Filial Therapy with Court-Ordered Parents of Maltreated Children: A Multiple Case Study

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Abstract

Using a mixed methodology, the effectiveness of an 8-week modification of Landreth's (1991) 10-week group filial therapy training model was investigated with parents (n = 5) court-ordered for remedial parenting services due to physical abuse and/or neglect of their school-age children. A comparison group (n = 3) concurrently received an 8-week parent education course. Three primary questions were explored. Do filial therapy group participants demonstrate a greater decrease in child physical abuse potential and parenting stress following training when compared to parent education group participants? In addition, do filial therapy group participants show evidence of stronger parent-child relationships following training when compared to participants in the parent education group? Pre- and post-measures were utilized, and anecdotal and qualitative data were also collected. Following the analysis of both the quantitative and qualitative data, it was determined that the group quantitative results detracted from the richness of the qualitative findings, and the former were subsequently dropped. Instead, individual pre- and posttest quantitative scores, along with the anecdotal data, were compiled to create participant profiles that provided additional descriptive information to the emergent focus group themes. Due to the size of the sample (N = 8), findings were only preliminary and merit further study. Participants demonstrated social desirability in their assessment responses; therefore, it is recommended that qualitative or mixed methodology, as well as multiple measures of each construct, be incorporated to combat this phenomenon in future studies with this population. Results of this study further suggested that there are clinical benefits to utilizing a mixed sample of both court- and self-referred participants. In addition, the court-mandated population is heterogeneous and requires multiple treatment options coupled with screening protocol for appropriate treatment assignment. Future filial therapy research with this population should provide greater support to participants in conducting filial therapy sessions, as well as alternative ways of documenting these sessions. In addition, it is proposed that a combination of individual and group filial therapy models that is longer-term would be more effective with this population than the 8-week model used.

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I am indebted to my mother for her genetic endowment of a love of learning and the way she purposefully engineered my environment from infancy to support my innate curiosity. I have always been in awe of her intelligence and eloquence with the English language. She has been, as every mother should be for a child, the single most constant influence in my life. In those moments when I have lacked belief in myself, her faith in me has been my guiding star.

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Introduction

Even a brief perusal of any child development textbook reveals that human development is predicated on change. In fact, change is so rapid between birth and adulthood that it is not surprising many parents struggle with how to raise their children in the face of such constant cognitive, emotional, physical, and social oscillations.

Unlike most other roles we assume as adults, parenting does not require formal education or training. "Ironically, parenting is the one significant task people can engage in without first demonstrating the knowledge and skills required. Many parents have not learned parenting skills, nor have these skills come naturally to them" (Christmas, Wodarski, & Smokowski, 1996, p. 246). One population of parents who demonstrate parenting skill deficits are those who physically abuse and/or neglect their children. Most physically abusive parents are reasonably intelligent, have at least some high school education, and demonstrate insight and motivation regarding their parenting (Crittenden, 1988). The majority of them possess knowledge of both appropriate developmental expectations and discipline for their children, but this information is not applied in stressful situations (Crittenden, 1996). Unlike physically abusive parents, neglectful parents generally have low IQs, completed the eighth grade and were in classes for the mentally retarded, and show little if any insight or motivation regarding their parenting (Crittenden, 1988). They are usually part of a multigenerational, closed family system that supports maintenance of the status quo (Crittenden, 1988, 1996).

When child maltreatment is viewed within a larger sociocultural and political context, it is clear that marginalized ethnic and cultural groups experience more life stressors than more privileged groups and also have a higher incidence of child maltreatment (Crittenden, 1988). In addition, there is a relationship between poverty and physical child abuse that is even stronger between poverty and neglect (Crittenden, 1996). Meanwhile, the allocation of funding for resources and services to at-risk families of low socioeconomic status are limited (Abney, 1996; Crittenden, 1988). Consequently, "members of low-income, at-risk minorities…need more optimal individual functioning to be successful as parents than individuals whose culture provides more buffers" (Crittenden, 1988, p. 163). Although physically abusive and neglectful families are often

grouped together, they demonstrate unique characteristics with regard to many issues, including relationships and interactions, affect, and power.

As might be expected, physically abusive and neglectful families have trouble with relationships. While the research is mixed as to the percentage of maltreating adults who were also maltreated as children (Caliso & Milner, 1994), most were raised in "hostile, controlling and punitive environments" (Crittenden, 1988, p. 168). The presence of a supportive peer or adult relationship in childhood appears to be a mediating factor that was not present for physically abused children who become physically abusive adults (Caliso & Milner, 1994). Their adult relationships are described as "unstable-open" (Crittenden, 1988, p. 168): they initiate many relationships that they are subsequently unable to maintain. They also have a "negative cognitive-attributional style" (Kolko, 1996, pp. 25-26), meaning that they view their children's behavior more negatively than nonabusive parents. In fact, physically abusive homes are characterized not only by a number of negative descriptors, such as aggressive, coercive, and hostile; but also by an absence of positive interactions (Kolko, 1996). Understandably, physically abusive parents and children are frequently insecurely attached (Crittenden, 1996). Children in such homes tend to respond to their parents in one of two ways. Either they become very obedient, or they angrily rebel. Sadly, both types of children lack experience with adults who accept them unconditionally (Crittenden, 1988, 1996).

Neglectful families, on the other hand, have stable but closed relationship networks, primarily consisting of extended family (Crittenden, 1988, 1996). Often neglectful parents live in the same environments in which they themselves grew up, which are economically, educationally, and socially impoverished, and only serve to reinforce their parental ineptness (Crittenden, 1988, 1996). Neglectful families have the least interactions with one another of any other type of family system, interactions which are "brief" and "lifeless" when they do occur (Crittenden, 1996, p. 163). Neglectful parents and their children learn to ignore one another, and neglected children not only become developmentally delayed because of the lack of interaction and stimulation, but also see their parents as psychologically unavailable (Crittenden, 1988, 1996).

Not surprisingly, physically abusive parents have challenges with affect regulation, and even demonstrate a hyperreactivity to stimuli (Milner & Chilamkurti, 1991). They have high expectations of themselves, as well as a need for affirmation from others. They want their children to reflect well on them (Crittenden, 1988). Their children either learn to inhibit negative affect, or to have problems similar to their parents with its dysregulation. Because there is an incongruity between emotion and behavior, with "hostility and aggression often [underlying] abusers' smiles and apparently playful or affectionate behavior" (Crittenden, 1996, p. 160), members of physically abusive homes learn to distrust and often misuse communication (Crittenden, 1996).

While neglectful parents have outbursts when they feel overwhelmed, unlike physically abusive parents these are "unpredictable and unfocused" (Crittenden, 1996, p. 164). They have "few or very vague expectations of either their children or themselves" (Crittenden, 1988, p. 173), and instead seem to simply exist from day to day. "Neglectful parents are completely unable to comprehend or manage the demands of their maturing families. The outcome is chaos: families with little structure, few rules, and family members without learned self-control" (Crittenden, 1996, p. 163). Perhaps as a result of so little interaction with one another, "neglecting parents also display very little affect and appear unaware of their partner's and children's feelings" (Crittenden, 1988, p. 184).

Both physically abusive and neglectful families have issues with power. For physically abusive families, the focus is on maximizing control by utilizing one's relative power differentially in any given situation (Crittenden, 1988, 1996). Therefore, a mother may be coercive with a child, but submissive and manipulative with her partner (Crittenden, 1988, 1996). In contrast, neglectful families see themselves and the world around them as powerless (Crittenden, 1996). Therefore, any personal effort is pointless, as "luck and fate" are responsible for everything (Crittenden, 1996, p. 163).

Physical abuse and neglect, like all forms of maltreatment, are "family problem[s]….[and] should be understood, prevented and treated in the context of families" (Crittenden, 1996, p. 158). Despite this understanding of the systemic nature of abuse, maltreating parents are often the primary targets of treatment, while "the majority of treatment programs have either not included or not evaluated child-focused intervention components" (Kaufman & Rudy, 1991, p. 91). In addition, "there remains a

lack of consensus regarding the most efficacious treatment approaches" (Kaufman & Rudy, 1991, p. 83).

Filial therapy is a treatment modality that engages the parent-child dyad of the family system by training parents to become change agents for their own children through play. Parents are taught four skills in either an individual or group setting: structuring, empathic listening, child-centered imaginary play, and limit-setting. They are then invited to conduct weekly half-hour play sessions with their children in their own home using these four skills. Play sessions also utilize a filial toy kit, which contains toys chosen to elicit communication, creativity, emotional expression, and interaction.

Developed in the 1960s in response to helping professional shortages, filial therapy was not a major player in the mental health fields until the 1990s, when a series of similar studies began replicating a 10-week group filial therapy training model (Landreth, 1991) with various populations and child presenting problems. These studies primarily investigated filial therapy's effectiveness in increasing parental empathy towards and acceptance of their children, and in decreasing parental stress and parental perceptions of child behavior problems, with overall positive results (Rennie & Landreth, 2000). In addition, a handful of them also sought to modify the 10-week group model (Landreth, 1991) in terms of either hours or weeks of training, with mixed results. In their recent review of the filial therapy literature, Rennie and Landreth (2000) have indicated that "further research is needed to investigate the effectiveness of condensing the filial therapy training time" (p. 32). Filial therapy has now been empirically proven to be efficacious with single parents (Bratton & Landreth, 1995), Chinese and Korean parents (Chau & Landreth, 1997; Jang, 2000), incarcerated mothers and fathers (Harris & Landreth, 1997; Landreth & Lobaugh, 1998), Head Start families (Johnson, Bruhn, Winek, Krepps, & Wiley, 1999), and Native Americans living on reservations (Glover & Landreth, 2000). In addition, filial therapy is a viable treatment for children with: chronic illnesses (Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992), conduct behavior problems (Clark, 1996), pervasive developmental disorders (Beckloff, 1998), and learning difficulties (Kale & Landreth, 1999). Two of the most recent filial therapy studies have addressed child maltreatment in successfully training non-offending parents

of children who have been sexually abused (Costas & Landreth, 1999), as well as physically abusive and neglectful parents (Ginsberg, 2002).

Although the study with physically abusive and neglectful parents (Ginsberg, 2002) utilized a different, long-term filial therapy treatment model than the previously cited studies, incorporating both individual and group filial therapy, it did establish some of the potential benefits of filial therapy with this population. With regard to treatment issues surrounding relationships and interactions, Crittenden (1988) has suggested that physically abused children need to interact with caring adults who accept them unconditionally; likewise, neglected children require responsiveness and cognitive stimulation from adults. Filial therapy has the potential of teaching maltreating parents and their children to interact with one another in new ways. Through its central skill, empathic listening, parents learn to communicate unconditional acceptance of their children and of their children's feelings. If only for 30 minutes a week, physically abusive parents and their children could have some positive interactions that, over time, could generalize into their relationship and help to address their attachment issues. Similarly, as neglectful parents and their children have so little interaction, filial therapy could ensure that they have at least 30 minutes a week. During this special play time, the empathic listening skill could aid neglectful parents in providing the responsiveness for which their children are so desperate, and the child-centered imaginary play skill could initiate needed cognitive stimulation. In what better setting could potential relational healing take place than in the parent-child dyad (Ginsberg, 2002), creating new relational models through healthy interactions from previously distorted ones.

Filial therapy also has promise in addressing the affect issues of physically abusive and neglectful families. The limit-setting skill is intended to help both parents who have a tendency to overcontrol, such as physically abusive parents, and those who undercontrol, such as neglectful parents (Van Fleet, 1994). Ginsberg (2002) asserts that filial therapy, as a whole, "enables children to improve their mastery, self-acceptance, and emotional regulation" (p. 71). Through the empathic listening skill, physically abusive parents could be taught to demonstrate acceptance during filial play sessions both of their children who inhibit affect as well as those who defiantly display it. At the same time, neglectful parents, who lack very fundamental emotional skills, could learn to

attend to their children's feelings in play, thus being more psychologically available to them.

Finally, both physically abusive and neglectful families could experience a new kind of power, empowerment, as a result of new behaviors and interactions that yield desired outcomes for both parents and children:

> The educational, skill-training basis of filial therapy shifts the emphasis on sickness or dysfunction to learning a constructive functional way to engage with children. It helps parents learn more realistic and developmentally appropriate ways to view their children and parent them. It focuses on the strengths of the family and its members, and also enables client families overcome their resistance to change so that they can collaborate in creating change. (Ginsberg, 2002, p. 71)

Thus, physically abusive parents could utilize their insight and motivation regarding their parenting to become catalysts for positive change in their parent-child relationships. In like manner, as neglectful parents were able to see the relational meaning of behavior and their role in parent-child interactions, they might be able to move beyond their paradigm of powerlessness.

This study extended the current filial therapy literature through an 8-week modification of Landreth's (1991) 10-week group filial therapy training model with parents court-ordered for remedial parenting services due to physical abuse or neglect of their children. Three primary questions guided this inquiry. Do parent participants manifest decreased child physical abuse potential following the modified filial therapy training? Similar to previous studies, do they demonstrate a decrease in parenting stress, as well as an increase in the strength of their parent-child relationships?

Review of Literature

Filial therapy has come to be regarded as an effective treatment modality with various populations and child presenting problems (Rennie & Landreth, 2000). This study extended the current filial therapy research by utilizing an 8-week modification of Landreth's (1991) filial therapy model with parents who were court-ordered for services due to maltreatment of their children. Filial therapy's history and recent research will first be reviewed, followed by an outline of physically abusive and neglectful family characteristics and treatment recommendations. A summary of research regarding parents who are subsequently court-ordered for services due to maltreatment will be next, including studies addressing compliance versus non-compliance and suggestions for working successfully with this population. This review will conclude with an outline of Landreth's (1991) 10-week filial therapy model, as well as modifications that have been made to it.

Filial Therapy

Bernard and Louise Guerney developed filial therapy during the 1960s as a treatment for children with social, emotional, and behavioral problems (Cleveland & Landreth, 1997, p. 19). Filial therapy is also known as Child Relationship Enhancement (CRE) therapy (Guerney & Guerney, 1987), Child Relationship Enhancement Family Therapy (CREFT; Van Fleet, 1994), and Child-Parent Relationship Training (CPR for parents; Landreth, 1991). "The word filial comes from the Latin words filius, meaning 'son,' or filia, meaning 'daughter' " (Sweeney, 1997, p. 165). "Filial therapy is a hybrid form of child-centered play therapy in which parents (or other primary caregivers) engage in play therapy with their own children (Guerney, 1964; Guerney & Guerney, 1987; Landreth, 1991)…Whereas child-centered play therapy focuses on building the therapeutic relationship between the therapist and the child, filial therapy aims to build this relationship between parents and children" (Johnson et al., 1999, p. 170).

Because "filial therapy training fulfills the dual function of intervention and prevention of future problems" (Landreth & Lobaugh, 1998, p. 158), it "is appropriate for parents of all children, not just children who are experiencing emotional and behavioral difficulties" (Sweeney, 1997, p. 172). Filial therapy is generally utilized with children

between the ages of 2 or 3 and 10 or 12 years (Guerney & Guerney, 1987; Van Fleet, 1994). This is, of course, dependent upon the maturity of the child. Van Fleet (1994) suggests that play sessions may be replaced with one-on-one time to extend their applicability into adolescence.

Originally developed for use with biological parents and their children, filial therapy was first extended outside of this primary relationship in the late 1960s when teachers and teachers' aides were trained to use it with students (Guerney, 2000). A more recent corollary to this extension is Kinder therapy (White, Flynt, & Draper, 1997; White, Flynt, & Jones, 1999). It has since been used with a myriad of caregivers, from soon-to-be parents and grandparents, to foster parents and adoptive parents (Sweeney, 1997).

Although filial therapy has application to individual families (Van Fleet, 1994) *and* parent groups (Landreth, 1991), it was originally designed as a group therapy modality. The first parent groups met for one year, and then these were shortened to 5 or 6 months with "comparable gains" (Guerney, 2000, p. 8). In Landreth's (1991) group filial therapy model, which has been widely used and published since the early 1990s, the length of training has been further streamlined. "Parent training groups consist of six to eight parents who attend ten once-a-week two-hour training sessions" (Cleveland & Landreth, 1997, p. 19). The group format is aimed at maximizing resources, in an age when there is a shortage of time available to helping professionals and families alike. "A therapist…[can] see 6 to 8 parents in a group and their respective …children…in the time that would otherwise have been required to see only one parent and…child" (Guerney, 2000, p. 9). Mobilizing caregivers as therapeutic consultants (whether individually or in the group setting) is also a way of helping to ensure that the benefits of filial therapy will extend beyond the period that HMOs have allotted for care (Van Fleet, 1994).

The Four Filial Therapy Skills

There are four basic skills that are taught in filial therapy training: structuring, empathic listening, child-centered imaginary play, and limit-setting. In Landreth's (1991) 10-week group filial therapy training model, the four filial therapy skills are taught during the first three sessions. The remaining seven sessions primarily involve processing (through both video and discussion) of parents' experiences in applying the

four filial therapy skills in their weekly parent-child play sessions. A brief description of each of these four skills follows.

Structuring. The structuring skill gives a context of both time and space to parent-child play sessions. Prior to their first play session, parents are instructed to choose an area of their residence in which play sessions can be conducted on a weekly basis. The criteria for choosing this area are that it is safe and relatively free of restrictions (such as breakables), that it is relatively private or adaptable to a more private space (i.e., chairs blocking the entrance to a kitchen), and that it not be the child's room (Landreth, 1991) or other area of the residence where most of her/his toys are kept (because these could distract the child from the toys in the filial toy kit that are used only for the parent-child play sessions). The physical boundaries of the play sessions can also be mobile, such as in the use of a blanket (Van Fleet, 1994). After choosing the space in which they would like to conduct their parent-child play sessions, parents are invited to make a sign with their child (Landreth, 1991) that they can hang or place at the boundary between the play area and the rest of the residence during play sessions. This sign is intended to indicate that a play session is in progress, and that the participants are not to be disturbed. Parents are also encouraged not to allow interruptions to their sessions by answering the phone or door. In addition to these two structuring steps, caregivers are also taught how to approach entrance into the special play area, how to handle bathroom breaks, and how to end sessions (Van Fleet, 1994).

Entrance into the special play area is always to be acknowledged, emphasizing that it is a time and space "set apart" from other activities and areas. Caregivers are instructed to state that they are now in a "very special room" or space upon entering it, and to let their child know that they can do "almost anything" they want to do in this time and space, and that if there is something that is not permissible, they will be told (Van Fleet, 1994, p. 15). In this way, play is not constrained by a lengthy list of rules.

Bathroom breaks can be limited by preceding sessions with a trip to the bathroom. However, Van Fleet (1994) recommends that children be allowed to leave the session once (depending on their age) to go to the bathroom. When the child returns, entrance back into the special play time and space is acknowledged: "You're back in the special playroom now" (Van Fleet, 1994, p. 16).

Both a 5-minute and 1-minute warning are recommended by Van Fleet (1994) before ending special play sessions. Caregivers are taught to be "pleasant but firm" as they give their children these warnings, and as they end their play sessions (Van Fleet, 1994, p. 16). Landreth (1991) adds that:

> Timers are not allowed for keeping up with the time because this displaces responsibility. The parent is responsible for ending the session even though the child would like to continue. Thus the child learns the parent can be firm and will follow through (p. 347).

It is also advised that caregivers facilitate a prompt end to their sessions by being the ones to clean up (Landreth, 1991). In my personal experience, many children have attempted to extend play session time under the guise of 'helping to clean up' when I, or the parents I was training, have disregarded this advice.

Empathic listening. At the heart of filial therapy training is the skill of empathic or reflective listening. Landreth (1991) indicates that the "training focus [of filial therapy] is primarily on [caregivers] developing sensitivity to their children and [learning] empathic responding" (p. 345). Parents are taught to reflect, in their own words, their children's feelings. Often these emotions are not formally expressed by children, but can be perceived through the child's body language, including tone of voice and facial expressions. Parents are to simply acknowledge what they observe, and then make a tentative statement about what they think their child is feeling. For example, a parent might say, "I notice that you are squinting your eyes, clenching your fists, and speaking very loudly. You must be feeling angry." The beauty of this approach is that it gives the child the opportunity to either confirm or correct what the parent has said. Some parents are concerned about mislabeling their children's feelings; however, labeling or mislabeling feelings simply opens up the channels of communication in a way that not acknowledging what the child is experiencing cannot. The most important thing for parents to communicate through this skill is acceptance of their children's feelings. I spend considerable time with parents discussing the sociocultural values that are put on emotions, i.e., that some are perceived as good and others as bad. Instead, I suggest that as a society we are not doing a good job of teaching our children appropriate outlets for feelings such as anger. In other words, emotions in and of themselves are not bad, but the

way some choose to deal with them. Sometimes children's ways of processing feelings (particular actions, in and out of filial therapy sessions) need to be redirected, as outlined under the limit-setting skill. But the goal is always to let the child know that her/his inherent worth in the eyes of the parent is not dependent upon the child expressing only those feelings that the parent sanctions. According to Van Fleet (1994), the empathic listening skill serves four purposes. It:

> (a) demonstrates the parents' interest in the children, (b) allows children to clarify any misunderstandings the parents have of their intentions or feelings, (c) provides children with labels for their feelings, thereby increasing their ability to express their emotions in constructive ways, and (d) helps children accept themselves when they feel accepted by their parents. (pp. 16-17)

In addition to learning the skill itself, parents are taught how to pace their comments so as not to take the lead of play sessions (Van Fleet, 1994). Parents also learn to track their children's behaviors, in the active, play-by-play style of a sportscaster (Van Fleet, 1994). Younger children particularly appreciate behavior tracking, and seem to feel empowered by it. As children reach the school age and stage, however, I have found that they are annoyed by too much of this. They are now able to read more subtle cues that their parents are attending to them and do not need as much verbal behavior tracking.

Child-centered imaginary play. Quite simply, this skill focuses on teaching caregivers to be followers rather than leaders in their children's imaginary or pretend play. Van Fleet (1994) uses a film metaphor to help caregivers conceptualize this skill. She encourages caregivers to think of their children as directors and themselves as actors, willing to take on any role that they may be assigned by their children. In other words "the child decides whether or not the parent gets a part, 'writes the script' for the part, and indicates to the parent how to play it out" (Van Fleet, 1994, pp. 17-18). Over time, the goal is for caregivers to not only feel more comfortable engaging in pretend play with their children, but also for them to learn to be more receptive and responsive to their children's cues (Van Fleet, 1994). I teach parents to use a 'whisper voice' when they are unsure what their child would like them to do next. Children move seamlessly back and forth between planning and what adults would consider actual play, because it is all play

to children. The 'whisper voice' is a way for parents to communicate a break in the play sequence in order to receive further direction from their child.

Another essential aspect of the child-centered imaginary play skill is teaching parents to suspend their use of recognized names for toys or other objects during their play sessions. Toys in the filial toy kit are chosen because they encourage interaction, emotional expression, and creativity. Using prescribed names for toys restricts a child's creativity. Instead, parents are encouraged to use descriptors, such as the colors and shapes of objects, as well as vague nouns, such as 'thing,' when tracking behavior or seeking direction regarding their role in the child's play.

Limit-setting. This is a three-step skill designed to help both parents who have a tendency to overcontrol (such as physically abusive parents), as well as those who are more inclined to undercontrol (such as neglectful parents), be more consistent in their discipline (Van Fleet, 1994). As with aspects of the structuring skill, such as ending play sessions, caregivers are to maintain a "pleasant but firm" tone when using the limit-setting skill (Van Fleet, 1994, p. 20). This skill is also related to the structuring skill, in that children are not given a list of play session rules up front. Instead, rules or limits are given as they become relevant to the play sessions. Caregivers are to set their own rules, depending upon where the play sessions are being held, as well as the personal boundaries that each caregiver has. Hence, rules primarily relate to property, participants' bodies, and the structure of the sessions. Van Fleet (1994) has provided a list of some common rules in filial therapy:

1) The child should not throw anything at windows, mirrors, or cameras.
2) Crayons should not be used on the walls, furniture, or blackboards.
3) Sharp objects or hard-soled shoes should not be poked, thrown, or kicked at the [punching] bag.
4) The child may not leave the playroom except for one trip to the bathroom.
5) Dart guns should not be pointed or shot at people when they are loaded.
6) The child should not destroy valuable items or engage in mass destruction of toys.

7) Parents may need to set personal limits, kept to a minimum (e.g., no jumping on the parent's bad back; no dumping of an entire container of water on the parent). (p. 19)

Again, caregivers are not to recite or post play session rules. Instead, rules are to be stated within the context of the parent-child play as children are about to break them.

The first step of the limit-setting skill is to state the limit or rule. When parents notice that children are about to break a play session rule, they are to use the child's name, reflect the child's desire to do whatever it is that they are about to do, clearly state what the limit is, and then redirect the child's behavior. For example, it is a common limit for dart guns not to be pointed or shot at people. If a parent noticed that her child was about to do this, she/he might say, "Jessica, you want to point that at me, but it is not for pointing or shooting at people. There are many other places you may point or shoot it. Two of these places are the floor or the punching bag."

The next step is a warning. If the child chooses to engage in the prohibited behavior after the first step, she/he is warned by the caregiver of the consequences of breaking a rule or limit. Parents address the child by name, restate the rule or limit, give the consequence, and then redirect the behavior. The consequence for disregarding a play session limit is always the same: the play session promptly ends. Parents are also taught to begin at this second step when their children disregard limits that have been given in previous sessions. Continuing with the previous example, the parent might say, "Jessica, remember we talked about how that is not for pointing or shooting at people? Well, if you choose to continue pointing that at me, we are going to end our play session for today, and try again next week. You may choose to point that at the wall or door, instead."

The final of the three limit-setting steps is to enforce the consequence of breaking a play session rule. Caregivers learn to use the child's name in restating the limit, acknowledging the child's choice in engaging in the prohibited behavior, and then ending the play session. So, the parent might say, "Jessica, that is not for pointing or shooting at people. Because you have chosen to keep shooting that at me, we are ending our session for today. I am disappointed that you have made this choice, but will look forward to trying again next week."

General Benefits of Filial Therapy

There are several benefits to utilizing the filial therapy model with families who have children, as outlined by Johnson (1995). First of all:

> Individual treatment's frequent exclusion of parents can create a barrier to addressing family issues, and the suggestion of family therapy to parents who specifically want help with their child is often met with resistance and a fear of being blamed for the problem. The filial therapy experience empowers parents to provide help for their own children and can be a stepping stone to family treatment. (p. 58)

Secondly, filial therapy provides an arena in which both systemic and individual issues may be processed: "Whereas family therapy has traditionally focused on systemic issues, while play therapy has focused on the issues of the child, filial therapy genuinely addresses both" (Johnson, 1995, p. 59).

Third, filial therapy has the potential to strengthen the caregiver-child relationship. Because filial therapy is based on a therapeutic play relationship between caregiver and child, rather than between therapist and child, it (1) enhances the caregiver-child bond, and (2) actively engages caregivers in the treatment process (Johnson, 1995).

Fourth, filial therapy offers caregivers skills, not guilt-trips. Johnson (1995) recognizes that there are a number of caregiver-training programs that are available. What makes filial therapy different is that it empowers caregivers "by offering [them]...an opportunity to become therapeutic agents for their children. It acknowledges their skill in parenting while teaching additional therapeutic skills" (p. 59).

Overview of the Literature

Between 1964 (filial therapy's inception) and 1989 there were only a handful of studies and articles about filial therapy, many of them unpublished dissertations; the majority of the filial literature has appeared since 1990. There was clearly a dearth in the 1970s and 1980s (with an average of less than one written work per year), followed by a rebirth in the early 1990s, peaking in 1997 (when more than twice the literature appeared in one year than had been written in any single year since 1964). To better understand filial therapy's early years, Guerney's (2000) historical review will first be summarized. Because the current study is an outgrowth of research conducted since the 1990s, this

literature will then be reviewed. For a more exhaustive review of the filial therapy literature, please see Rennie and Landreth (2000).

From 1964 to the 1990s. According to Guerney (2000), although many requests were made for reprints of the 1964 article (Guerney, 1964) that marked filial therapy's introduction into the professional mental health community, widespread application of the model did not immediately follow. Still, seeing the model's potential, the National Institute of Mental Health (NIMH) provided funding for a large-scale investigation of the new model in 1966. Results of this study, in which mothers of behaviorally and emotionally challenged children were trained to provide play therapy for their own children, were very encouraging. There was a 75% retention rate over the course of the treatment, which lasted for about a year. Not only did all 51 children who remained in treatment show improvements, but they also demonstrated average gains that rendered them comparable to normal population controls. In addition, the model's effectiveness was not a function of preexisting differences between the mothers or children in the study, as "the treatment was found to be equally effective across the range of the sample" (Guerney, 2000, p. 5). With such a promising beginning, one is led to wonder why "it [has been] difficult for most mental health professionals to see the potential… [of filial therapy] for nearly two decades" (Guerney, 2000, p. 7).

From Guerney's (2000) perspective, several barriers to filial therapy's acceptance existed in the 1960s. First, the Freudian influence was still very strong, which meant that most treatment was individual and intrapersonal. The family therapy field was very new, and interpersonal work with multiple family members was generally viewed with suspicion. Coupled with this was the view that children's presenting problems were symptoms of parental pathology.

In the 1970s, a new roadblock to filial therapy's influence emerged in the form of behaviorism. The Guerneys taught filial therapy to their graduate students at Rutgers and then at Penn State, but the introduction of behavioral approaches into the academic milieu translated into play and filial therapies not being taught in most other graduate mental health programs. Only a few academic devotees maintained the play and filial traditions at their respective institutions. With the formation of the Association for Play Therapy (APT) in the 1980s, and the fact that behaviorism did not turn out to be a 'cure-all,' the

play therapy field again began to regain some momentum. However, filial therapy still lagged behind. It was not until the 1990s that filial therapy gained general recognition, and Guerney (2000) has her own speculations regarding those factors that have contributed to its current prominence.

According to Guerney (2000), filial therapy was ahead of its time. The context in which it is currently being received has changed considerably since 1964. Not only is work with multiple family members now a widely recognized and utilized practice, but family members are also generally viewed from a strength-based (instead of a pathology-focused) lens in which their potential for helpfulness can be both perceived and harnessed. Filial therapy also fits right in with skills approaches aimed at improving behavioral problems, which are more common interventions than they were in the 1960s. In addition, there is now a third generation of filial therapists who have been trained by second-generation proponents now in academic leadership positions. Finally, Guerney (2000) feels that the work of Garry Landreth and his students has done much to raise interest in filial therapy. As this study is an outgrowth of their research, several of their most recent and representative studies will now be reviewed.

The prolific 1990s and beyond. The current study builds upon research that began in the 1990s and has continued to the present. This period has been largely dominated by research that has come out of the University of North Texas. Dr. Garry L. Landreth (whose 1991 book, *Play Therapy: The Art of the Relationship*, is a standard in the field of play therapy) is the director of the Center for Play Therapy there, which is the largest play therapy training facility in the world. He and his graduate students have been setting precedents in both quantitative and qualitative filial therapy research since the early 1990s.

The focus since the 1990s has been on establishing filial therapy's viability as a treatment method through expanding our knowledge of the applicability and efficacy of the group filial therapy training model to specific populations and presenting problems. Specific populations studied have included single parents (Bratton & Landreth, 1995), Chinese parents (Chau & Landreth, 1997), Korean parents (Jang, 2000), incarcerated mothers (Harris & Landreth, 1997), incarcerated fathers (Landreth & Lobaugh, 1998), Head Start families (Johnson et al., 1999), and Native Americans living on reservations

(Glover & Landreth, 2000). Parents/guardians of children with chronic illness (Glazer-Waldman et al., 1992), conduct behavior problems (Clark, 1996), pervasive developmental disorders (Beckloff, 1998), and learning difficulties (Kale & Landreth, 1999) have been trained in filial therapy for studies investigating specific presenting problems. In addition, one of the most recent studies, which speaks to the systemic nature of both the presenting problem and filial therapy, is a study conducted with non-offending parents of children who have been sexually abused (Costas & Landreth, 1999).

To date, a research design that is very similar across studies has been utilized with single parents (Bratton & Landreth, 1995), Chinese parents (Chau & Landreth, 1997), incarcerated fathers (Landreth & Lobaugh, 1998), incarcerated mothers (Harris & Landreth, 1997), and non-offending caregivers of sexually abused children (Costas & Landreth, 1999). These five studies will be described and compared to illustrate the most recent quantitative research that has been conducted on filial therapy. This will be followed by a review of two qualitative studies in the current literature.

A pretest-posttest, nonequivalent control group design (Campbell & Stanley, 1963) was chosen as the framework for each of the five studies. The control and experimental groups were drawn from non-probability samples of volunteers who met specific criteria. Some studies matched the control and experimental groups on demographic variables, others did not. The groups ranged in size from 10 (Harris & Landreth, 1997) to 22 caregivers (Bratton & Landreth, 1995). The experimental groups were generally divided into smaller groups of between (ideally) 6-8 parents, who then attended ten weekly filial therapy training sessions, each generally two hours long (Landreth, 1991; Harris & Landreth [1997] study sought to norm a 5-week filial therapy training design). It should be noted that assignment to one of the smaller experimental groups was not random, but was based primarily on demographic matching and/or common schedules. The control groups received no treatment during the studies, but were offered the option of filial therapy training after the completion of the same with the experimental groups. For the first three weeks of training, parents in the experimental group(s) were taught the four basic skills of filial therapy (structuring, empathic listening, child-centered imaginary play, and limit-setting), and were given opportunities to role play these with each other. Between the third and tenth training sessions, parents were

expected to practice the skills they had learned in weekly 30-minute home play sessions with their child(ren), videotape these sessions, and then share some of this video footage with the rest of the group. Hence, the first three weeks were didactic, while the remaining seven weeks primarily involved group process.

Each of these five studies sought to demonstrate that filial therapy effected a significant increase (by comparing experimental and control group adjusted posttest means) in both caregiver empathy towards and acceptance of their child(ren), and a decrease in caregiver stress and perceived child behavior problems. There was a basic battery of measures that was utilized in each of these studies, both pre- and posttest, to investigate each of these variables. Data was collected during additional meetings with participants prior to the first session, and again following the tenth session. First, to measure parental empathy, each participant in both the experimental and control groups was videotaped in a 20- to 30-minute play session with their child. After both the pre- and post-measure videotapes had been collected, they were then coded using the Measurement of Empathy in Adult-Child Interactions Scale (MEACI) (Stover, Guerney, & O'Connell, 1971; as cited in the following: Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; and Harris & Landreth, 1997). Next, participants in both groups were administered the Porter Parental Acceptance Scale (PPAS) (Porter, 1954; as cited in the following: Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; and Landreth & Lobaugh, 1998) to measure parental acceptance and the Parenting Stress Index (PSI) (Abidin, 1983; as cited in the following: Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; and Landreth & Lobaugh, 1998) to measure parenting stress. In addition, three of the five studies utilized the Filial Problem Checklist (FPC) (Horner, 1974; Bratton & Landreth, 1995; Harris & Landreth, 1997; and Landreth & Lobaugh, 1998) to measure parental perceptions of child problems. Instead of the FPC, the Costas & Landreth (1999) study utilized the Child-Behavior Checklist-Parent Report Form (CBCL) (Achenbach & Edelbrock, 1983, as cited in Costas & Landreth, 1999) for this same purpose. The target children of both the experimental and control group caregivers were also included in a couple of the studies' pre- and post-measure designs. In two studies, children were administered the Joseph

Preschool and Primary Self-Concept Scale (JSCS) (Joseph, 1979; as cited in the following: Costas & Landreth, 1999 and Landreth & Lobaugh, 1998). In the Costas and Landreth (1999) study, children were also given the Draw a Person: Screening Procedure for Emotional Disturbance (DAP: SPED) (Naglieri, McNeish, & Bardos, 1991, as cited in Costas & Landreth, 1999).

With only one exception (prison facilities in the Landreth and Lobaugh [1997] study did not permit videotaping of sessions), caregiver empathy was found to increase over the course of filial training at the .001 level of significance. Significant results ($p < .001$) were also reported across all five studies on increased caregiver acceptance of their child(ren). Only in the Harris and Landreth (1997) study did caregiver stress not significantly decrease, although the mean scores approached significance. In the three studies in which the FPC was utilized as a measure, there was also a significant decrease in the number of child problems perceived by caregivers in the experimental groups.

Both collectively and individually, these five studies have been important in quantitative filial therapy research. As a group, they represent an expanded number of populations with whom filial therapy has been shown to be effective. In addition, the populations represented by these studies have been marginalized in much of the social science research. It is of particular import that three out of these five studies (Bratton & Landreth, 1995; Chau & Landreth, 1997; Landreth & Lobaugh, 1997) included or were focused on fathers. They, too, represent a group who has traditionally been excluded from social science studies.

Individually, these studies also make significant contributions. In the Chau and Landreth (1997) study, filial therapy training sessions were taught in Cantonese, and related materials were translated into Chinese, thus reaching a population who would traditionally be excluded because of linguistic barriers. The Landreth and Lobaugh (1997) study utilized an additional measure, the JSCS, which documented dramatic increases in self-concept for those children whose fathers were in the experimental group. In addition, "a generalized result of the filial therapy training was that the fathers in the experimental group made additional contacts with their children through letter writing and phone calls" (p. 163). The Harris and Landreth (1997) study sought to show the efficacy of the traditional filial therapy training model, collapsed into 5 weeks (with

training sessions twice a week). Although the authors suggest (based on the results) that 5 weeks may not be enough time for the parenting stress of incarcerated mothers to be reduced, this shorter model did prove to be successful in terms of increased empathy towards and acceptance of their children by mothers who were in the experimental group. Further research with this shorter model may improve its efficacy.

Before leaving the work that Landreth and his colleagues have done at the University of North Texas, there are two qualitative studies that bear review. These are companionate studies, in that the first (Bavin-Hoffman, Jennings, & Landreth, 1996) was primarily focused on parents' perceptions of filial therapy, whereas the second (Cleveland & Landreth, 1997) concentrated on children's perceptions of filial therapy. In the first study, forty parents (twenty couples) who had participated in a 10-week group training in filial therapy were asked post-training (1) how their parent-child relationship had changed as a result of filial therapy, and (2) how their couple relationship had changed as a result of the same (Bavin-Hoffman et al., 1996). Almost two thirds of mothers and fathers reported improved interpersonal family communication skills. About three fourths of the mothers and fathers also indicated that partner communication had improved. In addition, more than three-quarters of the mothers and fathers felt that positive changes in their children's behavior had resulted. Finally, parents volunteered that their families had valued the experience. One of the unexpected results of this study was that parents were able to internalize the skills they learned in play sessions with their children and apply them in their couple relationships, resulting in greater reported unity between married partners.

Children's perceptions were harder to capture. Still, the Cleveland and Landreth (1997) study represents an important step in seeking, for the first time in the filial literature, the opinions of children. Five children between the ages of 3 and 8 years of age, whose parents had completed a 10-week group filial therapy training, were interviewed about (1) their perceptions of the practical process of filial therapy, and (2) their perceptions of how their parent-child relationship had been affected by filial therapy (Cleveland & Landreth, 1997). The researchers were not very successful in their attempts to invite the children in the study to verbalize their feelings. However, they

indicate that this very phenomenon was a testimonial to the practicality and success of filial therapy:

> Although most of these children could not verbalize the changes that had resulted from filial therapy, significant changes had indeed taken place in their lives. It is precisely because children's natural manner of expression is through play and not through words that filial therapy is as successful as it is. If children were able to verbalize their thoughts and feelings, then play therapy would not be useful. (p. 28)

These two studies point to the additional information that can be garnered from qualitative research. They also speak to the positive effects that filial therapy can have outside of the parent-child relationship. In addition, the second study indicates that additional research is needed to be able to access children's perceptions of filial therapy.

Filial therapy has emerged from decades of relative obscurity to become a well-recognized player in both the family and play therapy fields. It has clearly established itself as an empirically validated therapeutic modality that is effective with a variety of parent populations, as well as child presenting problems.

Filial Therapy with Court-Ordered Parents of Maltreated Children

In their recent review of the filial therapy literature, Rennie and Landreth (2000) outline the parent populations with whom filial therapy has proven effective, "including incarcerated fathers, incarcerated mothers, single parents, and parents of different nationalities" (p. 32). In addition, filial therapy has also been empirically validated with nonoffending parents of sexually-abused children (Costas & Landreth, 1999). This study provided an extension of the current literature by investigating filial therapy's effectiveness with parents court-ordered for remedial parent education due to maltreatment of their children. As this study was conducted at a church, it also added to the growing number of filial therapy studies that have been conducted in applied (as opposed to academic) settings. Some of the contexts for recent studies have included agencies (Costas & Landreth, 1999), churches (Chau & Landreth, 1997; Costas & Landreth, 1999), schools (Jang, 2000; Kale & Landreth, 1999), and prisons (Harris & Landreth, 1997; Landreth & Lobaugh, 1998).

Use of a sample drawn from the court-ordered population also necessitated several design modifications that were unique to this study. With the exception of the Glazer-Waldman et al. (1992) study, which had no control group, published group filial therapy training studies have utilized a 'no treatment' control group design, in which participants are given the option of filial therapy training *after* the study has been completed. However, 'no treatment' is not an option for the court-mandated population, whose members generally have a finite period during which they are to fulfill the courts' requirements for services and/or treatment. Hence, a partnership was formed between this author and the Prevent Child Abuse Roanoke Valley (PCARV) agency, which offers parent education classes for court-ordered parents. Participants in this study's comparison group received PCARV's parent education classes--concurrent to the experimental group receiving filial therapy training--in lieu of filial therapy training at a later date. This feature provided both an opportunity to compare two treatments, and a statistical challenge. It was anticipated that detecting statistically significant differences between two treatments with a small sample size would be difficult, and so both anecdotal and qualitative data were also collected. As has been outlined, recent filial therapy studies have primarily utilized either a quantitative or qualitative methodology. This study built upon the study by Jang (2000), which was one of the first in the literature to draw upon a mixed methodology. Lastly, this study required a modification to the length of the filial therapy training. It is Landreth's (1991) 10-week filial therapy training model that has been the basis of most of the recent group filial therapy training studies. However, PCARV uses an 8-week parent education model. Therefore, an 8-week modification of Landreth's 10-week model was developed for this study. This extended the literature, as it has been suggested that "further research is needed to investigate the effectiveness of condensing the filial therapy training time" (Rennie & Landreth, 2000, p. 32).

The child maltreatment literature will be reviewed, with a specific focus on the characteristics of physically abusive and neglectful families. This will be followed by a description of the court-ordered population, particularly parents required to obtain remedial parent education because of child maltreatment. Finally, Landreth's (1991) 10-

week filial therapy model will be outlined, coupled with changes that have been made to it.

Child Maltreatment

Instead of 'child abuse,' many researchers prefer the term 'child maltreatment' for two reasons. First, the latter acknowledges the multiple and disparate conditions of abuse. Secondly, this label is not as emotionally powerful as is 'child abuse' (Crittenden, 1988).

A major challenge in the prevention, study, and treatment of child maltreatment has been a lack of consensus regarding its definition. Initially identified as 'battered child syndrome' by Kempe and colleagues in the early 1960s (Ammerman & Hersen, 1990; Crittenden, 1988, 1996; Milner & Chilamkurti, 1991), the first documented cases of child abuse and neglect were severe, linked to physical injuries and even death (Ammerman & Hersen, 1990). In this emotional atmosphere, legal action and treatment took precedence over definition and etiology (Azar, Povilaitis, Lauretti, & Pouquette, 1998). The media continues to focus on such cases today, and the public's perception of child maltreatment as horrific helps to ensure necessary funding (Crittenden, 1988). However, such cases are not representative of the majority, which are "mild to moderate in severity" (Crittenden, 1988, p. 161). In fact:

> Most instances of maltreatment consist of neglect which, in its less severe form, is largely dependent on the judgment of the professional involved. Thus, in the majority of cases, physical evidence will be sufficiently unclear or absent as to cast doubt upon the occurrence of abuse or neglect. (Ammerson & Hersen, 1990, p. 7)

A second factor that has contributed to difficulties in defining child maltreatment is the fluctuation in mores that surround it. Accepted sociocultural values and standards are constantly changing. This is only further complicated by the private and detestable nature of child maltreatment, which translates to its reporting being subject to "error, distortion, and confabulation" (Ammerson & Hersen, 1990, p. 7). Third, the fields involved in child maltreatment are diverse, and often have competing interests (Ammerson & Hersen, 1990).

Lack of agreement regarding child maltreatment's definition has resulted in limited comparability across research (Cicchetti, 1994; Ammerson & Hersen, 1990):

> Researchers select their samples based upon criteria that differ from study to study. The criteria used in these investigations include parents who have engaged in substantiated incidents of maltreatment, those who are referred to child protective service agencies because of suspicions regarding maltreatment, and those who are judged 'at risk,' based upon various standards determined by caseworkers and/or clinicians. (Ammerson & Hersen, 1990, pp. 7-8)

Hence, the lack of a universally accepted definition of child maltreatment has only been exacerbated by research studies between which comparison is difficult and from which it is a challenge to draw conclusions which might lead to a more standardized understanding of the term.

Definition and research challenges aside, child maltreatment is comprised of at least the following four conditions: physical abuse, neglect, sexual abuse, and psychological and/or emotional abuse (Mash & Wolfe, 1991). Neglect is the most common form of child maltreatment, accounting for almost half of reported cases (Crittenden, 1988). Although "much is known [about neglect]…the paucity of studies and the methodological limitations of the studies reduce the certainty and breadth of understanding" (Crittenden, 1996, p. 158). The presentation of child physical abuse and neglect together are the next most common, followed closely by child physical abuse alone (Crittenden, 1988). "Much is known with considerable certainty" (Crittenden, 1996, p. 158) regarding child physical abuse, but when it is coupled with neglect the picture is less clear. The incidence of sexual abuse is approximately one in ten reported cases (Crittenden, 1988). There are no available statistics regarding the frequency of psychological and/or emotional abuse (Azar et al., 1998). It is addressed the least often in the literature, perhaps because it is the most difficult to define, identify, measure, and isolate (Ammerman & Hersen, 1990; Herrenkohl, 1990). Also, the research on sexual abuse and psychological and/or emotional abuse is more limited, compared to the research on child physical abuse and neglect, because the former are relative newcomers to the child maltreatment arena (Crittenden, 1996).

The sample in this study included parents who were court-mandated for parent education because of suspected or documented cases of child physical abuse and/or neglect. Therefore, this review focuses on the individual member and family characteristics of these two types of maltreating systems. "Maltreatment is a family problem. Although reported instances generally involve only one parent and child, these instances are embedded in the functioning of families" (Crittenden, 1996, p. 158). While the primary context for child maltreatment is the family, there are many other contributing contexts and factors. Early etiological theories were overly simplistic, but researchers have since recognized that child maltreatment is a complex phenomenon best viewed from a multi-faceted perspective (Azar et al., 1998). In light of this, additional contextual issues and factors are also included in the following review, along with treatment prognoses and recommendations. Much of the descriptive information presented is drawn from research done by Crittenden (1988, 1996). It has particular application to this study's sample, because it is based in part on investigations of over 300 low-income parents and children from a small urban community in central Virginia. The participants in this study were also primarily low-income and from a small city in southwest Virginia.

Characteristics of Physically Abusive Families

Parents. In physically abusive homes, parents are usually young with a couple of children (Crittenden, 1988) or young with many close-in-age children (Crittenden, 1996). If there is a father in the home, he is often the children's father. The relationship between the father and mother is frequently anxious, volatile, and abusive. In addition, there is tremendous relational instability, with many divorced, separated, or unmarried mothers. Physically abusive parents are of average intelligence, can read and write, and have finished some or all of their high school education. Some are employed and able to support themselves: like other families with a similar socioeconomic status, they are proud of their ability to take care of themselves. Others depend in part or completely upon public assistance and do not feel that there are sufficient resources to help them (Crittenden, 1988, 1996).

One of the most common beliefs about parents who physically abuse their children is that they, themselves, were physically abused during their childhood. In other

words, physical abuse is perceived as a transgenerational phenomenon. However, there is mixed support for this conjecture (Caliso & Milner, 1994). For example, an oft-cited study (Kaufman & Zigler, 1987) found that the majority (70%) of parents physically abused as children did not physically abuse their own children (compared to 30% who did). While most maltreating parents were "reared in hostile, controlling, and punitive environments," what differentiates them from parents who do not maltreat their children is that "they now [believe] that this harsh discipline, which they resented as children, [is] instrumental in enabling them to become the responsible and competent parents which they [believe] themselves to be" (Crittenden, 1988, pp. 168-169). Therefore, there appears to be an indirect relationship between physical abuse experienced in childhood and later adult perpetration of the same (Kolko, 1996). A mediating factor appears to be the presence of a positive adult or peer relationship during childhood (Caliso & Milner, 1994).

The absence of a caring relationship early in life may help to explain why physically abusive parents have difficulty with most of their adult relationships, from immediate and extended family, to friends, employers, and coworkers (Crittenden, 1996). The problems do not appear to be in the initiation of relationships, as they appear to have many, but in their maintenance: "their networks could be described as unstable-open…with a high turnover of short-term, non-reciprocal relationships" (Crittenden, 1988, p. 168).

A third characteristic of physically abusive parents is that they demonstrate a "negative cognitive-attributional style": children's behavior is viewed more negatively than by nonabusive parents (Kolko, 1996, pp. 25-26). This is often accompanied by an external locus of control, in which they view "powerful others and chance factors" as responsible for their behavior (Milner & Chilamkurti, 1991, p. 352). Physically abusive parents have high expectations of themselves as parents, and require affirmation of their competence from their children and other sources (Crittenden, 1988). While they are able to verbalize normal, developmental expectations of their children, their personal standards and need for external praise appear to "put pressure on their children for high performance" (Crittenden, 1988, p. 169).

Physically abusive parents also use power differentially to meet their wants and needs. This translates into them assessing every situation and relationship based on their power and how they can best use it to have maximum control:

> When they [are] relatively very powerful, as a parent is to a small child, abusing parents [are] openly coercive. When they [have] less overt power but some emotional influence, as an abused woman has to her partner, they [tend] to behave compliantly using persuasiveness and deceit cautiously. (Crittenden, 1988, p. 168)

Hence, the variety of behaviors utilized by physically abusive parents are a function of perceived power in a given context.

A fifth characteristic of physically abusive parents is their hyperarousal or hyperreactivity to stimuli, as measured by skin conductance (Kolko, 1996; Milner & Chilamkurti, 1991) and respiration rates (Milner & Chilamkurti, 1991). High-risk and maltreating adults (including some neglectful parents and non-parents) have displayed greater physiological responsivity to both child-related and nonchild-related stimuli. Such findings point to a predisposition of autonomic hyperarousal or hyperreactivity in some adults; still, the relationship between this condition and child physical abuse is, as yet, unclear (Milner & Chilamkurti, 1991). For an extensive review of the characteristics of child physical abuse perpetrators, please see Milner and Chilamkurti (1991).

Children. It is a commonly held belief that children who are abnormal in some way are more susceptible to physical abuse. According to this perspective, children with medical or physical problems, mental challenges, developmental handicaps, or difficult temperaments are at a higher risk for abuse. However, the research is divided, and there is at best mixed evidence for this factor (Ammerman & Hersen, 1990; Kolko, 1996). Kolko (1996) suggests that child abnormalities are more likely the result of physical abuse, not antecedents to it. Still, child abnormalities can contribute to parental stress, which has been found to be a contributing factor in physical abuse (Kolko, 1996). It has also been noted that child conduct problems such as oppositional defiance are indirectly correlated with physical abuse in that they can exacerbate parent-child conflictual interactions that lead to abuse (Ammerman & Hersen, 1990). Difficult child personalities and behavior problems also contribute to insecure parent-child attachment, which is characteristic of physically abusive parent-child dyads (Crittenden, 1996; Kolko, 1996).

Physically abused children tend to develop into one of two distinct types: either they become compulsively compliant or aggressively angry (Crittenden, 1988). The first is wary of the physically abusive parent, and is able to reduce the abuse by trying to meet the parent's expectations of them. This way of coping not only decreases the abuse, but also increases the parent's satisfaction with the child and improves the parent-child relationship. In addition, "attempting to identify and comply with the [parent's] high standards leads the child to develop a set of valuable social skills and an achievement orientation" (Crittenden, 1988, p. 170). However, there are also long-term costs to this approach. Early inhibition of negative affect in order to meet the parent's expectations can lead to a disconnection from real feelings. As a result of success in controlling the parent's behavior, the child may begin to feel responsible for it, and have this belief reinforced by the parent. The most damaging consequence is that the child loses her/his sense of self: worth is dependent upon how others see her/him (Crittenden, 1988). Each of these costs has a devastating effect, as well, on the formation and maintenance of relationships with others.

The aggressively angry child demonstrates the intent to resist control of any kind, and at all costs. In contrast to the compulsively compliant child, who seems to feel responsible for the parent's behavior, the aggressively angry child displays a total lack of responsibility for her/his own behavior and that of others. This can eventually lead to delinquency. The aggressively angry child invests tremendous time and energy in anger and indignation regarding the unfairness of the abusive situation. She/he is openly defiant and difficult; hence, her/his belief that others will attempt to coerce, reject, and take advantage often becomes a self-fulfilling prophecy. Such a child often experiences more abuse than the compulsively compliant child, but is also able to maintain a sense of self and avoid some of the psychological consequences of the maltreatment. Still, even potentially healthy relationships with others are threatened because of the child's beliefs about others, and her/his inability to comply or compromise. In addition, the aggressively angry child does not develop "internal regulatory strategies" (Crittenden, 1996, p. 161) such as impulse control. Sadly, both compulsively compliant and aggressively angry children usually lack experience with adults who accept them unconditionally. Consequently, the two types of physically abused children have an

inherent distrust of others, and a belief that power is the key to obtaining what they want (Crittenden, 1988, 1996).

Families as a whole. There is a higher incidence of child physical abuse among minority groups and low-income families. Both groups also experience more stressors than more privileged groups and classes. Therefore, the sociopolitical context of child physical abuse for these families is related to national policies on the allocation of resources and the relative disadvantage of such families. In addition, our cultural attitudes are more tolerant of mild dysfunction, which translates into scarce preventive services for at-risk, low socioeconomic status families. In short, resilience and other individual mediating factors must be present in at-risk minority and/or low-income families in order for them to be successful in sociopolitical and cultural contexts that do not provide adequate buffers for them (Abney, 1996; Crittenden, 1988; Kolko, 1996).

The primary characteristics of physically abusive families have to do with their communication and interactional styles. Crittenden (1996) has found that "hostility and aggression often underlie abusers' smiles and apparently playful or affectionate behavior" (p. 160). Small wonder, then, that members of abusive families have a tendency to misread communication cues. When compared to controls, they display a heightened negative response to negative communications while also classifying positive communications as negative (Crittenden, 1996). Physically abusive families interact with each other less than nonabusive families, and have very little positive contact when they do interact (Crittenden, 1996; Kolko, 1996). Instead, interactions between family members are aggressive, coercive, controlling, critical, demanding, hostile, interfering, and negative (Crittenden, 1988; Kolko, 1996). Children and parents engage in interactions that are negatively reinforcing. As has been previously discussed, physically abusive parents demonstrate high expectations of themselves, a negative cognitive-attributional style, and issues with power. When they use poor child management techniques and receive a negative response from their child, physically abusive parents tend to interpret this as either rejection or disobedience (Crittenden, 1988). However, instead of changing the approach or technique, as do nonabusive parents, they tend to respond with even more of the same. This curtails child misbehavior and affective expression in compulsively compliant children, but increases both in aggressively angry

children. Either way, the parent views the child as needing further discipline because it is working with the former, or not working with the latter. With aggressively angry children, the aversive interactions with physically abusive parents escalate, whereas they tend to decrease (at least short-term) with compulsively compliant children.

Treatment prognosis and recommendations. The overall treatment prognosis for physically abusive families is good, when the treatment is appropriate for them. In general, physically abusive parents have a knowledge base of child development and appropriate child behavior management techniques. However, they clearly do not apply or misapply this information in situations where they choose to physically abuse their children. "Consequently, parent education may be of little value and may even be harmful in some cases by giving parents new weapons to misuse while concurrently increasing their feelings of competence and authority" (Crittenden, 1996, p. 161). Keeping in mind the beliefs and perspectives with which physically abusive parents present, Crittenden (1988) has outlined several recommendations for working with them in treatment. First, because parents of these families have the mental capacity for insight as well as high expectations of themselves, they tend to be motivated and believe in their capacity for change. Helping professionals need to communicate honor for worthy parenting goals and intentions, not reinforce the abusive label. Otherwise, parents will become resistant to help and change. Secondly, the physically abusive parent's respect for power can be used, where appropriate and necessary, as a motivator for obtaining more effective ways of meeting their worthy parenting goals. Court-mandated treatment is an example of the use of power as a motivator, although the literature is divided as to whether it is either appropriate or necessary. Third, physically abusive parents tend to look to others for performance standards and reinforcement of their parenting. Helping professionals who are aware of this tendency can remember to affirm parents as they learn new skills, adopt new standards, and make progress in treatment. Crittenden (1988) also cautions that:

> Abusers are looking for rules that will always work. Successful child-rearing results form knowing when to apply which principles; it calls for judgment more than rules. Abusive parents must be encouraged to learn to interpret accurately

> the behavior of others (especially their children) and to focus on strategies that yield the desired outcome. (p. 183)

Last, but certainly not least, treatment will be most successful if it takes place within the context of the entire family. If there are two parents in the home, treatment should include them both. Otherwise, it risks failure over one parent's feelings of divided loyalties, and the other's lack of engagement. Of course physically abused children need treatment, as well:

> The goal of intervention with both compliant and acting-out abused children must be to engage them in interaction with sensitively responsive adults soon enough and long enough that their patterns of interaction…are not limited to those derived from interaction with their parents. Only if they are able to recognize and respond appropriately to a sensitive adult will they be able to…break out of the cycle of abuse. (Crittenden, 1988, pp. 183-184)

This final recommendation regarding treatment for physically abused children suggests that filial therapy, with its emphasis on the primary skill of empathic listening, has the potential of being a successful intervention, when used with physically abusive parents and their children, in interrupting patterns of child physical abuse in the family. Filial therapy may also help physically abusive families to experience a different kind of power—empowerment as a result of behaviors and interactions that yield desired outcomes for both parents and children. Finally, filial therapy may improve families' distorted relational models and combat parents' negative cognitive-attributional style by increasing the number and frequency of positive parent-child interactions.

Characteristics of Neglectful Families

It is important to note that there are substantial differences between the research on physically abusive families and the research on neglectful families. The neglectful family literature has not had the recognition or the national support that investigations of physically abusive families have had (Azar et al., 1998; Crittenden, 1996). There are fewer researchers, fewer quantitative findings, and, as a result, theory development lags behind that of physical child abuse (Crittenden, 1996). "The lack of theory in this area is striking, given that neglected children typically outnumber those who have encountered the other forms of maltreatment (Azar et al., 1998, p. 15). One of the challenges that

plagues all maltreatment research is its lack of definition, which, for neglectful families, has meant that they have rarely been studied independent of other maltreating families in order to better establish their unique characteristics. Instead, in many studies (including this one) and reviews of the literature, neglecting families are included with physically abusive families. Neglect is also difficult to study because of "the diversity of behaviors that are labeled neglectful," as well as the challenge "posed by measuring acts of omission…which [are] more difficult…[to assess] than observable and quantifiable acts of commission" (Azar et al., 1998, pp. 14-15). Still, actions classified as neglectful have included parental failures to provide the following for their children: "medical care, supervision, nutrition, personal hygiene, emotional nurturing, education, and safe housing" (Azar et al., 1998, p. 16; see also Gaudin, 1993).

Parents. While most maltreating parents have less education than parents who do not maltreat their children, neglectful parents have the least education of them all. They have low IQs; are often illiterate; and were only in school through the 8th grade, during which they were usually assigned to classes and curriculum for the mentally retarded (Crittenden, 1988, 1996). Neglectful parents also present as depressed, although few have been diagnosed. There is probably an interaction between mental retardation, depression, and neglect, but the relationship is, as yet, unclear (Crittenden, 1996).

In contrast to physically abusive parents, who demonstrate an external locus of control and an enchantment with power, neglectful parents view the world from a perspective of pervasive powerlessness. Put another way, there is no point in making any effort when no one possesses the power to effect change: everyone is powerless, and "luck and fate (e.g., 'If it is meant to be, it will happen') become the primary explanatory mechanisms" (Crittenden, 1996, p. 163). Such a paradigm is reflective of neglecting parents' depression and closed family systems, and is then learned by their children.

The main focus for neglecting parents is daily existence, without any clear plans or goals to ensure subsistence for themselves or their children. Hence, they have no real expectations of anyone, and instead are quite confused when asked about the concept (Crittenden, 1988). Usually they have very little experience with problem-solving, because their coping mechanisms of choice are to ignore a problem, withdraw from it,

and/or relinquish authority/responsibility to someone else (Crittenden, 1988). Sometimes the latter is accomplished through someone taking pity on the family.

Children. The overarching feature of neglected children is that they are developmentally delayed. Due to a lack of interaction and stimulation, infants quickly become apathetic, listless, and passive. As their mobility increases, they develop into one of two types of children. The first type explores their world in a frenetic, disorganized fashion, with little or no adult supervision: "Although this massive input of stimulation [holds] the potential for reducing the cognitive deprivation of the infants, in fact, they are so easily distracted by new stimuli that they rarely [attend] to the effects which they [are] creating" (Crittenden, 1988, p. 173). Their behavior is akin to that displayed by hyperactive children with attention deficits. Children of the second type display a sort of learned helplessness, and do not utilize their new locomotion:

> It [is] as if these very passive, stimulation-deprived toddlers [stand] up, [look] around, [find] nothing of interest and [sit] back down. They [do] not show the excited random exploration of other neglected children and [seem] sadly resigned to the limitations of their world. (Crittenden, 1988, p. 174)

One of the tragedies for both types of children is that, because of the lack of interaction and stimulation during the critical first months of their lives, they remain at a cognitive disadvantage with delays that only get worse with age (Crittenden, 1988).

The family as a whole. Azar and colleagues (1998) have pointed out that it is hard to identify who the perpetrator in a neglectful family is, although the mother is usually assigned the label even if there is another caretaker in the home. This may be because in neglectful families, "everyone is neglected…there is not even the appearance of winners or of the misuse of strength; there are only losers and pervasive incompetence" (Crittenden, 1996, p. 162).

Neglectful families are either new with a couple of young children (Crittenden, 1988) or large, with more children than adults (Crittenden, 1996). The family structure is matriarchal, with temporary, tangential males (usually boyfriends of the mother) and a maternal grandmother who is a more permanent mother figure to her daughter and grandchildren. The fact that the grandmother is the primary head of the household is

evidence of the mother's abdication of parental authority and responsibility (Crittenden, 1988, 1996).

Poverty is even more strongly correlated with neglect than with physical abuse. While some physically abusive families are self-supporting, most neglecting families are unemployed and depend almost entirely upon public assistance (Crittenden, 1996). Still, the poverty of neglectful families goes far beyond their socioeconomic status. As has been outlined, parents are educationally impoverished. Such families are also characterized by social poverty. Their social networks are described as stable and closed, and primarily consist of extended family "who are as impoverished as the neglectful parents and who often reinforce the parents' limited understanding of parenting roles" (Crittenden, 1996). In addition, urbanization has translated into further social isolation for rural neglectful families, and frequent relocation and relative social instability for urban neglectful families (Crittenden, 1996).

As has been alluded to in discussions of parents and children in neglecting families, there is less interaction in neglectful families than in any other type of family, maltreated or not (Crittenden, 1996). "Moreover, the interaction that does occur tends to be brief, lifeless, and, especially with older children, negative" (Crittenden, 1996, p. 163). Parents rarely initiate activities with their children, and offer caregiving only when they happen to think of it, not in response to signals from their children (Crittenden, 1988). In turn, children become as successful at ignoring their parents as their parents have been at ignoring them (Crittenden, 1988). They see their parents as psychologically unavailable, which "has been associated with greater developmental problems than the hostility and anger of abuse or even the deprivation of physical neglect" (Crittenden, 1996, p. 163).

Chaos is the most succinct descriptor of the neglectful home, in general. There are few rules and very little structure or discipline. Even the frequent angry or frustrated outbursts by neglectful parents when they become overwhelmed are unpredictable and unfocused. Hence, children do not learn self-control, nor do they gain an understanding of how to anticipate and accommodate in interactions with others (Crittenden, 1996).

Treatment prognosis and recommendations. There is generally a poor prognosis for the treatment of neglecting families, for several reasons. First, neglecting parents are mentally restrained from being able to see the deficits in their parenting. Secondly, their

adherence to the powerlessness paradigm translates into a lack of faith in the fruits of their own efforts. Third, there appears to be a negative correlation between enmeshment in a multigenerational, impoverished economic and social system and treatment success. In short, neglectful families "lack skills, goals, resources and motivation" (Crittenden, 1988, p. 184). Instead, prevention is preferred, but does not generally occur for many of the same reasons (sociopolitical and cultural) outlined under physically abusive families.

Crittenden (1988, 1996) has made several recommendations regarding the treatment of neglecting families as a result of her research with them. First, the surrounding community must recognize the need to assist with some of the most basic needs of such families (Crittenden, 1996). Secondly, because of their limited intellectual capacity, it is suggested that the following may overwhelm neglectful parents and should not be employed: treatments that have a strong cognitive basis, treatments that are short-term and focused on swift transformations, or more than one treatment at any given time (Crittenden, 1996). Third, neglectful parents should be helped to move beyond the powerlessness paradigm by understanding that behavior has meaning, that interactions are recursive, and that positive efforts, over time, will yield positive outcomes (Crittenden, 1996). They also need basic training in the recognition, expression, and identification of affect, beginning with their own and then extending to the affect of others (Crittenden, 1988). Similar to physically abusive families, it is in this area that filial therapy could be particularly effective with neglectful families. Fourth, due to the stable, closed social network in which neglecting families operate, relatively few helping professionals should work with as much of the extended family system as possible, and establish a long-term relationship with them (Crittenden, 1996). Fifth, children in neglectful families demonstrate pervasive developmental problems that are difficult to treat past infancy (Crittenden, 1988). Again, prevention is the ideal, but rarely happens. Treatment for neglected children should be in a setting in which they 1) receive sensitive feedback regarding their behavior, and 2) are able to be stimulated cognitively (Crittenden, 1988). Filial therapy has the potential of providing for both of these child needs through its empathic listening and child imaginary play skills. As has been mentioned, the empathic listening skill, as well as the relational setting of filial therapy, could also help both parents and children in these families to learn about affect. In

addition, filial therapy's focus on the parent-child relationship seems to mesh with the closed social systems of neglectful families. Like physically abusive families, neglectful families may be able to feel empowered, rather than powerless, as they experience meaning in their parent-child interactions. If only for 30 minutes a week, neglectful parents may be able to learn to respond to their children, and in turn, their children may see them as more psychologically available.

It is important to note that child physical abuse and neglect are usually not isolated from one another, but often present together:

> Most families that maltreat children experience forms of both abuse and neglect. Very few studies, however, differentiate this group from others; consequently, less is known about the unique characteristics of families who both abuse and neglect their children than about families in which the conditions are separate. (Crittenden, 1996, p. 164)

Because less is known about this group than about families who physically abuse or neglect their children, helping professionals should look for how hostility (which is more characteristic of physically abusive families) and unavailability (which is more typical of neglectful families) are integrated in physically abusive and neglectful families. For some such families, the combination of these two characteristics is fairly predictable, for others it is not (Crittenden, 1996).

Parents Court-Ordered for Services Due to Maltreatment of Their Children

Adults in the United States are court-ordered to seek various kinds of services for various reasons. A review of the literature reveals that common antecedents for court-mandated treatment services are child maltreatment, divorce, spousal abuse, and substance abuse. As has been demonstrated through the review of maltreating families, each of these issues is systemic and has a complex etiology. In addition, due to the aforementioned, each of these issues often presents in concert with other issues (i.e., substance abuse with child maltreatment and/or spousal abuse). While the impossibility of separating out issues that may accompany child maltreatment is recognized, and while participants in this study did demonstrate multiple presenting problems, this review focuses on parents court-mandated for remedial parent education due to child maltreatment (hereafter court-ordered or court-mandated parents).

Not all parents who maltreat their children are subsequently court-ordered for related treatment. This is due, in part, to problems with reporting, including the lack thereof (Ammerman & Hersen, 1990). In addition, most maltreatment is "mild to moderate in severity," (Crittenden, 1988, p. 161) and subjectivity is a primary issue in its identification (Ammerman & Hersen, 1990). When parents present with multiple issues, the chaos of the family system, as well as the severity and immediacy of other problems, may also result in child maltreatment being overlooked. Although generally subsumed under the labels of court-ordered or court-mandated, not all parents in these categories have been given treatment requirements by the courts:

> Court-ordered and mandated parents are defined as those who are assigned by a court or other agency for the purposes of remediating a parenting deficiency…. For example, a court may order parents to attend parent education to remediate abusive behaviors. Another possibility is that an agency will intervene and recommend parent education so that parents can demonstrate their willingness to retain [or regain] custody of their children. Additionally, military commanders may refer parents to a parent education program as part of an intervention with the family. (Dinkmeyer, 1999, p. 101)

In other words, court-ordered or court-mandated parents have been given remedial parenting requirements by any number of institutions with authority over them, including but not limited to the judicial system.

The hallmark characteristic of court-ordered parents is resistance (Dinkmeyer, 1999), a trait not uncommon to many other clinical populations, as well. It seems to be human nature to resist what is required of us because of our desire to make our own choices. Helping professionals are divided as to the therapeutic helpfulness of court mandates: some feel that they increase resistance and decrease receptivity to treatment, while others claim that they contribute to a reduction in drop-out rates by providing therapeutic leverage (Irueste-Montes & Montes, 1988). Several studies have compared the therapeutic engagement of court-ordered maltreating parents to that of self-referred parents. For example, an oft-cited study by Wolfe and colleagues included a sample of 71 parents: 50 parents had been mandated for treatment by the Department of Health and Rehabilitative Services because of filed reports of child physical abuse, the other 21 had

been referred by social service agencies because of suspected child physical abuse for which there was insufficient evidence (Wolfe, Aragona, Kaufman, & Sandler, 1980). The first group was required to complete treatment in order to have complete child custody rights returned to them. The parents participated in a program that consisted of 8 sessions of group treatment focused on child management skills and 8 weekly visits to the home. Wolfe et al. (1980) found that court-ordered parents were five times more likely than referred parents to successfully complete the program, while referred parents were five times more likely to refuse treatment or withdraw from it than court-ordered parents:

> Almost without exception, the data suggest that those parents who refused treatment were those who had no strong contingencies to motivate their initial participation. On the other hand, those parents who had little choice but to comply with the court order began the process of change. Once this was initiated, the new skills were readily learned and improvement in child management techniques was forthcoming. (p. 133)

Hence, court mandates did increase physically abusive parents' engagement in and successful completion of the outlined program.

Famularo, Kinscherff, Bunshaft, Spivak, and Fenton (1989) did not administer a treatment to court-mandated parents, but instead compared the court records of 218 parents whose child maltreatment had resulted in the loss of child custody. Close to 90% of these parents were court-ordered for various services. Roughly 60% were mandated to receive alcohol or drug treatment and individual psychotherapy. Another almost 30% were required to seek family therapy. Famularo et al. (1989) found differences in compliance that were primarily based on the type of child maltreatment and the multiplicity of presenting issues. First, parents who had been neglectful of their children were more likely to fulfill treatment requirements than those who had physically or sexually abused their children. Second, parents who had both physically and sexually abused their children were the least compliant overall. Third, maltreating parents who were also substance abusers were less compliant than those who were not classified as substance abusers, with multiple drug users being the least compliant of the former group. These results indicate that for some kinds of severe child maltreatment, especially when coupled with substance abuse, a court order is not sufficient to ensure compliance.

A third study conducted by Irueste-Montes and Montes (1988) is an important addition to this literature not only because it involved court-mandated and volunteer parents, but also because it investigated the effectiveness of a long-term, multi-dimensional program. The families in the study had documented cases of abuse and neglect, and the Child Protection Unit of the Department of Social Services (DSS) was involved with each of them. What differentiated the mandated from voluntary parents was that the former had been threatened with legal consequences for nonparticipation in the program, whereas the latter had not. Although the exact length of treatment for each family is not given, "the program [itself] ran for 3 years and treated 42 families (56 individuals) out of 65 eligible referrals (65%)" (p. 36). It included a therapeutic day care component (32 hours a week) for dependent children, a weekly 2-hour parent group, and a weekly home session to reinforce what was learned in the group. The authors concluded that "court-ordered families participated in treatment and improved at levels very similar to those of families who were not forced into treatment" (pp. 36-37). Casual comments made by some of the court-mandated parents indicated that they might not have participated had they not been legally compelled to do so. Therefore, the importance of the court's role in the treatment of maltreating parents was supported in this study. In summary, court orders appear to be an effective motivator in seeking treatment for the majority of maltreating parents. The exceptions are the minority of parents whose maltreatment is severe, involves multiple types of abuse, or presents concurrently with substance abuse.

Dinkmeyer (1999) has outlined five strategies for encouraging compliance in court-mandated parents. First, join with them. They have a need to tell their own version of their circumstances, their story, which can be elicited by asking simple, open-ended questions such as, "Who wronged you?" (p. 104). Dinkmeyer also suggests wearing similar clothes to and using the vernacular of court-ordered clients. Secondly, establish clear expectations. These should incorporate the criteria given by the authority that is requiring the treatment, be measurable, and be evaluated periodically. Third, don't be surprised by resistance, or take it personally. Instead, remember that it serves a purpose for some clients, who may be using it to engage in a power struggle or to manipulate, and that it is a reflection of discouragement for others. Fourth, make room for the oscillations

that are a part of growth and change. When clients appear to be relapsing as part of the learning process, maintain the therapeutic join and the expectations, while at the same time communicating respect for and faith in them. Fifth, assign homework. The only way that clients are going to make significant changes in their parenting is by applying what they learn in treatment to real-life situations with their own children.

Group Filial Therapy Training Models

Since this study consisted of a modification of Landreth's (1991) 10-week training model, his model is briefly summarized below. This is followed by a review of studies that have made changes to his model.

Landreth's (1991) 10-week Model

It is this model that has been utilized in the majority of the group filial therapy training studies (published and unpublished) since the early 1990s. It consists of three training sessions that are primarily focused on the learning and practice of the four filial therapy skills. Parents are taught the skills, through live and video demonstration, and then are invited to practice them with each other in session. Handouts and educational videotapes are also used to reinforce principles taught. Related between-session homework is assigned, to be completed with each participant's child of focus during the upcoming week. After the third session, parents begin holding and videotaping weekly parent-child play sessions in their own homes. In the ten-week model, sessions four through nine consist of group process around videotaped play sessions that are shared by one or two parents. The tenth and final session is similar to sessions four through nine, except that the final hour consists of closure, in which caregivers share their perceptions of the training, and the changes that have occurred in their relationships with their children. Each session is two hours long, resulting in 20 total hours of filial therapy training. In empirical studies of this model with various parent populations and child presenting problems, pre- and post-sessions (in addition to the ten weeks of training) have been held during which measures were completed by participants and videotaped footage of individual parents and children playing together were taken.

Modifications to Landreth's (1991) 10-week Model

Rennie and Landreth's (2000) recent review of the filial therapy literature suggests that one of the areas of research that requires further exploration is that of the length of filial therapy training:

> Further research is needed to investigate the effectiveness of condensing the filial therapy training time….We have yet to learn what parents can assimilate into their parenting behaviors in a short period of time. (p. 32)

To date, there are several group filial therapy training studies that have investigated the effectiveness of shortening the total training time of Landreth's (1991) 10-week model, either in terms of weeks or hours. The first was the Harris and Landreth (1997) study, which was conducted with incarcerated mothers in a prison setting. In this study, 2-hour sessions were conducted on a bi-weekly basis, such that the 10-week training model was condensed into five weeks. In other words, the same 20 hours of total training time from the original 10-week model was given over five weeks, with two filial therapy training sessions being held each week for five weeks. It was hypothesized that as a result of the five-week training, mothers' stress (as measured by the Parenting Stress Index [PSI]; Abidin, 1983, as cited in Harris & Landreth, 1997) and perceptions of their children's problems (as measured by the Filial Problem Checklist [FPC]; Horner, 1974) would decrease, whereas their acceptance of (as measured by the Porter Parental Acceptance Scale [PPAS]; Porter, 1954) and empathic behavior towards their children (as measured by the Measurement of Empathy in Adult-Child Interactions Scale [MEACI]; Stover et al., 1971) would increase. Of these four conjectures, only the hypothesis that mothers' stress would decrease was not upheld, although the results approached significance. This led the authors to conclude that:

> The results of the PSI may indicate the 10-week filial therapy training model condensed into a five week model is not enough time to significantly reduce [the] parental stress of incarcerated mothers. (Harris & Landreth, 1997, pp. 68-69)

Given that five weeks was not sufficient time to yield significant reductions in the parenting stress levels of incarcerated mothers, and that significant reductions in parenting stress have been found with other populations as a result of the ten-week

model, it seemed appropriate that this study investigate an 8-week model that is between these two.

In their study with incarcerated fathers, Landreth and Lobaugh (1998) also modified Landreth's (1991) 10-week model. They held sessions once a week over ten weeks, but shortened the actual time of each session to one and a half hours, yielding a total training time of 15 hours. The purpose of the study was to determine the effectiveness of filial therapy in increasing incarcerated fathers' acceptance of their children (as measured by the Porter Parental Acceptance Scale [PPAS]; Porter, 1954), as well as in improving the self-concept of their children (as measured by the Joseph Preschool and Primary Self-Concept Scale [JSCS]; Joseph, 1979, as cited in Landreth & Lobaugh, 1998). Two additional hypotheses were that filial therapy would decrease imprisoned fathers' parenting stress (as measured by the Parenting Stress Index [PSI]; Abidin, 1983, as cited in Landreth & Lobaugh, 1998) and their assessment of the number of family interaction problems (as measured by the Filial Problem Checklist [FPC]; Horner, 1974). All four of these conjectures were significant, indicating that there is promise in condensing the total filial therapy training time to 15 hours over 10 weeks. Landreth and Lobaugh's (1998) study has particular application to the current study, because each training session was shortened by half an hour. This study also utilized one-and-a-half hour training sessions.

A third study that altered Landreth's (1991) 10-week model was that of Kale and Landreth (1999). While trying to organize filial therapy training groups with parents of children experiencing learning difficulties, the authors determined that:

> The experimental group parents' schedules necessitated a slight modification in the Landreth (1991) 10-week training model. Three fourths of the time in Sessions 1 and 10 was used for testing. Instead of a full 2 hours of training, parents received only 30 minutes of training in each of these sessions. (p. 45)

Hence, the total training time was 17 hours, instead of 20 hours. Despite the condensed training time, significant reductions in parenting stress, as measured by the Parenting Stress Index ([PSI]; Abidin, 1983, as cited in Kale & Landreth, 1999), were reported. In addition, caregivers in the experimental group showed significantly more acceptance of their children than did caregivers in the control group, as measured by the Porter Parental

Acceptance Scale ([PPAS]; Porter, 1954). The results of this study lend support to the current study's 8-week model, with regard to completing pre- and posttesting during training sessions. Although the measurement battery (pretest) in this study was completed prior to the eight sessions, the posttest took place at the end of the eighth session.

Most recently, Jang (2000) conducted group filial therapy training with mothers in Korea. Not unlike Kale and Landreth (1999), Jang had some scheduling challenges that led the author to condense the training time:

> Because mothers indicated they lacked the time to participate for 10 weeks, Landreth's (1991) 10-week filial therapy training model was shortened to 8 sessions for 4 weeks. The objective was to reduce the potential for drop-outs. (p. 42)

As pre- and post-training sessions were used for testing, as in the original 10-week model, this resulted in a total training time of 16 hours. The hypotheses of this study were similar to those of previous studies, namely that as a result of filial therapy training, parenting stress (as measured by the Parenting Stress Index [PSI]; Abidin, 1983, as cited in Jang, 2000) and perceptions of the number family interaction problems (as measured by the Filial Problem Checklist [FPC]; Horner, 1974) would decrease, whereas parental acceptance of (as measured by the Porter Parental Acceptance Scale [PPAS]; Porter, 1954) and empathy towards the child of focus (as measured by the Measurement of Empathy in Adult-Child Interactions Scale [MEACI]; Stover et al., 1971) would increase. A Korean translation of each of the measures was utilized. Interestingly, only one of the four hypotheses was upheld: parental empathy, alone, significantly increased in the experimental group. However, qualitative data gathered from phone interviews with participants in the experimental group following the study indicated that as a result of the filial therapy training, positive changes not only occurred in the parent-child relationship, but in other immediate and extended family relationships, as well.

These four studies have yielded mixed results in their attempts to condense Landreth's (1991) 10-week group filial therapy training model. Clearly, the two studies (Harris & Landreth, 1997; Jang, 2000) that doubled their weekly sessions (shortening the total number of weeks of training from 10 to 5 and 4, respectively) were less successful

than those that shortened only the total number of training hours (Kale & Landreth, 1999; Landreth & Lobaugh, 1998). Still, there were some statistically significant results in all four studies, with total training times ranging from 15, 16, and 17 hours to 20 hours. Each of these studies were conducted in either school or prison settings, and serve to highlight the challenges of theoretical application in applied settings where real-life constraints to academically-derived models often necessitate modifications. In light of the results of these studies, this study was comprised of one session per week over 8 weeks. Each of these sessions was reduced by 30 minutes from the 10-week model, resulting in 11 hours and 15 minutes of total training time (8 weeks at one and a half hours each week equals 12 hours, minus 45 minutes during the last half of the final session for posttesting).

Method

Sample

This study utilized a non-probability convenience sample drawn from the court-ordered population in southwest Virginia. There were a total of 8 participants—5 in the experimental group and 3 in the comparison group. The experimental group consisted of two divorced women, two single sisters, and a single male. In contrast, there was a married couple and a man separated from his spouse in the comparison group. The mean age of the participants in both groups combined was 28.6 years. However, due to outliers in each group (the youngest participant in the experimental group was 22, whereas the oldest participant in the comparison group was 33), the mean ages for the experimental and comparison groups were 27.4 years and 30.7 years, respectively. One quarter of the sample was African-American, while three quarters of the participants claimed Caucasian ethnicity. The mode for income was in the $0 to $9,999 range (reported by 5 participants). Two participants made between $10,000 and $19,999, and one participant earned $30,000 or more. The average education level was some high school; nevertheless, three participants completed high school, and one had an associate's degree. Three of the eight participants indicated that they had been abused and/or neglected as children. Only one of the eight participants claimed any use of alcohol or drugs.

With regard to the participants' role as parents, only one quarter of them had custody (one participant had shared custody) of their children of focus. The rest of the target children were in the care of relatives (three) or in foster care (two). Half of the participants reported that they had had an open case with Child Protective Services (CPS).

The participants' target children ranged in age from five to nine years, with the mode for age being six years. There were seven target children between the eight participants, as the married couple in the comparison group shared the same child of focus. Two of these children were girls, while the remaining five were boys. Four of the five participants in the experimental group shared that their target children had been diagnosed with ADHD. Two of these participants classified their children of focus as having 'special needs,' the other two did not.

Participation Criteria

In designing this study, certain criteria for participation were established in order to control for extraneous variables and have greater statistical control. The participant screening process was conducted by the agency with whom I partnered, Prevent Child Abuse Roanoke Valley (PCARV). Their primary objective was to serve as many clients as possible, not to conduct research. I helped them to meet this goal by leading a filial therapy group while I, in turn, gained access to participants for this study. McCollum and Stith (2002) have asserted that, "success in collaborating with community agencies requires that researchers be adaptable, deal with ambiguities, and develop creative solutions, even when such solutions seem outside the realm of what researchers 'ought' to do" (p. 6). In like manner, I quickly learned to be flexible and creative as I approached the criteria for participation: there were exceptions to many of them, as outlined below. The criteria included, first, that caregivers be either court-referred or court-mandated to participate in parent education services offered by PCARV because it was suspected or documented that they had either physically abused or neglected one or more of their children. This first criterion was met by all but one participant in the experimental group, who self-referred. The other seven participants were court-ordered to participate. Secondly, at least one child under the participants' primary care should be between the ages of 6 and 10 years. There were two problems with this second criterion. Because of the first criterion, three quarters of the participants had lost custody of their children and had only limited visitation rights, some of which was supervised. The other two participants had primary and shared custody, respectively. In establishing this criterion, I revealed my lack of experience with this population. In addition, although PCARV did organize their groups around the ages of participants' children (5 years and under, and 6 to 10 years) they inadvertently assigned a participant to my comparison group who had a 4-year-old and a 5-year-old. The third criterion was that participants be able to read and write the English language at a minimum third-grade level in order to be able to complete the measures for the study. This criterion was met by all the participants, in that each had a minimum tenth-grade education. Still, erratic responses on measures by at least one participant, Marcel, as outlined in the results section, did raise questions regarding his reading comprehension levels. Fourth, participants must be willing to attend all 8 weeks

of either the parent education course or the filial therapy training at the scheduled times. Because this study's design was based upon a modified group filial therapy model, reduced by both time per session and total number of sessions, this criterion was very important to me. However, perhaps because of their experience with the realities of social service work, PCARV allowed each participant to miss one of the eight sessions and still successfully complete the course. As a result, 7 of the 8 participants did miss one session. I worked with two participants, who missed the critical second session in which much foundational information was taught regarding the filial therapy skills, to make this up by coming early to the fourth and fifth sessions. The 8th participant completed four of the eight sessions, as discussed hereafter under the results. Fifth, participants must be willing to complete both pre- and post-measure research instruments. This criterion emerged from our focus group discussion as a negative aspect of this study for some experimental group participants. This was not surprising (as many participants do not relish this experience), and may help to explain why there were measures and anecdotal data sheets (from both groups) that were not completed, as well as some of both that were partially or carelessly completed. Again, inadequate literacy skills cannot be ruled out, either. Sixth, participants must be willing to sign the informed consent form. This criterion contributed to a reduced number of participants in the comparison group. I received pre-measure data and anecdotal data sheets that could not be used in this study because they were from participants in the concurrent parenting course who, even after several invitations, would not sign the informed consent form.

Two additional criteria were specific to the experimental group. Participants in this group must also be willing to participate in weekly caregiver-child play sessions between sessions 3 or 4 and 8, and to videotape at least one of these sessions during this time to be shared with the rest of the group. This criterion represented my naïveté with regard to the population from which the sample was drawn. The majority of participants in both groups did not have custody of their target children, and many had supervised visitation in settings that were not conducive to one-on-one filial play sessions with their children. As a result, the only video data of filial play sessions that was obtained during the group was from the one participant who had shared custody of her child of focus. Finally, experimental group participants must consent to have the focus group discussion

during the first half of the eighth session videotaped. Happily, none of the participants objected to this.

Procedure

In the Fall of 2000, arrangements were made by this study's author and a colleague to conduct filial therapy training groups concurrent with parent education classes offered by Prevent Child Abuse Roanoke Valley (PCARV). Data collection subsequently occurred during the Fall of 2001. In August and September, Roanoke-area court-referred and court-mandated parents were interviewed by PCARV agency staff. During these initial interviews, a short parenting history was obtained and parents paid their participation fees (as required by PCARV). In addition, parents were briefed about this study. Those who agreed to participate received copies of the measurement battery, which included the following self-report measures: a demographic data sheet, the Child Abuse Potential Inventory (Milner, 1986), the Parenting Stress Index Short Form (Abidin, 1995), the Parent-Child Relationship Scale (Pianta, 1992), and a PCARV parenting survey. The measurement battery was completed at the conclusion of the initial interview, with PCARV staff available to assist.

The parent education groups and the filial therapy training groups were conducted concurrently on eight consecutive Tuesday evenings, from October 2, 2001 to November 20, 2001 at a church in southwest Virginia. The groups met from 7 p.m. to 8:30 p.m., and childcare was provided by PCARV for the dependents of all participants. At the beginning of the first session, the informed consent form (see Appendix A) was reviewed with participants in both groups, any questions were answered, and the invitation to sign it extended. This procedure was briefly repeated two additional times prior to the second and third sessions in the comparison group, as there were those in this group who had agreed to participate in this study during the initial interviews but failed to sign the informed consent form during the first session. However, these efforts did not yield any additional participants. Prior to sessions one through seven, copies of an anecdotal data sheet were left with the parenting class facilitator along with instructions that participants in this study complete them at the end of each of these classes before leaving. These same anecdotal data sheets, with the addition of one question specific to the treatment model, were given to experimental group participants at the conclusion of the same

sessions with identical instructions. The remainder of sessions one through seven consisted of the modified filial therapy training for the experimental group, and the parenting course material for the comparison group. As court mandates necessitated some communication between myself and court-appointed representatives (mostly social service personnel), bilateral releases of oral and written confidential information were obtained from experimental group participants before any such contact was made (see Appendix B). Between sessions three and five, experimental group participants received a filial toy kit to use in play sessions with their target children. Parents who had custody of their children (n = 2) were given their filial toy kits following session three for use at home. Toy kits were taken to the agencies where parents who did not have custody of their children (n = 3) had their supervised visits between sessions four and five. Between sessions three and eight, two video cameras were also made available to experimental group participants in order that they might capture their filial play session experiences on film to later share with the rest of the group. Consent forms were also created for target children on which they could give their signed permission both to be videotaped and for segments of this footage to be shown to the experimental group. Two different forms were created that were identical except for the fact that one was for children of focus whose participating parent was their mother, and one was for children of focus whose participating parent was their father. Appendix C contains a copy of the consent form for target children whose participating parent was their mother. For the experimental group, the first half of session eight consisted of a videotaped focus group discussion, while the last half of the session was spent in participants completing the measurement battery, minus the demographic data sheet. Comparison group participants also completed the same measurement battery at the end of the final parenting class. A detailed outline of the experimental group's modified filial treatment, as well as the comparison group's parenting class, follows.

An 8-week Modification of Landreth's (1991) 10-week Model

The 8-week training model utilized in this study was a departure from Landreth's (1991) 10-week model. In his model, weekly sessions of two hours each are conducted over 10 weeks, for a total training time of 20 hours. Two additional sessions are also

scheduled (one prior to the beginning of the 10-week training, and one following the end of the 10-week training) for the administration of pre- and posttesting.

In part, the modifications made to Landreth's (1991) 10-week filial therapy model for this study were in response to procedures that PCARV uses to structure their parent education classes, one of which ran concurrently with the filial therapy group in this study and served as its comparison group. Historically, PCARV conducted 10-week parent education groups, but found that retention was difficult. They report that participant drop-out rates have been reduced since they abridged their 10-week groups into 8 weeks. For example, during the year 2000, over 80% of participants completed PCARV's 8-week parent education programming, yielding a drop-out rate of less than 20%. Another change that PCARV has made to which they attribute their increased retention is to charge each parent $10 per session. Hence, PCARV charged all participants in this study $80 for the eight sessions, which had to be paid prior to the first class or session. As the parent education groups already being offered by PCARV last for one and a half hours, one and a half hour group filial therapy training sessions were conducted in this study, instead of two-hour sessions. In addition, pre-measures were administered to all participants prior to the first class or session, while post-measures were completed during the last half (45 minutes) of the eighth session. This resulted in a total training time of eleven hours and fifteen minutes, compared to the 20 hours of training that is included in the 10-week model. In addition to the practical reasons for modifying the 10-week model into 8 weeks, such changes also served to extend the current research regarding condensation of filial training time (Rennie & Landreth, 2000).

The author also made some changes to Landreth's 10-week model that are reflective of the child development literature. The filial therapy literature indicates that filial therapy is generally appropriate for children between the ages of 2 or 3 and 10 or 12 years (Guerney & Guerney, 1987; Van Fleet, 1994). No reasons, theoretical or otherwise, are given for these age parameters. In fact, the ages of the children whose parents have received group filial therapy training in published group filial therapy studies have seemed somewhat arbitrary. In the first published group filial therapy training study (Stover & Guerney, 1967), the participants' children were between the

ages of 5 and 10 years. Since that time, the ages of participants' children in published group filial therapy training studies have varied widely between 4 and 8 years (Glazer-Waldman et al., 1992; Landreth & Lobaugh, 1998), 3 and 7 years (Bratton & Landreth, 1995), 2 and 9 years (Chau & Landreth, 1997), 3 and 10 years (Harris & Landreth, 1997), 4 and 10 years (Costas & Landreth, 1999), and 4 and 9 years (Jang, 2000). It is noteworthy that one of the most recently published group filial therapy training studies (Kale & Landreth, 1999) did not even give the ages of the participants' children. In addition, there are no published group filial therapy training studies with caregivers of children older than 10 years of age.

In contrast to filial therapy studies, research in child development does not perceive the variable of a child's age as arbitrary. The age span from 2 to 12 years encompasses multiple stages of development, as well as increased cognitive, emotional, physical, and social skills with age. The child-centered imaginary play skill, with its accompanying filial toy kit, provides an example of the developmental disparity between the ages for which filial therapy has been deemed appropriate, and the way the skill is outlined and taught. Regardless of the age of the child, filial therapy prescribes a specific list of toys (a toy kit) that are to be procured by parents and used only during weekly parent-child play times. Toys are selected to elicit a particular type of play from children, symbolic play, and use of these toys only during weekly parent-child play sessions is intended to render this time special. According to Piaget, children's development is reflected in the different kinds of play that are dominant as they grow (Piaget, 1951/1962). While the various types of play do not disappear from a child's repertoire, they do become less prominent as a child develops and plays in new ways (Rogers & Sawyers, 1988). With regard to filial therapy, of particular interest is the classification of children's play between the ages of 2 and 12. Piaget indicated that children between the ages of 2 and 7 primarily engage in symbolic play, whereas 7- to 12-year-old children prefer games with rules (Piaget, 1951/1962). It follows that different kinds of toys elicit different types of play, and are therefore more or less developmentally appropriate for children, depending upon their age (Rogers & Sawyers, 1988). Because the target children in this study were between the ages of 5 and 9 years, the author made some developmental changes to Landreth's model, which are outlined hereafter.

The first session in the 8-week model was very similar to the original model. Participating parents introduced themselves, their families, and their children of focus. The facilitator then explained the goals and objectives of filial therapy (see Appendix D), and caregivers were instructed to conduct weekly play sessions only with their target children:

> Special times of another nature, baking cookies, etc., are arranged for other children in the family. Initially, parents typically want to have play sessions with all their children and, when allowed to do so, soon find their schedules too hectic to maintain their original commitment and become inconsistent in carrying through with the special play times (Landreth, 1991, p. 345).

Because the primary goal of filial therapy is to strengthen the caregiver-child relationship, the empathic listening skill is the focus of the first session in the 10-week model, and is both taught and role-played. This was true of the modified 8-week model, as well. A developmental extension of the 8-week model was that caregivers were taught to tune in to both the verbal and body language that their target children use when they are experiencing and expressing a wide range of emotions. This is in contrast to the 10-week model, in which caregivers are taught to identify four primary emotions (anger, happiness, sadness, and surprise). The former is developmentally more appropriate for older children, who have a larger feelings vocabulary than do younger children. The homework for this session was for parents to identify (both body and verbal language) at least four emotions that their target children expressed during the week, and then offer empathic responses to each and write them down to share with the group. Handouts included a worksheet to help with the homework assignment, and a parent's own description of empathic listening (from a prior pilot study conducted by the author and colleague, Dr. Katherine F. Walker). Some handouts were created by the author and/or her colleague; others were used by permission (G.L. Landreth, personal communication, October 25, 2001). Copies of session handouts are provided in Appendix E.

As per the 10-week model, session two began with a discussion of the homework, and a review of the empathic listening skill. Two handouts were used for this, one created by the facilitator which reviews the principles of the empathic listening skill, and a second which gives statements made by children with blanks for parent responses. The

child-centered imaginary play skill was then taught. A videotape of Landreth playing with a preschool child was also shown to demonstrate the empathic listening and child-centered imaginary play skills in the context of an actual play session (Landreth, 1997). With regard to child development, it was not only child-centered imaginary (symbolic) play that was discussed, but also games with rules play, so that parents had an understanding of how children's play changes as they grow. Challenges to playing, in general, and games with rules play, specifically, were also covered. For example, one of the things caregivers are encouraged not to do during special caregiver-child play times is teach or preach. However, because adult play is very 'by the book' (Caldwell, 1985), it was anticipated that it would be tempting for caregivers to impart of their knowledge of game rules during their play times with their children. Therefore, caregivers were taught how to follow their children's lead, even in games, and to allow their children's 'making up' and changing of game rules to be a part of this special time. Parent homework for this session, in accordance with the 10-week model, was for them to decide where in their home they would conduct their weekly caregiver-child play sessions. Three of the five participants who began the group did not have custody of their children, and had supervised visitation at a social service agency, which posed challenges to conducting filial therapy sessions with their children. Following the second session, and sessions three through seven, parents who did not attend were contacted by phone, and an invitation for continued participation was extended. However, similar to Landreth's (1991) 10-week model, which closes groups to new participants after the second session, this study did not allow new participants to join the group after the first session. In other words, only those participants who attended the first session of filial therapy training, but subsequently missed a session, were contacted. PCARV allowed participants to miss one session and still successfully complete the group.

In accordance with the 10-week model, the limit-setting and structuring skills were taught during session three of the 8-week model. The main developmental difference with this model was that caregivers were taught to use related sanctions or consequences (Piaget, 1932/1965) in setting limits. In Landreth's (1991) filial therapy model, the consequence for not observing a limit (the third step of the limit-setting skill) is always cessation of the play session until the following week. This may be viewed as a

punishment by the child, especially if it seems unrelated to the limit that has been disregarded. Punishment and rewards lead to heteronomy, or a "morality of obedience" (Kamii, 1984, p. 12), not allowing the child to develop autonomy or self-governance. In contrast, "related consequences…provide the answer for effective immediate results that are compatible with long-term positive outcomes" (Fields & Boesser, 1998, p. 157). For example, if a child breaks a toy during the play session, the natural consequence of this is that the child is no longer able to play with it. In addition, the related sanction of restitution could also be applied to this situation, which means that the child would need to find a way to repair or replace the broken toy. The facilitator created a handout that explained the five different types of consequences, as well as one that outlined the three steps of the limit-setting skill. In addition, participants received a third handout that listed what to do and what not to do during a filial play session.

The balance of the third session was spent reviewing the play skill and introducing parents to their filial toy kits. In the 10-week model, it is during session two that caregivers are given a list of toys to purchase and bring to the following session. In contrast, the filial toy kits were modified to include games with rules toys for the 8-week model (see Appendix F), and were provided to parents in the experimental group of this study. The toy kits were used to demonstrate and role play during the third and fourth sessions. Prior to having their first play session, parents were instructed to make a sign with their child of focus to hang outside the room or area where their play sessions would be held. This sign was an indication to others that a play session was in progress and that the participants were not to be disturbed.

Following the third session, the two parents who had custody of their children were given their filial toy kits and invited to conduct their first half-hour parent-child play session before our next group. They were also asked to videotape their play sessions to share with the group the following week. Two used video cameras (purchased by the facilitator from a pawn shop) and videotapes were made available to participants for this purpose. The other three parents seemed to need further practice with the four filial therapy skills, and so their filial toy kits were retained by the facilitator.

The majority of session four was spent reviewing the play skill through role playing. In most cases, the facilitator played the role of the child, and the parents

alternated playing the parent role. No videotaped sessions were available for viewing because one of the parents was sick and did not attend that week, and the other had been unsuccessful in conducting her first play session with her daughter. Between the fourth and fifth sessions, the remaining filial toy kits were transported by the facilitator to the social service agencies where the other three parents had their supervised visits.

Session five was spent reviewing the videotape of one of the participants, and processing it as a group. By this session, it was clear that this participant, who had custody of her child of focus, might be the only participant who would be able to provide videotaped material for the group. Various constraints for those parents who did not have custody of their children made both conducting and videotaping filial play sessions very difficult. Because videotapes of parents' play sessions with their children are intended to provide the primary material for sessions four through nine in the 10-session model (and sessions five through seven in the 8-week model), significant adjustments to the training became necessary.

Choices, consequences, and discipline were the primary themes for session 6, and included the viewing of the videotape, *Choices, cookies, and kids: A creative approach to discipline* (Family Care Productions, 1996), which Landreth also includes in facilitating his 10-week model. This session was intended to help parents extend filial therapy's limit-setting skill and generalize it outside of the weekly play sessions. Handouts for this session included several that reviewed basic principles of play and filial therapy, as well as one that outlined two practical discipline techniques.

The first few minutes of the seventh session were spent reviewing what had been discussed the previous week, and sharing two additional handouts with participants that are focused on what to do when things are not going well in the parent-child relationship, in or out of a filial therapy session. Then the participant who had shared video footage during our fifth session shared additional footage with the group, which was followed by group process. The balance of the seventh session was spent playing a game, in a television game show format, that the facilitator created. The game was developed for two reasons. First, the participants in this study primarily had target children who were in the games with rules developmental play stage. Secondly, these parents seemed to struggle to learn the filial therapy skills, especially because several of them were not able

to apply them in formal filial therapy sessions. Participants were divided into two teams of two participants each, and each team had an opportunity to answer questions that were worth either $100, $250, $500, or $1000. There were four categories named for each of the four filial therapy skills, and each category had one question with each of the four monetary values, for a total of 16 questions. For a copy of these questions, please see Appendix G. In keeping with the playful focus, pretend money was used to reward the two teams for questions that were answered correctly. Of course, non-monetary recognition, such as through certificates of participation, could be incorporated into the game instead of the play money.

Session ten of the 10-week model is traditionally a closure session, during which participants share their impressions of the training, and the changes that have taken place as a result of it, particularly in their caregiver-child relationship. Following this lead, the first half (45 minutes) of the final session of this study's 8-week model consisted of a focus group. Participants were videotaped as they shared feelings and experiences they had had in filial therapy training and with their children of focus. The last half of the session was spent administering the posttest measures. At the end of session seven, participants were invited to bring food to the last session as a way of celebrating their achievement in finishing the group, and to make the completion of the posttest measures less tedious. Everyone forgot to bring something but the facilitator. She brought Oreo™ cookies, which the participants seemed to enjoy, because several of them had really liked Landreth's Oreo Cookie theory (taught in session 6).

One of the additions to this model was that parents in both the experimental and comparison groups were asked to complete a short response form at the end of sessions one through seven. An example of one of these is provided in Appendix H. This form invited parents to rate (on a scale from 1 to 10) their level of parenting stress during the previous week and the quality of their parent-child relationship. In addition, they were to list the information taught during that night's session that they felt they would actually use. Finally, at the end of sessions four through seven, this form also included a question for the experimental group about which toys in the filial toy kit were used during the previous week's parent-child play sessions.

PCARV's 8-week Parent Education Classes

Although previous empirical research on group filial therapy training has primarily utilized a no-treatment control group, this is not an appropriate design for the court-mandated population from which this study's sample was drawn. The legal system generally dictates a window of time during which such clients are to seek and either complete or show consistent progress towards the completion of treatment and/or services. Accordingly, this study utilized an alternative treatment comparison group, comprised of a parent education curriculum implemented by the staff of Prevent Child Abuse Roanoke Valley (PCARV). It is designed for two groups of parents: those with children under 5 years of age, and those with children between the ages of 6 and 10. Parents with children in the latter age range were included in this study's sample; hence, the corresponding curriculum for children in this age-range was taught. This curriculum was presented in a group setting over 8 weeks, concurrent with the filial therapy group that was conducted by this author. A brief synopsis of this program is provided below.

The format of these parent education classes is primarily didactic, and focuses on a variety of topics that are taught through lecture, handouts, videos, and discussion. Each class begins with an icebreaker, which consists of one to two short-answer statements that participants are to complete. For example, the topic for the fifth class is stress and anger. Caregivers are asked to finish the following two sentences: "When I'm angry, I usually…" and "One way I'd like to express my anger is to…."

The first class involves introductions and orientation to the curriculum, followed by the presentation of a video about alternatives to physical punishment. The remainder of the time is centered on the topic of children's needs (including mental, physical, spiritual, and leisure). The class ends with the presentation of a video about noticing what children do right.

The topic for the second class is the child development of middle childhood, focused specifically on 6- to 10-year-olds. Social and emotional development are covered, and information about ADHD is also given. The final activity is a video that addresses typical interactional patterns for children in this age group. One of the primary goals of this class is to help caregivers adopt developmentally appropriate expectations of their children.

During the third class, caregivers are presented with a variety of topics that are issues for school-age children, including peer pressure, power struggles, and teasing. Communication tips are shared, and information about the emotional and physical health of school-aged children is also given. The video that concludes this session is about how caregivers can assist their children in resisting peer pressure.

Supervision and safety are the topics for class four. Caregivers are given criteria for judging whether or not their children are safe. In addition, television as a form of supervision is discussed. Finally, consequences for children being home alone are outlined.

The fifth class centers on stress and anger. First stress is defined. Then ways of both avoiding and controlling stress are discussed. In talking about anger, it is emphasized that it is not bad to feel angry, but that anger can lead to negative consequences. Class members are invited to think of ways to handle their anger. If there is time at the end of the class period, a visualization activity is incorporated.

Both the sixth and seventh classes are focused on discipline. The included topics range from rewards and punishments, to time outs, rules, and limits. The first of these classes emphasizes the importance of discipline with children, and the second class follows this up by presenting different discipline techniques. Most of the techniques shared are behavioral.

The eighth and final class serves several purposes. First, participants watch a video on strengthening their children's self-esteem. Then they are invited to complete the same PCARV parenting survey that they did in their initial interviews. The class ends with the presentation of certificates of completion and a party.

As can be seen from the preceding outlines, the 8-week filial therapy training that was conducted by the author and the parent education classes that were presented by PCARV are each unique in several ways. One difference is with regard to format, and the second relates to content. The parent education classes are primarily didactic in nature, whereas filial training combines both didactic and hands-on methodologies. There is extensive literature in a number of fields indicating that information is retained better and longer if it is learned through a number of different senses and if it is applied. Hence, it was expected that the filial therapy training would be more effective overall than the

parent education classes. Secondly, the parent education classes are topic-focused, whereas filial therapy training centers on skills. This relates to the first difference between these two treatments, outlined above. Some of the same topics (such as limit-setting) were addressed by both modalities, but in the filial therapy model these topics were discussed in the context of parents actually applying the skills they were learning in their relationships with their own children. Again, it was predicted that filial therapy training would prove more effective than the parent education classes because it incorporates the application of knowledge learned. Third, the parent education classes were led by rotating agency volunteers, whereas the filial therapy training was conducted by the same facilitator every week (a trained clinician completing her doctorate). Regardless of differences which may have existed in the training and experience of each group's facilitators, which is a topic that has yielded mixed outcomes in empirical research (Bergin & Garfield, 1993), it would be reasonable to assume that the filial therapy group would be more effective than the parent education classes by virtue of the fact that one consistent facilitator could establish a better join with the participants than several rotating ones. There is a fourth, and perhaps more fundamental, difference between these two treatment modalities. While the clients in the parent education classes appear to be the parents, in the filial therapy model the caregiver-child relationship is the client. Hence, it was expected that as a result of focusing on this relationship in filial therapy training, greater reductions in participants' child abuse potential and parenting stress would be observed than in the parent education classes. In addition, the strength of the parent-child relationship for parents in the filial therapy training was expected to increase more than that of participants in the parent education classes.

Measures

Due to the high drop-out rate of the court-referred/court-mandated population from which this study's sample was drawn, great care was taken in the selection of measures so as to maintain the highest quality, while also being mindful of the importance of economy. For this reason, the author chose to use the following measures to investigate the variables of physical child abuse potential, parental stress, and the parent-child relationship: The Child Abuse Potential Inventory (Milner, 1986), the Parenting Stress Index Short Form (Abidin, 1995), and the Child-Parent Relationship

Scale (Pianta, 1992). PCARV also administers a parenting survey as part of its programming, consisting of 15 multiple-choice questions primarily related to general child development knowledge, discipline, and safety. Comparison of pre-/posttest scores is used to document the effectiveness of their parent education. Because of the partnership with PCARV for this study, this parenting survey was included, but not analyzed. A copy of the full measurement battery is provided in Appendix I. With the exception of the demographic data sheet, which was only given at pretest, each of the measures was completed during participants' initial interviews and again at the conclusion of the eighth session. Additional data collected, including information gathered from the anecdotal data sheets, will be discussed as it pertains to each of the variables.

Demographic Data

This is the sole information that was gathered at pretest only. The Prevent Child Abuse Roanoke Valley (PCARV) agency, with whom the author partnered for this study, collects demographic data on all of its participants in both survey and interview formats. This information includes the race, gender, age, number of people in the household, household income, city/county of residence, and drug and alcohol use for each participant. In addition, participants are asked about the following: age and gender of their child(ren), who has custody, concerns they have about their child(ren), whether they are concerned about one child over another, whether they have a child(ren) with special needs, how their relationship is with their child(ren), and if there are outside factors that affect their parenting. Finally, there are several questions regarding why they are enrolling in the parenting course, their own abuse/neglect histories as children, and whether they have ever had an open case with Child Protective Services. One of PCARV's conditions for collaborating on this study, in order to save time and decrease participant test fatigue, was that the demographic data they collect be used for this study, as well. To this end, it was agreed that no additional information sheets or sets of demographic questions would be constructed or administered. All of the demographic data was kept confidential during the data collection phase of the study, in order that this information might be used to personalize the filial therapy training, and so that participants could be contacted for various reasons over the course of the group (e.g., if

they missed a session). Because of the mixed method design of this study, which included qualitative components, each participant's demographic information and pre- and post-measures were not coded during analysis but kept confidential. While writing up the results, each of the participants', as well as their children's', names were changed in order to protect their privacy.

Child Physical Abuse Potential

The Child Abuse Potential Inventory (CAP Inventory; Milner, 1986) was the sole instrument used to measure participants' child physical abuse potential. It was developed as a screening measure for this purpose (Milner, Charlesworth, Gold, Gold, & Friesen, 1988), and has come to be regarded as the premiere inventory in the child physical abuse and neglect literature. Multiple studies have proven this measure's effectiveness in distinguishing physical abusers from nonabusers (Milner, Gold, & Wimberley, 1986; Milner & Wimberley, 1979; 1980).

Composed of various validity scales and indices, an Abuse scale, six factor subscales, and two special scales, the CAP Inventory is a 160-item self-report measure. It utilizes a bipolar forced-choice response set, meaning that those who complete the instrument are instructed to indicate whether they agree or disagree with each item by circling either "A" for agree or "DA" for disagree. Although fairly long, it is appropriate for a wide range of ages and education levels, as it has been assessed at a third-grade reading comprehension level (Monroe & Schellenbach, 1989).

The first step in analyzing CAP Inventory scores is to determine if a respondent has left any items blank or marked any items twice (by circling both "A" and "DA"). Such items are treated as nonscorable. If any scale contains more than 10% of such responses, it is considered invalid. However, if the Abuse scale contains less than 10% of these nonscorable responses, then the Abuse scale score can be prorated. "The recommended proration procedure is to assign to each missing response a score equal to the mean item score for the Abuse scale" (Milner, 1986, p. 10). As this study's CAP Inventories were analyzed with the aid of a computer scoring program developed specifically for this measure, the process of proration occurred automatically.

Next, the six scales and indices designed to assess the internal validity of responses given on the Abuse scale must be examined. There are three validity scales,

including a Lie scale (18 items), a Random response (RR) scale (18 items), and an Inconsistency (IC) scale (comprised of 20 item pairs). These scales represent three of the most common response distortions. In the case of the Lie scale, there appears to be a correlation between scores on this scale and education (Milner, 1986). Because the mean education level for participants in this study was some high school, the cut-off for these participants was raised by one point, as recommended by the measure's manual (Milner, 1986). If none of the validity scales are elevated, then one can feel confident that the Abuse scale has not been disturbed by them. However, if any one of them is above its established cut-off score, then the response distortion indices should also be calculated. There are three of these, as well: a Faking-good index, a Faking-bad index, and a Random response index (Milner, 1986). Each of these indices is a combination of scores on two of the validity scales. The Faking-good index is composed of the Lie scale and the Random response scale, whereas the Faking-bad index and the Random response index are both comprised of the Random response scale and the Inconsistency scale (different cut-offs are used for these last two indices). Generally, if any one of these indices is elevated, then the Abuse scale score is considered invalid. However, there are two exceptions. The first is if a participant has both an Abuse scale score and a Faking-good index score that are elevated. "While the elevated Abuse score might still be higher if the examinee was not faking-good, the fact that an elevated Abuse score was obtained despite attempts to distort responses in a positive manner permits use of the Abuse score for classification purposes" (Milner, 1986, p. 11). The second situation is if an Abuse scale score is below the cut-off, while the Faking-bad index is high. "In this case, the Abuse score is in a normal range despite attempts on the part of the examinee to present him/herself in a negative manner" (Milner, 1986, p. 11) and should be interpreted.

The 77-item Abuse Scale is the heart of the CAP Inventory, and once it has been determined that this score is valid, it can be utilized for classification of participants with regard to their child physical abuse potential. Two cut-off scores have been established for this scale. For purposes of this study, the more conservative of these two cut-off scores was employed in order that the number of false positive classification be reduced. A participant score above this cut-off not only "indicates that the examinee has characteristics similar to known, active physical child abusers" (Milner, 1986, p. 12), but

also that there is a need for further evaluative data to corroborate with this finding. When a participant score is below the cut-off, it is considered in the normal range.

Six factor scales also capture different dimensions of the Abuse scale: Distress (36 items), Rigidity (14 items), Unhappiness (11 items), Problems with child and self (6 items), Problems with family (4 items), and Problems from others (6 items). The first three factor scales explore psychological difficulties, while the last three investigate interpersonal problems (Milner, 1986). An elevated score on any of these subscales suggests factors that may be contributing to the overall Abuse score, thus rounding out the participant's abuse profile. However, "normal range and elevated factor scores should only be employed for descriptive purposes and for the formulation of tentative clinical hypotheses about the examinee" (Milner, 1986, p. 13).

The Abuse Scale is the most widely-used component of the CAP Inventory, and boasts superlative reliability:

> Milner (1986) reports CAP Abuse scale reliabilities (KR-20s) that range from .91 to .96 for a variety of control, at-risk, neglect, and abuse groups, and test-retest reliabilities from .91, .90, .83, to .75 for control subjects across 1-day, 1-week, 1-month, and 3-month intervals, respectively. (Milner et al., 1988, p. 282)

In addition, split-half reliability for the Abuse scale is between .96 and .98 (Milner, 1986).

The remainder of the measure consists of two special scales, a 40-item Ego-strength scale and a 15-item Loneliness scale. These were not analyzed as a part of this study. Due to the length of this measure, a breakdown of the items on each scale, subscale, and index is provided in Appendix J.

Parenting Stress

Research indicates that there is a positive correlation between stress and child abuse potential (Holden, Willis, & Foltz, 1989). The Parenting Stress Index/Short Form (PSI/SF; Abidin, 1995) was chosen as the primary measure of participants' stress related to their roles as parents. Recent empirical filial therapy studies have used the Parenting Stress Index (PSI) to measure parenting stress with a variety of parent populations (Athanasiou & Gunning, 1999; Bratton & Landreth, 1995; Chau & Landreth, 1997; Landreth & Lobaugh, 1998). Hence, use of the PSI in this study was designed to yield

results that could be compared with previous filial therapy studies on the parenting stress variable. As the PSI/SF was developed from the PSI, a short description of the PSI is given, followed by a more comprehensive overview of the PSI/SF.

The Parenting Stress Index, Third Edition (PSI; Abidin, 1995) contains 120 self-report items that identify problematic parent-child interactions that may put the child at risk for emotional disturbance. Each item is scored on a 5-point Likert-type scale. The measure is divided into two domains. The child domain consists of 47 items with six subscales including: Adaptability, Demandingness, Mood, Distractibility, Hyperactivity, Acceptability, and Reinforcement of the Parent. The parent domain has 54 items divided into seven subscales: Depression, Competence, Attachment, Spousal Support, Health, Role Restriction, and Social Isolation. In addition, there is an optional Life Stress scale. Cronbach's alphas for the child and parent domains are .90 and .93, respectively. The scale as a whole yields a Cronbach's alpha of .95. The reported alphas for the individual subscales are lower, ranging from .70 to .83 for the child subscales, and from .70 to .84 for the parent subscales. Test-retest reliability for the Life Stress scale ranges from .65 at 1 year follow-up to .96 at 1-3 month follow-up (Allison, 1998).

The Parenting Stress Index/Short Form (PSI/SF; Abidin, 1995) represents an improvement over the original measure because it is shorter (thus reducing time to administer and score it, and minimizing test fatigue), while also maintaining statistical robustness. Abidin (1995) reports a .94 correlation between the PSI/SF and the original PSI. Because of these strengths, the PSI/SF was chosen over the PSI for use in this study.

The PSI/SF "was designed to identify parent-child systems under stress, as well as specific sources of stress" (Sheeran, Marvin, & Pianta, 1997, p. 203). It consists of 36 items and three subscales, including Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC). Scores on each subscale are obtained by summing the responses given to each item on the subscale. As with the original PSI, parents respond to a 5-point Likert-type scale on the PSI/SF that is a range of agree and disagree responses (Strongly Agree, Agree, Not Sure, Disagree, Strongly Disagree) and numbers. The measure is administered with a carbon between the response and scoring sheets, such that all responses are automatically converted to their corresponding numbers for scoring. Items are written from a negative perspective, so that agreement

with them yields higher scores, whereas disagreement yields lower scores. In addition, by summing the three subscales together, a Total Stress score may be obtained. This scale measures the overall parenting stress of a participant, and does not examine stresses associated with other roles and areas of a participant's life. Raw scores on each subscale and the Total Stress scale are converted to percentile ranks, which are plotted in order to see patterns in a participant's profile. The normal range is between the 15th and 80th percentiles. Converted scores at or above the 85th percentile are considered high. A Total Stress score at or above the 90th percentile represents clinically significant parenting stress levels.

The Parental Distress (PD; items 1 through 12) subscale includes items such as, "I feel trapped by my responsibilities as a parent," and "There are quite a few things that bother me about my life." This subscale is a function of personal factors: "impaired sense of parenting competence, stresses associated with the restrictions placed on other life roles, conflict with the child's other parent, lack of social support, and presence of depression" (Abidin, 1995, p. 55). The Parent-Child Dysfunctional Interaction (P-CDI; items 13 through 24) subscale captures the perceived discrepancies between parental expectations and the realities of their relationships with their children, with items such as, "My child is not able to do as much as I expected," and "I expected to have closer and warmer feelings for my child than I do and this bothers me." The Difficult Child (DC; items 25 through 36) subscale reflects the degree to which parents perceive their children as being more or less difficult than other children, through questions such as, "My child seems to cry and fuss more than most children" and "My child is so active that it exhausts me."

Originally normed on a sample of 800 Caucasian mothers, the PSI/SF yielded alpha coefficients of .87 for the Parental Distress subscale, .80 for the Parent-Child Interaction subscale, and .85 for the Difficult Child subscale (Abidin, 1995). The corresponding alpha that was reported for the Total Stress scale was .91 (Abidin, 1995). Test-retest coefficients for the three subscales and the Total Stress scale were, respectively, .85, .68, .78, and .84 (Abidin, 1995). Since its introduction, the PSI/SF "has been validated for use with both…[Caucasian] and ethnic minority families, and includes national norms" (Deater-Deckard & Scarr, 1996). The PSI/SF has been normed on

lesbian and single mothers (Golombok, Tasker, & Murray, 1997), African American mothers (Bhavnagri, 1999), teenage mothers (Nitz, Ketterlinus, & Brandt, 1995), substance-abusing mothers (Kelley, 1998), mothers sexually abused as children (Douglas, 2000), dual-earner mothers and fathers (Deater-Deckard & Scarr, 1996), and grandmothers (Musil, 1998). In addition, normative data on the PSI/SF is available for parents of children with specific presenting medical and psychological diagnoses, including ADHD (Harvey, 1998), brain tumors (Radcliffe, Bennett, Kazak, Foley, & Phillips, 1996), cerebral palsy (Button, Pianta, & Marvin, 2001; Weiss, Marvin, & Pianta, 1997), leukemia (Kazak & Barakat, 1997; Kazak et al., 1996), and various disabilities (Miller, Cate, & Johann-Murphy, 2001; Smith, Oliver, & Innocenti, 2001; Wolf, Fisman, Ellison, & Freeman, 1998).

For this study, an additional source of data regarding participant parenting stress was gathered from a single question which was asked of participants following sessions one through seven. This question was one of four asked of experimental group participants, and one of three asked of comparison group participants as part of an anecdotal data sheet. Participants were instructed to "circle the number that best describes your stress level as a parent over the past week." Below this statement, the numbers 1 through 10 were listed, with the notations "worst ever" under the number 1 and "no stress" under the number 10. This data was used to expound upon pre-/post-measure data collected on the PSI in creating profiles for each participant.

Parent-Child Relationship

The Porter Parental Acceptance Scale (PPAS) (Porter, 1954) and the Measurement of Empathy in Adult-Child Interactions Scale (MEACI) (Stover et al., 1971) are the measures of choice that have been utilized in previous filial therapy research to document changes in the parent-child relationship as a result of filial therapy training. In these studies, a strong parent-child relationship has been conceptualized as a combination of accepting parental attitudes towards their children and parental empathy actually expressed to their children. Due to limited and dated normative data available on these two instruments, a more current instrument that succinctly captures multiple aspects of the caregiver-child relationship was selected for this study.

The Child-Parent Relationship Scale (CPRS) (Pianta, 1992), and its corollary, the Student-Teacher Relationship Scale (STRS) (Pianta, 1992) both have a theoretical foundation in the attachment research from the child development literature. In essence, this research indicates that securely attached children have greater success intellectually and socially than do insecurely attached children (Pianta, 1996). Because physically abused and neglected children have attachment and other relationship difficulties with their maltreating parents, the CPRS seemed appropriate for this investigation.

Both a 33-item and a 30-item version of the CPRS exist. The 30-item version was used for this study. It is comprised of three subscales: A Conflicts subscale, a Positive aspects of relationship subscale, and a Dependence subscale. Each item has a 5-point Likert-type response set, ranging from 1 (Definitely does not apply) to 5 (Definitely applies). Scores for each subscale are obtained by summing the numeric response chosen for each item. As the scale is intended to be used descriptively and not for diagnosis or categorization, there are no cut-offs or ranges (R.C. Pianta, personal communication, March 12, 2003). Instead, each subscale is scored continuously, and scores are interpreted with regard to where they fall in the total score range for each subscale. There are no reverse-scored items. Each item is worded so that lower range scores on a subscale are indicative of less construct presence in the parent-child relationship (i.e., less conflict, positive aspects, or dependence), whereas higher scores on a subscale point to more construct presence in the parent-child relationship (i.e., more conflict, more positive aspects, more dependence). The Conflicts subscale contains items 2, 12, 14, 17, 18, 19, 21, 23-25, and 27-28. Its score range is between 12 (low) and 60 (high), with 36 at the mid-range. The Positive aspects of relationship subscale has a score range of 10 (low), 30 (middle), and 50 (high). It includes items 1, 3, 5, 8, 10, 13, 16, 22, and 29-30. The smallest of the three, the Dependence subscale, is comprised of items 6, 9, 11, and 26. The lowest and highest possible scores on this subscale are 4 and 20, respectively, and 12 is at the middle.

The STRS has been published, whereas the CPRS has not. Still, these two measures share developmental histories, as evidenced by the fact that the current 28-item STRS is virtually identical to the 30-item CPRS, with two exceptions. First, items that include the phrase “this child” on the STRS have been modified to “my child” on the

CPRS. In addition, the phrase "as a parent" was tacked on to the end of item 28 on the STRS (which is item 30 on the CPRS) when it was added to the CPRS. On the CPRS, this item now reads, "My interactions with my child make me feel effective and confident as a parent." Secondly, two items (7 and 26 on the CPRS) that are not on the STRS have been added to the CPRS and read, "My child does not want to accept help when he/she needs it" and "I often think about my child when at work."

In his scoring guide for the CPRS, Pianta (personal communication, September 4, 2001) reports that this measure was originally normed on the parents of 714 children between the ages of 4 and 5, and yielded alphas for each of the three subscales (Conflicts, Positive aspects of relationship, and Dependence) of .83, .72, and .50, respectively. While compiling the results of the current study, communications with Kate Driscoll, one of Pianta's graduate students, revealed that the CPRS had been subsequently used in a National Institute of Child Health and Human Development (NICHD) study Pianta conducted beginning in 1995 (K. Driscoll, personal communication, March 2003). Data was collected at ten sites nationally, including: Little Rock, Arkansas; Irvine, California; Lawrence, Kansas; Boston, Massachusetts; Morganton, North Carolina; Philadelphia, Pennsylvania; Pittsburgh, Pennsylvania; Seattle, Washington; and Madison, Wisconsin. Mothers (14% of whom were single) of 1,364 children (76% of whom were Caucasian) completed the CPRS when their children were in kindergarten, and then a year later when they were in first grade. The mothers' average education level was 14.4 years; still, 11% of the mothers did not complete high school. The mean family income for the participants was 3.6 times the poverty threshold.

An updated version of the CPRS, revised on July 5, 1995, was used for this NICHD study. Although this author communicated directly with Pianta (personal communication, September 4, 2001) regarding access to and permission to use the CPRS, she was not given this updated version. It is unclear whether this was simply an oversight, or whether the revised CPRS was not released because the NICHD data had not yet been analyzed. Those interested in conducting research with the CPRS are alerted to several differences between the 1992 and 1995 versions of this instrument. Both contain the same 30 items, with minor changes in wording. However, the 30-item 1995 version is now considered the long form, so there is apparently a shorter form that also

exists. A primary difference between the two measures is that the Dependence subscale has been dropped, as this construct was not validated with the kindergarten and first-grade sample as it had been with the original 4- and 5-year-old sample. In addition, the names of the remaining two subscales have been modified and now match the corresponding subscales of the STRS, namely Conflict and Closeness. In terms of scoring, item 18 is no longer included in the Conflict subscale, while item 20 has been added and is reverse-scored. Similarly, item 4 has been added to the Closeness subscale, and is also reverse-scored.

Returning to the parent-child relationship variable in the current study, an additional question was asked of participants regarding their parent-child relationship as part of an anecdotal data sheet administered following sessions one through seven. This question was virtually identical in both wording and response format to the parenting stress question and read, "Circle the number that best describes your relationship with your child over the past week." Again, participants were to rate their parent-child relationship on a scale from 1 to 10. Only the numbers 1 and 10 were described as representing "worst ever" and "best ever" relationships, respectively. This information provided subjective support for the quantitative data gathered from the CPRS with regard to the parent-child relationship and contributed to the formation of tentative participant profiles.

Additional Data

In addition to the quantitative measures and anecdotal data already outlined, supplementary sources of data were utilized to expand the profiles of participants. The first of these was a focus group conducted during the first half of the eighth session with the experimental group. The focus group discussion lasted approximately 40 minutes, and was with four of the five participants who originally began the filial therapy group: Connie, Latoya, Marcel, and Raquira. It was videotaped for later transcription and coding. Guiding the discussion were questions developed by colleague, Dr. Katherine F. Walker, who conducted a filial therapy group concurrent to this study with parents of younger target children (five years and under). Appendix K contains a copy of these questions.

A second source of additional data collected was the video footage of filial play sessions between experimental group participants and their target children. Three of the five participants in the experimental group (Latoya, Marcel, and Raquira) did not have custody of their children, and the settings for their supervised visits were not conducive to filial play sessions. One of the participants (Jacqueline) who did have custody of her child of focus only attended four of our eight sessions, and her daughter was resistant both to the play sessions and to the videotaping. In short, only one participant (Connie) conducted filial play sessions and was able to videotape them. Due to technical difficulties in videotaping, only two of these play sessions were shared with the group, during our fifth and seventh sessions.

Triangulation of data was made possible not only through quantitative (the measurement battery) and qualitative data (the focus group and video footage), but also through anecdotal data (gathered following sessions one through seven), in-session observations and notes, out-of-session phone calls with participants and their social workers, personal visits with participants' social workers, and attendance sheets.

Two questions were asked of participants on the anecdotal data sheets that were not subsequently included in the data analysis. The first of these was, "What did you learn tonight that you think you will actually use?" Responses to this question ranged from "nothing" to lengthy paragraphs in which the very language used gave information regarding class versus group dynamics. In short, the data generated from this question alone proved to be of sufficient breadth to form the foundation for an additional study regarding the differences between filial therapy and parent education for these parents. The second question was asked of experimental group participants after sessions four through seven, and was intended to provide validation for the modification of the filial toy kit for the 6- to 10-year-old age range. It read, "What toys did your child play with during your special play time this past week?" As only one of the experimental group participants conducted filial play sessions with her child of focus, this question was not applicable to the experimental group as a whole.

Results

Design and Analysis

This study originally utilized a mixed method design, composed of both quantitative and qualitative components. However, following the analysis of both the quantitative and qualitative data, it was determined that, due to the small sample size, the group quantitative data was not statistically meaningful and actually detracted from the richness of the qualitative findings. Therefore, the group quantitative results were subsequently not included. Instead, individual participant profiles were created by comparing each participant's pre- and posttest scores to corresponding interpretive information from the measures, as well as to anecdotal information collected following sessions one through seven. These profiles were used, along with participant descriptions, to add breadth and depth to the qualitative findings. For the purposes of replicating the quantitative portion of this study with a larger sample, a brief description of the quantitative design and analysis follows.

The quantitative portion of this study was based on a modification of Campbell and Stanley's (1963) pretest-posttest nonequivalent control group design. Because a no-treatment control was contraindicated for the population from which this study's sample was drawn, an alternative treatment comparison group was utilized. In addition, the court-mandated population necessitated a convenience sample, from which participants were assigned by PCARV to either the treatment or comparison group. This assignment was primarily based upon parents' willingness to participate in this study (those not interested in participating had to be placed in the comparison group), and so was not random.

The analysis that is widely recognized as the most appropriate for the pretest-posttest control group design (Pedhazur & Schmelkin, 1991) is the analysis of covariance (ANCOVA). This is also the analysis that has been used with similar designs in previous studies on group filial therapy training with various populations (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999). In this study, the independent variable (IV) was group filial therapy training (experimental group) or parent education (comparison group). The dependent variable (DV) was the posttest scores on the three

measures and their subscales, and the covariate was the pretest scores on the same. Three main questions were explored. First, did experimental group adjusted posttest means show a significant decrease in child physical abuse potential? Secondly, did experimental group adjusted posttest means show a significant decrease in caregiver stress? Third, did experimental group adjusted posttest means show a significant increase in the strength of the caregiver-child relationship?

For the first two of the three questions, analysis of covariance (ANCOVA) was performed. This analysis was not possible with the third question, because posttest data was missing for two of the three comparison group participants. However, Pearson's product-moment correlations and corresponding two-tailed t-tests were conducted to determine if there were any strong linear relationships between subscales of the PSI/SF and CPRS that might help to answer the third question.

The qualitative analysis of the focus group was phenomenological, aimed at capturing the meaning of the filial therapy training process for the experimental group participants. The first step in the analysis was to transcribe the video recording of the focus group discussion. The subsequent steps are outlined by Creswell (1998). Next, the author's own perspectives and experiences were bracketed while reading the focus group transcript in order to gain understanding of the experimental group participants' perspectives and experiences. This was followed by horizontalization, in which each significant statement from the focus group transcript was highlighted and given equal value. Following horizontalization, significant statements were clustered into themes. At this stage, a second reader looked for identical and any additional patterns in the focus group transcript. These observations were then reviewed by the author. While compiling the significant statements and themes into a written format, the author utilized reflexivity to interweave her own experiences relative to the emergent themes into the resulting narrative. Finally, the narrative was submitted to the second reader for confirmation.

Results of the qualitative data, and its accompanying descriptive data, are presented below. Descriptions of each participant are given first, followed by individual participant profiles. The results conclude with a summary of focus group themes.

Participant Descriptions

Experimental Group

Raquira and Latoya. Raquira and Latoya were sisters. They lived together with at least one younger sister and their mother. The presence of the maternal grandmother as a primary caretaker for two generations is typical of neglecting families, and underscores not only the multigenerational nature of neglect, but also the fact that Raquira and Latoya had not fully accepted their adult responsibilities, including being parents (Crittenden, 1988). Because of the similarities in their backgrounds and stories, it seems appropriate to discuss Raquira and Latoya together. Raquira was the younger sister, and her first initial could well have stood for "Resistant" as for her first name. Her mood swings during group were reminiscent of working with an adolescent. At times she displayed a giddiness that seemed unrelated to whatever it was that we were doing as a group, accompanied by outbursts of laughter. At other times she seemed sullen or defiant—with her arms folded across her chest, she almost dared any of us to elicit her participation. Like a teenager in detention or an academic course that she does not relish, Raquira demonstrated an overall demeanor of boredom. In general, she did little more than show up and put in her time. During our final session focus group, Raquira's voice was virtually silent, and barely emerged in the ensuing transcript.

There are, however, contextual and developmental factors to consider. Our group ran from October to November and Raquira was expecting her second child in December. There must have been a tremendous amount of hormonal changes that were happening in Raquira's body, simultaneous to her participation in our group, which may have accounted for some of her mood swings. There was also a significant age difference between Raquira and the other participants in both the experimental and comparison groups. The average age of the participants in both groups, combined, was 28.6 years. The mean age for participants in the experimental group was 27.4 years. At 22, Raquira was by far the youngest participant. Her child of focus was a six-year-old son. If we do the math with her and her son's birthdates, she got pregnant not long before her 16th birthday and had her son before she turned 17. When her son was conceived, Raquira was sexually active with more than one partner, because she did not know who the father was at first. She also stopped attending high school about the time that she got pregnant,

as 10th grade was the highest grade level she completed. It is likely that her development was somewhat arrested about this time, as well, as she became a teen mom who didn't get to complete her own childhood.

Raquira was court-ordered to attend our parenting class because of a neglect charge, which she claimed had been dismissed. In group, this neglect charge was referenced in talking about an incident in which a belt was wielded. Apparently, the belt's use on Raquira's son was threatened by a member of the extended family as a form of discipline. The demographic data sheet completed by the PCARV worker who originally interviewed Raquira prior to the start of our group also had the following, somewhat cryptic phrase as to another reason that Raquira had been mandated to attend—"2 years for drug charges."

Latoya, who at 24 was two years Raquira's senior, may have had some influence on her younger sister's development and behaviors. She had her first child, a son, when she was 14. Among other things, she started but did not complete two parenting classes, and lost her parenting rights of this son who had since been adopted. Latoya, who self-described as a "bookworm," spoke briefly in our focus group of the developmental challenge that parenting classes posed at a time in her life when she was still in high school, herself. To her credit, she did continue with her schooling after her first son was born and completed 11th grade.

She got pregnant with her second son in the late summer or fall of her 16th year, and discontinued her high school education at about the same time. She gave birth in the middle of her 17th year. Our group constituted either the second or third parenting class that she had been required to take in reference to her second son. Apparently, Latoya had an open Child Protective Services case of neglect against her in reference to her son having "dirty clothes." In a phone conversation with her and Raquira's social worker, who had called to check on Latoya and Raquira's attendance at our group, he indicated that if the sisters did not complete our group, their parenting rights would be terminated for their 7- and 6-year-old sons, respectively. Happily, both did finish our group.

When we started our group, both Latoya and Raquira's sons had been in foster care for almost one and a half years. There were many similarities between these two cousins, in addition to them being just a year apart in age. They were both diagnosed

with ADHD and took medication. Neither of their mothers agreed with their sons being medicated, but were somewhat powerless to initiate other alternatives because they were not currently the primary caregivers. Given that Latoya and Raquira shared many of the characteristics of neglectful parents, could it be that their sons actually displayed the ADHD-like symptoms of neglected children, seeking stimulation in a disorganized, uncontrolled manner (Crittenden, 1988, 1996)? Both mothers also reported behavior problems with their sons. For Raquira, these were primarily related to her son's attitude. In addition, she indicated that he was a biter. Latoya attributed her son's behavior problems to the fact that she and his father were no longer together.

Since their sons had been in foster care, the two sisters had had joint, weekly, supervised visitation at the local Department of Social Services. Their own descriptions of these visits seemed consistent with the view that they were child-mothers whose own childhood was cut short with the onset of parenthood. For example, Raquira giggled as she recounted a recent visit with her son during which her primary focus was she and her younger sister's boyfriends, rather than her son:

> Like, I visit, and he [her son] was like, he didn't want to play. I went in, he gave me a hug, and it was just like, he was playin' mostly with Jamel, with his cousin. So I was like, "Let them have their play time," and I was sittin' there, and I talked to my baby sister, and my baby sister was sittin' there talkin' about our boyfriends, even though we supposed to been doin' it. But we was just sittin' there, and we let the kids play. And we took 'em to the snack machine, and stuff like that.

Clearly, Raquira's current developmental stage was age-appropriate for a teenager, but was out-of-sync with her son and his needs. It is interesting to note, as well, the reference to the snack machine, which was also a part of Latoya's visits with her son. Was this simply a tradition that strengthened both the parent-child bond and established some predictability and continuity (and, hence, security) in the relationship, or was it reflective of the mothers' desire to make up for not being there for their sons by buying them things? During our focus group, Latoya described how going to the store used to be with her son before she learned the skills of filial therapy. Again, there was the theme of a bond at least partially based on possessions. Her son would ask for something; she would

say no; he would throw a fit, whining "Oh, well you always get me stuff;" and she would feel guilty and eventually go back and buy him what he had requested. The danger, of course, with a relationship built on the accrual of material goods is that children begin to equate their self-esteem with how many things they have, which limits not only the child's feelings about self, but also the parent-child relationship. It does appear, however, that this focus changed somewhat for Latoya in her relationship with her son as she learned how valuable the application of filial skills could be in their relationship.

Returning to the discussion about Latoya and Raquira's arrested development, Latoya was very open about this reality in her life; however, in contrast to her sister, she seemed able to be a child *with* her son by using her childlike nature to enhance their relationship:

> As far as his [her son's] play time with me, he always have that strong play time, 'cuz he know…I act like a kid, sometimes. Because I missed out on my childhood by having a child early. So, I missed out on my childhood, so I act like a kid, myself. So, he be like, "Well, my Mama understands a whole lot."

It appears that even before she learned the filial play skill, Latoya was able to enter into her son's world of play in part because she never left childhood herself.

It is perhaps Latoya's awareness of how her development was compromised by teen motherhood that made her a very different participant than her sister. Whereas Raquira was too much a teenager to be able to see the consequences of her behavior in her own and others' lives, Latoya's awareness may have reflected the fact that she was oscillating between her current and the next developmental stage. In other words, she had a vision of where she was headed and how our group could help her to get there. Latoya was very vocal in group, and gave many evidences of responsible and responsive parenting in what she shared. Group dynamics seemed to play a role in her participation, as well. During our focus group, she shocked all of us by describing herself as a "quiet person." She indicated that normally Raquira was the social one. However, as the older sister, I think she felt compelled to step in when her sister declined to participate, even though her natural inclination was (supposedly) to take more of a back seat. She may have also felt an unconscious need to protect the family's honor, as well.

Partway through the group, the father of Latoya's son, whom Latoya describes as a "child still growing up," obtained custody (probably temporary) of their son. This was very frustrating and stressful for Latoya, because although her son's father sought her help and advice with their son when he needed it, he was not cooperative in facilitating regular times that she could visit with their son. An additional stressor that both Raquira and Latoya acknowledged in their initial interviews with PCARV was housing. Their demographic data sheets listed their annual incomes as somewhere between $0 and $10,000 each. As has been noted, poverty is especially linked to neglectful families (Crittenden, 1996). Still, it must be frustrating to live at home after having started their own families and discouraging not to have the finances to live on their own.

Marcel. I honor Marcel for being the only father in our group. His child of focus was his only child, a son, who turned 8 just prior to our final session. Marcel, himself, turned 32 just after our group finished. Like most of the other participants, he had some high school education (10th grade) and a low income (less than $10,000 per year). He was court-ordered to attend our group for reasons that were never quite clear. At our first session, Marcel mentioned having been away in the military for 13 months as a way of accounting for his attendance. There were also references made by his case manager and Marcel, himself, to substance abuse issues and a "year-long program" that he had participated in related thereto. Admittedly, I worried and wondered about active substance use during group, as Marcel often seemed tired, distracted, and 'out of it.' In addition, there were threads of denial woven into his presentation that are very common in substance abuse populations. For example, according to Marcel, he was a great father, and there were no problems in his relationship with his son. His favorite role in group was that of counselor to other participants, in which he gave them unsolicited advice about what they could do to improve their parent-child relationships. Quite honestly, I found it frustrating and exhausting trying to redirect the focus away from his larger-than-life, condescending persona and back to filial therapy and the other participants. His seeming lack of insight into how his behavior affected other people made me concerned about arrested development due to substance abuse, a current altered state of consciousness, or both. Whatever the reasons he was required to attend our group, I do know that he wanted to regain unsupervised visitation rights with his son. His son was in

the custody of the biological mother, and Marcel did have weekly supervised visits at a local social service agency with him. From the limited information that was available about Marcel, it is unclear whether he is more typical of a physically abusive father, a neglectful father, or one who has both characteristics.

Connie. Connie was fairly unique to both the experimental and comparison groups, in that she was the only participant who self-referred, rather than being court-mandated to attend. With an associate's degree, she also had the most education of any other participant (all other participants completed some or all of high school), and reported the highest income of any of the participants in the experimental group. In addition, she was one of only two participants in both groups who had custody (of any kind) of her child of focus. This last aspect was critical to our group process, because Connie was the only participant who was able to obtain video footage (which she did twice) to share with the group of her home play sessions.

At the time of our group, Connie was a 31-year-old divorced mother of two sons who shared custody with her ex-husband. Her eldest son was 12, and her younger son and child of focus was almost 7. She had enrolled in our group because she felt that she had lost her relationship with her older son. Having "tried everything" with her younger son, she was actively looking for ways of preventing a similar collapse in their relationship. Meanwhile, her younger son was displaying a number of behavior problems in school that seemed to have a genesis in her and her husband's separation and ensuing custody battle over their sons. He was acting out, talking back, using inappropriate language, and had been suspended twice before he had even finished kindergarten. Like Latoya and Raquira's sons, he had also been diagnosed with ADHD.

Connie was a joy to know and have in group. Although she was fairly quiet, whenever she said something it was meaningful and added to, rather than detracted from, the group process. She was also respectful of and responsive to other group members. Her body language and nonverbals indicated that she was listening to others when they spoke. Her usual pattern was to listen and reflect upon what others said before she contributed. When Latoya and Raquira indicated that they may have trouble being on time because they would be dependent upon public transportation, Connie offered to take them to and from our group each week, which she did.

When our group began, Connie had visitation with her sons on weekends. Towards the end of the group, as she began to gain confidence in her skill level and see the fruits of her efforts in conducting filial therapy play sessions, she moved her younger son back home with her.

Jacqueline. Jacqueline had completed high school and, similar to other participants, had an annual income of less than $10,000. She was the only other participant in both groups, besides Connie, who had custody of her child of focus, and our only participant whose child of focus was a daughter. At 9-years-old, her child was also the oldest child of focus in both groups. However, like Latoya, Raquira, and Connie's sons, Jacqueline's daughter had also been diagnosed with ADHD. This meant that four out of the five experimental group children of focus had ADHD diagnoses. Interestingly, because of this diagnosis Jacqueline and Latoya felt they had "special needs" children, whereas Connie and Raquira did not.

At 29, Jacqueline was a divorced mother of two daughters, the youngest one being 3 years old. Her greatest concerns were clearly about her older daughter, who seemed beyond help, although she was also worried about the effects she was already seeing of her older daughter's behavior on her younger sister. The older daughter was described by Jacqueline as a liar, a thief, and a rule-breaker who was unresponsive to any form of discipline. She seemed to fit the profile of a physically abused child who became angry and defiant in response to the abuse, rather than compulsively compliant (Crittenden, 1988, 1996). However, it may also be that her difficult temperament and behavior increased her risk of being abused (Kolko, 1996). Jacqueline did have an open Child Protective Services case in which charges had been pressed for physical abuse. She admitted to spanking her daughter, but had also been accused of whipping her with a stick, leaving behind bruises. There were clearly larger systemic issues involved, as Jacqueline's father had been identified as a collaborator in Jacqueline's use of corporal punishment. It is probable that Jacqueline's father used similar forms of discipline with her, which she had resented as a child, but now saw as a way "to become the responsible and competent [parent]" she wanted to be (Crittenden, 1988, p. 169).

The PCARV worker who registered Jacqueline for our group described her as "angry and resentful" about both her involvement with the Department of Social Services

and their mandate that she complete a parenting course. This is an apt summary of my initial contact with Jacqueline in group, but she became steadily more hopeful and participatory in the ensuing weeks. It is ironic to think that some of the very behaviors Jacqueline found so frustrating with her older daughter, such as affect dysregulation, were probably modeled by her. Unfortunately, Jacqueline was only in our group for four of the eight sessions. The first week, she let us know that she would be moving across the country halfway through the group. As a researcher, this was disappointing because Jacqueline showed the most dramatic changes in only four weeks of all of the participants in the experimental group. I would have liked to follow her progress through all eight weeks.

Comparison Group

George. George, 28, had completed high school and had a higher income than most of the participants in either group, between $10,000 and $20,000 a year. His two children, whom he described as "well-behaved," were a 5-year-old son and a 4-year-old daughter. He was separated from his wife, who was charged with felony child abuse for burning their daughter. George, himself, was court-mandated to attend a parenting class in January 2001. Our group began in October, which led me to wonder if George had attempted courses prior to ours. He expressed two primary concerns regarding his children. First, he was worried about their mental health, and indicated that they were receiving counseling services. Secondly, he was distressed that his children have very little contact with their father. His children lived with their grandmother, who had custody. George did have visitation rights at the time of this study, but claimed that his son and daughter saw him more as an "uncle or close friend" than a father. In addition, the grandmother did not agree with George's visitation. He openly admitted to regular (1-3 times a week) use of illegal drugs (marijuana, I believe, is his drug of choice), which may have been part of the grandmother's issue(s). George's case was clearly complex; given his open drug use at the time of our study, he had probably regularly used with his wife, which may have led to both neglect and physical abuse of their children. However, the reasons for his court order were not specified, and there was not enough information about him to draw any definitive conclusions.

Patrick and Wanda. Patrick and Wanda were the only couple in either the comparison or experimental group. Patrick completed high school, while Wanda completed the 11th grade. At 33, Patrick was the oldest participant in either group, and also boasted the highest income, which was at least $10, 000 higher than any of the other participants. Wanda, 31, reported an income of between $0 and $10,000, so it was unclear whether or not she was also bringing in money or not. She had children from a previous marriage with whom she had no contact. Her current marriage to Patrick was conflictual, and there was some question about substance abuse issues. In addition, each brought to their marital and parenting relationships their own histories of child abuse and/or neglect. The couple was court-ordered to complete a parenting class after psychiatric evaluations raised concerns about Wanda's mental stability. They had had an open Child Protective Services case and their three shared children—two daughters, ages 8 and 6; and a son, age 4—had been in family foster care with an aunt for about a year and a half when this study was conducted. While Patrick saw the children every other weekend, Wanda had apparently not seen the children for 8 months when she participated in the comparison group. They described their overall relationship with their children as "loving," and claimed that "discipline" was their primary challenge. Between her lack of interaction with both sets of children and her mental health issues, Wanda presented like a neglectful parent. Undiagnosed depression is common in neglectful parents (Crittenden, 1988, 1996); still, it is unclear what her mental health issues were. Patrick, on the other hand, seemed motivated as a parent. Perhaps, as a couple, they represented a combination of neglectful and physically abusive families; in terms of their problems with discipline, maybe Patrick had a tendency to discipline harshly, whereas Wanda provided no limits. Of course, all of this is purely conjecture based on very limited information.

Participant Profiles Based On Quantitative and Anecdotal Data

In order to aid the reader in following the participant profiles, Table 1 contains pre- and post-measure data for each participant on the CAP Inventory, the PSI/SF, and the CPRS.

Table 1

Participant pre- and post-data on the CAP Inventory, the PSI/SF, and the CPRS

Participant	Group	CAP Inventory		PSI/SF								CPRS					
		Pre-Abuse	Post-Abuse	Pre-PD	Post-PD	Pre-P-CDI	Post-P-CDI	Pre-DC	Post-DC	Pre-TS	Post-TS	Pre-Confl.	Post-Confl.	Pre-Pos. asp. rx	Post-Pos. asp. rx	Pre-Dep.	Post-Dep.
Raquira	E	100 (Invalid)[a]	79 (Invalid)[a]	21	27	33	23	23	25	77	75	27	31	43	44	14	17
Latoya	E	353	347	25	40	16	25	35	32	76	97	27	23	43	42	15	15
Marcel	E	51	72 (PR)[b]	26	23	23	27	24	31	73	81	12	28	30	27	5	8
Connie	E	46	70	28	30	21	21	37	31	86	82	45	34	44	47	17	19
Jacqueline	E	127 (Invalid)[a]	**	25	**	27	**	35	**	87	**	37	**	44	**	16	**
George	C	180 (PR)[b]	306 (PR)[b]	30	29	34	39	32	29	96	97	36	38	29	32	14	14
Patrick	C	64 (Invalid)[a]	87	21	26	18	21	21	27	60	74	22	**	49	**	14	**
Wanda	C	99	102	24	20	15	19	22	25	61	64	22	**	49	**	14	**

Note. Missing data is denoted with double asterisks. E = Experimental group; C = Comparison group.
[a](Invalid) = Uninterpretable due to elevated Faking-good response distortion index scores. [b](PR) = Prorated due to 10% or less missing items.

Experimental Group

Raquira. Raquira was one of two participants in the experimental group whose CAP Inventory scores could not be interpreted. At both pre- and posttest, Raquira's Lie (L) scale was elevated, which led to the computation of her Faking-good index, which was invalid. In short, the combination of an invalid Faking-good index and a low Abuse score render the Abuse score uninterpretable because it is unclear whether the Abuse score is genuinely low or if it is low due to the participant's ability to dupe the measure. At both data collection periods, it was Raquira's Rigidity factor subscale that was elevated. Although Raquira could not be accurately classified in terms of her child physical abuse potential, it was themes surrounding rigidity that contributed to her overall Abuse score. Such themes include unrealistic expectations of children and their behavior, in addition to beliefs that children need strict rules and that a home should be immaculate and well organized.

Total Stress scores for Raquira, from the PSI/SF, were in the normal range at both pre- and posttest. However, her Parent-Child Dysfunctional Interaction (P-CDI) subscale scores went from being between the 95th and 99th percentiles (very high) to being at the 70th percentile (normal range). The P-CDI subscale investigates the degree to which the parent-child relationship does not meet the parent's expectations and is a negative aspect of her/his life. According to the reduction in Raquira's scores on this subscale, it would appear that filial therapy helped her to feel more positive about her relationship with her son. Her anecdotal data did not help to clarify her parenting stress profile over the course of the group. Her ratings seemed to have little or no relevance to her actual experience. Maybe her tendency towards social desirability, as was evident on the CAP Inventory, revealed itself in her two initial rankings of 10 (no stress) in the first and third groups (she did not attend the second group due to illness). Her remaining ratings--7, 4, 8, and 2, respectively—seemed erratic.

In contrast, Raquira's anecdotal data regarding her relationship with her child of focus seemed more consistent. Keeping in mind the missing data for the second session, her rankings were 10, 10, 8, 5, 9, and 8 in the remaining 6 sessions. These scores indicate that Raquira generally felt quite positive about her relationship with her son. The challenge, of course, is that this data does not coincide with Raquira's P-CDI score at

pretest. Are her weekly anecdotal ratings of her caregiver-child relationship further evidence of her desire to look good as a parent to others? A graph of Raquira's parenting stress and parent-child relationship anecdotal data is presented in Figure 1. Raquira's scores on the Positive aspects of relationship subscale of the CPRS were in the middle to high range at both pre- and posttest, pointing to a parent-child relationship with an average to high number of positive aspects. In addition, her Conflicts subscale scores were in the low to mid-range at both data collection periods. These scores confirm her anecdotal data, but conflict with her P-CDI pretest score. Her Dependence subscale scores went from mid-range at pretest to between the middle and high ranges at posttest. The only change on this subscale was that she went from "not really" thinking about her son at work (Item 26), to "definitely" doing so.

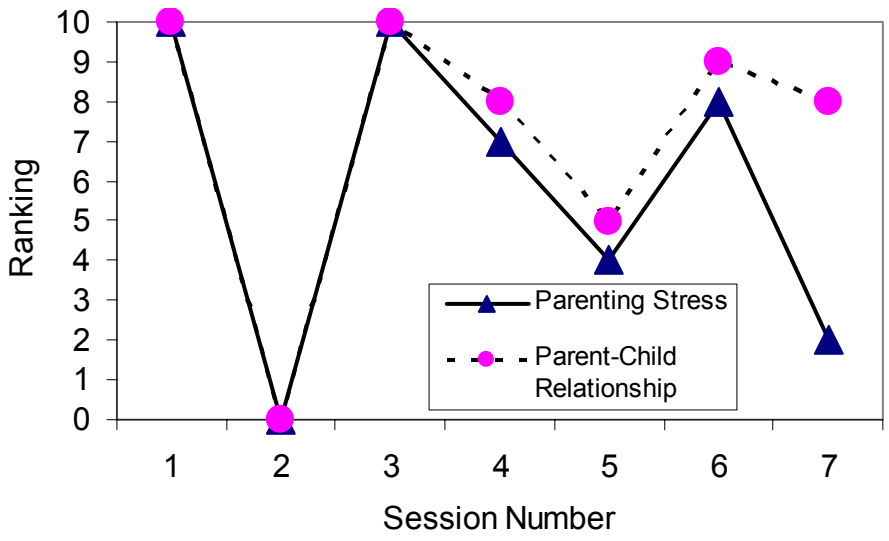

Figure 1. Anecdotal data collected from Raquira following sessions 1 through 7. On the rankings, 1 represents "Worst Ever" for both questions, while 10 represents "No Stress" for parenting stress and "Best Ever" for the parent-child relationship.

Latoya. Latoya was the only participant in the experimental group who had elevated Abuse scale scores on the CAP Inventory. Both her pre- and post-measure scores on this scale were well above the cut-off, an indication that her profile is similar to

documented physical child abusers. As her scores were almost identical at both data collection periods, on both the Abuse scale and its elevated factor subscales, it appears that Latoya's child physical abuse potential was high at the beginning of the group and did not change over its course. The four factor subscales that contributed to her Abuse scale score were representative of both psychological and interactional constructs, and included Distress, Unhappiness, Problems with family, and Problems from others. In sum, they described a participant who had multiple personal adjustment problems and was unhappy with her life and relationships. Overall, others were not to be trusted or depended upon, and relationships were painful instead of being resources.

At pretest, Latoya's Total Stress score was in the normal range, as were two of her three subscale scores. Her Difficult Child (DC) subscale score was high. The fact that the other two subscales, Parental Distress (PD) and Parent-Child Dysfunctional Interaction (P-CDI), were at or below the 75th percentile and the DC subscale was just under the 90th percentile was an indication that either a short-term consult or psychoeducational course that addressed parenting strategies should be sufficient to remedy the participant's situation. However, this theory did not hold true for Latoya. By posttest, her Total Stress score was clinically significant, her Parental Distress (PD) score was high, and her other two subscale scores were bordering on high (they were both at the uppermost limit of the normal range). Because her PD subscale score was the highest of the three subscales, it was recommended that her personal adjustment be examined. From these pre- and posttest scores alone, it appears that the filial group raised, rather than lowered, Latoya's stress level as a parent. However, her anecdotal data contradicts this conjecture. She ranked her stress level as a parent a 6 after the first session. By the third session, this had dropped to a 4. It remained at a 2 following the fourth and fifth sessions, was a 1 (no stress) after the sixth session, and only rose again to a 5 at the seventh session. A contextual factor that contributed to Latoya's stress was that her son was removed from foster care partway through our group and placed under the temporary care and custody of his father. This was a tremendous source of stress for Latoya. Could it be that this change occurred between the 6th and 7th group sessions, thus contributing to Latoya's raised score following the seventh session?

A similar pattern emerged from Latoya's anecdotal data regarding her relationship with her child of focus. Her scores for the same sessions outlined above were, respectively, 6,4,1,3,1, and 5. One of the things that made her son's new living arrangements so stressful for Latoya was that his father was not cooperative with her about having regular visits with their son. Prior to their son going to live with his father, Latoya had had weekly supervised visits through the Department of Social Services. Again, might this change have happened between the sixth and seventh sessions, since the scores went up considerably following the seventh session? A graph of Latoya's parenting stress and parent-child relationship anecdotal data is presented in Figure 2. There was no change in the overall range of Latoya's CPRS subscale scores from pre- to posttest. Comparisons between individual item responses at both data collection periods indicated that there was minimal movement, generally by only one point in either direction (there is a 5-point Likert response set on this measure). Latoya's Conflicts subscale scores were in the low to middle range. At posttest, she did not respond to one item on this subscale, which resulted in a slightly lower score on this subscale than she had had at pretest. In addition, she went from a 4 at pretest (Applies somewhat) to a posttest 2 (Not really) on item 27, which reads, "My child whines or cries when he/she wants something from me." From this item alone, it appears that the filial skills reduced this dynamic between Latoya and her son. Latoya's Positive aspects of relationship subscale scores were in the middle to high range. Interestingly, the most dramatic change on this subscale was on item 29. It reads, "My child openly shares his/her feelings and experiences with me." At pretest, Latoya felt that this item had definite application to her relationship with her son (a 5). However, at posttest she gave this item a 2 (Not really). Was this reflective of the frustrations that Latoya was experiencing in her struggle to establish regular visitation arrangements with her son's father? Might it correspond to her anecdotal rating of her relationship with her son following the 7th session? Finally, Latoya's Dependence subscale scores were unchanged from pre- to posttest, and were in the middle to high range.

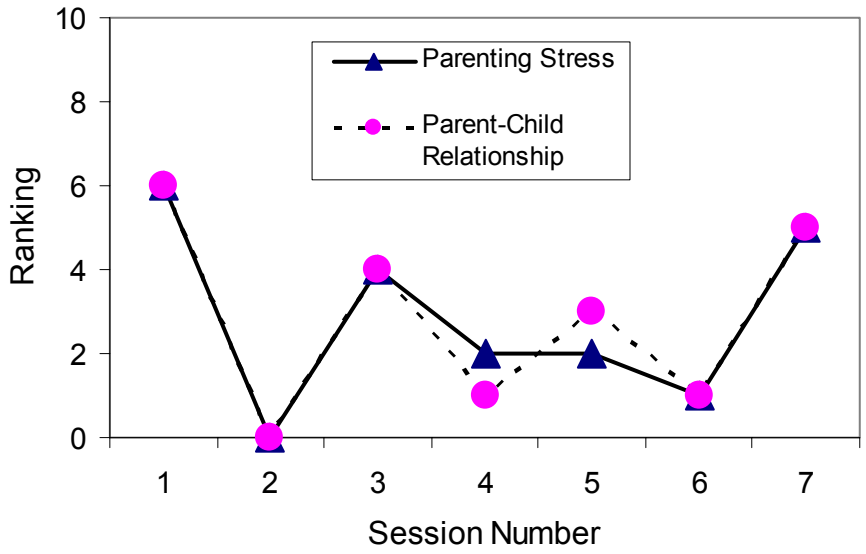

Figure 2. Anecdotal data collected from Latoya following sessions 1 through 7. On the rankings, 1 represents "Worst Ever" for both questions, while 10 represents "No Stress" for parenting stress and "Best Ever" for the parent-child relationship.

Marcel. Marcel's pretest CAP Inventory scores were within the normal range, both the Abuse scale score and its attendant factor subscale scores. The same was true of his posttest scores, except that his Abuse scale score was prorated. This procedure is employed when there are blank responses on the measure that amount to less than 10% of the total items. As a computer scoring program was used, this process occurred automatically. At posttest, only the Unhappiness factor subscale was elevated, indicating that overall unhappiness with life and relationships contributed to his Abuse scale score. Incidentally, his posttest Unhappiness score was almost three times his pretest score. Did something occur over the course of our group that affected Marcel's global life satisfaction? In general, Marcel's pre- and posttest scores suggest that his child abuse potential was low throughout the group. Still, the erratic pattern of his responses raises some doubts as to the validity of his results. This pattern seemed to correlate with a desire to complete the measures quickly, but certainly literacy issues cannot be overlooked as a possible explanation, either.

Not unlike his CAP Inventory scores, Marcel's PSI/SF Total Stress scores were within the normal range at both pre- and posttest. At posttest, his Difficult Child (DC) subscale was at the high end of normal (80th percentile). Only his Parent-Child Dysfunctional Interaction (P-CDI) subscale was elevated at posttest. As has been discussed in the profiles of other participants, a high score on this subscale suggests a parent-child attachment that is either threatened or has never taken place. Anecdotal data related to parenting stress was an 8 (remember, 10 represents "no stress") following every session (except the 6th session, which Marcel missed). These numbers could confirm Marcel's normal-range PSI/SF Total Stress scores: perhaps because he had little day-to-day contact with his son, Marcel was, indeed, experiencing very little parenting stress. On the other hand, they may represent a desire to look good to others.

Marcel's parent-child relationship anecdotal data seemed to speak to the challenge of maintaining a relationship with his son even when he did not actually see him during a given week. Not unlike Patrick in the comparison group, for Marcel the rating questions did not seem to apply to him when he did not have physical contact with his son. He chose not to rate the relationship at all in the second and fourth sessions. Following the third and fifth sessions, Marcel again made no ranking, but instead wrote, "Didn't see him," and "Haven't seen him!" We might assume that whenever Marcel *did* see his son he felt the relationship was very good, such as after the first and seventh sessions when he rated it an 8. A graph of Marcel's parenting stress and parent-child relationship data is presented in Figure 3. Marcel's response pattern on the CPRS changed dramatically from pre- to posttest. At pretest, two-thirds of his responses were a 1(Definitely does not apply), with very few responses in the mid-range (2, 3, and 4). In contrast, only 10% of his posttest responses were a 1, while the majority were in the mid-range. Was Marcel more realistic by posttest, or did participation in our group cause him to reevaluate his relationship with his son and, in this transition, to be less sure of the state of their relationship? At the same time, his response patterns might be nothing more than erratic, reflective of a lack of investment in the research aspect of this study or of his lack of comprehension of the questions. His Conflicts subscale scores more than doubled from pre- to posttest, going from the low range to the low to middle range. He missed one item on this subscale at pretest, and two at posttest so there would have been additional

shifting in scores on this subscale had these items been marked. Two items (17 and 23) went from a 1 (Definitely does not apply) at pretest to a 4 (Applies somewhat) at posttest. The first reads, "My child sees me as a source of punishment and criticism," and the second, "When my child is in a bad mood, I know we're in for a long and difficult day." These two items seem to correlate with Marcel's elevated posttest P-CDI scores, in that parents with high P-CDI scores often do not feel reinforced in their parenting role as a result of their interactions with their children (Abidin, 1995). Marcel's pre- and posttest scores on the Positive aspects of relationship subscale remained in the mid-range. Examination of individual items on this subscale seems to indicate that Marcel was simply trying to complete the measurement battery quickly, because it is difficult to find any pattern to his responses from pre- to posttest, other than that they are erratic. However, again, he may not have been able to read and/or comprehend the questions, which would have reflected a literacy problem over a lack of investment in the research process. Responses on the Dependence subscale were in the low range at pretest and the low-to-middle range at posttest. There are only four items on this subscale, and again there was no pattern to Marcel's responses.

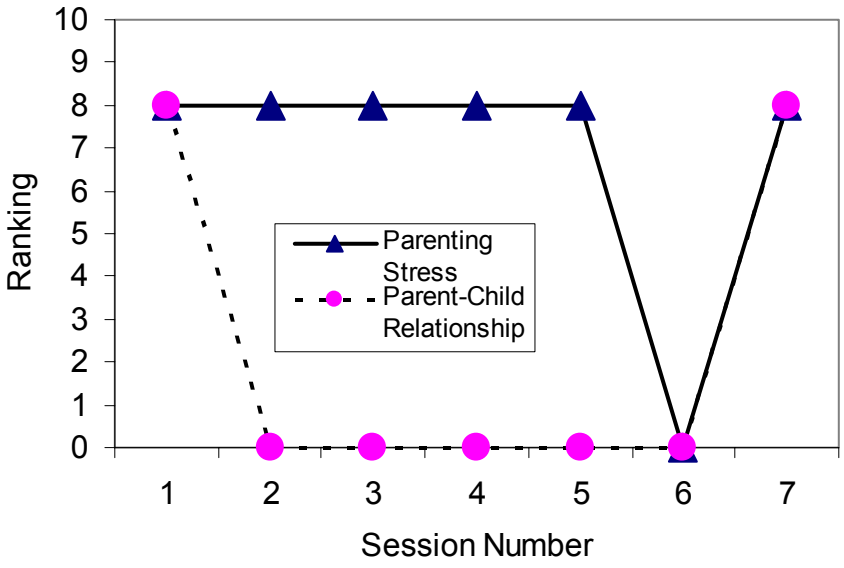

Figure 3. Anecdotal data collected from Marcel following sessions 1 through 7. On the rankings, 1 represents "Worst Ever" for both questions, while 10 represents "No Stress" for parenting stress and "Best Ever" for the parent-child relationship.

Connie. Neither Connie's CAP Inventory Abuse scale scores nor her factor subscale scores were elevated at pre- or posttest. Therefore, it is unlikely that participation in our filial therapy group had much effect on her child abuse potential, as it was already low.

With regard to her stress level as a parent, Connie's PSI/SF Total Stress scale score was high (85th percentile) at pretest, but did not represent clinically significant levels of stress. In addition, her Difficult Child (DC) subscale score was between the 90th and 95th percentiles. A high score on this subscale generally means that the parent is struggling with behavior management of her/his child in the form of limits and cooperation. When this score is the highest of the three subscales while the remaining two subscales are not above the 75th percentile, which was the case for Connie at pretest, then a short-term parent consult or psychoeducational course focused on parenting is purported to be effective. This proved to be so for Connie. By posttest, Connie's Total

Stress score and her DC subscale scores were at the 80th percentile (high end of the normal range). Hence, the filial therapy group was successful at helping to reduce Connie's stress and increase her child behavior management skills. Connie's anecdotal data confirm an overall trend towards reduced parenting stress over the course of our group. Connie did not attend our 4th session, but her rankings following the other six sessions were, respectively, 4, 3, 6, 2, 7, and 8. It appears that Connie had a setback between the third and fifth sessions (which may have been correlated with her non-attendance the fourth week), but again the overall trend was in the direction of reduced parenting stress.

Based on Connie's anecdotal data regarding her relationship with her child of focus, their rapport could be described as mediocre over the first two weeks of our group. However, between the second and third session, there was the start of a definite trend towards a strengthened parent-child relationship. Keeping in mind Connie's absence from our fourth session, her other scores were, respectively, 5, 4, 7, 7, 8, and 9. A graph of Connie's parenting stress and parent-child relationship anecdotal data is presented in Figure 4. On the CPRS, there was a considerable change in Connie's Conflicts subscale scores from pre- to posttest. At the initial data collection, Connie's score on this subscale were in the middle to high range. However, by the end of the eighth session, her score was in the low to middle range. This was an indication of less conflict in her relationship with her son, and confirms the reductions in her DC subscale data, as noted above. There was very little change on the other two subscales from pre- to posttest. The Positive aspects of relationship subscale score increased by three points, with three items that Connie had previously assigned a 4 (Applies somewhat) being given a 5 (Definitely applies). These were items 5, 13, and 22. They read, "My child values his/her relationship with me," "My child tries to please me," and "I've noticed my child copying my behavior or ways of doing things" respectively. The shift on item 5 is noteworthy because Connie admitted from the outset that she was afraid of losing her relationship with her child of focus as she had with her older son. The Dependence subscale remained in the middle to high range at pre- and posttest.

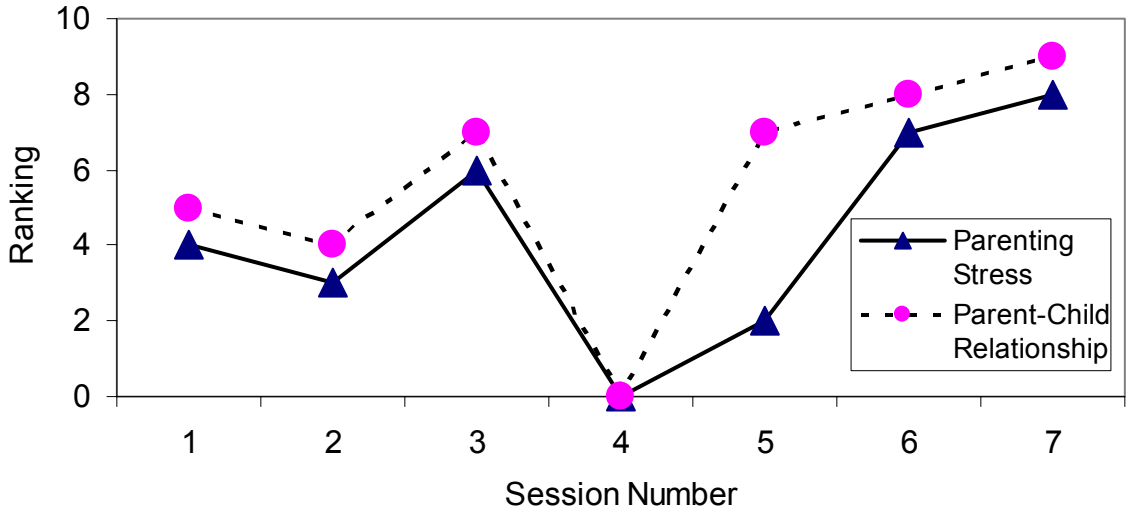

Figure 4. Anecdotal data collected from Connie following sessions 1 through 7. On the rankings, 1 represents "Worst Ever" for both questions, while 10 represents "No Stress" for parenting stress and "Best Ever" for the parent-child relationship.

Jacqueline. Jacqueline was the sole participant in either the comparison or experimental groups who did not finish the eight-week course. Therefore, it is impossible to do a pre/post profile on her, because she only completed the pretest measures. However, as she did consent to participate in this study, her data has been included so that it can be compared to that of the other participants. With regard to her abuse potential, a classification at pretest was not made. Like Patrick in the comparison group and Raquira in the experimental group, Jacqueline's low Abuse scale score should not be interpreted because her Lie scale score was elevated and her Faking-good index invalid. Consequently, we cannot be certain whether her Abuse scale score should be interpreted as normal, or whether she was able to outsmart the measure. All that is clear is that the primary contributor to her overall Abuse scale score was her elevated Problems with child and self factor subscale score. This subscale identifies a participant who perceives her/his child of focus as problematic, and her/himself as having physical limitations.

Jacqueline's Total Stress score on the PSI/SF was high (between the 85th and 90th percentiles), but did not represent clinically significant levels of stress (a score at or above the 90th percentile). However, both her Parent-Child Dysfunctional Interaction (P-CDI) subscale and Difficult Child (DC) subscale were high, as well. This combination of elevated subscales rendered a profile that was somewhat unique to Jacqueline in comparison to the other participants in both groups. Like other participants, Jacqueline's P-CDI subscale score pointed to either an at-risk parent-child attachment or one that had never been properly formed. Unlike the other participants, her pattern of scores identified her child of focus as an outlier in terms of the degree of difficulty of both her behavior and temperament. In addition, an intensive intervention that includes assessment of the child of focus was outlined as the treatment of choice. Had the PSI/SF been used as a screening measure for participation, it would have been evident that our eight-week filial therapy group would not have been adequate to address the needs of Jacqueline or her child of focus. Unfortunately, Jacqueline's anecdotal data related to her stress as a parent did not add to her profile. Her rankings were a moderate 5 in the first session, followed by moderately high to high scores of 8, 9, and 7 in the next three sessions (10 is equivalent to "no stress"). It appears that social desirability may have confounded Jacqueline's child physical abuse potential data as well as her anecdotal data.

The same could be said of her parent-child relationship anecdotal data. Despite what emerged from the quantitative measures and from Jacqueline, herself, in group, she rated her rapport with her child of focus an 8,8,9, and 8 (10 equates with "best ever") over the four sessions that she attended. A graph of Jacqueline's parenting stress and parent-child relationship anecdotal data is presented in Figure 5. Her CPRS scores were equally intriguing, in that they, too, did not correspond with the other quantitative measures or with Jacqueline's presentation of herself and her situation during our sessions. Her Conflicts subscale score was in the middle range, while her Positive aspects of relationship and Dependence subscale scores were both in the middle to high range. Such scores paint a picture of a 'normal' parent-child relationship, while most of the rest of the data (with the exception of the anecdotal data) indicated that Jacqueline's relationship with her daughter was in serious trouble.

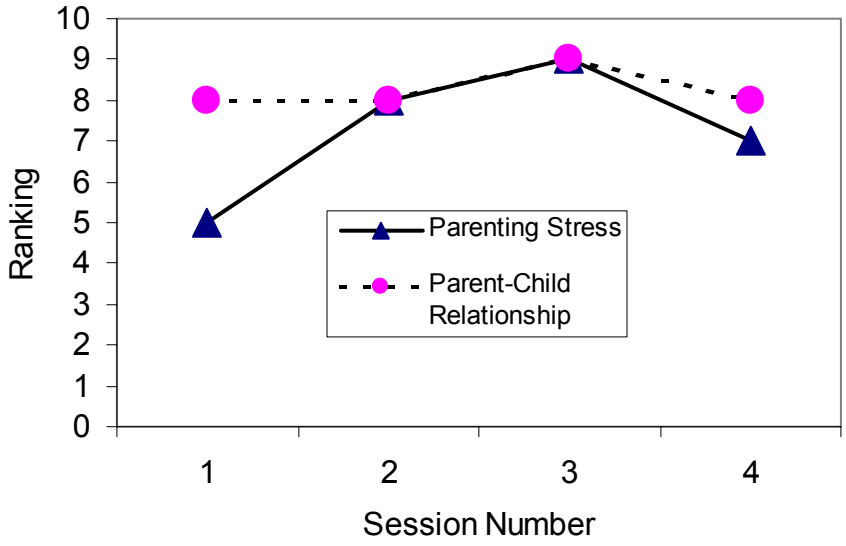

Figure 5. Anecdotal data collected from Jacqueline following sessions 1 through 4. On the rankings, 1 represents "Worst Ever" for both questions, while 10 represents "No Stress" for parenting stress and "Best Ever" for the parent-child relationship.

Comparison Group

George. Comparisons of pre- and post-measure CAP Inventory data for George indicate that his potential to physically abuse his child of focus increased over the course of the parenting class. While his Abuse scale score at the beginning of the course was within the normal range, it was elevated at posttest. This means that he shared characteristics with known physical child abusers. Of the six factor scales that compose the Abuse scale, four were also above the cut-off scores at this time—Distress, Unhappiness, Problems with child and self, and Problems from others. For George, the elevated scales represented both psychological and interpersonal difficulties. They pointed to a participant with many personal adjustment problems who was unhappy with his life and his relationships, particularly those with his child of focus and others outside of his family. In general, relationships with others were a source of pain and distrust.

Examination of PSI-Short Form Total Stress scores at the beginning and conclusion of the parenting course revealed that George was experiencing clinically

significant levels of stress at both data collection periods. We could thus conclude that George's overall parental stress level was probably clinically significant throughout the class. Of particular concern were his Parent-Child Dysfunctional Interaction (P-CDI) subscale scores, which were above the 95th percentile at pre- and posttest. Such scores indicate, at best, a parent-child attachment that is either at-risk or has never properly occurred and, at worst, a participant with the potential to neglect, reject, or abuse his child of focus. In George's case, because the other two subscales, Parental Distress (PD) and Difficult Child (DC), were within the normal range his potential to abuse was less likely. Still, his potential must be considered in the context of his clinically significant Total Stress scores as well as his elevated Abuse scale scores (see above). Although George's anecdotal data was incomplete, it did confirm that he was experiencing significant stress as a parent throughout the class. George did not fill out anecdotal data sheets following the 3rd, 4th, and 7th classes. After the first class, he indicated that his stress level as a parent was a moderate 5. By the end of the second class, his stress level was a 2. It was a 1 (worst ever) and a 1+ (worst ever and then some) following the 5th and 6th sessions, respectively.

Similar anecdotal data regarding George's relationship with his child of focus coincided with the attachment interpretations of the P-CDI subscale (see above). His ratings of his relationship with his child of focus remained a 1 (worst ever) following the first, second, and fifth sessions. He even added the word "non-existent" to his second session rating of the relationship. The highest the rating ever got was a 2 after the sixth class. A graph of George's parenting stress and parent-child relationship anecdotal data is presented in Figure 6. Not unlike Marcel in the experimental group, George's pattern of responses on the CPRS seemed primarily erratic. At pretest, all but two items out of 30 were marked with a 3 (Neutral, not sure). Although there was a little more of a range in his responses at posttest, his scores at both data collection periods remained at or immediately around the median on all three subscales. As at pretest, most items on the Conflicts subscale were given a 3 at posttest. Only item 21 ("Dealing with my child drains my energy") was marked as a 5 (Definitely applies). There were few responses on the Positive aspects of relationship subscale that highlighted positive aspects of George's relationship with his son, as punctuated by his 2 (Not really) rating of item 1 ("I share an

affectionate, warm relationship with my child"). On the Dependence subscale, George only assigned item 26 ("I often think about my child when at work") a 5 (Definitely applies) at both pre- and posttest.

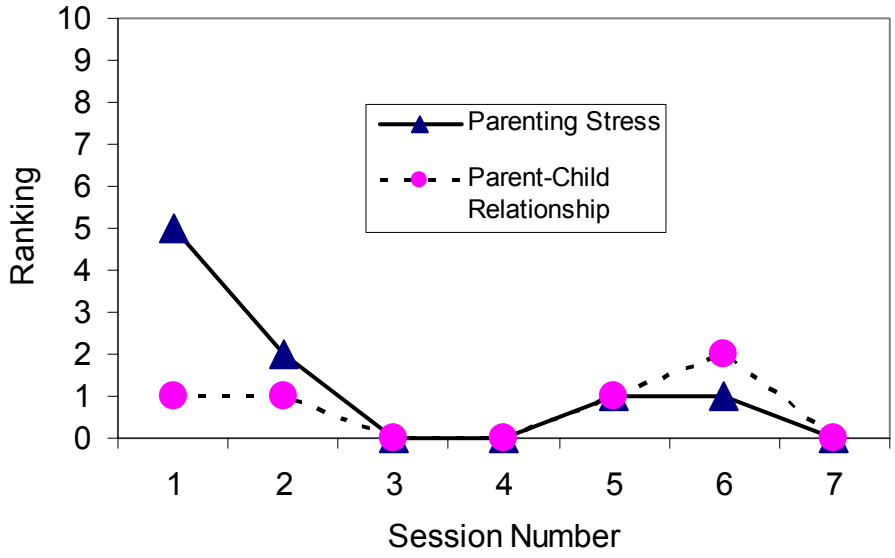

Figure 6. Anecdotal data collected from George following sessions 1 through 7. On the rankings, 1 represents "Worst Ever" for both questions, while 10 represents "No Stress" for parenting stress and "Best Ever" for the parent-child relationship.

Patrick. Patrick was the only member of the comparison group whose pretest CAP Inventory scores were not able to be interpreted. One of his validity scale scores, on the Lie (L) scale, was elevated which meant that the response distortion indexes also needed to be examined. His Faking-good index was invalid, and his Abuse scale was low. In such cases, the Abuse score should not be interpreted, because it is difficult to determine whether the Abuse scale score is an accurate assessment of the participant's child physical abuse potential, or if this score is low due to the participant's ability to outwit the measure. At posttest, Patrick's validity scales and indexes were valid and his Abuse scale score was within the normal range. However, without a valid pretest score, we are unable to draw conclusions regarding Patrick's child abuse potential over the course of the class.

Like his wife, Wanda (see below), Patrick's PSI/SF scores were within the normal range at pre- and posttest. Before the comparison group began, Patrick's scores on the Total Stress scale and the three related subscales were between the 20th and 50th percentiles. His profile shifted somewhat at posttest, with all four scores being between the 55th and 65th percentiles—an increase—but, again, these continued to be in the normal 15th to 80th percentile range. Unfortunately, Patrick's anecdotal data regarding his parental stress was all over the map, and so it did not help to elucidate his PSI/SF scores. We have data for his first six classes, and his scores were, respectively, 7, 3, 8, 5, 3, and 2.

Patrick seemed to feel that the questions and ranking system on the anecdotal data sheets had no application to him, because he appeared to choose numbers at random, rather than selecting them to represent his own experience. This was equally true of how he ranked his stress level as a parent as it was of how he rated his relationship with his child of focus over the previous week. For example, after assigning his relationship a 9 following the second class, Patrick added, "I do not have custody," as if to say, "I don't think this question applies to me since I do not have custody of my child of focus and so do not see her/him on a regular basis, but I will play along and just mark something." For the record, his other relationship rankings for the first and third through sixth sessions were, respectively, 6, 1, 5, 1, and 3. He did not complete an anecdotal data sheet after the seventh session. A graph of Patrick's parenting stress and parent-child relationship anecdotal data is presented in Figure 7. Unfortunately, Patrick's wife, Wanda, completed a CPRS at pretest for both of them, and neither of them completed a CPRS at posttest. Patrick's resulting profile leaves more questions about his child physical abuse potential, parental stress, and relationship with his child of focus than it answers.

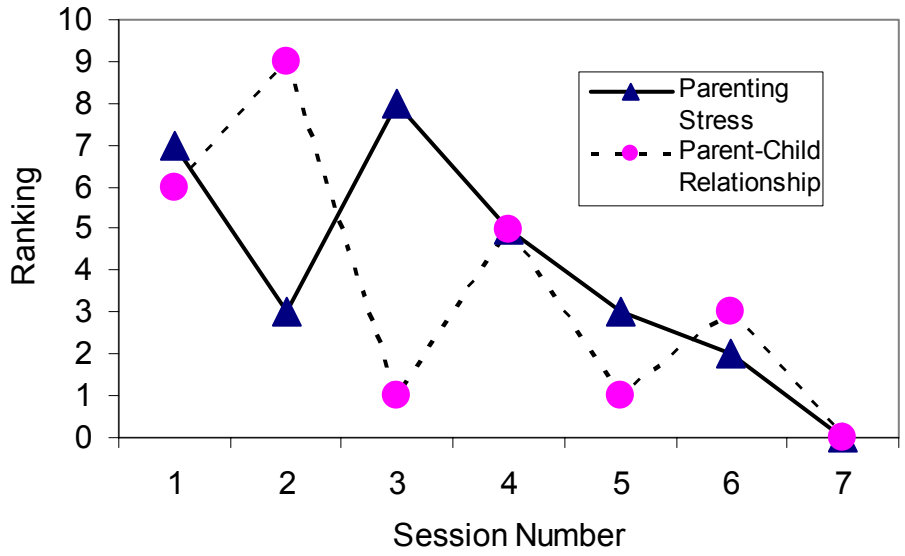

Figure 7. Anecdotal data collected from Patrick following sessions 1 through 7. On the rankings, 1 represents "Worst Ever" for both questions, while 10 represents "No Stress" for parenting stress and "Best Ever" for the parent-child relationship.

Wanda. Wanda's pre- and post-measure scores on the Abuse scale of the CAP Inventory were well within the normal range. In addition, there was only a difference of three points between the two scores, indicating Wanda's physical abuse potential was low and did not change over the course of the class.

According to Wanda's PSI/SF scores, her stress level as a parent was also normal. Total Stress scale scores and subscale scores were at or below the 50th percentile at both time periods. However, her anecdotal data told a different story. She rated her stress level as a parent a moderate 5 following the first class. After the second class, she circled a three and added, "I do not have custody of her right now. So stress is high." By the third class, she felt her parenting stress was the worst ever (a 1 rating), and in explanation she wrote, "He does not live with us. I have not seen him in 8 months. So stress is extremely high." Ratings were twos for the fourth and fifth sessions; her husband, Patrick, completed a joint sheet for them both following the sixth session (he also rated their stress levels as parents a 2), and there is no anecdotal data for the 7th session.

Notice that Wanda refers to two different children (a female and male) in her second and third session comments. Although age dictated who her child of focus would be for the study, she was thinking about other children, as well. Clearly she was experiencing some sort of distress—perhaps depression—which the PSI/SF did not capture.

The tone of Wanda's anecdotal data regarding her relationship with her child of focus was similar. After classes one through five, she rated this relationship a 1 (worst ever). Her comments were equally telling: "I have no contact with my child right now. I haven't had any communication with her" accompanied the fourth class rating and "I don't have custody. No contact" was with the fifth. It seemed challenging for Wanda to rate her relationship with her child of focus as anything but the "worst ever" without custody and any contact. It was her husband, Patrick, who gave their relationship its highest rating—a 3—when he did a joint data sheet for them both following the sixth class. Neither of them completed an anecdotal data sheet for the seventh class. A graph of Wanda's parenting stress and parent-child relationship anecdotal data is presented in Figure 8. As noted under Patrick's profile above, Wanda completed a CPRS at pretest for both herself and Patrick. Because it is probably more representative of Wanda's perspectives, it is being shared as part of her profile and not as part of Patrick's. Neither Patrick nor Wanda filled out a CPRS at posttest. According to Wanda, her relationship with her child of focus had lower than average conflict, many positive aspects, and an average level of dependence. None of the 30 items on the measure were marked a 3 (Neutral, not sure). On the Conflicts subscale, Wanda rated all items a 1 (Definitely does not apply) or a 2 (Not really) with the exception of two. Both item 18 ("My child expresses hurt or jealousy when I spend time with other children") and item 27 ("My child whines or cries when he/she wants something from me") were rated a 4 (Applies somewhat). On the Positive aspects of relationship subscale, almost every item was given a 5 (Definitely applies). Only item 22 ("I've noticed my child copying my behavior or ways of doing things") was given a 4 (Applies somewhat). This meant that Wanda had a subscale score of 49 out of 50, the highest score on this subscale of any other participant, pre- or posttest. Of course, this did not coincide with her anecdotal relationship data. Was social desirability a factor, or was Wanda completing the CPRS from the perspective of her wishes or fantasies for her relationship with her child of

focus? With only four items, the Dependence subscale was more difficult to interpret. Two items, 6 and 11, were rated a 2 (Not really). The remaining two items, 9 and 26, were rated a 5 (Definitely applies). These items read, "My child reacts strongly to separation from me," and "I often think about my child when at work," respectively.

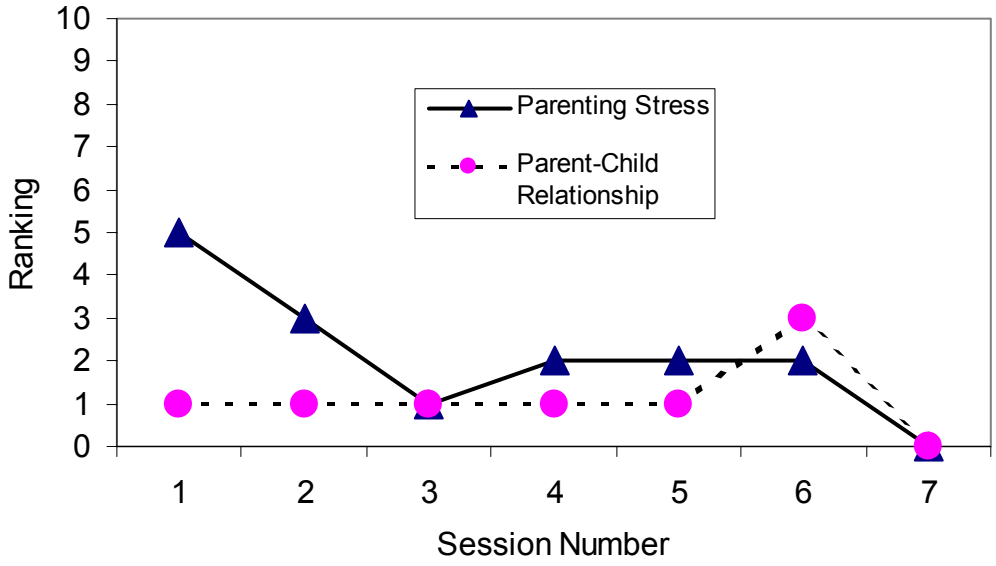

Figure 8. Anecdotal data collected from Wanda following sessions 1 through 7. On the rankings, 1 represents "Worst Ever" for both questions, while 10 represents "No Stress" for parenting stress and "Best Ever" for the parent-child relationship.

Qualitative Data

Focus Group Themes

From "bad guy" to "the guy that helps out": Participants felt a number of negative emotions regarding their roles as parents prior to filial therapy training; application of the filial skills helped them to feel better about their parenting roles. During the first few weeks of the group, I expended a considerable amount of energy redirecting the focus back to the filial therapy skills because the participants seemed anxious to demonstrate their competence as parents. They wanted to share anecdotes and stories from their parenting experience. This was particularly true for those who were court-mandated to attend (which included four of the five participants who began the

group). There must have been some degree of shame for these participants in being forced to improve on a role that much of the world considers innate. I wonder, too, if it wasn't humiliating to be instructed by someone (me) who, at the time, was not a parent herself. Something inside of me told me that their defensiveness must be a reflection of their feelings of inadequacy as parents. So throughout the group, I worked very hard to champion their understanding and application of new skills. Behind my redirecting and my obvious enthusiasm for filial therapy was the genuine belief that if these participants were to have any hope of feeling better about their role as parents, then I needed to take advantage of what little time we had together. In short, it was not until the last evening that we met together, in the context of a focus group about their experience, that the negative emotions many of the participants felt about their role as parents prior to filial therapy training were openly expressed. Looking back, I must have been touched by their willingness to be so vulnerable. At the end of the focus group, I told them that I had intentionally engineered my role to be different from that of their social workers, judges, or other institutional representatives. I shared my decision to know very little about their histories, and instead to get to know them through our interactions in group. It was my hope to be able to sincerely approach them as competent parents. What emerged from our discussion is at least a testimonial to filial therapy's effectiveness with this sample, and is perhaps a tribute to my relationship with them, as well.

One of the primary emotions that participants felt about their parenting before beginning filial therapy training was guilt. They took a lot of responsibility for how their children felt, and for the quality of the parent-child relationship. Connie described how she felt as a parent before filial therapy training, and how the skill of empathic listening improved her outlook on parenting:

> It was horrible. I was stressed, and frustrated, and afraid of losing my bond with Aaron [her younger son and child of focus for filial therapy] like I did with Samuel [her older son]. Like him [gestures towards Marcel with her pencil], I let Aaron do a lot of talking, whereas I didn't listen before. Then I've learned a lot of things to take it off of my shoulders, where I felt guilty. And I've learned how to ask, or, not ask, but do the reflection. Whereas before, it was like, if he looked mad, I took it personally. You know, "Oh, God, what'd I do now. I can't win,"

> you know, "no matter what I do." When he may not have even been mad, or upset about anything.

Latoya also appreciated how use of the empathic listening skill resulted in her feeling better as a parent:

> [Reflecting] helped me out better as a mother, 'cuz now he knows that I'm there and I understand what he's goin' through and what he's tryin' to say to me now. And like before I be like, well, if he got mad, I was mad…I was walkin' around like I had a monkey on my shoulder. "Okay, we just goin' to be mad for the day."

The empathic listening skill was also mentioned by Marcel during the focus group. In fact, it seemed to be the most important skill he learned in filial therapy training, because he came back to it numerous times during our discussion. In reviewing and reflecting upon Marcel's comments about his use of empathic listening with his son, it appears that he had a complete paradigm shift as a parent through his use of empathic listening. Before filial therapy training, he projected his own perspective onto his son. As he listened empathically to his son, he was able to see things from his son's point of view. These are his words:

> I thought that he [his son] would understand more than, you know, I thought, you know, about the situation between me and his mother splittin' up and everything like that. But come to find out, you know, he didn't know as much as I thought he did…The kid's smart, you know, my son's smart. He can sense it, you know…now as…I listen to him more…it shows me what he knows, you know…Yeah, and by talking to him more, and…I mean, actually listenin' to him, not really talkin', just lettin' *him* do the talkin'. You know, and it kind-of, you know, like, I understood then.

About halfway through our filial therapy training, I dropped off Marcel's filial toy kit at the agency where he had weekly supervised visits with his son and had an opportunity to speak to his case worker. She indicated that most of his visits were spent doing activities—such as playing video games and with remote control vehicles—that did not allow Marcel and his son much interaction. However, Marcel's self-report during our focus group several weeks later pointed to changes in how he approached being a parent to his son:

> Being a parent for my son, the only thing I've gave him is more time and listenin' to him. But he's older now, see, he's older now, and everything…I went through a program. It's been like a year, over a year, so, you know, he's done got older now, and now he's talkin' more. So, you know, I've always been there for him as a parent, but, you know, I listen to him more now, you know… When I was workin' I didn't have that time, much time, you know, to really spend with him, you know, 'cept maybe at the dinner table playin' a little bit, you know, goin' to the park a little bit…So, that's basically, you know, basically about it. Just more time. I'm givin' him more time. Talking to him more. I mean, playing and going to the lake and all of that, you know, havin' fun and stuff like that, I mean, he's always having fun. But never really sittin' down and really listening to him, you know, really talking, seeking his point of view, and stuff like that… during the visitation, the last maybe 10, 15 minutes, you know, I try to get everything up early, and then we sit down and we talk. So, you know, it's basically lettin' him talk…I mean, Jason [his son], he's 8, but I'm telling you, he's real smart.

By using the empathic listening skill, Marcel seemed to approach his parenting role differently. It became less about doing things and more about being present with his son. I sense awe and wonder between the lines of Marcel's words, as he outlines his discovery of his son as a separate, unique—and intelligent--person, not just the physical representation of a responsibility.

While empathic listening was by far the most talked about of the four filial therapy skills, the structuring and limit-setting skills were also mentioned. The play skill may not have been talked about because it is less tangible, but seems to follow naturally when caregivers have been able to master the other three skills. When I asked the group what the most helpful thing that they had learned was, Connie immediately piped up about "consistency." When I asked for clarification, she elaborated about the structuring skill: "Just having it [the filial play session], having it in the same spot. Him [her son] knowing that this is our time, and no one's going to interfere."

Marcel also gave credit to the structuring skill in helping to create a setting that is conducive to his son being able to talk with his father: "Then, you know, he'd just run

around, but now he knows he's got his time, then, you know, then he talks. He knows he's got the floor."

With regard to the limit-setting skill, it sounded like from what Marcel said that he was already using aspects of it with his son before he did the filial therapy training:

> Usually I take somethin' away from him, 'cuz you know, he likes to ride his power wheels, or somethin' like that. And I'd say, "Well, you do this, I ain't givin' no more chances--three strikes, you're out. We're not gonna be ridin' no toys, or playin' with this today." So, you know, like, you know, it's settin' limits for him, you know.

In contrast, Latoya did not know this skill before filial therapy training: "At first, I wasn't a strong enforcer…I let him [her son] get away with a lot of things." At the end of our group, she was the one who primarily sang the praises of the limit-setting skill as being the most helpful concept she acquired, in company with the empathic listening skill and the Oreo Cookie Theory.

Interestingly, the Oreo Cookie Theory is not one of the four filial therapy skills and so was new to both the participants and myself. When my research partner and I communicated with Garry Landreth about our study, we obtained his permission to use his handouts and videotapes. One of the videotapes we had previously used in our pilot study. In it, Landreth demonstrates three of the four filial therapy skills in a play session (Landreth, 1997). However, a second videotape (Family Care Productions, 1996), which Landreth shows during the second half of his filial therapy groups, discusses his Oreo Cookie Theory. This videotape appears to be a distinguishing feature of Landreth's filial therapy model, because it adds an additional concept or skill to the standard four filial therapy skills that I have never seen in the literature. The theory derives its name from a personal experience that Landreth had with one of his daughters when she was three years old. One night, she emerged from the kitchen with an armful of Oreo cookies. Landreth realized that his daughter had not yet had the opportunity to make any choices of her own, and so he gave her her first choice: she could return all of the cookies to the kitchen, or she could eat one of them and return the rest. She made her decision (the latter, of course), and the theory was born. Essentially, the theory is a practical, everyday extension of the limit-setting skill, coupled with Piaget's concept of consequences. The

idea behind the theory is that children have the opportunity to learn that when they make a choice, they are also committing themselves to a consequence. To emphasize the child's responsibility, parents are encouraged to use the words "you choose" in stating the choices and consequences. For example, a parent might say, "If you choose to clean up your room, you are choosing to go to the park this afternoon. If you choose not to clean up your room, you are choosing not to go to the park today."

One of the wonderful aspects of the theory, when properly applied, is that it takes parents out of the punisher role. This was Latoya's experience in applying the Oreo Cookie theory:

> 'Cuz now it don't make me feel like, well, I oughtta punish him, that I'm like, "Oh, gosh, he goin' to hate me forever." 'Cuz his daddy doin' a whole lot of punishing, and not caring for him the way he been used to. So I don't want to be the bad guy on everything, so now I just give him choices, and he goes by 'em. And he'll say…'cuz we did use the choice, the Oreo Cookie, Thursday, also. 'Cuz he wanted a juice--one of 'em was a $1.19, one of 'em was a $1.00. And he wanted a soda that was $.55 or $.70. And I said, "Well, you got a choice between all three of 'em. Either you get you a soda, that's $.70, and your oatmeal cake or cookies or somethin' like that, or you just get the juice, and no cakes or nothing." And he was like, "Hmmm." [She imitates his expression—pursed lips, head down, in an obvious state of reflection]. And he went over there, and then he got the oatmeal cake, and he looked, and he said, "How much money you got, Momma?" And I didn't have to count nothin' for him, and then I just opened my hand, and he told me exactly how much money I had in my hand, and I was like, "Hmmm, you're smart." So, I got the soda and the water, and we just immediately started sharing. And he was like, "Well, that's fine," and even though he drunk all the soda. That was fine with me.

She further explained what it used to be like going to the store with her son, and how this changed when she introduced the Oreo Cookie Theory:

> At first, he'll get in a store and he'll fall out, and like [she imitates her son's tone, which is whiny] "Oh, well you always get me stuff," and I'll feel guilty, and I end up goin' back there. "Well, sit right here for a minute." I leave him in the car

> with his aunts, go back in the store, end up getting the stuff for him. So now he know he gotta make a choice, and he be like, "Well, I'm okay with that, because if I make the choice…I made the choice."

Latoya no longer felt guilty when she put the decision, and accompanying consequence, on her son's shoulders. Connie described the Oreo Cookie theory as a concept designed for her, as a parent, in relieving her of some of the weight of parenting: "Yeah, the reflecting benefited Aaron [her younger son and child of focus for filial therapy] more so, and then being able to give him the choices, the Oreo Cookie, just took it right off my shoulders and made me feel a whole lot better."

I experienced similar success with the theory. Simultaneous to conducting the filial therapy group, I was working with seven three-year-olds at my church for two hours each Sunday. When I learned about the Oreo Cookie theory along with the participants, I was intrigued and began to use it with these kids. It worked so well that soon parents were asking me to teach them what I was doing. Although not a parent at the time, I went from feeling overwhelmed to empowered in my caretaking role with these children.

Both Connie and Latoya used the term 'bad guy' to capture their experience of their previous parenting roles. Filial therapy helped Connie "to not look like, well, feel like, the bad guy." Latoya expressed it this way: "You don't have to be the bad guy no more. You can be the guy that helps out now." Summarizing the changes that had taken place for her as a parent, Connie said:

> I feel better. Feel a bit more stronger…I don't have that knot in my stomach like I did a few months ago…I have some tools, some skills now that I can apply that seem to be working. And so I feel a little bit better about it. I don't feel all guilty and hating myself for whatever it is I thought I wasn't doin' before. I mean, like I say, I may not have even been doing anything.

Clearly, participants' feelings about their role as parents became more positive over the course of filial therapy training. Overall, they seemed empowered, and were able to articulate which aspects of the training (i.e., which skills) had had the greatest effect on them as caregivers.

One of the five participants who began the filial therapy training, Jacqueline, was not a part of the focus group because she moved halfway through our sessions. Although

she was only in our group for four of the eight weeks, I do not want to overlook or discount her experience, particularly in the context of her feelings about her parenting role. I have, therefore, tried to capture her voice by recounting my interactions with her over the first four weeks. The first week, she expressed both verbally and with her body language that she did not want to be there. My overall impression was that she was depressed and angry, and throughout most of that first session she kept her head down, and did not make much eye contact. My approach was to openly acknowledge what I was seeing in and sensing from her, and to let her know that I was okay with it. During the second session, she opened up more. She talked about how she had tried everything with her daughter, and how nothing had worked. She shared parenting 'horror stories.' In addition, she intimated that she was moving clear across the United States to get away from her social worker, who she felt was forcing her to participate in our group. By the third week, she was asking specific questions about how to apply the filial therapy skills to her daughter. Some of these were hypothetical—"What do I do if my daughter does or says this?" or "What if this happens?" At the end of this session, we talked for some time. She had her filial toy kit in a cardboard box in her arms, and a video camera in a bag slung over her shoulder. She was going to try to initiate her first filial play session with her daughter that week, and then return the following week and report to the group. She seemed encouraged, and I remember the sparkle in her beautiful, big, brown eyes when she said that she was excited to try the filial approach. She said that she wanted to get all of the handouts for the sessions she would miss, and wanted to keep in touch even after she moved. When we met with Jacqueline for the last time, our fourth session, I knew by her presentation that she had not felt successful during the week. Her report to the group confirmed this: her daughter had been skeptical of both the play session and the videotaping as parenting class 'homework assignments,' (i.e., she questioned her mother's motivation for having the play session), and had refused to do either. I responded by encouraging Jacqueline to let her daughter know that it was her decision to have the play sessions when she was ready, and that her mother would be ready when her daughter was. I also suggested that she forget about the videotaping. She borrowed the video camera again, nonetheless, because she was hopeful that by not pressuring her daughter, she could still capture some of their experience on tape. I was impressed with

how empowered she had become in only four weeks, even with a setback. That was the last that we saw of her. She dropped the video camera off at PCARV before she moved, but did not leave any forwarding information. My attempts to contact her relative (whose number she had given as her contact while she was living in the area) resulted in a message being left on that person's answering machine indicating that messages for Jacqueline's family would be ignored. I can only hope that she has been able to build on the encouraged demeanor she seemed to demonstrate during the third and fourth weeks in group, and feel more successful as a parent wherever she and her family now find themselves.

There are other ways to talk about parental empowerment besides through the medium of the filial skills. For Latoya, simply completing our group was a significant accomplishment. Several weeks into our group, I received a phone call from Latoya and Raquira's social worker. He indicated that Latoya's parental rights had been terminated with her older son because, among other things, she had not completed a parenting course. Apparently, Raquira had a similar history with parenting classes. The primary purpose of his call was to verify that Latoya and Raquira were attending our group because they were both at risk for losing their target children if they were noncompliant. As Latoya and Raquira *did* finish our group, I was curious about what was different this time. There must have been contextual factors that had nothing to do with me or my chosen approach. For example, perhaps both knew from Latoya's previous experience in losing her first son that 'the powers that be' would follow through on their threats. Maybe, too, the maturing process had enabled them to take more responsibility for their parenting. Still, I hoped that there was something about our group when compared to the others that Latoya and Raquira had attended that had made a difference. Raquira offered very little in this regard, other than "this is not my first time in parenting classes, this is like the fourth time, so…I learned something from them, and here." Latoya, however, did allude to both contextual factors and unique content as contributing to her successful completion of our group:

> All my other former parenting classes—I did two with my first son, two with Obadiah [her child of focus], but I was in school at the time they was doin' it, so,

> this one, it was just somewhat the same, but it was different. Because the skills…like the limit-setting…I didn't know those.

Although Latoya was not in the comparison group, she has been in several other parenting classes like it and so speaks with considerable experience. From her perspective, one of the things that contributed to our group was the inclusion of the limit-setting skill in the curriculum. This insight led me to reflect on one of my initial interactions with Latoya and Raquira, during the first few minutes of our first group. They wanted to know if it would be all right for them to be a few minutes late each week, due to the bus schedule. My gut response was, "No." I felt that some boundaries needed to be set immediately, a response which is probably best understood in the context of my role as a therapist. For me, limit-setting is more than just a concept to be taught as part of the filial curriculum. I believe in it, and consistently use it in my clinical work with clients. In addition, I have found that any positive concept I am working on with clients is best internalized by them if it is modeled by me and woven into our interactions and relationship. Similarly, Latoya and Raquira's initial question seemed to warrant an intervention in limit-setting, the very concept I hoped to teach them a few weeks later. Of course, these insights were subconscious at the time. What I was aware of was that neither Latoya nor Raquira wanted to be there, and I guessed that their proposal was a convenient way to get out of some of their mandated group time. However, in order not to overstep the bounds of the agency with whom I was partnering, I checked with an on-site PCARV staff member, who confirmed that this would not be acceptable. When I relayed this to Latoya and Raquira, the potential power of their idea to sabotage our work with each other was instantly diffused and the issue virtually forgotten. As if on cue, Connie responded with an offer that was both within the boundaries that had just been set and hard to refuse--to give Latoya and Raquira rides to and from our groups. Returning to Latoya's comment that limit-setting was a novel concept in her parenting class experience, I am led to wonder what part of it was new. It is hard to imagine that any parenting class would *not* cover limit-setting as part of its curriculum. Was this a completely new idea for Latoya, or did she grasp it for the first time in our group because it was not just part of our curriculum, but also our relationship?!

The end result of Latoya's experience in our group was that she was not only successful in completing the group, but also felt more successful as a parent. However, all indications (from my observations to her reflections) are that she started out as skeptical of our group as she had been of her previous parenting classes. During our focus group, when I asked participants what their initial impressions of filial therapy were, Latoya showed no qualms in saying:

> I thought it was a joke (laughs). Especially when you [referring to me] was like, "We're going to be in here playing with toys," and I thought it was a joke. And I sensed it as a joke. Well, what parent out here *doesn't* play with their child?!" So, I just took it as a joke.

The idea of playing with toys as part of a parenting class was amusing and novel for Latoya, because, from her perspective, play is an innate part of the caregiver-child relationship. It is ironic that she was in such disbelief about play being a part of our curriculum: in the end it seems to be the very thing that kept her coming—what she really wanted and needed. These are her words:

> When we first got into it, I was like "Well, here go another parenting class that I'm gonna' drop out of, 'cuz I already know how to do these things." So, that's the way I felt about it at first, until we got into it, like in the 4th or 5th week, getting hands-on training, different methods of Oreo Cookie theory and all the methods…giving the child a choice, that made a big difference right there.

Still, even after learning the four filial therapy skills and practicing them in 'mock' play sessions as a group, Latoya was unconvinced that the primary skill, empathic listening, would be effective with her son:

> The reflecting, at first I was like, "Well, that's not going to help the kid"…'Cuz at first I thought he was goin' to take it as, well, "Why you bein' so nosy?"…Because my son…when you ask him certain questions, he like, "I don't want to talk about it," and that's how he'll get, and he'll get sour…He's been goin' through…a lot emotionally. And I've been seein' it on phone conversations; sometimes when I see him. But now since I've been reflecting, I'm like "O it sound like/it look like you upset," and "Wanna talk?"…So…the reflecting did pretty much help.

Latoya's good experiences using reflecting (and the other filial skills) with her son, and her successful completion of our group, led to the realization that group filial therapy training offers things that other parenting classes do not. She knows of what she speaks, having attended several other parenting classes. Her son, Obadiah's, father has had to attend at least one parenting class, as well. She sums up both of their experiences by saying: "He didn't learn the same things we learned in parenting classes. Just the general parenting that he learned—about how not to shake the kid—and so he didn't learn what we learned." Apparently, group filial therapy training helped participants to feel successful by teaching them "hands-on" skills that went beyond "general parenting" knowledge.

"Mama, I'm a man now": Participants' use of filial therapy, in general, and their use of empathic listening, specifically, resulted in their children feeling "bigger." Three of the four participants talked about how one of the specific results of using empathic listening with their children was that their children felt "bigger." This theme emerged as somewhat of a surprise, as it was not the result of a specific question but was woven into the narratives of the participants. Connie expressed this theme by saying: "It makes them feel…like a bigger person, when we allow them to have time to talk, and give them their time." Her words seem to imply that it is not just empathic listening, specifically, that has this effect, but the process of filial therapy, in general (i.e., "giv[ing] them their time"). Later, she added: "The reflecting benefited him [her younger son and child of focus for filial therapy] and made him feel bigger and more important."

Two of the children expressed their "grown up" feelings openly to their parents, and the parents' retelling of these experiences confirmed their ability to apply both the empathic listening and play skills. Marcel indicated that his son:

> Always says, "I'm a big boy, now." So I let him, you know, I let him go ahead, and, you know "Okay, you a big boy, okay," and I play along with him, listen to what he's goin' to say. So that's helped me…yeah, it makes him feel like he's bigger than me. So, I let him play it out.

Latoya is also able to 'play along' with her son when he is feeling like a grown up: "One day he told me, 'Mama, I'm a man now.' And I said, 'Yes, you are.' So I agreed with him that he was a man, so that made him feel good, too." Now her son knows that it does

not threaten his relationship with his mother to pretend to be something he is not in reality. He thinks:

> "I don't have to be like I'm the kid all the time--play the kid role." So he's played the little big guy, and all that. So, he's a grown man now. And I'm like, "Well, you think you're a grown man, you're a grown man."

This theme may also provide some support for the validity of using filial therapy with school-age children: the fact that three of the four participants' children felt "bigger," as opposed to infantilized, through the process is an indication that it is a type of therapy which may be modified and extended for use with older children. This should not be surprising. The filial therapy skills encompass many of the elements that set the context for a healthy relationship with someone else, regardless of the age of either party. These include structure or context, limits or boundaries, clear roles, and attending behavior.

"Mama, you changed": Positive changes occurred in caregiver-child relationships as a result of implementing filial therapy skills. Two caregivers, Connie and Latoya, talked about how their caregiver-child relationships changed as they applied filial therapy skills. Prior to introducing filial therapy to her son, Connie described him as requiring a tremendous amount of her attention. However, between her first and second home play sessions, Connie reported to the group that her son was no longer "constantly on [her]" to play with him, nor was he "coming to [her] for reassurance 20 times throughout the day." By the time we had our focus group during our last group meeting, Connie had had several home play sessions and was convinced that filial therapy:

> Took away from that, "Mom, come play with me," "Mom, come here and sit by me," "Mom, come here." You know, as long as he gets that 30 minutes, it seemed that all of that other neediness died down.

Instead of the persistent need for his mother's attention and reassurance, Aaron (her child of focus) became very protective of his weekly play session time with her. "He look[ed] forward to it." Saturday morning was their designated time. So great was Aaron's anticipation that following their second play session, Connie admitted, "I have to fight for my time Saturday mornings—to get ready, take a shower, have breakfast." As Connie

described her relationship with Aaron before versus after having introduced filial therapy play sessions, she wryly quipped:

It's a lot better. Maybe almost a little TOO much. Because just like when Samuel [her older son] is around now, Aaron doesn't want to give up our time. So it has actually brought us closer. So it's all been a good thing.

Latoya also felt that her bond with her son had been strengthened as a result of introducing filial therapy skills. This was especially evident when compared to her son's relationship with his father. Their son, Obadiah, was in foster care during most of our group, but towards the end his father gained temporary custody of him. Lacking skills that he saw in Latoya, Obadiah's father began to seek Latoya's help in parenting Obadiah. The night before our last session and focus group was one such time. As Latoya described this encounter, it became clear that there was a qualitative difference in the two parents' relationships with their son:

> So only thing I got to do as a mother is try to get him [Obadiah] to open up with his father…'Cuz he don't have a strong skills of opening up with his father. And his father can sense it, 'cuz when his father came stormin' through our door last night and was like, "Oh, I am so exhausted." And he can't find his medication. And I'm sittin' there like, "Uh, duh, duh, duh, duh. Well, this is the way it got's to do, he have to sit down with you and talk to you." He was like, "Yeah, but, sometimes I really don't know what's on his mind, because I can't see it…I don't understand, so whenever I have a problem, I'm gonna' come run to you." I said, "Well, you can, but he's not gonna give me the hassle that he gives you." Because the comin' to the…doin' the filial therapy, it made our bond stronger than it was before.

Listening to Latoya, it was as if she were saying, "You [Obadiah's father] can focus on 'what to do' all you want, but until you begin to focus on Obadiah, over skills, you are going to continue to struggle." In other words, until the relationship with the child is paramount, as it is in filial therapy, it doesn't matter what skills are used. They will be less effective, and the relationship will not be strengthened.

Obadiah could feel the difference in his relationship with his mother, and was able to articulate it. I got chills as Latoya shared the following conversation in our focus group:

> He told me, well, Saturday before last, he told me, "Mama, you changed." And I said, "Well, how did Mama change?" He said, "'Cuz, well, I know you used to always talk to me before, but you understand a lot more now." And he said, "Sometimes I don't have to tell you anything," he say, "you can just look at me or you can just hear me and hear my voice, and now you know." And I was like, "Mmm-hmm." And I tell him I'm not there to pressure him--if he wanna talk about it, I just let him know I'm there.

Latoya's weekly visits with her son at the Department of Social Services (until his father gained temporary custody) were at the same time as visits between other caregivers and their children (including Raquira and her son, Max). All of them met together in a large room, which was not conducive to one-on-one filial play sessions. However, Latoya reported that she used the filial skills during these and other contacts (such as the phone) with her son. In contrast, Connie applied the skills during weekly filial play sessions. Yet both mothers experienced qualitative differences in their relationships with their sons. It seems that the filial skills enhanced time spent together, whether this was in formal filial sessions or not, such that the caregiver-child relationship was strengthened.

"Why are you giving me limits and consequences?": Participants generalized the filial skills to other relationships. Perhaps because of the positive changes that participants saw in their caregiver-child relationships, they began to generalize the filial skills to other relationships. For example, when Obadiah's father gained temporary custody of him, he began coming to Latoya for parenting help and advice. In addition to giving these, Latoya also began to set appropriate boundaries in her relationship with Obadiah's father:

> Pretty much, I used the limit-setting skills on him (general laughter). And he looked at me like, "Well, wait a minute, why are you giving *me* limits and consequences if I don't do this?" And I'm like, "Well, if you don't want to go by it, then…you don't have to go by it. But the consequence is I'm not going to speak to you the way you want me to speak to you."

Similarly, both Latoya and Marcel were able to share the related concept of choices being connected to consequences—as outlined in Landreth's Oreo Cookie theory—with two of their relatives. Marcel included this idea in a goal-setting discussion with his niece:

> I've used, you know, some of the skills with my niece by setting, you know, goals and…sitting around, say "Well, if you do this, this is going to be the consequences, " or "You got a couple of consequences," you know.

For Latoya, the power of the Oreo Cookie theory was not lost on her younger sister, who is developmentally less mature and has a difficult time making decisions:

> My baby sister…sometimes she nitpicks (she chuckles). She like to get on my nerves. She like to curl up under me. I'm like, "Katrina, either you wanna curl up under me, or you wanna sit over there." So, I give her a choice. Or, "Katrina, do you wanna go to the store with me? You gonna have to stop doin' this. Make up your mind, because once you make that choice, I'm not going to take it back." And she was like, "(Sigh). Okay." So she get the little pouty face, too.

Connie, who earlier in our focus group described the empathic listening skill as of greater benefit to her son than to her, later talked about how much it helped *her* to clarify the state of her relationship with her boyfriend:

> Yeah, I had been datin' someone for, I don't know, close to two years. We split up about halfway through this, which is not a bad thing. But, yeah, I used the reflective feeling on him, you know…I guess, not just with Aaron, but I'm like that with everybody…If they look mad…I just think, "I messed up, or something," you know. Instead I [now] say, "Well, you look like you're pissed off today,"…and that worked. 'Cuz I got a lot of, "No, I'm just sittin' here, watchin' T.V." kind of thing.

Having learned new skills that they found helpful in their caregiver-child relationships, three of the four participants began to use these skills to more successfully maneuver their way through other relationships.

"Now that he done got older": Filial skills can be modified to be appropriate for school-age children. One indication that filial therapy can be successfully modified for school-age children was in the theme that three of the four participants' children felt "bigger" as their parents used the filial skills with them. One participant, Latoya, also

talked about how the filial skills helped her to respond to the changing dynamics in she and her son's relationship as he grew:

> At [the beginning of our group], I wasn't a strong enforcer. I [used to be able to] just look at my son a certain way, and he [knew] right then and there to stop. Now it's getting to the age where it don't matter which way you look at him, "I'm not going to listen to you. I'm still going to do it."

Previous methods of "controlling" her son's behavior were now no longer effective; the limit-setting skill helped to bridge the developmental gap in discipline. Similarly, empathic listening enabled her to get in touch with her son's thoughts and feelings now that he was at an age where he did not want to be asked a lot of questions:

> The reflecting—I was doin' part of that when Obadiah was younger. But I [became]…stressed out more now that he done got older and he keeps everything hidden inside. But [empathic listening] helped me out better as a mother, 'cuz now he knows that I'm there and I understand what he's goin' through and what he's tryin' to say to me now.

While Latoya gained skills that helped her to better parent her changing son, Connie learned to adapt the empathic listening skill so that it was a good fit for her son. She raised the important point that perhaps the issue is not so much the age of the child, but the caregiver's flexibility in modifying the skills so that they are appropriate for the many contextual factors in the child's life, including her/his age:

> I think it just goes for the individual person…finding your own little niche in the thing…just like with the broadcasting deal, I had to calm that down. But that doesn't mean it would be wrong for…someone…who is the parent of a five-year-old, or somethin'…That's just the only thing that didn't work for me, but, you know…the whole idea worked…just not that part…that degree of it.

In conclusion, there were many positive things that resulted from the participants' exposure to and experiences with filial therapy. In fact, when I asked them about what *didn't* work for them—with regard to the group itself or filial therapy--they had nothing to say other than that some of them would rather not have had to complete the self-report measures. Instead, they felt more successful as parents, their children felt more grown up, and their parent-child relationships were strengthened. In addition, participants

generalized the filial skills to other relationships, and gave indications that filial therapy can be appropriately modified for school-age children. In summarizing her own experience doing filial therapy sessions with her son, Connie provided a fitting overall conclusion:

> It kind of tickles me to see him feel so good, and so empowered, you know, when he's doin' this stuff…I can just tell how good he feels about himself, and then that makes me feel good.

Discussion

The primary objective of this study was to investigate the effectiveness of a modified filial therapy model with court-ordered, maltreating parents of school-age children. Three main questions guided this inquiry. First, did the modified filial therapy training reduce participants' child physical abuse potential? Secondly, did the modified filial therapy training reduce participants' parenting stress? Third, did the modified filial therapy training strengthen the parent-child relationship?

Child Physical Abuse Potential

There were a surprising number of participants whose quantitative scores at pretest represented low child abuse potential. Only one of the participants in either group had a high Abuse scale score on the CAP Inventory. Three others had invalid Abuse scores, and the remaining four had Abuse scores that were below the cut-off (representing low child physical abuse potential). Because the participants had either already abused or neglected their children, or were considered at risk for so doing (with the exception of one in the experimental group, who self-referred), it was assumed that most of them would be classified as child physical abusers. Why this did not occur is unclear, but there are several possible hypotheses. One is that the CAP Inventory is more likely to yield false positive classification errors than false negatives (Milner, 1986). In other words, some of the participants whose Abuse scale scores were below the cut-off might actually have been child physical abusers who were misclassified. There was also the issue of the small sample size, which may not have been representative of the court-mandated population as a whole. On the other hand, perhaps the sample was more representative than it might have at first appeared, in that it included a range of profiles (i.e., statistically speaking, a greater number of court-ordered parents would probably score in the normal range of a distribution than at its extremes). Social desirability may have also played a role in this phenomenon. Three participants had invalid Abuse scale scores at pretest due to distorted responses, which may have masked their true child physical abuse potential.

It was Jacqueline, Patrick, and Raquira who attempted to present themselves in a socially desirable manner on the CAP Inventory, thus rendering their pretest (and posttest for Raquira) Abuse scores invalid. There are three validity scales and three response

distortion indexes on the CAP Inventory. It is interesting to note that all three of these participants had the same combination of elevated scores—both their Lie scale and Faking-good index scores were high. Only Patrick had a valid Abuse scale score at posttest (Raquira's score was still invalid, while Jacqueline did not complete posttest measures). Walker (2002) facilitated a similar study of filial therapy's effectiveness at the same time that this study was being conducted. She had a larger sample of 12, which included court-referred parents who had maltreated their children ages 5 and under. Six of the seven participants in her filial therapy treatment group had invalid Abuse scale scores at pretest due to elevated Faking-good distortion index scores, as did two of the five participants in her comparison group. Interestingly, at posttest six of the seven participants in the experimental group and four of the five in the comparison group had valid Abuse scale scores. Because this phenomenon was present in both the experimental and comparison groups, it suggests that both types of intervention were successful at reducing participants' tendency to present in a socially desirable manner. In addition, this pattern may point to a trend in terms of a common response pattern for the court-ordered population: they feel shame regarding their court-mandated status and have a need to 'save face.' In my weekly interactions with the experimental group participants in this study, I sensed that they felt shame about being court-mandated for remedial parenting help. It seemed important to them that they demonstrate their competence as parents, especially during our first few sessions. This observation was confirmed in their participant profiles. Some participants gave socially desirable responses, on the CAP Inventory and the anecdotal data sheets in particular, in apparent attempts to look good to me (and perhaps to others). The focus group further complemented this finding, adding additional layers to the shame theme. The first question I asked during the focus group was about participants' relationships with their children of focus before our group began. I was amazed as I listened to them give voice to their shame for the first time since we had started meeting together eight weeks earlier. They used different descriptors, such as guilty, stressed, frustrated, and afraid. They talked about physical symptoms, such as knots in the stomach. Connie said she had previously hated herself as a parent, while Latoya was concerned that her son hated her. Connie had also felt like she "couldn't win" as a parent. Both Connie and Latoya saw themselves as "bad guy[s]."

This shame theme has important implications for future clinical work and research. Based on the way some of the participants distorted their responses on the CAP Inventory, it would be a measurement challenge for *any* instrument to correctly classify their child physical abuse potential. Kolko (1996) confirms that "it is difficult to identify abusers by using individual self-report measures" (p. 27). It seems that the most reliable method of assessing child physical abuse potential is by first building a relationship of trust with the person, and then utilizing qualitative methodology, particularly interviewing, to access her/his own story. In hindsight, this study would have greatly benefited from interviews with each of the participants, particularly given the small sample size and the author's very limited contact with the comparison group. An interview aimed at assessing a court-ordered individual's child physical abuse potential (in a clinical *or* research setting) might begin with open-ended questions such as, "Who wronged you?" (Dinkmeyer, 1999).

Joining is an essential part of any therapeutic alliance. In fact, it has been recognized as the single most important factor that contributes to and determines clinical success. Court-ordered individuals need such a connection as much as, or more than, others. While they may genuinely need parenting instruction, they often feel silenced by the very systems that have required this assistance, who have pigeon-holed them into a category (court-ordered or court-mandated) that is more heterogeneous than homogeneous. Is it any wonder that their discouragement and disempowerment manifests as resistance, earning them an additional label of 'difficult?' As a case in point, when I told my grandfather, a retired physician, about this study he chuckled and said, "That sounds like my granddaughter—always tackling the tough populations!" He then proceeded to name other 'difficult' populations, such as inner-city and prison, with whom I had previously worked. How does such a classification affect our work with clients from these populations? Often the label subsequently becomes a self-fulfilling prophecy, and enables us as helping professionals to exonerate ourselves of any culpability when the client is not successful. In short, it keeps us from joining with such clients.

My interactions with the court-ordered parents in this study challenged this tendency. I wanted the study to be successful, and in order for this to happen I

instinctively knew that I needed to treat the participants differently than they may have been treated by other representatives of various institutions. They needed me to demonstrate my belief and investment in them. A large part of this was accomplished through what I will call honor. I see honor as the clinical antithesis of the almost palpable shame that court-ordered individuals, and others also labeled as 'difficult,' carry. It is a way of giving space and recognition to what people are doing that is worthy, rather than giving 'air time' to further evidence of their perceived failures. For example, when Latoya and Raquira missed the second session, I had a choice. PCARV would allow them to successfully finish our group with one absence. However, without the second session, they would be without foundational knowledge regarding the filial therapy skills that is critical to conducting home filial therapy sessions. So, I called them and made arrangements to meet prior to the following week's group. When they were late for this rendezvous, we met for a few minutes and then tried again the following week. This time they came at the appointed hour and I was able to help them catch up. Given their history with parent education, it would have been easier to dismiss them as proven delinquents. But I didn't know their history at the time. I tried to honor the participants by not seeking information about them (other than what they offered in group) until we had completed the eight-week filial therapy training. Even then, I only obtained demographic data sheets on each participant, as well as a few notes from the PCARV worker who did the initial interview with each one. This step enabled me to genuinely approach each participant as competent, without our interactions being colored by others' opinions or perspectives.

Another aspect of honor is creating an environment in which people feel validated for their own feelings and experiences, for who they are. Like most of us, court-mandated individuals have a need to be heard and understood, to give voice to their unique circumstances and stories, and to experience the power of empathy from others. I strove to create a context of emotional safety for the experimental group in this study. I struggled to strike a balance between relaying the information that comprises the filial therapy training and allowing sufficient time for participants to share things about themselves. This was difficult. Because the experimental group participants, with the exception of one, were not conducting filial therapy sessions with their target children,

what they wanted to talk about was often unrelated to filial therapy. It did seem to be related to their need to prove their parenting competence. For example, Marcel gave me a copy of what he called 'the triangle,' which is a model of three different roles that we can assume in our interactions with others. He had received it in a previous treatment setting. At the time, I accepted it from him and tried to redirect the group's focus back to filial therapy. Weeks later during the focus group discussion, Marcel asked me about 'the triangle.' It was significant to him, a point of connection.

I believe it is no accident that the experimental group's feelings of shame emerged during our last session together, in the focus group: we had established a rapport over our eight weeks together. I don't think that the same experience would have been possible in the comparison group. These participants did not have the same facilitator every week. Instead, volunteers provided rotating coverage of the class. The facilitator variable has yet to be addressed in the filial therapy literature. This is due, in part, to the fact that previous group filial therapy studies have utilized a no-treatment control group, thus not allowing for a comparison between facilitators of filial therapy and facilitators of the alternative treatment. How do a facilitator's training and characteristics impact treatment, and filial therapy specifically? Most of the studies in the filial therapy literature from the 1990s onwards have been conducted by Landreth and his students. As such, these students have not only received training from Landreth, but have also had his supervision of their research. I, on the other hand, have not been trained by Landreth, but am largely workshop and self-taught in the basics of filial therapy. As a consequence, was this study less effective than it might otherwise have been? What of my additional training and education, and my personality? Did these variables offset my lack of formal filial therapy training in conducting this study? How might my characteristics have compared to those of the volunteer comparison group facilitators in terms of outcomes? Does it make a significant difference to have the same facilitator(s) over the course of a treatment, as opposed to rotating facilitators? Clearly there is a need in the filial therapy literature for research designed to study the facilitator variable.

In summary, a smaller number of participants were classified as child physical abusers at pretest than was expected. While there are a number of possible reasons for this, one contributing factor may have been social desirability in response to feelings of

shame for being court-mandated for remedial parenting services. It is recommended that clinical work and research with the court-ordered and other populations labeled as 'difficult' foster a therapeutic alliance that honors and utilizes interviewing. With regard to joining, future filial therapy research should investigate the facilitator variable.

Parenting Stress

Perhaps the most exciting finding from the individual participant profiles was that there were positive changes for two of the participants in the experimental group with regard to the parenting stress variable. No such positive changes were noted for any of the participants in the comparison group. At pretest, both Connie's PSI/SF Total Stress score and Difficult Child subscale score were high. The first was at the 85th percentile, the second was between the 90th and 95th percentiles. By posttest both were at the high end of the normal range (the 80th percentile). Such scores indicate that Connie's overall parenting stress decreased over the course of the filial therapy group, while her child behavior management skills increased. Similarly, Raquira had a very high PSI/SF Parent-Child Dysfunctional Relationship subscale score at pretest, between the 95th and 99th percentiles. However, by posttest this score was well within the normal range at the 70th percentile. This score decrease points to a threatened parent-child attachment that was subsequently strengthened during our group. These changes in pre-/posttest scores reflect clinical significance for these two participants. In contrast to statistical significance, which can result from trivial changes in a large sample, clinical significance is conceptualized as meaningful change over the course of a treatment for individual participants. It is measured by movement from dysfunctionality towards functionality, such as in symptom reduction (Bergin & Garfield, 1993). As has been outlined, both Connie and Raquira's scores went from being outside the normal range at pretest to being within the normal range at posttest.

Not unlike participants' child physical abuse potential, there were more participants whose Total Stress scores on the PSI/SF were within the normal range than was expected. Perhaps this was partly a reflection of participants' custody status. Only one quarter of the participants had custody of their children. It may be that the other three quarters were not experiencing as much parenting stress as those who had daily interaction with their children. In examining each participant's scores on the PSI/SF, this

theory seems to have some credibility. George was the only participant with high Total Stress scores who also did not have custody of his child of focus. A second hypothesis as to the high number of normal range Total Stress scores is that the PSI/SF's constructs may not have accurately captured some participants' experiences with the challenges of parenting. Patrick and Wanda, the married couple in the comparison group, provide an interesting illustration of this theory. Their PSI/SF scores at both data collection periods were well within the normal range. However, Wanda's anecdotal ratings of her parenting stress, as well as her accompanying comments, completely contradicted her PSI/SF scores. She was obviously experiencing some kind of distress, such as depression, that the PSI/SF did not address. While Wanda's anecdotal data seemed to have more credibility than her quantitative scores, it is unclear which (if either) was more valid for Patrick because his anecdotal data was so erratic.

Individual scores on the PSI/SF did reveal a trend regarding the types of parenting stress this sample was experiencing, namely stress related to difficulties with child behavior management and discipline and stress related to poor attachment bonds. Participants had high scores (some at pretest, some at posttest, some at both data collection periods) on either the Difficult Child subscale, the Parent-Child Dysfunctional Interaction subscale, or (less commonly) both. There are three subscales on this measure, but only one participant (Latoya) had a high score on the Parental Distress subscale (at posttest). When scores are high on the Difficult Child subscale, this is reflective of parental challenges with child behavior management and discipline. Connie, Jacqueline, and Latoya each had elevated pretest scores on this subscale. As a marriage and family therapist, I can attest to the fact that child behavior management and discipline are common therapy issues when there are children in the home. At the same time, when these issues are extreme, I am usually alert to other contributing factors. For court-mandated parents, there are any number of contributing factors to their difficulties with these issues, not the least of which is the multitude of larger contextual stressors that are associated with poverty and marginalized ethnocultural group membership (Abney, 1996; Crittenden, 1988). There is also the chaos that has either led to and/or followed from their court orders for parenting help. Children need structure and consistency, and these are certainly elements that are missing from neglectful homes (Crittenden, 1996), such as

Latoya and Raquira's. Of course, it is the reverse in physically abusive households, in which parents have problems with child behavior management and discipline because they are overcontrollingling and only increase, rather than change or decrease, the discipline when it is unsuccessful (Crittenden, 1988).

Elevated scores on the P-CDI "suggest that the parent-child bond is either threatened or has never been adequately established" (Abidin, 1995, p. 56). Given that three quarters of the sample did not have custody of their target children and had little or no visitation with them, it is not surprising that attachment issues would be present. Poor attachment has been identified in the literature as a correlate to child maltreatment. It may be a predisposing factor in cases where children have developmental, mental, or physical problems (Herrenkohl & Herrenkohl, 1979; Kolko, 1996) or difficult temperaments and antisocial behavior (Kolko, 1996), but attachment issues may also be the result of maltreatment, and /or a combination of the two. Consistent with the research on the relationship between attachment and maltreatment, when scores are above the 95th percentile on the P-CDI subscale (as was the case for Raquira at pretest, and George at both pre- and posttest) then child abuse potential must be considered relative to the Total Stress scale score and other subscale scores. In both George and Raquira's cases, their overall PSI/SF profiles were hard to interpret in this regard, especially when coupled with their CAP Inventory Abuse scale scores. Both had normal-range Parental Distress (PD) subscale scores, which would suggest that they were not likely to lose control in the form of child physical abuse (Abidin, 1995). However, George had clinically significant Total Stress scores at both pre- and posttest and a high prorated Abuse scale score at posttest. Raquira had normal-range Total Stress scores, but her Abuse scale scores were invalid, meaning that distorted responses on this measure may have masked her true child physical abuse potential.

Jacqueline was the only participant who had high scores on both the Difficult Child (DC) and Parent-Child Dysfunctional Interaction (P-CDI) subscales, as well as on the Total Stress scale. In her case, there were probably systemic issues surrounding poor attachment and ineffective behavioral management. Wouldn't an insecurely attached child act out more to elicit the parent's attention? At the same time, wouldn't the parent

of this child find behavior management and discipline difficult because of her/his lack of connection with the child?

Of the three quantitative measures used in this study, only the PSI/SF offered treatment recommendations based on a participant's pattern of scores. Had it been used as a screening device in this study, at least two participants would have been referred to other services. George was the only participant in either group whose Total Stress score represented clinically significant levels of parenting stress at pretest. Such a score merits further evaluation and diagnosis, in addition to professional help. Is it any wonder, then, that George's participation in PCARV's parent education course produced no reduction in his parenting stress? Similarly, Jacqueline's PSI/SF profile pointed to an intensive intervention, including "careful diagnostic assessment of [her] child's behavioral adjustment and functioning" (Abidin, 1995, p. 56), as the treatment of choice for she and her daughter. While Jacqueline did not complete our group, some of her frustrations during the first four weeks may, in part, be explained by the fact that she was inappropriately assigned to our group, which did not have the treatment components she and her daughter needed. In contrast, Connie's pretest scores on the PSI/SF predicted that a "short-term parental consultation or a parent-education class focused on management strategies" (Abidin, 1995, p. 56) would give her the help she required, and the clinical significance of her posttest scores confirms this. Still, quantitative measures are not infallible in their ability to categorize and predict, nor do they account for contextual factors and individual characteristics. The same short-term intervention that was successful with Connie was unsuccessful with Latoya, despite the fact that her pretest scores indicated that it would be. Despite her demonstrated motivation in group, the temporary placement of Latoya's son with his biological father was a significant stressor for her that occurred towards the end of our group. The court-mandated population's reputation for being "difficult" may be the result, at least in part, of them being pigeon-holed into a 'one-size-fits-all' treatment modality that is not always a good fit. As Crittenden (1996) puts it:

> If the research suggesting that there is more than one type of abusive family is accurate, then we must presume that more than one type of intervention is needed.

> Moreover, as with pharmacological treatment, applying the wrong intervention to a family may be harmful. (p. 161)

A clinical implication of this study is that multiple treatment options, as well as some kind of screening protocol for appropriate treatment assignment, need to be implemented with the court-ordered population.

With regard to future research, one of the benefits of utilizing the PSI/SF in this study was that, like the anecdotal data, it contained constructs that overlapped with constructs on the other two measures, thus allowing for corroboration of findings. In working with shame-based populations such as the court-mandated population, which have a tendency to distort their responses on measures in the direction of social desirability, it would be good research practice to utilize multiple measures and/or methods. This study was one of the first in the filial therapy literature to employ a mixed methodology. Prior filial therapy studies have primarily utilized either a quantitative or qualitative design. One exception was the study conducted by Jang (2000) with Korean parents, in which the author conducted phone interviews with participants in addition to utilizing pre- and post-measures. Jang's (2000) and this study are part of a growing trend to combine methodologies, largely because this allows for triangulation of data (Creswell, 1994).

In conclusion, clinically significant results were found on the PSI/SF for two participants in the experimental group. Similar to the child physical abuse variable, there were fewer participants in this study who had high levels of parenting stress. The fact that three quarters of the sample did not have custody of their children, as well as limited visitation, may have contributed to this phenomenon. In addition, some anecdotal parenting stress data was inconsistent with the quantitative data on parenting stress, suggesting that some participants were experiencing distress that the PSI/SF did not capture. Comparisons of individual scores on the PSI/SF revealed that the two primary sources of parenting stress for this sample were child behavior management and discipline, as well as poor parent-child attachment. As the only measure in this study that made treatment recommendations, the PSI/SF highlighted the need for more than one type of treatment for court-ordered parents. Mixed methodology is recommended in

future research with shame-based populations in order to increase the reliability and validity of results.

Parent-Child Relationship

Unlike the CAP Inventory and the PSI/SF, the CPRS was not developed as a diagnostic tool; hence, it was difficult to draw meaningful clinical conclusions from its data. Still, there were some interesting findings from the individual participant profiles and the anecdotal data. Although the CPRS is not intended to be used to categorize individuals, Connie's scores from pre-to posttest on the Conflicts subscale did seem to point to clinically significant changes in her relationship with her child of focus. At pretest, her score on this subscale was in the middle to high range; by posttest, it had decreased to the low to middle range. These results support the clinically significant changes that were reflected in Connie's PSI/SF scores in terms of decreased overall parenting stress and increased behavior management skills.

Pre- and posttest comparisons of even individual items on the CPRS told parts of participants' stories. For example, Connie had been very open throughout our group about the fact that she was afraid of losing her relationship with her child of focus as she felt she had with her older son. Item 5 on the Positive aspects of relationship subscale reads, "My child values his/her relationship with me." The fact that Connie assigned this item a 4 (Applies somewhat) at pretest and then subsequently ranked it a 5 (Definitely applies) at posttest seems to reflect she *and* her son's feelings of encouragement regarding their relationship. In like manner, Latoya spent considerable time in the focus group describing how difficult going to the store with her son had been prior to our group, and how much better it was now that she had acquired some new skills. As a reflection of this change, she went from a 4 at pretest (Applies somewhat) to a posttest 2 (Not really) on item 27 of the Conflicts subscale, which reads, "My child whines or cries when he/she wants something from me." A general trend on the Dependence subscale was for participants to feel that Item 26, "I often think about my child when at work," had application to them. There did not seem to be a significant difference between custodial and non-custodial parents on this. Because of the strong positive correlation between the Positive aspects of relationship subscale and the Dependence subscale, high scores on

this item (and on the Dependence subscale overall) are supportive of a good parent-child relationship.

In addition to comparisons with the CPRS, participants' anecdotal relationship data was compared to their scores and profiles on the Parent-Child Dysfunctional Interaction (P-CDI) subscale of the PSI/SF. The results were intriguing. For example, both Jacqueline and Raquira had high pretest scores on the P-CDI, indicative of poor attachment bonds with their children of focus. But their anecdotal relationship data reflected a strong parent-child relationship. Raquira demonstrated a profound lack of insight regarding her parenting skill deficiencies and the effect of these deficits on her parent-child relationship. This would be typical of a neglectful parent (Crittenden, 1988, 1996). Jacqueline, on the other hand, was very open in group about her parent-child relationship challenges. So why the discrepancy in their data? It could have been that they responded in socially desirable ways, as has been previously discussed. I also wonder if the more positive parent-child relationship data resulted from Jacqueline and Raquira responding from a fantasy perspective—how they *would like* their relationships to be. This may have also been the case for Wanda, whose pretest score on the Positive aspects of relationship subscale (49 out of 50) was higher than any other participant, pre- or posttest, and did not coincide with her anecdotal relationship data. Did such pretense bring hope, and lessen the potential despair of the relationship realities?

Three participants' ratings on the anecdotal relationship data brought insight to their definitions of their parent-child relationships. Marcel, Patrick, and Wanda all wrote comments beside this question that suggested it was very difficult for them to rate their parent-child relationship when they did not see their children. Given the number of other available ways to maintain a relationship, such as phone and email contact, this finding was interesting. It suggests that for these participants, their loss of custody and inconsistent visitation was a direct affront to their definition of the relationship (i.e., it was primarily defined by physical contact).

There would have been much more parent-child relationship data if experimental group participants had conducted the filial therapy sessions and videotaped them to share with the rest of the group. Videotaping was definitely a challenge in this study, and illuminated the fact that filial therapy is really a middle-to-upper class therapy because of

the videotaping requirement. With a modal income of less than $10,000, a video camera was hardly at the top of most participants' lists of things to obtain. Two video cameras and a number of videocassettes were provided to participants in recognition of this. But the challenges were more fundamental than equipment: the play sessions themselves were difficult for parents in this study to do, largely because of custody and visitation issues. Future filial therapy studies with this population would do well to consider alternative methods of documenting play sessions--such as audio taping, live observation, or self-report-- as well as additional ways of supporting the execution of the play sessions, themselves. In Harris and Landreth's (1997) study of incarcerated mothers, videotaping was considered a "major concession in the county jail system policy" (p. 60), and required that the facilitator(s) of the study be present to videotape every play session. In Landreth and Lobaugh's (1998) subsequent study of incarcerated fathers, prison regulations did not permit any videotaping of father-child filial play sessions. Instead, the self-report method was used to maintain the group process element that is such an important part of group filial therapy training. To support the execution of the play sessions, a supervised clinical setting with video equipment could be provided during certain hours every week so that parents could sign up for its use over the course of a study. Although much more labor-intensive, perhaps more effective still would be home visits, in which helping professionals could observe filial play sessions in the home environment and provide hands-on feedback and support (Ginsberg, 2002). In addition, participation of court-ordered parents in future studies might be based upon the cooperation and permission of the custodial caregivers, who could be given the opportunity to participate, as well. Some of the challenges relative to conducting play sessions in this study were related to mistrust of non-custodial parents (i.e., the majority of the participants) by custodial caregivers. It is anticipated that the positive effects of filial therapy would be even more powerful for target children if filial therapy skills were utilized by both custodial and non-custodial caregivers.

Because the majority of published filial therapy studies utilize the 10-week group filial therapy model (Landreth, 1991), it did not occur to me to consider other alternatives. In hindsight, I wonder if a combination of individual and group filial therapy models would not be optimal for court-mandated parents. The group setting

helped participants to learn from each other and feel less alone in their challenges. At the same time, each of them had needs that were so pervasive and profound that I found it challenging to address them while we met together. While writing up the results of this study, I learned that Ginsberg (2002) has developed his own, more long-term version of filial therapy which combines individual and group components. Following 10-week group filial therapy training, individual family units then participate in what Ginsberg calls "booster sessions," which are follow-up sessions intended to give more personalized support to the gains that have already been made in the group setting:

> These booster sessions are typically scheduled with decreasing frequency (i.e., every other week, monthly, or every 2 to 3 months, when requested by the family) and encourage families to be responsible for incorporating the [filial therapy] skills in their lives. (p. 72)

Booster sessions can take place in a clinical office setting, or in the family's home, and continue as long as the family needs them. Because of the booster sessions, Ginsberg's (2002) model appears to have more long-term promise than Landreth's (1991). To date, no follow-up studies have been done on Landreth's (1991) 10-week group filial therapy training model, so it is uncertain whether gains made over the training period are able to be maintained longitudinally.

The most support for the parent-child relationship variable came from the focus group. Of the five themes that emerged from this discussion, all of them were relationally oriented, and four were specific to the parent-child relationship. This is not surprising, as it is neither the parent, child, nor skills that are the focus of filial therapy, but rather the parent-child relationship. Three of these themes were particularly exciting, because they have overtones of empowerment. The first of these was that the filial therapy skills enabled parents in the experimental group to feel better about their parenting roles. Secondly, three of the four children felt more grown up as their parents utilized the filial therapy skills, particularly empathic listening, with them. The third theme, strongly related, was that two participants, and their target children, experienced strengthened parent-child relationships over the course of our group. Abney (1996) has identified empowerment as an important treatment goal with maltreated families. She defines empowerment as "a process that enables clients to exert their personal power to

obtain needed emotional, physical, or social resources" (p. 416). In contrast, physically abusive parents have learned to misuse and manipulate power, while neglectful parents generally feel that they and the world around them are powerless (Crittenden, 1988, 1996). However, both the participants in this study, and their target children, seemed to experience power in a new way through the filial therapy skills. By virtue of their own efforts, participants felt more competent in their parenting role, and some also saw the fruits of these efforts in strengthened relationships with their children.

Because only one of the participants actually conducted filial play sessions with her child of focus, the three aforementioned themes are also a testimonial to the universality of the primary filial skill, empathic listening. Whether used in a formal filial play session, in therapy, or at the dinner table, its effect is the same. As has been previously discussed, all of us have a need to be heard and understood. Empathic listening also involves the communication of acceptance, the filial equivalent of Carl Rogers' unconditional positive regard. It seems to capture the responsiveness that Crittenden (1988, 1996) indicates physically abused and neglected children need from adults in treatment, and seems to be what some of the participants' children in this study received from their parents. Like Aaron, Jason, and Obadiah, do we not each feel a little bigger, regardless of our age, when someone gives us the gifts of their time, attention, understanding, and acceptance? Like Aaron, do we not express and experience less neediness in our relationships when we receive such gifts? I have long felt that the current need for helping professionals is not only because of what is happening in the world at large, but also what is happening closer to home, in people's relationship worlds. When we consider our increasing disconnection from one another, as has been noted by scholars like Putnam (2000) and others, we can have more compassion for the dynamics of neglectful families, for example. Perhaps my efforts to model and incorporate empathic listening into my relationships with the experimental group participants had a carryover effect in some of their parent-child relationships. For example, I was touched when Connie shared that her son, Aaron, wanted to come for our last session and meet me. As he felt more connected to his mother, he also felt a connection with me, who he saw as instrumental in strengthening this bond.

Before concluding the discussion of the parent-child relationship variable, it seems appropriate to mention another relationship that was powerful in this study: it was between one member of the experimental group and the rest of the experimental group participants. Connie was the only member of either group who self-referred. Because this study was intended to target a sample from the court-ordered population, I initially viewed her as a confounding variable. However, she was so motivated that her enthusiasm positively affected the other participants. She was the only participant who conducted actual filial play sessions (others reportedly used the filial skills with their children of focus), and subsequently provided the only videotaped participant play session material. The fact that her presence meant I was able to account for less of the statistical variance seemed far less important than the clinical impact she had on the other participants. My experience with Connie is reminiscent of how segregation in public education was eventually replaced by desegregation. Previous filial therapy studies have, understandably, been designed to target particular parent and/or child populations (i.e., parents of children with particular presenting problems). However, with this particular population future research (filial and otherwise) would benefit clinically from a mixed sample, comprised of those who want to participate as well as those who are required to do so.

In summary, the P-CDI provided valuable information regarding the parent-child relationship variable, along with the CPRS and the anecdotal data, for the individual participant profiles. One participant's pre- and posttest scores on the Conflicts subscale of the CPRS seemed to suggest clinically significant change in the direction of reduced conflict over the course of the filial group. Comparisons of pre- and posttest ratings of individual CPRS items revealed aspects of participants' experiences. Discrepancies between the anecdotal data and some subscales of the PSI/SF and the CPRS may have reflected some participants' tendency to either respond in socially desirable ways or to view their parent-child relationship from a fantasy perspective. Comments written next to the anecdotal relationship question by some participants indicated that they defined their parent-child relationship by physical contact. In future filial therapy studies with the court-mandated population, alternative forms of documentation, as well as greater support for the execution of filial play sessions, should be minimum additional

provisions. In addition, it is recommended that filial therapy with this population be longer-term, and combine both group and individual components, as well as "booster sessions" (Ginsberg, 2002). Four focus group themes were directly related to the parent-child relationship variable, and three displayed overtones of empowerment, as well as speaking to the universality of the empathic listening skill. Finally, research would benefit clinically from a mixed sample of court- and self-referred individuals.

Additional Questions

Through the process of the data analysis, the author became aware that there were two additional questions underlying this study. First, was there support for the developmental modifications made to filial therapy for school-age children? Secondly, what was the meaning of the filial therapy experience for participants? The modified treatment's effectiveness in reducing child physical abuse potential and parenting stress, as well as in strengthening the parent-child relationship were intended to answer the first of these supplementary questions. In other words, significant changes in any of the three aforementioned variables would demonstrate support for the modified treatment. However, the contextual challenges that the court-ordered parents faced in this study resulted in only one of the five parents in the experimental group actually conducting filial therapy sessions with her child of focus. While her experience was positive, it was insufficient to draw any conclusions with regard to the developmental extension. An additional anecdotal question, regarding which toys the experimental group target children used in their home filial sessions, was even designed to lend support to the developmental modifications made for school-age children. Again, this question became extraneous due to the fact that four of the five experimental group participants did not conduct filial therapy sessions. Perhaps investigation of the developmental modifications was larger than this study's design and sample could accommodate. After all, this was one of the first filial therapy studies, along with Ginsberg's (2002) and Walker's (2002), to be conducted with the court-mandated population. Perhaps the standard 10-week group filial therapy protocol should have been utilized first before exploring modifications to it in later studies. Researchers interested in this developmental extension of filial therapy would probably be more successful recruiting parents of school-age children, and then doing a comparative treatment study in which one group

receives the established filial therapy training, and a second group is trained in the developmental extension of it.

With regard to the second additional question, it was the focus group that was primarily designed to capture the experimental group's overall experience with filial therapy, and the meaning that this experience had for them. The focus group provided an opportunity to widen the scope of inquiry, beyond the three variables investigated. It was from the focus group discussion that I learned about Latoya's previous history with parent education, as well as how participants were using the filial therapy skills in other relationships. Their feedback regarding the filial therapy process was overwhelmingly positive. The only negative comments, by two of the four participants, were with regard to completing the pre- and post-measures. Latoya also indicated that she only became engaged in our group about halfway through when we became more hands-on in our application of the skills learned. In hindsight, I would have liked to ask participants more about the research process. For example, was there anything beneficial about completing the pre- and posttests? Not unlike McCollum et al. (1996), in their study with drug-abusing female clients and their partners, I thought of the filial therapy training and the pre- and posttesting as separate. In my mind, the former was both treatment and research, whereas the latter was strictly research. However, in their interviews with participants, McCollum et al. found that participants did not make such a distinction. Instead, their feedback indicated that "participating in research assessments had an impact on them aside from the tedium of filling out forms and taking part in exercises" (p. 612). In the current study, there may have been positive aspects to the research process that I did not access because I thought of the treatment and assessment aspects of the research as separate. As McCollum et al. have suggested, perhaps we, as researchers, do not give participants enough credit for how they personally benefit from research (beyond what they contribute to our larger research objectives).

Filial therapy seemed to have a different meaning for each participant. For Latoya, it represented her first successful completion of court-mandated parent education, a strengthened relationship with her son, and new parenting skills to share with her son's father. For Marcel, it meant an opportunity to demonstrate his parenting expertise, as well as the acquisition of some aspects of the filial therapy skills. For Connie, filial

therapy training represented weekly home filial therapy sessions, and a renewed bond with a son she had previously felt at risk of losing. In addition, it meant an opportunity to assist other participants, by giving them rides to and from our sessions and sharing video footage of her home play sessions. For Raquira, it was difficult to determine what meaning the filial therapy experience had for her, either from her participation in group or from the focus group discussion, as she was virtually silent during both. Two comments in response to the anecdotal data question, "What did you learn tonight that you think you will actually use," gave a glimpse of her feelings. These are her words following the first session: "[I learned] a lot about kids and working with others and talk[ed] with other parents about their kids and how their kids are and the pain they feel." At the conclusion of the fifth session, she wrote: "[I learned] about [Connie] playing with her child on tape and she ha[d] good skills with her child and I learned a lot about the video." Despite what I interpreted as a lack of participation, Raquira was apparently more involved than she appeared. Filial therapy apparently represented an opportunity to connect with other parents like herself.

Limitations

The principal weaknesses of this study were essentially a function of the decision to conduct clinical research in an applied setting with a 'difficult' population. Each substantially reduced the statistical power of the instruments used to measure the three variables, such that the quantitative results were, at worst, inconclusive, and at best, limited to trends. Group quantitative results were subsequently not included and were replaced by individual participant profiles. The first limitations were with regard to the sample and the research design. The means of procuring the sample (convenience) and its size ($N = 8$) were the primary issues. Add to these the fact that the population from which the sample was drawn necessitated a treatment comparison group, in contrast to the no-treatment control groups that have been used in most previous filial therapy studies. Finally, participants in the sample were not matched on demographic variables in each group; rather, the two groups were nonequivalent, a modification of Campbell and Stanley's (1963) pretest-posttest nonequivalent control group design. As a result of these limitations, this study's ability to control and account for variance was limited.

Secondly, there was missing data. The agency with whom the author partnered for this study, PCARV, allowed each participant to miss one of the eight sessions and still successfully complete their court-ordered parent education. As a result, every participant missed at least one session. Additional data was incomplete or missing for a variety of other reasons. One participant in the experimental group, Jacqueline, only attended the first four of the eight sessions, and so no posttest data was available for her (or anecdotal data, for that matter, for sessions five through seven). The parenting class instructors were given copies of the measures and anecdotal data sheets with verbal instructions, but some data was missing or incomplete in the comparison group because the facilitators forgot to give the measures to the participants. Some of this challenge may have been a byproduct of the fact that the facilitators for the parent education class rotated, and were not the same every week. Meanwhile, this author was unable to administer the measures and anecdotal data sheets in the comparison group because she was doing the same with the experimental group. Some of the challenges with data collection may have been an artifact of test fatigue or participant lack of investment in the research process, as was mentioned in the focus group by some of the experimental group participants. In addition, at least one participant may have struggled to read and understand the items on the measures. Finally, it appears from the written comments made that the two rating questions on the anecdotal data sheets were an uncomfortable response format for some participants, who consequently opted not to respond to these questions following some sessions. While missing and incomplete data is a part of most research, it can be more easily compensated for in larger samples. In contrast, missing data in this study threatened the validity of the results with this small sample.

Due to the aforementioned limitations, extreme caution should be taken in generalizing the results of this study beyond this sample. Results have been presented and discussed in terms of individual participants, and some themes and trends may have application to other parents court-mandated for remedial parenting services due to physical abuse or neglect of their children. However, this was a preliminary study, and additional research is needed to further substantiate the findings. In addition, it should be noted that any changes in the three variables for individual participants over the course of the filial therapy training were due to application of the filial skills (with one exception),

and not to application of the treatment, itself. Connie was the only participant who actually conducted filial therapy sessions with her child of focus; the other participants purportedly used the filial therapy skills with their children of focus. This is an important distinction. Previous group filial therapy research has investigated the effectiveness of filial therapy training, of which weekly home play sessions between participants and their target children is a major component. While positive trends in this study suggest that the effectiveness of the filial therapy skills is not limited to play sessions alone, this study's results are limited in their comparability to other group filial therapy research.

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Appendix A: Informed Consent Form

Project Title: Filial Therapy with Court-Ordered Parents of Maltreated Children: A Multiple Case Study

Investigator: Clarice Evans Goodwin, M.S.

Supervising Faculty: Howard O. Protinsky, Ph.D.
Janet K. Sawyers, Ph.D.

I. Purpose: The main purpose of this study is to evaluate the effectiveness of a modified filial therapy model with court-mandated parents of school-age children. The filial therapy training will be the experimental group, and an alternative treatment comparison group, consisting of parent education classes offered by Prevent Child Abuse Roanoke Valley (PCARV), will be used to investigate the effectiveness of the modified filial therapy model. This study proposes that the modified filial therapy model will be more effective than the parent education classes at (1) reducing child abuse potential, (2) reducing parenting stress, and (3) strengthening the caregiver-child relationship. A mixed method design will be used in this study. The quantitative analysis will draw upon pre-and posttesting with three measures, and will utilize an ANCOVA, in which the adjusted pretest means are the covariates, the adjusted posttest means are the dependent variables, and the filial therapy training is the independent variable. Anecdotal data collected from participants at the end of each session will aid in the interpretation of ANCOVA results. Qualitative analysis will draw upon information shared during a focus group at the beginning of the eighth session. The focus group will be videotaped, transcribed, and analyzed according to the phenomenological tradition.

II. Procedures: Parents of school-age children who have been either court-referred or court-ordered to seek remedial parenting services through PCARV will be invited to participate in this study. During interviews with potential participants that will be conducted by PCARV staff, this study will be outlined, and those who agree to participate will be asked to complete a demographic data sheet and several measures during this first meeting. Between the interviews and the first group meeting, assignment to either the experimental or comparison groups will be made. Participants in both the experimental and comparison groups will meet concurrently on a weekly basis for eight weeks. Both groups will be conducted at a church in Roanoke between Tuesday, October 2nd, 2001 and Tuesday, November 20th, 2001, from 7 p.m. to 8:30 p.m. each evening. Both childcare and transportation will be provided for all participants. Participants in the filial therapy training group will learn four new skills during the first three weeks, and will be asked to conduct weekly caregiver-child play sessions using these skills between sessions three and eight. Filial therapy toy kits will be provided to all participants in the experimental group for use during the caregiver-child play sessions. At least one of these sessions will be videotaped by each participant to be shared with the rest of the group the following week. Both video cameras and videotapes will be provided for this purpose. These videotapes will be the basis of group processing during weeks four through seven. The first half of session eight will be a focus group that will be videotaped, and the last

half of session eight will be reserved for posttesting. Observations by the investigator will be conducted throughout the study.

III. Risks: A risk involved in participating in the filial therapy training group is that participants may feel some discomfort as they learn new skills.

IV. Benefits: If they choose to complete all eight weeks of programming, participants in both the control and experimental groups will benefit from this study by fulfilling the recommendations/requirements that have been made of them that they seek parent education services. For those in the experimental group, the primary benefits of filial therapy training, as demonstrated by prior research, are (1) decreased parenting stress and (2) strengthened parent-child relationships. Both of these often result in parent perceptions of improved child behavior following filial therapy training. In addition, participants in the experimental group may benefit from the cohesiveness that is generally a part of filial therapy training groups. There is, however, no promise or guarantee that participants will benefit from this study in these or other ways. In terms of larger societal benefits, it will be beneficial for therapists working with parents, children, and their families to know whether filial therapy is an effective treatment modality with court-mandated parents. In addition, this study will extend the current filial therapy research by condensing a 10-week model into 8 weeks.

V. Anonymity and Confidentiality: Information about participants and their children of focus will be kept confidential throughout this study. Participants in the filial therapy training group will be asked to videotape at least one caregiver-child play session which will be viewed by the group, after which participants will be free to keep or dispose of the tapes as they wish. The first half of the eighth session in the filial therapy training group will be videotaped for use in a qualitative analysis, but after this has been written up, the videotape will be destroyed. Written findings and any publications that result from this study will utilize pseudonyms if referring to specific participants, and other personal information about participants will be altered so as to keep their identities anonymous. The investigator will not maintain confidentiality if there is suspicion of child abuse or neglect during the course of the study, or if a participant is believed to be a threat to her/himself or others. A court order may require that the investigator release information to the courts.

VI. Compensation: Participants in both the control and experimental groups will receive free childcare for all of their dependents during the eight weeks of programming. Those who participate in the filial therapy training group will receive a free filial therapy toy kit (valued at $50) which they may use to conduct weekly caregiver-child play sessions during training, and may keep following the training. In addition, use of video cameras and videotapes will be provided so that at least one of their parent-child play session can be videotaped between sessions three and seven. No other compensations, monetary or otherwise, will be given to participants.

VII. Freedom to Withdraw: Participants are free to withdraw from this study at any time without penalty. In addition, participants are free to respond to all experimental

situations as they choose, including declining to answer questions. There may be circumstances under which the investigator may determine that a participant should not continue in the study, in which case a referral will be made.

VIII. Approval of Research: This study was approved by the Institutional Review Board for studies involving human subjects at Virginia Polytechnic and State University, the Department of Human Development at Virginia Polytechnic and State University, and Prevent Child Abuse Roanoke Valley (PCARV).

IX. Participant Responsibilities: I voluntarily agree to participate in this study. As a participant, I have the following responsibilities:

- To complete the pre- and posttests at the designated times
- To attend and participate in seven of the eight parent education classes or filial therapy training sessions
- To conduct five weekly parent-child play sessions of a half hour each with my child of focus between sessions three and eight (filial therapy training participants only)
- To videotape at least one of these five parent-child play sessions and share it with the rest of the group the following week (filial therapy training participants only)
- To agree to be videotaped during the first half of the eighth session (filial therapy training participants only)

X. Participant Permission: I have read and understand this informed consent and the conditions of this study. I have had the opportunity to have any and all of my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this study with my signature below. If I choose to participate, I may withdraw at any time without penalty. By choosing to participate, I agree to my responsibilities as a participant to abide by the conditions of this study.

_____

Signature Date

_____

Print Name Phone Number

If I have any questions about this study or how it is conducted, I may contact:
Clarice Evans Goodwin, Investigator at (540) 231-7201
Bud Protinsky, Supervising Faculty at (540) 231-6782
Janet Sawyers, Supervising Faculty at (540) 231-3194

Appendix B: Bilateral Release of Information for Third Parties

Virginia Tech
VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Department of Human Development (0416)

College of Human Resources and Education
366 Wallace Hall
Blacksburg, Virginia 24061
(540)231-4794 Fax: (540)231-7012

AUTHORIZATION TO RELEASE INFORMATION

In regard to information about _____,
(name of research participant)
born, _____, and their minor child _____, born _____,
(date of birth) *(name of child)* *(date of birth)*

I hereby give permission to Clarice Evans, M.S., a doctoral candidate conducting research (in which I am a participant) through the Department of Human Development at Virginia Polytechnic Institute and State University, to receive confidential information (oral and written) from:

_____
(Person or agency)

_____
(Street address)

_____
(City, State, and Zip Code)

(____) _____ /(____) _____
(phone) *(fax)*

This information is released for the purpose of: _____.

_____ _____
(Signature of client) *(Date)*

_____ _____
(Signature of witness) *(Date)*

This authorization will be in effect for 180 days, unless terminated earlier in writing by the research participant.

No information sent or received through this authorization may be re-released to any other persons or agency without specific written permission of the research participant.

Appendix C: Consent Form for Participants' Children of Focus

"My name is Clarice, and I LOVE to play. I am lucky, because I get to play a lot in my job. I am a therapist, which is a big word for somebody who helps people talk about and play out their feelings. I play with adults and kids. Playing with kids is easy, because they do it a lot. But many adults haven't played in a LONG TIME, and they have forgotten how to do it.

Right now, I am helping your Mom remember how to play. I can't be there when you play with your Mom. So, I would like to have your Mom videotape you and your Mom playing, one or two times. I will loan your Mom a video camera to use if she doesn't have one. I will watch the videotape of you playing with her, and help her get better at playing with you. After we are done watching the videotape of you playing with your Mom, I will give it to her for you to keep. If it is okay with you to be videotaped, will you please sign your name below? Thanks!"

_____

YOU Can Sign Here

_____

Please Ask Your Mom to Sign Here

_____

Please ask a witness (somebody other than you or your Mom) to sign here

Appendix D: Filial Therapy Goals for Children and Parents

(Van Fleet, 1994, pp. 3-4)

Therapeutic goals for children

1. To enable children to recognize and express their feelings fully and constructively.
2. To give children the opportunity to be heard.
3. To help children develop effective problem-solving and coping skills.
4. To increase children's self-confidence and self-esteem.
5. To increase children's trust and confidence in their parents.
6. To reduce or eliminate maladaptive behaviors and presenting problems.
7. To help children develop proactive behaviors.
8. To promote an open, cohesive family climate which fosters healthy and balanced child development in all spheres: social, emotional, intellectual, behavioral, physical, and spiritual.

Therapeutic goals for parents

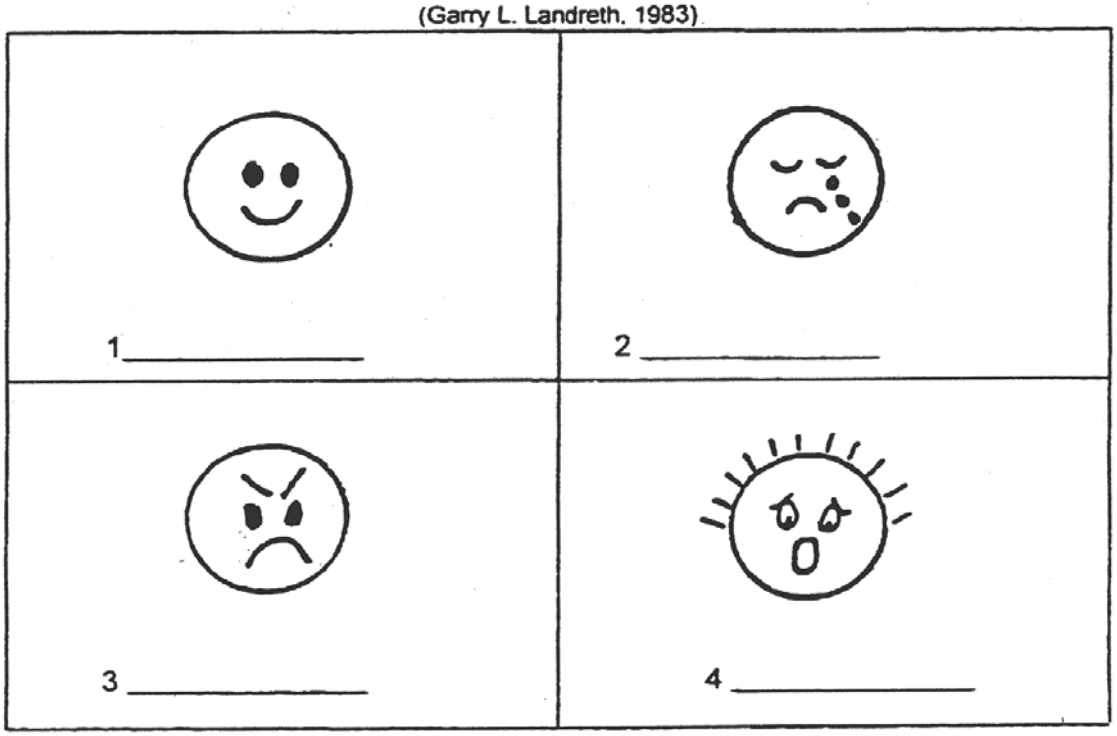
1. To increase parents' understanding of child development in general.
2. To increase parents' understanding of their own children in particular.
3. To help parents recognize the importance of play and emotion in their children's lives as well as in their own.
4. To decrease parents' feelings of frustration with their children.
5. To aid parents in the development of a variety of skills which are likely to yield better child-rearing outcomes.
6. To increase parents' confidence in their ability to parent.
7. To help parents open the doors of communication with their children and then keep them open.
8. To enable parents to work together better as a team.
9. To increase parents' feelings of warmth and trust toward their children.
10. To provide a nonthreatening atmosphere in which parents may deal with their own issues as they relate to their children and parenting.

*One of the ultimate goals of filial therapy, for parents, is for them to get so excited about what happens in their home sessions that they want to learn how to generalize the therapeutic skills they have learned to other situations with their child(ren).

Appendix E: Session Handouts

Session One Handouts

THE FOUR BASIC FEELINGS
(Garry L. Landreth, 1983)



Reflective responses this week.

1. _____
_____

2. _____
_____

3. _____
_____

4. _____
_____

REFLECTIVE LISTENING
As described by a parent after filial therapy

Basically what that is that when you see your child, whether they are feeling good or bad or just monotone, just reflect that feeling to your child as, 'Oh, I see you look very happy today. You have a smile on your face'. Then your child gives you feedback because you are noticing how that child is feeling, and that makes them feel good that you are recognizing that and bringing that to their attention that you care about how they feel. I think that, in itself, the reflective part, can be very esteem building because you have somebody's attention focused on you. . . . With Coles I've said 'you look sad', and he's like 'No Mom. I'm not sad. I'm just sitting here watching TV' or 'I'm just thinking.' So it also opens up ways for him to recognize his own feelings and ways for him to express to me how he is really feeling if I misinterpret it.

Session Two Handouts

Empathic Listening

Communicating Acceptance and Understanding of Feelings**:

- "That makes you (insert feeling)!" (Example: "That makes you mad!")
- "You're (insert feeling)!" (Example: "You're disappointed!")
- "It looks like you're (insert feeling)!" (Example: "It looks like you're feeling sad about our special play time being over!")
- "It seems like you're (insert feeling)!" (Example: "It seems like you're upset when I don't answer your questions right away!")
- "You must be (insert feeling)!" (Example: "You must be proud of yourself—you figured it out without any help!")
- "It's (insert feeling) when…" (Example: "It's frustrating when it doesn't go together the way you want it to!")
- "It's hard to make up your mind what to do," or, "You're wondering what to do next."

**You can also add what you notice about your child's body language, tone of voice, and facial expressions.

Communicating Acceptance of Actions:

- "You're really (insert action your child is doing)!" (Example: "You're really beating him up!")
- "You're going to (insert action it looks like your child is about to do)!" (Example: "You're going to kick him around!)
- "You're…!" (Examples: "You're being very careful to make it come out just right," or, "You're aiming very slowly so it will be sure to hit where you want it to!")
- "They're…!" (Example: "They're all going to be killed!)
- "You like/love to (insert action)!" (Example: "You really love to sit on my lap!")

THINK OF SPORTSCASTERS—TALK ABOUT WHAT YOU SEE!
DON'T BE SILENT AND DON'T JUST SOCIALIZE!

FILIAL THERAPY GROUP

(Garry L. Landreth, 1983)

Basic Principles of the Play Sessions

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

Goals of the Play Sessions

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

REMINDER

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

Toys for the Play Sessions

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

Place for the Play Sessions

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

Process

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

FACILITATING REFLECTIVE COMMUNICATION

(Garry L. Landreth, 1983)

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

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

Adult: _____

_____

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

Adult: _____

_____

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

Adult: _____

_____

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

Adult: _____

_____

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

Adult: _____

_____

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

Adult: _____

Session Three Handouts

Dos and Don'ts of Filial Therapy

(Garry L. Landreth, 1983)

DON'T

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

DO

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

Note. **The first seven don'ts are taken from Guerney, L.F. (1972).** ***Play therapy: A training manual for parents.*** **Mimeographed Report.**

The Limit-Setting Skill

Unlike school or other settings, during your special play times you will not give your child a long list of rules. Instead, you will let them know when they are about to break a rule.

Step 1—If you have already given a limit in a previous session, proceed to Step 2. The first time your child is about to break a limit, share the limit with your child and redirect her/his behavior (give her/him a couple of options). "Do you remember when we first started our special play times, I told you that you could do many of the things that you would like to do during this time? Well, dart guns are not for pointing at people. You CAN point them at the punching bag or the wall." You can also state limits using "we," to let your child know that the limits apply to both of you.

Step 2—Start with this step if you have already given a warning in a previous play session. If your child disregards the limit after you have given it, you give them a warning that includes a couple of options (again) and the consequence if they still decide not to observe the limit. You can also use reflective listening to let your child know what you have noticed about their behavior and feelings. "You really seem to like playing with the dart gun. Well, dart guns are not for pointing at people. If you decide to point the dart gun at me again, then you will not be able to play with the dart gun for the rest of our play time today."

Step 3—If, after you have done Steps 1 and 2, and your child still chooses to disregard the limit, then IMMEDIATELY impose the consequence. Be kind, but firm. Reflect feelings, such as their disappointment or frustration. "Since you have decided to continue pointing the dart gun at me, you will not be able to play with the dart gun for the rest of our play time today."

Consequences (Instead of Punishment)

Consequences build autonomy, punishment builds heteronomy

Natural Consequences—Happen automatically as a result of the child's behavior

Imposed Consequences—Linked/related to the child's behavior, but given by an adult. Used when natural consequences are not possible, either because other laws/rules won't allow for natural consequences, or because natural consequences are inappropriate**.**

- **Exclusion—**If the child is choosing to hurt others, then the child is not allowed to play with others *until she/he feels that they can do without hurting them.* This last part is important—the CHILD decides when she/he is ready

- **Deprivation—**The child is (usually temporarily) not allowed to use things that she/he has failed to use appropriately (i.e., if you don't take care of it, you lose privileges for using it)

- **Restitution—**"Making up for" something that has been lost or damaged (i.e., you break it, you fix it or buy a new one; you spill it, you clean it up, etc.); helping to care for someone who has been hurt by the child

- **Reciprocity—**Doing to the child what the child has done to someone else. Be very careful with this one. This does not mean hurting a child if she/he has hurt someone else. This would model a bad example for the child. Instead, an example of reciprocity would be not helping a child if the child had not done their assigned chores.

Imposed consequences *"are designed to help children think about why certain behaviors are unacceptable and others are desirable. This is a teaching approach in which punishment has no place. Consequences are designed to help children view themselves as capable and willing problem solvers. Punishment tends to have the opposite effect, making children consider themselves bad and teaching them to be sneaky to avoid being caught"* (Fields and Boesser, 1998, p. 158).

Session Six Handouts

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

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

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

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

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

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

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

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

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

[Axline, V. M. (1969). Play Therapy. New York: Ballantine Books. {pp. 72-73}]

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

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

Your responses should not convey:

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

[Guerney, L. F. (1972). Play therapy: A training manual for parents. Mimeographed Report.]

TWO TECHNIQUES OF DISCIPLINE THAT WORK

(Garry L. Landreth, 1983)

1. Firm limit-setting

A. Three steps:
   (1) Recognize the feeling – "I know you'd really like to . . . ", or "I can tell you're really feeling . . .", etc.

   (2) Set the limit – ". . . but you may not _____.", or ". . . but the cabinet door is not for kicking.", or ". . but the answer is no."

   (3) Provide an alternative – "You can _____ if you'd like.", or "You can choose to _____.

B. After three-step process, DON'T discuss: "I can tell you'd lie to discuss this some more, but I've already answered that question."

C. If you're not prepared to answer the question (want to talk it over with someone; want to get more information; want to think about it).

   (1) "I can't answer that question now . . . (because . . .)." "I'll let you know (specific time)."

   (2) Nagging begins: "If you must have an answer now, the answer will have to be NO."

D. If the child asks the same question again: Calmly – "I've already answered that question." Variations:

   (1) "Do you remember the answer I gave you a few minutes ago when you asked that same question?" (Child answers, "No, I don't remember.") "Go sit down in a quiet place and think and I know you'll remember."

   (2) "I've answered that question once (twice), that's enough."

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

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

2. Oreo Cookie Theory: Give the child a choice, providing acceptable choices commensurate with the child's ability to choose.

Session Seven Handouts

WHEN "SETTING THE LIMIT" DOESN'T WORK . . .
(Garry L. Landreth, 1983)

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

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

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

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

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

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

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

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

COMMON PROBLEMS IN FILIAL THERAPY

(Garry L. Landreth, 1983)

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

   A: _____

   _____

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

   A: _____

   _____

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

   A: _____

   _____

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

   A: _____

   _____

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

   A: _____

   _____

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

   A: _____

   _____

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

   A: _____

   _____

Appendix F: Contents/Cost of Filial Toy Kits for School-Age Children Itemized by Type of Play Each Toy Elicits

Constructive Play	Cost	Source (Retailer)
Clear tape	$0.50	Dollar Store
Construction paper	$1.00	Big Lots
Crayons	$0.40	Big Lots
Glue stick	$0.50	Dollar Store
Interlocking pieces construction set	$5.00	Wal-Mart
Markers	$0.60	Big Lots
Modeling compound	$2.00	Wal-Mart
Scissors	$1.00	Dollar Store
Subtotal	$11.00	

Symbolic Play	Cost	Source (Retailer)
Baby bottle	$1.00	Dollar Store
Bandages (plastic)	$1.00	Dollar Store
Car	$1.00	Dollar Store
Dart gun	$1.00	Wal-Mart
Doll family	$8.00	Big Lots
Doctor kit	$5.00	Big Lots
Handcuffs/Rubber knife	$1.00	Dollar Store
Play money	$1.00	Dollar Store
Play phone	$1.00	Dollar Store
Punching bag	$4.00	Big Lots
Rope	$0.50	Big Lots
Toy soldiers	$1.00	Dollar Store
Subtotal	$25.50	

Games With Rules Play	Cost	Source (Retailer)
Bat/ball	$1.00	Dollar Store
Block game	$4.00	Wal-Mart
Dominos	$1.00	Dollar Store
Jacks	$1.00	Dollar Store
Pair of dice	$0.50	Dollar Store
Set of board/card games	$5.00	Wal-Mart
Storytelling game	$1.00	Dollar Store
Subtotal	$13.50	

TOTAL COST PER KIT	$50.00

Appendix G: Questions for the Seventh-Session Game

	Structuring	Empathic Listening	Play	Limit-Setting
$100	Name three things that you do (or don't do) during special play times to let your child (and others) know that this is time just for the two of you.	This skill involves tracking your child's_____ and reflecting your child's_____.	In movie language, this skill means that your child is the_____and you are the_____.	The three limit-setting steps are:
$250	You normally have your special play times on Saturday afternoons, but on this particular Saturday, your child has been up late at a sleepover party, and is tired, hungry, and irritable. What do you do about your special play time?	During a special play time together, your child says some mean things, either about you or somebody else. What should you do?	During a special play time together, your child makes up her/his own rules for a game, and then changes these rules in the middle of the game. What do you do?	Whether you are giving a child a limit, or giving her/him a warning, it is always important to also: 1)_____her/his feelings and 2)_____her/his behavior
$500	You and your child are going to be away from your home for the holidays or a vacation. What can you do about your special play times?	During a special play time together, your child gets mad at you, and says that she/he is going to join a gang. How do you respond?	You were always taught that 'boys don't play with dolls,' but your son wants to play with the doll family during your special play time together. How do you respond?	During your last special play time together, you gave your child a limit. Now, a week later, they are 'testing' this limit again. Since you have already given them the limit, what steps do you follow?
$1000	You and your child have really enjoyed your special play times together for several years now. But your child has just turned 12 and is no longer interested in the toys in the kit. Can you still have special play times? If yes, how?	During a special play time together, your child refuses to play with the toys or interact with you. How do you respond?	Your child holds up one of the toys in the toy kit, and says, "What's this for?" How do you respond?	After giving a limit and a warning, your child has chosen to continue poking one of the pick up sticks in to the punching bag, and the base of the bag now has a hole in it, and water is getting all over the floor. Name two different consequences that you could use in response.

Appendix H: Anecdotal Data Sheet for Sessions One Through Seven[1]

Caregiver_____

Child_____ Age_____ Grade_____

1. Circle the number that best describes your stress level as a parent over the past week:

1 2 3 4 5 6 7 8 9 10

Worst Ever No Stress

2. Circle the number that best describes your relationship with your child over the past week:

1 2 3 4 5 6 7 8 9 10

Worst Ever Best Ever

3. What did you learn tonight that you think you will actually use:

4. What toys did your child play with during your special play time this past week?

[1]Question 4 was only given to experimental group participants, following sessions four through seven.

Appendix I: The Measurement Battery

Prevent Child Abuse Roanoke Valley is able to offer our programs at a low cost due to a number of important funding sources. As such, it is a requirement that we provide some basic client demographic information to these funders. Your name will not be shared with anyone, and will only be used for our confidential records.

Your Name_____
Today's Date_____

1. Age: _____17 & under _____18-29 _____30-39 _____40-49
   _____50-59 _____60+

2. Sex: _____Male _____Female

3. Number of people in family_____(Do not include extended family) (EX: A family with 2 parents and 3 children would have a total of 5 people in the family)

4. Ethnic/Racial Status: _____White _____Black _____Biracial
   _____Hispanic _____Asian _____Other (specify)_____

5. Residence: _____Roanoke City _____Roanoke County _____Salem
   _____Botetourt County _____Craig County _____Other (specify)_____

6. Annual Income: _____$0-$9,999 _____$10,000-$19,999
   _____$20,000-$29,999 _____$30,000+

7. Do you have custody of your children? _____Yes _____No
   If no, who has custody of them? _____Foster care _____Family member
   _____Other biological parent _____Other (specify)_____

8. Do you feel you were abused or neglected as a child? _____Yes _____No

9. Do you have a child with special needs? _____Yes _____No

10. Have you ever had an open Child Protective Services (CPS) case?
    _____Yes _____No

11. Do you drink alcohol? _____Yes _____No
    If yes, how often? _____Daily _____1-3 times/week
    _____1-3 times/month _____1-3 times/year

12. Do you use illegal drugs? _____Yes _____No
    If yes, how often? _____Daily _____1-3 times/week
    _____1-3 times/month _____1-3 times/year

Name_____ Date_____

6-10 Parenting Survey

1. Children who do poorly in school:
   a. should be punished b. will never succeed c. may have a learning disability d. both a and b
2. Children with ADHD can be helped with:
   a. medication b. limits and consequences c. structure d. all of the above
3. The appropriate length for time out for a 10 year old is:
   a. 20 minutes b. 10 minutes c. 30 minutes d. 5 minutes
4. Children misbehave to:
   a. make parents mad b. get attention c. show off d. none of the above
5. Your 7-year-old child wants to cook on the stove, do you:
   a. let him cook without supervision b. let him cook with supervision
   c. not let him near the stove d. none of the above
6. It is okay to leave your children alone in the car. True False
7. In order for children to behave, they need:
   a. consequences to be enforced consistently b. to be scolded
   c. to be told once what to do and that is enough d. a good spanking
8. Spanking your child:
   a. teaches them right from wrong b. is an effective method of discipline
   c. is a good way to let your child know you are angry
   d. may teach your child that hitting is a good way to solve problems
9. If the discipline technique you are using is not working, you should:
   a. give up b. try a new technique
   c. continue what you are doing until the child changes his behavior
10. Parents should keep secrets from their children about situations of death and illness. True False
11. Children age 6-9 can play outside without telling parents where they will be. True False
12. If parents manage their anger in a violent manner, children are:
   a. more likely to manage their anger violently
   b. less likely to mange their anger violently
   c. are not impacted by parents' anger management
   d. both a and c
13. Children should always do their homework immediately after coming home from school. True False
14. When parents keep secrets or lie to children, they:
   a. put up barriers to communication b. teach their children they are weak
   c. teach their children secrets and lies are acceptable d. none of the above
15. When establishing family rules parents should:
   a. develop them on their own b. sit down with the child and decide as a family
   c. have consequences in place for every rule d. both b and c

QUESTIONNAIRE FORM VI

Name: _____ Date: _____ ID#: _____

Age: _____ Gender: Male _____ Female _____ Marital Status: Sin ___ Mar ___ Sep ___ Div ___ Wid ___

Race: Black ___ White ___ Latino ___ Am. Indian ___ Number of children in home _____

Asian Am. ___ Other (specify) _____ Highest grade completed _____

INSTRUCTIONS: The following questionnaire includes a series of statements which may be applied to yourself. Read each of the statements and determine if you **AGREE** or **DISAGREE** with the statement. If you agree with a statement, circle **A** for agree. If you disagree with a statement, circle **DA** for disagree. Be honest when giving your answers. Remember to read each statement; it is important not to skip any statement.

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1.	I never feel sorry for others	A	DA
2.	I enjoy having pets	A	DA
3.	I have always been strong and healthy	A	DA
4.	I like most people	A	DA
5.	I am a confused person	A	DA
6.	I do not trust most people	A	DA
7.	People expect too much from me	A	DA
8.	Children should never be bad	A	DA
9.	I am often mixed up	A	DA
10.	Spanking that only bruises a child is okay	A	DA
11.	I always try to check on my child when it's crying	A	DA
12.	I sometimes act without thinking	A	DA
13.	You cannot depend on others	A	DA
14.	I am a happy person	A	DA
15.	I like to do things with my family	A	DA
16.	Teenage girls need to be protected	A	DA
17.	I am often angry inside	A	DA
18.	Sometimes I feel all alone in the world	A	DA
19.	Everything in a home should always be in its place	A	DA
20.	I sometimes worry that I cannot meet the needs of a child	A	DA
21.	Knives are dangerous for children	A	DA
22.	I often feel rejected	A	DA
23.	I am often lonely inside	A	DA
24.	Little boys should never learn sissy games	A	DA
25.	I often feel very frustrated	A	DA

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26.	Children should never disobey	A	DA
27.	I love all children	A	DA
28.	Sometimes I fear that I will lose control of myself	A	DA
29.	I sometimes wish that my father would have loved me more	A	DA
30.	I have a child who is clumsy	A	DA
31.	I know what is the right and wrong way to act	A	DA
32.	My telephone number is unlisted	A	DA
33.	The birth of a child will usually cause problems in a marriage	A	DA
34.	I am always a good person	A	DA
35.	I never worry about my health	A	DA
36.	I sometimes worry that I will not have enough to eat	A	DA
37.	I have never wanted to hurt someone else	A	DA
38.	I am an unlucky person	A	DA
39.	I am usually a quiet person	A	DA
40.	Children are pests	A	DA
41.	Things have usually gone against me in life	A	DA
42.	Picking up a baby whenever he cries spoils him	A	DA
43.	I sometimes am very quiet	A	DA
44.	I sometimes lose my temper	A	DA
45.	I have a child who is bad	A	DA
46.	I sometimes think of myself first	A	DA
47.	I sometimes feel worthless	A	DA
48.	My parents did not really care about me	A	DA
49.	I am sometimes very sad	A	DA
50.	Children are really little adults	A	DA
51.	I have a child who breaks things	A	DA
52.	I often feel worried	A	DA
53.	It is okay to let a child stay in dirty diapers for a while	A	DA
54.	A child should never talk back	A	DA
55.	Sometimes my behavior is childish	A	DA
56.	I am often easily upset	A	DA
57.	Sometimes I have bad thoughts	A	DA
58.	Everyone must think of himself first	A	DA
59.	A crying child will never be happy	A	DA
60.	I have never hated another person	A	DA
61.	Children should not learn how to swim	A	DA
62.	I always do what is right	A	DA
63.	I am often worried inside	A	DA
64.	I have a child who is sick a lot	A	DA
65.	Sometimes I do not like the way I act	A	DA
66.	I sometimes fail to keep all of my promises	A	DA
67.	People have caused me a lot of pain	A	DA
68.	Children should stay clean	A	DA
69.	I have a child who gets into trouble a lot	A	DA
70.	I never get mad at others	A	DA

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71.	I always get along with others	A	DA
72.	I often think about what I have to do	A	DA
73.	I find it hard to relax	A	DA
74.	These days a person doesn't really know on whom one can count	A	DA
75.	My life is happy	A	DA
76.	I have a physical handicap	A	DA
77.	Children should have play clothes and good clothes	A	DA
78.	Other people do not understand how I feel	A	DA
79.	A five year old who wets his bed is bad	A	DA
80.	Children should be quiet and listen	A	DA
81.	I have several close friends in my neighborhood	A	DA
82.	The school is primarily responsible for educating the child	A	DA
83.	My family fights a lot	A	DA
84.	I have headaches	A	DA
85.	As a child I was abused	A	DA
86.	Spanking is the best punishment	A	DA
87.	I do not like to be touched by others	A	DA
88.	People who ask for help are weak	A	DA
89.	Children should be washed before bed	A	DA
90.	I do not laugh very much	A	DA
91.	I have several close friends	A	DA
92.	People should take care of their own needs	A	DA
93.	I have fears no one knows about	A	DA
94.	My family has problems getting along	A	DA
95.	Life often seems useless to me	A	DA
96.	A child should be potty trained by the time he's one year old	A	DA
97.	A child in a mud puddle is a happy sight	A	DA
98.	People do not understand me	A	DA
99.	I often feel worthless	A	DA
100.	Other people have made my life unhappy	A	DA
101.	I am always a kind person	A	DA
102.	Sometimes I do not know why I act as I do	A	DA
103.	I have many personal problems	A	DA
104.	I have a child who often hurts himself	A	DA
105.	I often feel very upset	A	DA
106.	People sometimes take advantage of me	A	DA
107.	My life is good	A	DA
108.	A home should be spotless	A	DA
109.	I am easily upset by my problems	A	DA
110.	I never listen to gossip	A	DA
111.	My parents did not understand me	A	DA
112.	Many things in life make me angry	A	DA
113.	My child has special problems	A	DA
114.	I do not like most children	A	DA
115.	Children should be seen and not heard	A	DA

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116.	Most children are alike	A	DA
117.	It is important for children to read	A	DA
118.	I am often depressed	A	DA
119.	Children should occasionally be thoughtful of their parents	A	DA
120.	I am often upset	A	DA
121.	People don't get along with me	A	DA
122.	A good child keeps his toys and clothes neat and orderly	A	DA
123.	Children should always make their parents happy	A	DA
124.	It is natural for a child to sometimes talk back	A	DA
125.	I am never unfair to others	A	DA
126.	Occasionally, I enjoy not having to take care of my child	A	DA
127.	Children should always be neat	A	DA
128.	I have a child who is slow	A	DA
129.	A parent must use punishment if he wants to control a child's behavior	A	DA
130.	Children should never cause trouble	A	DA
131.	I usually punish my child when it is crying	A	DA
132.	A child needs very strict rules	A	DA
133.	Children should never go against their parents' orders	A	DA
134.	I often feel better than others	A	DA
135.	Children sometimes get on my nerves	A	DA
136.	As a child I was often afraid	A	DA
137.	Children should always be quiet and polite	A	DA
138.	I am often upset and do not know why	A	DA
139.	My daily work upsets me	A	DA
140.	I sometimes fear that my children will not love me	A	DA
141.	I have a good sex life	A	DA
142.	I have read articles and books on child rearing	A	DA
143.	I often feel very alone	A	DA
144.	People should not show anger	A	DA
145.	I often feel alone	A	DA
146.	I sometimes say bad words	A	DA
147.	Right now, I am deeply in love	A	DA
148.	My family has many problems	A	DA
149.	I never do anything that is bad for my health	A	DA
150.	I am always happy with what I have	A	DA
151.	Other people have made my life hard	A	DA
152.	I laugh some almost every day	A	DA
153.	I sometimes worry that my needs will not be met	A	DA
154.	I often feel afraid	A	DA
155.	I sometimes act silly	A	DA
156.	A person should keep his business to himself	A	DA
157.	I never raise my voice in anger	A	DA
158.	As a child I was knocked around by my parents	A	DA
159.	I sometimes think of myself before others	A	DA
160.	I always tell the truth	A	DA

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Name_____ Gender ____ Date of birth _____ Ethnic group _____ Marital status_____

Child's name_____ Child's gender_____ Child's date of birth _____ Today's date_____

SA = Strongly Agree A = Agree NS = Not Sure D = Disagree SD = Strongly Disagree

1.	I often have the feeling that I cannot handle things very well.	SA	A	NS	D	SD
2.	I find myself giving up more of my life to meet my children's needs than I ever expected.	SA	A	NS	D	SD
3.	I feel trapped by my responsibilities as a parent.	SA	A	NS	D	SD
4.	Since having this child, I have been unable to do new and different things.	SA	A	NS	D	SD
5.	Since having a child, I feel that I am almost never able to do things that I like to do.	SA	A	NS	D	SD
6.	I am unhappy with the last purchase of clothing I made for myself.	SA	A	NS	D	SD
7.	There are quite a few things that bother me about my life.	SA	A	NS	D	SD
8.	Having a child has caused more problems than I expected in my relationship with my spouse (male/female friend).	SA	A	NS	D	SD
9.	I feel alone and without friends.	SA	A	NS	D	SD
10.	When I go to a party, I usually expect not to enjoy myself.	SA	A	NS	D	SD
11.	I am not as interested in people as I used to be.	SA	A	NS	D	SD
12.	I don't enjoy things as I used to.	SA	A	NS	D	SD
13.	My child rarely does things for me that make me feel good.	SA	A	NS	D	SD
14.	Most times I feel that my child does not like me and does not want to be close to me.	SA	A	NS	D	SD
15.	My child smiles at me much less than I expected.	SA	A	NS	D	SD
16.	When I do things for my child, I get the feeling that my efforts are not appreciated very much.	SA	A	NS	D	SD
17.	When playing, my child doesn't often giggle or laugh.	SA	A	NS	D	SD
18.	My child doesn't seem to learn as quickly as most children.	SA	A	NS	D	SD
19.	My child doesn't seem to smile as much as most children.	SA	A	NS	D	SD
20.	My child is not able to do as much as I expected.	SA	A	NS	D	SD
21.	It takes a long time and it is very hard for my child to get used to new things.	SA	A	NS	D	SD

For the next statement, choose your response from the choices "1" to "5" below.

22.	I feel that I am: 1. not very good at being a parent 2. a person who has some trouble being a parent 3. an average parent 4. a better than average parent 5. a very good parent	1	2	3	4	5
23.	I expected to have closer and warmer feelings for my child than I do and this bothers me.	SA	A	NS	D	SD
24.	Sometimes my child does things that bother me just to be mean.	SA	A	NS	D	SD
25.	My child seems to cry or fuss more often than most children.	SA	A	NS	D	SD
26.	My child generally wakes up in a bad mood.	SA	A	NS	D	SD
27.	I feel that my child is very moody and easily upset.	SA	A	NS	D	SD
28.	My child does a few things which bother me a great deal.	SA	A	NS	D	SD
29.	My child reacts very strongly when something happens that my child doesn't like.	SA	A	NS	D	SD
30.	My child gets upset easily over the smallest thing.	SA	A	NS	D	SD
31.	My child's sleeping or eating schedule was much harder to establish than I expected.	SA	A	NS	D	SD

For the next statement, choose your response from the choices "1" to "5" below.

32.	I have found that getting my child to do something or stop doing something is: 1. much harder than I expected 2. somewhat harder than I expected 3. about as hard as I expected 4. somewhat easier than I expected 5. much easier than I expected	1	2	3	4	5

For the next statement, choose your response from the choices "10+" to "1-3."

33.	Think carefully and count the number of things which your child does that bother you. For example: dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.	10+	8-9	6-7	4-5	1-3
34.	There are some things my child does that really bother me a lot.	SA	A	NS	D	SD
35.	My child turned out to be more of a problem than I had expected.	SA	A	NS	D	SD
36.	My child makes more demands on me than most children.	SA	A	NS	D	SD

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CHILD-PARENT RELATIONSHIP SCALE

Robert C. Pianta

Child:_____ Age:_____

Parent:_____

Please reflect on the degree to which each of the following statements currently applies to your relationship with your child. Using the scale below, circle the appropriate number for each item.

Definitely does not apply 1	Not really 2	Neutral, not sure 3	Applies somewhat 4	Definitely applies 5

1.	I share an affectionate, warm relationship with my child.	1	2	3	4	5
2.	My child and I always seem to be struggling with each other.	1	2	3	4	5
3.	If upset, my child will seek comfort from me.	1	2	3	4	5
4.	My child is uncomfortable with physical affection or touch from me.	1	2	3	4	5
5.	My child values his/her relationship with me.	1	2	3	4	5
6.	My child appears hurt or embarrassed when I correct him/her.	1	2	3	4	5
7.	My child does not want to accept help when he/she needs it.	1	2	3	4	5
8.	When I praise my child, he/she beams with pride.	1	2	3	4	5
9.	My child reacts strongly to separation from me.	1	2	3	4	5
10.	My child spontaneously shares information about himself/herself.	1	2	3	4	5
11	My child is overly dependent on me.	1	2	3	4	5
12.	My child easily becomes angry at me.	1	2	3	4	5
13.	My child tries to please me.	1	2	3	4	5
14.	My child feels that I treat him/her unfairly.	1	2	3	4	5
15.	My child asks for my help when he/she really does not need help.	1	2	3	4	5
16.	It is easy to be in tune with what my child is feeling.	1	2	3	4	5
17.	My child sees me as a source of punishment and criticism.	1	2	3	4	5
18.	My child expresses hurt or jealousy when I spend time with other children.	1	2	3	4	5
19.	My child remains angry or is resistant after being disciplined.	1	2	3	4	5
20.	When my child is misbehaving, he/she responds to my look or tone of voice.	1	2	3	4	5
21.	Dealing with my child drains my energy.	1	2	3	4	5
22.	I've noticed my child copying my behavior or ways of doing things.	1	2	3	4	5
23.	When my child is in a bad mood, I know we're in for a long and difficult day.	1	2	3	4	5
24.	My child's feelings toward me can be unpredictable or can change suddenly.	1	2	3	4	5
25.	Despite my best efforts, I'm uncomfortable with how my child and I get along.	1	2	3	4	5
26.	I often think about my child when at work.	1	2	3	4	5
27.	My child whines or cries when he/she wants something from me.	1	2	3	4	5
28.	My child is sneaky or manipulative with me.	1	2	3	4	5
29.	My child openly shares his/her feelings and experiences with me.	1	2	3	4	5
30.	My interactions with my child make me feel effective and confident as a parent.	1	2	3	4	5

Appendix J: Item Breakdown of the Child Abuse Prevention Inventory Scales

Scale	Number of Items	Items
Abuse scale (Comprised of the 6 factor scales that follow it)	77	3, 5, 7, 9, 13, 14, 17, 18, 19, 22, 23, 24, 25, 26, 28, 29, 32, 36, 38, 39, 41, 45, 47, 49, 52, 54, 56, 63, 67, 68, 69, 73, 74, 75, 76, 77, 78, 80, 81, 83, 84, 90, 93, 94, 95, 98, 99, 100, 102, 103, 105, 107, 108, 109, 111, 112, 113, 115, 118, 120, 122, 127, 128, 129, 130, 132, 134, 138, 141, 143, 145, 147, 148, 151, 152, 153, 154
Distress scale	36	5, 9, 17, 18, 22, 23, 25, 28, 29, 36, 41, 47, 49, 52, 56, 63, 73, 78, 84, 93, 95, 98, 99, 102, 103, 105, 109, 111, 112, 118, 120, 138, 143, 145, 153, 154
Rigidity scale	14	7, 9, 24, 26, 32, 54, 68, 80, 108, 115, 122, 127, 130, 132
Unhappiness scale	11	14, 38, 75, 77, 81, 90, 107, 134, 141, 147
Problems with child and self scale	6	3, 45, 69, 76, 113, 128
Problems with family scale	4	39, 83, 94, 148
Problems from others	6	13, 67, 74, 100, 129, 151
Ego-strength scale	40	14, 17, 18, 20, 22, 23, 25, 28, 41, 47, 49 52, 56, 63, 65, 67, 73, 74, 78, 84, 93, 95, 98, 99, 102, 103, 105, 107, 109, 112, 118, 120, 136, 138, 140, 143, 145, 151, 153, 154
Loneliness scale	15	6, 18, 22, 23, 47, 49, 67, 73, 74, 78, 87, 98, 141, 143, 145
Lie scale	18	12, 34, 35, 44, 46, 57, 62, 66, 70, 106, 110, 146, 149, 150, 155, 157, 159, 160
Random response scale	18	1, 11, 16, 27, 31, 33, 43, 53, 58, 59, 60, 61, 65, 72, 89, 114, 116, 119
Inconsistency scale	20 pairs	3-76, 4-6, 5-9, 38-41, 44-70, 52-63, 58-72, 62-65, 75-118, 78-98, 83-94, 85-158, 87-141, 90-152, 95-107, 100-151, 105-120, 122-127, 124-133, 143-145

Appendix K: Focus Group Guide

(Developed by Katherine J. Walker, Ph.D.)

1. Describe your relationship with your child before the filial therapy process began. What was positive about that relationship? What were your major concerns?

2. How did you feel about your parenting ability then (before the filial process began)? How has that changed?

3. When I first explained filial therapy, what was your immediate/first impression of the process?

4. If you had to describe filial therapy in detail to a friend, how would you describe it? Would you recommend it to another parent or caregiver? Why? Under what circumstances?

5. What has been the most difficult for you during this process? Easiest?

6. How do you feel prior to filial meetings? Afterwards?

7. What has been you most important learning through filial therapy?

8. What are the most significant changes you have made?

9. What are the most significant changes you have noticed in your child?

10. How has your parenting changed since you began filial therapy?

11. Do you view your role as a parent differently? How?

12. Has this experience changed your interaction with others (spouses, friends, parents, other children, colleagues)? How?

13. What are some areas of improvement for your parenting skills? What do you hope to develop further in your growth as a parent?

14. What changes could be made in the filial therapy training process to meet your specific needs?

15. What was most helpful to you during the filial therapy training process? Least helpful? Was anything detrimental? How?

16. What else is important for you to communicate about your experience in filial therapy?

Vita

Clarice Evans Goodwin

Education:

2003	Ph.D.	Human Development Emphasis: Marriage and Family Therapy	Virginia Tech
1999	M.S.	Human Development and Family Studies Emphasis: Marriage and Family Therapy	Auburn University
1995	B.S.	Psychology Minor: French	Brigham Young University

Clinical Experience:

2002-2003 *Therapist Intern*, LDS Family Services Virginia Agency - Richmond, Virginia

1999-2002 *Therapist Intern*, Family Therapy Center of Virginia Tech - Blacksburg, Virginia

1998-1999 *Therapist Intern*, Marriage and Family Therapy Center - Auburn, Alabama

1998-1999 *Therapist Intern*, The Child Advocacy Center of East Alabama, Inc.- Opelika, Alabama

1996 *Associate Counselor*, Lakeside Milam Recovery Centers, Adolescent Inpatient Center - Seattle, Washington

1994-1995 *Psychological Technician*, Department of Mental Health, Utah State Prison - Draper, Utah

Teaching Experience:

1999-2001 *Instructor*, HD 3314 (Human Sexuality), Virginia Tech

1998 *Guest lecturer*, HDFS 157 (Family & Human Development), Auburn University

1994-1995 *Instructor*, Department of Mental Health, Utah State Prison

Presentations:

2000 *Linking Attitudinal and Perceptual Measures of Body Image: An Extension of the Waist-To-Hip Ratio Literature*
Poster presentation at the National Council on Family Relations (NCFR)
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