A COMPARISON OF AN INTENSIVE 4-WEEK FORMAT OF THE LANDRETH 10-WEEK FILIAL THERAPY TRAINING MODEL WITH THE TRADITIONAL LANDRETH 10-WEEK MODEL OF FILIAL THERAPY

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This research study investigated the effectiveness of an intensive format of the traditional Landreth filial therapy training (LFTT) model compared to the traditional LFTT model. Specifically, this study compared the intensive LFTT group and the traditional LFTT group at post-testing in the areas of: (a) reducing stress related to parenting, (b) increasing parental empathic behavior with their children, (c) increasing parental acceptance toward their children, and (d) reducing perceived child behavior problems.

The traditional LFTT group consisted of 13 parents in groups of up to six members for 10 90-minute weekly sessions. Traditional LFTT involved didactic instruction, required at-home laboratory playtimes, and supervision. Parents were taught child-centered play therapy skills of responsive listening, recognizing children’s emotional needs, therapeutic limit setting, building children’s self-esteem, and structuring required weekly playtimes with their children using a kit of specially selected toys.

The intensive LFTT group consisted of 13 parents in groups of up to four members who met on four Saturdays for 4 hours each. The traditional LFTT model was modified to teach the same material over fewer sessions. The difference in this delivery was fewer opportunities for parents to have home playtimes and receive feedback from
the researcher. To compensate for this difference and attempt to maintain the effectiveness of the traditional model, the researcher had parents bring their children to training. The researcher used the parents' children in live demonstrations of the skills being taught. Parents were able to practice the new skills with their own children under direct supervision from the researcher followed by immediate feedback. This modification provided supervision equivalent to that of the traditional LFTT model.

The results of this study were no statistically significant differences between the intensive and traditional groups at post-testing on overall parenting stress, parental acceptance and empathic behaviors with their children, and in reported child behavior problems.
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CHAPTER 1

Introduction

It has often been lamented that children do not come with a manual. Being a parent is a multifaceted, learned role that, done well, does not come naturally (Cooke, 1991). At one time or another, all parents encounter situations in which they are unsure of how to best parent. Most parents struggle with common parenting issues such as discipline, sibling rivalry, toilet training, temper tantrums, and chore completion. Other parents or caretakers face the additional challenges of parenting a child who is struggling with behavioral, social-emotional, and learning difficulties. To aid parents in improving their parenting skills and to equip them to meet the many demands of parenting, mental health workers and parent educators have developed a multitude of parenting programs.

These interventions vary greatly in the areas of length of instruction, size of groups, training level of the instructor, goals of instruction, degree of feedback provided to participants, and research available to support the effectiveness of the program.

In the early 1960’s, Bernard Guerney developed a training program for parents that he called filial therapy. He proposed that parents could be trained to intervene in their children's problems using client-centered play therapy during special home playtimes (1969). Guerney’s approach was a novel solution to the shortage of mental health professionals trained to work with children experiencing emotional and behavioral difficulties (Bratton & Ray, 2002). Louise Guerney (2000) indicated she and Bernard selected the term "filial therapy," because of what she described as the literal meaning
"...of or pertaining to a son or a daughter in relation to the parent (p. 4)." Training parents to utilize the skills and attitudes of client-centered play therapists during supervised playtimes with their children was based on the premise that parents are capable of becoming the therapeutic agent in their children’s lives. The focus of this training was to alter the parents’ attitudes and perceptions of their children’s behaviors in order to change those behaviors, whereas traditional therapy focused primarily on changing the child. In the Guerneys’ early model, the parents’ received training, supervision and feedback on the home playtimes for 12 to 18 months.

While the amount of training utilized by the Guerneys (1964) helped ensure mastery of the skills, the majority of parents face time and financial constraints that would make this training commitment a barrier. Landreth (1991) recognized the need for a model that accommodated the limited resources of families he worked with and responded by developing a 10-week model of filial therapy based on the same basic principles developed by the Guerneys. The LFFT model was designed with specific training objectives, including the provision of professional feedback through review of videotaped home playtimes as well as support and encouragement from other group members. In this model, parents are traditionally seen in groups of six to eight members for 10 weekly 90 minute to 2-hour sessions. The traditional LFTT model of filial therapy is a well-researched, empirically validated intervention that has proven effective with a variety of populations and presenting issues (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Glass, 1986; Glazer-Waldman, Zimmerman, Landreth & Norton, 1992; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang,
Outcome-based research studies on Landreth's model have demonstrated statistically significant gains in parental empathic behavior, parental acceptance, decreasing child behavior problems, and decreasing parenting stress levels. Ray, Bratton, Rhine, & Jones (2001) conducted a meta-analysis of play therapy outcome research and found that training parents to conduct playtimes with their children using child-centered play therapy procedures was a more effective method of treatment than play therapy delivered by trained professionals (p=.001). In their conclusion, Ray et al advocated a greater utilization of filial therapy programs of all formats. S. Bratton (personal communication, September 18, 2003) reported that further analysis of specific filial training models revealed that the traditional LFTT model demonstrated the greatest effects on children and families (d=1.25).

In light of the confirmed efficacy of the traditional LFTT model, the meta-analysis results, and recommendations to increase the utilization of filial therapy, the researcher was disheartened to have many experiences with parents who needed, and showed an interest in participating in filial therapy training, yet decided not to participate because they did not feel that their schedules would permit a weekly 90 minute to 2-hour commitment for 10 weeks as in the traditional LFTT model. These families were experiencing difficulties within the family which caused them to seek help, but could not face an additional stressor of the time commitment involved to participate in filial therapy. This commitment seemed only to add to their anxiety level. Society places
numerous demands on families and their time together. Dual income families, single parenting, and extracurricular activities for both the parents and children equate to less available free time and increased stress levels for parents and children. The Forum on Child and Family Statistics (2002) reported that in 1999, 32% of American children lived with only one parent (up from 23% in 1980) and children ages 3 to 6 were more likely (61%) to be in a center-based child-care situation. Between single parent homes and both parents choosing or needing to work outside the home, parents who need to or want to improve their parenting skills often find it difficult or impossible to commit to several weeks of training such as the traditional LFTT. In order to meet the needs of families who are struggling to meet the demands of parenting, work, and other life stressors, a training format that utilizes the proven methods and curriculum proposed by Landreth, yet responds to their time and financial constraints faced by these families is sorely needed.

Purpose of the Study

The purpose of this study was to compare the effectiveness of an intensive Landreth filial therapy training (LFTT) model with the traditional Landreth filial therapy training (LFTT) model for parents and their children. Specifically, this study was designed to determine the effectiveness of intensive LFTT in (a) increasing the parents’ empathic responsiveness with their children, (b) increasing parents’ communication of acceptance of their children, (c) decreasing children’s problem behaviors, and (d) decreasing parental stress compared to the traditional LFTT model.
Review of Related Literature

Related research is discussed in four areas: (a) play therapy, (b) filial therapy, (c) traditional Landreth filial therapy research, and (d) intensive play therapy/intensive filial therapy.

Play Therapy

According to Axline (1947), play is a child's natural means of self-expression through which they can "play out" feelings and problems so that they become more manageable. In the early 1900’s, Melanie Klein (1955) and Anna Freud (1946) separately began using play in their therapy with children. Klein believed that children’s play was the equivalent of free association for adults and would interpret unconscious motivations as the child played. Anna Freud utilized toys as a way of developing a relationship with children before beginning to interpret their play.

Levy (1938, 1939) developed release play therapy that stressed the abreactive benefits of play over the interpretive aspects. He would specifically choose toys to recreate a scene of a specific traumatic event and present those to the child. The child was allowed through reenactment to release feelings of pain and anxiety related to that event. Hambidge (1955) built upon Levy’s work to develop structured play therapy. He would structure events to recreate the anxiety-producing event, allow the child to play out the situation, and then allow free play as a recovery from the recreation.

Taft (1933) and Allen (1939) emphasized the healing power of the relationship between the therapist and child as necessary for change. They viewed children as having the inner strength and capacity to constructively alter their behavior. Otto Rank (1936)
formulated the philosophical concept of relationship play therapy by stressing the importance of the here and now therapist-client relationship with very little emphasis on dealing with the past or the unconscious.

Virginia Axline (1947), a student and later colleague of Carl Rogers, applied Rogers' (1951) person-centered theory to her work with children and created child-centered play therapy. It is based on the same idea for adults: that is children’s behavior has the goal of striving for self-realization. Through her participation with the child during his or her play, Axline communicated the core conditions of change Rogers (1957) outlined as necessary and sufficient for personality change to occur.

Moustakas (1973) described play therapy as providing a relationship with broad boundaries within which children can express their feelings completely. They can also practice being silly, immature, mean, disgusted, resentful, and to assume many different roles such as being an adult, parent, or teacher. He described the play therapist as possessing a set of accepting attitudes that allow children to express themselves freely. Within this atmosphere, children may gain feelings of security, adequacy, and worthiness.

Landreth, Homeyer, Glover, and Sweeney (1996) reported on Guerney and Landreth in a comprehensive review of research and case studies that verify the effectiveness of play therapy as an intervention in abuse, neglect, aggression, attachment, autism, chronic illness, depression, grief, learning disabilities, low self-concept, as well as traumatization. Phillips and Landreth (1998) conducted a comprehensive national survey of play therapists and found acting-out/impulse control, enuresis/encopresis,
depression/withdrawal, phobias, physical/sexual abuse, and school adjustment/academic difficulties were also responsive to play therapy intervention.

Bratton and Ray (2000) reported on a comprehensive review of play therapy research studies emphasizing the effectiveness of play therapy with specific populations and a multitude of presenting issues. They found that in the areas of self-concept, behavioral change, cognitive ability, social skills, and anxiety, play therapy has been shown to be an effective treatment method for children. They noted that two main factors seem to increase the effectiveness of play therapy: parent involvement and duration of sessions. The effectiveness of play therapy was found to increase when therapy continued for up to 35 to 45 sessions. By 45 sessions, effectiveness reached a plateau and then decreased.

Filial Therapy

Sigmund Freud (1955) documented the first example of filial therapy in his work in 1909 with a father and his phobic son. Freud incorporated the father to act as the therapeutic agent in his son’s phobic resolution. Freud instructed the father in how to have playtimes with his child at home. Freud’s idea was that only the father could have a meaningful enough impact on the boy, through his unique knowledge of him, to convince him to change so dramatically.

Natalie Fuchs (1957) was one of the first parents to utilize child-centered play therapy principles in her intervention with her daughter’s anxiety over toilet training. Through letters written to her father, Carl Rogers, Natalie expressed her concerns and was advised to begin having weekly playtimes with her daughter using specially selected
toys that included a toy toilet. Her daughter was able to work through her anxiety of toilet training and reinitiated toileting on her own.

Clark Moustakas (1959) described another early example of instructing a parent on using play therapy techniques. He described play therapy in the home as providing the benefits of play therapy in addition to helping the child to determine his place in the family.

In 1964, Bernard Guerney coined the term "filial therapy" in his description of a parenting training program designed to maximize the use of the professional’s time and facilities. It was designed as an intervention for 3-10 year olds with emotional problems. Filial therapy utilizes a group format that trains parents to be the therapeutic agent with their children as they conduct weekly playtimes in their home in a very specific way. Through filial therapy, the child’s perceptions of the parent should change and also the parent’s perceptions of the child should change. The child, allowed to express thoughts and feelings he or she has not communicated to his or her parents, gains self-respect, self-worth, and confidence. Filial therapy training involves didactic, demonstration, and role-playing techniques.

Guerney (1964) described the rationale underlying filial therapy training in eleven tenets: (a) All maladjustment in the life of the child should be understood in the perspective of relationships in which the child is engaged. Patterns of conflict have been engendered to this child through these family relationships; (b) Two conventional paths have existed in treating childhood emotional problems: individual therapy with the child, or family therapy/consultation including the parents and child. Change is promoted in the
family system of the child that influenced and reinforced maladjusted patterns; (c) The primary goals of change in the child's life are permissiveness and understanding, by either the therapist in an individual setting, or by the parents in a family setting; (d) In the filial model the parents are not only inspired to be helped, but can actually be of help; (e) Parents can potentially learn the role of play therapist for their child reasonably well; (f) The process of learning the skills of play therapy often provides parents with insight into personal issues that they were not aware of previously; (g) The process, even for a short time, of changing roles can serve to impact the current ill-adapted roles by the parent; (h) The parent can gain a greater understanding of the child in the process of conducting special playtimes with the child; (i) The parent's attention to the child can prove to be therapeutic, even for a short period of time; (j) The role of the parent as therapist will increase the therapeutic progress for both the child, parent, as well as for the child-parent relationship; and (k) Parents benefit from the lessons of filial therapy long after formal therapy has ended based on the belief that parents can potentially be more effective in producing change in the child than a therapist attempting to perform the same function. (p. 307-308)

The goals of the playtimes are to let the child take the lead within safety limits, to develop empathic understanding in the parent, to communicate that understanding to the child, and for the child to accept responsibility for his or her actions. Parents are taught to use the specific techniques with empathy in order to strengthen the parent-child relationship (Guerney, 1964).
The reasons to choose filial therapy are well documented. Stover and Guerney (1967) cite several advantages of using filial therapy training with parents. Filial therapy avoids the fears and rivalry that may surface as the child begins to form a therapeutic relationship with the therapist. It reduces the guilt and helplessness parents may feel when they must rely on a professional to resolve problems with their child. Filial therapy creates a new environment for the child so that once the therapeutic goals for the child are reached, the child continues in a changed environment instead of returning to the same environment that contributed to the making or maintaining of problem behaviors in the child in the first place.

B. Guerney (1976) studied the clinical impression that filial therapy is a treatment method accepted by parents that keeps them motivated and thus leads to improved responses in their children. Results indicated that the children who received the treatment had statistically significant increases in their social adjustment and maternal satisfaction, statistically significant decreases in their emotional dysfunction and interpersonal conflicts, and significant decreases in the child’s number of symptoms.

Many other studies have been done to ascertain the usefulness of filial therapy with children who have various additional challenges. Andronico and Blake (1971) investigated the impact of filial therapy with parents of children who stutter. They reported that the child's stuttering diminished when the parents changed their interactional patterns with the child and were able to inhibit their previous patterns of pressuring or interrupting the child. Gilmore (1971) investigated the effects of filial therapy with children diagnosed with learning disabilities. He reported that the parents'
use of learned play therapy relational skills was the primary factor in improving their children's academic performance, self-esteem, and social functioning. Measures of family interaction improved as well.

In a meta-analysis of 60 clinical cases, Hornsby and Applebaum (1978) determined that filial therapy was clinically effective for children with a variety of initial diagnoses. They reported significant improvements in the children's behavioral difficulties and in child-parent relationships.

*Traditional Landreth Filial Therapy Training Research*

Landreth (1991) modified the Guerney’s (1964) model of filial therapy from a minimum of 6 months to 10 weeks. This version makes completing filial therapy training achievable for more families. During filial therapy training, parents learn to be sensitive to their children as they communicate to them four messages: (a) I am here; (b) I hear you; (c) I understand; and, (d) I care. Training begins with didactic lessons, role-plays, and observation of videotapes demonstrating child-centered play therapy skills. By the third training session, parents begin their special playtimes at home and bring in videotapes of their playtimes for review in the training sessions. Numerous research studies have been conducted on both models of filial therapy which demonstrate their effectiveness in intervening in child behavior problems. Rennie and Landreth (2000) reported on research of filial therapy which showed it to be an effective intervention for increasing parental empathy, acceptance, self-esteem, as well as decreasing parental stress and child behavior problems. They also reported on the effectiveness of filial therapy with various parent and child populations.
Several studies have been conducted to determine the effectiveness of the traditional LFTT model with a variety of groups of parents and children with various presenting issues. The findings support the value of this training with all groups evaluated thus far. Some studies did not find statistically significant improvements in some areas of measurement, but often they were able to report trends that would suggest some value in the training in those areas.

In 1986, Glass reported the first study to support the effectiveness of the traditional LFTT. Upon completion of the traditional LFTT, the parents demonstrated statistically significant increases in their feelings of unconditional love for their children and in their ability to understand their children’s play. The parents’ perception of expressed conflict in the family was also significantly decreased.

Glazer-Waldman, Zimmerman, Landreth, & Norton (1992) studied the effects of the traditional LFTT with parents of chronically ill children. Before filial therapy training, these parents confused their children’s anxiety level with their own and could not accurately evaluate the child’s state of anxiety as stated by the child. The parents tended to overestimate the anxiety levels of their children as compared to the child’s report. Although there was no significant change in the children’s anxiety level, the researchers did report an increase in the parents’ acceptance of their children. As a result of the training, parents were able to focus on positive interactions with their children instead of their prior focus on the child’s illness.

In a later study, Lahti (1992) examined the effects of the traditional LFTT model on the parent, child, and parent-child relationship using an ethnographic methodology.
Parents reported a decrease in their stress levels after conducting their special playtimes with their children. They also reported that viewing the videotaped special playtimes in class and receiving feedback from the researcher and other parents increased their objectivity for learning. The parents reported increased self-confidence, less need to be controlling, and increased awareness of their needs and the needs of their children. Parents reported increased closeness and improved communication in both the parent-child relationship and in the marital relationship. The parents reported more realistic expectations for their children and less friction between the parents and children. The parents perceived their children, as a result of filial therapy, as being happier, taking more responsibility for their actions, demonstrating fewer withdrawn behaviors and aggressive behaviors, and exhibiting overall enhanced communication.

Bratton and Landreth (1995) researched the effects of filial therapy with single parents. They reported statistically significant increases in empathic behavior of the parents and in perceived acceptance of their children. They reported statistically significant decreases in the parents’ levels of stress related to parenting and their level of stress based on their perceptions of themselves. The parents also reported a statistically significant decrease in the number of problem behaviors in their children following filial therapy.

Bavin-Hoffman, Jennings, and Landreth (1996) reported on the longitudinal effects of the traditional LFTT. Twenty married couples reported that filial therapy improved their parent-child communication, interpersonal communication, and behavior of their child of focus. They also reported increased confidence in their parenting, better
relationships within the family and the couple and better understanding of the child’s play.

Chau and Landreth (1997) reported on the effectiveness of filial therapy as an intervention method with Chinese parents. These parents showed statistically significant increases in their empathic behavior with their children. They demonstrated a statistically significant increase in their perceived acceptance of their children specifically in the areas of respect for the child’s feelings, appreciation of the child’s uniqueness, recognition of the child’s need for autonomy and independence and unconditional love. These parents also demonstrated a statistically significant decrease in their stress level related to parenting in both the parent domain and the child domain of the Parenting Stress Index.

Tew (1997) published research regarding the effectiveness of filial therapy training with families of chronically ill children. These parents demonstrated statistically significant decreases in their stress related to parenting and statistically significant increases in their accepting attitudes toward their children. The parents also perceived their children as having statistically significant decreases in their behavior problems, anxiety and depression.

Yeun (1997) published research of the effectiveness of filial therapy training with immigrant Chinese parents in Canada. Parents involved in this study demonstrated statistically significant increases in their empathic interactions with their children and in their attitude of acceptance of their children. These parents also achieved statistically significant decreases in their stress related to parenting and in the number of perceived
child behavior problems. The children achieved statistically significant increases in their self-concept as perceived by the parents.

Landreth and Lobaugh (1998) researched the effectiveness of filial therapy training with incarcerated fathers. They reported that these fathers achieved a statistically significant higher score on all areas of acceptance of their children as compared to the control group. The fathers achieved a statistically significant lower total score on total stress as measured by the PSI and a statistically significant lower score on the Parent Domain indicating reduced overall stress related to parenting and to their view of themselves as fathers.

Kale and Landreth (1999) researched the effectiveness of filial therapy as a treatment modality with parents of children experiencing learning difficulties. They reported a statistically significant increase in these parents’ respect for their child’s feelings, appreciation of the child’s unique makeup, and recognition of the child’s need for autonomy and independence. The parents also reported statistically significant decreases in their total scores and Parent Domain scores as measured by the PSI indicating that they had decreased stress levels regarding their role as a parent of a child with learning difficulties.

Costas and Landreth (1999) reported on research studying the effectiveness of filial therapy with non-offending parents of children who have been sexually abused. These parents achieved a statistically significant higher score on the total parental acceptance scale and the unconditional love subscale. These parents achieved statistically significant lower total stress scores on the PSI and statistically significant lower scores on
Glover and Landreth (2000) reported on the research studying the effectiveness of filial therapy with Native Americans. The parents demonstrated statistically significant increases in their empathy levels when responding to their children. Their children also demonstrated statistically significant increases in their desirable play behaviors. The researchers also noted positive changes in parental acceptance, decreased stress related to parenting, and increased child self-concept.

Jang (2000) examined the effectiveness of filial therapy training with Korean parents in Korea. After completing filial therapy training, the parents’ empathic interactions with their children increased significantly. They also reported significant decreases in their parenting stress and in their perceived number of problem behaviors in their children.

Jones and Rhine (2002) (2001) researched the effectiveness of training high school peer helpers in filial therapy to improve their empathic responding with young children. She published findings of statistically significant improvement in the students' empathy as measured by their communication of acceptance, allowing self direction, and involvement with the young children with whom they interacted as helpers.

Lee (2002) reported on research studying the effectiveness of filial therapy with immigrant Korean parents in the United States. These parents demonstrated statistically significant increases in empathic behavior, communication of acceptance, allowing the child self-direction, involvement, respect for the child’s feelings and the right to express
them, accepting the child’s need for autonomy, and unconditional love of their children. These parents also demonstrated a statistically significant decrease in their stress related to parenting.

Smith (2002) published research on the impact of filial therapy training with teachers of preschool deaf and hard of hearing children. He reported statistically significant increases in the attitude of acceptance and ability to allow students’ appropriate self-direction as well as increases in communication of empathy in the teachers following filial therapy training.

*Intensive Play Therapy/Intensive Filial Therapy*

An intensive model of play therapy supervision and training was described by Bratton, Landreth, & Homeyer (1993) which provides 27 hours of supervised play therapy training over three consecutive days. This model provides therapists with training of specific skills, live supervision of play therapy sessions, immediate feedback, observation of and by colleagues, and self-evaluation of playtimes. Though this model has not been empirically tested, the anonymous feedback provided by participants has been remarkably positive in terms of their dramatic gains in play therapy knowledge and skill.

Harris and Landreth (1997) reported on the effectiveness of filial therapy with incarcerated mothers using a modified version of the traditional LFTT model. The mothers attended two-hour filial therapy training sessions twice a week for five weeks and conducted 30-minute playtimes in between class sessions with their child who came to the facility twice a week. In this quasi-experimental design, the mothers in the
experimental group showed statistically significant increases in their empathic interaction with their children and their attitude of acceptance toward their children and reported a statistically significant decrease in the number of problems they perceived within their children.

Kot (1995) published research studying the effectiveness of intensive individual play therapy with children who had witnessed domestic violence. Children in this study received play therapy daily for 12 days. The results were statistically significant increases in the children’s self-concept. The children also achieved statistically significant decreases in their total behavior problems and overall externalizing behaviors. These children were also less withdrawn, had fewer somatic complaints, and had decreased anxiety, depression, and aggression following therapy.

Tyndall-Lind (1999) published research studying the effectiveness of intensive sibling group play therapy with child witnesses of domestic violence. For this study, the children received 12 daily sibling group play therapy sessions in which two siblings participated. The results were statistically significant increases in self-concept and statistically significant decreases in internalizing, externalizing, and total behavioral problems. Intensive sibling group play therapy was also found to be as effective as intensive individual play therapy.

Jones (2000) reported on research of the efficacy of intensive individual play therapy for children diagnosed with insulin-dependent diabetes mellitus. The children received 12 play therapy sessions during a 3-week summer camp term. The results
indicated that there were greater improvements of symptoms in several areas in the experimental group as compared to the control group.

Smith (2000) published research comparing the effectiveness of intensive filial therapy, training conducted daily for 2 weeks, with parent victims of domestic violence with intensive individual play therapy and intensive sibling group play therapy for child witnesses of domestic violence. Her results were consistent with the Kot (1995) and Tyndall-Lind (1999) studies. Intensive filial therapy in this study involved teaching the traditional LFTT in its original format for each session. The sessions were conducted daily instead of weekly as in the traditional LFTT. Parents attained statistically significant increases in their communication of empathy with their children. The parents also perceived a statistically significant increase in the self-concept of their children and a significant decrease in their children’s overall behavior problems, thus supporting the effectiveness of condensing the traditional LFTT model to 2 weeks. There were also no significant differences between the filial group and the individual play therapy or intensive sibling group play therapies, indicating that the parents were as effective in producing change with their children as were the trained professionals.

Statement of the Problem

The problem with which this study is concerned is how to modify the delivery system of the traditional Landreth filial therapy training (LFTT) model for those parents unable to attend a parenting program for 10 weeks yet maintain the effectiveness of that training. Based on a verbal account of Landreth’s attempt at delivering filial therapy training to a married couple over one weekend, the researcher explored alternative formats to train
parents in filial therapy, yet maintain a similar structure to the traditional LFTT model so as to maintain the effectiveness of the training. The supposition was that an intensive LFTT model could be developed that preserved the training curriculum of the traditional model by collapsing the curriculum and experiences into four four-hour weekend sessions.
CHAPTER 2
Methods and Procedures

A pretest-posttest comparison group design was used to measure the effectiveness of an intensive Landreth filial therapy training (LFTT) model compared to the traditional Landreth filial therapy training (LFTT) model. Parents in the Dallas/Fort Worth metroplex were recruited to participate in both filial training formats and were assigned to a treatment group based on random assignment and availability to attend the Saturday intensive LFTT format or the 2-hour weeknight traditional LFTT format.

Definition of Terms

Allowing the child self-direction is defined as the behavioral willingness in the parent 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 is operationally defined as the parent’s scores on the Allowing the Child Self-Direction Subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, & O’Connell, 1971).

Appreciation of the child’s unique makeup is defined as the parent’s attitude of appreciating and valuing the child’s uniqueness. For the purpose of this study, appreciation of the child’s unique makeup is operationally defined as the parents’ score on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Child Domain is defined as the total of all measured characteristics of the child that may be stressful to the parent. For the purpose of this study, child domain is
operationally defined as the parents’ score on this subscale of the Parenting Stress Index (Abidin, 1983).

**Child of focus** refers to a child age 2 to 10 years chosen by the parent to participate in special playtimes.

**Communication of Acceptance-High** is defined as the major factor in the communication of empathic feeling and considered by Rogers (1957) to be one of the necessary conditions for personality change. For this study, communication of acceptance-high is operationally defined as the parent’s scores on the Communication of Acceptance-High Subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, & O’Connell, 1971).

**Communication of Acceptance-Low** is defined as the major factor in the communication of empathic feeling and considered by Rogers (1957) to be one of the necessary conditions for personality change. For this study, communication of acceptance-low is operationally defined as the parent’s scores on the Communication of Acceptance-Low Subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, & O’Connell, 1971).

**Empathy** refers to parents’ sensitivity to their children’s feelings and to the parents’ ability to verbally communicate this understanding to their children. For this study, empathy is operationally defined as the parents’ scores on the total score of the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, & O’Connell, 1971).
Filial therapy is the unique approach used by professionals educated in play therapy to train parents to be the therapeutic agents with their own children through a format of didactic instruction, demonstration playtimes, required at-home laboratory playtimes, 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 playtimes with their children using a kit of specially selected toys. Parents learn how to create a nonjudgemental, understanding, and accepting environment which enhances the parent-child relationship and facilitates personal growth and change for the parent and child (Landreth, 1991).

Intensive Landreth Filial Therapy Training (LFTT) model – is the training model designed by the researcher as a modification of the traditional Landreth (1991) filial therapy training model. It consists of four 4-hour weekly sessions that teach parents the skills and attitudes of play therapists for use in specially designed playtimes with their children. This model will be referred to as intensive LFTT.

Involvement is defined as the parental behavior that conveys in a positive way that he or she is attending to and participating in or willing to participate in the child’s activities. For this study, involvement is operationally defined as the parents’ scores on the Involvement Subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, & O’Connell, 1971).

Limits in a playtime are set as needed to ensure the physical and emotional safety of children and parent (Bixler, 1949). Limits protect the physical safety of the parent and
facilitate acceptance of the child. Limits provide opportunities for decision-making, self-control, and self-responsibility in children. Limits anchor the playtime to reality by emphasizing the here and now. Limits provide consistency, preserve the relationship between child and parent, and protect the materials and room.

Loves Child Unconditionally is defined as the love the parent shows toward a child without placing conditions or minimum standards on the child’s behavior in order to receive that love. For the purpose of this study, loves child unconditionally is operationally defined as the parents’ score on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

Parent Domain is defined as the total of all measured characteristics of the parent that may contribute to the stress level of the parent. For the purpose of this study, parent domain is operationally defined as the parents’ score on this subscale of the Parenting Stress Index (Abidin, 1983).

Permissiveness is defined as allowing the child to do anything he or she wants during the playtime that does not damage property or persons or the therapeutic relationship (Kraft & Landreth, 1998).

Play Kits for this study were boxes of specifically chosen toys each parent used only during special playtimes with their child (see Appendix E, Handout 4).

Recognition of the Child’s Need for Autonomy and Independence is the parents’ understanding of the child’s need to differentiate and separate from their parents in order to achieve their own identity. For the purpose of this study, recognition of the child’s
need for autonomy and independence is operationally defined as the parents’ scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

**Respect for the Child’s Feelings and Right to Express Them** is the parent’s willingness to allow the child to express feelings and to show acceptance for the child. For the purpose of this study, respect for the child’s feelings and right to express them is operationally defined as the parents’ scores on this subscale of the Porter Parental Acceptance Scale (Porter, 1954).

**Special Playtimes** are 30-minute playtimes parents conduct at home or during training with their child of focus after being taught specific ways of playing with and responding to their child.

**Traditional Landreth Filial Therapy Training (LFTT) model** – is the unique approach used by professionals educated in play therapy to train parents to be the therapeutic agents with their own children through a format of didactic instruction, demonstration playtimes, required at-home laboratory playtimes, 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 playtimes with their children using a kit of specially selected toys. Parents learn how to create a nonjudgemental, understanding, and accepting environment which enhances the parent-child relationship and facilitates personal growth and change for the parent and child (Landreth, 1991). This model will be referred to as traditional LFTT.
Hypotheses

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

1. There will be no significant difference in the Total Score on the Parenting Stress Index posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model;
   (a) There will be no significant difference in the Child Domain of the Parenting Stress Index posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive traditional LFTT model.
   (b) There will be no significant difference on the Parent Domain of the Parenting Stress Index posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

2. There will be no significant difference in the mean Total Score on the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model;
   (a) There will be no significant difference in the mean score of the Communication of Acceptance subscale on the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.
(b) There will be no significant difference in the mean score of the Allowing the Child Self-Direction subscale on the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

(c) There will be no significant difference in the mean score of the Involvement subscale on the Measurement of Empathy in Adult-Child Interaction (MEACI) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive traditional LFTT model.

3. There will be no significant difference in the mean total score of the Porter Parental Acceptance Scale (PPAS) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model;

(a) There will be no significant difference in the mean score on the Respect for the Child’s Feelings and Right to Express Them subscale of the Porter Parental Acceptance Scale (PPAS) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

(b) There will be no significant difference in the mean score on the Appreciation of the Child’s Unique Makeup subscale of the Porter Parental Acceptance Scale (PPAS) posttest as compared with the pretest between parents who
receive the intensive LFTT model and parents who receive the traditional LFTT model.

(c) There will be no significant difference in the mean score on the Recognition of the Child’s Need for Autonomy and Independence subscale of the Porter Parental Acceptance Scale (PPAS) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

(d) There will be no significant difference in the mean score on the Loves Child Unconditionally subscale of the Porter Parental Acceptance Scale (PPAS) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

4. There will be no significant difference in the mean total score of the Filial Problem Checklist (FPC) posttest as compared with the pretest between parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Limitations of the Study

Because of the small sample size, the subject sample cannot be generalized beyond the sample group. Pretesting may have a sensitizing effect on the control group making them more aware of areas of parenting concepts to be addressed. As the sample was limited to volunteers from the Dallas metroplex area, the results cannot be generalized to all populations. Random assignment of all participants to the treatment groups was not possible due to scheduling limitations. Parents who were available for either group meeting-time were randomly assigned (n=10), but the majority (n=16) were
assigned to the groups that their schedules allowed. Volunteers, by definition, may be more willing to change than non-volunteers.

Instruments

Parenting Stress Index (PSI)

The PSI is a 120-item Likert-type scale that the parent can complete in about five minutes regarding the child of focus. The PSI has two domain scores, Parent Characteristics and Child Characteristics. High scores on the child domain indicate that certain characteristics of the child contribute to the overall stress level of the parent-child pair. On this domain, scores of ≥116 are within the clinical range. High scores on the parent domain reflect the source of stress originating in the functioning of the parent. On this domain, scores of ≥148 are within the clinical range. Total stress scores of ≥258 are within the clinical range. Factor analyses have indicated that the PSI subscales measure distinct factors of stress. The PSI has also been proven to be reliable and valid with a variety of populations, including substance-abusing mothers, negligent and/or abusive mothers, depressed mothers, battered mothers, mothers of low socioeconomic status, and mothers of children with behavioral and/or developmental problems (Abidin, 1983).

<table>
<thead>
<tr>
<th>PSI</th>
<th>Cronbach’s α</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Domain</td>
<td>.96</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>Parent Domain</td>
<td>.94</td>
<td>.93</td>
<td></td>
</tr>
<tr>
<td>Total Score</td>
<td>.97</td>
<td>.96</td>
<td></td>
</tr>
</tbody>
</table>
Reliability estimates for the data in the study are presented in Table 4. The high magnitude of these coefficients indicate that the data were measured reliably.

Measurement of Empathy in Adult-Child Interactions Scale (MEACI)

The MEACI measures three major aspects of empathy: (a) verbal communication of acceptance of the child by the parent, (b) allowing the child self-direction, and (c) involvement through attention to the child’s activities. Each scale is rated from 1 to 5. Low scores on the MEACI indicate high levels of empathy. Play therapists with advanced training viewed videotapes of playtimes at three-minute intervals and then rated the interactions based on the average level demonstrated for each scale except for the subscale Allowing the Child Self-direction on which the lowest score demonstrated was entered. Research on the validity of this instrument found highly significant results on each scale and on the average empathy score suggesting that these scales are extremely sensitive measures of the behaviors in question.

Table 2
Cronbach's Alpha for the Measurement of Empathy in Adult-Child Interactions (MEACI)

<table>
<thead>
<tr>
<th>MEACI</th>
<th>Cronbach’s α</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication of Acceptance</td>
<td>.80</td>
<td>.89</td>
<td></td>
</tr>
<tr>
<td>Allowing Self Direction</td>
<td>.70</td>
<td>.90</td>
<td></td>
</tr>
<tr>
<td>Involvement</td>
<td>.93</td>
<td>.85</td>
<td></td>
</tr>
<tr>
<td>Total Score</td>
<td>.78</td>
<td>.93</td>
<td></td>
</tr>
</tbody>
</table>
Porter Parental Acceptance Scale (PPAS)

The Porter Parental Acceptance Scale (PPAS) was developed by Porter in 1954. It is a 40-item self-report inventory type questionnaire. The acceptance scale is designed to measure parental acceptance of children as revealed in the behavior and feelings parents express toward, with, or about their child. The PPAS involves four dimensions of acceptance: (a) respect for the child’s feelings and right to express them, (b) appreciation of the child’s uniqueness, (c) recognition of the child’s need for independence and autonomy, and (d) unconditional love. The PPAS was used for this study because these four variables are closely associated with the training objectives of filial therapy. The PPAS is easy to administer and takes approximately 20 minutes to complete.

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

Porter (1954) reported a split-half reliability correlation of .766 raised by the Spearman Brown Prophecy formula to .865. Another research project reported a split-half reliability coefficient of .80 by utilizing the Spearman Brown Prophecy formula. Both coefficients are significant beyond the .01 level.

Burchinal, Hawkes, and Garner (1957) studied the internal consistency of the PPAS using an item analysis. They reported that the PPAS is internally consistent at the .001 level of probability.
Table 3

Cronbach's Alpha for the Porter Parental Acceptance Scale (PPAS)

<table>
<thead>
<tr>
<th>PPAS</th>
<th>Cronbach’s α</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect for the Child's Feelings and Right to Express Them</td>
<td>0.64</td>
<td>0.71</td>
<td></td>
</tr>
<tr>
<td>Appreciation of the Child's Unique Makeup</td>
<td>0.60</td>
<td>0.59</td>
<td></td>
</tr>
<tr>
<td>Recognition of the Child's Need for Autonomy and Independence</td>
<td>0.43</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Loves Child Unconditionally</td>
<td>0.71</td>
<td>0.84</td>
<td></td>
</tr>
<tr>
<td>Total Score</td>
<td>0.75</td>
<td>0.82</td>
<td></td>
</tr>
</tbody>
</table>

Filial Problem Checklist (FPC)

The Filial Problem Checklist (FPC), developed by Horner in 1974, has been used extensively by the Individual and Family Consultation Center at Pennsylvania State University in research on filial therapy. This self-report instrument lists 108 possible problem situations. Parents are instructed to consider each situation with one specific child in mind and to mark any of the items that are currently problematic for their family with a 1, 2, or 3. A 1 means that a situation is true for the child, but not considered a problem. A 2 means that a situation is considered a moderate problem for the child. A 3 means that a situation is a severe problem for the child. The FPC is easy to administer and understand and takes only about 15 minutes to complete. Normative statistics concerning validity or reliability are not available on this instrument. The FPC was used as a means to compare results by other studies on the effectiveness of filial therapy.
Table 4

Cronbach's Alpha for the Filial Problem Checklist (FPC)

<table>
<thead>
<tr>
<th>FPC</th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Score</td>
<td>.98</td>
<td>.99</td>
</tr>
</tbody>
</table>

Selection of Subjects

The researcher recruited 43 volunteer parents from three locations in the Dallas/Fort Worth metroplex. The researcher used the following criteria to select participants: (a) parents reported parenting difficulty, (b) child exhibited behavioral problems, (c) parents had at least one child between the ages of 2 to 10 years living with them, (d) parents were willing to participate in training for 10 weeks or 4 weeks, (e) parents were willing to be videotaped playing with their child before and after training, (f) parents were able to read and speak English, (g) parents were willing to complete pretest and posttest instruments, (h) parents were willing to sign the consent form, and (i) the children were not currently in therapy.

Participants who had more than one child living with them between the ages of 2 and 10 were asked to choose one child to be the child of focus for this training. Each parent based their selection by determining which child they felt needed them the most and/or who with whom they had the most difficulty relating.
<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive</td>
<td>4 (31%)</td>
<td>9 (69%)</td>
<td>13</td>
</tr>
<tr>
<td>Traditional</td>
<td>3 (23%)</td>
<td>10 (77%)</td>
<td>13</td>
</tr>
<tr>
<td>Age</td>
<td>Intensive</td>
<td>Traditional</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>-----------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Intensive</th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>12 (92%)</td>
<td>11 (85%)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1 (8%)</td>
<td>1 (7.7%)</td>
</tr>
<tr>
<td>Native American</td>
<td>0</td>
<td>1(7.7%)</td>
</tr>
<tr>
<td>African American</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
The average age for the participants in the intensive LFTT group was 35.4, and the average age for the participants in the traditional LFTT group was 35.2. The greatest variance among the groups was that there was only one Native American who participated in the traditional LFTT group. These demographics serve only to describe the comparison groups.

Table 7

Demographic Data of Comparison Groups: Age and Gender of Child of Focus

<table>
<thead>
<tr>
<th>Age</th>
<th>Intensive</th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Age Mean</td>
<td>5.5</td>
<td>4.17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Intensive</th>
<th>Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Male</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

The average age for the child of focus for the intensive LFTT group was 5.5 years old while the average age for the traditional LFTT group child of focus was 4.17. The intensive group consisted of all male children of focus while the traditional group was almost equally divided by sex (female=7; male=5).
Collection of Data

The researcher met with the participants individually before beginning filial therapy training to (a) explain the requirements and purpose of the filial therapy training, (b) explain how confidentiality will be maintained, (c) explain and administer the pretest instruments (PSI, PPAS, FPC, and demographic information), and (d) answer any questions before having the participants sign the consent form. In addition, the pretesting included videotaping a 20-minute parent-child playtime (for the MEACI) with each parent and his or her child of focus in a designated play area, using toys and materials recommended by Landreth (1991). Once the researcher met with all of the parents, collected parent consent and pretesting data, 13 parents participated in three intensive LFTT groups and 13 parents participated in two traditional LFTT groups. Both formats were offered at each location. Since parents and students were not told to pick up the toys or leave them before leaving the taping room, the decision was left to the parents. Virtually all parents picked up the toys, enlisting the child's help also. Even when the researcher told them it was not necessary to pick up the toys, parents insisted on helping and having their child help the researcher with the cleanup.

The posttest sessions were conducted immediately following the conclusion of each filial therapy training group. The video posttests followed the same protocol as the pretest sessions. Each parent and child of focus was videotaped for 20 minutes in the designated play area using the same toys as were used in pretesting. Also, each parent again completed the written instruments on his or her child of focus, the PSI, PPAS, and FPC.
Treatment

Ensuing is a description of the traditional LFTT model followed by a description of the modification of that model to an intensive LFTT model. Handouts used in training were identified by number and are included in Appendix E. Childcare was provided on site for the child of focus and other children of the participants as necessary for both groups.

*Traditional Landreth Filial Therapy Training Model*

The following session descriptions are described as detailed in Bratton (1995).

*Training Session One*

Parents introduced themselves, described their family, and their child of focus. Parents were asked what they hoped to gain from this experience for themselves as well as for their child. The researcher introduced herself describing her background as a special education teacher in a self-contained classroom for children with severe behavior problems, an elementary school counselor, a licensed professional counselor, and a doctoral candidate in counseling, specializing in play therapy. The researcher explained the goals and objectives of filial training, gave an overview of the training sessions and highlighted the focus of training to help parents develop sensitivity and empathic responding with their children. The researcher introduced reflective listening and tracking behavior, showed a videotape to demonstrate reflective listening and tracking behavior and then further illustrated these skills through role-play with one of the parents playing as a child (Appendix E, Handout1). Following the demonstration, questions were answered with an emphasis on the four messages: (a) I’m here, (b) I here/see you, (c) I
understand, and (d) I care. Parents were then given the opportunity to practice empathic responses in a similar role-play situation. They were instructed to make statements instead of asking questions and to follow the activity of their partner instead of trying to lead. Parents learned to reflect feelings, actions, and behaviors in their role-play partner. Through the use of the video Child's First Feelings, the parents were introduced to the facial expressions of children's emotions (Handout 3). Homework for this week was for each parent to notice a physical characteristic in their child not noticed before and to practice reflecting four different feelings one time during the week (Handout 2).

**Training Session Two**

Session two began with a review of the homework on identifying and reflecting feelings. The basic principles and guidelines of the special playtimes were explained (Handout 4). The researcher displayed the toys listed and discussed the rationale of selecting each toy. Parents were told that the toys did not have to be new, but to add to their “specialness,” toys should be reserved for use only during the special playtimes. The group watched a video of a parent-child playtime and role-played as parent and child making reflective responses. Their homework for this week was to put together the toy kit, read Handout 6, and select a time and place in the home for the special playtimes. Parents were asked to choose a location that had minimal distractions and the least amount of parental concern about possible messes. The researcher provided all parents with six of the toys needed for their play kits and also supplied complete play kits as needed for parents so as not to limit participation due to financial concerns.
Training Session Three

The researcher began by verifying that each parent had chosen a time and place for their special playtime as well as gathered the toys for their toy kits. A discussion of reflective communication followed as a review of Handout 6. The researcher explained the basic rules for filial therapy (Handout 5) in preparation for the parents' first special playtime. The researcher instructed the parents to tell their children that they were going to special classes to learn to play with them in some new ways. For older children, parents were instructed to tell their children that the parents are learning how to be better listeners and would be practicing those skills during special playtimes. Some commonly used phrases (Handout 7) were reviewed. The homework was for parents to help their child make a Do Not Disturb sign to hang on the door of the room for their special playtime and begin their special playtime Handout 8). The researcher asked two parents to videotape their playtime for review next week in class. Because the opportunity to provide support to their peers is a unique aspect of filial therapy that benefits the parents whose tapes are being watched as well as the parents giving support, the researcher made videotaping available on-site as needed for those parents without access to a video camera (Kraft & Landreth, 1998).

Training Session Four

Parents reported on their first playtime and the feelings they experienced. The researcher focused on examples to support, used those instances to reinforce the basic principles of filial therapy and to point out difficult situations. The Playtime Skills Checklist (Handout 10) was used to help each participant evaluate his or her effectiveness.
in the playtime. Most of this session consisted of parents sharing specific happenings in their playtimes and seeking advice on how to handle those situations. One goal of the researcher was to find something in each parent’s sharing to support and encourage. Parents were reminded that it is their responsibility to end the playtimes on time even though the children may want to continue playing.

The researcher showed the video “Choices, Cookies, and Kids” on limit-setting and reviewed Handout 11, 12, and 13 with the parents. They then practiced role-playing situations where a limit needed to be set. Discussion of these practice playtimes focused on the parents' feelings. Parents were reminded that it takes time and practice to learn new skills. Homework for this week was to read Handout 9. During the special playtime this week, parents were asked to notice one intense emotion in themselves. Parents were instructed to continue their special playtimes and for two more parents to videotape their playtimes for next week.

*Training Sessions Five through Ten*

The last five sessions followed the same general format for the first half of the session: each parent reported about his or her home playtimes of the previous week and videotaped playtimes of two of the parents were shown. The researcher provided a supportive environment by inviting group members to contribute encouragement as she provided suggestions, encouragement, and instructions to parents while continuing to focus on their feelings. The researcher helped the parents see that they were not alone in their childrearing difficulties by commenting frequently on experiences shared by several
The researcher took several opportunities to generalize the skills to other settings.

**Training Session Five**

Using Handouts 14 and 15, the researcher reviewed limit setting and focused on choice giving as a method of increasing the child's sense of responsibility and as a means of discipline. Reporting of special playtimes as well as an intense emotion was encouraged from each parent. Videotapes were reviewed as described previously. Role-playing was utilized during this session to review and practice those skills that the parents felt a need to review. For homework this week, parents were asked to practice giving one choice outside of the special playtime and read Handout 16. Parents were instructed to continue their special playtimes and for two more parents to videotape their playtimes for next week.

**Training Session Six**

Parents reported on their special playtimes, choice-giving homework, and comments regarding Handout 17. The researcher concentrated on children’s aggression and how parents could cope with it using Handouts 18 and 20. Parents were asked to write a note to their child of focus that points out a positive characteristic of the child’s in the form of: “I noticed…” Parents were instructed to continue their special playtimes and two more parents were asked to videotape their playtimes for next week.

**Training Session Seven**

Parents reported on their special playtimes and the researcher began asking the parents to look for themes in their children’s play. Some problems that frequently occur
during special playtimes were reviewed (Handout 19). This discussion was used to
review the reflective listening, limit setting, and giving choices. The researcher explained
the benefits of using encouragement in place of praise with their children by discussing
Handout 21. Parents were instructed to continue their special playtimes and read Handout
22. Two more parents were asked to videotape their playtimes for next week.

Training Session Eight

The researcher and group reviewed parent videotapes as previously discussed.
The researcher invited feedback and discussion regarding encouragement versus praise
(Handout 21) as well as perfectionism (Handout 22). The researcher assisted parents in
identifying themes in their child’s play and focused on the parents’ perceived changes in
their own behavior as well as changes in their child’s behavior. Parents expressed support
and encouragement of other group members’ progress. This feedback exemplified the
giving parent’s growing self-confidence in his or her new skills and was sometimes more
encouraging than feedback from the researcher. Parents were instructed to continue their
special playtimes and for two more parents to videotape their playtimes for next week.

Training Session Nine

Parents were asked how they wanted their children to remember them. The
researcher encouraged and reinforced their hopes through examples of previously shared
progress. The researcher and group reviewed parent videos and parent reports of their
special playtimes. The researcher asked parents to report on perceived changes in their
child’s play behavior. Parents were instructed to continue their special playtimes and for
two more parents to videotape their playtimes for next week.
Training Session Ten

The researcher and group reviewed videos of special playtimes. The researcher gave parents a list of recommended further reading (Handout 23). The researcher reviewed with the group the parents’ descriptions of their children at the beginning of training as compared to the end of the training. The researcher reviewed skills learned in previous sessions. Parents shared their perspectives on what was most important to them in the training and how they hoped to continue using those skills with their children. The researcher emphasized the importance of continuing their special playtimes.

Intensive Landreth Filial Therapy Training

Intensive LFTT was designed to include all of the procedures of the traditional LFTT model condensed into four 4-hour sessions. The primary difference of the intensive model is that there are fewer opportunities for parents to have home playtimes with their children and receive feedback from the trainer. The researcher attempted to make up for that difference by providing supervised playtimes for each parent/child during the training session. Thus, parents brought their child with them to the classes and left them with the volunteer babysitter except when they participated in special playtimes with their parents. Each training session was conducted according to the following format that is a reorganization of the same skills and concepts covered in the traditional LFTT model. All training ideas and Handouts are derived directly from information delivered either verbally or through Handouts in the filial therapy graduate course at the University of North Texas with Garry Landreth.
Training Session One

Introduction.

Parents introduced themselves, described their families, and identified concerns for their child of focus. Parents were asked what they hoped to gain from this experience for themselves as well as for their child. The researcher introduced herself describing her background as a special education teacher in a self-contained classroom for children with severe behavior problems, an elementary school counselor, a licensed professional counselor, and a doctoral candidate in counseling, specializing in play therapy. The researcher explained the goals and objectives of filial training, gave an overview of the training sessions and highlighted the focus of training to help parents develop sensitivity and empathic responding with their children. The researcher gave an overview of the training sessions and special home playtimes required for training.

Reflective listening.

The researcher introduced reflective listening and tracking behavior using Handout 1 (see Appendix E) and answered any questions. Then the researcher asked parents to pay attention to her instead of the child as she brought in one of the parents’ children for a live demonstration. A short discussion followed highlighting specific skills used and situations encountered. Following the demonstration, questions were answered with an emphasis on the four messages: (a) I’m here, (b) I here/see you, (c) I understand, and (d) I care. Then the parents were given a few toys to practice reflecting and tracking with their own child. Each parent found an area to have a playtime, brought their child over and practiced the new skills. The researcher walked around observing each parent.
and child during the 10-minute playtime. Parents were then asked to stop, children were returned to the volunteers who were watching them, and the parents reconvened for feedback from the researcher. Feedback consisted of finding examples to support each parent’s use of reflective listening skills and providing suggestions for situations in which parents were unsure of how to respond. In one group, the researcher role-played a demonstration of how to respond when the child asks the parent a direct question. Role-play or live demonstrations were made available whenever needed for conceptualizing a skill or concept.

Reflection of feelings.

It was explained that tracking and reflecting are beginning steps to demonstrating the parent’s understanding of the child. For deeper understanding, parents were instructed to include reflections of the child’s feelings in their responses. In order to do this, the parents must attempt to see the world through their child’s eyes and use that view to reflect the feelings the parent believes the child may be feeling in that situation. To illustrate how adult responses influence behaviors in young children, parents watched portions of the video Life's First Feelings. The video demonstrated the impact of parents' responding appropriately to the child's feelings. Using Handout 2, parents practiced responding to four basic emotions. A discussion followed detailing the developmental sequence of emotional expressions (see Handout 3). The researcher then demonstrated tracking behavior and reflection of feelings during a short playtime with a child of one of the parents. Parents were then asked to take a few toys and practice reflecting feelings in a short playtime with their child as described previously. Feedback followed as
previously described. The researcher focused on helping each participant feel confident enough in the teaching environment to find an appropriate response. Parents were assured that even though they found it difficult at first to find an appropriate response, with practice and patience with themselves they would find this task increasingly easier. Also, the researcher explained that there was not just one correct response, but many ways of responding. Parents were assured that it was okay if they reflected the wrong feeling because no one can ever know exactly what another person is thinking or feeling all of the time. They were encouraged to make their best guess because their child would appreciate attempts at truly understanding them and not be disappointed if the parents missed the emotion or intention. An additional playtime was held as necessary to ensure understanding and basic competency of the skills taught.

Basic rules and special playtime.

Basic rules for special playtimes were discussed as well as the toys needed for those playtimes as detailed on Handout 4 and 5. Each toy was shown and discussed with the parents to explain its purpose for inclusion in the toy kit. Parents were asked to use these toys only during their special playtimes with their children to add to the special distinction of the playtimes. Instructions concerning setup, beginning, and ending the special playtimes was described in great detail. The researcher then gave a live demonstration of a shortened version of a special playtime to include demonstration of setting up for the playtime, beginning, and ending the playtime. Parents were then given a few toys to practice these skills for 10 minutes with their children including the introductory statement, giving a one minute warning, and ending the playtime while the
researcher observed. Discussions followed concerning parents' impressions of their playtimes, with the researcher focusing on the appropriate use of tracking behaviors and reflections of feelings. The researcher used examples from their playtimes to reinforce basic principles of filial therapy, to point out difficult situations, and to focus on how the parents felt during the playtimes. Reflective communication was reviewed using Handout 6 to choose responses to situations that might occur in a playtime. This handout was designed to prepare parents for topics or situations they had not previously considered encountering in a playtime. Additional supervised practice followed by feedback was repeated as time permitted.

Conclusion of session.

To end the first training session, the researcher reviewed the set up of the home playtimes emphasizing an established time and place as well as the need for that time to be undisturbed. Parents were reminded that it is their responsibility to end the playtimes on time even though the children may want to continue playing. Some commonly used phrases (Handout 7) were reviewed and an example of a sign for the playtime door was given (Handout 8). Homework assignments were to (1) notice one physical characteristic about their child they had not seen before, (2) collect and/or buy toys for the play kit, (3) select a regular time and place in their homes for the special home playtimes that would provide the least amount of distraction and least concern of messes for the parent and child, (4) conduct and videotape their first special playtime, and (5) read Handout 9. The researcher provided all parents with six of the toys needed for their play kits and also
supplied complete play kits as needed for parents so as not to limit participation due to financial concerns.

*Training Session Two*

*Homework review.*

Support at the beginning of session two was very important for the participants. While each parent was given an opportunity to briefly share experiences of their home playtime, the researcher had to also be aware of time because in this session and the next two sessions all participants' videos would be reviewed. While reviewing the homework assignments, the researcher asked each parent about the physical characteristic they noticed about their child. The researcher also asked where and when each participant decided to have their special playtime, if they were able to find the toys for their play kits, and if they had any problems concerning videotaping their special playtimes.

Handout 9 was also discussed with a focus on how the author changed from trying to be in control and be informative to really trying to hear and understand others. Parents were encouraged to begin allowing themselves during the special playtimes to let their child express himself or herself without feeling that they need to teach or correct.

*Supervision of home playtime videos.*

Videos of home playtimes were reviewed for each participant. Questions were addressed and the researcher looked for something to support in each parent’s special playtime. The Playtime Skills Checklist (Handout 10) was used to help each participant evaluate his or her effectiveness in the playtime. The focus of feedback was to support appropriate skills
and help participants identify skills they needed to work on. Group members were encouraged to find other ways to support each other's playtimes.

**Limit-setting.**

Limit-setting was introduced to participants by reviewing Handout 11 on ACT and Oreo Cookie Theory. The parents learned to A- Acknowledge the child’s feeling, C- Communicate the limit, and T- Target acceptable choice(s). Following that discussion, participants watched the Choices, Cookies, and Kids video. The choice giving process was reviewed using Handout 12, 13, 14, and 15.

**Conclusion of session.**

For homework, parents were instructed to write a note to their child of focus that points out a positive characteristic of the child’s, and read Handouts 16 and 17. Parents were instructed to continue their special playtimes and the researcher arranged for all parents to videotape their home playtimes for next week. Parents were also asked to give one choice to their child outside of the special playtime.

**Training Session Three**

Parents reported on their special playtimes and their choice giving homework. All tapes were reviewed as described before with feedback from the researcher and group members. Some problems that frequently occur during special playtimes were reviewed (Handout 19). Choice-giving was reviewed and what to do when setting limits doesn’t work was reviewed (Handout 20). The researcher provided role-play opportunities with other parents followed by supervised playtimes with their children. The researcher and other group members provided feedback, focusing on appropriate examples in each
playtime. The researcher asked parents to begin identifying themes in their children’s play. Parents were instructed to continue their special playtimes and read Handout 22. The researcher arranged for all parents to videotape their special playtimes for next week.

*Training Session Four*

The researcher and group reviewed parent videos and parent reports of their special playtimes. The researcher explained the benefits of using encouragement in place of praise with their children (Handout 21) and invited discussion on perfectionism from Handout 22. Aggression in children was addressed using Handout 20. The researcher asked parents to report on perceived changes in their child’s play behavior. The researcher reviewed parents’ descriptions of their children at the beginning of training as compared to the end of training. Parents were asked if changes were noticed in their child, themselves, or both. Parents conducted supervised special playtimes with their children followed by feedback. The researcher gave parents a list of recommended reading (Handout 23). The researcher asked parents to continue their special playtimes.

*Follow-up meeting/collection of posttesting data*

The researcher met with the parents one week later to monitor their progress since the last meeting providing feedback as necessary. Posttesting videos were recorded and questionnaires completed.

Throughout training, parents who missed a class were contacted immediately to schedule a make-up training session before the next session. Parents were also asked to make-up any missed playtimes with their child. Parents who missed more than three training sessions in the traditional format (n=5) were dropped from the study. Parents
who missed more than one session in the intensive format (n=2) were also dropped from the study.

Facilitator

The researcher, a doctoral level graduate student in counseling, facilitated the intensive groups and the traditional groups and holds a master's degree in counselor education from the University of North Texas is a licensed professional counselor in the state of Texas, seven years experience as an elementary school counselor and play therapist. In addition, the researcher has 5 years of teaching experience with children in a self-contained special education classroom for elementary age children labeled emotionally disturbed and has completed coursework in Introduction to Play Therapy, Advanced Play Therapy, Group and Activity Play Therapy, Filial Therapy, Doctoral Practicum in Play Therapy, and an Internship in Play Therapy.

Analysis of Data

The pretest and posttest instruments were blind-scored by a research assistant and double checked by a second research assistant. The researcher entered the data into the computer and analyzed using SPSS for MS Windows Release 11.0. The data were then analyzed via a sequence of doubly multivariate analyses of variance (DM MANOVA). The independent variables for the analysis were group membership (i.e. intensive LFTT or traditional LFTT); the dependent variables for the first DM MANOVA were change of scores on the Total PSI, Total MEACI, Total PPAS, and the Total FPC. The dependent variables for the second DM MANOVA consisted of change of scores for the Child Domain and Parent Domain subscales of the PSI. The dependent variables for the third
DM MANOVA consisted of change of scores for the Communication of Acceptance, Allowing Self-Direction, and Involvement subscales on the MEACI. The dependent variables for the fourth DM MANOVA consisted of change of scores for the Respects Child's Right to Express Feelings, Fosters Uniqueness, Recognizes Child Need for Autonomy, and Loves Child Unconditionally subscales on the PPAS. A level of significance of .05 was established as the criterion for either rejecting or failing to reject the hypotheses. Effect sizes were calculated using eta-squared ($\eta^2$) to determine the practical significance of the results.

The pretraining and posttraining videotapes were rated at the end of the study so that raters would not know whether they are viewing a pretraining or posttraining video. Over a four-week period, four doctoral students with advanced training and course work in play therapy and filial therapy scored the videos using the Measurement of Empathy in Adult-Child Interaction (MEACI) and procedures outlined by Stover et al (1971). Tapes were assigned so that no rater rated both the pretest and posttest for the same participant. Inter-rater reliability was established for the four raters during an initial training session and a midpoint session. A coefficient of reliability, Kendall's W, was use to calculate inter-rater reliability.
Table 8

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

<table>
<thead>
<tr>
<th>Variables of the MEACI</th>
<th>Kendall’s Coefficient W</th>
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<tbody>
<tr>
<td></td>
<td>Precoding</td>
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<tr>
<td>Communication of Acceptance</td>
<td>.75</td>
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<tr>
<td>Allowing Self-direction</td>
<td>.74</td>
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<td>Parental Involvement</td>
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CHAPTER 3

Results and Discussion

Of the forty-two participants recruited for this study, twenty-six completed the training and posttesting. Of this total, 13 parents participated in the intensive Landreth filial therapy training (LFTT) format and 13 participants participated in the traditional Landreth filial therapy training (LFTT) format. This chapter presents a description of the statistical analyses performed, the specific results of each hypotheses, consistent trends identified in the analysis of the data, a discussion of the potential meaning and implications of these findings, and recommendations for future research.

Results

The results of this study are presented in the order the hypotheses were tested. Doubly Multivariate Analysis of Variances (DM MANOVA) were performed on all four hypotheses. A level of significance of .05 was established as a criterion for either rejecting or failing to reject the hypotheses.

Prior to analysis, data were screened and assumptions were verified. Assumptions of DM MANOVA include independence of the observations and multivariate normality (Stevens, 2002). Box's Test was used to verify multivariate normality of the data, Box's M=81.20, p=.053.
Overall Comparison of Intensive LFTT and Traditional LFTT

Table 9 presents the results for the DM MANOVA on total scores of the PSI, MEACI, PPAS, and the FPC. The occasion main effect was found to be statistically significant, $F=75.13$, $p<.001$, $\eta^2=0.94$. The score of the between-group main effect was not statistically significant, however, $F=1.24$, $p=.33$, $\eta^2=0.19$. The results indicate that

<table>
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<tr>
<th>F-Tests</th>
<th>Wilks' Lambda</th>
<th>F</th>
<th>df</th>
<th>$p$</th>
<th>$\eta^2$</th>
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<td>Group</td>
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<td>&lt;.001*</td>
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<td>1, 24</td>
<td>0.62</td>
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*p<.05
while there were no statistically significant differences between the intensive LFTT and traditional LFTT groups regardless of test occasions, there were statistically significant differences between test occasions regardless of group membership. The interaction effect was not statistically significant, \( F = .64, \ p = .64, \ \eta^2 = 0.11 \), indicating no interaction between the groups’ scores by test occasion. Overall, as the traditional LFTT group scores improved across test occasions, the intensive LFTT group improved as well.

Because the small sample size most likely negatively influenced statistical power, thus affecting the statistical significance results of the tests, eta-squared (\( \eta^2 \)) values were calculated to measure the practical significance of the scores. The occasion main effect was found to be practically significant, (\( \eta^2 = 0.94 \)). This large effect size explains 94% of the variance in the total test scores, reinforcing the statistical significance of total score differences across test occasions not taking group membership into account.

Table 9 presents the results of the univariate analyses that were examined to determine which test scores contributed to the multivariate effect. The PSI occasion main effect was not statistically significant, \( F = 3.28, \ p = .08, \ \eta^2 = 0.12 \), indicating that, ignoring group membership, the scores on the pretests and posttests did not differ. The PSI group main effect was not statistically significant, \( F = 1.24, \ p = 0.33, \ \eta^2 = 0.19 \), indicating that there were no differences between the two groups on the PSI total score regardless of test occasion. These results indicate that neither group had statistically significant or practically significant decreases in parental stress. The MEACI occasion main effect was statistically significant, \( F = 295.68, \ p = <.001, \ \eta^2 = 0.93 \), indicating that the scores on the pretests and posttests differed regardless of group membership. The MEACI group main
effect was not statistically significant, \( F=3.46, p=.08, \eta^2=0.13 \), indicating that there were no differences between the two groups on the MEACI total score regardless of test occasion. These results indicate that on the MEACI both groups had statistically significant change from pretest to posttest and that there were no statistically significant differences between the groups at posttesting. The PPAS occasion main effect was statistically significant, \( F=17.20, p<.001, \eta^2=0.42 \), indicating that the scores on the pretests and posttests differed, not taking into account group membership. The group main effect on the PPAS was not statistically significant \( F=0.72, p=0.40, \eta^2=0.03 \), indicating that there were no differences between the two groups on the PPAS total score regardless of test occasion. These results indicate that on the PPAS both groups had statistically significant change from pretest to posttest and that there were no statistically significant differences between the groups at posttesting. The FPC occasion main effect was not statistically significant, \( F=0.21, p=0.65, \eta^2=0.01 \), indicating that the scores on the pretests and posttests did not differ regardless of test occasion. These results indicate that there were no statistically significant changes for either group at posttesting.

**Hypothesis 1**

There will be no significant difference in the Total Score of the Parenting Stress Index (PSI) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 9 presents the results for the univariate analysis of the between-group effect on the PSI indicating no statistically significant differences between the two groups on the PSI Total score \( (p=0.14) \). Table 10 presents the mean scores of the PSI total score
indicating decreases at posttesting for both groups. The clinical range for the Total Score is \(\geq 258\). This table reveals that the intensive LFTT group was much more stressed than the traditional LFTT group at pretesting. On the basis of this data, hypothesis 1 cannot be rejected.

Table 10
Mean Scores and Standard Deviations on the Parenting Stress Index (PSI) Total Score

<table>
<thead>
<tr>
<th>Mean</th>
<th>Pretest</th>
<th>Intensive Group</th>
<th>Change</th>
<th>Traditional Group</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>248.86</td>
<td>229.50</td>
<td>19.36</td>
<td>214.75</td>
<td>3.83</td>
</tr>
<tr>
<td>SD</td>
<td>50.79</td>
<td>33.84</td>
<td></td>
<td>50.80</td>
<td></td>
</tr>
</tbody>
</table>

* Decreasing scores indicate a decrease in measured stress.

_Hypothesis 1 (a)_

There will be no significant difference in the Child Domain of the Parenting Stress Index at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 11 presents the results for the univariate analysis of the between-group effect on the Child Domain of the PSI indicating no statistically significant differences between the two groups \((p=.13)\). Table 12 presents the mean scores on the Child Domain of the PSI. The clinical range for the Child Domain is \(\geq 116\). This table shows that the intensive LFTT group was much more stressed than the traditional LFTT group at pretesting. A decrease in scores on the PSI indicates a decrease in measured stress. On the basis of this data, hypothesis 1 (a) cannot be rejected.
Table 11
Multivariate Analysis of Variance for the Child Domain Subscale and Parent Domain Subscale on the PSI

<table>
<thead>
<tr>
<th>F-Tests</th>
<th>Wilks' Lambda</th>
<th>F</th>
<th>df</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multivariate Analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>0.90</td>
<td>1.22</td>
<td>2, 23</td>
<td>0.32</td>
<td>0.10</td>
</tr>
<tr>
<td>Occasion</td>
<td>0.87</td>
<td>1.76</td>
<td>2, 23</td>
<td>0.19</td>
<td>0.13</td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>0.94</td>
<td>0.71</td>
<td>2, 23</td>
<td>0.50</td>
<td>0.06</td>
</tr>
<tr>
<td>Univariate Analyses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Domain (PSI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>2.51</td>
<td>1, 24</td>
<td>0.13</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>Occasion</td>
<td>3.45</td>
<td>1, 24</td>
<td>0.08</td>
<td>0.13</td>
<td></td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>1.15</td>
<td>1, 24</td>
<td>0.29</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>Parent Domain (PSI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>2.51</td>
<td>1, 24</td>
<td>0.13</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>Occasion</td>
<td>1.62</td>
<td>1, 24</td>
<td>0.22</td>
<td>0.06</td>
<td></td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>1.00</td>
<td>1, 24</td>
<td>0.33</td>
<td>0.04</td>
<td></td>
</tr>
</tbody>
</table>

*p<.05

Table 12
Mean Scores and Standard Deviations on the Parenting Stress Index (PSI) Child Domain

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>121.86</td>
<td>111.57</td>
</tr>
<tr>
<td>SD</td>
<td>31.67</td>
<td>20.09</td>
</tr>
<tr>
<td>Change</td>
<td>10.29</td>
<td>2.75</td>
</tr>
</tbody>
</table>

* Decreasing scores indicate a decrease in measured stress.

Hypothesis 1(b)

There will be no significant difference on the Parent Domain of the Parenting Stress Index at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.
Table 11 presents the results for the univariate analysis of the between-group effect on the Parent Domain of the PSI indicating no statistically significant differences between the two groups (p=.13). Table 13 presents the mean scores of the Parent Domain on the PSI. The clinical range for the Parent Domain is ≥148. This table shows that the intensive LFTT group was much more stressed than the traditional LFTT group at pretesting. On the basis of this data, hypothesis 1 (b) cannot be rejected.

<table>
<thead>
<tr>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>127.00</td>
</tr>
<tr>
<td>SD</td>
<td>26.31</td>
</tr>
</tbody>
</table>

* Decreasing scores indicate a decrease in measured stress.

**Hypothesis 2**

There will be no significant difference in the mean Total Score on the Measurement of Empathy in Adult-Child Interaction (MEACI) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 9 presents the results for the univariate analysis of the between-group effect on the MEACI indicating no statistically significant differences between the two groups on the MEACI Total Empathy score (p=0.08). Table 14 presents the mean scores of the MEACI total score indicating decreases at posttesting for both groups. On the basis of this data, hypothesis 2 cannot be rejected.
Table 14
Mean Scores and Standard Deviations on the Measurement of Empathy in Adult-Child Interaction (MEACI) Total Empathy Score

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th></th>
<th>Traditional Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Change</td>
<td>Pretest</td>
</tr>
<tr>
<td>Mean</td>
<td>13.80</td>
<td>8.17</td>
<td>5.63</td>
<td>13.39</td>
</tr>
<tr>
<td>SD</td>
<td>1.13</td>
<td>2.19</td>
<td></td>
<td>1.17</td>
</tr>
</tbody>
</table>

* Decreasing scores indicate an increase in empathy.

**Hypothesis 2 (a)**

There will be no significant difference in the mean score of the Communication of Acceptance subscale on the Measurement of Empathy in Adult-Child Interaction (MEACI) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 15 presents the results for the univariate analysis of the between-group effect on the Communication of Acceptance subscale of the MEACI indicating statistically significant differences between the two groups ($p=0.02$) at posttesting. Table 16 presents the mean scores on the Communication of Acceptance subscale of the MEACI indicating that the traditional LFTT group performed better on Communication of Acceptance at a statistically significant level as compared to the intensive LFTT group. On the basis of this data, reject hypothesis 2 (a).
Table 15

Multivariate Analysis of Variance for the Communication of Acceptance Subscale, Allowing the Child Self-Direction Subscale, and Involvement Subscale on the MEACI

<table>
<thead>
<tr>
<th>F-Tests</th>
<th>Wilks' Lambda</th>
<th>F</th>
<th>df</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multivariate Analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>0.78</td>
<td>2.06</td>
<td>4, 21</td>
<td>0.14</td>
<td>0.22</td>
</tr>
<tr>
<td>Occasion</td>
<td>0.07</td>
<td>91.39</td>
<td>4, 21</td>
<td>&lt;.001*</td>
<td>0.93</td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>0.91</td>
<td>0.73</td>
<td>4, 21</td>
<td>0.54</td>
<td>0.09</td>
</tr>
<tr>
<td>Univariate Analyses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comm. Of Accept.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>2799.78</td>
<td>1, 24</td>
<td></td>
<td>&lt;.001*</td>
<td>0.99</td>
</tr>
<tr>
<td>Occasion</td>
<td>231.35</td>
<td>1, 24</td>
<td></td>
<td>&lt;.001*</td>
<td>0.91</td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>2.38</td>
<td>1, 24</td>
<td></td>
<td>0.14</td>
<td>0.09</td>
</tr>
<tr>
<td>Allow Self-Dir.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>0.43</td>
<td>1, 24</td>
<td></td>
<td>0.52</td>
<td>0.02</td>
</tr>
<tr>
<td>Occasion</td>
<td>124.93</td>
<td>1, 24</td>
<td></td>
<td>&lt;.001*</td>
<td>0.84</td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>1.17</td>
<td>1, 24</td>
<td></td>
<td>0.29</td>
<td>0.05</td>
</tr>
<tr>
<td>Involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>2.16</td>
<td>1, 24</td>
<td></td>
<td>0.15</td>
<td>0.08</td>
</tr>
<tr>
<td>Occasion</td>
<td>55.46</td>
<td>1, 24</td>
<td></td>
<td>&lt;.001*</td>
<td>0.70</td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>0.001</td>
<td>1, 24</td>
<td></td>
<td>&lt;.001*</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

*p<.05

Table 16

Mean Scores and Standard Deviations on the Measurement of Empathy in Adult-Child Interaction (MEACI) Communication of Acceptance Subscale

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>3.35</td>
<td>2.19</td>
</tr>
<tr>
<td>SD</td>
<td>.22</td>
<td>.50</td>
</tr>
</tbody>
</table>

* Decreasing scores indicate increases in communication of acceptance.
**Hypothesis 2 (b)**

There will be no significant difference in the mean score of the Allowing the Child Self-Direction subscale on the Measurement of Empathy in Adult-Child Interaction (MEACI) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 15 presents the results for the univariate analysis of the between-group effect on the Allowing the Child Self-Direction subscale of the MEACI indicating no statistically significant differences between the two groups ($p=0.52$) at posttesting. Table 17 presents the mean scores on the Allowing the Child Self-Direction subscale of the MEACI. On the basis of this data, hypothesis 2 (b) cannot be rejected.

Table 17
Mean Scores and Standard Deviations on the Measurement of Empathy in Adult-Child Interaction (MEACI) Allowing the Child Self-Direction Subscale

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>4.09</td>
<td>2.16</td>
</tr>
<tr>
<td>SD</td>
<td>0.54</td>
<td>1.05</td>
</tr>
</tbody>
</table>

* Decreasing scores indicate increases in allowing the child self-direction.

**Hypothesis 2 (c)**

There will be no significant difference in the mean score of the Involvement subscale on the Measurement of Empathy in Adult-Child Interaction (MEACI) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 15 presents the results for the univariate analysis of the between-group effect on the Involvement of the MEACI indicating no statistically significant differences
between the two groups \((p=0.15)\) at posttesting. Table 18 presents the mean scores on the Involvement subscale of the MEACI. On the basis of this data, hypothesis 2 (c) cannot be rejected.

Table 18
Mean Scores and Standard Deviations on the Measurement of Empathy in Adult-Child Interaction (MEACI) Involvement Subscale

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>3.01</td>
<td>1.64</td>
</tr>
<tr>
<td>SD</td>
<td>0.89</td>
<td>0.39</td>
</tr>
</tbody>
</table>

* Decreasing scores indicate increases in involvement.

_Hypothesis 3_

There will be no significant difference in the mean total score of the Porter Parental Acceptance Scale (PPAS) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 9 presents the results for the univariate analysis of the between-group effect on the PPAS indicating no statistically significant differences between the two groups on the PPAS Total score \((p=0.40)\) at posttesting. Table 19 presents the mean scores of the PPAS total score indicating increases at posttesting for both groups. On the basis of this data, hypothesis 3 cannot be rejected.
Table 19
Mean Scores and Standard Deviations on the Porter Parental Acceptance Scale (PPAS)

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>142.00</td>
<td>152.79</td>
</tr>
<tr>
<td>SD</td>
<td>13.96</td>
<td>12.75</td>
</tr>
</tbody>
</table>

* Increasing scores indicate an increase in parental acceptance.

**Hypothesis 3(a)**

There will be no significant difference in the mean score on the Respect for the Child’s Feelings and Right to Express Them subscale of the Porter Parental Acceptance Scale (PPAS) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 20 presents the results for the univariate analysis of the between-group effect on the Respect for the Child’s Feelings and Right to Express Them subscale of the PPAS indicating no statistically significant differences between the two groups ($p=0.14$) at posttesting. Table 21 presents the mean scores on the Respect for the Child’s Feelings and Right to Express Them subscale of the PPAS. On the basis of this data, hypothesis 3 (a) cannot be rejected.
Table 20
Multivariate Analysis of Variance for the Respect for the Child’s Feelings and Right to Express Them Subscale on the PPAS, Appreciation of the Child’s Unique Makeup Subscale on the PPAS, Recognition of the Child’s Need for Autonomy and Independence Subscale on the PPAS, and Loves Child Unconditionally Subscale on the PPAS

<table>
<thead>
<tr>
<th>F-Tests</th>
<th>Wilks' Lambda</th>
<th>F</th>
<th>df</th>
<th>p</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multivariate Analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>0.89</td>
<td>0.66</td>
<td>2, 23</td>
<td>0.63</td>
<td>0.11</td>
</tr>
<tr>
<td>Occasion</td>
<td>0.51</td>
<td>5.06</td>
<td>2, 23</td>
<td>0.01</td>
<td>0.49</td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>0.87</td>
<td>0.76</td>
<td>2, 23</td>
<td>0.56</td>
<td>0.13</td>
</tr>
<tr>
<td>Univariate Analyses</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respect Child's Feelings (PPAS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>2.34</td>
<td>1, 24</td>
<td>0.14</td>
<td>0.09</td>
<td></td>
</tr>
<tr>
<td>Occasion</td>
<td>12.86</td>
<td>1, 24</td>
<td>&lt;.001</td>
<td>0.35</td>
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</tr>
<tr>
<td>Group*Occasion</td>
<td>0.74</td>
<td>1, 24</td>
<td>0.40</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Child's Unique Makeup (PPAS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>0.29</td>
<td>1, 24</td>
<td>0.60</td>
<td>0.01</td>
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</tr>
<tr>
<td>Occasion</td>
<td>5.70</td>
<td>1, 24</td>
<td>0.25</td>
<td>0.19</td>
<td></td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>0.41</td>
<td>1, 24</td>
<td>0.53</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>Recognition of Child (PPAS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>0.38</td>
<td>1, 24</td>
<td>0.55</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>Occasion</td>
<td>18.00</td>
<td>1, 24</td>
<td>&lt;.001</td>
<td>0.43</td>
<td></td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>0.850</td>
<td>1, 24</td>
<td>0.37</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Loves Child (PPAS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>2.33</td>
<td>1, 24</td>
<td>0.14</td>
<td>0.09</td>
<td></td>
</tr>
<tr>
<td>Occasion</td>
<td>0.33</td>
<td>1, 24</td>
<td>0.57</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>Group*Occasion</td>
<td>0.02</td>
<td>1, 24</td>
<td>0.88</td>
<td>&lt;.001</td>
<td></td>
</tr>
</tbody>
</table>

*p<.05
Table 21
Mean Scores and Standard Deviations on the Porter Parental Acceptance Scale (PPAS)
Respect for the Child’s Feelings and Right to Express Them Subscale

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>31.79</td>
<td>37.21</td>
</tr>
<tr>
<td>SD</td>
<td>6.29</td>
<td>4.49</td>
</tr>
</tbody>
</table>

* An increase in scores indicates an increase in respect for the child’s feelings and right to express them.

Hypothesis 3 (b)

There will be no significant difference in the mean score on the Appreciation of the Child’s Unique Makeup subscale of the Porter Parental Acceptance Scale (PPAS) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 20 presents the results for the univariate analysis of the between-group effect on the Appreciation of the Child’s Unique Makeup subscale of the PPAS indicating no statistically significant differences between the two groups ($p=0.60$) at posttesting. Table 22 presents the mean scores on Appreciation of the Child’s Unique Makeup subscale of the PPAS. On the basis of this data, hypothesis 3 (b) cannot be rejected.
Table 22
Mean Scores and Standard Deviations on the Porter Parental Acceptance Scale (PPAS) Appreciation of the Child’s Unique Makeup Subscale

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th></th>
<th>Traditional Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Change</td>
<td>Pretest</td>
</tr>
<tr>
<td>Mean</td>
<td>33.71</td>
<td>35.79</td>
<td>2.08</td>
<td>33.92</td>
</tr>
<tr>
<td>SD</td>
<td>4.51</td>
<td>4.92</td>
<td></td>
<td>6.67</td>
</tr>
</tbody>
</table>

* An increase in scores indicates an increase in appreciation of the uniqueness of the child.

Hypothesis 3 (c)

There will be no significant difference in the mean score on the Recognition of the Child’s Need for Autonomy and Independence subscale of the Porter Parental Acceptance Scale (PPAS) at posttesting for parents who receive intensive LFTT model and parents who receive the traditional LFTT model.

Table 20 presents the results for the univariate analysis of the between-group effect on the Recognition of the Child’s Need for Autonomy and Independence subscale of the PPAS indicating no statistically significant differences between the two groups (p=0.55) at posttesting. Table 23 presents the scores on Recognition of the Child’s Need for Autonomy and Independence subscale of the PPAS. On the basis of this data, hypothesis 3 (c) cannot be rejected.
Table 23
Mean Scores and Standard Deviations on the Porter Parental Acceptance Scale (PPAS)
Recognition of the Child's Need for Autonomy and Independence Subscale

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>41.07</td>
<td>43.21</td>
</tr>
<tr>
<td>SD</td>
<td>4.46</td>
<td>2.72</td>
</tr>
</tbody>
</table>

*An increase in scores indicates an increase in recognition of the child’s need for autonomy and independence.

Hypothesis 3(d)

There will be no significant difference in the mean score on the Loves Child Unconditionally subscale of the Porter Parental Acceptance Scale (PPAS) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 20 presents the results for the univariate analysis of the between-group effect on the Loves Child Unconditionally subscale of the PPAS indicating no statistically significant differences between the two groups ($p=0.14$) at posttesting. Table 24 presents the scores on Loves Child Unconditionally subscale of the PPAS. On the basis of this data, hypothesis 3 (d) cannot be rejected.

Table 24
Mean Scores and Standard Deviations on the Porter Parental Acceptance Scale (PPAS)
Loves Child Unconditionally Subscale

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th>Traditional Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
</tr>
<tr>
<td>Mean</td>
<td>35.43</td>
<td>36.57</td>
</tr>
<tr>
<td>SD</td>
<td>6.58</td>
<td>8.17</td>
</tr>
</tbody>
</table>

* An increase in scores indicates an increase in unconditional love of the child.
Hypothesis 4

There will be no significant difference in the mean total score of the Filial Problem Checklist (FPC) at posttesting for parents who receive the intensive LFTT model and parents who receive the traditional LFTT model.

Table 9 presents the results for the univariate analysis of the group effect on the FPC indicating no statistically significant differences between the two groups at posttesting on the FPC Total score ($p=0.14$). Table 9 also shows the results for the occasion effect indicating no statistically significant change for both groups at posttesting. Table 25 presents the mean scores of the FPC total score indicating a decrease at posttesting for the traditional LFTT group and a slight increase for the intensive LFTT group. On the basis of this data, hypothesis 4 cannot be rejected.

Table 25

Mean Scores and Standard Deviations on the Filial Problem Checklist (FPC)

<table>
<thead>
<tr>
<th></th>
<th>Intensive Group</th>
<th></th>
<th>Traditional Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pretest</td>
<td>Posttest</td>
<td>Change</td>
<td>Pretest</td>
</tr>
<tr>
<td>Mean</td>
<td>50.79</td>
<td>51.57</td>
<td>.78</td>
<td>50.08</td>
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<tr>
<td>SD</td>
<td>52.34</td>
<td>61.26</td>
<td></td>
<td>58.06</td>
</tr>
</tbody>
</table>

* Decreasing scores indicate a decrease in perceived child problems.
Discussion

The results of this study suggest overall that the intensive model developed by the researcher was as effective as the traditional Landreth filial therapy training (LFTT) in these four areas (a) decreasing parental stress, (b) increasing parental empathy, (c) increasing parental acceptance, and (d) decreasing child behavior problems. Specifically, univariate analyses of each instrument were calculated to compare the two models and revealed that while there was no statistically significant differences in the two groups on total scores, there were no statistically significant decreases in total stress or in child behavior problems. In addition, 13 specific hypotheses were tested, of which 12 were retained, and 1 was rejected.

Parental Stress

There were no statistically significant differences between the groups in the reduction of parenting stress as a result of their participation in filial therapy training. As shown in Table 9 and Table 11, the participants in the intensive LFTT group and the traditional LFTT group had no statistically significant differences ($p = .14$) in their parenting stress levels as measured by the Parenting Stress Index. DM MANOVA results reveal there was no statistically significant decrease in total parental stress for either group ($p = .08$), although both groups’ mean posttest scores (Tables 10, 12, and 13) show that the parents in the intensive LFTT group and traditional LFTT group had decreased stress levels. Furthermore, it is important to note that the participants in the intensive LFTT group began under much higher levels of stress (78th %ile) related to parenting than participants in the traditional LFTT group (40th %ile) and they lowered their stress...
much more. This large decrease in stress for the intensive group seemed to be related to the support group effect experienced by these participants. With a maximum of four members in addition to sessions lasting four hours at a time, the researcher noticed that these members became more cohesive and felt more supported in their role as parent from the researcher and other group members.

These results are inconsistent with earlier filial studies (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Glover & Landreth, 2000; Jang, 2000; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee, 2002; Tew, 1997), which showed statistically significant decreases in total stress. Three participants in the intensive LFTT group had children who may be more stressful to parent due to their diagnoses of bipolar disorder, autism, and conduct disorder. A pervasive concern for parents of children with special concerns is a lack of support and understanding from others. When dealing with more common parenting concerns, parents have many resources for guidance and support from family, friends, schools, churches, etc. Belsky (1984) referred to massive evidence highlighting the beneficial impact of social support on psychological/physical health and its positive relation to parental functioning. Such resources are not as readily available to parents with more serious concerns and they often feel isolated in their attempts to find appropriate solutions for their children. Parents in the traditional LFTT group did not report as severe child behavior problems as those noted above. Because their pretest mean total stress scores were at the 40th %ile, this measure was not an area of need for this group.
Although attempts at random assignments were made, some parents were only available during the weekday evenings while others were only available for weekends. This did cause the groups to be different from the outset. As was the researcher’s basic assumption, the parents who were only available for four weekend sessions were the parents with greater need for filial therapy training as evidenced by the difference in beginning stress levels of the two groups.

**Empathy in Parent-Child Interactions**

As shown in Table 9 and Table 15, the participants in the intensive LFTT group and traditional LFTT group had no statistically significant differences in their empathic behavior during observed playtimes with their children as measured by the allowing self-direction and involvement subscales on the Measurement of Empathy in Adult-Child Interaction. In addition, Tables 17 and 18 show that both groups had statistically significant increases in total empathic behavior with their child. These findings support the notion that both models are effective in increasing parental empathy. Therefore, the intensive LFTT format was as effective as the traditional LFTT format in increasing empathy levels. However, in further analysis of the subscales, there were statistically significant differences between the intensive LFTT model participants and the traditional LFTT model participants in their communication of acceptance of their child as measured by this subscale of the MEACI. Decreased scores on Table 16 indicate that the intensive LFTT group did not improve at the same rate as the traditional LFTT group. Mean scores show decreased scores at posttesting for both groups indicating increased empathy levels. These results are consistent with other filial therapy studies (Bratton & Landreth, 1995;
Chau & Landreth, 1997; Costas & Landreth, 1997; Glass, 1986; Glover & Landreth, 2000, Jang, 2000, Kale & Landreth, 1997; Lee, 2002; Yeun, 1997), which showed statistically significant increases in empathy levels. A possible explanation for the lack of significant increases in empathy for the intensive group is that learning to express empathy is a difficult skill to master for parents as well as beginning play therapists so it was difficult for the intensive group to assimilate the information and improve enough to reach statistical significance in only four weeks. The traditional LFTT group had the advantage of continued practice in order to master this skill and thus demonstrate significant change.

Fox, Platz, and Bentley (1995) looked at how parenting behaviors related to parenting practices, developmental expectations, and perceptions of child behavior problems and found an inverse relationship between perceived child behavior problems and empathic parental responses. They also reported a greater utilization of corporal punishment associated with higher developmental expectations. This was supported by the comments from participants of this study. Several parents were surprised to hear of the feelings and fears that are expected at various ages. Insufficient knowledge of children’s emotional/social development can lead to unrealistic expectations of children. As parents began to be more empathic in their understanding of their children, they were able to respond to the child where he or she was instead of being frustrated with them. As parents demonstrated greater empathy with their children, they also reported that they no longer felt that misbehavior in their child was an affront to themselves as parents and began to look for other reasons for the behavior.
**Parental Acceptance**

As shown in Table 9 and Table 20, there were no statistically significant differences between the intensive LFTT model participants and the traditional LFTT model participants in their perceived acceptance of their children in all four subscales measured by the Porter Parental Acceptance Scale (PPAS), as well as in the total score. Mean scores in Table 21 through Table 24 show increased scores at posttesting for both groups indicating an increase in acceptance of their child. These findings suggest that an intensive LFTT format is an effective treatment for increasing parental acceptance when compared to the empirically-validated, traditional LFTT. These results are consistent with other filial therapy studies (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1997; Glass, 1986; Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Kale & Landreth, 1997; Lee, 2002; Yeun, 1997), which showed statistically significant increases in acceptance of their children.

**Child's Problematic Behaviors as Perceived by the Parent**

As shown in Table 9, there was no statistically significant difference between the intensive LFTT model participants and the traditional LFTT model participants in their reported child problems as measured by the Filial Problem Checklist (FPC). Mean scores show decreased scores at posttesting for both groups indicating a decrease in child problems. The groups did not achieve statistically significant change at posttesting with the intensive group actually increasing reported problems by 1 point at posttesting. These results are inconsistent with other filial therapy studies (Bratton & Landreth, 1995; Jang,
2000; Tew, 1997), which showed statistically significant decreases in reported child behavior problems.

The researcher noticed that as parents completed this checklist they tended to mark all zeros or all higher numbers resulting in either very high or very low scores. Instructions were given uniformly for completion, yet there seemed to be more confusion regarding the completion of this instrument.

These findings are inconsistent with parents report during the final sessions that their children’s behavior had improved. The findings regarding a lack of child problem reduction in the intensive group are consistent with several parents in that group reporting that the same problems were still present, but they (the parents) were better equipped to respond to them. However, it would be very difficult to notice change in child behavior over the short time span of the intensive LFTT unless those children had experienced some traumatic event prior to training. The parents in the traditional LFTT model did have enough time to change their interaction patterns with their children for a long enough time to experience changes in their child's behavior.

Conclusion

The overall findings of this study were that the intensive Landreth filial therapy training format was as effective as the traditional Landreth filial therapy training in decreasing parental stress, increasing parental empathy, increasing parental acceptance of their children, and decreasing child behavior problems. Both groups increased their acceptance of their children and empathic behavior with their children at statistically
significant levels. While both groups had decreased parental stress and decreased child behavior problems, those changes were not statistically significant.

*Uniquenesses of Intensive Model That Make It Work*

For this research study, the traditional Landreth filial therapy training (LFTT) model was altered carefully to fit the need of some parents. These participants represent those with a common problem in today's society--stressful lives with little free time. The resulting Intensive LFTT model was found to be as effective as the traditional LFTT model. The sessions were reduced from 10 90-minute meetings to 4 4-hour meetings to better accommodate busy schedules. The group size of the intensive LFTT model was limited to four members instead of six members as in the traditional LFTT model to provide adequate time for feedback for each parent. The observed result of this smaller size group was that the group began to function much like a support group in terms of cohesiveness and support provided by each parent for each other. The final modification was the inclusion of the children of the participants in the training process. In the traditional LFTT model, demonstrations of new skills are provided by videotape examples, facilitator demonstration with another group members and role-play of skills by parents paired with each other during the session. For the intensive LFTT model, the researcher had each parent bring his or her child with them to the training. Childcare was provided on-site for the children when they were not involved in training. Having the children available for training allowed the researcher to perform live demonstrations of skills being taught as well allowing the parents to practice the skills with their own child. Practicing the skills with their children provided several advantages to the intensive
LFTT model. The practice sessions were realistic for the parents instead of the simulated sessions provided by role-play with each other. Parents experienced less anxiety when practicing these skills because they were given immediate feedback. Also, by not waiting until after the third session to begin practicing these skills with their children as in the traditional LFTT model, the parents in the intensive LFTT model did not have much built up anxiety concerning practicing these skills with their child for the first time. Also, the practice playtimes conducted on-site were not videotaped, but monitored by direct supervision from the facilitator. Not having a video camera present during initial practice playtimes helped the parents and children feel more comfortable in these playtimes.

These modifications of the well-researched, empirically validated, traditional LFTT model made the intensive LFTT model a unique therapeutic tool that works. The traditional Landreth filial therapy training model shows yet another effective use with parents requiring more adaptability.

**Group Differences**

There were two noticeable differences between the intensive LFTT group and the traditional LFTT group in regards to severity of the child’s problems and parenting stress. Two autistic children, and one child who was not concurrently in counseling but had been diagnosed with Bipolar Disorder and was hospitalized for one week toward the end of the parent’s training were in the intensive LFTT. In the traditional LFTT, one parent had a child with severe speech delays (no verbal expression at age 3). Initial testing also showed that parents in the intensive model were much more stressed (78th %ile) than parents in the traditional model (40th %ile). This stress level seemed to coincide with the
parents’ availability for training. As originally assumed by the researcher, parents under more stress and thus most in need of filial therapy training were only available for the intensive LFTT model.

It was interesting to note that the one thing parents all reported enjoying about this training was how much they and their children enjoyed the uninterrupted time together. They reported that even though they do spend time with their children, it is seldom uninterrupted or one on one, and often the parents are also trying to do other things and thus do not give their children their undivided attention. They realized by the end of training how little focused attention they truly give their children on a daily basis and what a difference it makes just doing that.

Differences in Results

There were also noteworthy differences in the results of two training formats. Parents in the traditional LFTT model demonstrated greater skill development, as measured by the MEACI, specifically in the areas of communication of acceptance, acceptance of the child’s need for autonomy, and reduction of child behavior problems. Because this group met for more sessions of a shorter duration, the atmosphere was much like that of a classroom. Parents were focused on skill learning and enhancement and had more time to assimilate the information presented. The skill of communication of acceptance is the hardest skill taught in filial therapy, yet they were able to improve in this area at a statistically significant level. The longer duration of training made reduction of child behavior problems possible because there was enough time for parental responses to impact child behavior to a noticeable degree.
In contrast to the skill development as a main concern of the traditional LFTT model, parents in the intensive LFTT model seemed to develop the cohesiveness and support associated with group support meetings due to the amount of time spent together initially and the degree of discussion about their families that was necessary in that time for training. They became comfortable with the researcher and others sooner, asked more questions and overall became more insightful about their parenting, themselves, and the motives of their children. Unlike the traditional group, which was more like a class, the intensive group seemed to be working together to learn the new parenting skills and attitudes. This increase in the support effect seemed to be a contributing factor to their greater reduced stress levels and their greater increases in unconditional love for their child subscale on the PPAS.

These findings support this investigator’s proposed assumptions that parents whose schedules and needs do not permit them to attend 10 weekly sessions of the Landreth filial therapy training model could benefit from an intensive format of that model. The findings from this study open the door for other studies to further test the flexibility of the filial therapy format and validates the assumption that the format of filial therapy training can be tailored to more short-term training needs such as in-patient settings, homeless shelters, with parents of hospitalized children, and other settings where the parents or children are available for a limited time.
Recommendations

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

1. The utilization of intensive LFTT for parents who are unable to commit to 10 weeks of training sessions.

2. The utilization of intensive LFTT for settings and situations in which the therapist only has short-term access to the parents such as in a shelter.

3. Further research of intensive LFTT with a larger, more homogeneous group to confirm the effectiveness of fewer meetings in achieving the goals of filial therapy.

4. Follow-up of the intensive LFTT group by posttesting again after 10 weeks.

5. Research effectiveness of delaying fourth session of the intensive LFTT by one week and adding a follow-up session after 10 weeks.

6. Improve clarity on the Filial Problem Checklist directions by adding a 0 value for behaviors that do not apply to the child as a response choice to eliminate confusion related to marking not applicable statements.
Appendix A

Recruitment & Consent
Sign up Now!

For Parent-Child Relationship Enhancement Classes

Volunteer for participation in a research study and receive training that many studies have shown can significantly improve your parenting relationship with your child. You may choose to attend either:

- 10 weekly evening meetings for 1 ½ hours each (Mondays or Thursdays)
- 4 weekend meetings for 4 hours each (Saturdays or Sundays)

Classes are for parents only and childcare will be provided on location if needed.

Possible benefits of participation in Parent-Child Relationship Enhancement Classes/Filial Therapy (as reported in research):

- significant decreases in your child's behavior problems
- significant decreases in your own stress related to parenting.
- significant increase in your acceptance or your child’s behavior
- improvement in your child’s emotional adjustment and self-concept.
- increased self-esteem in both you and your child

In Filial Therapy, you will learn through direct instruction, viewing videotapes, and role playing how to create a nonjudgmental, understanding, and accepting environment in which your child can feel safe enough to explore other parts of himself or herself and other ways of relating to you. The setting for this new environment is a required weekly thirty-minute playtime with just the two of you and a set of specially selected toys.

Classes will be provided by Lisa Ferrell, a doctoral candidate in the Counselor Education program at the University of North Texas and under supervision by Sue Bratton, Ph.D. (940-565-2066). I am a Masters level Licensed Professional Counselor with doctorate level training and over twelve years experience working with parents and their children.

If you are willing to participate, please call Lisa Ferrell at ###-###-####.

Thank you and happy parenting!

Lisa Ferrell, M.Ed., LPC

This study has been reviewed and approved by the UNT Committee for the protection of Human Subjects (940-565-3940).
Before agreeing to participate in this research study, it is important that you read and understand the following explanation of the proposed procedures. It describes the procedures, benefits, risks, and discomforts of the study. It also describes the alternative treatments that are available to you and your right to withdraw from the study at any time. It is important for you to understand that no guarantees or assurances can be made as to the results of the study.

**Purpose of the study and how long it will last:**

The purpose of this study is to compare the effectiveness of an intensive/collapsed 4-week format of the Landreth 10-week filial therapy training with the Landreth 10-week filial therapy training for parents and their children. Specifically, this study is designed to determine the effectiveness of intensive 4-week filial therapy in: (a) increasing the parents' empathic responsiveness with their children; (b) increasing the parent's communication of acceptance of their child; (c) decreasing children's problem behaviors and, (d) decreasing parental stress as compared to the Landreth 10-week filial training. If you have more than one child, please choose one child of focus for this study.

Participation in this study will require a total of 20 hours of your time. The pre-test and post-test will take about 1 hour each. You will meet once a week for either 10 weekly 1-1/2 hour training sessions or for four 4-hour training sessions. You will also have a special playtime with your child at home for 30 minutes beginning the first week of training for a total of three playtimes for the 4-week model.

You will then be randomly assigned to one of two comparison groups. If you are selected for the Landreth 10-week model of filial therapy training, then they will be asked to attend 10 1-1/2 hour weekly training sessions. In addition to this time, beginning in the third week, you will be asked to conduct one 30-minute playtime with your child at home each week. You will be asked to videotape these sessions and bring your tapes to training sessions to allow the researcher and other participants to provide feedback to you concerning ways in which you are appropriately demonstrating understanding of the techniques being taught. If you are selected for the intensive adaptation of filial therapy training, you will be asked to attend four 4-hour weekly training sessions. In addition to this time, after the first class, you will be asked to conduct one 30-minute playtime with your child at home each week. You will be asked to videotape these sessions and bring your tapes to training sessions to allow the researcher and other participants to provide feedback to you concerning ways in which you are appropriately demonstrating understanding of the techniques being taught.
UNIVERSITY OF NORTH TEXAS
RESEARCH CONSENT FORM (Continued)

At the end of filial therapy training, you will be asked to come in for post-testing which involves being videotaped having a special playtime with your child and completing post-test instruments which should take approximately one hour total. You will be asked to come in a total of twelve or six times depending on the length of training.

You will be asked to gather a specific set of toys for your playtimes. You will most likely own many of the toys needed, but you may have to buy a few toys. If you chose to buy a completely new set of toys, it would cost approximately $60. A set will be provided for you is this represents a financial hardship. You will receive six toy items for your set provided by the researcher regardless of whether you are able to complete the training or not.

Description of the study including the procedures to be used:
Filial therapy utilizes a group format that trains you to be the therapeutic agent with your child as you conduct weekly playtimes in your home in a very specific way. Through filial therapy, the child’s perceptions of you should change, the child is expected to express thoughts and feelings not expressed before, and the child’s self-respect, self-worth, and confidence are anticipated to increase. Filial therapy training involves didactic, demonstration, and role-playing techniques. At times, the researcher will also help you explore your feelings and attitudes by inquiring about your fears, worries, and expectations that may be interfering in your ability to better relate to your child.

The goals of the playtimes are to let the child take the lead within safety limits, to develop empathic understanding in you, communication of that understanding to the child, and for the child to accept responsibility for his or her actions.

Description of procedures/elements that may result in discomfort or inconvenience:
This study involves minimal risk (no personal risk or discomfort) to participants. Emotions such as anger, frustration, and sadness in the child may be expressed during the special play times, but the sessions will not increase these emotions. Participation in this study is voluntary. The potential benefits far outweigh the risks.

Benefits to the subjects or others:
The possible benefits of filial therapy training are: (a) an improved relationship between you and your child, (b) your greater understanding of your child, (c) a sense of improved parenting abilities and skills, and (d) an improvement in your child’s self-esteem.

Confidentiality of research records:
Confidentiality will be upheld throughout the study by implementing the following safeguards.

1. Your name and your child’s name will not be disclosed in any discussion or publication of the data obtained from this study.
2. Instruments will be recorded with code numbers.
3. Only the investigator will have access to a list of these names. The list of these names will be destroyed at the completion of this study.

Research Consent Form -Page 2 of 4 ___________ Participant's initials
4. Video recordings of playtimes will be only reviewed by graduate students. These students will be informed of the importance of maintaining confidentiality of you and your child. The students will not have access to your name or your child’s name.

5. The researcher will destroy videotapes within six months after post-testing.

Review for protection of participants:

This research study has been reviewed and approved by the UNT Committee for the Protection of Human Subjects (940) 565-3940.

RESEARCH SUBJECTS’ RIGHTS: I have read or have had read to me all of the above.

_________________________________________ has explained the study to me and answered all of my questions. I have been told the risks or discomforts and possible benefits of the study. I 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 or loss of rights or benefits or legal recourse to which I am entitled. The study personnel may choose to stop my participation at any time.

In case there are problems or questions, I have been told I can call Sue Bratton at telephone number 940-565-2066.

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

Subject's Signature ___________________________ Date ___________________________

Witnesses' Signature ___________________________ Date ___________________________

For the Investigator or Designee:

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

Principal Investigator's Signature ___________________________ Date ___________________________

Research Consent Form - Page 3 of 4 ____________ Participant's initials
CONSENT FORM
FOR RESEARCH INVOLVING CHILDREN

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 (under the age of 7) to participate, that you have read (or have had read to you) the information provided in this Consent Form and that you have received a copy of it.

Parent's or Guardian's Signature  Date

Investigator's Signature  Date

Witnesses' Signature  Date

ASSENT OF CHILD (ages 7 to 14)

__________________________________________ (name of child) has agreed to participate in research


Child’s Signature. Parent or Guardian signature must be substituted if waiver of assent is required  Date

WAIVER OF ASSENT

The assent of ____________________________________________ (name of child) was waived because of

___________ Age

___________ Maturity

___________ Psychological state of the child

Parent's or Guardian's Signature  Date
Appendix B

Measurement of Empathy in Adult-Child Interaction (MEACI)
**MEASUREMENT OF EMPATHY IN ADULT-CHILD INTERACTION**

Rating Form

<table>
<thead>
<tr>
<th>Communication of Acceptance</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Total</th>
<th>Score/Avg Total</th>
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</thead>
<tbody>
<tr>
<td>Score Highest Level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Score Lowest Level</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allowing the Child Self-Direction</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Total</th>
<th>Score/Avg Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score Lowest Level</td>
<td></td>
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<td>Comments:</td>
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<table>
<thead>
<tr>
<th>Involvement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Total</th>
<th>Score/Avg Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score Lowest Level</td>
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<table>
<thead>
<tr>
<th>Empathy Score</th>
<th>Grand Total</th>
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</thead>
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</tbody>
</table>

This form was adapted by Bratton (1993) from Stover, B. Guerney, and O'Connell (1971).
Appendix C

Porter Parental Acceptance Scale (PPAS)
PORTER PARENTAL ACCEPTANCE SCALE

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

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

It is essential that all questions be answered. If you do not closely describes your feelings or actions.

GENERAL INFORMATION

1. Sex: Male _____ Female _____
2. Year of Birth _______________
3. Year of Marriage ____________
4. Living with spouse at present time Yes ____ No ____
5. Married more than once Yes ____ No ____
6. If married more than once, was previous marriage ended because of death ____ divorce ____ other (please state) _______________________
7. Draw a circle around the number of years of schooling you have completed.
   12345678  1234  1234  1234
   Graduate school High school College Post graduate
8. Religious Affiliation:
   ____ Protestant _____ Jewish ______ None
   ____ Catholic ______ Other _______________________
9. Was your childhood and adolescence, for the most part, spent in:
   ____ open country or village under 1,000 ______ a town of 1,000 to 4,999
   ____ a city of 5,000 to 9,999 ______ a city of 10,000 to 49,999
   ____ a city of 50,000 to 99,999 ______ a city of 100,000 to 249,999
   ____ a city of 250,000 or over
10. Presently family income (annual)
    ______ under $15,000 _______$15,000 to $24,999
    ______ $25,000 to $34,999 ______$35,000 to $49,999
    ______ $50,000 to $74,999 ______ $75,000 to $99,999
    ______ $100,000 or more
11. Husband's occupation (Be specific such as computer specialist, CPA, salesperson, teacher, auto mechanic, lawyer, etc.) _____________________________
12. Wife's occupation (Be specific as illustrated above) _______________________

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13. Ages of children (to nearest birthday)
   Ages of boys ______; ______; ______; ______;
   Ages of girls ______; ______; ______; ______;

   While responding to the following questions, please think of only one child. If you have a child in the age range of 6 to 10 years, choose that one. If you have more than one child in that age range, choose the one nearest to 10. If your children are all younger than six years, choose the one nearest six. Place a circle around the age (in question 13 above) of the one which you will be thinking of while answering the questions about your child. Be sure and refer only to this child while answering the questions.

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

INFORMATION ABOUT YOUR CHILD

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

<table>
<thead>
<tr>
<th>Check One Column For Each Item Below</th>
<th>Degree of Feeling or Affection</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Much more than usual</td>
</tr>
<tr>
<td>1. When my child is obedient.</td>
<td></td>
</tr>
<tr>
<td>2. When my child is with me.</td>
<td></td>
</tr>
<tr>
<td>3. When my child misbehaves in front of special guests.</td>
<td></td>
</tr>
<tr>
<td>4. When my child expresses unsolicited affection. &quot;You're the nicest mommy/daddy in the whole world.&quot;</td>
<td></td>
</tr>
<tr>
<td>5. When my child is away from me.</td>
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</tr>
<tr>
<td>6. When my child shows off in public.</td>
<td></td>
</tr>
<tr>
<td>7. When my child behaves according to my highest expectations.</td>
<td></td>
</tr>
<tr>
<td>8. When my child expresses angry and hateful things to me.</td>
<td></td>
</tr>
<tr>
<td>9. When my child does things I have hoped my child would not do.</td>
<td></td>
</tr>
<tr>
<td>10. When we are doing things together.</td>
<td></td>
</tr>
</tbody>
</table>
Listed below are several statements describing things which children do and say. Following each statement are five responses which suggest ways of feeling or courses of action.

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

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

11. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
   a. feel annoyed.
   b. want to know more about what excites my child.
   c. feel like punishing my child.
   d. feel that I will be glad when my child is past this stage.
   e. feel like telling my child to stop.

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

13. When my child is unable to do something which I think is important for him/her, I:
   a. want to help my child find success in other things.
   b. feel disappointed in my child.
   c. wish my child could do it.
   d. realize that my child can not do everything.
   e. want to know more about the things my child can do.

14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
   a. realize that my child is growing up.
   b. am pleased to see my child's interests widening to other people.
   c. feel resentful.
   d. feel that my child doesn't appreciate what I have done for him/her.
   e. wish my child liked me more.
15. When my child is faced with two or more choices and has to choose only one, I:
   a. tell my child which choice to make and why.
   b. think it through with my child.
   c. point out the advantages and disadvantages of each, but let my child decide.
   d. tell my child that I am sure he/she can make a wise choice and help my child foresee the consequences.
   e. make the decision for my child.

16. When my child makes decisions without consulting me, I:
   a. punish my child for not consulting me.
   b. encourage my child to make many of his/her own decisions.
   c. allow my child to make many of his/her own decision.
   d. suggest that we talk it over before he/she makes the decision.
   e. tell my child he/she must consult me first before making a decision.

17. When my child kicks, hit, or knocks his/her things about, I:
   a. feel like telling my child to stop.
   b. feel like punishing him/her.
   c. am pleased that my child feels free to express himself/herself.
   d. feel that I will be glad when my child is past this stage.
   e. feel annoyed.

18. When my child is not interested in some of the usual activities of his/her age group, I:
   a. realize that each child is different.
   b. wish my child were interested in the same activities.
   c. feel disappointed in my child.
   d. want to help my child find ways to make the most of his/her interests.
   e. want to know more about the activities in which my child is interested.

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

20. When my child prefers to do things with his/her friends rather than with the family, I:
   a. encourage my child to do things with his/her friends.
   b. accept this as part of his/her growing up.
   c. plan special activities so that my child will want to be with the family.
   d. try to minimize his/her associations with friends.
   e. make my child stay with the family.
21. When my child disagrees with me about something which I think is important, I:
   a. feel like punishing him/her.
   b. am pleased that my child feels free to express his/her thoughts and feelings.
   c. feel like persuading my child that my way is best.
   d. realize my child has ideas of his/her own.
   e. feel annoyed.

22. When my child misbehaves while others in his/her group are behaving well, I:
   a. realize that my child does not always behave as others in his/her group.
   b. feel embarrassed.
   c. want to help my child find the best ways to express his/her feelings.
   d. wish my child would behave like the others.
   e. want to know more about his/her feelings.

23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
   a. give my child something quiet to do.
   b. tell my child that I wish he/she would stop.
   c. make my child be quiet.
   d. let my child tell me about what is so exciting.
   e. send my child somewhere else.

24. When my child seems to be more fond of someone else (teacher/relative) than me, I:
   a. try to minimize my child's association with that person.
   b. let my child have such associations when I think he/she is ready for them.
   c. do some special things for my child to remind him/her of how nice I am.
   d. point out the weaknesses and faults of the other person(s).
   e. encourage my child to create and maintain such associations.

25. When my child says angry and hateful things about me to my face, I:
   a. feel annoyed.
   b. feel that I will be glad when my child is past this stage.
   c. am pleased that my child feels free to express himself/herself.
   d. feel like punishing my child.
   e. feel like telling my child not to talk that way to me.

26. When my child shows a deep interest in something I don't think is important, I:
   a. realize my child has interests of his/her own.
   b. want to help my child find ways to make the most of this interest.
   c. feel disappointed in my child.
   d. want to know more about my child's interests.
   e. wish my child were more interested in the things I think are important for him/her.
27. When my child is unable to do some things as well as others in his/her group, I:
   a. tell my child he/she must try to do as well as the others.
   b. encourage him/her to keep trying.
   c. tell my child that no one can do everything well.
   d. call attention to the things he/she does well.
   e. help my child make the most of the activities which he/she can do well.

28. When my child wants to do something which I am sure will lead to disappointment for him/her, I:
   a. occasionally let my child carry such an activity to its conclusion.
   b. don't let my child do it.
   c. advise my child not to do it.
   d. help my child with it in order to ease the disappointment.
   e. point out what is likely to happen.

29. When my child acts silly and giggly, I:
   a. feel that I will be glad when he/she is past this stage.
   b. am pleased that my child feels free to express himself/herself.
   c. feel like punishing my child.
   d. feel like telling him/her to stop.
   e. feel annoyed.

30. When my child is faced with two or more choices and has to choose only one, I:
   a. feel that I should tell my child which choice to make and why.
   b. feel that I should point out the advantages and disadvantages of each.
   c. hope that I have prepared him/her to choose wisely.
   d. want to encourage my child to make his/her own choices.
   e. want to make the decision for my child.

31. When my child is unable to do something which I think is important for him/her, I:
   a. tell my child he/she must do better.
   b. help my child make the most of the things which he/she can do.
   c. ask my child to tell me more about the things which he/she can do.
   d. tell my child that no one can do everything.
   e. encourage him/her to keep trying.

32. When my child disagrees with me about something which I think is important, I:
   a. tell my child he/she should not disagree with me.
   b. make my child quit.
   c. listen to my child's side of the issue and change my mind if that seems reasonable.
   d. tell my child maybe we can do it his/her way another time.
   e. explain that I am doing what is best for him/her.
33. When my child is unable to do some things as well as others in his/her group, I:
   a. realize that my child can't do as well as others in everything.
   b. wish that my child could do as well.
   c. feel embarrassed.
   d. want to help my child find success in the things he/she can do well.
   e. want to know more about the things my child can do well.

34. When my child makes decisions without consulting me, I:
   a. hope that I have prepared my child adequately to make his/her decisions.
   b. wish that my child would consult me.
   c. feel disturbed.
   d. want to restrict his/her freedom.
   e. am pleased to see that as my child grows, I am needed less.

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

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

37. When my child prefers to do things with friends rather than with the family, I:
   a. wish my child would spend more time with us.
   b. feel resentful.
   c. am pleased to see my child's interests widening to other people.
   d. feel my child doesn't appreciate us.
   e. realize that he/she is growing up.

38. When my child wants to do something which I am sure will lead to disappointment, I:
   a. hope that I have prepared him/her to meet disappointment.
   b. wish that my child did not have to experience unpleasant events.
   c. want to keep my child from doing it.
   d. realize that occasionally such an experience will be good for him/her.
   e. want to postpone these experiences.
39. When my child is not interested in some of the usual activities of his/her age group, I:
   a. help my child realize that it's important to be interested in the same things as others in the group.
   b. call attention to the activities in which he/she is interested.
   c. tell my child it is all right not to be interested in the same things as others in his/her group.
   d. see to it that my child does the same things as others in his/her group.
   e. help my child find ways of making the most of his/her interests.

40. When my child shows a deep interest in something I don't think is important, I:
   a. let my child go ahead this interest.
   b. ask my child to tell more about this interest.
   c. help my child find ways to make the most of this interest.
   d. do everything I can do discourage my child's interest in it.
   e. try to interest him/her in more worthwhile things.

THANK YOU VERY MUCH FOR YOUR COOPERATION
Appendix D

Filial Problem Checklist
Filial Problem Checklist

INSTRUCTIONS

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

- A 1 means "This item is true for my child, but is not really a problem."
- A 2 means "This item is true for my child, and it is a mild problem."
- A 3 means "This item is true for my child, and it is a severe problem."

EXAMPLE

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

20) Bites nails 1

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

20) Bites nails 3

If you have any problems completing this list, please do not hesitate to call for assistance.
Filial Problem Checklist

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

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

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>1. Eats too little</td>
<td></td>
</tr>
<tr>
<td>2. Not eating the right foods</td>
<td></td>
</tr>
<tr>
<td>3. Wets bed at night</td>
<td></td>
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<tr>
<td>4. Gets lower grades in school than should</td>
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<tr>
<td>5. Does not talk plainly, poor pronunciation</td>
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<tr>
<td>6. Shy with other children</td>
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<tr>
<td>7. Too few friends</td>
<td></td>
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<tr>
<td>8. Feels inferior to other children</td>
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<tr>
<td>9. Picked on by children</td>
<td></td>
</tr>
<tr>
<td>10. Has no self-confidence</td>
<td></td>
</tr>
<tr>
<td>11. Nervous, tense</td>
<td></td>
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<tr>
<td>12. Sad, unhappy too often</td>
<td></td>
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<tr>
<td>13. Cries too easily</td>
<td></td>
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<tr>
<td>14. Feels helpless</td>
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<tr>
<td>15. Blames self too much</td>
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<tr>
<td>16. Gets into trouble</td>
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<tr>
<td>17. Destroys property of others</td>
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<tr>
<td>18. Steals</td>
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<td>19. Lies</td>
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<tr>
<td>20. Bites nails</td>
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<tr>
<td>21. Picks nose</td>
<td></td>
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<tr>
<td>22. Always late, dawdles</td>
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<tr>
<td>23. Difficulty falling asleep or sleeping</td>
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<td>24. Troubled restless sleep</td>
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<td>25. Slow in reading</td>
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<tr>
<td>26. Cannot keep mind on studies</td>
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<tr>
<td>27. Does not pay attention to teacher</td>
<td></td>
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<tr>
<td>28. Restless in class</td>
<td></td>
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<tr>
<td>29. Headaches for no physical reason</td>
<td></td>
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<tr>
<td>30. Stomach cramps, aches</td>
<td></td>
</tr>
<tr>
<td>31. Feels different from other children</td>
<td></td>
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<tr>
<td>32. Easily led</td>
<td></td>
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<tr>
<td>33. Left out by children of own age</td>
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<tr>
<td>34. Never chosen as a leader</td>
<td></td>
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<tr>
<td>35. Is self-conscious about own body</td>
<td></td>
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<tr>
<td>36. “Big-shot”</td>
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<tr>
<td>37. Gets angry too easily</td>
<td></td>
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<tr>
<td>38. Fear of darkness</td>
<td></td>
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<td>39. Panics when afraid</td>
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<tr>
<td>40.</td>
<td>Too easily discouraged</td>
</tr>
<tr>
<td>41.</td>
<td>Breaks promises</td>
</tr>
<tr>
<td>42.</td>
<td>Thumb sucking</td>
</tr>
<tr>
<td>43.</td>
<td>Bad table manners</td>
</tr>
<tr>
<td>44.</td>
<td>Untidy</td>
</tr>
<tr>
<td>45.</td>
<td>Has bad dreams</td>
</tr>
<tr>
<td>46.</td>
<td>Afraid to speak up in class</td>
</tr>
<tr>
<td>47.</td>
<td>Fights too much with children</td>
</tr>
<tr>
<td>48.</td>
<td>Blow his/her top</td>
</tr>
<tr>
<td>49.</td>
<td>Sulks, pouts</td>
</tr>
<tr>
<td>50.</td>
<td>Gripes too much</td>
</tr>
<tr>
<td>51.</td>
<td>Fear-ridden child</td>
</tr>
<tr>
<td>52.</td>
<td>Unusual fears</td>
</tr>
<tr>
<td>53.</td>
<td>Does not do chores</td>
</tr>
<tr>
<td>54.</td>
<td>Takes advantage of people</td>
</tr>
<tr>
<td>55.</td>
<td>Disobeys parents</td>
</tr>
<tr>
<td>56.</td>
<td>Not close to parents</td>
</tr>
<tr>
<td>57.</td>
<td>Scratches self a lot</td>
</tr>
<tr>
<td>58.</td>
<td>Swears, uses dirty language</td>
</tr>
<tr>
<td>59.</td>
<td>Unable to keep to a time schedule</td>
</tr>
<tr>
<td>60.</td>
<td>Uses hands in poorly coordinated way</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
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</tr>
<tr>
<td>80. Unsire of self in school</td>
<td>___</td>
</tr>
<tr>
<td>81. Has had a number of accidents</td>
<td>___</td>
</tr>
<tr>
<td>82. Plays too much with younger children</td>
<td>___</td>
</tr>
<tr>
<td>83. Bossy with brothers and/or sisters</td>
<td>___</td>
</tr>
<tr>
<td>84. Jealous of brothers and/or sisters</td>
<td>___</td>
</tr>
<tr>
<td>85. Preoccupied with own thoughts</td>
<td>___</td>
</tr>
<tr>
<td>86. Loses temper</td>
<td>___</td>
</tr>
<tr>
<td>87. Is erratic, unpredictable</td>
<td>___</td>
</tr>
<tr>
<td>88. No control over emotions</td>
<td>___</td>
</tr>
<tr>
<td>89. Fights back, talks back to elders</td>
<td>___</td>
</tr>
<tr>
<td>90. Too dependent upon Mother, Father</td>
<td>___</td>
</tr>
<tr>
<td>91. Inconsiderate of parents</td>
<td>___</td>
</tr>
<tr>
<td>92. Bumps into furniture, trips, etc.</td>
<td>___</td>
</tr>
<tr>
<td>93. Watches TV all the time</td>
<td>___</td>
</tr>
<tr>
<td>94. Trouble adjusting to a new school</td>
<td>___</td>
</tr>
<tr>
<td>95. Tries to get attention in class</td>
<td>___</td>
</tr>
<tr>
<td>96. Fights brother(s) and/or sister(s)</td>
<td>___</td>
</tr>
<tr>
<td>97. Gets people angry, provokes</td>
<td>___</td>
</tr>
<tr>
<td>98. Loses own possessions</td>
<td>___</td>
</tr>
<tr>
<td>99. Gets completely out of control</td>
<td>___</td>
</tr>
<tr>
<td>100. Oversensitive to criticism from parents</td>
<td>___</td>
</tr>
<tr>
<td>101. Behind other children on dressing</td>
<td>___</td>
</tr>
<tr>
<td>102. Feels bad about own physical appearance</td>
<td>___</td>
</tr>
<tr>
<td>103. Elimination problems (e.g. diarrhea, constipation, gas, holds urine, etc.)</td>
<td>___</td>
</tr>
<tr>
<td>104. Dangerous habits (describe)</td>
<td>___</td>
</tr>
<tr>
<td>105. Sex-related problems (e.g. “peeps”, exposes self, etc.)</td>
<td>___</td>
</tr>
<tr>
<td>106. Physical tension problems (e.g. hives, ulcers, colitis, sweats, nausea, dizziness, etc.)</td>
<td>___</td>
</tr>
<tr>
<td>107. Excessively passive, meek</td>
<td>___</td>
</tr>
<tr>
<td>108. Body movement problems (e.g. clumsy in using legs, jerky movements, lazy, apathetic, has no energy, head banging, paralyzed, moves too slowly, has twitches, rocks all the time, etc.)</td>
<td>___</td>
</tr>
</tbody>
</table>
Appendix E

Parent Handouts
• Play is the child’s language. It is based on actions not words.
• Filial therapy helps prevent problems because you become aware of your child’s needs.
• Techniques from play therapy will: 1) return control to you; 2) provide closer, happier times with your child; 3) Give you the key to your child’s inner world

• Reflective Listening:
  • Reflect behaviors, patterns and feelings.
  • Don’t ask questions. (If you have enough information to ask a question, you have enough information to make a statement.)
  • This is a way of following, rather than leading.

Your responses should convey these 4 messages:
• I'm here
• I hear you
• I understand
• I care

Not:
• I always agree.
• I must make you happy.
• I will solve your problems.

Homework:
• 30 Second Burst of Attention
• Practice reflective listening
• Notice one physical characteristic of your child’s you haven’t seen before.

RULE OF THUMB: You can’t give away what you do not possess.
As a parent, you may be coming to the sessions aware of your shortcomings as a parent. Yet you can’t effectively enter this process by being impatient and unaccepting toward yourself while trying to extend patience and acceptance to your child.
Label the feelings in the boxes below:

Practice reflecting feelings:

1. Child said or did:
   
   My response:

2. Child said or did:
   
   My response:

3. Child said or did:
   
   My response:

4. Child said or did:
   
   My response:
Emotional capacities present at birth:
   Pleasure
   Surprise
   Disgust
   Distress

By 6-8 wks: Joy

3-4 mos: Anger

8-9 mos: Sadness & Fear

12-18 mos: Tender affection

18 mos: Shame

2 years: Pride

3-4 years: Guilt

5-6 years: Social emotions -- insecurity, humility, confidence, envy

Teens: Romantic passions, Philosophical brooding
Handout #4

Setting Up Special Playtimes

Basic Principles of the Playtimes:
1. Your child should be completely free to determine how he/she will use the time. He/She leads and you follow without making suggestions or asking questions.
2. Your major task is to empathize with your child, to understand the intent of his/her actions, and his/her thoughts and feelings.
3. Your next task is to communicate this understanding to your child by appropriate comments, particularly, whenever possible, by verbalizing the feelings that your child is actively experiencing.
4. You are to be clear and firm about the few “limits” that are placed on your child. Limits to be set are time limits, not breaking specified toys, and not physically hurting either of you.

Goals of the Playtimes:
1. To help your child change his or her perceptions of your feelings, attitudes, and behavior.
2. To allow your child – through the medium of play – to communicate his or her thoughts, needs, and feelings to you.
3. To help your child develop more positive feelings of self-respect, self-worth, and confidence.

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

Toys for the Playtimes:
Crayons (8 colors), paper, blunt scissors, rubber knife, piece of rope, family of small dolls, small car, small baby doll, blanket, doctor kit (include 4 Band-Aids), inflatable bop bag, ring toss/bowling game, a couple of domestic and wild animals, craft items for older child. Provided: Play-Doh, Lone Ranger mask, nursing bottle, toy soldiers, blocks, cardboard box.

Place for the Playtimes:
Choose a room you feel has the fewest distractions to your child and the greatest freedom from concern about breaking things or making a mess. Set aside a regular time in advance. This time is to be undisturbed – no phone calls, interruptions by other children, etc. You may wish to explain to your child that you are having these playtimes because you are interested in learning how to play with them in a different, “special” way than you usually do. For older children, explain that you are learning how to be a better listener.
Process:

Let your child use the bathroom prior to the playtime. Tell your child, “we will have 30 minutes of special playtime and you may play with the toys in many of the ways you like.” Let your child lead from this point. Play actively with your child if he/she requests your participation. Set limits on behaviors that make you feel uncomfortable. Track his or her behaviors and feelings verbally. Do not identify toys by their normal names; call them “it,” “that,” “her,” “him,” etc. Give your child a 5-minute advance notice before ending the playtime. "We have five minutes left in our special playtime. Do not extend the time limit by more than two or three minutes.

Where to Purchase Toys: Constructive Playthings, Toys R Us, dollar stores, and grocery stores.

**RULE OF THUMB: When a child is drowning, don’t try to teach him/her to swim.**

If your child is feeling upset, that is not the moment to teach a rule or value.
Basic Rules for Filial Therapy

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

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

Check your responses to your child. Your responses should convey:
1. “I’m here.”
2. “I hear/see you.”
3. “I understand (how you feel or what you are doing).”
4. “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.”

Basic limits: “I’m not for shooting.” (You’re not for hurting and I’m not for hurting.)
“That’s not for breaking, throwing, etc.”

Rule of Thumb: Be a thermostat, not a thermometer.
Reflecting feelings creates an environment that is comfortable and accepting, as opposed to merely reacting to feelings.
Choose the most helpful response.

1. Joe: (with wrinkled brow, red face, and tears in his eyes) We lost. That team didn't play fairly!
   Parent: ________________________________________________________________
   a. Big boys don't cry. You'll do better next time.
   b. It really hurts to lose.
   c. Why do you think they didn't play fairly?

2. Jill: (enters with C- test paper in hand) I tried so hard but it didn't do any good.
   Parent: ___________________________________________________________
   a. You'll do better next time.
   b. Well, if you had studied harder, you might have done better.
   c. It's really frustrating not to do as well as you'd like.
   d. You can't expect to do as well as your sister.

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: ___________________________________________________________
   a. Well, if you'd learn to be more organized, you wouldn't lose things.
   b. You're so excited and want to look just right.
   c. (pushes her aside) Here, let me find it.

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: ___________________________________________________________
Commonly Used Phrases

- You got it! / You did it!
- You see many different things in here.
- You’re not sure what you’d like to do next.
- You know just what you want to do.
- In here, you can decide.
- Sometimes it’s hard to decide.
- You decided to...
- I heard that too.
- You’re finished __(painting)___ for now.
- You made that go all the way up/over there.
- You figured it out.
- You know what that is.
- In here, it can be what you want it to be.
- You found a different way to do/use that.
- You know how to make sounds with that.
- You’d really like to know what I think, but in here you can decide.
- You've decided to do something else.
- Show me what you want me to do.
- Hmm.
- You're wondering what I'm going to say.
- You're wondering...
- You look happy, proud, sad, etc....about that.
- Show me what happens when you try.
Do

Not

Disturb
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 radii 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 foundation 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 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..."

Playtime Skills Checklist

Date: ______________
Parent: ______________

<table>
<thead>
<tr>
<th>Skills</th>
<th>Too much</th>
<th>Appropriate</th>
<th>Need More</th>
<th>Missing</th>
<th>Examples/Comments (*Star your strengths)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lean forward/open</td>
<td></td>
<td></td>
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<tr>
<td>Relaxed/comfortable</td>
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<tr>
<td>Appear interested</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracking behavior</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Reflecting feelings</td>
<td></td>
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<tr>
<td>Facilitative responses</td>
<td></td>
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<tr>
<td>Rate of responses</td>
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<tr>
<td>Match child’s tone/intensity</td>
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<tr>
<td>Genuine expression</td>
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<td></td>
</tr>
<tr>
<td>See world through child’s eyes</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limit setting</td>
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</tbody>
</table>

1. What themes were identified?

2. What feelings did I have during the session?
1. Firm limit-setting
   A. **ACT:**
      1. **Acknowledge the feeling** - "I know you'd really like to...", or "I can tell you're really feeling...", etc.
      2. **Communicate the limit** – "but you may not __________ (because...)" or "but the answer is no," or "but the cabinet door is not for kicking."
      3. **Target the choices** - "You can _____." 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 you know (give specific time)."
      2. Nagging begins: "If you must have an answer now, the answer will have to be no."

   D. If he/she asks the same question again: Calmly - "I've already answered that question."

      Variations:
      1. "The answer I gave you a few minutes ago when you asked the same question is still the same." (Child answers, "I don't remember.") "That is your responsibility to remember."

      2. "You're hoping I will change my mind. I haven't."

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

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

   2. **Oreo Cookie Theory:** Give the child a choice, providing acceptable choices equivalent with the child's ability to choose. (Little choices for little kids and big choices for big kids.)

**RULE OF THUMB:** Good things come in small packages.
We enter our child's world in little ways, not big ones. We can't expect to be part of only the big events in our child's life.
Oreo Cookie Theory
Format for Choice Giving:

**Choices**

“If you choose to (continue action), then you choose (consequence).
If you choose to (stop action), then you choose (consequence).”

**Consequence**

“You chose (consequence).”

**Reflection**

“That shows (attribute).”
AND/OR “You feel…”

1. Use choice giving in playtime only after limit is actually crossed three times & intervention not required (physically preventing harm to others or objects).

2. Clearly state two **choices**
   - Consequences of each choice should be natural or logical – **not punitive**.
   - Both choices must be **acceptable** to you – **relevant & enforceable**.
   - Both choices can be phrased positively:
     Examples:
     a) “If you choose to keep putting your shoes on the couch, then you choose to take them off.
        If you choose to stop putting your shoes on the couch, then you choose to keep them on.”
     b) “If you choose to play with markers, then you choose to play on the drop cloth.
        If you choose to put the markers down, then you choose to play anywhere in here.”

3. Clearly state the chosen **consequence**.
   - Fulfill on consequence **without fail** and **without anger**.
   - Toy removal consequence in playtime is for “today” only.
4. Reflect child’s choice
   - Make facilitative observation of self-control or any movement toward self-control.
   - Reflect feelings of child (proud, angry, etc.).

5. Example of choice giving sequence:
   “I see you are very angry, but the toy is not for kicking, (point) the shoe box is.”
   [Kicks toy fourth time]
   “If you choose to kick the toy, then you choose not to play with it any more today.
   If you choose to stop kicking the toy, then you choose to keep playing with it.”

   [Kicks the shoe box instead] -- OR -- [Kicks the toy again]
   “You chose to kick the shoe box.
   That shows self-control, especially when you feel so angry!”
   “You chose to stop playing with the toy today. You may play with it next time.”

   [Instead of kicking the toy again, nudges it toward you with toe reluctantly.]
   “You stopped yourself from kicking it.
   Pushing it instead of kicking it shows self-control.”
### Attributes

<table>
<thead>
<tr>
<th>accountable</th>
<th>affectionate</th>
<th>appreciative</th>
<th>assertive</th>
</tr>
</thead>
<tbody>
<tr>
<td>brave</td>
<td>careful</td>
<td>caring</td>
<td>clever</td>
</tr>
<tr>
<td>compassionate</td>
<td>confident</td>
<td>considerate</td>
<td>cooperative</td>
</tr>
<tr>
<td>courageous</td>
<td>courteous</td>
<td>creative</td>
<td>decisive</td>
</tr>
<tr>
<td>dependable</td>
<td>determined</td>
<td>diligent</td>
<td>direct</td>
</tr>
<tr>
<td>empathic</td>
<td>enjoyable</td>
<td>enthusiastic</td>
<td>energetic</td>
</tr>
<tr>
<td>fair</td>
<td>feeling</td>
<td>flexible</td>
<td>forgiving</td>
</tr>
<tr>
<td>friendly</td>
<td>fun</td>
<td>generous</td>
<td>gentle</td>
</tr>
<tr>
<td>goal oriented</td>
<td>good sport</td>
<td>grateful</td>
<td>helpful</td>
</tr>
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<td>honest</td>
<td>humble</td>
<td>idealistic</td>
<td>intelligent</td>
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<tr>
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<td>joyful</td>
<td>kind</td>
<td>loving</td>
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<tr>
<td>loyal</td>
<td>modest</td>
<td>neat</td>
<td>orderly</td>
</tr>
<tr>
<td>outgoing</td>
<td>patient</td>
<td>peaceful</td>
<td>persistent</td>
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<tr>
<td>polite</td>
<td>purposeful</td>
<td>punctual</td>
<td>quiet</td>
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<tr>
<td>reliable</td>
<td>resourceful</td>
<td>respectful</td>
<td>responsible</td>
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<td>self-disciplined</td>
<td>sensitive</td>
<td>sincere</td>
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<td>smart</td>
<td>supportive</td>
<td>tactful</td>
<td>team player</td>
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<td>thoughtful</td>
<td>tolerant</td>
<td>trustworthy</td>
</tr>
<tr>
<td>truthful</td>
<td>unstoppable</td>
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</tr>
</tbody>
</table>
1. Limit setting is for the growth of your child.
   - Limits are not punitive.
   - Limits facilitate acceptance of your child by him/herself and by you, the parent.
     Your child learns all feelings, desires, and wishes are acceptable but not all behaviors.
   - Limits promote healthy boundaries.
     Limits help protect your child and you physically and emotionally.
   - Limits help your child to develop decision-making skills, self-control and personal responsibility.
     In response to the limit, the decision is your child’s.
     Free your child – with freedom comes responsibility.
   - Limits anchor the playtime to reality and emphasize the here and now.
     Limits in playtimes help your child learn to stop him/herself in the real world.
   - Limits promote consistency.

2. Set limits for playtimes that fit within your house rules but allow more freedom for exploration and expression.
   - Limits in playtimes are readily understood to be unique to that setting.
     Children easily adapt to different rules for different settings.
   - Determine your own limits ahead of time.
     Examples: Toy damage, throwing toys, pouring water on the floor, hitting you, etc.
   - Be consistent.
     Before setting a limit, ask yourself, “Is this limit necessary?”
     Before allowing a behavior, ask yourself, “Can I consistently allow this?”
   - State limit only when need arises.

3. Use patience.
   - Don’t try to force your child to accept a limit.
   - Restate limit three times before giving choices.

RULE OF THUMB: Where there are no limits, there is no security.
Without limits, your child is left to set limits by him/herself. This places too much responsibility on him/her.
Practice Choice Giving

1. Your child begins to drip water slowly from the baby bottle onto the floor.
   Limit: ____________________________________________________________
   ____________________________
   Choice: ____________________________

2. Your child unscrews the baby bottle lid and begins to pour the water on the floor.
   Limit: ____________________________________________________________
   ____________________________
   Choice: ____________________________

3. Your child sits on the rug and opens the play dough.
   Limit: ____________________________________________________________
   ____________________________
   Choice: ____________________________

4. Your child aims the dart gun at you and says, “You’re the bad guy. I’m going to shoot you.”
   Limit: ____________________________________________________________
   ____________________________
   Choice: ____________________________

5. Your child scatters the toys across the floor.
   Limit: ____________________________________________________________
   ____________________________
   Choice: ____________________________
The Importance of Play and Play Activities

HOW DOES PLAY RELATE TO OTHER BEHAVIORS?

1. Play provides the opportunity for children to practice new cognitive, social-emotional, and physical skills.

2. Play offers numerous opportunities for children to act on objects and experience events.

3. Play is an active form of learning that unites the mind, body, and spirit.
   NOTE: Until at least the age of 9, children’s learning occurs best when the whole self is involved.

4. Play enables children to use their real experiences to organize concepts of how the world operates.

5. Through play, children can see how new experiences are related to previous learning.

6. As they play, children can develop a playful attitude – an attitude toward inventiveness that contributes to being able to think up many ideas, new ways to do things, and ways to solve problems.

7. Art appreciation develops through play.

8. Play enables children to learn about learning – through curiosity, invention, staying with the task, and in a host of other ways.

9. Play reduces the tension that often comes with having to achieve or needing to learn.

10. Through playing with peers, children develop skills for seeing from another person’s point of view, cooperating, helping, and sharing, as well as for solving problems.

11. Children express and work out emotional aspects of everyday experiences as well as frightening events, especially through dramatic play.

EVERY ASPECT OF A CHILD’S LIFE IS INTERWOVEN WITH PLAY. THIS IS THE NATURE OF A CHILD.
WHAT CAN ADULTS DO TO SUPPORT PLAY?

1. Let children choose their activity.
2. Let children determine how long they will play.
3. Provide activities and materials that challenge various levels of skills.
4. Make sure the physical environment is safe.
5. Arrange space so as to minimize interruptions.
6. Allow children to use objects and try out new skills in unusual ways.
7. Plan the schedule so that children get the most from their play.

WHEN CHILDREN ARE PRETENDING –

8. Always allow choice – never require pretend play.
9. Unless children are playing dangerously, it is usually best to allow them to act out even negative scenes.
10. Allow children to enact roles and events differently than they are done in real life.
11. Supply props for themes of interest to each developmental level.
12. Provide the stimulus for make-believe by arranging experiences such as – going on field trips, having visitors to the school, reading books, and occasionally seeing a movie or a stage play.
13. Participate when needed, observe when not.

WHEN CHILDREN ARE MAKING OR BUILDING –

14. Focus on the process, not the product.
15. Do not use competitions to compare products.
16. Give children the freedom to be messy.
17. Provide more materials as children grow older.
### Common Fears in Infancy, Childhood, and Adolescence

<table>
<thead>
<tr>
<th>Age</th>
<th>Objects of Fear</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 months</td>
<td>Loss of support, loud noise</td>
</tr>
<tr>
<td>7-12 months</td>
<td>Strangers; sudden, unexpected, and looming objects</td>
</tr>
<tr>
<td>1 year</td>
<td>Separation from parent, injury, toilet, strangers</td>
</tr>
<tr>
<td>2 years</td>
<td>Loud noises, animals, dark room, separation from parent, large objects or machines, change in personal environment</td>
</tr>
<tr>
<td>3 years</td>
<td>Masks, dark, animals, separation from parents</td>
</tr>
<tr>
<td>4 years</td>
<td>Separation from parent, animals, dark, noises</td>
</tr>
<tr>
<td>5 years</td>
<td>Animals, &quot;bad&quot; people, dark, separation from parent, bodily harm</td>
</tr>
<tr>
<td>6 years</td>
<td>Supernatural beings (ghosts or witches), bodily injuries, thunder and lightening, dark sleeping or staying alone, separation from parent</td>
</tr>
<tr>
<td>7-8 years</td>
<td>Supernatural beings, dark, media events, staying alone, bodily injury</td>
</tr>
<tr>
<td>9-12 years</td>
<td>Tests and examinations in school, school performance, bodily injury, physical appearance, thunder and lightning, death</td>
</tr>
<tr>
<td>Teens</td>
<td>Personal relations, personal appearance, school, political issues, future, animals, supernatural phenomena, natural disasters, safety</td>
</tr>
</tbody>
</table>
When “Setting the Limits” Doesn’t Work

You have been careful several times to ACT:

A

C

T

Acknowledge your child’s feelings -- Communicate clear, fair limits – Target choices

(other ways to express his or her feelings)

Now your child continues to deliberately disobey. What to do?

1. Look for natural causes for rebellion.
   - Check for 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 your child.
   - You are not a failure if your child rebels.
   - Your child is not bad.
   - All kids “practice” rebelling.

3. Get the attention of your child.
   - To set a new limit for a recurring situation or change an existing limit established by default or intention, announce authoritatively:
     “We’re about to institute a new and significant policy immediately effective within the confines of this (house, car, etc).”

4. Establish the limit by clearly stating the behavior and associated choices one time only.
   - Allow your child to make either choice, but set reasonable consequences for each.
     Example: “If you choose to fight in this car, then you choose to not watch TV tonight. If you choose not to fight, then you choose to watch TV tonight.”

5. Enforce the consequences and reflect as appropriate.
   - Example: “I can see you really want to watch TV right now, but the moment you chose to fight in the car, you chose not to watch TV tonight.”
   - Always follow through. 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.

6. If your child refuses to choose, you choose for him/her.
   - Your 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 one that is most convenient for me.” (Stand firm. Your child gave up his or her choice so do not let him/her choose now.)
7. Never tolerate violence.
   • Provide compassionate control – physically restrain a violent child without becoming aggressive.
   • Reflect your child’s anger and frustration.
   • Offer alternative ways for your child to express angry feelings.
8. Recognize signs of depression.
   • The chronically angry or rebellious child is in emotional trouble and may need professional help.
   • With a sudden onset, look for a traumatic experience your child has been involved in that you are not aware of such as physical/sexual abuse, witnessing a traumatic event, etc.

RULE OF THUMB: DON’T TRY TO CHANGE EVERYTHING AT ONCE.

Establish one new limit at a time and give it time to settle.
Common Problems in Playtimes:
1. Q: My child notices that I talk differently in the playtimes and wants me to talk normally. What should I do?
   A: Reflect your child’s feelings. You may also want to work more on conveying interest (“I’m here, I hear and see you, I understand, I care”) with your responses and your facial expressions.
2. Q: My child asks many questions during the playtimes and resents my not answering them. What should I do?
   A: The purpose of not answering questions is to return responsibility to the child. If you give your child the answers, he/she doesn’t have the opportunity to experience his or her own wisdom. However, some questions may be answered. For example, if your child asks a question such as, “You went shopping yesterday, didn’t you?” you wouldn’t respond with, “You’re wondering if I went shopping yesterday.” Instead, you would respond with, “You remembered that!” answering the question in essence but not in a way that makes you the expert.
3. Q: My child just plays and has fun. What am I doing wrong?
   A: Nothing. Your child is supposed to use the time however he/she wants.
4. Q: I’m bored. What’s the value of this?
   A: The message you send by simply being there is extremely valuable because you have put aside your own needs for your child’s. It might be valuable to explore your feelings of boredom.
5. Q: My child doesn’t respond to my comments. How do I know I’m on target? When is it okay for me to ask questions, and when is it not okay?
   A: Usually when you are on target, your child will let you know. Often no response means you were on target. Otherwise, you may get a weird look from your child to let you know you are off target. If this happens, you may want to explore other feelings he/she might be having or convey that you’re trying to understand. For example if you have reflected, “You really are angry,” and your child doesn’t respond or nonverbally indicates that you are wrong, you might say, “or maybe it’s not anger you are feeling. Maybe you’re just feeling really strong and powerful.” If your child still doesn’t respond you might say, “Maybe that’s not it either.” Allow your child to either explain or say nothing.
6. Q: My child hates the playtimes. Should I discontinue them?
   A: No. Your child can use the playtimes any way he/she wants to and is free to use them in a way that he/she enjoys. Always try to see the world through his or her eyes, though. Does he/she hate the playtime because it is scheduled during his or her favorite TV show or because he/she has to stop doing something he/she is enjoying? If this is the case, you may want to reconsider the scheduled time and give him/her two choices of other times for the playtimes. If he/she still does not want to have the special playtime, suggest that he/she try it for 10 minutes and decide whether or not to continue for the day. Also watch what you are doing that may make this uncomfortable for him/her.
7. Q: My child wants the playtime to be longer. Should I extend the playtime?
   A: No. Sticking to the length you have decided is very important because it sets a limit.
   Use this as an opportunity to reflect your child’s feelings and build his or her coping skills. You can still spend time with him/her doing fun things together or listening to him or her after the playtime, just be sure to set the limit on special playtime.

8. Q: My child wants to play with the toys at other times during the week. Is that OK?
   A: No. The toys are only used for special playtime. If your child is allowed to play with them anytime during the week, he/she may not be interested in having your special playtime. The toys lose their “specialness” if they can be played with anytime. Use this as an opportunity to build coping skills.
Some Thoughts on Aggression

Aggression is a process whereby your child (and many times you) feels more and more helpless. This helplessness builds through a 4 stage process as follows:

Stage 1  Irritant + Inability to remove = Frustration  (Awareness)
Stage 2  Frustration + Inability to remove = Anger    (Focused Action)
Stage 3  Anger + Inability to remove = Rage      (Beginning Distortion of Action)
Stage 4  Rage + Inability to remove = Fury      (Complete Distortion of Action)

After fury is reached, exhaustion occurs and both child and parent are left feeling temporarily overwhelmed and powerless. The increased powerlessness/helplessness felt by a child and often by a parent only serves to feed aggression.

In order 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.

This list of techniques is effective in increasing the power of both parent and child.
1. Check that your responses to your child are respectful.
2. Lower your voice and talk softly.
3. Use your child's name over and over in a reassuring voice.
4. Refer to your child's last success and compliance.
5. Use silence for thirty to sixty seconds when your child's aggression builds.
6. Leave the room giving your child time to gain self-control and thus, "save face."
7. Switch the subjects of conflict to some topic of non-threatening nature for a few minutes.
8. Give permission to be angry.
9. Exaggerate the conflict to humorous proportions.
10. Interpret the aggression to your child - determine and discuss the true origin of the aggressive behavior.

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."
To praise is to commend the worth of or to express approval or admiration. Encouragement, on the other hand, refers to a positive acknowledgment response that focuses on the child's efforts and/or specific attributes of work completed. Unlike praise, encouragement does not place judgment on the child or give information regarding the value of the child.

In a study of second graders in science classrooms, Rowe (1974) found that praise lowered students' confidence in their answers and reduced the number of verbal responses they offered. The students exhibited many characteristics indicative of lower self-esteem, such as responding in doubtful tones and lack of persistence or desire to keep trying. In addition, students frequently try to "read" or check the teacher's eyes for signs of approval or disapproval.

In a series of six studies of subjects ranging in age from third grade to adult, Meyer (1979) found that under some conditions, praise led recipients to have low expectations of success at difficult tasks, which in turn resulted in decreased persistence and performance intensity at the tasks.

Kamii (1984) notes that praise, as commonly used, is like other forms of reward and discourages children from judging for themselves what is right or wrong. Praise may lead to dependency because children come to rely on the authority figure to tell them what is right or wrong, good or bad.

Praise causes children to focus on external rewards rather than the task at hand and the intrinsic rewards that come from the task (Brophy, 1981). Praise can actually lessen self-motivation and cause children to become dependent on rewards (Martin, 1977; Stringer & Hurt, 1981).

Encouragement is specific. Instead of saying, "Alice, your painting is beautiful," make specific comments about Alice's painting. Such statements as "You used a lot of blue" or "You worked a long time on that." Judgment about the quality of Alice's painting is left to Alice. Furthermore, statements of encouragement avoid labeling or interpreting the painting and embarrassing you and the child when you call the rocket a horse.

Encouragement focuses on improvement of process rather than evaluation of a finished product. Focus should be on the child's efforts. Instead of saying "Good job," say "You did that all by yourself" or "I noticed you have been working here all morning" or "You've really improved your free throwing."

Encouragement is having faith, giving hope, reducing competition, and eliminating unreasonably high standards and double standards. Encouragement means accepting children as they are and separating their work from their worth. Children will thrive in environments where they do not fear being evaluated, where they can make mistakes and learn from them, and where they do not need to always strive to meet someone else's standards of excellence.

<table>
<thead>
<tr>
<th>Praise</th>
<th>Encouragement</th>
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<tbody>
<tr>
<td>Good job!</td>
<td>You did it!</td>
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I believe that perfectionism may be in part learned from a child's interaction 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 with 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 is contingent on the child's success, the parent 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.

Excerpted from the body of an article by David D. Burns titled "The Perfectionist's Script for Self-Defeat."

Psychology Today November, 1980
Other Things to Remember

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

2. What is important is not what a child knows, but what a child believes.

3. One of the best things we can communicate to our children is that they are competent. Tell children they are capable and they will think they are capable. Tell children enough times they can’t do it and sure enough, they can’t.

4. Give children credit for making decisions: “Oh, you’ve decided to …”

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

6. Praise limits creativity and freedom.

7. Free the child. With freedom comes responsibility.

8. In the playtime, the adult is not the source of answers. Reflect questions back to the child.


10. Support the child’s intent even if you can’t support the child’s behavior.

11. Reflective responses can diffuse anger.

12. When we are flexible in our stance, we can handle anger much more easily. When we are rigid, the child and we can end up hurt.

13. When you’re just trying to solve the problem, you lose sight of the child.

14. Today is enough. Don’t push you child toward the future.

Resources

- Landreth, Garry. *Parents as Therapeutic Partners*. 
Appendix F

Training Guides
Filial Therapy Training: A Four-Week Model

Filial Session #1:
I. Introduce self, welcome group, give nametags and Handouts #1-9 to all members.

II. Overview of Filial Training:
   • Play is the child’s language.
   • Play is based on actions, not words.
   • Filial therapy is a way of preventing problems because adults become aware of child’s needs.
   • Techniques from play therapy will:
     - Return control to you.
     - Provide closer, happier times with your child.
     - Give you the key to your child’s inner world.

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

III. Group Introductions:
   • Describe entire family – help pick child of focus.
   • Share concerns about this child.
   • Make generalizing comments to other parents.

IV. Provide Basic Agenda:
   • One-half hour playtimes.
   • Everyone will videotape each home playtimes for replaying in the group.
   • Live demonstrations before starting.
   • Patience is important in learning a new language.

V. Teach Reflective Listening: (Handout #1)
   • It is a way of following, rather than leading.
   • Make statements instead of asking questions.
   • Reflect behaviors, patterns, and feelings.

   Responses say:
   - I am here.
   - I hear you.
   - I understand.
   - I care.

   Not:
   - I always agree.
   - I must make you happy.
   - I will solve your problems.
• Demonstrate reflective listening by having one parent describe a frustrating event that occurred recently to them. Instruct the other parents to watch instructor during the exercise. Ask the group what they noticed about the listener. Did responses send the four messages (I’m here, I hear you, I understand, and I care)? What body language was noticed? (Facing forward, not doing other things while the person was talking, direct eye contact with the speaker)

• Bring in a child to demonstrate reflective listening during a short playtime (5-10 minutes) while parents watch. Avoid reflections of feelings at this time. After returning the child to the babysitter, review and discuss the playtime with the parents.

• Have parents take a few toys and find a place to have a 10-minute playtime with their child focusing only on reflective listening and conveying the four messages. Following playtimes, reconvene to give feedback and support to parents.

VI. Show videotape of “Life's First Feelings.”

VII. Go over “Playtime Basics” (using a demonstration box to explain the toys; emphasize the “how to” of playtimes. Review “Basic Rules for Filial Therapy.”)

VIII. Discuss how to explain the special playtime with their child.

IX. Show videotape of or do a live demonstration of a playtime.

X. Practice reflective listening with child of focus.

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

Homework:  1. Notice some physical characteristic about your child you haven’t seen before.
            2. 30-second burst of attention.
            3. Buys toys for special playtime.
            5. Select a time and place for playtimes.
            6. Conduct first playtime at home this week.
Filial Session #2:
I. Begin by finding out how the special playtimes went.

II. Review homework:
   1. Physical characteristic.
   2. 4 faces sheet.
   3. 30-second burst of attention.
   4. Toys bought.
   6. Time and place for playtimes.

III. During reporting, use their examples to illustrate rules of filial therapy. Also focus on how they were able to reflect on their child’s feelings. Find something positive to comment on for each parent.

IV. Handout: “Two Techniques of Discipline that Work” (show video clip on limit setting) Go over importance of using this as the first step in the discipline process.

V. Show videos of special playtimes. Encourage feedback from group members. Comment on things parents are doing right. Ask what they would like to do differently this week.

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

Homework:
   1. Continue special playtimes.
   2. Notice one intense feeling in yourself this week during the special playtime.
   3. Conduct playtime at home this week.

Filial Session #3:
I. Debrief special playtimes. Ask about an intense feeling the parent felt during the special playtime.

II. Handout: “When Setting Limits Doesn’t Work”
   "Enslaved Parent"
   "Common Problems in Filial Therapy"
   "Learning to be Perfectionistic" & "Encouragement vs. Praise"

III. Review parent/child playtimes as before. By now the parents are generally feeling more confident in their ability to give feedback to each other. Use group facilitation skills to help each member have a chance to give feedback. Allow time to discuss common problems parents are experiencing.
IV. Arrange for parents to videotape their playtime this week.

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

Homework: 1. "Sandwich hugs"
2. Write a note to your child of focus (as well as other children in the family) for three weeks pointing out a positive character quality you appreciate. "I was just thinking about you and I wanted you to know that I really appreciate _____________ (or think you are _____). That is such an important quality."
3. Write down any other unanswered questions.
4. Conduct playtime at home this week.
5. Notice one intense feeling in yourself this week during the special playtime.
Filial Session #4:

I. Debriefing combined with report on one intense feeling they experienced this week during the playtime. Focus on the importance of awareness of themselves in the playtimes.

II. Go over homework: Sandwich hugs, note to the child, one intense feeling in yourself in the special playtime, & unanswered questions.

III. Review videos of special home playtimes.

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

Closing Process:

Review important learnings for each parent and discuss how each perceives his or her child now compared with 10 weeks ago. (Has the child really changed that much or has the parent's perception changed, i.e. more accepting?)

Encourage feedback within the group on positive changes made. They may be concerned about their ability to continue what they have learned with the safety and support of the group. Emphasize the importance of follow-up meetings. Ask for a volunteer to coordinate.

Emphasize the importance of continuing playtimes. Ask parents to sign a contract stating how long they will commit to continuing the playtimes. "If you stop now, the message is that you were playing with your child because you had to, not because you wanted to."

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

Homework: 1. “Sandwich Hugs”  
2. Continue special playtimes.  
3. Practice giving one choice outside of playtime.  
4. Conduct playtime at home this week.
Filial Therapy Training: A 10-Week Model

Filial Session #1:
I. Introduce self, welcome group, give name tags and booklets to all members.

II. Overview of Filial Training:
   • Play is the child’s language.
   • Play is based on actions, not words.
   • Filial therapy is a way of preventing problems because adults become aware of child’s needs.
   • Techniques from play therapy will: Return control to you.
     Provide closer, happier times with your child.
     Give you the key to your child’s inner world.

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

III. Group Introductions:
   • Describe entire family – help pick child of focus.
   • Tell concerns about this child.
   • Make generalizing comments to other parents.

IV. Provide Basic Agenda:
   • One-half hour playtimes.
   • Everyone will videotape at least one playtime for replaying in the group.
   • We will see demonstrations before starting.
   • Patience is important in learning a new language.

V. Show videotape of “Children’s Emotions”

VI. Teach Reflective Listening:
   • It is a way of following, rather than leading.
   • Make statements instead of asking questions.
   • Reflect behaviors, patterns, and feelings.

Responses say:
   I am here.
   I hear you.
   I understand.
   I care.

Not:
   I always agree.
   I must make you happy.
   I will solve your problems.
VII. Suggest “Listening” and “Self-Care” as reading this week.

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

Homework: 1. Notice some physical characteristic about your child you haven’t seen before.
2. Practice reflective listening this week (Handout w/4 faces).
3. 30-second burst of attention.

Filial Session #2:

I. Review homework: 1. Physical characteristic
   2. 4 faces sheet
   3. 30-second burst of attention

II. Go over “Filial Therapy Parent Group” using a demonstration box to explain the toys; emphasize the “how to” of playtimes.

III. Show videotape of or do a live demonstration of a playtime.

IV. Pair off and practice reflective listening.

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

Homework: 1. Buys toys for special playtime.
3. Select a time and place for playtimes.

Filial Session #3:

   3. Time and place for playtimes.

II. Handout: “Basic Rules for Filial Therapy”
    Review rules for playtime.
    Go over basic limits: “I’m not for shooting, but the Bobo is for shooting.”

III. Discuss how to explain the special playtime with their child.

IV. Show Life's First Feelings clips.

V. Watch another demonstration video or do a live demonstration.

VI. Arrange for 1-2 parent(s) to videotape their playtime this week.

RULE OF THUMB: Be a thermostat, not a thermometer.
Homework: 1. Review handouts.
2. Conduct first playtimes at home this week.

Filial Session #4:
I. Begin by finding out how the special playtimes went.

II. During reporting, use their examples to illustrate rules of filial therapy. Also focus on how they were able to reflect on their child’s feelings. Find something positive to comment on for each parent.

III. Handout: “Two Techniques of Discipline that Work” (show video clip on limit setting) Go over importance of using this as the first step in the discipline process.

IV. Show videos of special playtimes. Encourage feedback from group members. Comment on things parents are doing right. Ask what they would like to do differently this week.

RULE OF THUMB: Good things come in small packages.

Homework: 1. Continue special playtimes.
2. Notice one intense feeling in yourself this week during the special playtime.

Filial Session #5:
I. Debriefing combined with report on one intense feeling they experienced this week during the playtime. Focus on the importance of awareness of themselves in the playtimes.

II. Handout: “When Setting Limits Doesn’t Work” & “Enslaved Parent”

III. Review videos of special playtimes.

RULE OF THUMB: The most important thing may not be what you do, but what you do after what you have done. It’s not whether we make mistakes, but how we handle our mistakes that counts.

Homework: 1. “Sandwich Hugs”
2. Continue special playtimes.
3. Practice giving one choice outside of playtime.
Filial Session #6:
I. Have each parent report on giving one choice and continue debriefing playtimes as done previously.

II. Handout: "Common Problems in Filial Therapy"

III. Arrange for next parents to come in for videotaping or to bring their videos.

IV. Review parent/child playtimes as before. By now the parents are generally feeling more confident in their ability to give feedback to each other. Use group facilitation skills to help each member have a chance to give feedback. Allow time to discuss common problems parents are experiencing.

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

**Homework:**
1. Write a note to your child of focus (as well as other children in the family) for three weeks pointing out a positive character quality you appreciate. "I was just thinking about you and I wanted you to know that I really appreciate ______________(or think you are ______). That is such an important quality."
2. Continue playtimes -- notice patterns of play that are showing up.

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Filial Session #7:
I. Debriefing on playtimes with focus on patterns in child's play.

II. Review "Common Problems in Filial Therapy." Use as opportunity to review reflective listening, setting limits, giving choices, etc.

III. Show videotape of parent/child playtimes and continue to provide encouragement and support. Parents should be able to recognize what the videotaped parent is doing right and give constructive feedback on what they might try differently is a very important part of the learning.

IV. Handout: "Learning to be Perfectionistic" & "Encouragement vs. Praise"

V. Arrange for next parents to come in for videotaping or to bring their videos.

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

**Homework:**
1. Notice the number of times during the week you touch your child.
2. Continue playtimes.
Filial Session #8:
I. Parents report on the number of times they physically touched their child and continue debriefing playtimes, focusing on parents' perceived changes in their own behavior.

II. Go over Handout on "Learning to be Perfectionistic" & "Praise vs. Encouragement."

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

IV. Show videotapes of parent/child playtimes following procedure from last week.

V. Arrange for videotaping for next week.

RULE OF THUMB: If you draw your gun, shoot. (Idle threats harm your relationship with your child.)

Homework: Continue playtimes.

Filial Session #9:
I. Debrief playtimes, focusing on perceived changes in the child's play behavior. Give time for questions on various topics.

II. Show videotapes.

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

IV. Arrange for videotaping of last playtime.

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

Homework: Continue playtime.

Filial Session #10:
I. Show last videotapes and briefly debrief playtimes, focusing on observed growth and change in both parent and child.

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

III. Closing Process: Review important learnings for each parent and discuss how each perceives his or her child now compared with 10 weeks ago. (Has the child really changed that much or has the parent's perception changed, i.e. more accepting?)
Encourage feedback within the group on positive changes made. They may be scared about their ability to continue what they have learned with the safety and support of the group.

IV. Emphasize the importance of follow-up meetings. Ask for a volunteer to coordinate.

V. Emphasize the importance of continuing playtimes. Ask each parent to sign a contract stating how long they will commit to continuing the playtimes. "If you stop now, the message is that you were playing with your child because you had to, not because you wanted to."

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


