

Filial Therapy with Parents Court-Referred for Child Maltreatment

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(Abstract)

The general purpose of this study was to both evaluate the effectiveness of filial therapy and describe the filial treatment process with parents court-referred for maltreatment. In filial therapy, parents learn basic play therapy skills in a group format that they implement in weekly home play sessions. They then generalize these skills into their parenting. Three research questions guided the quantitative portion of this investigation: (1) Is filial therapy effective at reducing the child abuse potential of parents court-referred for maltreatment? (2) Is filial therapy effective at reducing parenting stress for parents court-referred for maltreatment? (3) Is filial therapy effective at strengthening the parent-child relationship for parents court-referred for maltreatment?

Qualitative data about parents' experience in the filial group was also collected and addressed the following questions: (1) How does the filial therapy process affect participants? (2) How does the filial therapy process affect treatment outcome? (3) What changes, in addition to those measured quantitatively, are reported by parents. The experimental group participants (n=7) received 8 weeks of filial therapy (modified from Landreth's (1991) 10-week model) in 1½-hour weekly sessions. The control group (n=5) received a local agency's standard treatment. Parents completed two instruments, the Parenting Stress Index (PSI) and the Child Abuse Potential Inventory (CAP). Analyses of covariance indicated that parents significantly reduced their parenting stress and strengthened the parent-child relationship. Although parents did not significantly reduce their child abuse potential in this study, those results were based on an incomplete analysis. Most of the pre-test CAP scores for parents in the experimental group (6 of 7) were invalid as a result of excessive "faking good responses." As a result, only post-test scores could be compared between the experimental and control groups. The qualitative data revealed that parents made important changes during the filial therapy process.

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CHAPTER I INTRODUCTION

Counselors working with children and their families are aware of the importance of quality parenting that combines expressing love and affection with structure and discipline. Often, counselors are educated about positive parenting skills and are willing to impart this knowledge as well as listen to the frustrations of what some consider the most difficult job in our society--raising a child. Their difficulty comes from finding the best way to impart this expertise in a meaningful way, one that opens the opportunity for change and healthy growth for families in distress. This work is even more imperative when counselors face the task of helping parents who have resorted to using abusive measures with their children. Counselors need to know what they can do to help those with the most severe parenting problems learn more positive ways to interact with their children. How can they give maltreating parents the help they desperately need to meet the awesome demands of parenthood?

Rationale

The importance of meeting this demand cannot be understated. Child maltreatment is a significant problem in the United States with major consequences for the nation's social foundation. Despite heightened awareness of child maltreatment, alarming increases in the incidence of child abuse and neglect have occurred. The Third National Incidence Study of Child Abuse and Neglect (NIS-3) described alarming trends for the years 1993-1994. Congress mandated the first of the National Incidence Studies (NIS) in 1974. The three NIS studies completed to date are the most complete references to the occurrence of child maltreatment in the United States (Sedlak & Broadhurst, 1996).

National Incidence Study-3

In order to fully grasp the statistics presented by the NIS-3 study, it is important to understand the two standards of child maltreatment applied in the study: the Harm Standard and the Endangerment Standard. The Harm Standard involved an act or absence of action that resulted in clear, substantiated harm to a child. It was the more objective and narrower of the two standards. The only exceptions made to the evidentiary requirement of the Harm standard resulted from knowledge of such horrendous abuse or neglect that harm could be inferred without direct verification. The Endangerment Standard was the more liberal standard. The Endangerment Standard included the requirements of the Harm Standard as well as documented cases of children who were considered at risk of harm from the abuse or neglect. In addition, it comprised abusive and neglectful incidences perpetrated by alternative adult caregivers.

Using the stricter standard, the Harm Standard, the number of abused (including sexually abused) and neglected children increased 67% between the second NIS (NIS-2) published in 1986 and the NIS-3, and 149% from the first NIS (NIS-1) published in 1980. A 102% increase in the number of physical neglect victims occurred between the NIS-2 and the NIS-3. The number of emotionally neglected children increased 333% in the same time period. Physically abused children experienced a 42% rise. Not only did an increase of incidents of physical abuse occur, but there was also an escalation in the degree of damage to children. Between the NIS-2 and the NIS-3, the number of children seriously injured by abuse (including sexual abuse) or neglect increased by 298%. Although it is conceivable that a portion of the statistics listed above could be attributable to heightened awareness, it alone cannot account for all of the increases, particularly the rise in serious injuries. The authors of the study asserted that their data clearly indicated an increase in both the extent and severity of child abuse and neglect in the United States (Sedlak & Broadhurst, 1996).

Treatment in the Child Maltreatment Literature

There is no consensus in the field about which treatments are most effective for physically abusive parents. This lack of consensus may have resulted from a shift in focus away from the early 1980's surge of outcome research with physically abusive families. The two areas of the abuse and neglect literature that have received significantly more attention since then are prevention and child sexual abuse. From 1979 to 1982, 30% more articles on physical abuse than sexual abuse were published in *Child Abuse & Neglect*. From 1982 to 1986, however, 15% more articles on sexual abuse as opposed to physical abuse appeared in that publication. Between 1987 and 1990 a sizeable 300% more articles on sexual abuse than physical abuse were published in the journal (Kaufman & Rudy, 1991). Neglect has consistently received little attention in the literature, and when it does appear in research, it is generally included with physical abuse (Kolko, 1998).

The disagreement in the literature about the most effective models has made it difficult for counselors to select treatment models that address the considerable deficits in skills and knowledge of maltreating parents. Counselors who work with maltreating parents do so in individual, family and group sessions. Group treatment may be more beneficial for this treatment population because it attends to an important problem many maltreating parents face, a lack of social support (Milner & Chilamkurti, 1991).

Filial Therapy

Parenting groups have been designed for diverse populations with a wide range of problems. A special form of treatment, known as filial therapy, recently has received attention in the quantitative research literature, particularly efficacy studies (e.g., Beckloff, 1998; Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; Landreth & Lobaugh, 1998).

Filial therapy is an integrated model of treatment based on the principles of client-centered therapy. As developed by Bernard Guerney (1964), it is a form of treatment that improves the parent-child relationship through teaching the parent(s) basic client-centered play therapy skills. Louise Guerney (1997) writes that filial therapy "adds what strictly behaviorally-oriented psychoeducational training programs do not have - the nesting of the training in new behaviors within a humanistic approach to change . . . and both components are necessary to make therapy complete" (p. 157). The two major components of treatment are: (1) replacing inappropriate parenting behaviors with more positive and productive behaviors, and (2) providing empathy and support to parents through the interaction of the group members and the counselor.

This model of treatment is generally conducted in groups of six to eight parents who participate in play therapy with their children aged 3 through 11. It was initially designed to engage parents as treatment agents to improve their children's problem behaviors, but filial therapy has been increasingly used to strengthen the parent-child relationship (VanFleet, 1994b). Because the parent is the primary person in a child's life, Bernard Guerney (1964) believed change through play therapy implemented by the parent would be more effective than play therapy implemented by a clinician. In order to provide filial therapy, mental health providers become the supervisors and trainers of parents who take on the role of therapist. The counselors provide parents training in non-directive play therapy, much as they would train a professional student, but they generally use simpler vocabulary with less professional jargon (Stover & Guerney, 1967).

The treatment professional implements the instruction for the parents in five stages: training, practice, home play sessions, generalization and transfer, and termination. The training phase involves play therapy demonstrations, instruction and role-plays. This is followed by a series of practice sessions for parents with the treatment professional and group members observing, generally through a one-way mirror. These practice sessions last no more than 15 minutes. Practicing ordinarily takes the group two sessions to complete, but can be extended to three sessions if the parents are struggling. At that point, parents are ready for the home play sessions using a toy kit or sessions in the play therapy room of the treatment center. Parents complete between four and six home sessions before entering the generalization and transfer phase.

In the generalization and transfer phase, skills and principles that parents have learned during the process are applied to real life; filial therapy is a treatment that combines parental education with play therapy. Brief empathic responding sessions (5-10 minutes), the application of structuring skills and limit setting for problem behaviors are all assigned. In the termination phase, play sessions are phased out and modified to “special times,” where the child still leads a play activity of his or her choice. For younger children, special times may be a continuation of the play sessions (Guerney, L., 1997).

Although the filial therapy model is based in group format, it can be modified for individual families (Guerney, L., 2000). The group format is generally the preferred method because parents provide support for one another, and the most progressive parents “pull” the other parents along (Guerney, L., 1997). Goals of the therapy include improving the parent-child relationship, reducing child symptoms, increasing the child’s self-image and coping ability and improving parenting skills (Guerney, L., 1997; Landreth, 1991).

Using parents as healers provides children with play therapy treatment while strengthening the parent-child relationship. Parents are also able to generalize the skills learned in the training session to parenting situations encountered at home. Current research indicates that filial therapy is effective with the following parent populations: parents of different nationalities (Chau & Landreth, 1997; Glover & Landreth, 2000; Jang, 2000, Yuen, 1997), incarcerated fathers (Landreth & Lobaugh, 1998), incarcerated mothers (Harris & Landreth, 1997), single parents (Bratton & Landreth, 1995), non-offending parents of sexually abused children (Costas & Landreth, 1999), and parents of children experiencing learning difficulties (Kale & Landreth, 1999).

Filial therapy, however, has not been studied with abusive parents or parents under suspicion for child abuse. Research indicates that maltreating parents relate to their children with less mutual interaction, more negative comments, less physical (e.g., pointing, repositioning) and verbal attention-directing behaviors (e.g., descriptions, labeling, questions) and less flexibility transferring parenting skills from free play to problem-solving situations (Alessandri, 1992). In order to help parents who are maltreating or at risk of maltreating their children, these interactive behaviors must be addressed. Filial therapy directly targets parent-child interaction in treatment.

Statement of the Problem and Purpose

Given that there is much ambiguity about effective therapeutic intervention for maltreating parents, it is important to evaluate a treatment modality that has real potential with this population. Because its goals, process and results address the most critical etiological factors highlighted in the child maltreatment literature, it is sensible to consider filial therapy treatment for maltreating parents. Although filial therapy is a theoretically logical choice for implementation with this population, prior to this study counselors did not know if filial therapy

is effective with this group of parents. In addition to determining the effectiveness of filial therapy with parents court-referred for maltreatment, it is also important to qualitatively examine the process of filial therapy with parents who maltreat their children. The two purposes of this study are to evaluate the effectiveness of filial therapy with maltreating parents and to describe the process of filial therapy with this parent population. The following questions address the aforementioned problems.

Research Questions

The primary focus of this study is determining the effectiveness of filial therapy with parents court-referred for maltreatment. The main hypothesis is that filial therapy is effective at improving maltreating parents' care of their children. The quantitative research questions include:

1. Is filial therapy effective at reducing the child abuse potential of parents court-referred for maltreatment?
2. Is filial therapy effective at reducing parenting stress for parents court-referred for maltreatment?
3. Is filial therapy effective at strengthening the parent-child relationship for parents court-referred for maltreatment?

The qualitative portion of this project address the following research questions:

1. How does the filial therapy process affect participants?
2. How does the filial therapy process affect treatment outcome?
3. What changes, in addition to those quantitatively measured, are reported by parents?

Definition of Terms

The precise meaning of key words helps clarify important concepts as they relate to the descriptions, rationales and results of research. Although most of the terms below are commonly used in the field, it is important to explain the definitions that suit the purposes of the study.

Child Maltreatment Terms

Child Maltreatment

Child maltreatment includes the physical or psychological abuse or neglect of a child in this study. It does not include child sexual abuse unless otherwise stated.

Abuse

Abuse refers to physical child abuse. This does not include child sexual abuse unless otherwise stated.

Neglect

Neglect is the gross absence of action in response to the physical, emotional, or psychological needs of a child.

Court-Referred.

Court-referred describes parents who have been court-ordered to parenting classes for neglect or abuse, or court-ordered to comply with Child Protective Services (CPS) or Department of Social Services (DSS) recommendations (which include parenting classes) as a result of neglect, abuse, or suspicion of neglect or abuse, or court suggested parenting classes and/or compliance with CPS or DSS recommendations.

Filial Therapy Terms

Filial Therapy

Filial therapy involves teaching parents basic play therapy skills that they use in special sessions with their children.

Play Therapy

Play therapy, defined by Landreth (1991), is a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication, play. (p. 14)

Empathy

Empathy refers to parents' accurate understanding of and sensitivity to their children's feelings and experience.

Dependent Variables

Child Abuse Potential

Child abuse potential entails a parents' predisposition towards exhibiting maltreating behaviors against their children. Child abuse potential is operationally defined as parents' scores on the Child Abuse Potential Inventory (CAP; Milner, 1986).

Parenting Stress

Parenting stress is defined as the degree of stress a parent experiences in the parent-child dyad. For the purposes of this study, parenting stress is operationally defined as the parents' scores on the Parenting Stress Index, Short Form (PSI/SF; Abidin, 1995).

Parent-Child Relationship

Parent-child relationship refers to the interaction within the parent-child dyad. It is operationally defined as the Parent Child Dysfunctional Interaction (P-CDI) subscale on the PSI/SF (Abidin, 1995).

Summary

This chapter has presented an overview of the study. The prevalence and severity of child abuse and neglect in the United States and the lack of consensus about effective treatment for maltreating parents indicates that outcome research addressing this problem is warranted. Because filial therapy is effective with varied parent populations and addresses significant concerns highlighted in the maltreatment literature, it is a potentially useful treatment for parents who maltreat their children. The research questions reviewed focus the examination into the effectiveness of filial therapy with abusive and neglectful parents. Definitions of terms clarified the precise meaning of important terminology used in the study.

CHAPTER II LITERATURE REVIEW

This chapter presents a review of literature relevant to the study. An examination of important theoretical considerations, etiological information, and treatment outcomes in the child maltreatment literature supports the use of filial therapy with this population. Outcome studies of the treatment model, filial therapy, are also important to consider. These studies indicate that filial therapy is effective treatment for multiple parent populations.

Child Maltreatment Literature

Literature reporting well-designed studies of treatment outcome for maltreating parents is lacking (Dore & Lee, 1999; Kolko, 1998; Oates & Bross, 1995). Studies addressing parenting groups for at risk populations and parenting populations with children with specific behavioral problems, however, are more frequently represented in the literature. According to the outcome studies for those populations, treatment has resulted in positive gains for parents. Maltreating parents, however, are a difficult population to treat, and some may not be amenable to treatment (Cohn & Daro, 1987). Despite this, the limited research into treatment outcomes for abusive parents has demonstrated that treatment can be effective (Brunk, Henggeler, & Whelan, 1987; Dore & Lee, 1999; Kolko, 1998; Oates & Bross, 1995). Before looking at that research, however, it is important to understand characteristics of maltreating parents and the etiology of maltreatment.

Etiology of Maltreatment

Herrenkohl (1990) asserted that current, simplified models of maltreatment do not adequately explain this very complex phenomenon. Existing etiological theories do, however, provide important structure and insight into child maltreatment as well as its possible causes, antecedents and related constructs. Because physical abuse has received the most attention in the literature, etiological theories related to physical abuse are also relatively numerous. Crittenden (1988) provided a useful classification system for the broader category of child maltreatment. These classifications will be examined in detail following a review of assumptions of etiological theories and a description of factors associated with child maltreatment.

Assumptions of Etiological Theories

There are four possible assumptions of etiological theories of physical abuse. These four assumptions are based on the following causes: defects, deficiencies, disruptions and transactional problems. Because a defect assumption requires a form of permanent impairment that is either impervious or highly resistant to treatment, this pessimistic, deterministic model is of little use to practitioners. It also has insufficient support in the literature. The deficiency assumption maintains that physically abusive families lack important skills. This assumption underlies educationally based approaches. The third assumption attributes abuse to a disruption, an external event that interferes with family functioning. Services traditionally associated with case management (as opposed to therapeutic intervention) address this assumption. The final assumption involves a transaction. This assumption can be applied to that of the parent-child relationship or even broader models of interaction. Some recent models join assumptions (Azar, Povilaitis, Lauretti, & Pouquette, 1998).

Etiological Theories

Belsky and Vondra (1989) stressed that there are multiple determinants of parenting. They asserted that parental psychology, child temperament and sociological factors influence parental functioning, and the combination of these issues underlies child maltreatment. These

factors are not, however, equally influential. They assigned parental psychology a central role in their ecologically integrated model.

In order to develop an integrative etiological model of child maltreatment, Pianta, Egeland, and Erickson (1989) conducted the Mother-Child Interaction Research Project at the University of Minnesota. Two hundred sixty-seven low socioeconomic status (SES) women were identified as “at risk” for maltreating their children as a result of their financial, educational and social adversity. During the last trimester of their pregnancies, at birth of their first children, at every three month interval during their first children’s first year and then at six month intervals in their second, third and fourth years, the researchers examined variables related to child maltreatment through interviews, observations and multiple measurement scales.

From this longitudinal investigation, the investigators determined that maternal psychological characteristics most differentiated abusive mothers from non-abusive mothers. The most important psychological characteristics were those “which tapped mothers’ thoughts and feelings about dealing with interpersonal relationships and the extent to which they are able to reflect on those thoughts and feelings” (p. 246). This finding supports Belsky and Vondra’s (1989) assertion of the centrality of parental psychological factors in the etiology of maltreatment. Although external stressors and lack of support are associated with maltreatment, through this study, the researchers determined that maternal social cognitive characteristics were a central component in child maltreatment. By only examining low SES mothers, they controlled for environmental factors associated with maltreatment and concluded that low parental interpersonal functioning is an integral component in the etiology of maltreatment.

Factors Associated with Child Maltreatment

Nevertheless, sociological and environmental conditions are very much associated with child maltreatment. These factors are of particular concern in the intergenerational transmission of child maltreatment (Gabinet, 1983). Demographically, parents who mistreat their children are most likely to be low-income, poorly educated, single mothers. (Christmas, Wodarski, & Smokowski, 1996; Dore & Lee, 1999; Milner & Chilmakurti, 1991). In addition, they are more likely to be younger than their non-abusive counterparts and have their first child at a younger age (Christmas, Wodarski, & Smokowski, 1996). As demonstrated in the above study, maltreating parents tend to be socially isolated and have an emotional disorder like clinical depression. In addition, they frequently have high autonomic reactivity to child-related stimuli (Milner & Chilmakurti, 1991). Abusive parents are more likely to have been abused as children, and their environments are also likely to be more stressful than their non-abusive counterparts. There is an increased likelihood that their environment contains substance abuse and interpersonal violence (Christmas, Wodarski, & Smokowski, 1996; Dore & Lee, 1999; Milner & Chilmakurti, 1991).

Maltreating Families

Family functioning provides a context for understanding maltreating parents. In a synthesis and analysis of three studies performed in central Virginia, Crittenden (1988) established five patterns of family functioning related to child maltreatment. This information provides a helpful, research-based framework for differentiating types of maltreatment. The patterns differentiated abusing families, neglecting families, abusing and neglecting families, marginally maltreating families and adequate families.

Abusing families were characterized by parental exertion of control through interference and hostility. The children in these families tended to be either compulsively compliant or the opposite extreme, openly defiant. Neglecting families, on the other hand, were characterized as

chaotic with empty relationships among members. The infants in neglecting families were passive and the children often cognitively delayed. Some of the older children displayed hyperactivity.

Crittenden (1988) described the children in abusing and neglecting families as out of control because they had to manage chronic anxiety. This anxiety resulted from facing violent situations like children in abusive families as well as the impassive and chaotic environment children in neglectful families had to face. Marginally maltreating families had corroborated complaints of abuse or neglect that did not warrant protective services' direct interference. These families had more skills than the abusing, neglecting and the abusing and neglecting families. Although there was a wide variation in family structure among the families in this category, all of the marginally maltreating families lacked stability. Crittenden characterized the children of marginally maltreating parents as whining, disorganized and craving attention. Stability provided the foundation for adequate families. These families consisted of responsive parents and children.

Like Pianta et al. (1989), Crittenden (1988) emphasized that interpersonal relationships differentiated maltreating parents from non-maltreating parents. She further described these patterns among the different maltreating groups in terms of how parents viewed themselves and interpreted the actions of others. Abusing parents conceptualized themselves and others in terms of relative power. Neglecting parents thought of themselves as ineffectual and powerless. They did not believe that their efforts could change circumstances. They also viewed others in this way and attributed differences among groups and individuals to chance.

Parents in the abusing and neglecting category shared self and other perceptions with both the abusing and neglecting groups. Marginally maltreating parents viewed themselves as worthy of love but unable to solicit dependable support from others. They identified others as responsive, but not consistently so. Adequate parents perceived themselves as both lovable and emotionally responsive and expected the same from others.

Little research has categorized the abusive and neglectful group separately, and therefore less is understood about these families than the other maltreating families. In these families, parental behavior vacillates between extremes. In some families this vacillation is predictable; in others it is not. The less predictable the fluctuation, the more dangerous the situation is for the children. It is difficult for them to read their parents' signals and respond protectively in a given situation (Crittenden, 1996).

The Etiological Roles of Attribution, Affective Communication, and Empathy

Attribution. In an important, frequently cited review of the literature on physically abusive parents, Milner and Chilmakurti (1991) determined that the use of physically coercive techniques may be less a result of awareness of other discipline techniques and more a result of their belief that certain child behaviors are wrong and that coercion allows them to gain control of those behaviors. This focus on attribution as opposed to parental knowledge or actual child behaviors has support in the literature (Alessandri, 1992; Miller & Eisenberg, 1988; Wiehe, 1997).

Affective communication. Bugental, Mantyla, and Lewis (1989) described a transactional model of physical abuse. In their model, they focused on the reciprocity of behavior with an emphasis on care giving attributions of the parent. They determined that affective communication mediates transactions between parent and child. In a pilot study in which researchers observed abusive or potentially abusive mother-child and abusive or potentially abusive mother-unrelated child interaction, mothers who were more blaming used a more

negative tone of voice. The roles of both attribution and affective communication played in this study indicates that treatment needs to go beyond addressing parent and child behaviors and particularly attend to parents' perceptions of these behaviors. In addition, treatment should help parents communicate affect more productively.

Empathy. Related to both affective communication and attribution is empathy. Empathy is an important construct in understanding the etiology of child abuse. According to Feshbach (1989), "the psychological process and dimension of empathy has theoretical properties that are relevant to the prevention and reduction of child abuse" (p.367). Although she recognized that empathy is only one of the variables involved in child abuse, she asserted, "empathy appears to have a special potential for the regulations of physical violence towards children" (p.367). In relation to this position, she developed a three-dimensional model of empathy. The cognitive component of empathy includes both "discrimination of affective cues" (p.355) and perspective. This cognitive dimension incorporates the concept of attribution and appears to be the most related (of the three dimensions) to reduced child abuse occurrence. The second dimension, the emotional element of empathy, is also a critical component. The third dimension entails the delineation of clear boundaries between self and others. Empathy has a positive association with prosocial behaviors and a negative association with socially maladjusted behaviors (Feshbach, 1989).

Empathy is also inversely related to aggressive behavior (Feshbach, 1989; Miller & Eisenberg, 1988), and abusive parents exhibit significantly less empathy than non-abusive parents (Rosenstein, 1995; Miller & Eisenberg, 1988; Feshbach, 1989). In addition, maltreated children tend to have lower levels of empathy than their unabused peers. Fortunately, empathy can be increased through psychoeducational intervention (Miller & Eisenberg, 1988). Although empathy training is a central component in treatment of other violent offenders (including sexual offenders, in particular), it generally has not been the treatment focus for physically and emotionally abusive parents. Weihe (1999) called for experimenting with empathy-focused treatments for maltreating parents.

Kropp and Haynes (1987) studied abusive mothers' interpretation of infants' emotional responses, a construct that is comparable to Feshbach's discrimination of affective cues. During the study, researchers asked participants to identify emotions exhibited on 14 slides of infant facial expressions. The seven emotions included: joy, sadness, interest, anger, fear, surprise and distress-pain. A 2 X 3 MANOVA determined there was a significant difference between the abusive mother group and the non-abusive mother matched comparison group. Abusive mothers had more difficulty than non-abusive mothers identifying their infants' emotional signals. This is an important and relevant finding because accurately recognizing and interpreting affective signals are essential components of empathetically responding.

Not only are abusive parents less empathetic with their children, they also are less interactive with their children, and the interaction they do have is less positive and more negative than nonabusive parents (Milner & Chilmakurti, 1991). In addition, it is the actual absence of positive interaction as opposed to differences in negative interaction that sets abusive parents apart from non-abusive parents (Caliso & Milner, 1994).

Treatment for Maltreating Parents

Despite the deep-seated problems that are associated with child maltreatment, interventions can work with these parents. Information presented in conjunction with practical skills can be effective with maltreating parents. Programs for maltreating parents also should go beyond parenting behavior and include anger management, stress control and problem solving

strategies. Also a focus on the emotional part of parenting is important (Dore & Lee, 1999). Kelly (1990) stated “an overly narrow focus in child-management training may equip a parent to handle only a few isolated problem situations, but fail to grasp underlying principles needed to appropriately deal with other problems that were not specifically covered in training” (p.281).

Crittenden (1996) contended that treatment for physically abusive families should target three goals: “curbing” hazardous parental behavior, attaining coping skills to gain emotional distance during conflict and altering communication patterns by targeting affective communication in particular. She also indicated that treatment should be individualized, though it still can be delivered in a group setting.

Meta-Analyses of Child Maltreatment Literature

Meta-analyses of studies performed prior to 1990 indicated that parent training worked to alter the behavior of parents, principally those who had children with particular problem behaviors. It also was apparent, however, that behaviorally based programs were not as successful with depressed, socially isolated, undereducated or low SES parents (Dore & Lee, 1999). These are the predominant demographic characteristics of maltreating parents.

There is a lack of published post-1990 outcome studies of treatment for abusive parents with clear parent training or treatment that could be replicated. (Dore & Lee, 1999; Kolko, 1998; Oates and Bross, 1995). In their literature review of articles on child physical abuse, Oates & Bross (1995) found 12 articles that included more than 5 subjects in the sample, had at least 15% of children known to have been physically abused, and used one of three comparison methods: randomized treatment and control

(4 studies), comparisons between treatment group and matched comparison (3 in addition to the previous 4 studies), or treatment only pre-post test measures (5 studies). Five studies used treatments of 8 weeks or less. Three presented treatments between 3 and 6 months duration. Two provided yearlong treatment, and two did not specify duration. All of the studies on parental treatment found some improvement for the programs, although this was not true for their concurrent review of studies of treatment for abused children. Based on their review, the authors concluded that little is known about how to treat physically abusive parents. They highlighted the obstacles facing researchers examining child abuse and neglect treatment, citing difficulties like funding, compliance and a transient population.

Outcome Studies with Maltreating Parents

There are, however, outcome studies that provide important insight into treatment effectiveness. Wolfe, Sandler, and Kaufman (1981) developed a behaviorally oriented intervention for abusive parents and examined its efficacy using a pretest-posttest experimental design. The local child welfare agency referred 16 families recently investigated for physical abuse for participation in the study. The standardized instruments used for this study included the Parent-Child Interaction Form (PCIF) and the Eyeberg Child Behavior Inventory (ECBI). Parents in the treatment group participated in weekly 1½-hour parent training groups, weekly individualized home-based training procedures and standard child-welfare services. The no-treatment control group received only the standard services. Treatment resulted in increased parental effectiveness and reduced negative parent and child behaviors. No recidivism was reported for the treatment group parents at a 1-year follow-up. This landmark study is frequently cited in the child maltreatment literature (e.g., Brunk, Henggeler, & Whelan, 1987).

Using a multi-probe design, Lutzker, Megson, Webb, and Dachman (1985) determined that low SES mothers under suspicion of child maltreatment can benefit from parent-child interaction skills training through play with their children. The two mothers who participated in

the experiment were also able to generalize skills learned from structured play sessions with the child of focus to their other children. One parent was able to complete training after four 60 to 90 minute sessions. She improved from a baseline of 42% constructive adult-child behaviors to 87.5% at the end of training. A booster session was given at 28 weeks after treatment. At follow-ups that continued to 42 weeks after training, she maintained a minimum of 75% constructive adult-child behaviors. The second mother successfully completed training in two sessions where she moved from a baseline of 50% of the constructive adult-child behaviors to 91.5%. Only data from the 8-week follow up was available for her, and she had a level of 83% of the constructive adult-child behaviors. Although this was an extremely limited study with a sample size of 2 and no control group, it indicated that play interaction skills can be taught to low SES, maltreating mothers. It also demonstrated that a short intervention that focuses on play and interaction can benefit maltreating mothers.

Crimmins, Bradlyn, St. Lawrence, and Kelly (1984) reported that parent training focused on increasing positive verbal statements and positive verbal physical gestures was effective with a neglectful and abusive mother whose son had been temporarily removed from her custody. Training was delivered through two structured activities involving cooperative interaction (play activities) and compliance interaction (directional tasks). The mother was given instructions during the training through a bug in the ear device for thirty-five 5-minute trials. In a 4-month follow-up most of the treatment effects were stable. No additional abuse or neglect charges had been made at an 18-month follow-up contact.

Acton and During (1992) examined a standardized group treatment for parents involved (either concurrent with the study or prior to the study) with a governmental child protective agency. The treatment concentrated not only on anger management, communication and problem solving but also on improving parents' empathic responding. The group met for 1½ hour for 13 weeks. The instruments used in the study include the Parenting Stress Index (PSI), The State-Trait Anger Scale (STAS), Index of Parenting Attitudes (IPA), Child Abuse Potential Inventory (CAP), and the Eyeberg Child Behavior Inventory (ECBI). The researchers implemented a pretest, posttest design with no control group. This lack of control presented a considerable limitation of the study.

Analyses indicated that the aggressive parents benefited from treatment, with the CAP, PSI, IPA, and STAS means significantly reduced. There was no significant difference between the pre- and posttests of the child behavior portion of ECBI. It is also important to highlight that the means not only significantly differed on the CAP, but that the CAP post-treatment mean moved below the clinically significant cut-off mark to well within the normal range. The researchers stated that the parents reported that "it was far easier to control arousal when they were able to empathize and openly communicate with their children" (p. 415) following treatment. This study indicated that empathy training is an effective and important part of treatment for abusive parents.

Iwaniec (1997) compared individual parent training to individual parenting training in conjunction with group training. Treatment lasted for 10 weeks. Group training focused on stress management, problem solving and emotional regulation skills. The individual parent training focused on parent-child interaction and behavior management. Observations by the caseworker and researchers as well as maltreatment status were used as outcome measures, and the State-Trait Anxiety Inventory (STAI) was the only standardized instrument used. Parents with group training in addition to individual training achieved significantly better results than those with

individual training only. A serious limitation of this study was the lack of random assignment to groups.

Brunk, Henggeler, and Whelan (1997) used an experimental, pretest and posttest design to compare multisystemic therapy to parent training with a sample of 43 families consisting of at least one parent investigated for abuse or neglect. The following standardized measurements were used: Symptom Checklist (SCL), Behavior Problem Checklist (BPC), Family Environment Scale (FES), and the Family Inventory of Life Events and Changes (FILE). Parent-child interactions were observed using a coding system. The participants were randomly assigned to the treatment groups, and both treatments were delivered in 1½ hour weekly sessions for 8 weeks. In the multisystemic therapy treatment group, providers focused on the systemic processes underlying behaviors as opposed to the behaviors themselves. It was conducted with individual families. The parent training groups were modeled after Wolfe et al's. (1981) previously reviewed program, but less comprehensive because they did not include an in-home component of the treatment.

Parents in both groups experienced a reduction in stress, psychiatric symptomatology, and individual and familial problems. Both treatments effectively decreased problematic parenting behaviors. Because of its focus on the parent-child relationship, multisystemic therapy, however, was more effective at improving parent-child reciprocal interaction than behaviorally oriented parent training. Parent training, on the other hand, was more effective at reducing both social problems and work-related stress. The researchers contended that this may have been a result of participating in a group. Social support is an integral component in improving child rearing in maltreating families (Lovell & Richey, 1991). The implications of this study for the use of filial therapy with maltreating families are important. Filial therapy combines many of the advantages of multisystemic therapy with behaviorally oriented parent training in that it focuses on the interaction of the parent-child system and provides treatment in a group setting.

Parpal and Maccoby (1985) investigated the effect of mother-child interaction on children's ensuing responses to parental directives. Thirty-nine subjects with children aged 3 and 4 participated in one of the three experimental groups. The three group conditions consisted of three 15-minute mother-child interactions: non-interactive, free play and responsive play. For the non-interactive condition, mothers filled out papers with their backs turned away from their children playing. The mothers in the free play group were told to play with their children as they normally would. In the responsive play group, mothers had received a 15-20 minute training and participated in child-directed play. Each of mothers' behaviors during the interactive (or non-interactive) period was coded.

Analyses demonstrated that the mothers' behavior in the responsive play session was significantly different from that of the mothers participating in free play. Following the interaction, each mother was instructed to give a series of commands to her child without repeating or coaxing. An observer coded the child's behavior. A one-way ANOVA indicated child compliance was significantly higher following non-interactive and responsive play than free play. Furthermore, there was a pattern of increased child compliance among children identified by teachers and mothers as "difficult" following the responsive play, and this was in contrast to the behavior of the "difficult" children following free-play and non-responsive play. Brief play training for mothers increased child compliance. Although this study did not examine treatment for maltreating parents, it did focus on a related construct, child compliance. Child compliance is a component of child abuse. Noncompliant children are more likely to suffer

abuse, although child temperament certainly does not begin to adequately explain parental maltreatment of their children (Kolko, 1996).

Outcome studies have demonstrated that thoughtful, theoretically sound treatment can work with this difficult population, even in short-term treatment of 8 weeks (Brunk et al., 1987; Wolfe et al., 1981). Child-directed play training can also be effectively incorporated into treatment in order to increase child compliance with non-abusive populations (Parpal & Maccoby, 1985). Incorporation of structured play with an abusive and neglectful mother was also effective (Lutzker et al., 1985). Recently, there has been an emphasis in the child-maltreatment literature on transactional models that include parent-child interaction as a central factor. The role of empathy, in particular, has been emphasized. Treatment focused on parent-child interaction, empathic responses and affective communication is grounded in the literature.

As described in the introduction, filial therapy is a comprehensive parent-training program with a foundation in the teaching of child-directed play therapy skills. It addresses the majority of the etiological and treatment issues highlighted in the child maltreatment literature including improving empathy, altering parental attributions, changing parental behaviors, addressing difficult child behaviors, teaching parenting and interpersonal skills and providing support.

Filial Therapy Literature

Filial therapy can be delivered through several treatment models. VanFleet (1992, 1994a, 1994b) has utilized filial therapy with individual families and works with the families for various lengths of time. Landreth (1991) has developed a 10-week group model. Stover and Guerney (1967) originally studied filial therapy delivered in a 10-week period, but in some later studies on the Guerney model, treatment lasted for months in duration (e.g., Boll, 1973; Sywulak, 1977). Johnson (1995) asserted that filial therapy addresses the child's issues without losing sight of the important systemic framework through a focus on parent-child interaction, and Ginsberg (1989) agreed that the filial therapy is a family therapy approach

Anecdotally, filial therapy has been useful for multiple populations including adoptive parents, foster parents, parents of mentally retarded children (Ginsberg, 1984), and teacher-referred parents of acting out or withdrawn students (Ginsberg, Stutman, & Hummel, 1978). Head start aides used filial therapy for 16 weeks with six children in the program. Positive results were reported by the aides and the four parents contacted (Andronico & Guerney 1969). Johnson, Bruhn, Winek, Krepps, & Wiley (1999) illustrated through a case study that the parenting skills, support, and treatment offered in filial therapy can help families whose children are involved in Head Start. Ginsberg (1976) contended that filial therapy can be practically applied in agency and community mental health settings, and this is supported by research conducted by Glass (1986).

The Guerneys' Model

In the first outcome study published on filial therapy, Stover and Guerney (1967) implemented an experimental-control design with a sample of 28 mothers seeking psychological intervention for their children aged 5 through 10 at Rutgers University. The filial training groups met for a total of ten 1½-hour sessions. The researchers determined that mothers trained through filial therapy, could conduct child-centered play sessions using increased reflective statements and reduced directive behavior with their children.

Boll (1973) examined filial therapy with mothers of mentally retarded children. Twenty-one mothers were randomly assigned to one of two treatment groups, a filial discussion or a filial therapy treatment group, or the control group. There were important problems with treatment

implementation in this study. Not only did the discussion group teach no skills, the treatment group used behavioral techniques like extinction and reinforcement. Neither of these is in keeping with the Rogerian foundation of filial therapy. Treatment did not result in improved maternal attitude. Both treatment groups, however, reported increased socially adaptive child behaviors, and the study contributed support to using parents as therapeutic agents.

In Sywulak's (1977) study of filial therapy, the 19 participating families served as their own controls in order to compare four months of filial treatment to a four month no treatment control period. Though this design presented important limitations (i.e., no random assignment), it controlled for improvements resulting from time or help seeking behavior. Parents exhibited increased acceptance of their children and improved perceptions of child behavior. Parents also subjectively reported that they learned the value of parent-child communication, accepting their children's feelings, and paying individual attention to their children. In addition, they reported increased feelings of parenting competence and improved relationships with their children. In a follow-up of Sywulak's (1977) study, Sensue (1981) determined that the gains made from filial therapy remained stable for 3 years following treatment.

Dematatis (1981) used a pretest-posttest experimental design to compare filial therapy with filial therapy integrated with Interpersonal Process Recall (IPR). IPR was originally developed as a therapy model but has been frequently used as supervision model. In the latter context, it involves interrupting the videotape for discussion of the internal processes of the supervisee related to the video content of his or her recorded counseling session (Bernard & Goodyear, 1998). Although both groups made significant gains in parental acceptance, affect sensitivity, child adjustment and acquisition of play therapy skills, the study did not demonstrate that filial therapy integrated with IPR was superior to traditional filial therapy.

Lebovitz (1983) conducted a study of filial therapy with 23 children aged 6 through 10 and their mothers recruited on a volunteer basis from elementary schools in Galveston, Texas. Along with a no-treatment control group, Lebovitz included a clinical comparison group that engaged in play session observation. Checklists and ratings of videotaped play sessions were used as outcome measures. The study confirmed Stover and Guerney's (1967) determination that filial therapy skills can be transmitted to parents in a 10-week period. Filial group mothers exhibited greater acceptance, were less directive and became more involved with their children than the play session observation and control groups. Children in the filial group exhibited significantly decreased problem behaviors as rated by their teachers than children in the comparison or control groups, but both the filial and the play session groups' children showed a decrease in problematic behaviors on other measures.

Clark (1996) studied 52 mother/child dyads randomly assigned into filial, play therapy and control groups. She used the SESBI, Eyeberg Child Behavior Inventory (ECBI), and the PARQ as outcome measures. Filial group children exhibited stronger declines in behavioral problems than the play therapy group, which in turn experienced stronger declines than the control group. Interestingly, behavioral problems continued to decrease for the children who participated in the filial group 2 months following treatment. Parental acceptance was also greater for the mothers in the filial group, and this improvement maintained through a 2-month follow-up. The play-only parents also increased their parental acceptance, although this did not continue at follow-up.

The Landreth Model

During the 1990's much of the research on filial therapy originated from the University of North Texas (UNTX). Although most of the studies are quantitative, some qualitative studies

of filial therapy also came out of UNTX. The quantitative studies examined the efficacy of the Landreth (1991) model with different parent populations, whereas the qualitative studies were more process-oriented.

Quantitative Studies

Glass (1986), studied filial therapy delivered in groups using a precursor to the Landreth (1991) model of filial therapy at a counseling center. She used a nonrandomized pretest-posttest control group design, and the waiting list served as the comparison group. Twenty-seven parents and 20 children (aged 5 through 10) participated in the study. Fifteen of the parents participated in one of three filial groups, and 12 parents on a waiting list served as controls. The standardized scales used with parents in the study included the Porter Parental Acceptance Scale (PPAS), Coopersmith Self-Esteem Inventory (SEI), Madanes Family Hierarchy Test (MFHT), and the Family Environment Scale (FES). The filial group parents significantly increased their affective expression and feelings of unconditional love. Glass also noted important trends including increased parental acceptance of their children, increased parental self-esteem, improved parent-child relationships and increased parental understanding of their children through play. Not only did this study pioneer examination of the Landreth (1991) model, it is the only study to date of that model in a community agency setting.

Costas and Landreth (1999) conducted research examining the effectiveness of Landreth's 10-week filial treatment model with non-offending parents of sexually abused children. This experimental study included 31 (26 completed the study) non-offending parents of children aged 4 through 10 who had suffered sexual abuse. The researchers used the following instruments with parents: Porter Parental Acceptance Scale (PPAS), the Parenting Stress Index (PSI), and the Child Behavior Checklist-Parent Report Form (CBCL). With the children, the experimenters used the Child Anxiety Scale (CAS), Joseph Pre-School and Primary Self-Concept Screening Test (JPPCST) and the Draw A Person: Screening Procedure for Emotional Disturbance (DAP: SPED). Videotaped play sessions were also rated using the Measurement of Empathy in Adult-Child Interactions (MEACI).

The analysis of covariance (ANCOVA) revealed that the experimental group scored significantly higher on the PPAS, lower on the PSI, lower on the MEACI, but not the CBCL. Filial therapy increased parental empathy and acceptance and lowered parental stress with non-offending parents. Although non-offending parents and offending parents are vastly different parental populations, this research indicated that families with abuse histories benefited from filial therapy. This study was designed to determine if this treatment is effective with the family members with the behaviors most in need of change, those of the abusive parent.

Another important study on filial therapy was conducted with incarcerated fathers. Landreth and Lobaugh (1998) evaluated the effectiveness of the Landreth (1991) model with incarcerated fathers. The sample of 32 was equally divided into experimental and control groups of 16. Several of the same scales utilized in the Costas and Landreth (1999) study were used, the PSI, PPAS, and the CBCL. The MEACI was not used because the prison facility did not allow videotaping. Parents in the experimental group had significantly higher rates of acceptance, lower parental stress and reduced child behavior problems.

In a study of filial therapy with incarcerated mothers, Harris & Landreth (1997) also used a pretest, posttest experimental design. The sample size was 22 with 12 mothers in the filial group and 10 in the control group. The incarcerated mothers had children from the ages of 3 through 10. Like the previous study, the researchers used ANCOVA for analysis. However, they used a 5-week filial therapy model as opposed to the 10-week model. Mothers participating in

the filial group significantly increased parental acceptance, reduced perceived child behavior problems and increased empathic behaviors. Although the reduction in parenting stress did not reach the .05 level of significance, the authors explained that this might have resulted from the shortened model. They pointed out that reduction approached significance, and that the fathers in Landreth and Lobaugh's (1998) study achieved a highly significant reduction in parenting stress. The demographic composition of the sample in these studies, particularly Harris and Landreth's study, is comparable to that of maltreating parents.

Bratton and Landreth (1995) examined filial therapy's efficacy with single parents. The design of this study was very similar to that of Landreth and Lobaugh (1998) with many of the same instruments: PPAS, PSI, and the MEACI. The Filial Problem Checklist (FPC) was used instead of the CBCL. The sample size was largest of all the studies on the Landreth model. Forty-three single parents with children aged 3 through 7 participated, 22 in the filial group and 21 in the control group. As with the other filial studies mentioned, an ANCOVA was used for analysis. The researchers found significant differences in empathic responses, parenting stress, parental acceptance and perceived child behavior problems among treatment and control groups. This study is of particular relevance to this research because parents who abuse or neglect their children are more likely to be single mothers (Christmas, Wodarski, & Smokowski, 1996; Dore & Lee, 1999; Milner & Chilmakurti, 1991).

Kale and Landreth (1999) examined the effectiveness of the 10-week filial therapy model with parents of children with learning difficulties. Using a sample size of 22 (equally divided into treatment and control groups of 11), the researchers found significant differences in parental acceptance and parenting stress among treatment and control groups. There were no significant differences, however, in parent or teacher ratings of child behavior.

Glazer-Waldman, Zimmerman, Landreth, and Norton (1992) used filial therapy with parents of chronically ill children. They implemented a one-group pretest-posttest design. Five parents completed the group. The researchers used the State-Trait Anxiety Inventory (STAI) to measure parental anxiety, the Child Anxiety Scale (CAS) to measure child anxiety and the PPAS to measure parental acceptance. Although the Wilcoxin matched pairs signed-ranks test did not indicate any significant differences between pretest and posttest parental anxiety, child anxiety or parental acceptance, a positive trend in parental acceptance was noted. In addition, parents significantly increased the accuracy of their estimations of their children's anxiety after filial treatment. There were very important limitations to this study. There was no control group, and the small sample consisted of only five participants. Significant threats to internal validity such as testing, instrumentation, history and maturation resulted from these limitations.

Tew (1997) studied a sample of 23 parents with chronically ill and hospitalized children. Using a randomized, control pretest-posttest design, she determined that filial therapy decreased parenting stress and perceived child behavioral problems and increased parental acceptance of their children. The improved design validated the findings of Glazer-Waldman, Zimmerman, Landreth, and Norton (1992).

Landreth's filial therapy model has also been effective with culturally diverse populations (Chau & Landreth, 1997; Glover & Landreth, 2000; Jang, 2000; Yuen, 1997). In a study that shortened Landreth's 10-week model to 8 sessions in 4 weeks, Jang (2000) examined the effectiveness of filial therapy with Korean mothers. Data was collected using the MEACI, PSI, PPAS, and the FPC in pre- and post-training meetings. Jang examined a sample of 30, 14 in the filial treatment group and 16 in the control group. Significant reductions in problem behaviors of children and increases in empathic behavior during observed play sessions resulted from filial

therapy. No significant differences were found between treatment and control means for parenting stress and parental acceptance in the quantitative analysis. Qualitative data suggested, however, that filial therapy helped participating mothers increase their sensitivity to their children, improved communication between couples and improved participants' relationships with other members of the family

Using the MEACI, PSI and PPAS, Chau & Landreth (1997) demonstrated that filial therapy increased parental empathy and acceptance and reduced parental stress with Chinese parents with children from the ages of 2 to 10. Eighteen of the parents participated in the filial group and 16 participated as controls. The parents also reported improved communication in their marriage. The researchers pointed out that, for cultural reasons, the parents in their study were more comfortable with the didactic component of filial therapy and were more amenable to the concept of a parenting class as opposed to counseling.

Yuen (1997) examined filial therapy using a sample of 35 immigrant Chinese parents with children aged 2 through 10 in Canada. He also found significantly increased levels of empathy and acceptance and decreased levels of parental stress and perceived child behavior problems.

Glover and Landreth (2000) found similar changes resulting from filial therapy with Native American parents on the Flathead Reservation in Montana. Her sample included 21 parents of children aged 3 to 10. Children in the filial group significantly increased desirable play behaviors. On the measures of parenting stress (PSI) and parental acceptance (PPAS) positive trends were evident, but they did not reach statistical significance.

To close this review of the quantitative studies of Landreth's (1991) model, research that did not originate out of North Texas requires mention. In a study of two parents who consistently participated in a filial therapy group using Landreth's 10-week model, Athanasiou and Gunning (1999) examined the effects of the models on parenting stress and child behavior. One of the parent's stress score, as measured by the PSI, decreased from a rank of 97 to 47 following treatment, and the other parent experienced an inconsequential decrease. The child of the first parent also experienced a decrease from clinical to non-clinical levels for both internalizing and externalizing behaviors on the Behavior Assessment for Children. The second child did not have any significant decrease. Parents reported improvements in their relationships with their children, increased confidence in parenting abilities, and a transfer of skills learned in therapy to their parenting outside of the sessions. With a minute sample of 2 and no control, the information from this study could only indicate that further research into using the Landreth model in an applied setting to reduce child behavior problems may be warranted.

Qualitative Studies

The limited number of qualitative studies have focused on either the children (Cleveland & Landreth, 1997), couples in university research settings (Bavin-Hoffman, Jennings, & Landreth, 1996), or the parent and child in individual filial treatment (Packer, 1990). These qualitative studies provide contextual information that both supports and enriches the quantitative data.

Bavin-Hoffman, Jennings and Landreth (1996) asked two questions in a 3-year follow-up interview of 20 married couples that had participated in filial therapy groups. They used convenience and snowball samples to recruit volunteers. The participants completed filial therapy between 1991 and 1994 in 2 private practice and 1 agency setting. They participated in Landreth's 10-week training model with 2-hour group sessions and 30-minute home play sessions.

The research questions were “1. What changes, if any, in family functioning take place after the parents have completed the filial therapy experience?” and “2. What changes, if any, occur in the couple relationship during and after the filial therapy experience?” (37). Themes that emerged from the collected data included improved communication between parents and children, as well as between spouses, and improved child behavior. Parents indicated that they not only improved their relationships with their children but also indicated that their children used more self-regulating behaviors. An unexpected finding was that relationships between couples improved as a result of filial therapy. Couples incorporated communication and relational skills into their interaction with their spouses and reported more harmony in their relationship. Although this is not a goal of filial therapy, it may be a secondary benefit. This has important implications because stress in the marital relationship can contribute to child abuse (Christmas, Wodarski, & Smokowski, 1996).

Using a semi-structured interview format, Cleveland and Landreth (1997) described five children’s and their two parents’ perceptions of the filial therapy process and outcomes. The researchers had difficulty in obtaining child perceptions, and this difficulty underscored the central role that play has in the treatment of young children and their families. Young children’s verbal expression is limited, and they communicate much more effectively through their natural language, play. The children responded to the researchers questions that the special play times were “fun” but were generally unable to elaborate much further. Their responses contrasted sharply with their parent’s specific descriptions of the benefits of filial therapy. Parents cited important gains such as increased communication skills that transferred to other relationships, knowledge of limit setting with natural consequences, and dramatic changes in their behavior, their children’s behavior (across settings), and their relationships with their children.

Using ethnographic methodology with two subjects, Lahti (1993) examined the Landreth model with two guiding questions: “1) What is the nature of the filial therapy process and how is change facilitated?” and “2) How is the parent/child relationship affected?” (p. 24). As in Bavin-Hoffman, Jennings and Landreth’s (1996) study, parents also conveyed that improvement occurred in other relationships, particularly their marriages. She reported that the combined approach of didactic teaching, group counseling, modeling and experiential methods facilitated profound change. Parents moved further away from a power and control orientation to a more open, communicative one. Participants gained more realistic expectations of their children and reduced levels of frustration in those relationships. In addition, parents performing new behaviors for short periods of time during practice and play sessions reduced their feelings of being overwhelmed. Viewing themselves on videotape gave parents more objectivity about their behavior. As convincingly demonstrated by the quantitative studies, parents in Lahti’s (1993) study experience increased empathy and acceptance and reduced parenting stress through filial therapy.

Summary

Collectively, these studies establish that filial therapy is effective with multiple and varied parental populations. Jang's (2000) study is important because it demonstrated that an eight-session modification of the Landreth (1991) model implemented in a 4-week period can benefit parents. Of particular importance is its effectiveness with non-offending parents of sexually abused children (Costas & Landreth, 1999), single parents (Bratton & Landreth, 1995) and incarcerated parents (Harris & Landreth, 1997; Landreth & Lobaugh, 1998) because of the demographic similarities of these populations to maltreating parents. As a result of filial therapy's efficacy with those parent populations, it is logical to consider using the filial treatment model with abusive parents. Given the information reviewed in the child abuse literature and the emphasis within that body of work on improving empathy, altering parental attributions, changing parental behaviors, addressing difficult child behaviors, teaching parenting and interpersonal skills, and providing support, filial therapy is particularly suited for this parent population.

CHAPTER III METHODOLOGY

Researchers have studied legal, etiological, assessment, treatment, and child impact issues related to maltreatment, and this research is frequently fraught with methodological problems. Methodological issues can dramatically impact the results of research into child abuse and neglect, even with the most basic of issues, whether child abuse is increasing or decreasing. A second study of National Incidence and Prevalence Study of Child Abuse and Neglect (NIS-2) that covered the years 1980-1986 determined that the number of physically abused children increased by 58% in that period (Sedlak & Broadhurst, 1996). The National Family Violence Re-Survey (NFVS), however, reported that the number of physically abused children decreased by 47% during a similar time. These contrary results resulted from methodological differences in sampling and definitions of physical abuse (Mash & Wolfe, 1991).

Other methodological problems evident in the child maltreatment literature include inadequately defined and confounded variables, absence of a priori predictions, a focus limited to physical injuries, sampling defects, poorly constructed or inappropriate outcome measures, improper data analysis and faulty inferences and conclusions (Mash & Wolfe, 1991). In their literature review of articles on child physical abuse, Oates and Bross (1995) found only 12 articles that included more than 5 subjects in the sample, had at least 15% of children known to have been physically abused, and used one of three comparison methods: randomized treatment and control (4 studies), comparisons between treatment group and matched comparison (3 in addition to the previous 4 studies), or treatment-only pre-post test measures (5 studies). Based on their review, the authors concluded that little is known about how to treat physically abusive parents. They highlighted the obstacles facing researchers examining child abuse and neglect treatment. Difficulties like funding, compliance and the transience of the population were examples of these obstacles.

Quantitative Research

Quantitative Research Questions

The primary focus of this study was to determine the effectiveness of filial therapy with parents court-referred for maltreatment. The main hypothesis was that filial therapy is effective at improving the parenting of maltreating parents. The following questions were related to the hypothesis:

1. Is filial therapy effective at reducing the child abuse potential of parents court-referred for maltreatment?
2. Is filial therapy effective at reducing parenting stress for parents court-referred for maltreatment?
3. Is filial therapy effective at strengthening the parent-child relationship for parents court-referred for maltreatment?
4. The independent variable was filial therapy. The three dependent variables were child abuse potential, parenting stress and parent-child relationships.

Sample/Population

Before looking at specific information about the sample for the study, it is important to highlight the difficulties related to working with the maltreating parent population. Maltreating families are considered to be the least likely of all problem families to benefit from treatment. Recidivism and attrition rates are also problematic (Cohn & Daro, 1987; Wolfe, Edwards, Manion, & Koverola, 1988). The target population for this study was parents of children aged 1 to 6 in the Roanoke Valley who were court-referred to enroll in parenting education courses.

Irueste-Montes and Montes (1988) determined that court-ordered parents participate in treatment programs at equivalent levels as voluntary parents.

The sample consisted of 12 parents enrolled in courses at Prevent Child Abuse of Roanoke Valley (PCARV), in Roanoke, Virginia. The researcher had no direct contact with children, and children were not the subjects of this study. The agency agreed to allow all parents of children under age 6 enrolled in this cycle of classes to participate in the study. The small sample size presented a significant limitation of the study, a limitation that is common in the literature (Kaufman & Rudy, 1991; Mash & Wolfe, 1991). Because the sample consisted of only 12 parent subjects, the sample was more prone to sampling error. Demographic information including age, socioeconomic status, gender and race was collected.

According to data collected by PCARV staff for the year 2000, the demographics of their service population were generally consistent with those reported in the literature. Sample attrition can be a problem in child maltreatment research, and the less obvious sample loss resulting from a lack of cooperation is also common with maltreating parents (Kaufman & Rudy, 1991; Smith, Rachman, & Yule, 1984). Approximately 81% of the parents enrolled in the PCARV program in the year 2000 completed the classes, however, and according to PCARV staff this was an increase from previous years. This was associated with the agency's change from a 10-week program to an 8-week program and addition of a nominal one-time fee of \$10.00. The majority of the class participants were female (69%). Other PCARV demographic data indicated that 30% of participants had family incomes below \$10,000, and another 30% had income between \$10,000 and \$19,999. Twenty-two percent had incomes between \$20,000 and \$29,999. The remaining 19% had family incomes of \$30,000 or more. Race was broken down into the following percentages: White, 75%, Black, 20%, Native American, 1%, Asian, 2%, and Biracial, 1%.

Instruments

The selection of instruments is an important step in conducting sound research. Inadequate measures can lead to findings that are not replicable or interpretable and therefore of little use to researchers and clinicians. The child abuse and neglect literature has frequently included studies with poorly designed and inconsistently applied measures. Using case records or other archival records results in unstandardized and possibly inaccurate, selective, and/or biased reports. These often underestimate abusive behaviors of parents (Mash & Wolfe, 1991). Caseworker report is an unreliable predictor of abuse risk (Milner, Murphy, Valle, & Tolliver, 1998). In the study, two standardized instruments were used. Demographic data was also collected.

Demographic Data

The Demographic Data Sheet was given to participants in order to gather information regarding demographic variables including: age, gender, family income, locality, and race. This instrument preceded the others. The form used was that developed by PCARV staff per their request (see Appendix A).

Child Abuse Potential

The Child Abuse Potential Inventory (CAP) was used in this study because of its predominance in the child abuse and neglect literature (Dukewich, Borkowski, & Whitman, 1996; Milner & Chilamkurti, 1991; e.g., Acton & Doring, 1992). It is also considered the best self-report assessment strategy for child maltreatment (Lutzker, 1998). It is not, however, designed for child sexual abuse potential. Because this population does not receive treatment at PCARV, this was not an issue for this study. The reported accuracy of this inventory in

classifying abusing parents is 80-90% of referred cases. Split-half reliabilities for the abuse scale range from .96 -.98. Test-retest reliabilities are .91 (1 day), .90 (1 week), .83 (1 month), and .75 (3 months). KR-20 reliability calculations fall into the range of .85-.96 for different populations. The CAP has been used successfully for program evaluation and is sufficiently sensitive to treatment effects.

The Child Abuse Potential Inventory, a 160-item questionnaire, uses true-false items to measure a parent's predisposition for physical abusing his or her child. The inventory consists of 12 scales. The scale for Abuse includes: Distress, Rigidity, Unhappiness, Problems with Child and Self, Problems with Family, Problems with Others, and Total Physical Child Abuse. Within the Validity scales there are Lie, Random Response and Inconsistency Scales. The CAP also includes 3 Response Distortion Indexes: Faking-Good, Faking-Bad, and Random Response.

Parenting Stress

Recent group filial therapy empirical studies have used the Parenting Stress Index (PSI) to measure parenting stress (Athanasίου & Gunning, 1999; Bratton & Landreth, 1995; Chau & Landreth, 1997; Landreth & Lobaugh, 1998). In addition, it has been frequently used in the child abuse literature and is recommended for research with this population (Abidin, 1995; Holden, Willis, & Foltz, 1989; Kolko, 1998; e.g. Acton & During, 1992). Holden, Willis, and Fultz (1989) compared the PSI with the CAP. They determined that although the instruments measure similar constructs, they are different enough to be used together in child maltreatment research. Both the CAP and the PSI are important tools in child maltreatment research. For these reasons, the PSI was also included in this study. The short form version of the PSI, however, was utilized.

The Parenting Stress Index/Short Form (PSI/SF; Abidin, 1995) contains 36 self-report, 5-point Likert-type items that identify problematic parent-child interactions that may put a child at risk for emotional disturbance. The items were chosen from the long form and are identical in content and wording. It was developed in order to address the needs of researchers and clinicians who required a less than 10-minute administration.

The measure generates a Total Stress score and three subscale scores. The Total Stress Score indicates the level of parenting stress experienced by the respondent. The three subscales are titled Parental Distress (PD), Parent-Child Dysfunctional Interaction P-CDI), and Difficult Child (DC). The PD subscale indicates problems in the respondent's role as a parent. Parental expectation and child reinforcement of the parent are the focus of the P-CDI. The DC indicates the level of difficulty of child behavior for the parent. The PSI/SF also includes a Defensive Responding Scale.

The test-retest reliability for the PSI/SF is .84. The test-retest reliabilities for the subscales are as follows: .85 (PD), .68 (P-CDI), and .78 (DC). Coefficient alpha was calculated as an indicator of internal consistency, and the Total Stress estimate is .91. The PD, P-CDI, and DC are .87, .80, and .85 respectively.

These calculations are comparable to the PSI, Long Form. The PSI, Long Form is divided into the Child and Parent Domains. Cronbach's alpha for Child Domain is .90, Parent Domain is .93, and Total Stress is .95. The subscales of the domains have alphas that are lower, ranging from .70 - .83 (Child) and .70 - .84 (Parent; Abidin, 1995).

There is a high correlation between the PSI/SF and the full length PSI as indicated by a Pearson correlation coefficient of .94. At this time the PSI/SF does not have a large body of independent research to establish its validity, although 36 published studies used the PSI/SF since its development and publication. Validity is established for tests for specified purposes and populations. The full length PSI is a valid measure of current stress as it relates to child

maltreatment. Because it should have validity equivalent to the full-length PSI, the PSI/SF is an appropriate instrument for use with maltreating parents (Abidin, 1995).

Parent-child relationship

The Parent-Child Dysfunctional Interaction (P-CDI) of the PSI, Short Form was used to measure the parent-child relationship. This subscale focuses on parental expectations and parental perceptions of child reinforcement of the parent (Abidin, 1995).

Conducting the Study

The self-report measures were administered to the parents prior to the first group session. These same measures, with the exception of the Demographic Data Sheet, were again administered following the last treatment group. The participating parents were randomly assigned to the treatment or control groups. The treatment group received filial therapy according to a modified version of Garry Landreth's (1991) 10-week filial therapy model. The model was modified for 8 sessions in order to fit with the agency schedule (see Appendixes C and D). The control group received agency developed, didactic treatment focused on the following topics: children's basic needs, child development, discipline, supervision and safety, stress and anger, school preparation, childcare, health and self-esteem (see Appendix K). All treatment and control groups met on Tuesday nights from 7:00 p.m. to 8:30 p.m. Prevent Child Abuse Roanoke Valley (PCARV) provided childcare as well as transportation to parents who did not have transportation of their own.

PCARV staff generally divides the parenting education groups into the following categories according to children's ages: 0 to 5, 6 to 11, and adolescent. The 0-5 group was further divided into treatment and control groups by random assignment prior to the first meeting night. The agency encourages parents with children under 1 to take the infant care class so the parents in the 0-5 group actually had children aged 1 through 5. Filial therapy is designed for parents of children ages 3 through 11, although parents of 2-year-olds have implemented this treatment. For the parents with children below the age of 2, a modified version of filial therapy was used. This modification involved switching some of the standard toys to those that are more developmentally appropriate and changes in parents tracking behavior in the play sessions. The researcher conducted the group for the 0 to 5 group. Agency volunteers ran the control groups according to PCARV's standard procedures, and they used the agency curriculum (see Appendix L).

Attrition is often a problem for PCARV's parenting education classes. Another issue for this study was that some parents had their children placed in foster care. The parent without custody in the filial group had supervised visitation every other week at social services. This meant that this parent was only able to implement less than half of the play sessions generally prescribed in treatment.

Risks and Benefits

The only risk to parents above and beyond those involved in entering the PCARV program was possible discomfort that may have arisen from learning new skills in a group format with peers. The major benefits of filial therapy are improved parenting and strengthened parent-child relationship. Prior to the study, it was hypothesized that filial therapy might reduce child abuse potential, which would have had positive benefits for the families involved and society at large.

Confidentiality

The subjects were identified by a code with information stored under double lock (locked file cabinet in a locked room) with only the researcher having access. The parents used

videotaping, and the tapes were considered their property for their use, not the property of the researcher. Research data was not retrieved from videotapes, other than what the parents chose to show during the group sessions. Parents shared the tapes in the filial group as part of the standard procedure and kept and discarded tapes as they wished.

Informed Consent

PCARV staff consented to the research conducted there. They based this decision on their review of the research proposal, data generated by the pilot for this study at Blue Ridge Community Services in Roanoke, Virginia and information presented to them in meetings. Each participant received a copy of the informed consent (see Appendix F) and participated in the study only if he or she chose to do so.

Limitations

This study design utilized three of the four methods of control: manipulation, statistical control, and randomization. Participants were assigned by random process to treatment and control groups. For statistical control, a pretest was used to control for any statistical differences between the treatment and control groups. The independent variable, filial therapy, was administered to the treatment group while the control group received standard agency treatment, thus implementing manipulation as a method of control.

There were, however, important threats to internal validity in this study. One was maturation. Child behavior was an issue in this study and because children develop quickly, any improvements demonstrated could have been related to their development as opposed to treatment. The pretest measures also presented maturation concerns. Another threat to internal validity was regression toward the mean. Parents who have been abusive toward their children may score at the extreme end of some of the tests, and their scores on the posttest could have regressed toward the mean. There was also a threat of diffusion or imitation. Participating parents were court-involved, and many received other services. Some change may have resulted from the other services. A very important threat to this study was mortality. The literature frequently cites this as an issue with this population, and PCARV has had a history of a high dropout rate in their parenting education program, although this improved in 2000 when they moved to an 8-week model and required a \$10.00 fee from each parent. Twenty-percent or 3 (1 from the treatment group and 2 from the control group) of 15 original participants dropped out of the study resulting in a sample size of 12.

Another important consideration was external validity. External validity involves the generalizability of the results. The pretest presented a threat to external validity in that it calls into question whether treatment is effective only for those who have taken the pre-test. Another issue involved having parents from the Roanoke area only. The results may not translate to other localities. The population PCARV serves, however, is varied in terms of rural, urban and suburban environment. According to PCARV data from 2000 the bulk of their treatment population resided in Roanoke City (48%). Another 20% lived in Roanoke County, and 13% in the small neighboring city of Salem. The remaining 19% resided in the rural counties of Botetourt, Bedford, Franklin, and Montgomery. Perhaps the biggest problem for the study was sample size. The sample size was a mere 12 participants, and this greatly reduced the power of the study.

Analysis

Because this study used an experimental treatment control, premeasures and postmeasures design, the method of data analysis was analysis of covariance (ANCOVA). One analysis required a one-way analysis of variance (ANOVA) because a majority of the CAP

pretests were invalid. Quantitative data was analyzed using both statistical programs SAS and SPSS 9.0 for Windows. Descriptive statistics on demographic variables provided a sample profile. These statistics were expected to be comparable to those of PCARV's 2000 demographic statistics and those of related studies (e.g., Christmas et. al., 1996).

Qualitative Research

In addition to determining the effectiveness of filial therapy with maltreating parents based on quantitative data, it is important to understand more about the filial therapy process. Kolko (1996) called for further research into treatment process for both victims and perpetrators of child abuse and neglect, highlighting the need for information regarding both impediments and restrictions of treatment programs. In addition, he pointed out that clients' levels of progress and reactions to treatment impact treatment outcome, and more knowledge is needed to understand this relationship. This is best achieved through an integration of research methods.

The qualitative portion of this study addressed the following research questions:

1. How does the filial therapy process affect participants?
2. How does the filial therapy process affect treatment outcome?
3. What changes, in addition to those measured quantitatively, are reported by parents?

The parents were profiled weekly. A code for each participant was developed for confidentiality. In order to structure these observations, the Filial Therapy Process Form (FTPF) was developed for this study. This form was based on the four basic skills of filial therapy (VanFleet, 1994b) and information derived from parental perceptions of the process from the pilot study for this project (see Appendix E). The FTPF organized both qualitative and supplemental quantitative information.

The process was viewed from multiple perspectives because filial therapy is a multi-level interactive process. In the filial group, parents learn new ways of interacting with their children. They videotape these interactions and bring them to the group. The group (including the leader) then interacts with the parent presenting the tape. In addition to teaching responsibilities, the group leader facilitates this interaction within group. Group leader's notes following each group meeting were collected.

Summary

This chapter described the methodology for the study. Following a statement of the research questions, information about the sample was discussed based on PCARV 2000 statistics and demographics delineated in the literature. The norms, reliability and validity of the PSI/SF and the CAP were reviewed. The quantitative portion of the study used a premeasures, postmeasures treatment-control design, and the strengths and limitations of the study's design were reviewed. Finally, a description of the qualitative research process was given.

CHAPTER IV RESULTS

This chapter presents the demographic data for the sample and the results from both the quantitative and qualitative analysis of the data collected for this study.

Demographic Data

Demographic data was collected for both the treatment and control groups. For family size and age of participants, independent t-tests of the treatment and control group means were run. Table 1 shows the means and standard deviations for age and family size for the treatment and control groups. The analysis indicated that there were no significant differences between the groups for family size or age. See Table 2.

Table 1

Means and Standard Deviations for Age and Family Size

Variable	Groups	N	Mean	Standard Deviation	Standard Error Mean
Age	treatment	7	24.1429	3.5790	1.3527
	control	5	32.2000	13.3116	5.9532
Family Size	treatment	7	3.7143	1.6036	.6061
	control	5	2.8000	.8367	.3742

Table 2

Independent Samples Test of the Means for Age and Family Size

Variable	t-test for Equality of Means		
	t	df	Significance
Age	-1.320	4.416	.251
Family Size	1.157	10	.274

For the categorical demographic data collected: income range, gender, race, child custody status, residence, CPS investigation history, marital status, history of abuse and special needs child, a Chi-Square analysis was run to test for significant differences between the treatment and control groups. The analysis indicated that only residence was significantly different between the groups, $p = .035$.

Table 3

Categorical Demographic Data

Variable	Treatment	Control	Chi Square Value	Significance of Chi Square
Income Range			2.126	.547
\$ 0 - \$9,999	(42.9%) 3	(40%) 2		
\$10,000 – \$19,999	(42.9%) 3	(40%) 2		
\$20,000 – \$29,999	(14.3%) 1	0		
\$30,000 +	0	(20%) 1		
Gender			.171	.679
Male	(28.6%) 2	(40%) 2		
Female	(71.4%) 5	(60%) 3		
Race			1.714	.190
Black	(28.6%) 2	0		
White	(71.4%) 5	(100%) 5		
Child Custody Status			4.827	.306
Full Custody	(71.4%) 5	(40%) 2		
Other Biological Parent	(14.3%) 1	(20%) 1		
Other Family Member	0	(20%) 1		
Friends of Family	0	(20%) 1		
DSS	(14.3%) 1	0		
Residence			12.00	.035*
Roanoke City	(57.1%) 4	0		
Roanoke County	0	(60%) 3		
Salem	0	(40%) 2		
Bedford County	(14.3%) 1	0		
Floyd	(14.3%) 1	0		
Franklin County	(14.3%) 1	0		
CPS Investigation History			1.029	.310
Yes	(85.7%) 6	(40%) 2		
No	(14.3%) 1	(60%) 3		
Marital Status			2.743	.098
Married	(14.3%) 1	(60%) 3		
Single	(85.7%) 6	(40%) 2		
History of Abuse			.114	.735
Yes	(28.6%) 2	(20%) 1		
No	(71.4%) 5	(80%) 4		
Special Needs Child			.343	.558
Yes	(57.1%) 4	(40%) 2		
No	(42.9%) 3	(60%) 3		

* $p < .05$

Quantitative Results

For most of the hypotheses, analysis of covariance was performed. An exception was made for the hypothesis testing related to the scores on the CAP because 6 of the 7 pretests from the treatment group (and 2 for the control group) were invalid as a result of excessive “faking good” responses by the participants. For this hypothesis, a one-way ANOVA of the scores from the valid posttests (6 of 7 from the treatment group and 4 of the 5 from the control group) was performed. The established standard of a .05 level of significance determined whether a hypothesis was retained or rejected.

Hypothesis 1

Hypothesis 1 addressed the research question: Is filial therapy effective at reducing the child abuse potential of parents court-referred for maltreatment? The hypothesis is stated as follows: Filial therapy reduces the child abuse potential of parents court-referred for maltreatment.

Table 4 presents the posttest means and standard deviations for the experimental and control groups. Table 5 presents the one-way ANOVA data and shows that the *p*-value was .480 indicating no significant reduction in the experimental group participants’ average scores for the CAP. It is important to note that 1 score from the experimental group and 1 from the control group had to be removed for invalid results based on excessive “faking good” on the posttest. On the basis of this data, research hypothesis 1 was not supported.

Table 4

Posttest Mean Scores for the CAP

Groups	N	Mean	Standard Deviation	Standard Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Treatment	6	137.0000	109.3161	44.6281	22.2798	251.7202	21.00	324.00
Control	4	175.0000	114.9928	57.4964	-7.9791	357.9791	63.00	282.00
Total	10	152.2000	106.9193	33.8108	75.7146	228.6854	21.00	324.00

Table 5

One-way ANOVA Data for the Scores of the CAP posttest

	Sum of Squares	df	Mean Square	F Ratio	Significance of F
Between Groups	3465.6000	1	3465.600	.279	.612
Within Groups	99420.000	8	12427.500		
Total	102885.6	9			

Hypothesis 2

Hypothesis 2 addressed the research question: Is filial therapy effective at reducing parenting stress for parents court-referred for maltreatment? The hypothesis is stated as follows: Filial therapy reduces parenting stress of parents court-referred for maltreatment.

An ANCOVA was initially run to test whether the linear trend between scores on the PSI pretests and posttests were the same for the treatment and control groups. The linear trend for the

treatment and control groups was significantly different $p = .0377$. Therefore, the assumption of homogeneity was not met and two separate lines for treatment and control groups were analyzed. See Table 7.

Table 6 presents the pretest and posttest least square (LS) means and standard deviations for the experimental and control groups. LS means were used because these are adjusted by the covariate, and therefore more meaningful. Table 7 presents the analysis of covariance data and shows that the p -value for the main effects was $p = .0383$, indicating a significant reduction in experimental group participants' average scores for the PSI. On the basis of this data, research hypothesis 2 was supported. Filial therapy reduces parenting stress of parents court-referred for maltreatment.

Table 6

Posttest LS Mean Scores for the PSI

Groups	LS Mean	Standard Deviation	N
Treatment	82.752	6.981	7
Control	92.50	9.106	5

Table 7

Analysis of Covariance Data for the Scores of the PSI

Source of Variation	Type III Sum of Squares	df	Mean Square	F	Significance of F
Main effects	2023.641	1	2023.641	6.13	*.0383
Covariates	1190.351	1	1190.351	2.289	.165
Main effects *covariate	2040.804	1	2040.804	6.19	*.0377
Error	2639.074	8	329.884		

* $p < .05$

Hypothesis 3

Hypothesis 3 addressed the research question: Is filial therapy effective at strengthening the parent-child relationship for parents court-referred for maltreatment? Hypothesis 3 is stated as follows: Filial therapy reduces parent-child dysfunctional interaction for parents court-referred for maltreatment.

An ANCOVA was run to test whether the linear trend between scores on the P-CDI subscale pretests and posttests were the same for the treatment and control groups. The linear trend for the treatment and control groups was significantly different $p = .0062$. Therefore, the assumption of homogeneity was not met and two separate lines for treatment and control groups were analyzed.

Table 8 presents the pretest and posttest LS means and standard deviations for the experimental and control groups. LS means were used because these are adjusted by the covariate, and therefore more meaningful. Table 9 presents the analysis of covariance data and

shows that the p -value for the main effects was $p = .0041$ indicating a significant reduction in the experimental group participants' average scores for the P-CDI subscale of the PSI. On the basis of this data, research hypothesis 3 was supported. Filial therapy reduces parent-child dysfunctional interaction for parents court-referred for maltreatment.

Table 8

Posttest LS Mean Scores of the PSI subscale P-CDI

Groups	LS Mean	Standard Deviation	N
Treatment	22.549	2.082	7
Control	28.723	2.502	5

Table 9

Analysis of Covariance Data for the Scores of the PSI subscale P-CDI

Source of Variation	Type III Sum of Squares	df	Mean Square	F	Significance of F
Main effects	473.432	1	473.432	15.81	*.0041
Covariates	15.314	1	15.314	.51	.4948
Main effects* covariates	406.377	1	406.377	13.57	*.0062
Error	239.512	8	29.40		

* $p < .05$

PCARV's Birth – 5 Parenting Survey

An ANCOVA was run to test whether the linear trend between the scores on PCARV's Birth – 5 Parenting Survey (a content-oriented instrument developed by the agency; see Appendix B) pretests and posttests were the same for the treatment and control groups. The linear trend for the treatment and control groups was not significantly different $p = .0862$. It was expected that the control group would receive significantly higher scores because the content of the agency's curriculum is directly related to the instrument.

Table 10 presents the pretest and posttest LS means and standard deviations for the experimental and control groups. LS means were used because these are adjusted by the covariate, and therefore more meaningful. Table 11 presents the ANCOVA data and shows that p -value for the main effects was $p = .216$ indicating no significant reduction in the experimental group participants' average scores for the PCARV's Birth – 5 Parenting Survey.

Table 10

Posttest LS Mean Scores for PCARV's Birth – 5 Parenting Survey

Groups	LS Mean	Standard Deviation	N
Treatment	73.169	3.497	7
Control	81.363	4.307	5

Table 11

Analysis of Covariance Data for the Scores of PCARV's Birth – 5 Parenting Survey

Source of Variation	Type III Sum of Squares	df	Mean Square	F	Significance of F
Main effects	120.295	1	120.295	1.773	.216
Covariates	119.844	1	119.844	1.766	.217
Error	610.785	9	67.865		

Supplementary Quantitative Data and Related Qualitative Information from the Filial Therapy Process Form

Following each group the researcher, who also served as the group leader, completed a Filial Therapy Process Form (FTPF; see Appendix E) for each member. The FTPF was developed for this study and served as a tool to target and organize supplemental quantitative data and qualitative information about the filial therapy process. The form utilized a *circle the best choice* format, a 1 to 5 Likert Scale, and blanks for brief description. The information collected on the forms is summarized according to each section on the form.

Participant Mood

The leader's perceptions of the participants' moods at the beginning of the first session were suspicious (2 members), anxious (1 member), dazed (1 member), calm (1 member), content (2 members). At the end of the session they were cautious (2 members) calm (1 member), content (2 members), dazed (1 member), and enthusiastic (1 member). This was the only session in which suspicion was evident to the group leader.

For the second session, the participants' emotional states were recorded as anxious (1 [new member]), cautious (3), enthusiastic (1), and content (1) at the beginning of the session. By the end of the session, cautious (3 [but less so than at the beginning of the session for 2 of the 3]), encouraged (1), enthusiastic (1), and calm (1) affects were observed.

At the beginning of the third group session, the following moods were noted: content (1), calm (1), somewhat cautious or cautious (2), enthusiastic (1), and at the end enthusiastic (3), more hopeful (1), and interested (1). Toy kits were distributed to the families, and this generated increased enthusiasm among the group members.

The participants presented with the following emotions at the fourth session: sad (1), contentment (2), enthusiasm (2), hope (1), withdrawal (1) and at the end exhibited sadness (1), contentment (1), enthusiasm (3), and quiet (1). It is important to note that the two group members, the participating couple, present had missed the third session because her father committed suicide during that week in their home. This obviously profoundly affected those 2 participants' moods.

The leader's descriptions of the participants' moods at the beginning of the fifth session were anxious (1) enthusiastic (1), quiet (1), tired (1), content (1). At the end of the session, moods documented by the leader included: concerned (1), enthusiastic (1), quiet (1), tired (1), and content (1). The participant who was observed as being anxious was very apologetic because the camera had fallen off the seat on the bus and had broken. His mood moved to concern as he described serious family issues during group.

During the sixth session, quiet (1), engaged (1), enthusiastic (1), calm (1), cautious (1), confident (1), and tired (1) were the emotional descriptors used by the group leader about the participants. At the end of the session she described the participants as quiet (1), calm (1), content (1), enthusiastic (1), confident (1) and tired (1).

For the seventh session, participants presented with the following emotions: quiet (1), confidence (1) contentment (2), enthusiasm (1), concern (1) and tiredness (1) and at the end of the session: quiet (1), enthusiasm (2), contentment (2), concern (1) and tiredness (1), but that participant was more engaged when he described his first play session.

During the last session, all participants were engaged and most (6 of the 7) expressed enthusiasm for the process. The other member expressed appreciation for the process but reported that his family required more intervention and had decided to seek family and individual counseling.

Participant Levels

Following every session, the researcher chose a number from 1 to 5 on a Likert Scale for each participant in order to score his or her receptivity to the process, attribution of blame to the child, expressed level of conflict, expressions of competence as a parent, expressions of respect for the child and knowledge of child development. An average for every category for each session was calculated. The averages for the first and last sessions are reported here and compared.

The average perceived participant receptivity to the process was 2 during the first session and increased by 2.75 to 4.75 for the last session. The mean perceived participant attribution of blame to the child was 3.25 during the first session; this score was reduced by 1.75 to 1.5 the last session. The perceived participant level of expressed conflict with the child decreased by 2.24 from 3.67 during the first session to 1.43 for the last session.

The average perceived participant expressions of competence as a parent was 1.33 during the first session. This rating increased by 3.17 points to 4.5 for the last session. Expression of respect for the child improved from 2.75 during the first session to 4.2 for the last session. The average perceived participant knowledge of child development was 1.4 during the first session and 3.43 for the last session. The last rating reflects a 2.03 increase in the group's average.

For each of the 6 categories, the group leaders' perceived improvement is reflected by the change in scores. The most dramatic changes (2.75 points or over) were recorded for participant expressions of competence and participant receptivity to the process. Perceived levels of expressed conflict with the child and participant knowledge of child development improved by over 2 points.

Skills

During the first group meeting, each participant attempted and effectively demonstrated the reflective listening skill. Although no skills were practiced during the second group, the group described how they implemented the reflective listening skill at home as well as their child's response to it. Although each member communicated effective execution of the reflecting skill at home, only one member received an apparent positive response from her child. In

addition, one member received a negative response. He was frequently told by his stepson to “shut up” when he used reflective listening with him. Structuring skills were also discussed, and each member was assigned the task of setting up a place, time and day of the week to have their home play sessions.

In the course of the third group each member briefly practiced imaginary play skills. Limit setting and structuring skills were also discussed but not implemented. As the parents continued to implement reflective listening at home, one participant’s stepson continued to respond negatively (with the exception of one interaction). The participant commented, however, that using the skill made him aware that his stepson was angry most of the time. Another member offered that her 19-month old had become increasingly verbal (babbling), and she believed this was a result of the reflective listening preventing his older sister from answering questions for him. In addition, the same participant used reflective listening with her boyfriend, and she noticed that he became more communicative when she used it with him. The parent who reported positive results from reflective listening after the first session observed increased verbal responsiveness with continued implementation of reflective listening. Another participant conveyed that her son was slightly more communicative as a result of reflective listening.

Parents conducted their first home play sessions after the third session. According to the parents’ descriptions of the home sessions, they each effectively implemented structuring and reflective listening skills. Only one parent had to implement a limit, and this resulted from her child’s refusal to end the play session. For 2 participants, their child did not engage them in their play. One participant did not allow her child to lead the play. Another participant, however, effectively implemented imaginary play skills. The 2 participants who missed the third session did not have play sessions with their child.

During the fifth session 2 participants presented videotapes of their home play sessions. In both tapes the skills that were required were effectively implemented, although one parent received feedback that he needed to reflect more emotions during the session. He did not use imaginary play skills because his stepson did not engage him in play. Another parent continued to have some trouble with the imaginary play skill related to her difficulty allowing her child to lead the play. In addition, although she generally reflected effectively, she had some difficulty refraining from judgment or giving direction during reflection. Two of the participants, still reeling from a traumatic suicide in their home, did not perform a play session but continued to use reflective listening. Another parent did not have a session because her child was in the custody of DSS, and she did not have a visit.

During the sixth session, the parent who had had the most difficulty mastering the skills presented her tape, and her observed skill level was much higher than expected from her reports. Structuring skills and reflective listening skills were clearly demonstrated. Although imaginary play skills were not solicited from the child this session, the parent created an environment conducive to her child’s imaginary play and she interpreted underlying meaning to her child’s imaginary play. Two other participants continued effective implementation of skills but were not engaged in imaginary play. They created, however, an environment conducive to imaginary play. Limit setting skills were not necessary this session, but one described effective implementation in the past. The 2 participants with the trauma in their lives did not perform play sessions.

During the seventh session, 1 participant still had not performed a play session. The biological father of her identified child (who was also a group participant), however, performed his first session. He described effective implementation of structuring and reflective listening skills. Imaginary play and limit setting skills were not required during the home session.

A videotape presented by another participant demonstrated effective implementation of the skills with the exception of the imaginary play skills. As with the other parents not solicited by their children to engage in imaginary play, she created an environment conducive to imaginary play. During the tape, an interruption was allowed and this was addressed as a structuring skill that needed to be developed. All of the children, except the two under 2, engaged in imaginary play during their sessions, and one engaged her parent in that play. During the group, a parent of a child under 2, described that she allows for more throwing of toys and that kind of behavior, taking into account her child's age. She reported that her child has tantrums when the session is over, and this was addressed as a structuring issue with an emphasis on the importance of consistent warnings prior to exiting the play session and enjoyable, planned activities following the session. The other parents effectively implemented the required skills. Only 1 parent, however, was invited into imaginary play by her child.

One participant still had not held a play session before the last group meeting. The other participants, however, reported no difficulty implementing the skills. The daughter of one of the participants engaged her in imaginary play for the first time during their home play session.

Changes in Child Behavior and Family Interaction

During the second session, the filial participants described no changes in family interaction. Two parents, however, noticed changes in child behavior. One reported change in a positive direction, that her child was more verbal and open. As stated in the skills section, the other parent noted a negative change in that his stepson told him to "shut-up" when he used reflective listening. During the third session, a parent of a child under 2 noted that her son was much more verbal (babbling). She also noted two changes in family interaction. Asking her son fewer questions meant that her daughter was speaking for her little brother less, and her boyfriend had opened up to her more as a result of using reflective listening. The stepparent with the negative reaction reported that the "shut-ups" continued but that he also experienced one significantly improved interaction during which he felt his stepson was more open with him. In addition, he reported increased understanding of his child's behavior as a result of implementing reflective listening. Use of that skill had made him realize that his stepson appeared angry most of the time. The one parent who had noted improvement during the second session reported that the trend toward more responsive verbal interaction had continued. Another parent informed the group that her child was slightly more communicative.

During the fourth session, 3 of the 5 parents attending noted changes in both their child's behavior and family interaction. This trend continued into the fifth session. During the sixth session, most parents noted changes in their child's behavior and increased communication among family members. By the eighth session all of the filial participants but 1 reported changes in both familial interaction and child behavior.

Qualitative Results

The qualitative results provide important information about the process of filial therapy with parents court-referred for maltreatment. The data gives rich description and responds to the following qualitative questions:

1. How does the filial therapy process affect participants?
2. How does the filial therapy process affect treatment outcome?
3. What changes, in addition to those measured quantitatively, are reported by parents?

The information is presented according to the data collection method and salient themes.

Qualitative information gathered on the Filial Process Form was included with the quantitative data collected on the form. A review of the group leader's narrative summaries for each session

is presented in this section followed by information related to developmental considerations. Finally, participants' feedback regarding VanFleet's goals as well as their narrative responses are presented.

Group Leader's Narrative Session Notes Summary

Following each meeting, the filial group leader wrote a narrative about the session. A review of those narratives is presented in this section.

During the first session, the group members were somewhat guarded with their emotions and each made a point during the introductions to express that he or she believed he or she was a good parent. All except for one described their children as "intelligent". When discussing play, participants could come up with examples of their children's play but were unable to describe symbolic play. A parent asked the leader a very basic, specific parenting question, and she returned it to the group. The group was unable to respond in helpful ways and their comments revealed their lack of knowledge about child development. Although all of the participants were court-ordered to comply with DSS' recommendation to attend, most reported that they were there by choice.

The group members learned reflective listening during the first group session. The skill transfer required repetition, and the participants exhibited some difficulty absorbing and integrating the information. As a result, the discussion moved away from how they could reflectively listen to their children to an immediate group experience. The leader modeled reflective listening with a group member who shared her experience of her child's great-grandfather's death, an emotional experience that she felt was not too personal to share with the group. After the group leader demonstrated reflective listening, the participant described how it felt for her. Then each group member practiced a reflective listening response to the experience shared. Each group member accurately reflected some part of her experience, and the volunteer related to the group that their understanding felt very positive to her.

Once the group practiced reflective listening with their fellow participants and directly observed its benefits, they not only knew the skill but also experienced the power of it. Because this skill is imbedded in the foundation of filial therapy, it was important to establish it early in the process.

When they returned to the group the following week, each member had practiced reflective listening at home. Only one parent reported a positive change, but she related that this change was dramatic. As reported earlier, another parent recounted that his stepson told him to "shut-up" every time he attempted to reflectively listen. The five reports of little change were surprising and contrary to the group leader's prior clinical experience with filial therapy. Although, little change was apparent to parents at this time, by the end of eight sessions, 5 of the 7 reported that this was the most important skill they learned. The importance of structuring the sessions was also highlighted during the second session. The group leader emphasized to the group that it was important to begin the sessions at the same time on the same day of the week and to end them 30 minutes after they had begun (15-20 minutes for the first session or for those under 2 at the parents' discretion).

Engagement and enthusiasm for the process was evident during the third group. The participants asked more questions about the process and increased their consultations with each other about discipline. There was more playfulness and volunteering for play simulations, and the parents received their toy kits during the third session.

The enthusiasm continued into the fourth session, and parents were excited to report their experiences in the play sessions. One of the parents noted that her child engaged in aggressive

play, and this led to a discussion about emotions that parents find more acceptable and the futility and potential harm of limiting emotions that are less acceptable. The importance of helping children find ways to express those emotions more productively was emphasized to the group.

A parent whose child was in the custody of DSS discussed her child's play. The parent reported that her ex-husband sexually abused their daughter and that he had denied the allegation, maintaining that she was coaching her. As a result of the conflict, DSS took custody of the child. At the beginning of their play session, her daughter rolled out the play dough, cut it down the middle to make a "boo-boo" and applied band-aides to cover the "boo-boo." She directed her mother to also perform this task and repeated this process for the entire session. The group members expressed interest and surprise at the purposefulness of her play. The participant communicated her feeling of relief because her daughter was finding ways to heal through therapeutic play. She was concerned, however, that her daughter's play would be focused on the trauma alone. Interestingly, the mother added that her child's communication during the second part of the visit was much more guarded and closed. The mother reported that after the play session, she spent the second half of the visit asking many questions.

Another mother expressed concern that her son may have been sexually abused. She feared that it would come out in his play, and she would not be able to handle it. The group helped her explore her emotions about this, and they then discussed behaviors to limit during the session. As she further described the situation and her concerns, she came to the realization that the filial session was actually a safe place for her to experience the possible disclosure because she had a system of response that was neither emotional nor judging. She reported that the discussion helped her feel more comfortable because if he made the disclosure, he would be doing it on his own terms and based on his own decisions. After all, he was leading the play.

The end of the session was focused on developmental differences in play and the relationship this has to discipline. The parents received a discipline handout the leader developed (see Appendix J). When the group leader left the building 45 minutes after the session had ended, the two group members who were dealing with sexual abuse issues with their children were still outside talking to one another. Also after the session, a participant informed the group leader that she could not attend the previous week's session because her father, who was living with her at the time, committed suicide. The participant found him in the kitchen. When she briefly disclosed that a tragedy had occurred in her family during the next session, the group could not provide much sustained support. The leader, however, gave emotional support that evening as well as after subsequent sessions. In addition, she referred them for individual and family counseling.

In the fifth session, a group member expressed significant concerns about this family situation. He reported that his increased awareness of his stepson's behavior had made him aware that his stepson's behavior was much more aggressive and oppositional when his wife was at home. He expressed frustration that she did not follow-through with discipline. He reported that he was contemplating leaving. The group encouraged him to seek family therapy and acknowledged the difficulty of dealing with a situation that involved two parents with only one attending the group. Following the discussion of his concerns, the participant presented his videotape of his play session. His son displayed aggressiveness in a playful manner. The group observed the child's display of strength and power. The stepfather reported that his stepson was calm after the session and that the aggressive play did not result in increased aggression in other

settings. He noted that his play during the session was often less aggressive than his behavior outside of the session.

The group also viewed the tape of the daughter in DSS custody's play during the fifth session. In addition to showing her tape, the parent expressed concern about the supervising DSS worker interfering with the play session. During the filial session, the caseworker would occasionally talk and ask her daughter questions. We discussed explaining the process to the worker prior to the next session and asking that she hold any questions to the second half of the supervised visit.

The mother had accurately described her daughter's play, but the video demonstrated the intensity of the daughter's activity. The little girl was clear and directive with her mother and very focused on her task. Viewing that tape was very powerful for the group. They remarked that they felt she was working on something very important to her. Witnessing the perceived benefit of child-directed play as demonstrated by the videotape also encouraged a parent who was having difficulty giving up control in the play session to discuss her ongoing struggle with that issue with the group.

Another important issue came up before the fifth group session began. One of the video cameras broke when it was thrown from a seat in the city bus on the way over to the session. The borrower was reassured that these things happen and this was a risk assumed in transporting cameras back and forth from homes to group meetings. The group member's concern and his obvious protectiveness of the camera during the session led to consideration of the responsibility placed on the parents through loaning them the cameras.

During the sixth session, the parent who had the most difficulty understanding the skills and allowing her child to lead the play presented her videotaped play session. She reported that the "mommy doll" frequently tells everyone what to do in her daughter's play scenarios. The group member reported that watching the "mommy's" behavior in her daughter's play made her realize how her daughter perceives her. Based on what she had learned from her daughter's play, the group member had decided to change what she now perceived as an overly controlling parenting style. She received much support from the group for her acceptance of that feedback from her daughter without defensiveness and for her willingness to make such a dramatic change. When asked how she felt about giving up control, she reported that she had actually been gradually doing so since the group began. She stated that giving up more control was actually a "relief." The mother also demonstrated clear understanding and implementation of all of the skills. She had clearly mastered each of the four skills, and also received positive feedback about her performance. The last half hour of the session was spent watching the *Choices, Cookies and Kids: A creative approach to discipline* (Landreth, 1994) video. The parents nodded their heads, smiled and occasionally commented during the video. In a very brief discussion of the video, all of the members reported that Garry Landreth's approach presented in the video made sense to them. They each agreed to use a choice with their child during the upcoming week.

During the seventh session, the group further discussed the video. The parents agreed that the information Landreth presented was helpful to them, and the group discussion indicated that each group member had at least a general grasp of the information presented in the video. The conversation primarily focused on giving children age appropriate responsibility and the importance of consistent follow-through. The parent who showed her video reported that she had to end the session early as a result of her son's behavior. She successfully verbalized and ultimately followed through with the limit. Another important development during the session was that a parent had his first session with his daughter. He had been very quiet and almost non-

participatory during each of the group meetings. When he described his play session with his daughter, however, his affect and body language completely changed. He smiled and became animated, describing his session as “wonderful.”

Parents also talked about their initial reactions to filial therapy. Some expressed initial skepticism, others intimidation about their ability to effectively perform in the process. Only one parent reported that she was excited about the process from the beginning. One parent recounted that she did not initially think that anything could be gained from playing with her child, but her father was the person who helped her open up to the process. She learned from talking with him about filial therapy after the first session that she herself had participated in play therapy as a child, and the therapist had worked with her parents to help them facilitate her play behavior. He told her that he thought it was very helpful for their family.

For the final session, no videos were presented because the participant scheduled to tape purchased the wrong type of videocassette. The parent who presented her tape in the sixth session reported that her child engaged her in imaginary play for the first time. Her daughter had also reduced play centered on a controlling mother, and she attributed this to her reduction in controlling behaviors and her daughter working through her emotions about it. The parent of the boy just under the age of 2 reported that her son was mad because she had to change the schedule on him and do the session later. He expressed his anger in session by sulking and giving her angry looks. She reflected his feelings, and he then played with the blocks for the entire sessions. She also reported that she felt like he was able to work out his feelings with her present and believed this was very valuable.

One parent’s son refused the play session. She believed this resulted from his father, whom he had recently visited, telling him not to participate. Another participant’s stepson wanted to end the session early because he was tired. He did not engage his stepfather during the play during any of their sessions. The stepfather again remarked that it was during the play session that his son is most under control, exhibiting aggression with toys designed for that purpose but not against him. He also reported that his wife was more receptive towards the idea of counseling for their son and the family. The participating couple did not engage in any play sessions during the previous week. Another parent did not have a play session because she did not have visitation at DSS the preceding week. Three parents indicated interest in conducting play sessions with their other children after they completed the filial group.

Developmental Considerations

Filial therapy is designed for children between the ages of 3 and 11, although it has been successfully implemented with 2-year-olds. Children under 2 do not engage in complex imaginary play, a major element in filial therapy. During the first group session, however, it was clear that several parents had children of focus under the age of 2. As a result, filial therapy was modified for these parents to address their children’s developmental play.

Three of the parents in the treatment group had a child of focus under 2. One parent’s child was 19-months of age at the beginning of the group, and another child was 18-months of age. The parental dyad for the 18-month-old included in the group was a biological father and his live-in girlfriend. This was the only child in the home and the only child in their lives. The other parent was a single mother who also had a daughter aged 3. She had concerns because her son was not talking when the group began, and she thought he might be “slow.” The lack of verbal skills was her principal concern regarding her son’s behavior and development.

Because imaginary play does not develop in children on a significant level until after the age of 2, it was clear that filial therapy required selected modifications for these parents. One of

the modifications involved changing some of the toys. The young toddlers did not receive dollhouses, guns or swords in their toy kits. Instead they received toys that involve more gross motor activity, an oversized bat and ball, for example. The toy kits also contained several toys that were larger than those of the older children. In place of the dollhouse and small doll family included for imaginary play, the children under 2 received a larger-sized baby doll. Another modification included the parents of the toddlers beginning with a shortened, 15-minute session and then lengthening the following sessions to 20 minutes. Parents used their discretion in deciding to extend the session the full 30 minutes based on their child's behavior in session and their knowledge of their child. One parent with a young toddler extended her sessions to the full 30 minutes. The other parents only had one session with their child, so they were not able to address this issue.

The most significant modification made for home play session with younger children involved how parents tracked their children's play. In traditional non-directive play therapy, labeling objects is avoided because the adult's label of an object may stifle the creativity and imagination of the child. For example, if a child waves a spoon through the air making humming noises and a parent reflects, "You're waving that spoon in the air," this could interfere and redirect the play to a conventional use of spoon for eating. If the parent reflects "You're waving that in the air" the child may then continue flying the "spoon" through the air and say, "Yes, and the plane is about to land." Because imaginary play is not developmentally available for children under 2, the potential interference of labeling objects described is not of concern. The development of verbal skills, however, is extremely important during this stage of development, and labeling helps foster this development.

The major concern about the labeling modification was that it would be confusing to have participants in the same group tracking differently. The concern, however, was unfounded. The parents were able to successfully track differently and demonstrated an understanding of why they were tracking differently. The different tracking methods allowed for conversation about child development. The parents discovered that interaction with children at different ages and different stages of development is in fact, different. The adjustment also allowed the parents of the younger children to observe how traditional filial therapy with older children was performed for use with their child in the future or with use with their older kids. The parents of the older children also understood that if they decided to have filial sessions with their younger children that specific modifications would be required.

As stated earlier, 1 of the participants with a toddler performed only one home play session, and his participating girlfriend performed no sessions. With his very limited filial experience, he reported satisfaction with the modifications. The parent who consistently used filial therapy with her child was impressed with the results. During her first session, her child talked for the first time by repeating a word (car) that she labeled for him over and over again as she tracked his play. When she reported on her first play session, she said, "if that is all that happens in the group or in these sessions, then it would be worth it." Her son's verbal skills, however, took off. It is important to note that this could very well be an unrelated event. Given his age and stage of development, his verbal skills may have progressed rapidly without intervention. The parent, however, attributed the quick and dramatic change in verbal skills to reflective listening and modified filial therapy.

VanFleet's Goals

At the conclusion of the final session of the filial therapy group, parents filled out a sheet that requested a yes or no response to each of VanFleet's (1994b) goals and then a narrative response

to five questions (see Appendix L). The responses that indicated whether or not VanFleet's (1994b) goals were met are summarized first. This summary is followed by a review of the participants' narrative responses.

All of the participants agreed that most of VanFleet's (1994b) goals were met by filial therapy. Three parents reported that filial therapy did not reduce or eliminate their children's problem behaviors. One of these parents reported that this was because she did not experience any significant problem behaviors from her child. Only 2 of the 7 filial group participants reported that filial therapy did not meet all of the parental goals.

Several participants could not respond to the goal of improving communication with the spouse or live-in partner because they were single parents. Three of the participants with live-in partners concluded that filial therapy did help them communicate with their spouses or live-in partners. Another participant also responded that filial therapy did not help her work with her live-in partner (who was also in the group).

Overall, the parents overwhelmingly reported that filial therapy met the vast majority of the child goals described by VanFleet (1994b). All but one agreed that filial therapy helped their children recognize and express his or her feelings fully and constructively. All of the parents responded that filial therapy helped give their child the opportunity to be heard, increased their child's self-confidence and self-esteem, increased their child's trust and self confidence in the participating parent, and promoted an open, cohesive family climate (although one did not answer). They also agreed that filial therapy increased their understanding of child development, increased their understanding of their child, help them recognize the importance of play and emotion in their child's life as well as their own, helped them develop skills that would result in improved child-rearing outcomes, increased their confidence in their ability to parent, increased their feeling of warmth and trust toward their child (although one did not answer) and provided a safe place to deal with their own issues as they related to their child and parenting.

Participants' Narrative Response Summary

As stated earlier, participants received a form with yes/no responses to VanFleet's goals and questions requesting narrative responses (see Appendix L) at the end of the final session. The free response questions were as follows: (a) Would you recommend filial therapy to other parents? Why or why not? (b) What was the most important skill you learned in filial therapy? (c) What problems or concerns do you have with filial therapy? (d) What changes would make filial therapy more helpful to you? (e) Any other comments? A summary of their responses is organized according to the questions.

Would you recommend filial therapy to other parents? Why or why not?

Every parent reported that they would recommend filial therapy to other parents. One participant had already recommended it to a relative. Parents had varied explanations for why they would recommend filial therapy. Some focused on the benefit to children stating that it helps children "open up," encourages parents to "express things that you might not notice in daily routine," and that it is "good for their [children's] self-esteem." Most described the benefit to parents and one offered "filial therapy opened me up to what my child is doing and going through;" another said it "helped me get to know my child better." A parent wrote that it facilitates an "understanding of your child's behavior and emotions" or "new and disruptive behaviors." Though all gave feedback in a relational context, one parent emphasized the parent-child relationship describing filial therapy as a "wonderful bond and experience with your child."

What was the most important skill you learned in filial therapy?

Five of the seven parents reported that reflective listening was the most important skill they learned in filial therapy. Two of the parents who reported the reflective listening was the most important skill added that setting limits with choices was also very beneficial. The non-custodial parent stated she learned, “I don’t have to feel guilty about her choices.” Another parent stated that children “deserve to make choices sometimes instead of you always telling them what to do.” One parent reported that observing and understanding children’s play was most important because, “almost everything my child does in play reflects what he is going through in real life.”

What problems or concerns do you have with filial therapy? What changes would make filial therapy more helpful to you?

No parents had any problems or concerns with filial therapy. In terms of making filial therapy more helpful, one suggestion was to have the opportunity to use it with their other children during group. Another felt that longer classes would have provided more benefit.

Any other comments?

When asked for any further comments, all of the parents had more to express about their experience with filial therapy. Several expressed gratitude for the opportunity to experience the process. There were also expressions of enjoyment. Others restated that filial therapy was helpful in improving their understanding of their children and themselves as parents. One participant described it this way, “Filial therapy is a very helpful tool in helping adults learn how children think and what they think and how they learn from us without us realizing it.” Another exclaimed, “Filial therapy is excellent! All parents should experience this!”

Summary

The qualitative data provides a rich description of how parents in this study experienced the filial therapy process. It connects their experience in the process with their perceptions of changes they made in their parenting. Filial participants’ comments were generally positive, and they indicated that they received benefit from involving themselves in the group. The group leader also perceived that filial therapy was a productive and beneficial experience for the participants. The qualitative information is congruent with the quantitative data. The quantitative data indicated that filial therapy reduces parenting stress and strengthens the parent child relationship. It did not show that it was effective at reducing child abuse potential. That analysis, however, was based on incomplete data because the CAP pretests had to be removed as a result of excessive “faking good” responses by most of the participants.

CHAPTER V DISCUSSION

The quantitative and qualitative results of this study provide outcome and process data about filial therapy with parents court-referred for child abuse and neglect. In addition, these results generate ideas for future research with this and similar populations. The information about filial therapy modified for parents of children between the ages of 1 and 2 produced by this study also has important implications for research and treatment.

Quantitative

Although statistical analyses of scores on the CAP did not support the effectiveness of filial therapy at reducing child abuse potential for parents court-referred for maltreatment, there were important quantitative findings related to child abuse potential. A reduction from 6 out of 7 “faking good’s” on the CAP pretest to 1 out of 7 “faking good’s” on the CAP post-test for the treatment group may indicate that the filial group became more open and honest in the process. They were more willing to share information without defensive barriers. In addition, the lack of covariate data resulted in an inability to analyze whether the linear trend between pretests and posttests were the same for the treatment and control groups. This was an integral part of the ANCOVA analyses of the other outcome variables and certainly could have provided more meaningful information about filial therapy’s effectiveness in reducing child abuse potential with this population.

It is also important to note that this study compared filial therapy to an alternative treatment. Other filial therapy studies using the Landreth (1991) model compared treatment to no treatment (e.g., Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; Landreth & Lobaugh, 1998). Evaluating filial therapy’s effectiveness at reducing child abuse potential in comparison to no treatment may generate different results.

Parenting stress was significantly reduced for parents in the filial treatment group in comparison to those in the control group. This supports not only the use of filial therapy with parents court-referred for maltreatment, but also the use of an 8-week model. Filial therapy also significantly reduced dysfunctional interaction on the PSI subscale, the P-CDI thus indicating a strengthening of the parent-child relationship. That finding supports the use of filial therapy with this population.

Such a small sample size significantly limits these quantitative findings. The small size of the sample, however, also allowed the researcher to track the process of individual participants and gather rich qualitative data about the process of filial therapy with this population.

Filial Therapy Process Form

It was important to monitor variations in the group member’s affect throughout the filial process. As the therapy progressed, the filial therapist’s perceptions of the group’s mood changed. Anxiety and caution were no longer observed after the beginning of the third session, and suspicion was only evident at the first session. Enthusiasm was most noted at the final session, although there was another peak in enthusiasm when the participants received their toy kits. The changes observed in mood indicated that the leader generally noted a positive shift in mood from the beginning to the end of each individual session as well as from the beginning to the end of the therapy process. This perceived change is an important finding for this population in particular. All of the parents in the filial therapy group were court-referred. They did not sign up out of interest or of their own free will. Problems associated with a lack of motivation or cooperation are commonly cited in treatment research with maltreating parents (Kaufman &

Rudy, 1991; Mash & Wolfe, 1991). During filial therapy treatment, these problems were not evident after the first session.

The filial approach enlists parents as paraprofessionals to interact with their children in a new way. It does not focus on parenting deficits but on transferring professional therapy skills to parents. While parents may not initially believe filial therapy can make any difference in their lives, the challenge to hold play sessions does not presume they are “bad parents” or parents who cannot discipline their children. Enlisting parents to learn some basic skills of play therapists is not perceived as a threat to their parenting. This approach allows parents to be open to the information presented without feeling judged.

Once parents have mastered the play therapy skills in session, they learn more about their children in session and how the techniques change their interaction. From there, they can decide to make productive changes in their behavior based on the initial outcomes they experience with their own children’s behavior as well as the changes they observe in other parents’ interaction with their children. Discipline is initially discussed within the context of the home play sessions and is only later elaborated upon in terms of general parenting practice. The subject is introduced when parents are most receptive to a profound philosophical shift in their thinking, when they have already experienced interaction with their children in ways that were totally new. At that point in the process they have also observed productive outcomes from those new interactions.

This study also generated important information about participant receptiveness. The group leader perceived improvement in participants’ receptiveness to the process. On a scale from 1 to 5, the group process began with fairly low average with the leader rating the average level receptiveness at a 2 for the first session, and the group process ended with a much higher rating of 4.75 for the eighth session. Receptiveness is a construct related to mood. A person experiencing suspicion is less likely to be receptive to treatment than one feeling calm and confident. The course of filial therapy and its focus on positive interaction allowed parents to be open and receptive to the process.

Although receptiveness to treatment is an important element of success for any population, it is particularly important for a non-voluntary population. Certainly a participant who chose to engage in treatment is more amenable to treatment than one who is ordered into treatment. The fact that these court-referred participants became more receptive to filial therapy treatment as treatment progressed is remarkable, particularly because, as stated earlier, motivation for treatment is a common problem with this population (Kaufman & Rudy, 1991; Mash & Wolfe, 1991).

The Filial Therapy Process Form (FTPF) provided some important information about the skill transfer process in filial therapy. Each of the parents demonstrated reflective listening by the end of the first session. It is particularly encouraging that parents were able to demonstrate this skill so easily because most of the parents reported that this was the most important skill they learned in the process. The structuring skills were generally implemented, although the group members with more chaotic lives had difficulty with this undertaking. The imaginary play skill was not used by all participants, although most created an environment conducive to imaginary play in their play sessions. One parent had particular difficulty with this skill, but she had mastered the skill by the sixth session. Not all of the participants had to use the limit-setting skills in their home play sessions, but those who used the skills implemented them successfully. Parents’ experience in this study demonstrates that court-referred parents are capable of learning the four basic skills of filial therapy.

A related finding was that children engaged their parents in imaginary play less than what the researcher had observed in prior filial therapy experiences and less than typically described in the literature (VanFleet, 1994b). This may have been a result of the abuse and neglect history of the children working with the court-referred parent. Certainly abusive and/or neglectful interactions affect the parent-child relationship and children's play. This history could easily slow the process of children engaging their parents. The infrequency of this interactive play may indicate that these parents need more home play sessions to experience this development. The shortened model may not have allowed enough time for this population of children to engage in imaginary play with their parents. It is also important to note that two of the children were under the age of 2 and were not expected to be developmentally capable of engaging their parents in imaginary play.

Most parents noted changes in their child's behavior and in family interaction as a result of filial therapy. The perception of change is important in the therapeutic process. Concrete feedback that demonstrates to people engaged in the therapeutic process that the work they are putting forth is making a difference encourages continued implementation of the changes. Because most parents noted changes in their child's behavior during filial therapy, they were motivated to continue filial therapy after the group meetings ended.

The FTPF was a helpful resource for organizing both quantitative and qualitative information about the filial process and tracking the progress of the individual participants. This form was useful as both a clinical and research tool.

Qualitative *Group Leader's Narrative*

It was evident during the first session to the group leader that parents were struggling with the most basic of parenting issues, and the members were unable to constructively help each other. This group demonstrated, however, that court-referred parents can learn reflective listening in one session. It is also important to note that they were not able to initially learn the skill from the perspective of implementing it with their children. In order to accomplish that skill transfer, the leader had to take it out of the parenting context and demonstrate it with a group member reciting an event that was difficult for her. The group then had the opportunity to use reflective listening with that group member. Making the reflective listening process a concrete, here and now experience allowed the group members to better assimilate the information and demonstrate effective use of the skill. The group leader was then able to help the group transfer the reflective listening skill into the parenting context.

Effectively teaching this skill is essential to the filial therapy process. Most of the parents (5 of 7) in the filial group cited reflective listening as the single most important skill they learned during the entire process. It may even be helpful to provide a concrete, here and now experience for higher functioning parents so that they can observe and/or experience the benefit of the skill before trying it at home.

Although it took several sessions for the parents to recognize any benefit from reflective listening, as stated above, by the end of the therapeutic process most believed it was the most important skill they learned. It is important to understand that the benefit of this fundamental skill may not be evident immediately with certain populations.

The marked change in mood during the third session may be attributed to the group receiving the toys. Providing the toys to a non-voluntary population (although they volunteered to participate in the study, they did not volunteer for treatment) was important. Most of the parents in the group were living below the poverty line, and receiving the basket of toys was

certainly a perk to participating in the process. It was also fun. It also assured that the toys selected were appropriate for filial play sessions. In addition, providing the toy kits freed the parents from being overly restrictive with the children's play in order to protect an investment they had made in the toys. Because they had made no financial commitment to the toys, were specifically told that the toys were theirs to keep and warned that some of the toys may break, the participating parents were not compelled to limit the ways in which the children played with the toys, beyond the guidelines they had learned in training.

Providing the video equipment was also important, although it did create anxiety for a group member when one of the cameras broke. A case was not provided for the camera, and this would have most likely prevented the accident from happening. The group leader was prepared for the possibility of a lost or broken camera, but not for the added stress of that on the group member involved in the incident. The group members had little access to video cameras, however, and providing the equipment was essential. They were also given videotapes for recording their sessions. Obtaining funding for both the toys and video equipment for filial therapy with this population is important.

Filial therapy was not suited to support a family who experienced the profound trauma of a suicide in the middle of the process. They were, of course, referred for additional services, but the effect of the trauma interfered with the couple's ability to continue with therapy. They were able to attend group meetings but only performed one play session and were not able to contribute significantly to the group process. The magnitude of the trauma also presented the group with a situation for which they were not adequately equipped to provide support.

The parents in the filial group responded very favorably to the *Choices, Cookies and Kids: A creative approach to discipline* videotape (Landreth, 1994). Once they had generally learned the skills, they indicated that they wanted more support for their day-to-day parenting and the video helped in the transfer of the skills from the play sessions to daily life. It was important to show the video towards the end of the group because the participants were more receptive to the parenting ideas presented after having seen them in action. The combined experience of successfully conducting home play sessions and viewing and discussing a video that emphasizes age appropriate choices and responsibilities for children helped most of the parents determine that they wanted to provide a family culture based on those principles. Several parents commented on this profound shift in conceptualizing family functioning when asked about their most important learning from filial therapy.

By their own report, most of the parents were not receptive to filial therapy when the group began. They had volunteered to participate in the study but not for treatment, and when they initially learned about what they would be doing with their children, all but one was very skeptical. There were varying reasons for the skepticism. Some did not understand how playing with their children could be important while others did not think they were capable of learning basic play therapy techniques.

The fact that at the end of filial therapy every parent would recommend it to other parents is remarkable. It is a clear indication of the value they placed on the process. Some even reported that they would recommend it to all parents. One already had recommended it to a friend. The written comments the group members made about filial therapy were all positive. They underscored the group leader's perception that they were learning new skills, changing parenting behaviors and receiving great benefits from the process.

Developmental Considerations

Another important finding of this study was that filial therapy could be modified for parents of children between the ages of 1 and 2. The two major alterations made to filial therapy in the tracking technique and toy selection process made the modified version of filial therapy a relevant and viable option for parents with very young children. It is also important to highlight that the parents of the young children believed the therapy was helpful for both them and their children. This perception of benefit may be particularly significant because young children (ages 0 to 3) are at higher risk for child maltreatment, and maltreatment rates decline as child age increases (National Clearinghouse on Child Abuse and Neglect Information, 1999).

It was also important to observe that the modifications were not confusing for any of the participating parents, neither those who required the modifications nor those who did not. The modified filial therapy can be used in conjunction with the Landreth (1991) model without confusion.

This study indicated that there might be a potential for increased verbal skills for young children using the modified filial therapy techniques. Although one of the children under 2 spoke his first word during a filial session with his mother and his vocabulary dramatically improved during the course of treatment, it cannot be determined from this limited study that the modified filial therapy contributed to this development in any way.

Although it is clear that filial therapy can be adapted for parents of children between the ages of 1 and 2, more research is needed to determine the benefits of the modifications. Changes were made in order to adjust to the requirements of this specific research setting and opened the door for the expansion of filial therapy to a previously excluded population, parents of children between the ages of 1 and 2. Modified filial therapy may also benefit parents of 2-year-olds who have not engaged in imaginary play and developmentally delayed children. At the very least it provides parents with the opportunity to spend focused time with their young children.

VanFleet's Goals

Parents perceived that the vast majority of VanFleet's goals were met by filial therapy. The goal that was least met by filial therapy for these parents was that of reducing problem behaviors of the children, and filial therapy met more of the parent-related goals than the child-related goals. Although parental responses indicated that filial therapy met most of the child-related goals, the parents perceived it as even more effective at meeting the parenting goals. The factor of time may be relevant to this outcome. It is easier for parents to detect changes in themselves than in their children, particularly changes that are internal and less immediately apparent over time. It is possible that not enough time had elapsed for some of the participating parents to observe changes in child behaviors. It is important to note, however, that most of the parents did perceive changes in child behaviors. In addition, 1 of the 3 participants who did not perceive any child behavior changes during filial therapy did not identify any problem behaviors in her child prior to the filial group meetings.

Recommendations for Practice

Because the researcher also served as the group leader, it is important to consider the interaction effect of the researcher on the participants. The group leader had both a research and clinical interest in filial therapy's effectiveness and that may have impacted both her treatment delivery and her observations. This concern is related to issues inherent to sociobehavioral sciences research. Pedhazur and Schemelkin (1991) assert that acceptance of sociobehavioral sciences research requires the acknowledgment of "the role played by such factors as values, ideologies, and philosophies but maintain that, by being cognizant of them and by using

appropriate controls, it is still possible to arrive at relatively valid conclusions” (p. 160). Filial therapy significantly reduced parenting stress and strengthened the parent child relationship, and it is training that court-referred parents perceive as beneficial; therefore it is recommended that filial therapy be considered as a treatment option for this population. Based on the group leader’s process experience, several other recommendations are important to consider when implementing filial therapy with parents court-referred for maltreatment. In two-parent families in which one is court-referred for child abuse and neglect, both the court-referred parent and the non-referred parent should participate in filial therapy training, particularly if the court-referred parent is a stepparent. In this study, the court-referred stepparent faced difficulty implementing changes because he did not have the support of his non-referred partner, the biological mother. When participating parents are involved with CPS or DSS, the DSS or CPS workers need to be oriented to the program. If a parent is engaged in supervised visitation, the supervising caseworker in particular needs to be familiar with the process so he or she does not interfere with the parent’s play. Another recommendation involves the use of the Filial Therapy Process Form (FTPF). It helped organize and direct quantitative and qualitative observations about the therapeutic process and is therefore recommended for both clinical and research applications.

Recommendations for Future Research

When examining treatment outcomes for this population, researchers often use only the Abuse Scale of the CAP. The researcher’s experience of having to remove invalid pretests in the course of this study, however, highlights the importance of using the complete CAP to assess the interference of “faking good” responses. Future research into filial therapy with this population should also include funding for the provision of video equipment and toy kits. In terms of areas for further research, one might examine filial therapy training with non-custodial parents court-referred for child abuse and neglect who have regular, supervised visitation. If the supervised visitations occur less frequently than on a weekly schedule, the treatment period should be extended in order to allow parents an adequate number of play sessions.

Because the filial therapy participants cited reflective listening as the single most important skill of filial therapy, it is important to further understand the role it plays in treatment with this population. Comparing filial therapy to solely teaching reflective listening to parents would clarify the role reflective listening plays in treatment. Further research could determine whether reflective listening is an integral part of filial therapy or a single foundational skill that generates the change parents experience in the process. Other recommendations for future research include: filial therapy training with parents court-referred for maltreatment participating for the full 10-week program, a longitudinal study to determine the long-term effects of filial therapy training with parents court-referred for child abuse and neglect, filial therapy as a part of a more comprehensive intervention for families in which a parent has been court-referred for child abuse and neglect and filial therapy as modified in this study for children between the ages of 1 and 2. Additional research of modified filial therapy could also further investigate the process and determine if that process is a distinctly different treatment from filial therapy or simply an extension of filial therapy to parents with younger children.

Conclusion

Parents court-referred for child abuse and neglect perceive filial therapy training as an important intervention. They are capable of learning the basic skills and conducting play sessions at home. Filial therapy provides group support, parenting education and experiential opportunities for change. Both the quantitative and qualitative data indicate that court-referred parents in this study benefited from filial therapy, and these families were not only receptive to

the process but also reported enjoying it. Filial therapy helped parents conceptualize problems in a relational context as opposed to blaming themselves or their children. This helped them take a more problem solving as opposed to a punitive approach to parenting. This is very important because Milner and Chilmakurti's (1991) research indicated that attribution of blame is a significant part of abusive parenting profile. Parents reported significant changes resulting from the filial therapy process, and these changes were supported by the quantitative results of this study.

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Appendix A
PCARV's Demographic Data Sheet and Intake Forms

Prevent Child Abuse Roanoke Valley is able to offer our programs at a reduced charge 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 children in the family. _____

Number of adults (parents only) in the home. _____

4. Ethnic/ Racial Status:

White Black Biracial Hispanic Asian Other (specify) _____

5. Residence:

Roanoke City Roanoke County Salem
 Botetourt County Craig County Other (specify) _____

Zip code: _____

6. Annual Income:

\$0 - \$9,999 \$10,000 - \$19,999 \$20,000 - \$29,999 30,000 +

7. Who has custody of my children? Check one of the following.

I have full custody.	I have joint custody.	Social Services has custody	Other biological parent has custody.	A family member has custody.	Other (please 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

If yes, what special need? _____

10. Have you ever been investigated by Child Protective Services (CPS) for alleged child abuse?

Yes No

Administrative Office
201 Brandon Avenue, Suite 1
Roanoke, VA 24018
P: 540-344-3579
F: 540-344-3520
www.capc-roanoke.org
mail@capc-roanoke.org



5419 Lee Highway
P.O. Box 276
Troutville, VA 24175
P: 540-992-4849
www.capc-roanoke.org

Release for Information

Date: _____

I _____ give my permission for the below mentioned individuals and the class facilitators/staff to share information concerning my participation, progress and evaluation in the Parenting class. This is for professional purposes; all information that is exchanged is confidential.

This release is effective for 1 year from the date signed.

Name

Agency

Name

Agency

Signature

Witness

Administrative Office
201 Brandon Avenue, Suite 1
Roanoke, VA 24018
P: 540-344-3579
F: 540-344-3520
www.capc-roanoke.org
mail@capc-roanoke.org



**Prevent
Child Abuse**
ROANOKE VALLEY

5419 Lee Highway
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Troutville, VA 24175
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Group Confidentiality Statement

Before signing, please read the entire statement until the content is fully understood.

For the rights of and respect for myself, other members and facilitators of the class, I, _____ sign this statement/contract agreeing to keep all names, conversations, and all information communicated during the Prevent Child Abuse Roanoke Valley group meetings as confidential information*. A breach of confidence is a needless betrayal of trust.

The information received, by Prevent Child Abuse Roanoke Valley staff, from clients or other parties is kept strictly confidential. The information can only be shared within the agency for reasons of service delivery, or as authorized by a client release, subpoena or by law. In the event that a client reveals intentions to harm self or others or child abuse or neglect is suspected, PCARV staff is expected to take appropriate action and file appropriate reports.

Date

Name

***Confidential information is information that is not to be shared with anyone under any circumstances.**

1. Your Name:

2. Names and Ages of your children:

3. Why did you decide to take the parenting class? (If court ordered, what is the reason for the court order?)

4. What specific problems or concerns have you been having with your child(ren)?

5. Is there one child you have more concerns about or struggles with?

6. Overall, how has your relationship been with your child(ren)?

7. Are there any outside factors that impact your parenting? (Lack of health insurance, job skills, etc.)

Appendix B
PCARV's Birth – 5 Parenting Survey

Appendix C
Outline of 10-Week Filial Group
(Johnson, 1995, pp. 59-61)

The ten week group program developed by Dr. Garry Landreth has a specific format which is clearly described in his 1991 book, *Play Therapy: The Art of the Relationship*. In order to give the reader a sense of how the program is presented, the ten sessions and their primary purposes and content are briefly outlined below.

Session 1: The training focus of this first meeting is primarily on developing sensitivity to children and empathic responding, skills that will be used almost exclusively in the parent/child play sessions. Role-playing is employed by the therapists, and discussion centers around the importance of focusing on children's needs and emotions.

Homework assignments are given to the parents, requiring them to identify emotions of anger, happiness, sadness, and surprise in the child and to make a reflective response which will be reported to the group in the second session. Another assignment in this session is for the parents to notice something about their child that they had not previously seen.

Session 2: The focus of this session is for the parents to get a feel for using reflective responding in an actual play session. Group discussion centers on obstacles to reflecting children's emotions, and videotaped play sessions are shown to the group. Again, parents role-play in pairs, taking turns being the parent and the child. The parents are given a list of toys which they will purchase or find with the child for use in the parent/child play sessions.

The plan for the play sessions is for children to take the lead in a kind of play that will demonstrate their needs and issues for the parents. Toys are chosen which encourage creative play and emotional expression in children. For example, crayons and paper, a family of dolls, and a rubber knife fit these requirements. Mechanical gadgets and Barbie TM dolls, on the other hand, are attractive for their own sake and may actually lead the child to play in a prescribed manner. The homework is for the parents to put the toy kit together with the child and bring it to the next session.

Session 3: The purpose of this session is primarily to finalize plans for beginning the home play sessions. It is stressed that these sessions are "special time" which must not be interrupted. The parents discuss their fears about having these sessions and plan ways to circumvent problems. In this session, the therapists teach limit setting skills which can help parents to remain in charge of the sessions even though the children will be in the lead. Again, parents role-play these skills with each other, often developing skills which they will use outside of play sessions, as well.

Their homework is to have the first videotaped play session, as parents will subsequently bring in their tapes to be viewed by the group. Additionally, parents are to keep a journal documenting themes and reactions to the child's play as well as problems and good moments in the sessions. One parent (or couple) volunteers to bring a videotape for viewing by the group next week.

Sessions 4-9: These meetings provide opportunities for parents to report on their play sessions and to share their reactions with one another. The therapists intentionally turn parents to each other for advice, rather than directly providing answers to their difficulties, help to keep the therapists out of the "expert" position. Just as the parents are learning to pay close attention to their children's feelings, the therapists provide support for this process by focusing on the parents' feelings.

In each session, a different parent videotape is viewed and discussed, during which the therapist strive to maximize positive comments and minimize correction. Following the video, each parent reports on his or her play session. Training and role playing of play session principles and skills are continued in each session, while the therapist(s) help parents to identify newly developed coping skills and encourage the generalization of these skills.

Session 10: The goal of this session is to bring closure to the experience and to plan for future “special time” with the children. Parents share their evaluation of the experience and review the ways in which they and their children have changed. Parents share their perceptions of changes they have observed in other parents and children, and discuss areas for continued family growth.

Appendix D
Outline of 8-Week Filial Group
A Modification of Landreth's (1991) Model

- Session 1: Remains the same
- Session 2: Session is the same but the homework assignment is different because parents are provided toy kits and will have no need to purchase the kits. The homework is for parents to develop plans for home play sessions.
- Session 3: Remains the same with less time devoted to planning session because participants will have done so for their homework.
- Sessions 4-7: Remains the same. There are three as opposed to five sessions focused on parental report of home-play sessions
- Session 8: Is identical to Session 10 of Landreth's (1991) model.

Appendix E
Filial Therapy Process Form

Session Number:

Participant Code:

One word description of participant mood: _____

	<i>Low</i>		<i>Med.</i>		<i>High</i>
Receptivity to the process:	1	2	3	4	5

Attributions of blame of child:	1		2		3		4		5
---------------------------------	---	--	---	--	---	--	---	--	---

Level of expressed conflict with child:	1		2		3		4		5
---	---	--	---	--	---	--	---	--	---

Expressions of competence as a parent:	1		2		3		4		5
--	---	--	---	--	---	--	---	--	---

Expressions of respect for child:	1		2		3		4		5
-----------------------------------	---	--	---	--	---	--	---	--	---

Accurate knowledge of child development:	1		2		3		4		5
--	---	--	---	--	---	--	---	--	---

Noted changes in child's behavior:		Yes		No	
If yes list changes described _____					

Noted changes in family interaction:		Yes		No	
If yes list changes described _____					

Filial Therapy Basic Skills Attainment

(Circle one and describe)

Structuring skills:		
not attempted	attempted ineffectively	effectively implemented
Description _____		

Reflective listening skills:		
not attempted	attempted ineffectively	effectively implemented
Description _____		

Imaginary play skills:		
not attempted	attempted ineffectively	effectively implemented
Description _____		

Limit setting skills:		
not attempted	attempted ineffectively	effectively implemented
Description _____		

Appendix F

INFORMED CONSENT

Project Title: Filial Therapy with Maltreating Parents

Investigator: Katherine Walker

Supervising Faculty: Hildy Getz, Ed.D.

Kusum Singh, Ph. D.

I. Purpose: The general purpose of this study is to evaluate the effectiveness of filial therapy with parents who have been court-referred for child maltreatment. Three research questions guide this investigation: (1) Is filial therapy effective at reducing present child behavior problems with maltreating parents? (2) Is filial therapy effective at reducing parenting stress with maltreating parents? (3) Is filial therapy effective in an applied setting at strengthening the parent-child relationship with maltreating parents? The independent variable is filial therapy. The three dependent variables are children's behavior problems, parenting stress, and parent-child relationships.

The general purpose of the qualitative portion of this study is to examine the filial therapy process as it is experienced by parents participating in the group. Parents in the treatment group will be invited to participate in this part of the study.

II. Procedures: Parents referred to Prevent Child Abuse Roanoke Valley (PCARV) for parenting education classes for their fall term are invited to participate. For those who volunteer to participate, the researchers will provide necessary materials. The groups will meet from 7:00 p.m. to 8:30 p.m. on Tuesdays from October 2, 2001 through November 20, 2001. As a part of their standard procedure, the agency provides childcare and transportation for those in need of the services. The group is only for parents. In the group, participants will learn play therapy skills and will go home and practice these skills with their children. Sometimes, leaders will want participants to videotape a play session, the equipment to tape will be provided. The videotape itself is the property of the participants. Each participant in the Filial Therapy group will be provided with a play kit to use with his or her child. Observations will be conducted during the group throughout the research process.

III Risks: There is minimum risk to participating in the research. Above and beyond the risk parents assume becoming involved in the agency program, participating in the Filial Therapy group may involve participants feeling some discomfort from learning new skills in a group setting.

IV Benefits: The major benefit of filial therapy demonstrated by prior research is that of improved parenting and strengthened parent-child relationships; both of which often result in improved child behavior. There is, however, no promise or guarantee that participants will benefit from the study. Stated differently, it is hoped but not guaranteed that participants will benefit. In terms of larger societal benefits, it is beneficial for therapists working with parents, children and their families to know if filial therapy is effective at reducing child maltreatment. Participants will be welcome to receive the study's results if they request them from the researchers.

V Anonymity and Confidentiality: Neither participants nor their children will be identifiable from this study. Their pre- & post-test scores will be recorded under a number assigned to them. Participants will videotape play sessions with their children, but these tapes will be their property to keep or dispose of as they wish. A pseudonym will be used when referring to a participant. Investigators, however, will break confidentiality if there is suspicion of child abuse or if a participant is believed to be a threat to her/himself or others. A court order may require that researchers break confidentiality to release information to the courts.

VI. Compensation: There will be no compensation given to participants. If, as a result of this project, the investigators determine that a participant should seek counseling or medical treatment, referrals will be provided.

VII: Freedom to Withdraw: Participants are free to withdraw from this study at any time without penalty. Participants are free not to answer any questions or respond to experimental situations as they choose. There may be circumstances under which the investigators may determine that a participant should not continue in the project, in which case a referral will be made.

VII: Approval of Research: This research project has been approved, as required by the Institutional Review Board Involving Human Subjects at Virginia Polytechnic Institute and State University, by the Department of Education, and by Blue Ridge Community Services.

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

To take the pre- and posttests at the designated times (all participants in either control or treatment [Filial Therapy] groups)

To attend and participate in the Filial Therapy group or standard PCARV classes.

X. Participant Permission: I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project.

If I participate, I may withdraw at any time without penalty. I agree to abide by the rules of this project.

Signature

Date

Telephone number

If I have any questions about this research or its conduct you may contact:

Katherine Walker, Investigator/Researcher at (540) 342-2424/katherinewalker@cs.com

Hildy Getz, Supervising Faculty at (540) 231-8194/hgetz@vt.edu

Kusum Singh, Supervising Faculty at (540) 231-9729/ksingh@vt.edu

David M. Moore, Chair, IRB at 231-4991/moored@vt.edu

Appendix G Individual Session Outlines

SESSION #1 OUTLINE

- I. Welcome
 - Group leader introduction
 - Participant introductions:
 - Name
 - What each participant hopes to get out of the group
 - One word description of how they are feeling
 - A positive word to describe child of focus
 - Biggest concern about child of focus
- II. Discussion of play
 - Quotes for discussion:
 - The best way of getting to know children is by observing them play
-Soren Kierkegaard
 - You can discover more about a person in an hour of play than in a year of conversation – Plato
 - One of the most obvious facts about grown-ups, to a child, is that they have forgotten what it is like to be a child – R. Jarrell
 - Why we focus on play with children:
 - Easier for kids to talk to us through play than with words. Kids younger than 7 have more trouble talking with words than playing feelings out.
- III. Introduction to filial therapy:
 - Research has shown that filial therapy has helped parents feel less stressed about their parenting, reduced children’s behavior problems, helped parents understand their children’s feelings, and helped parents accept their children’s feelings.
 - Basically, we are going to teach you to conduct weekly play sessions with your children. Before you begin those sessions you will watch videos and practice. You are going to use a new way of speaking, and it can take some time to get used to this new way. (Example from leader’s training). We will provide you with the toys you will use and video equipment for you to tape training sessions (1-2). Set aside special time with your other children.
 - Quote from pilot study:
 - I think that this is such a positive thing for parents. I just wish this was available for everyone that is interested. To come and learn, and not only to help their children learn to work through things that they need to work through, but even if their kids are just doing great and fine still I think that it could be very emotionally bonding and help your children to feel confident. I think that this could help any parent, any child.
- IV. Reflective listening
 - Mirroring
 - Describe underlying feeling, behavior, or pattern.
 - Statements not questions
 - Reflective listening tells your child that you are present, you hear her, you understand her and that you care and believe what she is communicating is important. It does not

tell your child that you agree with her or that you must make her happy or solve her problem.

Other parent's description of it:

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

Handout

Practice in session

Assignment:

Identify anger, happiness, sadness and surprise in child this week.

Practice reflective listening every day for at least 10 minutes. Write down responses.

(For those who do not have child at home, find another target person to improve relationship)

SESSION #2

OUTLINE

Review reflective listening homework

Practice reflective listening in pairs

Find out if they have determined place for play sessions. Have them determine time. Discuss why it is important to have the same time every week--importance of structure. Discuss importance of no interruptions.

Play training video. Answer questions during the video and highlight important points.

Each participant repeats a response given in the video to practice.

Discuss video.

If there is time, practice play session.

Handouts

Homework:

Establish place and time if have not already

Continue and increase reflective listening

SESSION #3
OUTLINE

Review Homework
Hand out kits and review toys
Play demonstration
Practice play sessions in pairs
Handouts

Homework:
First play session

SESSION #4
OUTLINE

Review filial sessions with parents without videos
Review videotaped filial sessions.
Discuss videos.
Handouts

Homework:
Home play session

SESSION #5
OUTLINE

Review filial sessions with parents without videos
Review videotaped filial sessions.
Discuss videos.
Handouts

Homework:
Home play session

SESSION #6
OUTLINE

Review filial sessions with parents without videos
Review videotaped filial session.
Discuss video.
Cookies video.
Discuss cookies video.
Handouts

Homework:
Home play session
Use choice with child

SESSION #7

OUTLINE

Review choice outcomes
Review filial sessions with parents without videos
Review videotaped filial sessions.
Discuss videos.
Begin closure process--discuss initial vs. current conceptions

Homework:
Home play session
Increase use of choice

SESSION #8

OUTLINE

Review choice outcomes
Review filial sessions with parents without videos
Review videotaped filial sessions.
Discuss videos.
Closure--discuss experience
Review generalization of parenting skills to daily life
Name and number exchange for those who want continued support with "special times"
Instruments and surveys

Appendix H
Permission to Use Garry Landreth Handouts

Subj: Re: Fwd: Filial Therapy research
Date: 10/25/01 2:18:02 PM Eastern Daylight Time
From: Schumann@coefs.coe.unt.edu (Brandy Schumann)
To: KatherineWalker@cs.com

Katherine,
I spoke the Dr. Landreth and he is alright with you using the dissertation pieces. It turns out that many individuals have done the same. Let me know if you have any further questions.

Brandy Schumann
Assistant Director
Center for Play Therapy
University of North Texas
(940)565-3864
Schumann@coefs.coe.unt.edu

>>> <KatherineWalker@cs.com> 10/17/01 11:25PM >>>
Brandy (or Brandi?)

This email is in response to your recommendation to specifically request permission to use the handouts for filial sessions 1-6. These handouts have Dr. Landreth's name on them, and are presented in Costas' dissertation.

I received my initial non-directive play therapy training at a 3-day workshop with Dr. Landreth, and received subsequent filial training at a workshop with Louise Guernsey.

Thank you so much for your help.
Katherine Walker

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<DIV>I spoke the Dr. Landreth and he is alright with you using the
dissertation pieces. It turns out that many individuals have done the same. Let
me know if you have any further questions. </DIV>
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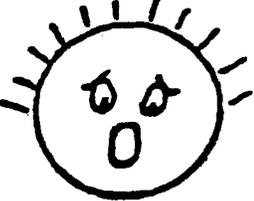
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<DIV>&nbsp;&nbsp;&nbsp;</DIV>
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<DIV>Brandy Schumann
Assistant Director
Center for Play Therapy
University of North Texas
(940)565-3864
Schumann@coefs.coe.unt.edu
```

>>> <KatherineWalker@cs.com> 10/17/01 11:25PM >>>
Brandy (or Brandi?)

Appendix I
Garry Landreth Handouts

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

 <p>1 _____</p>	 <p>2 _____</p>
 <p>3 _____</p>	 <p>4 _____</p>

Reflective responses this week.

1. _____

2. _____

3. _____

4. _____

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: _____

BASIC RULES FOR 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 give information or teach.
6. Don't preach
7. Don't initiate new behavior (These first 7 are taken from Guemey, 1972)
8. Don't be passive, 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's power and effort.
7. Do join in the play as a follower.
8. Do be verbally active.

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

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

Your responses should not convey:

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

**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.

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.

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 J
Handouts Developed for Treatment Group

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.

**Discipline the Filial Way
(Katherine Walker, 2001)**

Preventing problems

1. Give your child frequent, loving attention.
2. Allow your child to make choices and have autonomy when safety, courtesy, and kindness are not at issue. Give choices whenever possible.
3. When you set limits or give warnings, STICK to them.
4. Admit your own mistakes.
5. Allow your child to express feelings safely, even if those feelings bother you.
6. Don't push child's limits of hunger, fatigue, stress. Make sure needs of child are met.
7. Provide structure. Have routines for wake-up time, breakfast, lunch, dinner and bedtime.
8. Seek counseling if your child is consistently sad, angry, rebellious or unusually withdrawn for weeks.
9. Teach your child "I" statements and encourage your child's use of them-even if you don't always like what they have to say. You can do this by reflecting and telling your child you appreciate being told.

I feel _____
when you _____.
Next time, please _____.

Discipline is about teaching, not control.

1. Reflect the feeling or desire.
2. State the limit. "Your shoes are not for throwing."
3. Give child another, related choice. "You can go outside and throw the football."
No discussion. You can:
 1. Reflect desire to discuss.
 2. State that you will not discuss.
 3. NOT RESPOND.
 4. Change the subject.

Not all misbehavior requires a consequence. Sometimes it is better to ignore attention-seeking behaviors and give attention for more productive behaviors.

For aggressive behavior:

1. Make sure victim (dog, sibling) is okay. Shower victim with attention, concern and protection.
2. State firmly but without emotion _____ is not for hitting (or kicking, etc.).
3. Tell the child to go to established "thinking place" for 2 minutes because dog, sibling, needs to feel safe. Tell child to come up with a safe way to express the anger they are feeling. At the 2-minute mark ask if they have come up with the safe way. If so allow them to return to play. If not give them another minute. Ask again after one minute. If they have not come up with anything suggest an alternative and let them continue play.

Appendix K
PCARV's Session Outlines

Session 1
Topic: Orientation

Icebreaker and Check-in

- Have parents introduce themselves
- Have parents give the names and ages of their children.

Topic Presentation

- Orientation to new member packets
- Questions or concerns from parents
- Video- "Spanking, Shaking & Hitting: What to do Instead?"

Handouts

- New member packets

Clients will meet in the downstairs community room. The orientation will be for all parents together.

Topic: Basic needs of children

****** ADMINISTER PARENTING SURVEY BEFORE YOU START THE DISCUSSION******

Icebreaker and Check-in

- See how things have been going with families and then do icebreaker
 1. One need I have which is not being met is _____.
 2. Right now, my child seems to really need _____.

Topic Presentation and Discussion

- Discuss and complete "Wheel of needs"
- Complete Leisure barriers activity and discuss
- Discuss what every child needs for good mental health
- Building a child's conscience activity
- Nutrition discussion

Handouts

- Wheel of needs
- Leisure barriers
- 26 ways to calm a crying baby
- Building a child's conscience
- Parenting survey

Child development: Birth – 5

Icebreaker and Check-in

- The biggest frustration of being a parent is _____.
- The nicest part of being a parent is _____.

Topic Presentation and Discussion

1. Skill strips
2. Development sheets
3. The crazies and how to avoid them. Get the parent's input on how they have handled certain situations
4. Development booklets
5. Video: Child development: Birth – 5 (30 minutes)

Handouts

1. Skill strips
2. Development booklets

Session 3
Topic: Discipline

Icebreaker and Check-in

- I think you can spoil children by _____.

Topic Presentation and Discussion

1. Discipline exercise
2. Discuss discipline information
3. Differentiate between discipline and punishment
4. Video: Good discipline / Good kids (40 minutes)

Handouts

1. Discipline exercise
2. 101 ways to praise

Session 4 Discipline

Topic Presentation and Discussion

1. Types of punishments
2. Types of misbehavior and how you can respond
3. Techniques for improving behavior
4. Natural and logical consequences
5. Time out
6. Setting limits
7. Family rules
8. Video: Spanking, shaking and hitting (30 minutes)

Handouts

1. Discipline brochure
2. Family rules sheet

Session 5
Topic: Supervision and Safety

Icebreaker and Check-in

- One way I can keep my child safe is to

Topic Presentation and Discussion

1. Supervision exercise
2. My 8 rules for safety
3. Safety tips for parents
4. Television discussion
5. What's wrong with this picture?
6. Video: Car Seat safety (30 minutes)

Handouts

1. Safety brochure
2. Don't let your family go down the tube
3. Safety Picture

Session 6
Topic: Stress and Anger

Icebreaker and Check-in

- When I'm angry, I usually _____.
- One way I'd like to express anger is to _____.

Topic Presentation and Discussion

1. What is stress?
2. Stress management and prevention techniques
3. Discuss children's stress
4. Anger quiz and discuss that anger is a feeling and it isn't bad, but the way we express anger can be a problem.
5. Discuss ways to handle anger and have group brainstorm ways they deal with anger.
6. Visualization activity (if time)

Handouts

1. 18 ways to calm a stressed out parent
2. anger quiz
3. stress booklet
4. What is stress?

Session 7

Topic: Preparing for school and childcare and health issues

Icebreaker and Check-in

- My biggest fear about sending my child to school is _____.
- My child's first experience away from mom and dad was when she/he was _____. How was your child's experience? (Was it good or bad)

Topic Presentation and Discussion

1. Mental and Emotional development
2. Picking and keeping good child care
3. Preparing for kindergarten use pamphlet and information sheet in manual
4. Toilet training
5. Sleep problems
6. Childhood illnesses
10. Video: Child Care (30 minutes)

Handouts

1. Kindergarten pamphlet
2. Childcare pamphlet
3. Sleep problems
4. Toilet training
5. Childhood illnesses

Session 8
Topic: Self-Esteem

Icebreaker and Check-in

- One thing I've gained from taking this class is _____
- One thing I am going to miss is _____

Topic Presentation and Discussion

1. Video: Building your child's self esteem
2. Administer posttest
3. Present certificates and have party

Handouts

1. 50 phrases to encourage your child
2. Ten gifts we should give to children
3. Post test
4. Certificates

Appendix L
VanFleet's Goals and Narrative Response Form

Please circle yes or no in response to the question in order to help us determine if the goals of filial therapy were met. Feel free to write any additional comments.

Did filial therapy

1. help your child recognize and express his or her feelings fully and constructively?
YES NO
2. give your child the opportunity to be heard?
YES NO
3. help your child develop more effective problem solving and coping skills?
YES NO
4. increase your child's self-confidence and self-esteem?
YES NO
5. increase your child's trust and confidence in you?
YES NO
6. reduce ore eliminate problem behaviors?
YES NO
7. promote an open, cohesive family climate, which fosters healthy and balanced child development in all spheres: social, emotional, intellectual, behavioral, physical and spiritual.
YES NO

Did filial therapy

1. increase your understanding of child development?
YES NO
2. increase your understanding of your child?
YES NO
3. help you recognize the importance of play and emotion in your child's life as well as your own?
YES NO
4. decrease your feelings of frustration with your child?
YES NO
5. help you develop skills that will result in better child-rearing outcomes?
YES NO
6. increase your confidence in your ability to parent?
YES NO
7. help you open the doors of communication with your child and keep them open?
YES NO
8. help you work better as a team with your spouse or live-in partner?
YES NO
9. increase your feelings of warmth and trust toward your child
YES NO
10. provide a safe place for you to deal with your own issues as they relate to your child and parenting?
YES NO

Would you recommend filial therapy to other parents? Why or Why not?

What was the most important skill you learned in filial therapy? What part of the process was most helpful to you?

What could have made filial therapy more helpful to you?

What problems or concerns do you have with filial therapy?

Any other comments?

VITA-Katherine F. Walker
915 Welton Avenue S.W.
Roanoke, Virginia 24015

EDUCATION

VIRGINIA POLYTECHNIC AND STATE UNIVERSITY Blacksburg, VA
Doctor of Philosophy Candidate December 2002 (Expected graduation date)
Major Counselor Education
GPA 3.9

VIRGINIA POLYTECHNIC AND STATE UNIVERSITY Blacksburg, VA
Masters in Education May 1995
Major: Counselor Education
GPA: 3.9

UNIVERSITY OF VIRGINIA Charlottesville, VA
Bachelor of Arts May 1991
Major: History
GPA 3.0

HONORS

Chi Sigma Iota, Counseling Academic & Professional Honor Society (1994-2002)

LICENSES AND CERTIFICATIONS

Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Certified Sex Offender Treatment Provider

PROFESSIONAL ASSOCIATIONS

American Counseling Association (ACA)
Virginia Counselors Association (VCA)
Virginia Association for Clinical Counselors (VACC)

BOARD EXPERIENCE

Prevent Child Abuse Roanoke Valley (PCARV) 1997 - 2000
Young Women's Christian Association (YWCA) 1997 - 2000
Downtown Music Lab (Founding Board Member) 1999 - 2002

CURRENT EXPERIENCE

Director, Batten Leadership Institute, Hollins University Roanoke, VA

Designed the Institute's leadership curriculum. Responsible for administration of entire program, teaching skills seminars, supervising interns and students, recruiting, fundraising, evaluating outcomes and conducting research.

Executive Director, Allegheny Roundtable

Created and founded the Allegheny Roundtable, a conference at the Greenbrier Resort and Conference Center for a select group of mental health professionals. Responsible for coordinating, recruiting, fundraising, staffing and evaluating the conference.

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CLINICAL EXPERIENCE

- 2000 **APPALACHIAN COUNSELING CENTER** Roanoke, VA
Diagnosed according to DSM IV, assessed, and developed treatment plans. Provided individual, family, and play therapies to emotionally disturbed children, adolescents and their families in a private practice setting. Worked with parents to improve their parenting skills. Assisted in psychological test administration.
- 1995 – **CHILD AND FAMILY SERVICES, BLUE RIDGE BEHAVIORAL HEALTHCARE**
1999 Roanoke, VA
Outpatient Mental Health Therapist
Diagnosed according to DSM IV, assessed, and developed treatment plans. Provided individual, family, play and group therapies to emotionally disturbed children, adolescents and their families. Worked with parents to improve their parenting skills. Supervised therapist for licensure. Certified prescriber for recommending inpatient psychiatric hospitalization. Collaborated with staff psychiatrists and clinicians, as well as local school and mental health professionals.
- In-Home Services Mental Health Therapist**
Provided counseling, crisis intervention, and case management services. Advocated for client and family services, including FAPT and CPMT presentations.
- 10/99- **CHILDREN'S DAY TREATMENT**
12/99 **Consultant**, Blue Ridge Behavioral Healthcare Roanoke, VA
Reviewed clinician treatment plans and record documentation in accordance with Medicaid regulations. Observed and evaluated elementary school sites where services were being offered to children with severe emotional and behavioral challenges, and offered recommendations to coordinators.
- 1/95 – **YOUTH HAVEN II** Roanoke, VA,
8/95 **Residential Intern**
Led and planned weekly group and individual sessions. Provided treatment and case management in a residential setting.

OTHER RELATED EXPERIENCE

- 10/90 - **CHARLOTTESVILLE AREA SCHOOLS** Charlottesville, VA
4/91 **Suicide Prevention Educator**
Encouraged school administrators to implement the "Empty Chairs" program. Presented suicide prevention video to students and initiated class discussions.
- 4/89- **UNIVERSITY OF VIRGINIA** Charlottesville, Virginia
3/90 **Honor Investigator**
Conducted investigation within a single sanction honor system. Participated in the honor trial.

TEACHING EXPERIENCE

- 1/01- **VIRGINIA POLYTECHNIC INSTITUTE & STATE UNIVERSITY** Blacksburg, VA
5/01 **Supervision Intern**
Provided clinical supervision to masters students at a Roanoke-based clinical lab site. Received supervision of supervision by university professor and peer group.

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- 08/00 - **VIRGINIA POLYTECHNIC INSTITUTE & STATE UNIVERSITY** Blacksburg, VA
12/00 **Teaching Assistant**
Course: Clinical Internship
Assisted with a masters level course focused on providing students supervised clinical experience. Responsibilities included reviewing instructional materials with instructor, developing selected lectures, as well as assisting in evaluation of student progress.
- 03/00- **VIRGINIA POLYTECHNIC INSTITUTE & STATE UNIVERSITY** Blacksburg, VA
07/00 **Teaching Assistant**
Course: Lifespan Development
Responsibilities included assisting in the design and development of an on-line course. Participated in an on-line team teaching approach. Additional responsibilities included review and evaluation of student assignments.
- 1/91- **TANDEM SCHOOL**, Charlottesville, VA
5/91 **Seminar Instructor**
Created and taught course titled "Women in the Visual Arts." Organized and led field trips to Washington, D.C., local art museums and art studios

PRESENTATIONS

- 10/01 **VIRGINIA TECH, GRADUATE CLASS**
Guest Presenter for master's class
Presentation title: "Integrating Play Therapy in Child Treatment"
- 02/01 **VIRGINIA TECH, GRADUATE CLASS**
Guest Presenter for master's class
Presentation title: "An Introduction to Play Therapy"
- 09/00 **VIRGINIA TECH, GRADUATE CLASS**
Guest Presenter for master's class
Presentation title: "Play Therapy: Basic Techniques"
- 06/00 **PREVENT CHILD ABUSE ROANOKE VALLEY**, Roanoke, VA
Co-Presenter with Carol Gibson, Roanoke City DSS
Presentation title: "How to Help Your Child Cope with Divorce"
- 12/99 **CARILION SAINT ALBANS HOSPITAL**
Co-Presenter with Dr. Hildy Getz
Presentation topic: Clinical Supervision
- 09/99 **NORTH CAROLINA ASSOCIATION OF COUNSELOR EDUCATORS AND SUPERVISORS**
Participant
Interactive Television (VTEL) Demonstration
Presentation title: "Clinical Supervision Course via Interactive Television"
- 4/99 **FAMILY VIOLENCE COORDINATING COUNCIL, PROFESSIONAL TRAINING DAY**
Presenter
Presentation title: "Treatment for Child Sexual Abuse Victims"

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PUBLICATIONS & MANUSCRIPTS

Quinn, A., Getz, H., Greene, R., and Walker, K. Counselor Educators Go On-Line: An Analysis of Students' and Instructors' Experience with a Web-Based Course. Manuscript submitted for publication.

TECHNOLOGY COMPETENCIES

Distance Education:

- Instruction via Interactive Television (VTEL)
- Internet Instruction via Blackboard (developed with professor)
- Email

Other:

- Microsoft Powerpoint
- Microsoft Word
- Microsoft Excel
- SPSS