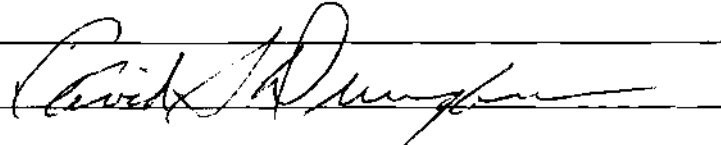


AN ABSTRACT OF THE THESIS OF

Denise E. Ray for the Master of Science
in Psychology presented on August 28, 1995

Title: The Effect of Filial Therapy on Parental Acceptance
and Child Adjustment

Abstract approved:



The present study was designed to investigate the effects of filial therapy on parental acceptance and child adjustment. It was hypothesized that parents who completed the filial therapy training program would increase their feelings of acceptance for their child, would reduce their level of parenting-related stress, and would report that their children were engaging in fewer problem behaviors. It was also hypothesized that the self-concept of the children involved would improve. The sample of 50 parent-child dyads were identified by the referral source as being "at risk" for developing parent-child attachment problems. The dyads were assigned to either the experimental or control groups and then scheduled to complete the pretest battery which consisted of the Porter Parental Acceptance Scale, the Parenting Stress Index, the Filial Problems Checklist, and the Joseph Pre-School and Primary Self-Concept Screening Test. After completing the pretest battery, those in the experimental group were assigned to one of two therapists to begin the filial therapy training process. Four filial therapy training groups each consisted of six to eight parent-child dyads. The training

for all four groups occurred over 10 weekly sessions and followed carefully outlined procedures. All control group members were placed on a waiting list during the 10 week treatment period. Upon completion of the treatment period all participants completed the posttest battery according to the same pretest procedures. After the posttests had been completed, the data were analyzed by calculating an analysis of covariance (ANCOVA) for each of the four dependent variables with pretest scores as the covariate. The results indicate that parents who completed the filial therapy training did significantly increase their feelings of parental acceptance. The trends in the data also indicate that there was a reduction in parenting related stress and the number of problem behaviors the children were experiencing. However, the findings suggest that no statistically significant improvement in child self-concept occurred.

THE EFFECT OF FILIAL THERAPY ON
PARENTAL ACCEPTANCE AND CHILD ADJUSTMENT

A Thesis

Presented to
the Division of Psychology and Special Education
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CHAPTER I

INTRODUCTION

Parents have been involved in the treatment of their children since 1909 when Sigmund Freud trained the father of a five year old phobic male client how to respond to the child during play. Freud noted that positive change was observed in the child as a result of the father's involvement (Freud, 1909/1959). Despite Freud's work, Hug-Hellmuth (1921) has been recognized as the first to introduce play into psychoanalysis. For her, as with most psychoanalysts, play was symbolic of the child's sexual and aggressive desires.

Baruch (1949) was the first to depart from the psychoanalytic tradition and suggest that home play sessions could be effective for improving the parent-child relationship. Fuchs (1957) was the next to employ this technique. Under the guidance of her father, Carl Rogers, she used special play sessions to help her daughter overcome an emotional reaction to toilet training. Through her work, Fuchs established that parents could be effective therapeutic agents. In 1959, Moustakas took the next logical step when he provided one of the earliest detailed descriptions of this approach.

Filial therapy, introduced by B. G. Guerney in 1964, is similar to the previous techniques in that parents are involved in the treatment of their children. However, B. G. Guerney was the first to incorporate systematic

training, close supervision, and group discussion. Filial therapy was developed with two specific goals in mind. First, this technique was intended to combat the emotional problems of children early in life thereby preventing such problems from becoming relatively fixed in the adult years. Second, this technique was developed to be efficient thus allowing the professional to reach a greater number of children in a limited amount of time (B. G. Guerney, 1964).

Statement of Problem

The quality of the parent-child relationship has a significant influence on the social and emotional development of a child. Sroufe and Fleeson (1986) suggest that secure parent-child relationships are associated with academic success, social adaptability, and emotional stability. Conversely, insecurely attached children lack appropriate social skills, suffer in terms of cognitive development, and require greater amounts of emotional support. In addition, insecurely attached children are more likely to engage in antisocial behavior than their securely attached peers (Patterson, DeBaryshe, & Ramsey, 1989). If these problems are not addressed, they may linger into adulthood and be passed from one generation to the next (Hartup, 1989). However, preliminary studies indicate that filial therapy can effectively arrest this cycle by improving the parent-child relationship.

Despite the suggested benefits, research on filial therapy has been minimal with studies limited to only a few

universities specializing in child psychotherapy. Due to this lack of research filial therapy has not been widely accepted or practiced. Additional studies are required before this method can be accepted as a viable alternative for the treatment of children with emotional problems.

Statement of Purpose

The author of this thesis hypothesized that filial therapy would contribute to parental acceptance and child adjustment. More specifically, parents who completed the filial therapy training program would demonstrate increased acceptance of their child, would report that their child was experiencing fewer problem behaviors, and would reduce their level of parenting related stress. Furthermore, the children of these parents would exhibit improved self-esteem and self-concept.

Statement of Significance

The number of children being treated at community mental health centers has increased in recent years. Unfortunately, for those children diagnosed with an emotional and/or behavioral disorder, the prognosis for long-term recovery is often poor. Although many factors contribute to this, the lack of effective treatment modalities designed specifically for children coupled with the increasing case load has left many professionals seeking more effective and efficient means by which to treat their young clients. Filial therapy is one technique that claims to meet both of these goals. Any technique

making these claims deserves further investigation.

Literature Review

Description and rationale. Filial therapy (B. G. Geurney, 1964) is recommended for children between 3 and 10 years of age who have behavioral and/or emotional problems. This approach involves training groups of six to eight parents how to conduct therapeutic, client-centered play sessions with their emotionally disturbed youngsters (L. F. Guerney, 1983). This process is intended to train parents to function in a therapeutic role with their own child, hence the term filial which means blood kin. Utilizing parents as therapeutic agents is intended to create an environment in which the children may become aware of previously unrecognized feelings and are then free to express those feelings to the parents through play. Acceptance of the children's feelings by the parents helps the children learn to cope with their feelings as they reexperience them during play. Also, the children's trust in the parents builds, thereby reducing the children's fear that honest emotional expression will result in loss of parental respect and affection as well as their need for extreme forms of emotional expression. Finally, the play sessions are intended to increase the children's feelings of confidence and competence by allowing them the freedom to make choices and experience the consequences of those choices. The parent's uninterrupted attention also contributes to the children's sense of worth (Schaefer,

1976). The afore mentioned goals are to be met during a three stage process to be described below.

Stage 1 begins as the therapist explains the goals, rationale, and expected outcomes of the filial therapy process. Next the parents are taught via didactic instruction and demonstration how to conduct client-centered play sessions with their child. Specific skills include empathic responding, limit setting, and allowing the child maximum self-direction during play. These skills are emphasized during a trial demonstration by the therapist with one of the group member's children or an unrelated child. Following the demonstration the group members are encouraged to discuss the observed play session to clarify and insure maximum understanding of the techniques employed. At this point most parents will be ready to attempt a play session on their own. The first play session between the parent and child will be observed by other group members and the therapist who will provide feedback and positive reinforcement. At this stage the parents will not be encouraged to practice the play sessions at home (B. G. Guerney, 1964).

Stage 2 begins after minimal proficiency has been demonstrated. Each parent is given a standardized list of toys to collect and instructed on how to begin the play sessions at home. The toy list includes two containers of play dough, an eight pack of crayons, scissors, a nursing bottle, a rubber knife or dart gun, family dolls, 10 to 15

plastic toy soldiers, a Lone Ranger mask, a cardboard doll house, three rooms of play furniture, a doctor's kit, play money, 3 to 5 feet of rope, a Bobo doll, a ring toss game, and a box of bandaids (Landreth, 1991). So as to make the play sessions special, the toys are stored in a box and only brought out during the play period.

Once all the toys have been gathered, the parent is ready to begin the sessions which will occur weekly for 30 minutes and should be scheduled during a time that does not interfere with other activities and in a place that will be free from interruption. Cancellations must be discussed with the child, and the appointment rescheduled. Otherwise, the child may interpret the cancellation as a rejection by the parent which could negatively effect the child's self-confidence. If there are other children in the home, arrangements should be made with a sitter so that the parent's attention can be concentrated on the child of focus. Pets should also be restrained so as not to distract the child. Before beginning the play sessions, the parents should briefly explain to their child that their time spent together is special (Schaefer, 1976). During the group meetings, the parents will continue to report on the previous weeks play session. Other group members are free to offer suggestions, and positive reinforcement is provided by the therapist. The home play sessions continue until the "child appears to have resolved conflicts and is demonstrating positive feelings and

actions towards him/herself and others in his play" (L. F. Guerney & B. G. Guerney, 1985, p. 510).

Stage 3 begins once sufficient mastery has been demonstrated by the parent and the therapist has observed positive change in the child's play. This final stage involves the transference and generalization of the skills used during the special play periods to real-life situations. This process begins as the parents are encouraged to discuss outside issues in group meetings and to identify problematic behaviors. The therapist should assist the parents in choosing a specific problem behavior that would allow them to easily apply the skills as they did during the play sessions. The parents are then instructed to focus on that behavior and to begin empathic responding sessions for 5 to 10 minutes each day. The empathic responding session requires the parent to respond empathically and set appropriate limits when the previously identified behavior occurs. This process allows the parents to adapt their skills to real-life situations. Once the parents are comfortable with the generalization process, they are ready to replace the play sessions with "special times." The "special times" involve an activity that the child likes to do but doesn't usually get a chance to do. The special times are like the play sessions in that they require the parents' uninterrupted attention and acceptance of the child's feelings without using excessive control. In a final session, the group evaluates the

parents' and child's progress during the play sessions and the generalization process. Success is determined by diminished aggression, increased independence, greater affiliation with the parent, and positive self-statements by the child. Once this is achieved, the parent is ready to terminate the training program (L. F. Guerney & B. G. Guerney, 1985).

Process and outcomes. The effectiveness of filial therapy was first demonstrated by Stover and B. G. Guerney (1967) who tested whether mothers trained in filial therapy techniques would increase the number of reflective statements made during play while decreasing the number of directive statements. The mothers' responding did change in the hypothesized direction. They also reported that the children significantly increased their nonverbal aggression defined as "overt hostile behavior toward a toy or the mother" (Stover & B. G. Guerney, 1967, p. 113). Aggressive behavior is commonly considered to be an important phase in effective client-centered play therapy. Though not statistically significant, the children also expressed more verbal negative feelings including annoyance, anger, and dislike. No change was observed in the children's verbal leadership or verbal dependency (Stover & B. G. Guerney, 1967).

B. G. Guerney and Stover (1971) found that mothers in the filial therapy training program allowed their children more self-direction during play and became increasingly

involved in the emotional life of their children. They also found that the mothers were able to reflect their children's feelings and express empathy. The results further indicate that the children improved in terms of psychosocial development. A follow-up study by L. F. Guerney (1975) demonstrated that 27 of the 42 children continued to improve after treatment. Eight of the children remained at the same level, and only 1 of the children had greater problems at follow-up than at termination of the program.

Since B. G. Guerney and Stover's (1971) design lacked a control group, Oxman (1971) matched the population in Stover and B. G. Guerney's (1967) study with an appropriate control group. Consistent with the previous findings, the behavior of children in the experimental group was positively effected by filial therapy while no such change was observed in the control group. Mothers in the filial therapy group also perceived their children as being closer to their ideal child at the conclusion of the study.

Sywulak (1977) investigated the effects of filial therapy on parental acceptance and child adjustment. Participants served as their own control group during a four month waiting period that was followed by a four month treatment period. This design was intended to provide a more accurate control group than Oxman (1971) by eliminating the possibility that time alone could have contributed to positive change in the treatment group. The

results indicate that parental acceptance was positively effected by participation in the filial therapy training program. In addition, filial therapy effectively eliminated a wide variety of problem behaviors that the children were experiencing. Furthermore, the findings demonstrate that the gains made in parental acceptance and child adjustment increased to a greater extent during the first two months of treatment but did continue to progress during the last two months.

Sensue (1981) conducted a follow-up investigation of Sywulak's (1977) study to determine whether improvements made in parental acceptance and child adjustment would be maintained three years following treatment. The results indicate that at follow-up, parents continued to be more accepting of their children than they were prior to treatment. In addition, the improvements were maintained three years after treatment.

Lebovitz (1982) investigated the process and outcomes of filial therapy. The data related to the process of filial therapy indicates that mothers in the filial therapy group surpassed control group mothers in their use of empathic responding skills thereby increasing the communication of acceptance. An analysis of the outcome measures demonstrates that children in the filial therapy group exhibited a decrease in the incidence of aggression, dependence, and withdrawal during play sessions. The amount of problem behaviors reported by mothers in the

filial therapy group also decreased.

Glass (1986) investigated the effect of using parents as primary therapeutic agents in the filial therapy training process. The results indicate that the parents involved did significantly increase their feelings of unconditional love for their children. The parents also reported a significant reduction of conflict in the parent-child relationship.

Special populations. Boll (1972) hypothesized that mothers in the filial therapy training group would perceive a greater increase in socially adaptive behavior in their educable mentally retarded children than would mothers in the filial therapy discussion group or mothers in the control group. The two filial therapy groups differed in the structure of their weekly group meetings. The filial therapy training group meetings were based on didactic lecture while conversation in the filial therapy discussion group was free flowing. The results indicate that only mothers in the filial therapy discussion group increased their perception of socially adaptive behavior in their educable mentally retarded children.

L. F. Guerney and Gavigan (1981) investigated parental acceptance of foster parents since it is assumed to be a necessary component of effective foster parenting. They found that parental acceptance as measured by the Porter (1954) Parental Acceptance Scale increased in a group of foster parents who had completed the filial therapy

training program. At posttest, the foster parents gained 9 to 11 points while control group parents had a gain of only 1 point. In a follow-up study four years later, these results maintained over time.

Payton (1980) examined the effects of parent and paraprofessional group training on the child's self-concept and personality adjustment and the parent's child rearing attitudes. Filial therapy did not significantly effect the self-concept of the children in either group as measured by the Piers Harris Children's Self-Concept Scale. Payton does suggest, however, that a more sensitive instrument may have produced different results. The child's personality adjustment, as measured by the Child Behavior Rating Scale, did show a significant gain in the parent treatment group while no gain was reported in the paraprofessional or control groups. Parents who had undergone the filial therapy training process with their child showed a significant improvement in their child rearing attitudes when compared to the paraprofessional or control groups. These findings suggest that parents may be more effective therapeutic agents in filial therapy than paraprofessionals.

Summary

While filial therapy may positively effect parental acceptance and child adjustment, only a few studies have focused specifically on this aspect. Thus, filial therapy has never been widely accepted or practiced since it's

introduction in 1964. In fact, the present study was the first to be conducted in the state of Kansas.

CHAPTER II

METHOD

The database, research design, experimental procedures, and statistical techniques used to assess the effects of filial therapy on parental acceptance and child adjustment are presented in this chapter. In addition, the instruments and their reliability and validity are presented.

Participants

The sample for the present study was comprised of 50 parent-child dyads identified by a referral source as being at risk for developing parent-child attachment problems. Those considered to be "at risk" were families who exhibited a previous history of attachment problems including abuse and/or neglect. Additional high risk groups included teen parents, single parents, and parents who have their own emotional problems.

Referrals were accepted from several agencies within Sumner County, a rural/suburban community in south central Kansas. Most referrals came from Head Start, district court, Social and Rehabilitation Services, and the county mental health center. All referrals were evaluated by the clinical staff at Sumner County Mental Health Center to determine their appropriateness for participation in the filial therapy training program. Priority was given to families who had exhibited a previous history of attachment problems, teen parents, and parents with children under

five years of age. Parents with children from 6 through 10 years of age were also eligible. After being approved for participation in the training program, all parents read and signed an informed consent document explaining that they were free to withdraw from the study at any time with no negative repercussions (see Appendix A). The document also informed parents of the confidentiality of their results and the results of their children.

Once the informed consent document had been signed, all participants were assigned to either the experimental or control group. Each group consisted of 25 parent-child dyads. The experimental group was comprised of 24 mothers and 1 father ranging in age from 19 to 57 ($\underline{M} = 34$, $\underline{SD} = 7.2$). The children in this group included 12 girls and 13 boys ranging in age from 3.6 years to 9.10 years ($\underline{M} = 5.1$, $\underline{SD} = 1.7$). The control group contained 22 mothers and 3 fathers ranging in age from 28 to 46 ($\underline{M} = 33$, $\underline{SD} = 5.4$). The children in this group included 15 boys and 10 girls ranging in age from 3.10 years to 9.10 years ($\underline{M} = 6.5$, $\underline{SD} = 2$).

Research Design

The present study was a quasi-experimental investigation of the effects of filial therapy on parental acceptance and child adjustment. The pretest-posttest control group design was employed to test the hypotheses stated below.

Hypothesis I. Parents who completed the filial therapy

training process would demonstrate increased acceptance for their child.

Hypothesis II. Parents would report that their children were engaging in fewer problem behaviors upon completion of the training program.

Hypothesis III. Parenting related stress for those who had completed the filial therapy training would be less.

Hypothesis IV. Children who were involved in the special play sessions would exhibit an improved self-concept.

Instrumentation

Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST). The JPPSST was the only child-completed instrument used in this study. This test is intended to identify children between the ages of 3.6 years and 9.11 years who are at risk for developing learning and/or adjustment problems due to a negative self-concept. The JPPSST consists of 16 items. The first item referred to as the Identity Reference Drawing requires children to draw their face on a picture of a same sex child. This is followed by 15 dichotomous questions to which the children are asked to identify which one is most like themselves. A coefficient of .87 indicates adequate test-retest reliability and concurrent validity has been demonstrated by comparisons with two teacher rated scales of self-concept (Telzrow, 1985).

Parenting Stress Index (PSI). The PSI was designed by

Abidin (1976) "to identify parent-child systems which were under stress and at risk for the development of dysfunctional parenting behaviors or behavior problems in the child involved" (p. 55). The test is a paper and pencil, self-report instrument consisting of 101 items that are rated on a 5-point Likert scale. The instrument provides a Total Stress Score as well as scores on several subscales. However, only the Total Stress Score was used in this study. This particular score has a reliability coefficient of .95. Concurrent validity has been demonstrated by correlations with the Child Behavior Problems Checklist and the State-Trait Anxiety Scale. Discriminant validity has been supported by the PSI's ability to discriminate between physically abusive and nonabusive mothers, amount of husband support, and single and married mothers (Wantz, 1989).

Filial Problems Checklist (FPC). The FPC is a paper and pencil, self-report tool developed by L. R. Guerney (1974) for use in filial therapy training programs. The instrument consists of 108 items describing a wide variety of problems children might have. The parents underline those items that apply to their children and then rate the item from one to three according to severity. This test is currently unpublished and information concerning the psychometric properties is not available at this time. However, the instrument appeared to have face validity as it was used in this study.

Porter Parental Acceptance Scale (PPAS). The PPAS was developed for the purpose of measuring parent's acceptance for their child. This self-report questionnaire consists of 40 items to which the parents respond by checking one of five answers that most accurately describes the feelings they have or the actions they take toward their children. Reliability was determined using the split-half method corrected for the full length using the Spearman Brown formula which gives a coefficient of .86. The PPAS was presented to five independent judges all of whom agreed on the validity of the instrument (Porter, 1954).

Procedure

Permission to complete the present study was obtained from the Human Subjects Review Board and the appropriate administrators. After approval was granted, the 50 parent-child dyads were identified and sent a letter explaining the present study with an informed consent document (see Appendix A). The document informed the parents of the confidentiality of their results and the results of their children. Confidentiality was assured by identifying participants only by an identification number.

After appropriate consent was obtained, all participants were assigned to the experimental or control group and then scheduled to complete the pretest battery. The pretest battery consisted of the Porter Parental Acceptance Scale (PPAS), the Parenting Stress Index (PSI), the Filial Problems Checklist (FPC), and the Joseph Pre-

School and Primary Self-Concept Screening Test (JPPSST). A description of each instrument as well as a discussion of test reliability and validity will be presented later in this chapter.

Prior to administration of the instruments all participants were informed they were free to discontinue the testing at any time. All testing was conducted by the author of this thesis in a private testing room at Sumner County Mental Health Center. Childcare was provided at the center while the parents completed the PPAS, the PSI, and the FPC. Once the parents had completed their testing, they waited in the lobby while the JPPSST was individually administered to each child. The testing continued in small groups of six to eight parent-child dyads until all participants had completed the pretest battery. The conditions under which the testing occurred remained constant throughout the collection of the data.

After completing the pretest battery, those in the experimental group were assigned to one of two psychologists, Dr. Richard Gaskill or Dr. Robert Bean. Both have been trained in filial therapy by Dr. Gary Landreth during a two-day intensive workshop and a third follow-up day to insure proper use of the filial therapy techniques. During their training Drs. Bean and Gaskill learned to conduct the filial therapy training via didactic instruction, video taping, and live demonstration.

Four filial therapy training groups consisted of six to

eight parent-child dyads. The training for all the groups occurred over 10 weekly sessions each lasting 2 hours. The sessions followed a specific format carefully outlined by Dr. Richard Gaskill (1993) (see Appendix B). All control group members were placed on a waiting list during the 10 week treatment period.

Upon completion of the treatment period, all participants were scheduled to complete the posttest battery according to the same procedures used during pretest. After the posttesting had been completed, the data were compared and analyzed according to the statistical procedures described in Chapter III.

CHAPTER III

RESULTS

After the data were collected, an analysis of covariance (ANCOVA) was conducted on the mainframe system at Emporia State University using the SPSS computer program to determine whether a significant difference existed between the experimental and control groups' adjusted posttest means for each of the study's four hypotheses. In each case the independent variable was the filial therapy training program. The four dependent variables were the posttest scores obtained on the Porter Parental Acceptance Scale (PPAS), the Parenting Stress Index (PSI), the Filial Problems Checklist (FPC), and the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST). The pretest scores obtained on each of these four instruments were the covariates to equate the experimental and control groups on this variable before exposure to training.

There was a statistically significant increase in parental acceptance for the parents who completed the training program, $F(1, 47) = 11.91, p < .01$ (see Table 1). Parents in the experimental group achieved a significantly higher total score mean on the PPAS than did parents in the control group (see Table 2 for means and standard deviations) indicating that parents in the experimental group did increase their feelings of acceptance for their child following the 10 week treatment period.

Table 1

Analysis of Covariance Data for the Porter Parental
Acceptance Scale

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u>
Training	1360.01	1	1360.01	11.91*
Covariate	5021.89	1	5021.89	43.99**
Error	5364.91	47	114.15	

*p < .01

**p < .001

Table 2

Total Score Means and Standard Deviations for the Porter
Parental Acceptance Scale

	<u>Experimental (n=25)</u>		<u>Control (n=25)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	142.48	155.24	134.68	140.48
<u>SD</u>	23.38	14.44	14.36	14.97

Table 3 indicates there was not a statistically significant reduction in parenting related stress for the parents who completed the training program, $F(1, 47) = 2.19, p > .01$. However, the total score means obtained on the PSI did change in the hypothesized direction (see Table 4 for means and standard deviations). The total score means of the parents who were in the experimental group decreased by 22.64 points while the total score means of the parents in the control group decreased by only .56 points. That is, parents in the experimental group did reduce their level of parenting related stress but not enough to achieve significance when compared to the control group.

The filial therapy training program did not contribute to a statistically significant reduction in the number of problem behaviors the children were experiencing, $F(1, 47) = 1.16, p > .01$ (see Table 5). However, the total score means reported in Table 6 show that, at the time of posttest, parents in the experimental group did report that their children were experiencing fewer problem behaviors than did control group parents. The total score means on the Filial Problems Checklist decreased by 19.64 points in the experimental group while the total score means for those in the control group increased by 1.68 points. However, this trend should be interpreted with caution given the difference in the total mean scores at pretest and the considerable variance.

Table 3

Analysis of Covariance Data for the Parenting Stress Index

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u>
Training	1737.04	1	1737.04	2.19
Covariate	73527.47	1	73527.47	92.73**
Error	37267.01	47	792.92	

**p < .001

Table 4

Total Score Means and Standard Deviations for the Parenting
Stress Index

	<u>Experimental (n=25)</u>		<u>Control (n=25)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	267.92	245.28	234.24	233.68
<u>SD</u>	52.59	40.06	57.39	54.88

Note. Improvement is indicated by a reduction in the total score means.

Table 5

Analysis of Covariance Data for the Filial ProblemChecklist

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u>
Training	1639.91	1	1639.91	1.16
Covariate	86372.00	1	86372.00	60.91**
Error	66646.96	47	1418.02	

**p < .001

Table 6

Total Score Means and Standard Deviations for the Filial
Problems Checklist

	<u>Experimental (n=25)</u>		<u>Control (n=25)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	84.24	64.60	47.28	48.96
<u>SD</u>	62.07	56.63	50.48	56.29

Note. Improvement is indicated by a reduction in the total score means.

There was not a statistically significant improvement in the self-concept of the children who were involved in the filial therapy training program, $F(1, 47) = .67, p > .01$, (see Table 7). Furthermore, there was not a significant increase in the total score means for either the experimental group or the control group (see Table 8 for means and standard deviations). The total score means increased by only 1.16 points for those children who were involved in filial therapy while increasing by .64 points for those who received no treatment. This indicates that at completion of the 10 week treatment period, there was no significant improvement in the self-concept of children who completed the filial therapy training program.

Summary

In sum, the only statistically significant effect the filial therapy training program had was to increase parental acceptance. The trends observed also indicate that the total score means on the Parenting Stress Index and the Filial Problems Checklist did change in the hypothesized direction. However, there was no statistically significant reduction in parenting related stress or the number of problem behaviors the children were experiencing. Furthermore, filial therapy did not contribute to a significant improvement in the self-concept of children who completed the training program.

Table 7

Analysis of Covariance Data for the Joseph Pre-School and
Primary Self-Concept Screening Test

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u>
Training	3.41	1	3.41	.67
Covariate	216.81	1	216.81	42.57**
Error	239.35	47	5.09	

**p < .001

Table 8

Total Score Means and Standard Deviations for the Joseph
Pre-School and Primary Self-Concept Screening Test

	<u>Experimental (n=25)</u>		<u>Control (n=25)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	24.40	25.56	26.76	27.40
<u>SD</u>	4.88	3.74	2.51	2.24

CHAPTER IV

DISCUSSION

As outlined in Chapter II, this study was conducted to assess the effect of filial therapy on parental acceptance and child adjustment. The four hypotheses investigated in this study are presented below along with a discussion of the meaning of these results.

Parental Acceptance

Parents who completed the filial therapy training program increased their feelings of acceptance for their child. This supports the previous findings (Glass, 1986; L. F. Guerney & Gavigan, 1981; Lebovitz, 1982; Sywulak, 1977) that parental acceptance increases as a result of filial therapy. Based on the previous findings and current results, filial therapy effectively increases a parent's feelings of acceptance for their child during a 10 week treatment period.

Parenting Related Stress

It was hypothesized that there would be a reduction in parenting related stress for parents who had completed the filial therapy training program. Although means on the Parenting Stress Index for those parents who were involved in filial therapy decreased by 22.64 points and only .56 points for control parents, these results were not statistically significant. One possible explanation for this lack of significance could be that participation in the training program may have created a certain amount of

stress as the parents attempted to master and apply the necessary skills. Additionally, the relatively small sample size may have contributed to this finding.

Child Behavior Problems

It was hypothesized that parents in the experimental group would report that their children were experiencing fewer problem behaviors upon completion of the filial therapy training program. Although the experimental group decreased by 19.64 points while the control group increased by 1.68 points, these results were not statistically significant. While the trend in the data indicates that parents who completed the training program did report that their children were engaging in fewer problem behaviors, this trend should be interpreted with caution given the difference in the total mean scores at the time of pretesting and the considerable variance observed. The variance could be attributed to the fact that the total scores on the Filial Problems Checklist could range from 1 to 324 points. Parents also could have become more involved in the emotional life of their children and, therefore, were more willing to accept the problem behaviors that their children continued to experience.

Child Self-Concept

It was hypothesized that the self-concept of the children who completed the filial therapy training program would improve. As can be seen in Table 8, the total score means on the Joseph Pre-School and Primary Self-Concept

Screening Test did not change in the hypothesized direction. As would be expected, given this finding, there was no statistically significant increase in the self-concept of those children who were involved in filial therapy (see Table 7). This could be attributed to the fact that five of the children in the experimental group scored in the highest possible category at the time of pretesting, despite the fact that they were all identified by the referral source as being "at risk". This could be due to a weakness in the test, although it is considered to be one of the best available for children in this age group (Gerken, 1985; Telzrow, 1985). Ten weeks also may not be long enough to expect such a complex change to occur.

Conclusion

While the results of this study demonstrate that the parents in the experimental group significantly increased their feelings of acceptance for their child, this does not appear to have contributed to an improvement in child self-concept. However, while not reaching statistical significance, the parents did report that their children were engaging in fewer problem behaviors upon completion of the training program. The trends in the data also indicate that there was a reduction in parenting related stress for those who were involved in filial therapy. Given the statistically significant result and the observed trends, filial therapy does seem to be a promising treatment modality. However, further research is required to

determine if filial therapy can effectively improve child self-concept.

Suggestions for Further Research

Based on the above findings and conclusions, the following recommendations are offered for future research in this area:

1) The treatment period should be longer to allow sufficient time for complex changes to occur.

2) A longitudinal follow-up study should be carried out to determine if the positive outcomes will be maintained following termination of the treatment period.

3) A larger sample should be utilized to increase generalization and the possibility of achieving significant results.

4) A treatment comparison group should be incorporated into the design. The present study appears to indicate that utilizing parents in a therapeutic role effectively increases parental acceptance and may reduce parenting related stress and the number of problem behaviors that the children engage in. However, based on the current findings, ruling out the fact that a more traditional mode of treatment could have produced similar results is impossible.

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APPENDIX A
Consent form

CONSENT FORM

Sumner County Mental Health Center supports the practice and protection of human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to allow the test data from the treatment program in which you are participating to be used in a research study. Your willingness to participate will allow valuable information to be collected that would otherwise be unavailable. You should be aware that even if you agree to participate in this study, you are free to choose to withdraw your test data at any time.

The purpose of this study is to assess the effects of Filial Therapy Training. If you choose to participate you will be asked to complete the same three questionnaires as the other participants. In addition, you will be asked to allow your child to complete an assessment instrument while with a therapist aide. It should take about one hour for you to complete your questionnaires and about fifteen minutes for your child's assessment. These activities are part of your treatment program, but agreement to participate in this study will allow the test information to be used as part of a research project. In the research study, all names and data will remain confidential and will be used only as group data.

"I have read the above statement, have been fully advised of the procedures to be used in this study, and agree to participate. I understand that I or my child can withdraw from the study at any time without being subject to reproach."

Parent/legal Guardian's Signature

Date

APPENDIX B
Filial Therapy Outline

CHILD PARENT RELATIONSHIP THERAPY

A DEMONSTRATION GRANT FUNDED BY
UNITED METHODIST HEALTH FUND, 1993

Project Director
Richard L. Gaskill, Ed.D.

Sumner County Mental Health Center
215 W. 8th
Wellington, Kansas

CHILD/PARENT RELATIONSHIP THERAPY

1. Ten to 12 session model with pre and post testing in sessions 1 and 12.
2. Eight to 10 parents in each group.
3. Two hours per session.
4. Each parent will have an "identified child" to work with; primary focus on children 5 and below, secondary focus on children under 10.
5. Weeks 1, 2, and 3 will have 1 1/2 hours of instruction video tape, and demonstration and 1/2 hour of role playing.
6. Weeks 3 through 10, training and supervision of sessions.

SESSION 1

I. Introductions

A. Brief Teacher Introduction

1. Name
2. Degree, position, experience, etc.

B. CPR/Filial Therapy

1. Defined

- a. Filial means "blood kin", hence therapy by one's own family
- b. Developed by Bernard and Louise Guerney in 1960's at Rutgers University and Penn State University.
- c. Way to improve society is to give parents professional skills (teach basic play therapy techniques)
- d. Filial therapy was first used with disturbed children
 - (1) Parents become the therapeutic agents for their children
 - (2) This worked well in helping the parents understand needs and resulted in fewer problems
 - (3) Since that time, it has been expanded to other populations (critically ill, handicapped, normal children)

2. CPR/Filial deals with child-parent relationship/attachment

- a. Attachment is the active, affectionate, reciprocal, social-emotional relationship between parent and child
- b. Attachment is not instinctual. It takes three weeks to three months to fully develop.
- c. Common attachment behavior:
 - (1) The mutual gaze: face to face
 - (a) Eye contact for information and monitoring
 - (b) Social play such as peek-a-boo or pat-a-cake
 - (c) Smiling
 - (d) Laughter
 - (2) Physical contact:
 - (a) Social pacification
 - (b) Jostling
 - (c) Cuddling
 - (d) Touch/Massage
 - (3) Smelling, thought to form neuro-chemical bonds
 - (4) Play, especially non-custodial activity
 - (5) Talking, especially warmly and softly
 - (6) Teaching/helping experience
- d. Attachment patterns are life-long patterns over 85% of the time:

- (1) Determines our relationship with our children
- (2) Determines our relationship with our spouse
- (3) Determines our relationship with friends/co-workers/family

e. High-risk groups for poor attachment:

- (1) Unstable homes
- (2) Single parents
- (3) high-stress homes
- (4) Neglect/abuse
- (5) Parents own emotional problems
- (6) Early pregnancies

C. Expectations

1. In 10 weeks you will be different
2. The intent is to return control of your child to you
3. Intent is to give you the keys to your child's inner world
4. To develop a closer understanding relationship with your child
5. To assist you in feeling more confident as parents
6. To help you assist your child in his or her positive development

D. Nature of play: (overhead 1)

1. Play is the most natural thing a child can do

2. It is universal; all children do it naturally when they are left to themselves
 3. It is the universal language of children
 4. It is action oriented, not word oriented
- E. Basic elements of play: (overhead 2)
1. Play is pleasurable
 2. Play is intrinsically complete
 - a. Adults do not need to be there or alter it in any way
 - b. It does not need to be rewarded (don't praise the child for play or you may inhibit the creative act)
 - c. It does not need other people
 3. Play is person rather than object dominated.
Play is not aimed at acquiring new information about an object but rather at making use of the object
 4. Play is highly variable across situations and children.
It cannot be generalized: it's very specific to the child
 5. Play behavior does not occur in novel or frightening situations.
 6. Play has flow.
There is a centering of attention in which action and awareness merger, a loss of self-consciousness occurs

- F. What children learn in play (overhead 3)
1. To respect themselves
 2. To identify their feelings and accept them
 3. Self-control
 4. To assume responsibility for themselves
 5. To be creative and resourceful in confronting problems
 6. To be self-directed
 7. To accept themselves
 8. To make choices and be responsible for their choices

II. Introduction of parents and child of focus

- A. "I know you will want to do this with all your children, but we don't have time, so you will have to focus on one child."
1. Which child needs you the most?
 2. Who do you have the most trouble with?
 3. Tell us the family structure and current circumstances.
 4. What is your daily routine?
 - a. Bedtime
 - b. Meals
 - c. Homework
 - d. Playing
 - e. Discipline procedures
- B. Trainers: Keep notes on each parent/child pair so that these may be reviewed in Session 10 (We will

compare what they say now with what they say later to see if anything has changed. Why is he different? Have you changed your approach?)

III. Reflective Listening

A. When we listen responsively to our child, we try to reflect back to the child the following information:

1. Reflect the child's feelings; don't just answer the child.
2. Keep your level of excitement at the child's level; you match them, not them you.
3. Stay out of the leadership role; "Show me what you want."
4. Don't identify or label objects; let the child do this. We are trying to let the children use objects as they see fit.
5. Set limits to keep you comfortable and objective.
6. An emotional block has occurred when a child breaks off play, probably due to anxiety about something.
7. A child's running account of events in their play is their way of including you in their play. Children who do this are less likely to include you physically in the play.
8. If you are sitting in a chair there is less likelihood of being included in the play than

if you sit on the floor.

B. How to listen reflectively (overhead 4)

1. Reflective listening is a mirror for your child. Reflect:
 - a. Facts
 - b. Feelings
 - c. This helps the child work out their own problems
2. Listen in a way that makes it clear that the listener appreciates:
 - a. The child's feelings
 - b. The meanings the child attaches to the feelings
3. This approach is firmly grounded in the attitude of the listener.
 - a. Respects the potential of the child.
 - b. Considers the child's rights.
4. Trust the child's capacity for self-direction.
5. When people, including children, have been listened to sensitively, they tend to listen to themselves with more care and make clearer exactly what they are feeling and thinking. They become more emotionally mature and less defensive, more cooperative and less demanding
6. The process is thinking with the child rather than thinking for the child.
 - a. Don't pass judgment as this makes free

- expression difficult.
- b. Advice or information are seen as efforts to change the child.
 - c. Even positive evaluations can be as blocking as negative.
7. Basically we're trying to get inside the speaker to grasp the speaker's point of view.
 8. Then, we try to convey to the speaker that we are seeing things from his point of view.
 9. Listen for the total meaning:
 - a. The content
 - b. The feelings underlying the content
 - c. The meaning that comes from the content and feelings
 10. Respond to feelings!
 - a. The content is less important than the feeling underlying it.
 - b. Full meaning comes from responding to the feeling component.
 11. Note cues:
 - a. The words that are spoken
 - b. Voice fluctuations
 - c. Facial expressions
 - d. Body posture
 - e. Hand movements
 - f. Eye movements
 - g. Breathing

12. "We are trying to convey by listening" (our demonstration of respect for the child)
 - a. I am here for you (fully and completely)
 - b. I hear you (say/not say, do/do not)
 - c. I understand (reflect what you hear, especially feelings - teach emotional language, especially labels for feelings)
 - d. I care (this one is easier than the first three, use facial expressions)
 13. A good rule of thumb is to assume one never really understands until he or she can communicate this understanding to the speaker's satisfaction.
 14. Merely parroting the words does not prove one understands.
- C. Handout: "Responding Facilitatively", to be done in class.
- D. Demonstrations with one or two parents and instructor
1. "Listen and watch me. I will ask what you have seen."
 2. Demonstrate reflective listening and ask for observations in process.
 3. Parents pair off and practice
 - a. Designate a talker and listener for three minutes
 - b. Ask them to give specific feedback to each

other: "When you said or did _____, I knew you heard me."

c. Switch

IV. Give Assignments

- A. Bring a notebook and a pencil to each class to write notes for yourself about your thoughts, the feedback you're given, and observations.
1. Study your child this week
 2. Record in your notebook something different you've noticed about your child, for example:
 - a. Some physical feature: a dimple, their ear, their hairline
 - b. Some behavioral quirk, such as the way they walk or talk.
- B. Handout: "Four Basic Feelings" (Start to fill it out in class)
1. Identify each emotion depicted by the face in class.
 - a. Label each
 - b. Find each emotion in your child this week
 - c. Record your reflective statement to your child for each emotion
 2. Role play each emotion and reflection with the class to practice these responses before they try it at home.

SESSION 2

I. Training

A. Review assignments (therapist recording answers from parents on each individual parent record form for later recall)

1. "What did you notice different about your child?"
2. Handout: "The Four Basic Feelings"
 - a. Do one emotion at a time starting with happy, do this for the whole group
 - b. Give help with responses and suggestions
3. Be encouraging of the parents that did not follow the homework through, let peer pressure work here

B. Handouts reviewed

1. Handout: "Child Parent Relationship Training" (CPR for parents)
2. Handout: "Tote Bag Playroom"

C. Review of toys:

1. This will be the first assignment - tell your child:

"I'm going to a special class to learn how to play with you. Here are the toys, let's fill the box together"

(or,)

"Let's get them together." (if buying some of the toys at a store)

2. Existing toys are ok, but use them only at the special playtime!
3. These special toys help
 - a. Signal the special playtime
 - b. Set boundaries
 - c. Help learn to delay gratification
4. Toys: Demo/Discuss/Review problems
 - a. Playdough - two containers only - may want a towel in the box if no place to use the playdough
 - b. Crayons - an eight pack only. Break points, break off about half, take off the wrapper; this encourages use
 - c. Scissors - plastic with metal edge
 - d. Nursing bottle - empty - ok to fill with water or juice; ok to suck on it; this signifies your acceptance
 - e. Rubber knife/dart gun - helps you deal with reactions of the child; it's a quick limit setting device. Message given "People are not for shooting."
 - f. Family dolls - not mandatory because they're expensive. Fischer Price dolls are fine. Best if you have a mom, dad, sister, and brother
 - g. Soldiers - 10-15 is ok, more is too many for parents to pick up

- h. Lone Ranger mask - it's an identity change.
Can get it at a party store or make one.
 - i. Doll house - Cut the door/window, mark off the box into rooms.
 - j. Three rooms of furniture - Kitchen, bathroom, bedroom
 - k. Doctor's kit - Fisher Price is excellent.
Look at garage sales, Wal-Mart, K-Mart
 - l. Play money - paper and coins are excellent
 - m. Cotton rope - 3-5 feet. A jump rope is ok but cut off the handles - you may get tied up in the process of doing this
 - n. Bobo - Wal-Mart or K-Mart, costs about \$3-4
 - o. Ring toss game
 - p. Box of band aids - take out all but five, put the others in as they get used up
 - q. Scotch tape - it's for creativity
 - r. Hand puppets - an aggressive one is best
5. Don't give in to requests for additional toys.
You can do this later if necessary.
 6. Lock up the box if necessary.

D. Special Problems

1. If the child resists the special play time, say: "let's do it for about 10 minutes. Then we will stop if you want to."
2. If you miss a special play time you must reschedule!

3. Don't have the play time in a carpeted place, living room, or child's room. These are not the best choice.
4. Special play times need to be in a place that is private.
 - a. Phone off the hook or turned off
 - b. Sign on the door
 - c. Pets outside
 - d. Other kids will not interrupt
5. Other kids in the family may want their own "special time" without the other kids
 - a. Have them help you bake cookies
 - b. Go on a trip to the park
 - c. Trip to the store
 - d. Need to make a special time for the children who are not in the CPR program
 - e. Role playing in pairs
 - (1) Practice responding
 - (2) Change partners
6. Assignments
 - a. Tell your child:

"I am going to a special class to learn to play with you. Here are the toys, let's fill the box."

OR

"Let's go get the toys." (if they are being purchased)

- b. Decide where and when you will have the special play time.
 - (1) At least one half hour after school
 - (2) The same time each week
 - (3) You must reschedule if you miss
 - c. Gather the toys together
- II. Demonstration, Live or Video (use an independent child for the first demonstration)
- A. Parents watch, take notes
 - B. If the demonstration is live, have the child leave before discussing the play period
 - C. Discuss:
 - 1. What did you notice?
 - 2. Did they say something you did not expect?
 - 3. Ask if the parents noticed:
 - a. That the parent did not ask questions
 - b. Reflected statements of feelings
 - c. Their use of toys
 - d. Were limits set?
 - e. Other Rogerian issues of unconditional positive regard
 - D. Another option is to have all the children and the parents come and play with the kids all at once. The therapist then moves around the room giving comments. This is a much harder process and should not be used except with very experienced therapists.

SESSION 3

I. Review Assignment

- A. How did the child respond to the gathering of toys for the special play time?
- B. Where/When is the special play time planned?
Record this in the parents chart.
 - 1. Is it private, not interrupted?
 - 2. When, time of day?
 - 3. At least one half hour after school
 - 4. Reschedule if you miss
- C. Ask if anyone is having trouble finding toys
 - 1. Help each other locate toys
 - 2. Parents may share in locating or share use toys

II. Handout: "Basic Rules for CPR Therapy"

- A. Generalize the points for everyone; explain and give examples.
- B. Discuss each point with parents
 - 1. Ask the parents to circle the do's and don'ts that will be the hardest for them
 - 2. Reinforce the "check your responses" section of the handout
- C. Rules of thumb (overhead 5)
Parents must learn to see the child's perception of the world to be helpful
 - 1. Be sensitive to how the world is perceived by the child!

- a. Appreciate it; hang pictures at kid's eye level (this is a good check of how parents view children)
- b. Move language down also
- c. Look through the child's eyes
- d. Get down on the child's level, literally - on hands and knees
 - (1) Do mobiles face out for the parent to see or so that the child can see, facing down
 - (2) Crouch, sit, stay at the child's level; crawl, lay down, etc.
 - (3) How would the child draw your face? What is the child's view? This is usually a drawing showing 2 circles for eyes and 2 circles for a nose and mouth, as they see straight up your nose
- e. Love is communicated at eye level and by touch.
- f. Give a "30 second burst of attention"
 - (1) Parents need to let their children know about their love without asking.
 - (2) This is given by talk, touch, and eyesight in focused attention or in time.
 - (3) Please have the parents do this each

week. It doesn't take much time.

- (4) Give examples of this 30 second burst of attention in each sense modality so the parents can see how it works
2. The important thing is not what the child knows but what he believes about himself.
"We are all prisoners of our self concepts."
by Jane Warters
3. As parents we cannot give away that which we do not possess. For example:
 - a. You cannot give someone \$1000 unless you have \$1000.
 - b. You cannot give love unless you love yourself.
 - c. You cannot give respect unless you respect yourself.
 - d. You cannot give esteem unless you have esteem for yourself.
4. Listen to your child. Listen with your eyes as well as your ears.
 - a. Crouch, listen, focus, pay attention
 - b. Play is the child's language and you cannot hear what isn't said so you must see it.
 - c. Play is the language, toys are the words.
 - d. The most important things children say you must hear with your eyes.

- e. Hear their thoughts, feelings, and opinions.
5. Don't ask questions you already know the answer to.
- a. Make statements in play - don't ask questions.
 - b. To ask what you know is to be dishonest.
 - c. Making statements helps share your humanness with the children.
6. The most important thing may not be what you do but what you do after what you have done.
- a. What did your child learn from the experience?
 - b. Help your children learn a skill
 - c. Help your child anticipate.

III. Preparing for the first session:

- A. Make a sign that says "Special Play Time - Do Not Disturb" (bring it to show the class)
- B. Hang it out so that everyone knows
 - 1. Nothing interferes; no phone calls, nothing
 - 2. No answering the door
 - 3. Nothing is as important as your time together
 - a. Put the younger kids down for a nap, or to bed
 - b. Ask the neighbor or your spouse to watch the children while you have the play time. Possibly you can trade off babysitting with someone.

- c. Let the children watch tv while you have the special time if there is no other way to entertain them or supervise them.
 - d. Trade off with other group members
4. The play session process (30 minutes per session, 1 session per week)
- a. Give your child the business card with the appointment time on it. (give parents the cards)
 - (1) This is just like going to their regular doctor's office
 - (2) Tell them "See your name and the time printed on the card"
 - (3) "Let's put it where it will remind us of our special play time"
 - (4) "Where do you want to put it?"
 - (5) It's best if you have the same time scheduled every week
 - b. Display the toys in the play session
 - (1) Get them out or they're not likely to be used
 - (2) The arrangement is unimportant
 - c. Hang out the sign
 - d. Tell the child:

"This is our special time. You can play with the toys in most of the ways you would like to."

- e. Sit down
- f. Follow the rules of the do's & don'ts
 - (1) "For the next 30 minutes you are dumb, you don't know anything"
 - (2) You are a sports announcer, just describe what happens
- g. How to end a session
 - (1) Advise the child when there is 5 minutes left
 - (2) Leave the toys for the parent to pick up as the children's toys are their statement and we do not want to insult this
 - (3) It's ok for the kids to help pick up if they insist

V. Show a demo tape

- A. Let the parents critique it
- B. Discuss the skills, what they saw

VI. Role Play

- A. Reverse roles after about 15 minutes

VII. Assignments

- A. Make the "Special Play Time - Do Not Disturb" sign, bring it to share with the group next time
- B. Give your child the appointment card
- C. We need a volunteer to bring their child for demonstration or a video tape for 20 or 30 minutes of feedback

1. Videos may be done at the mental health center with a student intern, make arrangements with her
 2. Do several videos with parents so that you are covered in case someone forgets
- D. Conduct your special play time with your child

SESSION 4

- I. Reports from each parent on their special play time
 - A. Have them show their signs
 - B. Ask them "What was the play session like for you?"
 - C. Were there problems?
 - D. Did it go fast or slow?
 1. Fast probably means you had a good time
 2. Slow means you may have struggled
 - E. Last person to describe their play session will be the live demo or the video (it is the parent volunteer)
 1. Be supportive and positive, this is a scary thing to do
 2. Review the tape or demonstration and be specific, what did he or she do with their child
 3. Point out the mistakes that they did not do, or, in other words, not doing something wrong is a positive as doing something right
 - F. Sum up the first efforts
 1. How was the eye contact?
 2. Were they focused?
 3. Were they patient?
 4. Was the child spontaneous?
 5. Were they at the child's eye level?
 6. How was the tracking?

II. Role playing

- A. Remind them to use the new skills they are learning as they go
- B. Reverse and change partners as indicated

III. Limit setting exercises

- A. Set limits to keep you comfortable and objective
Often the most difficult thing to do. Parents and therapists want to be liked and to please the child. Therefore, they often don't want to act. If you don't act the child learns you don't want to act and they don't have to. Set limits so the child is responsible. The parent should not be the maker.

B. Set Limits Therapeutically (overhead 6)

1. Protect the child, therapist, and materials
2. To help the child feel secure (this is the child's purpose of pushing boundaries)
3. Remember, consistency - predictability - security
4. Promote therapist acceptance by setting limits
5. Facilitate the child's development by allowing
 - a. Decision making
 - b. Self control
 - c. Self responsibility
6. Stages of limit setting (overhead 7)

- a. Acknowledge feelings/wants of child
- b. Communicate the limit
"I see you are angry with me but I am not for shooting."
- c. Target choices (refocus)
Stay calm, point out choices
"You may write on the paper."
- d. Restate the limit for the ultimate limit
 - (1) Use the word choice three times if you can
"If you choose to shoot me, you choose not to play with the dart gun. Which do you choose?"
 - (2) "You can choose to put it there or you can choose to put it there. Which do you choose?"
 - (3) Use big words to get attention for something important
"If you refuse to choose, you choose to let me choose."
 - (4) Practice thinking up choices so that you can tie what you like to choices
 - (5) We must make choices in life, some cannot be undone and we must remember this
 - (6) Limit setting protects the child from guilt

- (7) Limit setting anchors the session to reality, do this immediately, don't wait until you get upset
- (8) Watch the use of time out: this can be used as punishment or as a way of not giving alternatives

IV. Volunteer for a tape or demonstration

SESSION 5

- I. Reports from each parent on the special play time
 - A. How was it
 - B. Problems
 - C. Video of parent/child
 - D. Summary
- II. Handout: "Facilitative, Reflective Communication Exercise"
 - A. Do in class
 - B. Discuss
- III. Therapeutic responses (overhead 8)
 - A. Be interactive
 1. Often we say too much too often, try to use
10 words or less
 - B. Allow the child a lead
 1. Sit down, hands on your knees, stay put
unless you are asked to do something
 2. Don't follow or hover or intrude; let the
child invite you to join
 3. Wait on the child to lead! Little happens
accidentally in respect to this
 4. Eye contact - if the child looks at you, you
should be seen looking at the child
"Your toes should follow your nose!"
 5. Interact verbally as well as physically
 6. Respond to:
 - a. Feelings mentioned

- b. Let the child lead, don't suggest
 - c. Let them know they were heard and understood
 - d. Set limits
7. Responses should not disrupt:
- a. The focus
 - b. The action
 - c. Attention
8. Introduce the special play time
- "This is a place where you can play with the toys in a lot of the ways you would like to."
- C. Personalized
- 1. Avoid the third person: "David likes playing with the clay."
 - 2. Rather say, "You like playing with the clay."
- D. Teach feelings identification by giving labels
- E. Avoid questions; they take the child out of the lead. Say it as a statement!
- F. Take the risk to be direct
- G. Don't interrupt; help the child go on; let the natural flow of the child's play go
- 1. If the child stops playing you may have said too much
- H. Don't evaluate the play
- I. Don't praise - this encourages more of the same kind of play to get more praise

- J. Build self esteem by respecting the child's actions
 - 1. Make self esteem statements such as "You did that all by yourself!"
 - 2. Give the child credit
- K. Tracking responses are wondering/thinking from the child's point of view
 - 1. It puts the child in control, empowers them, they are in charge (their thoughts)
 - 2. "You're wondering where that piece goes!"
- L. Use empathetic grunts: "Oh, Uhuh, Mmmm"
- M. End the session with a five minute warning about the session ending
- N. Don't use a timer - Why? Because it gives up the responsibility to end on time to the clock and not the therapist
 - 1. Be flexible but the session must end
- O. Clean up: The toys are the child's language. If you have them clean up you will get less later. Messy behavior may be their statement. You may be saying "Your language is a mess, clean it up!" If you don't do this with adults, don't do it with kids. Have parent or therapist clean up later.
- P. Give 2 clues that time is up
 - 1. A verbal statement
 - 2. Get up and head for the door

IV. Questions to ask yourself about your responses

(overhead 9)

- A. Is it freeing to the child
- B. Did it facilitate decision making or responsibility
- C. Was it spontaneous or creativity facilitated
- D. Did the child feel understood. If questioned by the child say:

"In here it is whatever you want it to be." Don't tell them what it is

If you don't understand the child say:

"I did not understand you." Don't say "What did you say?"

V. Rules for responses

- A. When you do for the child what they can do for themselves, you teach them to be incapable
- B. Don't teach dependency
- C. Assist when needed only, try to end it with
 1. "There, you did it!"
 2. "We did it together", thus chaining behaviors and shaping behavior at each developmental level they are capable of
- D. Encourage creative responses
- E. When a child rearranges the big items in the playroom they are demonstrating environmental manipulation and growth

IV. Volunteer for next time

SESSION 6

- I. Report of sessions
- II. Video tape of parent
- III. Handout: "Child's Play - Important Business"
- IV. Volunteers for the next session

SESSION 7

- I. Review of article: "Child's Play - Important Business"
- II. Report on sessions
- III. Video tape of parent
- IV. Assignments
 - A. Handout: "List the Child's Unique, Positive Character Qualities"
 - B. Handout: "Common Problem in CPR Therapy" (do this in class)
- V. Volunteers

SESSION 8

- I. List of positive qualities from last week reviewed by the class for each parent and their child
- II. Report on sessions
- III. Video
- IV. Assignments - write a letter to the child
 - A. Dear _____:
I was just thinking about you and what I thought was that you are so _____.
 - B. Bring a addressed, stamped envelope with your letter next time and we will send it in the mail to the house.
 1. Read it to the child if need be
 - C. Put the character quality list that the parent made somewhere where the child can see it.
 1. On the refrigerator is great
 2. Process this with the child in terms of what this means
- V. Volunteer for next week

SESSION 9

- I. Review assignments from last week (letter and character list)
 - A. How did it go
 - B. What were the child's reactions
- II. Report on the parent's session
- III. Parent video
- IV. Assignment
 - A. Write another note but this time put it where the child can find it
 - B. Put it under their pillow, in their lunch box, on the mirror in the bathroom. Read it to them if necessary.
- V. Volunteer for next week

SESSION 10

- I. Review assignments
 - A. Discussion of the note that they left for the child
- II. Report of sessions with their child
- III. Parent video
- IV. Closure schedule for post testing next week
 - A. Review the original statements the parents made in the first session about their children
 - B. Ask about changes they have seen in their children and themselves
 - C. Tell them that certificates will be handed out next time for successful completion of the program
 - D. Make plans for refreshments and discussion of a need for possible continuing support groups

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Denise E Ray
Signature of Author

12/06/95
Date

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Title of Thesis

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