involvement.

Table 18.

*Analysis of Covariance for the: Involvement MEACI Subscale*

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
<th>$\eta^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accept pre-test</td>
<td>.59</td>
<td>1</td>
<td>.59</td>
<td>.20</td>
<td>.66</td>
<td>.01</td>
</tr>
<tr>
<td>Direct pre-test</td>
<td>14.30</td>
<td>1</td>
<td>14.30</td>
<td>4.91</td>
<td>.04</td>
<td>.18</td>
</tr>
<tr>
<td>Involve pre-test</td>
<td>.005</td>
<td>1</td>
<td>.005</td>
<td>.002</td>
<td>.97</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Main effect</td>
<td>37.57</td>
<td>1</td>
<td>37.57</td>
<td>12.89</td>
<td>.002</td>
<td>.37</td>
</tr>
<tr>
<td>Error</td>
<td>64.08</td>
<td>22</td>
<td>2.91</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases=27
Table 18 presents the univariate results for the MEACI Involvement subscale. The F ratio for the main effect was .002, indicating a statistically significant increase in the experimental group parents' attention to and participation in their children's play during observed play sessions. The dependent variable variance accounted for by the main effect was 37% ($\eta^2=.37$). This value indicates that the difference between the adjusted post-test MEACI Involvement subscale scores is of high practical significance. On the basis of this data hypothesis Seven was retained.

**Hypothesis Eight**

Parents who receive intensive filial therapy training will attain a significantly lower mean total score on the Parenting Stress Index (PSI) post-test than will the parents in the non-treatment comparison group.

Table 19 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison groups. Table 20 presents the results from the univariate analyses of covariance for the PSI Total score.

Table 19

**Total Mean scores for the PSI**

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=14)</th>
<th>Control (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>219.71</td>
<td>189.21</td>
</tr>
<tr>
<td>SD</td>
<td>33.29</td>
<td>25.32</td>
</tr>
<tr>
<td>Total cases</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

64
Table 20

*Analysis of Covariance for the Mean Total Scores for the PSI*

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>P</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBCL Pre-test</td>
<td>2067.69</td>
<td>1</td>
<td>2067.69</td>
<td>33.10</td>
<td>&lt;.001</td>
<td>.60</td>
</tr>
<tr>
<td>MEACI Pre-test</td>
<td>23.44</td>
<td>1</td>
<td>23.44</td>
<td>.38</td>
<td>.55</td>
<td>.02</td>
</tr>
<tr>
<td>PSI Pre-test</td>
<td>27.34</td>
<td>1</td>
<td>27.34</td>
<td>.44</td>
<td>.52</td>
<td>.02</td>
</tr>
<tr>
<td>Main effect</td>
<td>3641.13</td>
<td>1</td>
<td>3641.13</td>
<td>12.79</td>
<td>.002</td>
<td>.37</td>
</tr>
<tr>
<td>Error</td>
<td>6259.74</td>
<td>22</td>
<td>284.53</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total cases=27

Table 20 presents the univariate results for the PSI total score. The F ratio for the main effect was .002, indicating a statistically significant decrease in the experimental group parents' mean total scores on the PSI. The dependent variable variance accounted for by the main effect was 37% (η²=.37). This value indicates that the difference between the adjusted post-test PSI Total scores is of high practical significance. On the basis of this data hypothesis Eight was retained.

*Hypothesis Nine*

Parents who receive intensive filial therapy training will attain a significantly lower mean score on the "Parent Domain" of the PSI post-test than will the parents in the non-treatment comparison group.

Box’s Test for the Equality of Covariance Matrices was used to verify the homogeneity of variance-covariance matrices. Box’s $M$ was 6.07 ($p=.14$). Table 21 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison groups. Table
22 presents the results from the univariate analyses of covariance for the PSI Subscale: Parent Domain.

Table 21

**Total Mean scores for the PSI Subscale: Parent Domain**

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=14)</th>
<th>Control (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>120.14</td>
<td>102.50</td>
</tr>
<tr>
<td>SD</td>
<td>21.68</td>
<td>17.03</td>
</tr>
<tr>
<td>Total cases =27</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 22

**Analysis of Covariance for the Mean Total Scores for the PSI Subscale: Parent Domain**

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>Sum of Squares</th>
<th>Df</th>
<th>Mean Square</th>
<th>F</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covariates</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Pre-test</td>
<td>5442.39</td>
<td>1</td>
<td>5442.39</td>
<td>48.14</td>
<td>&lt;.001</td>
<td>.68</td>
</tr>
<tr>
<td>Child Pre-test</td>
<td>116.86</td>
<td>1</td>
<td>116.86</td>
<td>1.03</td>
<td>.32</td>
<td>.04</td>
</tr>
<tr>
<td>Main effect</td>
<td>1502.28</td>
<td>1</td>
<td>1502.28</td>
<td>13.29</td>
<td>&lt;.001</td>
<td>.37</td>
</tr>
<tr>
<td>Error</td>
<td>2600.44</td>
<td>23</td>
<td>113.06</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total cases=27</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 22 presents the univariate results for the PSI Parent Domain subscale. The F ratio for the main effect was <.001, indicating a statistically significant decrease in the experimental group parents' means scores on the PSI Parent Domain subscale. The dependent variable variance accounted for by the main effect was 37% (η²=.37). This value indicates that the difference
between the adjusted post-test PSI Parent Domain subscale scores is of high practical significance. On the basis of this data hypothesis Nine was retained.

*Hypothesis Ten*

Parents who receive intensive filial therapy training will attain a significantly lower mean score on the "Child Domain" of the PSI post-test than will the parents in the non-treatment comparison group.

Box’s Test for the Equality of Covariance Matrices was used to verify the homogeneity of variance-covariance matrices. Box’s *M* was 6.07 (*p*=.14). Table 23 presents the pre-and post-test means and standard deviations for the experimental and non-treatment comparison groups. Table 24 presents the results from the univariate analyses of covariance for the PSI Subscale: Child Domain.

Table 23

*Total Mean scores for the PSI Subscale: Child Domain*

<table>
<thead>
<tr>
<th></th>
<th>Experimental (n=14)</th>
<th>Control (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Mean</td>
<td>99.71</td>
<td>86.71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>105.46</td>
</tr>
<tr>
<td></td>
<td></td>
<td>102.62</td>
</tr>
<tr>
<td>SD</td>
<td>18.57</td>
<td>15.12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23.37</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27.88</td>
</tr>
<tr>
<td>Total cases</td>
<td>=27</td>
<td></td>
</tr>
</tbody>
</table>


Table 24 presents the univariate results for the PSI Child Domain subscale. The F ratio for the main effect was .024, indicating a statistically significant decrease in the experimental group parents' mean scores on the PSI Child Domain subscale. The dependent variable variance accounted for by the main effect was 20% ($\eta^2=20$). This value indicates that the difference between the adjusted post-test on the PSI Parent Domain subscale scores is of low practical significance. On the basis of the F ratio hypothesis Ten was retained.

Discussion

The results of this study, along with parents' comments and the facilitator observations, point to the effectiveness of filial therapy training as an intervention with Israeli parents and also provide information for future research studies with this population. Significant results were found on eight of the ten hypotheses comparing the intensive filial therapy group to the non-treatment comparison group. The experimental group parents improved their ability to effectively communicate empathy to their children, decreased their level of parental stress, and facilitated
change in their children's externalizing behavior problems. An interpretation of all scores is provided in the following sections.

*Behavior Problems*

Although the children of the parents in the experimental group evidenced fewer behavior problems as measured by the Parent Report on the Child Behavior Checklist (CBCL), the Total Behavior Problems scores and the Internalizing Behaviors subscale scores were not significant at the .05 level. A paired-samples t-test was used to determine the difference between the experimental group's pre- and post-test total scores on the CBCL. The results were statistically significant ($t=4.59, p<.001$). These results explained the large difference between the mean scores of the experimental group pre- and post-test.

Examination of the results for the experimental and non-treatment comparison group parents showed that at pre-testing, thirteen parents from the experimental group rated their children's behaviors in the normal range and one mother rated her child at the clinical range. Nine parents from the non-treatment comparison group rated their children's behavior's in the normal range, and four at the clinical range. The results were similar at the time of post-testing.

In comparing the results of this study to the results of another study of filial therapy training (Smith, 2002), mothers of children witnessing domestic violence rated their children’s behaviors in the clinical range prior to training. With scores farther from the mean, the likelihood of more significant change is possible. Scores that begin in the normal range tend to remain in the normal range. In addition, the mother who rated her child in the clinical range during pre-testing also rated the child in the clinical range during post-testing. Her child had the benefit of the intervention for only four weeks; thus, there may not have been enough time for change to be significant.

Children in the filial therapy group demonstrated a significant ($p=.04$) decrease in
Externalizing Behavior Problems as measured by the CBCL in comparison to the non-treatment comparison group at the time of post-testing. This means that the children's parents in the filial therapy group perceived a significant reduction in Externalizing Behavior Problems in their children. The Externalizing Behavior score is derived from the Aggressive Behavior subscale and the Rule-Breaking Behavior subscale of the CBCL. At the beginning of the filial therapy training, the parents reported on difficulties with disciplining their children and helplessness in dealing with their children's misbehaviors. At the end of the filial therapy training, the parents felt empowered, able to understand their children's needs, and able to respond to their emotional needs. In addition, they reported a significant decrease in their children's need to misbehave. One mother's comment may demonstrate this point:

> It is unbelievable, just by reflecting, attending to my child fully, and spending special time with her that all the whining, the screaming, and the temper tantrums have almost disappeared.

The parents were excited and proud to feel competent when dealing with their child's - and sometimes a relative child’s - misbehavior. One mother reported that, after effectively disciplining her child at a family gathering and helping discipline her nephew, she started to get phone calls from family members asking her advice about what to do in different situations with their children. She said smiling, "I am so proud of myself."

The findings of the present study are similar to Kale and Landreth's (1999) study with parents of children experiencing learning difficulties and Costas and Landreth's (1999) study with non-offending parents of children who have been sexually abused in that they demonstrated positive trends in decreasing children’s problematic behavior through the use of filial therapy training.

*Empathy in Adult-Child Interaction*

The parents in the intensive filial therapy experimental group showed a significant
increase in empathic behavior during observed play sessions with their children as measured by the three subscales of the Measurement of Empathy in Adult-Child Interaction. The experimental group parents' post-test total score (p<.001) decreased a dramatic 23.74 points, while the non-treatment comparison groups' total score decreased by only 3.13 points. For this scale, a decrease in the mean score indicates an increase in the desired behavior. These results are of particular interest because they are based on direct observation of specific parenting behaviors by trained raters rather than self-report.

The experimental parent group demonstrated a statistically significant increase in communicating acceptance (p<.001), with a very high effect size of 79% (η=.79). This indicates that the mothers made significant improvements in their ability to communicate genuine acceptance of their children’s feelings, thoughts and behaviors during the observed play times. According to Stover, Guerney, and O’Connell (1971), the verbal expression of acceptance is the major element in the communication of empathy. At the end of the training one father wrote in his feedback:

…The course changed us in so many ways. As parents we learned to understand our children better, to really connect with them and accept them. We understand better our limits and our ability to better connect with them. As human beings it filled us up with lots of love and empathy, helped us discover that the most meaningful thing is our feelings and the feelings of the people we love…

The greatest improvement in empathic behavior was found in the area of Allowing the Child Self-Direction. The parents in the filial therapy groups showed a statistically significant increase (p<.001), with the highest effect size of 91% (η=.91) on the Allowing the Child Self-Direction subscale. This subscale measures the parents’ progress in learning to replace judgmental, evaluative and directive statements with responses that allow children the freedom to select their way in play. Parents were taught to permit and encourage their children's freedom and self-expression in choosing activities and to withhold familiar habits like telling children what to
do and how to do it. One of the mothers in the group had a 9-year-old daughter that had
difficulties with constipation, eating problems, and constant whining over everything initially, the
mother described their relationship as “war,” “exhausting,” and a source of constant worry. After
six play sessions, she said:

You said that there is no magic, but this is a miracle. The change in our house is so
drastic! I do not ask her if she needs to go the restroom, she just goes. In a very surprising
way there is no power struggle any more. She started to do things on her own: she goes to
the kitchen and makes food for herself, and I do not interfere. Today she demands
complete independence to take a shower, wash her hair, go to bed, and even to read her
daily book without me asking. I could not believe that the annoying whining would ever
stop. They did! She cries only when she is really in pain. I think it is all changed because
we gave her the freedom to choose and gave up our controlling her.

The parents in the experimental groups showed a statistically significant increase (p=.002)
and an effect size of 37% ($\eta=.37$) in communicating involvement as measured by the MEACI.
Involvement means that the parents focused attention on their children while participating in their
play activities physically, verbally, and emotionally, as opposed to distancing or withdrawing
from the child or becoming distracted and preoccupied with themselves (Stover et al., 1971). An
illustration of the change in the parents’ abilities to be fully involved in their children’s play was
a mother that at the first training session, said that she hated to play with her children; she said
that she got bored, felt ridiculous, and did not think that it was her job to play with them. After a
few special playtimes, she said that what amazed her most was the need of her daughter to play
with her and the meaningful play her daughter was playing. She also said that now she
understood that the most important thing was to be focused on the child and not on the play, and
this understanding helped her feel better about herself playing with her daughter and focusing on
reflecting feelings and behaviors.

The significant positive changes indicated by this observational measure suggest that filial
therapy parent training is an effective treatment for increasing empathy, communicating
acceptance, allowing children self-direction, and heightening involvement in parent-child interactions. It is also suggests that filial therapy training might be an effective intervention for increasing parental empathy in the Israeli parents living in Israel.

The results of this study support earlier investigations in filial therapy that used the same direct observations to measure empathic behavior in parents as they interacted with their children in play sessions (Bratton and Landreth, 1995; Chau and Landreth, 1997; Costas and Landreth, 1999; Glover and Landreth's and Landreth, 2000; Gourney & Stover, 1971; Guerney et al., 1968; Harris and Landreth, 1997; Smith, 2002; Stover et al., 1971).

Parental Stress

The parents in the intensive filial therapy experimental group showed a statistically significant decrease in overall parental stress (p=.002) as measured by the Parent Stress Index. They also showed a statistically significant decrease in the Parent Domain (p<.001) and the Child Domain (p=.024) subscales of the PSI.

At the end of the five weeks, the parents of the experimental group appeared to be more accepting of their children and less stressed about their children, as evidenced by their significant child domain scores and about their role as parents, as evident by their significant parent domain score. During the course of the training, most of the parents felt that the main change was occurring in them, in the way they saw their children and in the way they reacted to their children's emotional needs. One of the mothers said at the fifth training session:

I have to face my demons. I feel that I have to give up the facade and the mask and show my child that I am human, I have feelings too. It is so difficult for me to show her that sometimes I, too, make mistakes and do not have all the answers..

At the end of the training, another mother said:

…I noticed that I was very critical toward my child, I am very sorry for that because I realized that this is what I least liked at my parents' house. I know now that even if I did not express my criticism verbally I communicated it to my child. Today I am trying to be
less judgmental; I know her better and understand that her behavior is normal for her age. I have learned to accept her the way she is.

The results of the PSI suggest that the five-week filial therapy training model is an effective treatment for decreasing overall parental stress. It is also suggests that filial therapy training might be an effective intervention for reducing parental stress in the Israeli parents living in Israel.

The findings in the present study are similar to those of other studies (Bratton and Landreth, 1995; Chau and Landreth, 1997; Costas and Landreth, 1999; Kale and Landreth, 1997; Landreth and Lobaugh, 1998; Tew, 1997; Yuen, Landreth and Baggerly, 1997) on the effectiveness of filial therapy relating to parental stress.

Observations

The parents in the filial therapy training group were eager and enthusiastic to participate in the training. They were excited to improve their parenting skills and to have better relationships with their children. One of the groups met from six to eight at night twice a week, had five members, four of whom did not miss any sessions. The fifth member, a mother of three boys and pregnant with her fourth child, missed two sessions. This group met at their children’s kindergarten classroom; the members and the facilitator provided snacks for the meetings.

The other filial therapy training group consisted of twelve members. This group met twice a week from nine to eleven at night. Although the facilitator had a room set up for the meetings, the group members decided not to use it and took turns hosting the training sessions in their homes. They also took turns to provide the snack. Five of the members did not miss any sessions, and five members each missed one session. Babysitting was not provided for the children in the groups.

The facilitator found it important to let the parents share their personal stories, problems,
and emotions. However, because there was so much to accomplish in the condensed class times, the facilitator arranged additional times before and after the meeting to talk with each one of the parents (as requested) and help with personal difficulties. The group members reported that the intensity of the meetings was important and beneficial in helping them to acquire the skills of parenthood and to feel that they were in a unique journey of self-discovery and personal change.

Implications

The results of this research indicate that the intensive model of the Landreth (2002) filial therapy training is an effective method for use with Israeli parents living in Israel. The parents demonstrated their ability to learn therapeutic skills by extending empathy, communicating acceptance to their children, allowing self-direction, and being more involved when interacting with their children during special playtimes. The parents also reported a decrease in externalizing behavior problems of their children and stress related to parenting.

The parents reported that they felt empowered by parenting skills designed to enhance the children's self-direction and responsibility, and were enthusiastic as they related the benefits of what they experienced through positive interactions in their children's lives. The parents were very excited when they recognized what bothered their children and how they could be of help.

Israel is a country in a war of terror, and the people there have devastatingly stressful life circumstances. The children are exposed to violence and death on a daily basis, and fear is a part of their lives. Not all children have opportunities to express feelings of fear, confusion, and worries. Most children have to adjust to dealing with the fearful life circumstances all by themselves. Filial therapy may be an outlet through which a large number of Israeli children can express their struggles, fears, and emotions, to more empathic parents. In the filial therapy training, the parents learn to be more empathic, communicate their care and understanding, and sensitive to their children emotional needs. The use of parents as therapeutic agents with their
children could potentially provide clinical services to a larger number of children, could prevent
the need for professional help, and give an answer to parents who struggle to help their children
cope with their reality.

Recommendations

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

1. Filial therapy training should be used as a viable intervention for Israeli parents living
   in Israel.

2. Follow-up research should be conducted with the subjects from this study, using the
   same instruments utilized in this study.

3. Further research should be done to explore the effectiveness of filial therapy training
   with special populations and children at risk in Israel.

4. Educational Psychological Services in Israel should provide filial therapy training in
   subsidized public schools and childcare that serves at-risk families and their children.

5. Further research should examine the effectiveness of filial therapy training in different
   settings, such as schools and preschools in Israel.

6. Comparative research need to be done with minority populations in Israel.

7. An investigation of the effect of filial therapy training on the self-concepts of Israeli
   children should be performed.

8. Compare the effectiveness of filial therapy training with other parenting classes.

9. Further qualitative research into the intensive filial therapy model to determine the
   process of change through self-report, studying of videotapes of class sessions and
   parent-child play sessions should be pursued.

10. Investigate the effectiveness of filial therapy training with Israeli families who have
    been traumatized by a terror attack.
11. Investigate the effectiveness of filial therapy training with Israeli families using new instruments to measure effectiveness of the filial model since there are not enough studies completed to verify the effectiveness of the model.

Concluding Remarks

Israel is a country in a war on terror that has implications for the life of each family. Some of the children in Israel experience the terror as victims, as witnesses, or as relatives to a victim. Most children are experiencing the terror through the media. In a country where children and adults are accustomed to being exposed to horrible violence, it is crucial to help the parents become aware of their children's emotional needs and learn how to respond to them appropriately.

This research proved the effectiveness of filial therapy training as an effective intervention with Israeli parents in improving therapeutic skills, increasing empathy, and reducing parental stress. Filial therapy training provides parents with skills that enhance their relationships with their children and assists parents in adopting a therapeutic role when it is needed. Filial therapy training guides and instructs parents in skills designed to listen to the child's inner world. Parents learn to communicate empathy and acceptance, so children can feel understood, learn to trust themselves, become self-reliant, and are able to express emotions appropriately.
APPENDIX A

ADULT CONSENT FORM
"Playing Together"

Filial Therapy - Play Therapy Training for Parents

Research Information for Parents

"Toys are the words and play is the language of children."

Virginia Axline (1947)

You and your child are invited to participate in a study to determine the effectiveness of play therapy training for Israeli parents (clinically termed filial therapy) and children. This study has been approved by the Human Subjects Board at the University of North Texas. Participation in this study is voluntary. You and/or your child may choose to withdraw at any time. As a participant, you would be asked to select one of your children, between the ages of 4 and 10 years old, to be your child of focus with whom you will have frequent parent-child play times. You will be asked to complete two questionnaires (about 15 minutes each) and to have a 20 minute Special Play Time before you begin the parent training classes.

**Parents as Therapeutic Agents of Change with their Children: Play Therapy Training for Parents** is a unique parent training program that utilizes the already existing bond between parent and child, thus the clinical term filial therapy. Parents are taught the core concepts and skills of play therapy in order to become a therapeutic agent of change in their children's lives. The model focuses on strengthening the parent-child relationship rather than the counselor – child relationship. Rather than focusing on child problems, the training focuses on the child and helping parents to understand and respond effectively to children's emotional needs, to increase the child's self-esteem and to set limits so as to foster self-discipline within the child.

**Parent Classes and Parent-Child Play Times:** You will attend parenting classes twice a week with a small group of parents for a total of 12 sessions. The class time will be two hours a session. Make-up classes will be made available due to occasional scheduling conflicts. To help you learn to use the new skills and to simultaneously help your child, you will conduct parent-child play times, 30 minutes in length, twice a week with your child for a total of 8 to 10 play sessions within 6 week time frame.

**Risks:** I foresee no personal risk or discomfort directly involved with this study. You will be asked to give some of your time, and to be willing to explore some new ideas and feelings related to the parenting of your child. There may be times during the play sessions when your child could express sadness, anger, or frustration. While these sessions cannot avoid these situations, neither will they increase the emotion. In fact, the training should help you deal with these situations more effectively.

**Benefits:** the benefits of intensive filial therapy can be (1) improving your child's self-concept, (2) reducing behavioral problems, and (3) improvement in your child's problem solving skills. Furthermore, you and your child may experience a fresh start in your relationship. During the Special Play Times, your child may communicate symbolically through play thoughts, feelings, experiences, and difficulties never before expressed to you or even to him/herself. The benefits
for you, the parent, can be (1) increasing your ability to respond to children's emotional needs, (2) an ability to nurture your child through this time of crisis, (3) a new way of setting limits that fosters self-discipline rather than parental punishment, (4) reduced parental stress, and (5) a renewed confidence in your effectiveness as a parent.

Confidentiality: the information you answer on the questionnaires will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of the material. Information from the questionnaires will be coded with only the researcher, Michal Kidron, having a list of the participant's names. Only the researcher and the research assistant will be watching the videotapes and at the end of this study, the list of participants' names and the videotapes will be destroyed.

If you agree to participate, please fill out and sign the consent form attached to this page. For further information, please contact Michal Kidron, (08-6239735). Thank you very much for your time cooperation and your participation.

Sincerely,

Michal Kidron, M.A.
Researcher
University of North Texas,
Department of Counseling,
Development and Higher Education
Telephone number: 001-940-565-2910
Contact number in Israel: 08-6239735

Major Professor:
Garry Landreth, Ed.D.
Department of Counseling, Development, and Higher Education
University of North Texas
001-940- 565-2916
landreth@unt.coe.edu
University of North Texas
Institutional Review Board
Research Consent Form

Subject Name ________________________________ Date ______________

Title of Study:
Filial Therapy: Child-Parent Relationship Training with Women in Domestic Violence Shelters in Israel.

Principal Investigator Michal Kidron
Co-Investigator(s) Dr. Gerry Landreth

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.

Start Date of Study 07/01/2003
End Date of Study 08/30/2003

Review for the Protection of Participants
This research study has been reviewed and approved by the UNT Committee for the protection of Human Subjects on Insert Approval Date Here. UNT IRB can be contacted at (940) 565-3940 or http://www.unt.edu/ospa/irb/contact.htm with any questions or concerns regarding this study.

Research Subject's Rights
I have read or have had read to me all the information about the research and my part in it: what is play therapy, the course and research requirements, the risk and benefits, and how the confidentiality will be kept. Researcher has explained the study to me and answered all of my questions. I have been told the risks and/or discomforts as well as the possible benefits of the study. I have been told of other choices of treatment available to me.

I understand that I do not have to take part in this study and my refusal to participate or to withdraw will involve no penalty, loss of rights, loss of benefits, or legal recourse to which I am entitled. The study personnel may choose to stop my participation at any time.

In case problems or questions arise, I have been told I can contact telephone number (phone number in Israel).

I understand my rights as research subject and I voluntarily consent to participate in this study. I understand what the study is about, how the study is conducted, and why it is being performed.
I have been told I will receive a signed copy of this consent form.

____________________________________  _______________
Signature of Subject                  Date

____________________________________  _______________
Signature of Witness                  Date

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

____________________________________
Signature of Principal Investigator    Date
APPENDIX B
ASSENT FORM
University of North Texas
Institutional Review Board
Research Assent Form

Subject Name [ ] [ ] Date [ ]

Title of Study
Filial Therapy: Child-Parent Relationship Training with Women in Domestic Violence Shelters in Israel.

Principal Investigator Michal Kidron
Co-Investigator(s) Dr. Gerry Landreth

You are making a decision about whether or not to have your child participate in this study. Your signature indicates that you have decided to allow your child to participate, that you have read or have had read to you the information provided in the Consent Form, and that you have received a copy of the Consent Form.

____________________________________  _________________
Signature of Parent or Guardian  Date

____________________________________  _________________
Signature of Witness  Date

____________________________________  _________________
Signature of Principal Investigator  Date
Assent of Child

The Child named [ ] has agreed to participate in the study mentioned above.

____________________________________   __________________________
Signature of Subject                        Date
Note: The signature of a Parent or Guardian must be substituted if waiver of assent is required.

Waiver of Assent

The Child named [ ] has been waived from signing an Assent for the following reason(s):

____ Age
____ Maturity
____ Psychological State of the Child

____________________________________   __________________________
Signature of Parent or Guardian                  Date
APPENDIX C

FILIAL THERAPY PLAY KIT
Play Session Toys List

- play doh (only one)
- crayons (8 colors)
- paper
- blunt scissors
- nursing bottle (plastic)
- pacifier
- rubber knife
- dart gun
- a family of small dolls
- toy soldiers (10-15 only, 2 colors)
- small plastic car
- lone ranger type mask
- a cardboard box (the kind Xerox paper comes in)
- hand puppet
- doll house furniture (kitchen, bedroom, bathroom)
- small baby doll
- blanket
- doctor kit
- box of band-aids (only 3 at a time)
- scotch tape
- play money
- an inflatable bop bag
- piece of rope
- deck of cards
- a ring toss
- a couple of domestic and wild animals
- craft items for older child
APPENDIX D

CURRICULUM MATERIAL
FILIAL SESSION #1

Reflective Listening:
A way of following, rather than leading
Don’t ask questions
Reflect behaviors, patterns and feelings

Responses:
Say:     Not:
I am here; I hear you    I always agree
I understand    I must make you happy
I care    I will solve your problems

Keep focus on the positive

RULE OF THUMB: You can’t give away what you do not possess
As significant caregivers we may be coming to the sessions deeply aware of our failures, yet we can’t effectively enter this process by being impatient and un-accepting toward ourselves while trying to extend patience and acceptance to a child

Notes:

Homework:

1) Notice some physical characteristic about your child you haven’t seen before

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

Listening is a magnetic and strange thing, a creative force… The friends that listen to us are the ones we move toward, and we want to sit in their radius as though it did us good, like ultra-violet rays… When we are listened to, it creates us, makes us unfold and expand. Ideas actually begin to grow within us and come to life… It makes people happy and free when they are listened to… When we listen to people there is an alternating current, and this recharges us so that we never get tired of each other. We are constantly being recreated.

Now there are brilliant people who cannot listen much. They have no ingoing wires on their apparatus. They are entertaining but exhausting too. I think it is because these lecturers, these brilliant performers, by not giving us a chance to talk, do not let us express our thoughts and expand; and it is this expressing and expanding that makes the little creative fountain inside us begin to spring and ease up new thoughts and unexpected laughter and wisdom.

I discovered all this about three years ago, and truly it made a revolutionary change in my life. Before that, when I went to a party, I would think anxiously: “Now try hard. Be lively. Say bright things. Talk, don’t let down.” And when tired, I would have to drink lots of coffee to keep this up. But now before going to a party, I just tell myself to listen with affection to anyone who talks to me, to be in their shoes when they talk; to try to know them without my mind pressing against theirs, or arguing, or changing the subject. Now my attitude is: “Tell me more. This person is showing me his soul. It is a little dry and meager and full of grinding talk now, but presently he will begin to think, not just automatically to talk. He will show his true self. Then he will be wonderfully alive…

Children need a relationship, time, and place to safely express:

1. Thoughts
2. Feelings
3. Beliefs
4. Rehearse behaviors
5. Enact solutions
6. Exert their will
7. Explore creativity
8. Express wishes, needs, wants, and desires
9. Recreate and resolve conflict
10. Discover self-awareness and self responsibility

"As the adult reflect back understanding and acceptance of the child's play the child (a) feels understood and accepted, and (b) gains self-awareness and self understanding."
FACILITATING REFLECTIVE COMMUNICATION
WORKSHEET
(Session #2)
Homework Assignment

Choose the most helpful response. Give your opinion as to why you think it is the best on the line below.

1. Joe: (with wrinkled brow, red face, and tears in his eyes) We lost, that team didn’t play fair!
   Parent: ___________________________________________________
   __________________________________________________________

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

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

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

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

6. Charlie: (Showing you his torn, smudged painting from school) Look MOM! Isn’t it neat! My teacher said I was a good artist!
   Parent: ___________________________________________________
   __________________________________________________________
Child-Parent Relationship Training CPR for Parents

Basic Principles of the Play Sessions

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

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

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

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

Goals of the Play Sessions

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

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

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

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

Toys for the Play Sessions

Play Doh, crayons (8 colors), paper, blunt scissors, nursing bottle (plastic), rubber knife, dart gun, a family of small dolls, toy soldiers (10-15 only, 2 colors), small plastic car, Lone Ranger type mask, a cardboard box (type copy paper comes in)-use the lid to indicate rooms by strips of tape, doll house furniture, small baby doll, blanket, doctor kit, an inflatable Bop bag, a piece of rope, a deck of cards, a ring toss, a couple of domestic and wild animals, craft items for older child. A hand puppet toy would be a special asset. Feel free to discuss with us the addition of other items.

Place for the Play Sessions

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

Let the child use the bathroom prior to the play session. Tell the child, "we will have thirty minutes of special play time and you may choose to play with the toys in lots of the ways you like to." Let the child lead from this point. Play actively with the child if the child requests your participation. Set limits on behaviors that make you feel uncomfortable. Track his/her behavior and feelings verbally. Do not identify toys by their normal names; call them "it," "that," "her," "him," etc. Give the child a five minute advance notice before terminating the session. Do not exceed time limit by more than two to three minutes.
BASIC RULES FOR FILIAL THERAPY
(Session #3 Handout)

Don’ts

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

Do’s

1. Do set the stage.
   "You can play with the toys in lots of the ways you'd like to"
   "In here, that's up to you...you can decide...that can be whatever you want it to be"

2. Do let the child lead.
   "You want me to put that on"...(whisper technique) "what should I say"..."show me what you
   want me to do"

3. Do track behavior.
   "You're filling that all the way to the top"..."You've decided you want to paint next"....You've
   got 'em all lined up just how you want them"

4. Do reflect the child's feelings.
   "You like how you look in that"..."that kinda surprised you"...You really like how that feels
   on your hands"..."You really wish that we could play longer"...."you don't like the way that
   turned out"

5. Do set limits.
   "I know you'd like to play with the play dough on the floor, but it's not for putting on the
   floor...you can play with it on the tray"

6. Do salute the child's power and encourage effort.
   "You worked hard on that and you did it"..."you figured it out"..."You've got a plan for how
   you want to _____"..."You know just how you want that _____"..."sounds like you know lots
   about ___"

7. Do join in the play as a follower.
   "You want me to be the robber and I'm supposed to wear the black mask"..."Now I'm
   supposed to go to jail until you say I can get out"

8. Do be verbally active.

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

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

Your responses should not convey:
1. "I will solve your problems for you."
2. "I am responsible for making you happy."
3. "Because I understand you that means I automatically agree with you."
THE EIGHT BASIC PRINCIPLES
(Of Non-Directive Play Therapy)

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

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

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

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

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

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

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

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

SETTING THE LIMITS: EXAMPLES
(Session # 4)

1. Susan picks up the dart gun, aims it at your head. Respond

2. John is anxious to play with friends and insists on leaving the room before your session is over. Respond.

3. Linda picks up the crayon, announces she is going to draw the outline of her hand on the wall. Respond.

4. Paul is very angry with you, curses you, and hits and kicks you. Respond.

5. Jennifer starts to pull the head off a $20.00 doll. Respond.

6. Jim wants to play doctor with you and asks you to take off your clothes. Respond.

TWO TECHNIQUES OF DISCIPLINE THAT WORK

1. Firm limit – setting

Three steps

1. **Recognize the feeling**—“I know you’d really like to…”, or “I can’t tell you’re really feeling…”, etc.
2. **Set the limit**- “…but the __ is not for __…”, or “but the answer is no”

3. **Provide an alternative**- “You can __ if you’d like” or “What you can do is __________”

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

C. If you’re not prepared to answer the question (want to talk it over with someone, want to get more information, want to think about it).
   1. “I can’t answer that question now…(because)”, “I’ll let know…(specific time)”
   2. Nagging begins: “If you must have an answer now, the answer will have to be NO.”

D. If (s) he asks the same question again: Calmly- “I’ve already answered that question.”
   1. “Do you remember the answer I gave you a few minutes ago when you asked that same question?” (Child answers, “No, I don’t remember.”) “Go sit down in a quiet place and think and I know you’ll remember.”
   2. “I’ve answered that question once (twice) and that’s enough.”
   3. “If you think s(he) doesn’t understand: “I’ve already answered that question. You must have some question about the answer.”

E. If you’re undecided and open to persuasion: “I don’t know…Let’s sit down and discuss it.”

2. **Oreo Cookie Theory (© Dr. Gary Landreth):**

   Give the child a choice, providing acceptable choices commensurate with the child’s ability to choose.
WHEN “SETTING THE LIMITS” DOESN’T WORK

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

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

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

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

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

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

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

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

Compassionate
Confident
Cooperative
Courageous
Creative
Decisive
Diligent
Enthusiastic
Fair-minded
Flexible
Generous
Loyal
Patient
Persistent
Respectful
Responsible
Sensitive
1. Q: My child notices that I talk differently in the play sessions, and wants me to talk normally. What should I do?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

9. Q: My child wants to play with the toys at other times during the week. Is that OK?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

10. Q: My child wants me to shoot at him during the play session. What should I do?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

OTHER PROBLEMS I'M HAVING IN MY PLAY SESSIONS: ______________________
SOME THOUGHTS ON AGGRESSION  
(Session #6)

Raoph Kantor describes aggression as a process whereby the child (and many times a parent) feels more and more helpless. This helplessness builds through a 4-stage process as follows:

1. Irritant + Inability to remove = Frustration (awareness)  
2. Frustration + Inability to remove = Anger (focused action)  
3. Anger + Inability to remove = Rage (beginning distortion of action)  
4. Rage + Inability to remove = Fury (complete distortion of action)

After fury is reached, Kantor continues, exhaustion occurs and both child and parent are left feeling temporarily overwhelmed and powerless. The increased powerlessness/helplessness felt by a child and often a parent only serves to feed aggression. In order, then, to successfully break the rise of aggression, the sense of powerlessness must be eliminated. A key to this shifted circle is an understanding by both parent and child that power is not something held over someone else but is, instead, power over self. The final thrust then, in learning to manage a child’s aggression is, in fact managing our own aggression.

Following is a list of techniques found effective in increasing the power of both parent & child.

1. Lower your voice and talk softly  
2. Use the child’s name over and over in a reassuring voice  
3. Refer to the child’s last success and compliance  
4. Use silence for thirty-six seconds as the child’s aggression builds  
5. Leave the room giving the child time to gain self-control and thus, “save face”  
6. Switch the subject of conflict to some topic of non-threatening nature for a few minutes  
7. Give permission to be angry  
8. Exaggerate the conflict to humorous proportions  
9. Interpret the aggression to the child – determine and discuss the true origin of the aggressive behavior  
10. Be a crisis anticipator – not a crisis intervener. Prevent a crisis before it happens when possible

Through an understanding of aggression and the use of techniques stated above, one can go beyond simple “child control” to the more complex and challenging task of “child development”
I believe that perfectionism may be in part learned from a child’s interactions with perfectionistic parents. This is the way I see the process working: a child is regularly rewarded with love and approval for outstanding performance; when the parents react to one child’s mistakes and failures with anxiety and disappointment, the child is likely to interpret that as punishment or rejection. The perfectionistic parent often feels frustrated and threatened when a child is having difficulties in schoolwork or in relationships with peers. Because the parent is unrealistically self-critical, he or she personalizes the child’s difficulties by thinking, “This shows what a bad mother (or father) I am.” Because the parent’s self-esteem puts great pressure on the child to avoid failure, consequently, when the troubled child turns to the parent for reassurance or guidance, the parent reacts with irritation, not love, and the child is flooded with shame.

The child begins to anticipate that mistakes will lead to a loss of acceptance. Because the child bases a sense of self-esteem on the parent’s approval, the child begins to fear mistakes and to avoid failure. This leads to emotional constriction and fear of any experience or adventure in which the outcome is not guaranteed. The child becomes anxious and upset about making mistakes, which further reinforces the perfectionistic parent’s belief that failure is dangerous and undesirable. Essentially, the parent and child are locked into a kind of folie-a-deux.

“The Perfectionist’s Script for Self-Defeat”
By David D. Burns
Psychology Today
November, 1980
PRAISE vs. ENCOURAGEMENT

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

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

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

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

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

Encouraging Phrases that Demonstrate Acceptance:

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

Encouraging Phrases that Show Confidence:

"I have confidence in your judgment:
"You'll figure it out."
"That's a rough one, but I'm sure you'll figure it out."
"Knowing you, I'm sure you will do fine."
"You'll make it."

Encouraging Phrases that Focus on Contributions, Assets, and Appreciation:

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

**Encouraging Phrases that Recognize Effort and Improvement:**

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

In summary, encouragement is: (1) valuing and accepting children as they are (not putting conditions on acceptance), (2) pointing out the positive aspects of behavior, (3) showing faith in children so that they can come to believe in themselves, (4) recognizing effort and improvement (rather than requiring achievement), and (5) showing appreciation for contributions.

One Hundred Years From Now…

It will not matter what my bank account was, the sort of house I lived in, or the kind of car I drove, but the world may be different because I impacted the life of a CHILD!!

One Hundred Years From Now…

It will not matter what my bank account was, the sort of house I lived in, or the kind of car I drove, but the world may be different because I impacted the life of a CHILD!!

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One Hundred Years From Now…

It will not matter what my bank account was, the sort of house I lived in, or the kind of car I drove, but the world may be different because I impacted the life of a CHILD!!
RULES OF THUMB AND OTHER THINGS TO REMEMBER

Rules of Thumb

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

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

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

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

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

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

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

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

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

10. If you can't say it in 10 words or less, don't say it.

Other Things to Remember

1. Reflective responses can diffuse anger.

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

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

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

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

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

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

8. Don't try to change everything at once.
9. In the play session, the parent is not the source of answers. Reflect questions back to child.
10. Free the child. With freedom comes responsibility.
11. Noticing the child is a powerful builder of self-esteem.
12. Support the child's intent even if you can't support his behavior.
13. When we are flexible in our stance we can handle anger much more easily. When we are rigid, we and the child can end up hurt. (Remember the stiff arm!)
15. Where there are no limits, there is no security.
16. In the play session, praise limits creativity and freedom.
17. In play, children express what their lives are like now, what their needs are, or how they wish things could be.
18. What a child doesn't do is as important as what he does do.
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