

A COMPARATIVE ANALYSIS OF INTENSIVE FILIAL THERAPY
WITH INTENSIVE INDIVIDUAL PLAY THERAPY AND
INTENSIVE SIBLING GROUP PLAY THERAPY
WITH CHILD WITNESSES OF DOMESTIC VIOLENCE

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The purpose of this study was to determine the effectiveness of Intensive Filial Therapy in: (a) improving the self-concept of child witnesses of domestic violence; (b) reducing internalizing behavior problems, such as withdrawal, somatic complaints, anxiety and depression, of child witnesses of domestic violence; (c) reducing externalizing behavior problems, such as aggression and delinquency, of child witnesses of domestic violence; (d) reducing overall behavior problems of child witnesses of domestic violence; and (e) increasing communication of empathy between mothers and child witnesses of domestic violence. A second objective of this study was to compare the effectiveness of Intensive Filial Therapy with Intensive Individual Play Therapy and Intensive Sibling Group Play Therapy with child witnesses of domestic violence.

The experimental group consisted of 11 child witnesses of domestic violence whose mothers received 12 Intensive Filial Therapy training sessions within a three week period and had 12 mother-child play sessions. The Intensive Individual Play Therapy comparison group, consisting of 11 child witnesses, and the non-treatment control group, consisting of 11 child witnesses, were utilized from the Kot (1995) study. The Intensive Sibling Group Play Therapy comparison group was utilized from the Tyndall-Lind (1999) study.

Children in all studies completed the Joseph Preschool and Primary Self-concept Screening Test and the Child Behavior Checklist. Mothers who received Intensive Filial Therapy training conducted pretest and posttest play sessions for the Measurement of Empathy in Adult-Child Interaction.

Analyses of Covariance revealed the children in the experimental group significantly increased in self-concept, and significantly reduced overall behavior problems. A comparison of t-test scores of the pretests and posttests revealed mothers in the experimental group significantly increased communication of empathy to their children.

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CHAPTER I

INTRODUCTION

During the heightened awareness of social injustice in the 1960s, the veil of secrecy surrounding child abuse and domestic violence was broken. The cultural belief that “what happened in the family stayed in the family” was no longer held sacred and the tragedy of child abuse and domestic violence was exposed (Knauer, 1999). “The nation reacted with the identification of the *battered child syndrome*...[and] all 50 states adopted child abuse reporting laws within a five year period, 1962-1967” (Reppucci, Britner, & Woolard, 1997, p. 2). Legislative mandates encouraged individual states to intervene “in the best interest of the child” when parents were not able to provide adequate care for their children (Reppucci et al., 1997, p. 2).

The number of child abuse and neglect cases reported each year continues to grow astronomically. In 1994, child protective services in 48 states received more than 2.9 million reports of alleged child maltreatment (U. S. Department of Health and Human Services, National Center on Child Abuse and Neglect [NCCAN], as cited in Reppucci et al., 1997, p. 1). Between 1990 and 1994, the number of victims of child abuse and neglect increased almost 27%--nearly half of the children being 8 years old or younger. Based on reports from 41 states, 80% of the child maltreatment was committed by the children’s parents (Reppucci et al., 1997).

Recent statistics indicate an estimated 3 to 4 million American families engage in domestic violence each year, yet only a small fraction of those families seek protection at

battered women's shelters (Roberts & Burman, 1998; Jaffe, Wolfe, & Wilson, 1990). The first domestic violence shelter in the United States was established in 1976. Statistics document over 1600 shelters for victims of domestic violence existed throughout the nation by 1991, not counting the hundreds of shelters that have opened their doors since that time (Edleson, 1997).

As the country responded to the outcry of female victims of domestic violence, a new group of "silent" and "unintended" victims was uncovered. These "forgotten victims" were the 3 to 10 million children each year that witness violence between their parents or between adult caregivers in their homes (Carlson, 1984; Straus, 1990). Some researchers suggest that at least one third of American children have witnessed violence between their parents, more than just isolated incidents (Straus & Gelles, 1990).

"Adult-to-adult domestic violence is most often defined as an 'act carried out with the intention, or perceived intention, of causing physical pain or injury'" (Straus, p. 76). Child witnesses of family violence are differentiated in the literature as: (a) a *child victim* of physical abuse, (b) a *child witness* (observer) of spousal abuse/domestic violence, or (c) an *abused witness* who is both a *child victim* of physical abuse and a *child witness* (observer) of adult-to-adult violence. An estimated 40% to 60% of child witnesses are also abused (Lehmann & Carlson, 1998; Sternberg, Lamb, Greenbaum, Cichetti, Dawud, Cortes, Krispin, & Lorey, 1993).

Nearly 20 years ago, Hughes and Barad (1983) identified a shortage of services addressing the emotional and behavioral needs of these "forgotten" victims, yet the inadequate amount of services continued into the 1990s (Groves, Zukerman, Marans, &

Cohen, 1993). Johnson, Crowley, and Sigler (1992) estimated that only 60% of battered women's shelters offered counseling of any type to children; yet 70% of the mothers who enter a shelter report the safety of their children as the primary reason for seeking assistance (Henderson, 1990; Hilton, 1992). The ramifications of the shortage of therapeutic services for child witnesses is alarming, particularly in light of the substantial negative impact of domestic violence on child development. Extensive empirical research has identified "a host of behavioral and emotional problems" in child witnesses of domestic violence in comparison to other children (Edleson, 1997, p. 860).

The phenomenon of *intergenerational transmission of violence* is a well-documented reality (Fantuzzo & Lindquist, 1989; Miller, Handal, Gilner, & Cross, 1991; Singer, Miller, Suo, Slovak, & Frierson, 1998). There is a correlational linkage between the exposure to domestic violence and a child's likelihood to exhibit violent behavior in the future (Miller et al., 1991; Singer et al., 1998; Spaccarelli, Coatsworth, & Bowden, 1995).

Child witnesses have been reported to demonstrate more internalizing and externalizing behaviors when compared to children not exposed to domestic violence (Fantuzzo, DePaola, Lambert, Martino, Anderson, & Sutton, 1991; Hughes, Parkinson, & Vargo, 1989). Children's exposure to adult domestic violence renders them more likely to cognitively justify their own use of violence (Carlson, 1991; Edleson, 1997; Spaccarelli et al., 1995; Wolfe, Zak, Wilson, & Jaffe, 1986).

Numerous studies have identified long-term developmental problems in adults who witnessed domestic violence during childhood--including depression, trauma-related

symptoms, low self-esteem, greater emotional distress, lower social adjustment, violent and violence-tolerant roles in intimate relationships, and later adult violent and criminal activity (Henning, Leitenberg, Coffey, Turner, & Bennett, 1996; Maker, Kemmelmeir, & Peterson, 1998; Silvern, Karyl, Waelde, Hodges, Starek, Heidt, & Min, 1995; Spaccarelli et al., 1995; Widom, 1989).

Only recently have researchers increased efforts at investigating appropriate prevention and intervention programs for children caught in the cycle of family violence (Tutty & Wagner, 1994). Further research is essential to develop a knowledge base of mediating factors that seem to protect children from the negative impact of domestic violence (Edleson, 1997). Horton, Cruise, Graybill, and Cornett (1999) identified a “paucity of quality research to guide the development of innovative treatment interventions for child witnesses...and a near absence of research-based treatment services for child witnesses of domestic violence” (p. 88).

Group programs have been identified as the most available services for school-aged child witnesses in domestic violence shelters (Layzer, 1986; Peled & Davies, 1994). The groups were highly structured with specific goals and educational activities designed to achieve these goals (Peled & Davies, 1994) and generally focused on information regarding abuse and protective behaviors (Jaffe et al., 1990). Tyndall-Lind (1999) expressed concern that, though structured educational groups may provide empowerment through knowledge, such treatment lacked “two crucial qualities: utilization of an expressive mode that can be accessed by children of all ages and verbal abilities; and

utilization of relationships and social skills to negotiate problematic issues which are occurring in the moment” (p. 3).

Watson (1986, as cited in Butterworth & Fulmer, 1991) recommended the use of play for assessment and play therapy with children for expression of feelings about the trauma of domestic violence. Kot, Landreth, and Giordano (1998) identified play therapy as a therapeutic intervention for meeting the breadth of needs of child witnesses residing in a shelter facility. Play therapy has been documented as an effective therapy of self-expression, facilitated by the emotionally safe presence of the play therapist (Axline, 1947; Gil, 1994; Ginot, 1961; Landreth, 1991; Moustakas, 1959). Kot, Landreth, and Giordano (1998) found that intensive individual play therapy with child witnesses of domestic violence facilitated a significant increase in self-concept, a significant reduction of behavioral problems and a significant reduction of externalizing behavior

Tyndall-Lind (1999) integrated group play therapy with Kot’s (1995) intensive play therapy treatment design and created an intensive sibling group play therapy model for use with child witnesses residing in a shelter facility. Tyndall-Lind asserted that group play therapy with siblings provided child witnesses an opportunity to address developmental issues, emotional issues, social issues, and family relational patterns, simultaneously, all within a short time frame. Tyndall-Lind’s results indicated that child witnesses who received sibling group play therapy experienced significant gains in self-concept, a reduction in reported behavioral problems, a lessening in levels of anxiety/depression, and a reduction of aggressive behavior.

Davies (1991) proposed conjoint treatment with the mother and child as an approach for very young children who had witnessed domestic violence. The physical and emotional safeties provided by shelter staff create a logistical *window of opportunity* for mother-child involvement. The family's sudden retreat to a shelter, temporarily distancing them from daily interaction with family, friends, and participation in after-school activities, provides an opportune time for mothers to become involved in their children's healing process. The existing parent-child bond fosters a safe beginning to explore and express the psychological distress that has accumulated amidst the violent turmoil within the family (Lehmann & Carlson, 1998).

The added value of involving parents in a child's clinical treatment has been well-documented across a variety of formats, presenting problems, and theoretical orientations (Esparza, 1993; B. Guerney, 1964; Gurman, Kniskern, & Pinsof, 1986; Hildebrand & Forbes, 1987; Kazdin, 1987; Landreth, 1991; Moustakas, 1959; Reppucci et al., 1997). Esparza (1993) cited the mother as a crucially important factor in a child's recovery from sexual abuse. Wolfe (1987) identified disturbances in the parent-child relationship as a factor associated with high-risk for developmental and behavior problems in children experiencing abuse and neglect, suggesting the need for healthy parent-child relationships as a mediating factor of problems within the child.

By building on the emotional bond which naturally exists between the parent and child professionals can empower parents by teaching them basic psychotherapeutic techniques. Filial therapy is an innovative model that trains parents to become *therapeutic agents of change* in their children's lives by utilizing the parent-child

relationship as the catalyst for growth, thus the term *filial therapy* (B. Guerney, L. Guerney, & Andronico, 1966; Landreth & Lobaugh, 1998). Filial therapy is well researched and has been shown to be effective with children presenting *normal* to *severe* behavioral and emotional problems and with families from very diverse backgrounds, stressful life circumstances, and *at risk* factors often correlated with poor child outcome (Andronico & Blake, 1971; Bratton & Landreth 1995; Chau & Landreth, 1997; Costas & Landreth, 1998, Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; B. Guerney, L. Guerney, & Vogelsong, 1980; Harris & Landreth, 1997; Landreth, 1991; Landreth & Lobaugh, 1998).

Filial therapy utilizes parents as the primary agent of treatment, training parents in child-centered play therapy skills for use with their own children (B. Guerney, 1964; L. Guerney, 1997; Landreth & Lobaugh, 1998). The primary objectives of filial therapy are to: (a) help children reduce problem behaviors and internal emotional distress, (b) assist parents in acquiring “play therapy skills” for eventual “use in everyday life when relating to [children], and (c) strengthen and enhance the parent-child relationship” (L. Guerney, 1997, p. 136).

The filial therapy model is based on the fundamental assumption that parents can learn and employ the therapeutic skills used by child-centered play therapists with such effectiveness that their children will emotionally and behaviorally recover from trauma and developmental difficulties (B. Guerney, 1964). In a small group educational format, parents receive didactic instruction, *hands-on* learning experiences, and emotional support from the group leader. Parents practice their new relational skills by conducting

special parent-child play sessions with their own children as advocated by Axline (1947) and Moustakas (1959).

“Unlike more behaviorally oriented therapies, this model of therapy is not directed toward specific problems, but rather focuses on strengthening the parent-child relationship” (Costas & Landreth, 1999, p. 3). The parent-child play sessions help the child come to understand more clearly the parents’ feelings, attitudes, and behaviors toward the child and allow the child to communicate thoughts, needs, and feelings to parents through the medium of play (B. Guerney, 1964; L. Guerney, 1997). As a result of the parents’ focused attention, acceptance and empathic understanding, the child gains a greater feeling of self-respect, self-worth and confidence (B. Guerney, 1964).

The rationale for using filial therapy with mothers of child witnesses of domestic violence is two-fold: (a) the proven effectiveness of filial therapy to help reestablish relationships of trust, respect, and understanding between parents and their children, and (b) the significant emotional and behavioral changes achieved within children and parents who have participated in previous filial therapy research studies.

Filial therapy has been found to be effective in increasing parental self-esteem, improving parental efficacy (Glass, 1987; Kezur, 1980; Packer, 1980), and increasing parental acceptance of their children (Bratton, 1995; Glass, 1987; Lebovitz, 1983; Landreth & Lobaugh, 1998; Sensue, 1981; Sywulak, 1979). Parental acceptance of their children has been linked to higher levels of self-esteem in children (Porter, 1954).

“Increased self-esteem in both parents and children provides confidence, energy, and optimism to master life’s tasks” (Glover, 1996). Many studies have shown filial therapy

to be effective in reducing parental stress, fostering a more positive parental attitude, improving communication with other family members, and increasing parents' involvement with their children (Bratton, 1995; Kezur, 1980; Packer, 1990; Wall, 1979).

Filial therapy has been effectively used with parents of emotionally disturbed children (Sensue, 1981; Sywulak, 1979); parents of children with mild to moderate emotional and behavioral difficulties (B. Guerney & Stover, 1971; Glass, 1986; Lebovitz, 1983; Oxman, 1972; Payton, 1980); teachers of withdrawn children, (B. Guerney, & Flumen, 1970), parents of learning-disabled children (L. Guerney, 1979; Kale, 1997); parents of children with stuttering problems (Andronico & Blake, 1971); parents of chronically-ill children (Glazer-Waldman, 1991; Glazer-Waldman et al., 1992; Tew, 1997); single parents (Bratton & Landreth, 1995), incarcerated fathers (Landreth & Lobaugh, 1998); incarcerated mothers (Harris & Landreth, 1995); parents of sexually abused children (Costas & Landreth, 1999); and parents of minority descent (Chau & Landreth, 1997; Glover, 1997; Yeun, 1997). In addition, process studies of methodology and qualitative studies have reported improved communication, greater feelings of parental competence, improvements in the behavior of the children involved and positive change in family dynamics (Bavin-Hoffman & Landreth, 1994; Lahti 1993; Packer, 1990).

A therapy that focuses on strengthening the parent-child relationship seems particularly appropriate in light of the dysfunctional relationships and imbalance of power that dominates families of domestic violence. The relational core of filial therapy could potentially begin a new pattern of reciprocal relationships within the family,

helping to break the current cycle of violence and victimization within the family system. Often the ability of child witnesses to trust others has been fragmented by the patterns of disregard and misuse of power within the family. Therefore, the safe process of one-on-one parent-child play sessions with a parent trained to respond with acceptance and empathy is well suited to the needs of child witnesses.

Purpose of the Study

The purpose of this investigation was to determine the effectiveness of an intensive version of the Landreth (1991) 10-week filial therapy model as a method of intervention for child witnesses of domestic violence. Specifically, this study was designed to determine the effectiveness of intensive filial therapy in: (a) improving the self-concept of child witnesses of domestic violence; (b) reducing internalizing behavior problems, such as withdrawal, somatic complaints, anxiety, and depression of child witnesses of domestic violence; (c) reducing externalizing behavior problems, such as aggression and delinquency, of child witnesses of domestic violence; and (d) reducing overall behavior problems, including internalizing and externalizing behavior problems, social problems, thought problems, and attention problems of child witnesses of domestic violence.

A second purpose of this investigation was to determine the effectiveness of intensive filial therapy with residents of a domestic violence shelter in increasing the mothers': (a) empathic responsiveness with their children, (b) communication of acceptance to their children, (c) allowance of self-direction by their children, and (d) involvement in their children's play activities.

A third purpose of this investigation was to compare the effectiveness of intensive filial therapy with intensive individual play therapy (Kot & Landreth, 1997) and intensive sibling group play therapy (Tyndall-Lind, 1999) with child witnesses of domestic violence who are residing in a domestic violence shelter.

Literature Review

Domestic Violence and Child Witnesses

“Battering of women is one of the most pervasive and dangerous social problems in American society” (Roberts & Burman, 1998, p.3). According to 1996 National Council on Child Abuse and Neglect (NCCAN) statistics, of the “1,011,628 children who were determined to be actual victims of abuse and neglect during 1994, 5,400 children died as a result of the maltreatment” (as cited in Reppucci et al., 1997, p. 2). Of all female homicides, 31% are attributed to domestic violence (U.S. Department of Justice, as cited in Mills, 1998). “The United States Advisory Board on Child Abuse and Neglect (1995) found that domestic violence is the single major precursor to child deaths in the United States” (Mills, 1998, p. 132). “There is a direct link between domestic violence and child abuse. Batterers do not limit abuse to partners. Studies suggest that 45 to 70% of batterers, also, abuse their children” (American Humane Society, as cited in Mills, 1998, p. 131). Only an estimated 11% of the women abused seek care in emergency departments (Mills, 1998). O’Keefe (1995) found that in 47% of families in which a batterer abused his adult partner, the batterer abused his children.

“Another form of child abuse is the witnessing of domestic violence itself. The effect of witnessing domestic violence can be devastating. Children who witness domestic violence show symptoms similar to children who have been physically, sexually, or emotionally abused” (Echlin & Marshall, 1995, as cited in Mills, 1998, p. 133). Witnessing a violent event is most commonly thought to mean that the child has actually *seen* first hand, the violence between parents. However, child witnessing includes, not only a child’s directly *seeing* violent behavior, but, also, *overhearing*, *being triangulated* in the fighting and [or] being involved in the *aftermath* of the violence. *Overhearing* leaves children with the horror of visualizing what is actually happening (e.g., hearing glass shatter...hearing a shot followed by dead silence...imagining a parent wounded or killed). Children find themselves being *triangulated* in violent episodes (e.g., physically defending one parent from the other, trying to distract or appease a parent to avoid injury) and/or handling the *aftermath* of violent incidents (e.g., calling 911, comforting younger siblings, cleaning up broken glass) in an effort to minimize the damage. Edleson (1999) reports that all four forms of witnessing...*seeing*, *overhearing*, *triangulation* and *involvement in the aftermath*...can be emotionally disruptive and damaging to children, potentially creating psychological stress and trauma that can be severe and long lasting.

Impact of Domestic Violence on Child Witnesses

A growing body of research has documented a wide range of “childhood problems statistically associated with a child’s witnessing of domestic violence” (Edleson, 1999, p. 845). Edleson (1999) concluded, “child witnesses of domestic violence

exhibit a host of behavioral and emotional problems, when compared to other children” (p. 860). These problems include difficulties with: (a) behavioral and emotional functioning, (b) cognitive functioning and attitudes, (c) family relational/family system dynamics, and (d) associated problems that cut across categories and provide evidence of long-term developmental issues for child witnesses (Edleson, 1999). Despite some contradictory information in the research and inconclusive findings in the literature, Kolbo (1996) asserted that the preponderance of evidence indicates it is “reasonable to assume that exposure to violence has some impact on children” (p. 113-114).

Child witnesses have been reported in numerous studies to demonstrate more aggressive and violent behaviors and more externalizing and internalizing behaviors when compared to non-exposed children (Fantuzzo et al., 1991; Hughes, 1988). Externalizing behaviors are generally defined as more aggressive- and antisocial-type behaviors, whereas internalizing behaviors are generally described as fearful and withdrawn behaviors (Edleson, 1999). Children from families living in shelters for battered women, both *abused* witnesses and *non-abused* witnesses, have elevated scores for externalizing and internalizing behaviors when compared to normative populations (O’Keefe, 1995; Sternberg et al., 1993). Of the child witnesses studied by O’Keefe (1994a) more than 21% of the children, ages 7 to 13, had externalized problems of such severity that they fell within the 98th percentile of severe disturbance; and 31% scored in the 98th percentile on internalized problems.

Discrepancies in the literature exist regarding the impact of domestic violence on cognitive functioning in child witnesses. However, research has confirmed that children’s

exposure to adult domestic violence renders them more prone to cognitively justify their own use of violence (Spaccarelli et al.; Carlson, 1991; Edleson, 1999). Rossman (1998) determined, from a sample of 400 children ages 4 to 13 years, children exposed to domestic violence exhibited somewhat poorer cognitive functioning (observed mainly in the younger children) and higher levels of Post-Traumatic Stress Disorder (PTSD) symptoms. PTSD symptoms appeared to compromise cognitive functioning and behavior problems involved in social and school performance. Numerous studies have identified long-term developmental problems with adults who witnessed domestic violence during childhood, including correlations with: (a) adult reports of depression, (b) trauma-related symptoms, (c) low self-esteem, (d) greater emotional distress, (e) lower social adjustment, (f) tolerance of violence in intimate relationships, and (g) later adult violent and criminal activity (Rivera & Widom, 1990; Silvern et al., 1995; Spaccarelli et al., 1995; Widom, 1989).

Henning et al. (1996) determined women who witnessed domestic violence as children were found to have more psychological and social adjustment problems in adulthood. Maker, Kemmelmeir, and Peterson (1998) found women who witnessed violence in their family of origin exhibited negative long-term adjustment difficulties and experienced more violence in dating relationships than non-witnesses. The witness group, likewise, exhibited more depression, more symptoms of trauma and higher levels of antisocial behavior than those who had not witnessed violence. While the exact causal relationship between witnessing violence in the home and further difficulties in functioning has not yet been determined, research clearly shows that this experience has a

negative impact on the continuing development of the child witness.

Silvern et al. (1995) statistically controlled for the co-occurrence of multiple stressors (e.g. histories of drug and alcohol abuse, single parenting, shelter residence and poverty) in order to isolate the long-term effects of domestic violence on adults who had witnessed domestic violence as children. Silvern et al. (1995) determined that when abuse as a child was statistically controlled, the effects of witnessing approached, but did not reach significance, for both men and women. A possible explanation was that most often children who have been studied were “from violent families characterized by multiple stressors and various forms of maltreatment (Aber & Cicchetti, 1984); therefore, researchers have had difficulty discerning how different forms of domestic violence affect children’s behavior and development” (Sternberg et al., 1993, p. 44). Sternberg et al. (1993) created a study for the purpose of discerning “how different forms of domestic violence affect behavior and development while controlling for the effects of [other factors]” (p. 44). The findings indicated children who witness violence in the family and are, also, abuse victims themselves were more likely to report depressive symptoms and internalizing and externalizing behavior problems than were reported by non-witness children in the comparison group (Sternberg et al., 1993).

An unexpected finding in the Sternberg et al. (1993) study was children who witnessed spousal abuse and were abused themselves were not reported to have more problems than non-abused child witnesses, a contradiction to the “double whammy” effect reported by Hughes et al. (1989). This “counterintuitive finding...suggested that the co-occurrence of victimization and witnessing did not add to the trauma experienced

by children who experienced abuse as victims or witnesses” (Sternberg et al., 1993, p. 51). Yet, Sternberg et al. predicted that a potential *cumulative effect* could eventually emerge with abused witnesses as a result of an accumulation of multiple stressors.

Research has revealed conflicting evidence concerning the age of greatest vulnerability for child witnesses. Some researchers suggested that older children are more vulnerable (Wolfe, Jaffe, Wilson, & Zak, 1985), while others reported younger children as more vulnerable to negative consequences of domestic violence (Eth & Pynoos, 1986; Hughes & Barad, 1983). Contradictory findings also exist around gender. Some research findings have indicated that girls are at a greater risk of psychological disturbances when witnessing domestic violence (Christopoulos, Cohn, Shaw, Joyce, Sullivan-Hanson, Kraft, & Emery, 1987; Hughes & Barad, 1983), while other studies indicated that boys are more vulnerable to its effects (Jaffe et al., 1986; Wolfe et al., 1985; Kilpatrick & Williams, 1998).

The incidence of PTSD among child witnesses has been identified in the literature. PTSD is an “anxiety disorder caused by overwhelming traumatic stress (American Psychiatric Association, 1995) with three major symptom categorizations: (a) re-experiencing the trauma, (b) persistent avoidance of trauma-related stimuli or psychological numbing, and (c) symptoms of increased arousal not present before the trauma” (Kilpatrick & Williams, 1998, p. 319).

A child’s subjective perception as to the danger of a threat has been considered to be a major contributor to the development of PTSD symptoms and may be correlated with witnessing violence in the home (Nader, 1993). Though not directly addressed with

child witnesses of domestic violence, several studies linked feelings of guilt or self-blame that may mediate the severity of PTSD (Pynoos & Nader, 1990). Noteworthy in the Kilpatrick and Williams (1998) study was the finding that “neither the intensity nor the frequency of the violence gained significance in predicting PTSD” (p. 328). This suggests that witnessing domestic violence has the potential to induce a trauma reaction within children regardless of how severe or how frequent the violence occurs. The time variable (six weeks to three years) was irrelevant in predicting PTSD levels, which suggests “being exposed to DV has a chronic, long-term impact upon the psychological well-being of the child witness...and suggests that children remain significantly disturbed long after the state of the crisis has eased...even when the children have stabilized in new living conditions” (Kilpatrick & Williams, 1998, p. 328).

Intergenerational Transmission of Violence and Need for Intervention Services

Witnessing domestic violence has been shown to create long-term developmental difficulties that converge into what has been identified in the literature as the *intergenerational transmission of violence* (Fantuzzo et al., 1991; Widom, 1989). Considering the power of parents’ modeling on their children, it is predictable (and confirmed empirically) that children whose parents engage in domestic violence carry a propensity to perpetuate the cycle of abuse into the next generation. Fantuzzo and Lindquist (1989) found that violence observed at home in childhood was repeated later in life. Strauss and Gelles (1986, as cited in Mills, 1998) found “in a comparison of violent men with a control group of nonviolent men--sons of violent parents have a rate of wife-beating 900 times greater than that of sons of non-violent parents” (p. 133).

Child witnesses of domestic violence are reported to: (a) use less direct problem solving, (b) use more aggression to cope with conflict, (c) condone violence to resolve relationship conflicts more readily than members of control groups (Wolfe et al., 1986), and (d) score significantly higher on the Child Abuse Potential Inventory than child non-witnesses (Singer et al., 1998).

Singer et al. (1998) found that being a recent victim or witness of violence at home was a significant factor in predicting reactive behaviors of violence in children 7 to 15 years of age. In studies of couples engaging in violent episodes, 10% of the couples reported repeated physical abuse. Couples who are between the ages of 20 and 30 are more likely to engage in physical violence than older couples and are more likely to have small children in the home (Fantuzzo & Lindquist, 1989).

Despite the expanding documentation that child witnesses are at extreme risk for psychological disturbance and are *at risk* of carrying the family legacy of conjugal violence into adulthood, “extensive therapeutic programs for child witnesses of domestic violence are rare” (Horton et al., 1999, p. 88). Clinical interventions and preventative measures for child witnesses have not kept pace with comprehensive services for female victims of domestic violence (Roberts & Burman, 1998). The National Clearing House on Family Violence (1995, as cited in Lehmann & Carlson, 1998) estimated that only 31% of the shelters in the United States and Canada have children’s programs.

Intervention Through Preventive Parent Training and Education

Parent training has been recognized in the literature as a primary avenue of prevention and intervention with child abuse and child maltreatment (Reppucci et al.,

1997). Reppucci et al. (1997) identified three types of prevention: (a) primary prevention, (b) secondary prevention, and (c) tertiary prevention. Primary prevention is an intervention designed to prevent a specified problem from occurring. Secondary prevention is an early identification and early intervention aimed at keeping the problem from developing further. Tertiary prevention is an intervention structured to reduce the severity and ensuing effects of a problem after it has occurred by means of rehabilitation and treatment.

Justification for parent education [training] as an intervention for improving family function (generally) and preventing abuse and neglect (specifically) have been based on developmental research on socioeconomic (SES) status, deprivation, critical periods, interactions between child and mother (at the expense of other caregivers), and laboratory manipulation (Reppucci et al., 1997, p. 24).

In an extensive review of the literature concerning parental behavior and child outcome, Clarke-Stewart (1983) concluded the lines of research converge on the conclusion that parental behavior does affect development throughout childhood, adding credence to the importance of parent training as a preventive intervention with child problems (p. 24).

Research studies of children with conduct disorder have shown that the utilization of parents as a treatment component contributes to successful treatment (Kazdin, 1987). An empirical link between parent training and children's gain, psychologically and behaviorally, is clearly confirmed by clinical psychologists who have trained parents as a treatment component for children with oppositional defiance and conduct disorder and have determined parent management training (PTM) to be among the most effective treatments for conduct disorder in children. Research findings indicated that not only did parent training help the child targeted for treatment, but that siblings benefited as well.

As parents generalized their new skills and attitudes with other siblings, the benefits were magnified within the family. What began initially as a treatment intervention for one child became a preventive intervention with the other children in the family (Kazdin, as cited in Reppucci et al., 1997, p. 28).

Parent education including a family support component has been validated as a crucial intervention for preventing family violence (Reppucci et al., 1997, p. 2). Wolfe concluded that intervention must be implemented conjointly on three levels: (a) the level of the individual family, (b) the community level, and (c) the societal level. An extensive review of research has verified the most effective parent programs with *at risk* families are: (a) child-centered, (b) parent-focused, (c) voluntary, and (d) neighborhood-based (Reppucci et al., 1997). *Child-centered* implies a focus on the needs of the child. *Parent-focused* refers to giving supportive attention to the personal needs of parents. The social support functions of parent education programs were found to be essential for positive changes to occur.

Werkerle and Wolfe (1993) identified a small group format for parent education as being a valuable, unique support function that is not available in individual sessions. The supportive presence of other parents and realization that others share similar struggles and questions is believed to strengthen the change process and enrich the experience for parents (Reppucci et al., 1997). Parents who interpret developmental limitations as deliberate non-compliance are likely to exhibit frustration and anger and become potentially abusive (Belskey & Vjondra, 1989). Showers (1991) noted parents' ignorance of child development and basic child-rearing practices as a major contributor to parental stress. Some physical abuse of children has been assessed as extreme forms of

discipline believed to be due to parents uncertainty about developmentally appropriate behavior coupled with unrealistic parental expectations (Altepeter & Walker, 1992).

Parent education that pairs parental support with pertinent education has been found to reduce parental stress. Research has clearly confirmed a higher success ratio in parents making positive changes when the parent training integrates “educational services with meaningful social supports” (Swick, 1989, p. 25). Willis, Holden, and Rosenberg (1992) summarized the underlying assumptions of parent education research as follows: *If* parental stress can be reduced, *if* parents can broaden their knowledge of child development, and *if* parents’ coping skills and supportive networks can be enhanced, *then* many forms of child maltreatment may be prevented.

Need for Intervention By Shelter Staff

From a trauma perspective, the “optimal time for prevention and intervention is during the acute period following exposure to the traumatic event, when intrusive reminders are most identifiable and associated affect is most available” (Pynoos & Nader, 1993, as cited in Lehmann & Carlson, 1998, p. 103). A domestic violence shelter serves as a “safety net,” providing a safe setting in which mothers and children have the opportunity to address the crises that accompany the recent or prolonged abuse (Lehmann & Carlson, 1998, p. 99). Ideally, children entering a shelter should have a stabilizing therapeutic relationship with an adult who can help them begin the journey to recovery (Alessi & Hearn, 1998; Lehmann & Carlson, 1998; O’Keefe & Lebovics, 1998). In the absence of a therapeutic connection with a trusted adult, child witnesses may find it more difficult, if not impossible, to begin the slow process of releasing emotional pain and

defensive behaviors which they have developed as coping strategies. Shelter counselors need to be equipped with an effective therapeutic intervention that will meet the varying treatment needs of child witnesses (Lehmann & Carlson, 1998).

Play Therapy Intervention with Child Witnesses

Play therapy is a dynamic therapy that has emerged to the forefront of child therapies over the past three decades (Gil, 1991; 1994; James, 1997; Landreth, 1991) and is recognized as a “most effective medium for conducting therapy with children” (Gil, 1994, p. 3). The first recorded account of using play as a method of therapy occurred in 1919 when “Hug-Hellmuth introduced the opinion that play was an essential part of psychoanalysis with children” (Gil, 1994, p. 3). Anna Freud (1928; 1948; 1964) and Melanie Klein (1959) contributed to the incorporation of play into the psychoanalytic treatment of children. “Virginia Axline, a student and later a colleague of Rogers, applied the principles of person-centered therapy as formulated by Carl Rogers (1951) to children and created what is commonly known as child-centered play therapy” (Landreth, 1997, p. 17). Clark Moustakas (1959) and Hiam Ginott (1961) contributed to Axline’s original work of adapting core phenomenological and existential ideas for use with children. The combined work of Axline (1947), Moustakas (1959), and Ginott (1961) emerged into the unique theory and methodology of child-centered play therapy that a type of child therapy which is developmentally appropriate for counseling with children presenting a wide range of difficulties & diagnoses (James, 1997).

The literature across clinical, educational, and developmental domains historically has characterized play as an essential activity in child development, a process crucial to

healthy child outcomes. Erikson (1963, as cited in Gil, 1994) depicted play “as an emotional laboratory in which the child learns to cope with [his or her] environment” (p. 4). Axline (1947) identified play as the child’s natural medium of self-expression and described toys as the words and play as the language of children. The child’s use of play as a language of expression can best be understood by looking at the developmental pathways of early childhood. Because children’s ability to think, conceptualize, and communicate through language develops in increments from infancy to adolescence, children are not able or ready to primarily express themselves through words (Landreth, 1991).

“Children do not rely exclusively on language...Children rely on and use facial expressions, intonations of voice, physical movement, and postures to communicate, whereas adults rely primarily on verbal communication, a far more limited repertoire” (Gil, 1991, p. 35). According to Landreth (1991), the therapist uses play with children because play is the child’s symbolic language of self-expression, an avenue in which children symbolically express the “internal conflicts, emotional turmoil, and uncertainties that are within them” (p.10).

The child-therapist relationship is recognized as pivotal to releasing the healing process within the child (Axline, 1947; Ginott, 1961; L. Guerney, 1983; Landreth, 1997; Moustakas, 1959). Landreth (1991) described the actual clinical treatment of a child as occurring within a relationship and within a physical context that is different from any other the child has experienced. The “play therapist’s objective is to relate to the child in ways that will release the child’s inner directional, constructive, forward-moving,

creative, self-healing power” (Landreth, 1991, p. 17).

In play therapy, children give concrete form and meaning to emotionally significant experiences and feelings that might be too frightening unless expressed in fantasy (Landreth, 1991). The child “strives to master perplexing confusions, conflicts and skills for living in the grownup world” (Frank, 1982, p. 24). Unfortunately, the *grown-up world* in which most child witnesses have lived is filled with contradictions and violence--experiences that, if allowed to remain dormant within the child, could become detrimental to the child’s healthy development. It is common for child witnesses to re-enact traumatic events in play and to create symbolic traumatic play themes (Pynoos & Nader, 1993). Pynoos and Nader (1993) reported that the attending adult’s response to the traumatic play of children in a shelter is crucial for the child to feel relief instead of increased anxiety. Though the literature reflects play therapy as a recommended treatment with children in shelter facilities, play therapy with shelter residents has been typically limited to very young children (Layzer et al., 1986).

Kot (1995) and Tyndall-Lind (1999) initiated similar, yet separate studies, focusing on treatment interventions for child witnesses who were residing in domestic violence shelters with their mothers. They utilized child-centered play therapy as the treatment of choice because of its proven effectiveness with emotional and behavioral problems commonly presented by child witnesses. Kot (1995) and Tyndall-Lind (1999) determined that child-centered play therapy seemed compatible with the needs of child witnesses to be engaged in a relationally based therapy that was nurturing, non-threatening and adaptable to the varying levels of emotional and behavioral dysfunction

frequently present in child witnesses. To accommodate the short length of stay families were at the shelter and to capitalize on the children's availability, Kot (1995) utilized an intensive individual play therapy model that collapsed the time between sessions from the traditional one-session-per week schedule into a two-week, daily treatment model. This collapsed model increased the frequency of sessions and, thereby, increased the overall number of sessions for the children than would have been possible with less intense studying.

Kot, Landreth, and Giordano (1995) reported that child witnesses who received 12 daily intensive individual play therapy sessions made a significant shift from conflict-ridden play themes to creative, constructive, and nurturing themes based on a direct observation coding system rated by trained raters (Kot, Landreth, & Giordano, 1998). Children receiving intensive play therapy as compared to the control group showed a significant increase in self-concept as indicated by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) and demonstrated a significant reduction in the scores on total behavior problems of the Child Behavior Checklist (CBCL). In addition, mothers reported that their children demonstrated less withdrawal, somatic complaints, anxiety, depression and aggression (Kot, Landreth, and Giordano 1998). Child witnesses in the experimental group showed a significant reduction on the externalizing behavior scale of the CBCL. Kot concluded that the study demonstrated the promising effectiveness of intensive play therapy as: (a) an intervention for problematic behaviors, (b) a prevention to preclude the development of problematic behaviors, and (c) a treatment intervention used to deal with the traumatic aspects of witnessing inter-parental

violence for children between the ages of 4 and 10 years old, residing at a domestic violence shelter.

Building on the Kot, Landreth, and Giordano (1998) study, Tyndall-Lind (1999) hypothesized that an even more dynamic treatment intervention could be achieved by incorporating the benefits of group play therapy and the established bond between siblings into Kot's daily play therapy treatment design. Tyndall-Lind's (1999) model was based on the assumption that siblings placed in a play therapy group together would address individual issues, sibling relationships and shared family dynamic issues, all within the context of the shared group experience. The children in the experimental sibling group play therapy showed a significant increase in self-concept while children in the control group without therapeutic intervention declined in self-concept, as determined by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST). The children in the intensive sibling groups demonstrated a significant decrease in total behavior problems at the time of posttesting as measured by the Child Behavior Checklist (CBCL) as compared to an increase in the control group's total behavior scores on the CBCL. A significant reduction in externalizing behavior problems which indicated a reduction in the children's level of hostility and conflicting behaviors, as reported on the CBCL, was noteworthy, particularly in light of the propensity of child witnesses to behave aggressively (Miller et al., 1991; Singer et al., 1998). The experimental group demonstrated a significant reduction in internalizing behavior problems on the CBCL, indicating that, "mothers perceived their children as exhibiting fewer behavior problems associated with withdrawal, somatic complaints, and anxiety/depression" (Tyndall-Lind,

1999, p. 87). Tyndall-Lind (1999) concluded the results of the study suggested that “participation in a sibling play therapy group may aid in the secure transition from the home to the shelter which, in turn, may account for a reduction of total behavior problems” (Tyndall-Lind, 1999, p. 82).

Tyndall-Lind’s (1999) comparative analysis revealed that the intensive sibling group play therapy and intensive individual play therapy were equally effective as an intervention with child witnesses. However, in comparing specific differences in measurement scores from the intensive individual play therapy with intensive sibling group play therapy, Tyndall-Lind (1999) concluded that “overall, intensive sibling group play therapy has the potential to be more helpful with issues related to emotional and social difficulties (as indicated by the significant reduction of scores on the total behavior scale, externalizing and internalizing behavior subscales on the CBCL), while intensive individual play therapy has the potential to be most helpful with attention and concentration difficulties” (Tyndall-Lind, 1999, p. 92). A possible explanation in favor of the intensive sibling group play therapy model may be these children began the therapeutic process within an already existing familial relationship. The “loving connection” between siblings may, in fact, have facilitated an experience of “non-threatening support” which, in turn, enhanced catharsis within the group experience (Tyndall-Lind, 1999, p. 95).

Filial Therapy Intervention with Child Witnesses

Just as the pre-existing relationship of siblings was believed to have expedited the therapeutic process in the Tyndall-Lind (1999) study, the use of the mother-child

relationship may be as promising, if not more so, in helping child witnesses. The literature across many educational and psychological fields has identified the mother-child relationship as one of most important relationships influencing a child's development (Ainsworth, 1979; Clark & Stewart, 1983; Esparza, 1993; Hamner & Turner, 1996; Mahler, 1968).

Edleson (1997) concluded, "children's relationships to their mothers...have been identified as a key factor in how children are affected by witnessing domestic violence" (p. 863). Training mothers of child witnesses to be an integral component of their child's treatment could conceivably facilitate positive change in, not only the child targeted for treatment, but in the mother who often is feeling so discouraged in herself as a parent (Lehmann & Carlson, 1998; Roberts & Burman, 1998). Such an intervention could potentially have multi-dimensional benefits for the children, the mother, and the entire family.

As early as the 1950s, Moustakas (1997) recommended parents have play sessions with their children, modeled after traditional play therapy. "Play therapy in the home is essentially a relationship...through which the child discovers himself...opens himself to emotional expression and in the process releases tensions and repressed feelings" (Moustakas, 1959, p. 275). Moustakas (1997) explained that,

Play presents opportunities for parents to enter their children's worlds and learn what is essential to them. It invites parents to convey they're valuing of their child, and their acceptance, support, and understanding of her or him. Children's play holds meanings; the parent-child relationship is enhanced when parents recognize these meanings (p.17).

Rather than expect children to struggle to use the abstract concepts of verbal language (used by adults), B. Guerney (1964) conceived of teaching parents to *re-learn* the child's *language of play* so that parents could enter the child's world to convey understanding and encouragement. He conceptualized filial therapy as a "preventive measure and as a method of building a foundation in childhood for better mental health and self-realization in adulthood" (p. 343).

Filial therapy is an innovative therapeutic model that is built on the premise that a child's relationship with his/her parent is a core determinant of child outcome, positively or negatively, and a powerful resource for facilitating healthy development in children. The objective of filial therapy is to enable the parent to become a "*therapeutic agent* in the child's life by utilizing the naturally existing parent-child bond, hence the term *filial therapy*" (Landreth & Lobaugh, 1998, p. 158).

B. Guerney (1964) believed that by training parents to relate differently to their children, the child, the parent and the parent-child relationship could all three be altered through the single intervention of filial therapy. He viewed child adjustment problems as "not typically a result of parental pathology...but a product of parents" not having learned "how to understand their children and to respect the children's perspectives" as well as "not knowing how to exercise reasonable nonviolent control over their *children*" (L. Guerney, 1997, p. 135).

The focus of filial therapy training is on the child rather than the child's problems, and on the parent-child relationship rather than the counselor-child relationship (Landreth & Lobaugh, 1998). Through a unique blend of didactic instruction, experiential learning,

and practicum experience, parents develop the abilities to convey acceptance, empathy and encouragement to their children. The filial therapy model provides parents with the training and support necessary to guide them step-by-step “toward healthier parent-child interactions” (Landreth & Lobaugh, 1998, p. 158). “This new creative dynamic of empathic responding...becomes the creative process through which change occurs *within* the parent, *within* the child and *between* parent and child” (Landreth, 1991, p. 339).

Typically, a filial therapy class is limited to a maximum of eight parents. This small group format provides a supportive, encouraging learning environment for parents and ample time for each parent to receive encouragement and support from the instructor. Additionally, parents are able to participate in *hands-on* learning experiences and receive feedback on weekly parent-child play sessions (L. Guerney & B. Guerney, 1989; Landreth, 1991; Landreth & Lobaugh, 1998). Parents are encouraged to put their new skills into practice by conducting assigned weekly play sessions with one of their children. In the Landreth (1991) model, these practice sessions consist of a 30-minute *Special Play Time* with a *child of focus*, generally conducted in the home with a specified set of toys and play materials. Guerney’s (1964) model allowed *Special Play Times* with all children in the family. If necessary, sessions can also be conducted at the instruction site.

A few differences exist between filial therapy models. The B. Guerney (1964) model includes a phase one period of several weeks to prepare parents before initiating parent-child practice play sessions. Guerney’s model usually requires six months to a year of training from start to finish (Guerney, 1983). The Landreth (1991) model

collapses similar parent training into a 10-week parenting class which meets two hours each week and prepares parents to begin the *at-home* parent-child practice sessions after the third class session (Landreth, 1991).

B. Guerney (1964) identified three objectives for the child from the interactive parent-child play times. First, the parent-child sessions are designed to break the child's "perception or misperception" of his/her parent's "feelings, attitudes, or behavior toward" him so as to create a *fresh start* in the parent-child relationship. Secondly, the sessions are structured to "allow the child to communicate thoughts, needs, and feelings to his/her parents which he/she has previously kept from them, and often from his own awareness," communicated primarily through the child's play. And thirdly as a result of the parents' "newly perceived attitudes" of acceptance and emotional understanding (conveyed to the child during play times,) the child is expected (now empirically validated) to gain a "greater feeling of self-respect, self-worth and confidence" (B. Guerney, 1964, p. 344). Central to the healing process within the child is the powerful impact of a parent's ability to convey a feeling of appreciation and acceptance of the child *as he/she is*, regardless of how the child is behaving (Landreth, 1991).

Filial Therapy Research

A growing body of research has validated filial therapy as an effective clinical treatment, a form of early intervention and a preventative measure for use with children whose adjustment spans from normal range to severe maladjustment. Empirical research can be categorized into five areas of study: (a) effectiveness of parents as *therapeutic agents of change* with their children; (b) effectiveness of filial therapy with children with

various types of emotional, symptomatic and behavioral problems; (c) effectiveness of methodology and integration of essential components of the model; (d) effectiveness in strengthening of the parent-child relationship and effectiveness of parents as therapeutic agents of change versus professionals and paraprofessionals; and (e) effectiveness with unique populations of families living with *at risk* factors and extremely difficult life circumstances.

Effectiveness of Parents as *Therapeutic Agents of Change*. Filial therapy research from the late 1960s through the 1970s was primarily designed to assess parents' ability to function effectively as *therapeutic agents* with their children and sought to identify the types of changes children could make as a result of filial therapy treatment.

Following the use of filial therapy in school settings, Andronico and B. Guerney (1967) reported a marked reduction in parental blame of the school for children's problems and a positive increase in parental motivation to enter and maintain a commitment to children's therapeutic treatment. The decreased blaming and increased commitment to the children's treatment on the part of parents receiving filial training was believed to be related to the reduction of parents' feeling of helplessness to facilitate positive change in their children.

Stover and B. Guerney (1967) found that mothers who received filial therapy training significantly increased their reflective type statements and decreased their directive type statements, changes not made by mothers who did not receive the training. Positive changes in the mothers' interactions with their children were found to have a positive effect on children's behavior. B. Guerney and Stover (1971) substantiated their

earlier (1967) findings with a group of 51 mothers and their children. The study confirmed that mothers could be trained to reflect feelings, allow self-direction, and demonstrate involvement in their children's emotional expressions and behaviors. "Significant improvement on psychosocial adjustment and on symptomatology of the children was indicated on a variety of measures completed by parents and by clinicians. All of the 51 children were rated by the clinicians as showing some improvement and 28 were rated as very much improved. No child remained the same or became worse" (Bratton & Landreth, 1995). The parents trained in filial therapy reported positive changes in their children's behavior, including increased engagement with mothers in activities outside of the mother-child play sessions, increased management of their feelings of aggression, more reciprocal interaction and sharing with their mothers, and an increase in their children's sense of independence even to the level of demonstrating some leadership abilities.

Due to the absence of a control group in the B. Guerney and Stover (1971) study, Oxman (1972) matched the parents in the study with volunteer parents on the variables of the parents' and children's ages, size of family, geographical location, and socioeconomic status. Parents in the experimental group reported positive improvement in their children's behavior whereas parents in the matched control group did not report change in their children's behavior.

L. Guerney (1975) conducted a longitudinal qualitative investigation of 42 participants in the B. Guerney and Stover (1971) study one to three years after treatment termination. Findings indicated that only three of the original 42 participants were

receiving professional help at the time of follow-up and 32 of the parents assessed their children as having continued to improve since termination of filial therapy. These results suggest that the filial training may still be in effect as long as three years after the completion of training.

Sywulak (1979) investigated the long-term impact of filial therapy as a treatment methodology with emotionally disturbed children under the age of ten. The research design utilized children as their own controls in an effort to control for potential differences between troubled families who seek professional help and those who do not. All subjects served as their own controls during a four-month waiting period, followed by four months of treatment in filial therapy training. Data was collected at intake, at the beginning of training, after two months of training and after four months of training. The results indicated the effectiveness of filial therapy to enhance parental acceptance and improve child adjustment at a statistically significant level. The research determined that children classified as withdrawn demonstrated faster changes than children who were classified as aggressive.

In a follow-up study of the 19 families in Sywulak's (1979) study, Sensue (1981) found that two to three years post treatment the children had maintained the positive gains they had made during the original study, with no significant reduction in adjustment identifiable. For comparative purposes, Sensue (1981) matched a control group of parents according to age, gender, socioeconomic status (SES), education and having children who were considered to have normal behavior with typical childhood problems. The children in Sywulak's experimental group in 1979 had been diagnosed prior to

treatment as maladjusted; however at the time of the follow-up conducted two to three years later, these same children were rated equally as well-adjusted as the children with normal behavior in the control group. Parents who received filial therapy training received significantly higher scores on acceptance of their children than did the parents in the control sample.

Glass (1986) conducted the first study of the Landreth (1991) 10-week filial therapy model and reported a significant increase in parents' ability to demonstrate feelings of unconditional love for their children and to understand the meaning of their children's play behaviors. Glass's (1986) findings relevant to the enhancement of the parent-child relationship are reported in a subsequent section on the impact of filial therapy on the parent-child relationship.

Filial Therapy with Various Child Problems and Diagnoses. In addition to determining the effectiveness of filial therapy as an alternative treatment for emotionally disturbed children, researchers have sought to identify the spectrum of child problems with which filial therapy is an effective treatment intervention. Studies have validated the effectiveness of filial therapy with children ranging from those determined to be well-adjusted needing a preventative measure and/or experiencing normal developmental interruptions to those with various maladapted behaviors, physical problems, clinical diagnoses, and traumatic occurrences.

B. Guerney and Flumen (1970) successfully implemented filial therapy with highly withdrawn children by using teachers, rather than parents, to function as the psychotherapeutic agents of change. All children in the experimental group showed a

consistent pattern of rising assertiveness while not one of the control group children showed such a pattern. There was a significant correlation between the adequacy of the teacher to perform the therapeutic role and the change score of the child.

Andronico and Blake (1971) found in a study of filial therapy with parents of children with stuttering problems that as parents changed their interactional patterns within the child's environment and learned to inhibit their tendency to interrupt or pressure the child, the child's stuttering was ameliorated. Gilmore (1971) studied the effect of filial therapy with children diagnosed as having learning disabilities and discovered that as a result of the parents' use of child-centered play therapy skills, their children's self-esteem, academic performance, and social functioning noticeably improved. Family interaction variables also improved.

Hornsby and Applebaum (1978) examined a series of 60 clinical cases and reported that filial therapy had been effective with children within a wide range of presenting diagnoses, including a child in active conflict with a parent, a borderline psychotic child, and a handicapped child. Appreciable improvement in parent-child relationships and children's behavioral problems were documented.

L. Guerney (1979) studied the use of filial therapy with parents of children diagnosed with primary disorders which were essentially physical in origin, including learning disabilities, hyperactivity syndrome, physical disabilities, and mild retardation. These same children had developed secondary adjustment difficulties. A consensus of research has verified that children with physical disorders are typically vulnerable to a negative self-concept, prolonged dependence on parents, and a lack of self-control.

However, contrary to this somewhat negative developmental prognosis for children with primary physical disorders, the children who received filial therapy made notable changes from negative to positive feelings about themselves and others, from dependence to greater independence, and from a lack of impulse control to increased self-control. The developmental factors measured in the experimental group were comparable to that of the control group that was made up of children who did not have physical or behavioral disorders.

Kale (1997) researched the effects of the Landreth (1991) 10 week filial therapy model with children with learning difficulties. The control group was made up of parents whose children had comparable learning disabilities to the children of parents in the experimental group. Parents in the filial therapy group significantly increased their acceptance of their children and reported a significant reduction in parental stress as related to parenting. No changes of similar magnitude were made by the control group parents or their children. The author highlighted these results as most noteworthy considering the high stress levels empirically verified as common in families with a learning-disabled child.

Filial Therapy Methodology and Impact on Parent-Child Relationship. With the growing amount of empirical validation of filial therapy as an effective intervention with parents and children with diverse problems and levels of severity, researchers began to study the instructional methods to discern the unique components that seemed to contribute to the overall effectiveness of the model. Emerging research began to, also, focus on the impact of filial therapy on the parent-child relationship. Researchers in the

eighties began comparing the effectiveness of parents versus the effectiveness of professionals and paraprofessionals (non-parents) in utilizing filial therapy as a treatment modality with children.

As early as 1972, Boll (1972) studied the effect of adding an instructional element (the teaching of reinforcement and extinction techniques) to the original model as developed by B. Guerney (1964) and associates. Mothers of educable mentally retarded children were randomly assigned to either a traditional filial therapy group (following the Guerney model, 1964), a filial therapy group receiving additional instruction in reinforcement and extinction techniques taught by an expert, or a control group which received no therapeutic intervention. Parents who reported the highest improvement in the children's socially-adaptive behavior was noted in the traditional filial therapy group, and mothers in both filial groups reported significantly greater social improvement in their children than did mothers in the control group. Boll (1972) noted that the traditionally trained filial group appeared to foster closer relationships with more consistent attendance than did the filial group in which the expert taught information on reinforcement and extinction techniques.

Wall (1979) examined three variations of filial therapy in which one group was comprised of parents who received filial training and conducted play times with their children, another group was comprised of therapist-trainees who received filial training and conducted play times with children, and a control group of parents who received no treatment intervention. The purpose of the study was to assess the viability of training parents in filial therapy in comparison to training graduate therapist-trainees as compared

to providing no training to parents. Wall reported a significant increase in the children's emotional adjustment as a result of parents' training in filial therapy, comparable increases did not occur in children who worked with graduate trainees or children whose parents received no filial therapy training. Children whose parents trained in filial therapy techniques demonstrated significantly improved adjustment in the expression of negative emotions and increased perception of negative attitudes in their families. Wall (1979) suggested that the parents' increased ability to communicate empathically likely accounted for the children's improved adjustment beyond children in either of the other two groups.

Payton (1980) conducted a study in which a group of parents and a group of paraprofessionals each received 12 weeks of filial therapy training and a comparison group which did not receive any training. Parents trained in filial therapy reported improvement in their children's behaviors and higher scores on parenting attitudes than was reported either by the paraprofessional group or control group. Payton (1980) found that parents trained in filial therapy were significantly more effective in impacting their children's personality adjustment than paraprofessionals or non-trained parents.

Kezur (1980) analyzed the mother-child communication patterns before and after filial therapy training and examined the effects of those communication patterns on the mother child relationship. The mothers in the experimental group received filial therapy training *while* their children were in play therapy sessions led by a trained therapist. The results of the study indicated improvement in parental communication skills and marked improvement in the self-esteem of the children and of their mothers. The children who

expressed anger towards their mothers in the therapist-facilitated play sessions became more open and communicative with their mothers in the parent-child play sessions.

Mothers who learned to honor their own needs were found more able to meet the needs of their children, and the mother-child relationship became more positive as both gained in self-esteem. The mothers who took advantage of the opportunity to review videotaped parent-child sessions and received frequent feedback in class made the most gain in implementing the skills and the mothers from the mother-child pairs in which the most change occurred reported improvement in other relationships as well as the parent-child relationship.

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

Lebovitz (1983) compared the effectiveness of filial therapy with a group of mothers receiving filial therapy training, a group of mothers receiving supervision of play sessions (without filial training), and a control group of mothers receiving no training or form of treatment. The mothers' therapeutic skills were measured and change in the children was assessed by parents, teachers, and independent observers. The mothers in the filial therapy group communicated more acceptance of children's feelings, allowed more self-direction, and demonstrated more involvement with their children than did

mothers in the supervised play session group or the control group. Children of filial parents evidenced a significantly greater decrease in dependence, aggression, and withdrawal. Both mothers and children from the filial training group perceived fewer problem behaviors as a result of the training as compared with the control group and the children's classmates. Children in the control group demonstrated the most problems and the least change.

In addition to the findings of Glass (1986) reported earlier in the research section on the effectiveness of parents as *therapeutic agents of change*, trends emerged in the Glass (1986) study which suggested filial therapy as an effective treatment for increasing closeness within the parent-child relationship while maintaining the hierarchy of parental authority and positively influencing family dynamics, especially in the areas of expressiveness, conflict, independence, and control.

Packer (1990) conducted a case study and identified significant change in family dynamics following filial therapy training. The dynamics of the mother-father-child triad shifted after filial therapy training, wherein the father was more readily accepted as an authority figure in the presence of the mother than had been the case prior to filial therapy training. As a result of 10 weeks of filial therapy training, the parents gained a new perception of themselves as possessing skills that could affect positive change in their children and the child demonstrated a growing ability to control escalation of rising emotions in both the home and the child care setting with a marked reduction of temper tantrums.

Bavin-Hoffman (1994) conducted qualitative study of married couples who had participated in the Landreth (1991) 10-week filial therapy model within the past one to three years (Bavin-Hoffman & Landreth, 1994). Recurring themes which emerged consistently indicated: (a) improved parent/child communication, (b) improved partner communication, (c) improved child behavior, specifically including an increase in self-control and a decrease in aggression, (d) increased unity in parenting techniques, in general, and, specifically, in child discipline, and (e) improved family relations, particularly in the areas of interpersonal communications and increased closeness in the parent-child relationship.

Utilizing ethnographic methodology, Lahti (1993) examined the effects of the Landreth (1991) 10-week filial therapy model on the child, parent, and parent-child relationship. Parents reported that their levels of stress lessened as a result of the practice parent-child play sessions and their objectivity for learning was enhanced through the viewing of parent-child videotaped sessions in class in which the facilitator and parents exchanged feedback. Participating parents reported increased self-confidence, less need to enforce parental control, and increased awareness of their own personal needs and the needs of their children. In the area of relationships, parents reported increased closeness and enhanced communication in both the parent-child relationship and the marital relationship, the development of more realistic expectations for their child, and a reduction of friction between parents and children. Crediting filial therapy for the changes within the family, parents perceived their children as happier, taking more

responsibility for their actions, being less withdrawn, demonstrating fewer aggressive behaviors, and exhibiting an overall increase and enhancement in communication.

Filial Therapy with Families, Classified as, *At Risk*. Much of the filial therapy research conducted in the 1990s has focused on the efficacy of filial therapy with families termed *at risk*. *At risk* factors are variables known to create increased stress on parents and children, putting a strain on optimal parenting, and potentially having a negative impact on child outcome. Many of the studies of filial therapy in the last decade were of families experiencing one or more of these risk factors.

Glazer-Waldman (1991) studied the effectiveness of the Landreth (1991) 10-week filial therapy model with five parents of chronically ill children. Quantitative and qualitative reports indicated important change in parents and children as measured and reported by parents, group leaders and an independent observer. Pre-tests showed that prior to filial therapy training, parents confused their child's level of anxiety with their own and were not able to accurately judge the child's state of anxiety as reported by the child. Initially, parents overestimated the child's level of anxiety (in comparison to the child's report); however, following filial training, parent assessments more closely matched the child's report of anxiety. A focus of this particular filial therapy training was to normalize the interaction between the parent and child and to decrease the primary focus of the relationship being on the child's chronic illness. Trends in the data appeared to support the success of that effort. In the parents' qualitative reports, they stressed the importance of the positive interactions shared with their child during the play sessions,

which was a dramatic, “refreshing” contrast to their formerly focusing primarily on the child’s illness prior to training.

Landreth and Lobaugh (1998) introduced the Landreth (1991) 10-week filial therapy model to incarcerated fathers in a federal correctional facility. The study was designed to determine the effectiveness of filial therapy as an intervention to enhance the parent-child relationship and to positively impact the self-concepts of children whose fathers were incarcerated. After the initial screening process, 32 men were randomly assigned to either the control group or the experimental group. The fathers in the experimental group selected one of their children who were between the ages of 3 to 7 years, to be the “child of focus” for the 10-week training period. The training sessions followed the methodology outlined by Landreth (1991) in which “the facilitators focused on increasing the fathers’ sensitivity to their children, understanding the emotional needs of their children, identifying children’s emotions, and empathic responding” (Landreth & Lobaugh, 1998, pg. 160). The fathers were required to practice their skills with the “child of focus” in weekly 30-minute play sessions held in a small room (door-less) in a correctional facility. The fathers who received filial therapy training scored significantly higher on parental acceptance and unconditional love and scored significantly lower on level of stress related to parenting as compared to fathers in the control group. They also scored significantly higher than control group fathers on a sense of competence as a parent and parent attachment, suggesting, “these fathers felt an emotional closeness to their children that they lacked before the filial therapy training” (Landreth & Lobaugh, 1998, p. 163). The children of experimental group fathers demonstrated highly significant

increases in their self-concept as measured in the areas of significance, competence, virtue, and power. The results of this study support filial therapy training as an effective intervention for incarcerated parents, capable of providing parents with the skills necessary for healthy parent child relationships and the strengthening of children's self-concept.

Bratton and Landreth (1995) researched the effectiveness of the Landreth (1991) 10-week filial therapy model with single parents. Significant results were found on each of the 13 hypotheses. The parents who received filial training demonstrated significant increases in empathic behavior with their children, communication of acceptance, allowance of self-direction, and involved participation in their child's play during a 20-minute session, as rated from videotaped pre and posttest sessions. The parents who received filial therapy training showed a significant improvement in their attitudes of acceptance toward their children and reported a feeling more confident in their ability to parent more effectively as a result of the training. Experimental group parents significantly increased respect for the child's feelings and the child's right to express those feelings, the child's unique make-up recognition of the child's need for autonomy and independence, and levels of unconditional love for their child. They, also, showed a significant decrease in their level of stress as related to parenting and a significant reduction in their perception of the number of behavior problems their children were experiencing. The control group attained no statistically significant changes in any of the factors or behaviors measured in the study.

Harris (1995) used a condensed version of the Landreth (1991) 10-week filial therapy model and found a significant change in 9 of 13 hypotheses tested for a group of incarcerated mothers. Mothers attended two-hour filial therapy training sessions, scheduled bi-weekly for five weeks and conducted 30-minute play sessions in between class sessions with their child who came to the facility twice a week. The results were compared with mothers in a control group. The mothers in the experimental group significantly increased their empathic interaction with their children and their attitude of acceptance toward their children and reported a significant decrease in the number of problems they perceived within their children.

Recent studies have investigated the effectiveness of the Landreth (1991) 10 week filial therapy model with three culturally different populations: Chinese parents residing in Texas, Native American parents residing on the Flathead Reservation in Montana, and Chinese parents residing in Canada following immigration from Asia, including immigrants and international students and/or spouses. Chau and Landreth (1997) were the first to investigate the use of filial therapy with Chinese parents. The parents who received training demonstrated significant changes not achieved by the parents in the control group. The experimental group evidenced significant increases in empathic interactions with their children, the communication of parental acceptance to their children, particularly, to their children's expressions of positive and negative feelings and behaviors. In spite of the Chinese cultural taboo toward the expression of negative feelings and anger by children, the findings suggest that Chinese parents can learn to accept their children's behaviors and feelings including anger and frustration. A

decrease in the experimental groups perceived level of stress as related to parenting was measured at a significant level.

Glover (1996) investigated the Landreth (1991) 10-week filial therapy model as a potentially effective intervention for Native American families living on the Flathead Reservation in Montana. An experimental and a control group were used for comparative purposes. The children in the experimental achieved a notable amount of desirable play behaviors with their parents as compared to the control group. Positive trends on increases of parental acceptance, reduction of parental stress, and improvements in children's self-concepts were noted. Glover (1996) suggested cultural differences in the concepts of parental stress, parental acceptance, and the use of measurement instruments normed for the majority culture may account for the lack of statistically significant change.

Yeun (1997) investigated the effectiveness of the Landreth (1991) 10-week filial therapy model with immigrant Chinese parents in Canada. Whereas the control group made no significant changes, the experimental group parents significantly increased the level of empathic interaction with their children and acceptance toward their children. Experimental group parents demonstrated a significant decrease in stress as related to parenting and identified a significant reduction in behavior problems within their children.

Tew (1997) studied the use of the Landreth (1991) 10-week filial therapy model with parents of chronically-ill children. Following the completion of filial training, the parents in the experimental group showed a reduction in stress related to parenting, an

increase in parental acceptance, a decrease in perceptions of problematic and anxious/depressed behaviors in their children, all of which were statistically significant. No changes were found to be statistically significant in control group participants.

Costas (1998) conducted research on the effectiveness of the Landreth (1991) 10-week filial therapy model with non-offending parents of sexually abused children, who had been identified as having been sexually abused by an investigating agency. She found that experimental group parents made several changes within the statistically significant range, including increased parental acceptance and unconditional love, reduction of stress as related to parenting, increased empathic interactions and communication of acceptance of children's feelings and behaviors during observed play sessions. At the completion of training, parents in the experimental group rated their children's behaviors within a normal range, a change that Costas (1998) identified as particularly noteworthy. Parents' assessment of their children with a more developmentally accurate perspective was interpreted as definite progress in light of the heightened anxiety typical of parents whose child has been sexually abused. Though control group parents maintained their attempts to control their children's behaviors, the parents in the experimental group made significant gains in following the child's lead and allowing the child more self direction. Costas (1998) identified the shift in parental control and imposed direction on the child as important because non-offending parents are often so over protective they inhibit the natural developmental flow in the child who has been a victim of abuse.

Summary

Child witnesses of domestic violence are often the “forgotten victims” of family violence. Exposure to family violence has been shown to interrupt healthy development in children and create psychological disturbances that can be severe and long lasting, posing a threat to the future mental health of child witnesses. If effective intervention is not forthcoming, child witnesses are *at risk* of developmental and psychological disturbances with a propensity for perpetuating the familial pattern of violence into the next generation.

Parental intervention through parent education programs is one highly researched method of intervening in the intergenerational cycles of abuse and child maltreatment. Parenting programs that blend training in child development and child-rearing practices with a support component that attends to the personal needs of parents have been found to help improve parenting practices, particularly with parents *at risk* of less than optimal parenting. Extensive clinical research documents the successful use of parents as primary components of clinical treatment with children with certain child problems.

From a trauma perspective, the optimal time for prevention and intervention is during the acute period following a traumatic event. Therefore, shelter programs should provide appropriate therapeutic interventions with child witnesses so that the recovery process can begin during a family’s short stay at shelter facilities. Play therapy is an effective therapy, seemingly compatible with the needs of child witnesses for a relational therapy that is non-threatening, nurturing and adaptable for use with various emotional and behavior problems. Intensive individual play therapy (Kot, 1995, as cited in Kot &

Landreth, 1997) and intensive sibling group play therapy (Tyndall-Lind, 1999) were presented as effective therapeutic models for use with child witnesses residing in a shelter facility, models that will be used for a comparative analysis in this study.

Intensive filial therapy is an innovative treatment intervention that teaches parents to integrate the core concepts and skills of child-centered play therapy into their relationships with their children. The model equips parents to function as *therapeutic agents of change* with their children, preparing parents to facilitate emotional and behavioral change within their child. Filial therapy is simplistic in format, concrete in content, and presented in a supportive, non-threatening manner giving parents step-by-step guidance and encouragement throughout the dynamic learning process. Integral to the success of filial therapy is the practicum component in which parents conduct parent-child play times with one of their children in order to practice using newly acquired skills with their child. The viewing of videotapes of parent-child playtimes followed by the receipt of feedback from the facilitator and classmates has been shown to enhance the parents' learning process.

Research has confirmed the effectiveness of filial therapy with parents from very diverse backgrounds, including parents who are typically not reached by traditional parent education and clinical programs. Filial therapy is proposed as a potentially effective intervention with child witnesses of domestic violence, particularly because the model makes use of the powerful mother-child bond to facilitate positive change *within* the child, *within* the parent and *within* the parent-child relationship.

CHAPTER II

METHODS AND PROCEDURES

This chapter presents the methods and procedures for data collected in this study. Sections included are: definition of terms, hypotheses, limitations of the study, the instruments administered for data collection, a discussion of the data collection, and treatment and an explanation of the data analysis procedures.

Definition of Terms

Aggression was defined as the initiation of a hostile act against another person. It is often an expression of inner turmoil, anger, and frustration. Behaviorally, aggression is exhibited by the child's decision to attempt to destroy objects or to hurt another. For the purpose of this study, aggression was operationally defined as the score on the Aggression subscale of the Child Behavior Checklist (CBCL).

Allowing the child self-direction was defined as the behavioral willingness, as demonstrated by parental behavior, to follow the child's lead rather than attempting to control the child's behavior. For the purpose of this study, allowing the child self-direction was operationally defined as the parents' scores on the Allowing Child Self-Direction Subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, & O'Connell, 1971).

Anxious/Depressed was defined as a psychological condition characterized by low mood, sadness, feelings of loneliness, nervousness, guilt and fear. For the purpose of

this study, anxious/depressed was operationally defined as the score on the Anxious/Depressed scale of the CBCL.

Child witness of domestic violence was defined as, children who enter a domestic violence shelter as a result of witnessing severe acts of physical and emotional abuse directed at their mother by her intimate partner. For the purpose of this study, child witness of domestic violence included children who see, overhear, or are triangulated into, or the aftermath of, the violence (Edleson, 1999).

Communication of acceptance as understood in this study referred to the parent's verbal expression of acceptance-rejection of the child. For the purpose of this study, communication of acceptance was operationally defined as the parents' scores on the Communication of Acceptance Subscale of the MEACI (Stover et al., 1971).

Delinquent behavior referred to behaviors that are associated with violation of legal or ethical standards. Some of these behaviors include: setting fires, lying, running away, stealing, and truancy. For the purpose of this study, delinquent behavior was operationally defined as the score on the Delinquent Behavior subscale of the CBCL.

Domestic Violence referred to physical, emotional, and psychological abuse of a woman by her intimate partner, which is specifically intended to cause injury or to maintain power and control.

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

Externalizing behavior problems referred to behaviors, which are outward manifestations of inner conflict. These behaviors can include: aggression, hyperactivity, and conduct problems. For the purpose of this study, externalizing behavior problems was operationally defined as the score on the Externalizing Behaviors scale of the CBCL.

Filial therapy was defined in this study as “a unique approach used by professionals trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision. Parents are taught basic child-centered play therapy skills, including responsive listening, recognizing children’s emotional needs, therapeutic limit-setting, building children’s self-esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent”(G. L. Landreth, personal communication, June 27, 1995).

Intensive individual play therapy involved collapsing the time between play therapy sessions in order to provide maximum benefit to transient children. For the comparative purpose of this study, each child participated in intensive individual play therapy, once a day, six days per week, 45-minutes per session, for two weeks (Kot, 1995).

Intensive filial therapy involved collapsing the time between parent training sessions to daily, or every-other-day, sessions to provide maximum benefit to transient

mothers and children. For the purpose of this study, each mother participated in 12 filial therapy training sessions (1 to 1 ½ hours in length) and 10 to 12 parent-child play times within a two to three week time period.

Intensive sibling group play therapy involved collapsing the time between group play therapy sessions in order to provide maximum benefit to transient children. For the comparative purpose of this study, each child participated in a sibling group play therapy session once a day, 45-minutes per session, six days per week for two weeks (Tyndall-Lind, 1999).

Internalizing behavior problems referred to behaviors that are inward, representing a cluster of behavioral characteristics symptomatic of attempts to cope emotionally--resulting from inhibition to express feelings. Behavioral characteristics included: withdrawal, anxiety, depression, and suicidal ideation. For the purpose of this study, internalizing behavior problems was operationally defined as the score on the Internalizing Behaviors scale of the CBCL.

Involvement was described in this study as an objective measurement of the parents' attention to and participation in the child's activities. For the purpose of this study, involvement was operationally defined as the parents' score on the Involvement Subscale of the MEACI (Stover et al., 1971).

Parent and/or Parenting included any significant maternal caregiver, not necessarily biological or adoptive parent, and the functions performed by such a caregiver.

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

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

Self-concept was defined as the extent of children’s own self-worth. For the purpose of this study, self-concept was operationally defined as the score on the Joseph Preschool and Primary Self-Concept Screening Test (JPPSST) (Joseph, 1979).

Sibling group play therapy referred to the use of play therapy principles to implement social, emotional, and behavioral changes with siblings within in the context of a play therapy group. This psychosocial method processed interpersonal change through peer and play therapist interaction. Each child had the opportunity to utilize the presence of the other children, toys, and play materials to *play out* and address issues of concern. For the comparative purpose of this study, group membership consisted of two siblings, each from the same family, who had been screened and selected as participants (Tyndall-Lind, 1999).

Somatic complaints referred physical manifestations of emotional distress. For the purpose of this study, somatic complaints were operationally defined as the score on the Somatic Complaint subscale on the CBCL.

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

Hypotheses

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

1. There will be no significant difference in self-concept mean scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

2. There will be no significant difference in self-concept mean scores on the Joseph Pre-School and Primary Self-Concept screening Test (JPPSST) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive sibling group therapy group.

3. Subjects whose mothers receive intensive filial therapy training will attain a significantly higher mean score in self-concept as indicated by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) posttest than will subjects in the non-treatment comparison group.

4. There will be no significant difference in Total Behavior Problems subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers received intensive filial therapy training and subjects in the intensive individual play therapy group.

5. There will be no significant difference in Total Behavior Problems subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers received intensive filial therapy training and subjects in the intensive sibling group play therapy group.

6. Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Total Behavior Problems subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the non-treatment comparison group.

7. There will be no significant difference in Internalizing Behaviors subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

8. There will be no significant difference in Internalizing Behaviors subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers received intensive filial therapy training and subjects in the intensive sibling group play therapy group.

9. Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Internalizing Behaviors subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the non-treatment comparison group.

10. There will be no significant difference in Externalizing Behaviors subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

11. There will be no significant difference in Externalizing Behaviors subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive sibling group play therapy group.

12. Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Externalizing Behaviors subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the non-treatment comparison group.

13. There will be no significant difference in Anxious/Depressed subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

14. There will be no significant difference in Anxious/Depressed subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers

receive intensive filial therapy training and subjects in the intensive sibling group play therapy group.

15. Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Anxious/Depressed subscales on the Child Behavior Checklist (CBCL) posttest than will subjects in the non-treatment comparison play therapy group.

16. There will be no significant difference in Aggressive Behaviors subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

17. There will be no significant difference in Aggressive Behaviors subscale mean scores on the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive sibling group play therapy group.

18. Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Aggressive Behaviors subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the control group.

19. Parents who receive intensive filial therapy will attain a significantly lower mean posttest score on the Total Empathy score of the Measurement of Empathy in Adult-Child Interaction (MEACI) than will be attained on the mean pretest score.

20. Parents who receive intensive filial therapy will attain a significantly lower mean posttest score on the Communication of Acceptance subscale of the Measure of

Empathy in Adult-Child Interaction (MEACI) than will be attained on the mean pretest score.

21. Parents who receive intensive filial therapy will attain a significantly lower mean posttest score on the Allowing the Child Self-Direction subscale of the Measure of Empathy in Adult-Child Interaction (MEACI) than will be attained on the mean pretest score.

22. Parents who receive intensive filial therapy will attain a significantly lower mean posttest score on the Involvement subscale of the Measure of Empathy in Adult-Child Interaction (MEACI) than will be attained on the mean pretest score.

Limitations

This study has the following limitations:

1. Subject selection was limited to volunteers from residents residing in a domestic violence shelter in the Dallas, TX area, and this produced small experimental, comparison, and control groups, which were not ethnically matched samples.

2. This study relied on volunteer sampling. Due to the nature of the population and the purpose of this study, random selection was not possible.

3. Subjects in intensive sibling group play therapy were selected three years after children were selected for the intensive individual play therapy group and for the control (non-treatment comparison) group.

4. Subjects in the intensive filial therapy group were selected five years after children were selected for the intensive play therapy group and for the non-treatment comparison group.

5. The experimental group of mothers who completed the Child Behavior Checklist had received the filial therapy training. This knowledge may have biased the mothers' ratings.

Instruments

Joseph Pre-School and Primary self Concept Screening Test

The Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) (Joseph, 1979), was first developed to measure the self-concept of pre-school children, however, Joseph later modified the testing mechanism to also meet the needs of elementary-aged children. This study included testing self-concepts of pre-school and elementary school-aged children. Testing procedures involve children's identification of pictures that they view to be most similar to themselves. The test administrator rates each child's self-esteem on a global index from zero to 30 based upon each child's perception of the pictures, activities within the pictures, and feelings about the pictures

The Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) can be used with children ranging in age from three years, six months--to nine years, eleven months. Testing protocol does not require reading ability nor does it require a high-level of administrator training. Because young children have short attention spans, the short-length of the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) (30 items), makes it an effective method for assessing children's self-esteem.

A test-retest sample established a reliability coefficient of .87. The Kuder-Richardson (20) formula established the internal consistency reliability to be between, 59 to .81, with a median correlation coefficient of .73. All test items have been shown to

significantly contribute to the overall test score performance. Construct validity has been established at a .51 significance at the .01 confidence level; the construct validity score was determined by correlating the global Self-Concept Scores of the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) with scores from the Self-Concept Judgment Scale of the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) (Joseph, 1979).

Child Behavior Checklist

The Child Behavior Checklist (CBCL) is a well-established and recognized instrument for the identification of behavioral and emotional difficulties in children ages four to 18. It consists of 120 items, requiring a fifth-grade reading level, and takes approximately 20 minutes to complete. It is categorized as a self-administered test, rating the existence of behavioral symptoms on a scale of 0 to 2--0 indicating the behavior is not true for the child, and 2 indicating that the child often demonstrates that behavior. This checklist was designed to record, in a standardized format, behavioral symptoms and competencies of children as perceived by their parents or surrogates.

Originally developed in 1986 by Achenbach and Edelbrock, the revised version of the Child Behavior Checklist (CBCL) (Achenbach, 1991) was used in this study. Specifically, this study focused primarily upon the Internalizing and Externalizing domains of the Child Behavior Checklist (CBCL) behavior scales. The mothers were relied upon to complete the checklist because the Child Behavior Checklist (CBCL) requires the perception and judgment of a child's behavior.

Internal consistency for the Child Behavior Checklist (CBCL) was demonstrated by Cronbach's alpha. For girls between the ages of 4 and 11, Cronbach's alpha is .90 for Internalizing behavior problems, and .93 for External behavior problems. For boys between the ages of 4 and 11, Cronbach's alpha is .89 for Internalizing behavior problems, and .93 for Externalizing behavior problems. Inter-interviewer reliability of item scores was established at .959. Intraclass correlations from three matched samples of children showed a high level of reliability between raters, indicating that scores obtained for each item are relative to scores from each other item.

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

Measurement of Empathy in Adult-Child Interaction

The Measurement of Empathy in Adult-Child Interaction (MEACI) is a rating scale adapted by Bratton (1994) from a scale developed by Stover et al. (1971) to operationally define empathy as related to parent-child interactions. This direct observational scale measures three specific parental behaviors: (a) communication of

acceptance; (b) allowing the child self-direction; and (c) involvement. These three behaviors are identified as major aspects of empathy in adult-child interactions and, when combined, provide a total empathy score. Lower scores indicate higher levels of positive behavior on the subscales and total scores.

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

The Allowing the Child Self-Direction subscale measures the verbal expression of acceptance and the behavioral willingness on the part of the parent to follow the child's lead rather than attempt to control the child's behavior (Stover et al., 1971).

The Involvement subscale measures the parents' attention to and participation in the child's activity. Stover et al. found that parents who exhibited high level of acceptance and allowed the child self-direction, also demonstrated high levels of involvement.

The Measure of Empathy in Adult-Child Interaction (MEACI) is a 5-point bipolar scale used to rate the three dimensions of parental behavior every three minutes for six consecutive coding intervals. The scale ranges from a high rating of 1 to a low rating of 4. Each point on the scale is followed by typical responses obtained from codings of the direct observations of parent-child interactions. Considering the three subscales together as components of empathic behavior, the highest levels of empathy are

evident when the parent is commenting frequently on the child's expression of feeling or behavior in a genuinely accepting manner; is clearly demonstrating that the child is fully permitted to engage in self-directed activity, and is attentive to the child's behavior. The lowest level of empathic communication is one in which the parent is verbally critical and rejecting of the feelings or behaviors of the child; cajoles, demands, and continually redirects the child's activity; and is self-involved, preoccupied, or shut off from the child.

Reliability coefficients were established for each of the three subscales. After four training sessions for collaborative rating on a half-hour play session, followed by discussions, six pairs of coders independently rated 7 to 10 parent-child play sessions of 20 minutes each.

The average reliability correlation coefficient for the Communication of Acceptance scale was .92. The Allowing the Child Self-Direction subscale had a median correlation of .89, and the Parental Involvement subscale had an average coefficient of .89 (Stover et al.).

Construct validity for each subscale and the total empathy score was demonstrated in a study group with 51 mothers who participated in filial therapy training (Guerney & Stover, 1971). The filial therapy training method was utilized to demonstrate the validity of the scales because this method involved training parents in empathic skills closely related to the behaviors the scales are intended to measure. The parents' levels of empathic interactions with their children were measured three times: (a) a pre-training play session; (b) the first post-training play session; and (c) the third post-training play session. Highly significant increases, at the .0005 level, between the pre-training and first

post-training play session were obtained on each subscale and for the total empathy score. A significant increase, at the .01 level, between the first and third post-training sessions demonstrated that the scales are extremely sensitive measures of empathic behaviors. Concurrent validity established by a .85 correlation at the .005 level between the Measure of Empathy in Adult-Child Interaction (MEACI) and previously developed empathy measure for adult-children interaction (Guerney, Stover, & DeMerrit, 1968).

Selection of Subjects

Volunteer subjects were recruited from two shelters in a large metropolitan area, which offered a length of stay that ranged from four to six weeks and four to twelve weeks. At the first shelter (hereafter referred to as the domestic violence shelter), personal contact was made with each new resident who had children residing with her who were between the ages of 4 and 10 years of age. The purpose and structure of the filial therapy training classes were explained and the mothers were invited to participate. The mothers were informed there was no charge for the training and that the directors of the shelter had pre-approved their participation if they had a desire to do so.

An unexpectedly low shelter census during the recruiting period created a need for the inclusion of a second shelter to participate in the study in order to obtain enough subjects within the time frame of the study. A second shelter (herein referred to as the homeless shelter) was added to the study, one month after training had begun at the first shelter. The recruiting process was different at the homeless shelter than the domestic violence shelter. Rather than individually talk with each mother, the researcher sent colorful invitations to all residents, titled “Just for MOMS...,” inviting them to an

evening banana split party and presentation titled, "Helping Your Child Through Play" by the researcher. Approximately 25 mothers came to the presentation in which the researcher made a lively 30 minute presentation about how play is a child's first language of self-expression and how valuable it is for parents to learn core concepts and skills of play therapy to nurture healthy development in their children. Also, included on the program was one of the mothers who was in the filial therapy class at the domestic violence shelter. She briefly shared her story of coming to the shelter, her children's different reactions to the trauma of domestic violence and their adjustment to moving into the shelter, and how the play therapy training was helping her to better understand her children, be closer to them and be more effective in disciplining her children. She encouraged the mothers to seriously consider joining the play therapy class for moms. After the program was completed and mothers were making banana splits for themselves and their children (who had joined them from the child care center), interested mothers asked questions and signed a list expressing interest in participating in the program. A meeting to describe the program and the study in greater detail was set for the next evening during the hour childcare was provided.

Although the two shelters were very similar in many ways, they differed in some respects. The domestic violence shelter was averaging 10 females (with a capacity for 14 families) in residence all of whom were victims of domestic violence, and most of the females brought children with them to the shelter. The homeless shelter was averaging a census of 25 to 30 families, all of whom brought children with them to the shelter. Approximately 80% of the female residents at the homeless shelter were victims

of domestic violence. The essential criteria for admission to the domestic violence shelter, was the mother's and children's experience(s) of domestic violence with accompanying concern/fear for safety. The essential criteria for admission to the homeless shelter, was a need for shelter and food for the mother and her children.

Participation in this study was on a volunteer basis. Participating mothers were selected to participate in the study based on the following eligibility criteria: (a) must be a victim of domestic violence and their children must have been a witness of domestic violence (refer to definition of child witness); (b) must be a resident in a shelter, at least 18 years of age, with either full or joint custody of a child who was residing with her at the shelter; (c) must select one of her children as a *child of focus* between the ages of 4 and 10; (d) must be able to speak, read, and write the English language; (e) must agree to complete all filial therapy training led by the researcher in the given time frame; (f) must be able to attend pre and post testing sessions to complete instruments and be videotaped playing with her child; (g) must agree to participate in 12 parent child play sessions, averaging 30 minutes in length; (h) must be willing to sign consent to participate form.

The researcher met with each participant who met the specified criteria to: (a) explain the purpose and the requirements of the filial therapy training; (b) provide information about how confidentiality would be maintained; and (c) answer any questions the participants had before they signed the consent form. Each parent was asked to select only one of her children, between the ages of 4 to 10 years, as the *child of focus*, and indicate that child by name on the consent form (Appendix D). The *child of focus* must be a child witness of domestic violence (refer to definition of child witness).

Children who were seven years old or older were asked to sign an assent form (Appendix C). Subjects were added to the experimental group if they met all requirements and voluntarily agreed to participate. A total of eleven subjects completed the study. Five subjects volunteered and completed the study at the domestic violence shelter. Nine subjects volunteered and six subjects completed the study at the homeless shelter. Three subjects at the homeless shelter did not complete the study because two subjects moved out of the shelter during the study, and one subject attended three sessions and then chose to not continue her participation.

Of the 11 mothers who completed the study, 3 of the 5 mothers from the domestic violence shelter had middle class homes and life styles to which they could have returned had they chosen to return to their husband who had been physically violent on repeated occasions. The other two mothers at the domestic violence shelter did not have a home or furnishings of their own, but did have boyfriends who had been physically violent whom they believed would have allowed them to return should they choose to do so. Four of the 6 women from the homeless shelter had no home to which they could return, even if they chose to reactivate their relationship with a violent husband or partner.

All of the participating mothers from both shelters were experiencing financial difficulties. Those residing in the domestic violence shelter had no financial means available to them because the perpetrator controlled the finances. Separating from the perpetrator had meant the loss of access to mutual financial resources. All of those living in the homeless shelter reported severe financial distress even though all but one had held steady jobs in the past.

Four of the five participants from the domestic violence shelter had graduated from high school and one had nearly two years of college. One participant was an eighth grade dropout. Among the homeless shelter participants, three were attending preparation classes at the shelter to prepare to test for the Graduation Equivalency Diploma (GED) exam and three had graduated from high school.

For the purpose of this study, the comparison groups were children who received intensive individual play therapy in the Kot (1995, as cited in Kot & Landreth, 1997) study, Intensive Play Therapy with Child Witnesses of Domestic Violence, and children who received intensive sibling group play therapy in the Tyndall-Lind (1999) study, Comparative Analysis of Intensive Individual Play Therapy and Intensive Sibling Group Play Therapy with Child Witnesses of Domestic Violence. The original control group from the Kot study served as the non-treatment comparison group for this study and the Tyndall-Lind study. The control group from the Kot study was comprised of 11 children, 7 girls and 4 boys, ages 4 to 9 with a mean age of 5.9 years. The population of the control group was 15% Caucasian, 15% Hispanic, and 70% African American.

Of the 40 children who volunteered for the Kot study (the treatment group and the control group), 21 completed the study and 19 left the shelter before the study was completed (Kot & Landreth, 1997). There were 11 in the experimental group and 11 in the control group. The intensive individual play therapy group was composed of 6 girls and 5 boys, ages 4 to 10 with a mean age of 6.9 years. The population was 46% Caucasian, 27% Hispanic, and 27% African American. Of the 20 children that volunteered for intensive sibling play therapy in the Tyndall-Lind (1999) study, 10

completed the study and 10 left the shelter before the study was completed. The intensive sibling group play therapy group was composed of 6 girls and 4 boys, ages 4 to 9 with a mean age of 6.2 years. The population was 60% Caucasian, 20% Hispanic, and 20% African American. Of the 11 children whose mothers completed the intensive filial therapy training, there were 4 girls and 7 boys, ages 4 to 10 with a mean age of 6.1 years. The population was 36.4% Caucasian (including one Polish citizen who was an immigrant to the United States), 9.1% Arabic, 9.1% Hispanic, and 45.4% African American.

An interview of shelter personnel, comparison of longitudinal intake profiles, review of each shelter, and a comparison of shelter services and program management concluded the shelters in the Kot, Tyndall-Lind, and this study were similar in services, shelter dynamics, and families served.

Collection of Data

A pre-test, post-test, non-treatment comparison group, two treatment comparison group design was used to carry out the objectives of this study. All parameters outlined by Kot and Landreth (1997) and Tyndall-Lind (1999) were closely matched in the collection of data in order to achieve comparable and generalizable results (Kot & Landreth). Pre-training sessions were held at each shelter. Three pre-training sessions during which the mothers completed the Child Behavior Check List, demographic information and consent forms, included one mother per session; three pre-training sessions included two mothers per session; and one training session included eight mothers. The mothers were informed that play therapy training sessions would be

held every day for the next two weeks to three weeks and that they would learn the core concepts of child-centered play therapy which they would, in turn, put into practice with one of their children, who was between the ages of 4 and 10 years of age, during parent-child play sessions. The mothers were informed that they would receive 12 sessions (adapted from the Landreth, 1991 model) of training that would be approximately 1 to 1½ hours in length each day and that they would be expected to have 12 parent-child play sessions that would average 30 minutes in length. The mothers were informed that child care would be provided, either by using the shelter's childcare when available or through child care provided by the researcher on an as needed basis. Mothers were informed that they would be provided a set of toys and play materials to use during their parent-child play times and that the toys would be given to each participating family at the end of the study, in hopes that each mother would continue parent-child play sessions after leaving the shelter. Mothers were reminded that their participation was voluntary, and they and their child could withdraw at any time, for any reason. It was explained that no risks had been identified in following the protocol.

During the initial pre-training session, parents were again informed that the information provided on questionnaires and the videotapes would be kept confidential through the use of code numbers. It was explained that only the researcher would have the list of names and that the names of both parents and children would not be disclosed in any publication or discussion of this material. The researcher pledged to destroy the list of names at the conclusion of the study. The participants were informed that though the research assistant would know them by their first names, he was aware that the

confidentiality of participants was to be maintained. The researcher explained that videotaped recordings of the subjects would be destroyed post analysis.

Each mother signed a consent form (Appendix D) and completed the Child Behavior Checklist (CBCL). Although the CBCL is a self-administered inventory, the researcher and the research assistant were available and actually read through the form with some mothers who desired them to do so. This assistance streamlined the process, but no mother seemed to have difficulty reading the instrument. The one Hispanic mother who was more fluent in Spanish than English was offered a Spanish form, but she chose to use the English form of the CBCL.

For the parent-child *Special Play Times*, the mothers were encouraged to select the child with whom they had the greatest concern or the child that seemed to be having the most difficulty with the domestic violence as the *child of focus*). However, there was one exception. At one shelter, the clinical staff requested that a particular mother not choose the child who appeared to be having the most difficulty with the domestic violence, but rather refer that child, a seven year old boy, to the shelter's play therapist. That mother, therefore, selected her withdrawn, internalizing six year old, daughter as her child of focus rather than her defiant, externalizing son.

Before any training of mothers began, each *child of focus* met with the researcher or the research assistant for the administration of the Joseph Preschool and Primary Self-Concept Screening Test (JPPSST). Children who were seven years old or older signed an assent form (Appendix C).

After the completion of the self-report instruments, each of the mothers and their *child of focus* were videotaped for 20 minutes in either a shelter play room, or a designated room furnished with a set of toys and play materials provided by the researcher. The types of toys were consistent with the Kot (1995) and Tyndall-Lind (1999) studies. The video camera was in place and ready for videotaping each mother and child were taken to the play room or play area for the pretest playtime. Each mother-child pair was given the same introductory explanation, “This is a room where children and parents can play together. You may play with the toys in lots of the ways you would like to. You will have 20 minutes for playtime. I’ll come and tell you at the end of 17 minutes, so you will know that you have 3 minutes before playtime will be over. Then I will come back to get you when your playtime is over.”

The posttest sessions followed the same protocol for a 20 minute videotape of a parent-child play sessions and the completion of the CBCL by the mothers and the JPPSST by the children.

Treatment

During the week, all children attended off-site child care or summer camp programs while their mothers attended appointments throughout the day; therefore the weekday sessions, Monday through Thursday, were conducted from 5:00 to 6:30 p.m. at the domestic violence shelter and from 7:00 to 8:30 at the homeless shelter. Shelter scheduling required the mothers to attend various programs or case management sessions that made it difficult for every mother to attend every class session. All five mothers at the domestic violence shelter functioned as one filial therapy training group, even though

frequently one or two mothers missed a session. The six mothers at the homeless shelter were placed in one group, except for two week nights during which three of the mothers attended General Equivalency Diploma (GED) classes. On the other five nights of the week, all of the mothers at the homeless shelter met as one training group. The mothers who missed sessions during the week were required to schedule make-up sessions on the weekends. These make-up sessions were in addition to the regularly scheduled weekend parent training/parent-child playtime sessions and were generally scheduled either before or after the regular weekend training sessions.

During the first two or three filial therapy class sessions at both shelters, the researcher recognized how earnest and eager the mothers were to help their children and yet how overwhelmed, worried and exhausted they were when they arrived for class. Testimony to the mothers' dedication was the fact that they were giving up either their supper hour or the only free hour they had to just be with their children or the only hour that they could relax and care for themselves while the children were involved in the evening children's program.

The Landreth (1991) 10-week filial therapy training model was collapsed into 12 daily sessions of one and a half hours rather than weekly sessions. The one and a half hour training periods included a parent training session and a parent-child play session, which began on the second session. The training sessions varied between 20 to 45 minutes in length, and the playtimes varied from 15 to 40 minutes in length, depending on the mother's readiness and shelter demands on the mother's time. For the purpose of comparison with the treatment of the Kot and Tyndall-Lind studies, the facilitator kept a

careful record of the specific time each parent was in class and the amount of time she spent in parent-child play times. Each parents' participation was equivalent to 10 to 12 parent sessions (1 to 1 ½ hours in length) and 10 to 12 parent-child play sessions (30 to 40 minutes in length).

Didactic instruction was blended with emotional support and empathic understanding. Demonstration videotapes of actual parent-child play sessions were included to model for participating mothers that they, too, had the ability to be equally effective as other parents who had participated in filial therapy classes.

Hands on learning experiences were core to the instruction (i.e., role plays in which the mothers related between being the parent and being the child in simulated parent-child play sessions with the instructor and with one another). At the end of the second training session, the mothers conducted their first parent-child playtimes, beginning the process of putting the skills into action. The initial practice sessions were only 15 to 20 minutes in length so as to not overwhelm the mothers. The parent-child playtimes gradually were extended to 30 and even 40 minutes in length and were generally conducted three to five times a week, with training extending over a two to three week time period. Each mother was videotaped in a minimum of two play sessions with her child; however, most chose to videotape five to eight sessions. The videotapes were viewed in the training sessions for feedback from the group and the instructor.

The domestic violence shelter had three fully equipped play therapy rooms in which the mothers conducted many of their parent-child playtimes; however, in preparation for continuing the playtimes after leaving the shelter, each mother-child pair

had three or four playtimes with the box of toys in their family's room at the shelter. At the homeless shelter, the facilitator set up a temporary play room in the children's library with toys very comparable to those in a play therapy room.

Each mother and child participating in the study were assigned a "toy box" to use during some of their parent-child playtimes while residing at the shelter. The toys were consistent with those recommended by Landreth (1991). The mothers wrote their child's name or the family's name on the box, and they used their own set of toys during playtimes. The mothers told their children that the toys would be used only during *Special Play Times* and that their family would get to take the box of toys with them when they left the shelter. The toy boxes were placed in clear plastic bags according to type of toy and were kept in a workroom adjacent to the training room for easy access and were used on an as needed basis.

Although most of the mothers in the experimental group were struggling with their own therapeutic issues and urgent needs the training maintained an educational format with the intentional inclusion of emotional support, but did not emerge into group therapy sessions. The class followed the curriculum as outlined by Landreth (1991) and the focus remained on 1) helping parents to better understand their child (not addressing specific child problems), 2) enhancing parenting skills and the parent-child relationship, 3) preparing parents to convey empathic understanding and parental acceptance to their child and 4) allowing the child to be self-directive and self-responsible. Parents learned to use therapeutic limit setting based on a model of choice giving and consequences designed to develop self-control within the child.

Modifications of the Filial Therapy Model for Use In the Shelters

In order to accommodate the mothers' high levels of stress, physical and emotional exhaustion, required attendance at other classes/meetings at the shelter and the childcare needs of all of the children of participating mothers, several adaptations, were made to the Landreth (1991) model:

(a) The teaching segment and the parent-child play times were merged into a one hour and a half training sessions. In order to accommodate the busy schedules of the mothers and still provide an equivalency of 12 training sessions (1 to 1 ½ hours in length) with each parent conducting 10 to 12 parent-child play sessions, 30 to 40 minutes in length within a two to three week period, the facilitator went to each shelter seven days a week. Training sessions on the weekends often involved a two hour block of time which incorporated training, practice parent-child play session and a review/critique of the mothers' videotaped play sessions.

(b) The weekends were dramatically quieter and less structured at the shelters, which provided time for participants to explore in greater depth the new concepts and methods they were learning. Seldom was a mother able to attend every class session during the week; therefore, the weekends provided vitally important learning experiences and make-up sessions for the mothers, individually, and as a group. The weekends, also, afforded the facilitator time to nurture, to listen and to encourage mothers, individually and collectively. Frequently, weekend sessions concluded with a snack (i.e., popcorn, oreo cookies and milk, donuts) shared by participating mothers and all of their children.

(c) Didactic presentations were reduced to 5 to 10 minutes followed by a 5 to 10 minute experiential learning exercises (i.e., a demonstration by the facilitator and/or role playing by mothers). Following the thirty to sixty minute training sessions, the mothers had a *Special Play Time*, after which they returned to class for the viewing of the play sessions just completed. Initially, the parent-child play sessions were only 15 to 20 minutes in length with the *child of focus* in an adjacent play therapy room or play place (a private area where the facilitator had already set up the toys for the one-on-one playtimes). Even though the mothers were initially clumsy and awkward in the play sessions, the immediate “try it...and put it into practice” was imperative in order to maintain the mother’s focus. Handouts highlighted each day’s skill or concept and included a visual graphic or cartoon to reinforce the learning (Appendix E).

(e) *Live* supervision and daily videotaping of parent-child play sessions were incorporated on a daily basis. During the parent-child playtimes, the facilitator rotated from one mother-child pair to another, affirming the mother’s progress and briefly modeling for a few moments a specific skill with the child, according to the mother’s needs. The video camera was moved from one play session to another, every 10 to 15 minutes, which meant that some of nearly every mother-child playtime was videotaped. These video segments from each mothers’ most recent play sessions were utilized in the training sessions to personalize instruction and aid in the teaching of other mothers in the group. The use of the video camera to capture a part of each play session and the daily viewing of the video tapes were vital to maintaining the mothers’ interest and

commitment to improvement. The mothers and children showed no observable signs of discomfort with the addition and/or removal of the camera.

(f) In a few instances, when a mother for one reason or another (i.e., too discouraged, embroiled in a problem/shelter assigned chore, or missed her bus) could not participate in class or have that day's play session with her child, the facilitator videotaped a 10 to 15 minute play time with the absent mother's child. The child was told his/her mother would watch the videotape at a later date. The facilitator encouraged the mother to come the next evening to view the videotaped playtime with her child and the facilitator. Watching her own child respond to the skills and attitudes of the facilitator seemed to spark new energy and interest within the mother. These mini-demonstration tapes seemed to serve as a "jump start" for the mothers, after which they actively re-involved themselves in the training.

A modified training format was developed to accommodate schedule interruptions and other parent obligations. Although the facilitator preferred to follow the traditional class format in which all parents were present at a designated time for 1 to 1 ½ hours of instruction, the schedule often followed a more staggered, rotational-type schedule. Sometimes, several mothers would gather for 20 minutes of teaching that focused on a specific skills. Then those mothers would have a playtime to specifically practice the set of skills. In the meantime, two or three other mothers would arrive at class. Then, they would have a mini-lesson on the same skill and would begin parent-child play sessions at the time the first mothers were ready to return to class to report on their session and view videotaped segments of the session they had just completed. The next evening would

likely begin with the reviewing of the videotapes not yet critiqued from the night before. No matter how tired and over-burdened the mothers appeared upon arrival to class, the reviewing of their own videotaped play sessions seemed to always generate enthusiasm for learning.

Session by Session Outline of Landreth (1991) Filial Therapy Model

The following is the traditional outline of the Landreth (1991) filial therapy training sessions with modifications utilized in this study. All of the curriculum in the traditional outline was accomplished, but the timing and continuity followed an order of its own as was necessary to accommodate the changing circumstances and emotional needs of the mothers involved in the intensive filial therapy training:

Training Session One

Mothers introduced themselves, described their families, and identified concerns for their children, most particularly their *child of focus*. Goals of the filial therapy training were explained, and the facilitator gave an overview of the training sessions. The importance of developing sensitivity to their children and responding with empathy was emphasized, and a videotape of a parent-child playtime was shown to help the mothers conceptualize what a parent-child play session might be like. The tape, also, was instructional and demonstrated a parent who was reflecting feelings and tracking behavior in the play session with his child. Using a tape of a parent and child was intentional to convey to the mothers that they too, like the parent in the demonstration tape, could implement therapeutic skills that would facilitate growth in their child(ren). The facilitator demonstrated tracking behavior and reflecting feelings through role-play

with one of the mothers, and then all of the mothers paired up and practiced the two skills, using toys provided for the exercise. The homework assignment was for mothers to: (1) review handouts, (2) practice reflecting feelings (sad, glad, mad and afraid) to their children and write down one example for each emotion on the Reflecting Feelings handout. Handouts Folder: Partners in Play, The 3 R's of the Therapeutic Relationship, Reflect the Child to the Child, Listening, Four Feeling Faces. Article: Child's Play Important Business (Smith, 1986).

Training Session Two

Session two began with a review of the mothers' homework assignment on identifying and reflecting feelings. The facilitator demonstrated empathic responding with a volunteer from the group. The basic guidelines and principles of the 30-minute play sessions were explained, as presented in the Child-Parent Relationship Training handout. The facilitator displayed the toys to be used during the play times and discussed the rationale for selecting specific toys. The mothers were reminded that the box of toys were for the play sessions only, and not for general use. The facilitator reviewed the two beginning skills: (1) tracking behavior and (2) reflecting feelings. A brief introduction to limit setting, a three step process as developed by Landreth (1991), was presented in case the mothers needed to set a limit during their first brief parent-child play time. The group watched a videotape segment that clearly demonstrated a therapist therapeutically setting limits during a play therapy session. After a brief role-play of setting the limits in the play session, the mothers had a 15-20 minute introductory playtime with their *child of focus*. Parent-child play sessions occurred simultaneously at several play places in which the

toys were prearranged so the mother would not need to use any of the limited instructional time in setting out the toys. No videotaping was done of the first play session in order not to create a feeling of self-consciousness within any of the mothers.

Homework assignment: (1) completing “Facilitating Reflective Communication” handout, (2) noticing a physical characteristic or trait about your child you have never noticed before, (3) reading handouts. Handouts: Facilitating Reflective Communication.

Article: The Enchanting Power of Play (Appendix E).

Training Session Three

The session began with a discussion of “Facilitating Reflective Communication” handout and the first playtimes from the evening before. The facilitator presented the cluster of skills entitled Returning Responsibility (Appendix E) to the Child and showed a video that demonstrated the skills: (1) allowing the child to lead, (2) crediting to the child’s effort, (3) refraining from positive, judgmental praise, (4) returning the responsibility for decision making to the child, (5) not asking or answering questions, and (6) not referring to toys by name or a child’s play before the child does. After role playing the skills, the mothers conducted their second play sessions, and several mothers volunteered for their session to be videotaped. The facilitator told the mothers she would come observe and model a few minutes of “returning responsibility skills” with their child during each of their playtimes. Homework assignment: (1) notice examples of the child shifting responsibility to the parent and notice herself stepping in and usurping the child of responsibility, (2) write a note to your child as directed. Handouts: Returning

Responsibility to the Child, Do's and Don'ts of Play Therapy, Roles and Responsibilities of a Facilitative Adult (Appendix E).

Training Session Four

The session began with a report and discussion of the mothers' play sessions, particularly focusing on: (1) how did their child respond to their mother's returning responsibility to the child, (2) what was it like for them to shift responsibility to the child for the play session. The facilitator used examples from mothers' comments to reinforce the basic principles of filial therapy, identify difficult situations, and focus on how mothers felt during the sessions. Much of the training session consisted of the mothers sharing certain happenings that occurred in the plays sessions and seeking advice on how to handle those situations. The facilitator was intentional to find something in each mothers' sharing to affirm and encourage, taking care to be supportive, leaving suggestions for change to be presented at later sessions so as to not intimidate any mother. Suggestions were presented only in a generic manner, rather than making a specific suggestion to an individual mother. With the mother's permission, the class viewed short snippets from one another's videotaped sessions from the night before. Mothers were reminded that it is their responsibility to end the play sessions on time. Before mothers went to have the evening play session, the facilitator went over the Do's and Don'ts in Play Therapy. Homework assignment: Review Roles and Responsibilities of a Facilitating Adult handout (Appendix E).

Training Session Five

The class began with a discussion of the Roles and Responsibilities of a Facilitative Adult handout. Mothers were invited to evaluate where they were succeeding and where they were having difficulty with facilitative responses and to report on their most recent play sessions. The facilitator focused in-depth on therapeutic limit-setting. Landreth's (1991) handout titled, Techniques of Discipline that Work, to generate much discussion among the mothers about how these techniques could be applied in everyday interactions with their children as well as during *Special Play Times*. The methods of therapeutic limit setting and the skill of giving choices and consequences as a method of self-discipline were presented with demonstration. After viewing a videotape segment illustrating therapeutic limit setting with different types of children (cued and ready for viewing), the mothers role-played limit setting situations. Mothers were asked to utilize the limit setting skills as needed in that evening's play session. Homework assignment: Practice setting limits with choice giving technique two or three times outside of the play session during the next twenty-four hours. The session concluded with mothers conducting playtimes with their child while the facilitator observed, modeled and moved the video camera between the mother-child play sessions. Homework assignment: Review Techniques of Discipline handout and practice therapeutic limit setting two or three times in the next 24 hours. Handouts: Techniques of Discipline That Work, Characteristics of Therapeutic Limit Setting, Safe Person Safe Place Safe Process (Appendix B). Article: The Risk of Rewards.

Sessions Six through Twelve

The following sessions followed the same general format in which: (1) mothers reported on their homework assignments at the beginning of class, (2) discussed their most recent parent-child play session, generally including a viewing of a brief segment of the videotape of the session and receiving encouragement and suggestions from the facilitator and the other mothers, (3) reviewed and expanded core skills, reinforced with additional handouts and supplementary articles to increase understanding, mastery of the skills, (4) completed a brief experiential exercises (i.e., role playing) as needed, (5) focused on skills mastery in the daily play sessions with guidance for application outside of parent-child play sessions, (6) discussed pertinent homework assignments, and (7) began planning for the continuation of parent-child play sessions after leaving the shelter and transitioning to other children within the family. The facilitator continued to affirm each mother's progress, targeted specific (rather than generic) suggestions, and provided emotional support to each of the mothers, highlighting the mothers' ability to make a life changing difference in their children's lives. Parental coping skills were identified to help mothers gain a sense of personal power. The facilitator also overviewed the skills that had been learned and specifically credited the mothers' effort and described their improvement to help them recognize and internalize how much progress they had made.

Training Session Six

The class focused more on issues of limit setting, utilizing the handout, When Setting Limits Doesn't Work and the article, How to Stress Proof Your Child (Saunders, 1984). The discussion invited the mothers to look at their ability to help break the

intergenerational transmissions of violence and focused on their ability to calm themselves, not escalate emotionally, avoidance of feeling victimized and learning to attend to their own needs in order to increase their ability to handle frustration with their children. Handout: When Setting Limits Doesn't Work. Article: How to Stress Proof Your Child (Appendix E).

Training Session Seven

The facilitator discussed with the mothers common problems they were experiencing in the play sessions, as presented in the handout, Common Problems in Filial Therapy. The teaching, also, focused on expanding the concept of increasing children's positive self-concept through the parents' affirming and crediting their child's effort rather than judgmentally praising the child's product. A short portion of the article, In Praise of Praising Less, was read to assist in teaching the value of using descriptive praise as opposed to traditional, judgmental praise. Homework assignment: Practice descriptively crediting their child's effort and identify appropriate choices to use when setting consequences for their children's inappropriate choices. Article: Are You an Enslaved Parent (Appendix E).

Training Session Eight

Debriefing of the previous session's parent-child play sessions continued with a focus on the mothers' perceived changes in their own behavior as well as how they see their children changing. The mothers' confidence in their newly learned skills was evident and they were encouraged to speak more freely in critiquing each other's skills

and offer suggestions as the videotapes were reviewed. Handouts: Learning to Be Perfectionistic, Spanking (Appendix E). Article: Parents Who Spank.

Training Session Nine

The mothers were asked how they wanted their children to remember them. The facilitator aimed to reinforce and encourage their hopes through the examples of progress that they had made. The remainder of the session was spent on critiquing videotaped play sessions. Mothers were encouraged to continue plays sessions on a weekly basis after the class was completed. Handouts: Just Playing, Characteristics of the Therapeutic Process (Appendix E).

Training Session Ten

The mothers' videotaped play sessions continued to serve as the focal point of the class. The facilitator intentionally encouraged the mother's to share experiences in which they were applying the skills in everyday "real life" experiences. Mother's were encouraged to support one another's growth by identifying positive changes they had observed within one another's parenting. The instructor reinforced the value of continuing the play times on a weekly basis after completion of the class and on their preparing to gradually shifting to having play times with each of their other children within the ages of 3 to 12 years of age.

Training Session Eleven

Mothers were encouraged to critique their own, videotaped sessions as viewed in class, with an emphasis on identifying the skills and attitudes they were implementing in the session. Additions to the toy kit for older children (10 to 12 years of age) were

presented with an accompanying handout. Mothers were again encouraged to assess their child's need for continued play times in comparison to the need of siblings. The facilitator encouraged a discussion as to each mother's plan as to when, where and how they would continue play times after the completion of the class and upon leaving the shelter. The notebook of accumulated handouts and articles were reviewed to reinforce and integrate the learning into a holistic approach for relating to children.

Training Session Twelve

The final session was used to review the mothers' progress and the children's progress as a result of the training. Mothers were encouraged to offer their perspectives on what was most important to them, what they had gained and hoped to retain from the training. The facilitator asked them to think back to the beginning of the sessions and describe their child when they started and then identify specific changes they are observing in their child made during the past three weeks. Mothers were encouraged to identify behavioral and attitudinal changes they had made within themselves during the course of training. The importance of continuing the play sessions was emphasized, and mothers were encouraged to seek out professional support and guidance for themselves and their children in the future.

Facilitator

The filial therapy training groups were facilitated by the researcher of this study. The researcher is a Licensed Marriage and Family Therapist in the State of Texas, Registered Play Therapist-Supervisor, an Approved Supervisor of the American Association of Marriage and Family Therapy, and an Approved Supervisor of Licensed

Professional Counselors by the Texas State Board of Examiners. She has been a play therapist for twenty-five years and a filial therapy facilitator for sixteen years. As a part of her doctoral requirements, she had completed an introduction to play therapy course, an advanced play therapy course, a filial therapy course, a doctoral level practicum in play therapy, and a doctoral internship in play therapy. She is co-founder and director of a counseling center where she provides therapy to children, adolescents, adults, families, and where filial therapy training is available to parents on an ongoing basis.

Analysis of Data

For comparative analysis, the following data was utilized from the experimental group and the control group from the Kot (1995) study and from the experimental group from the Tyndall-Lind study (1999): the total mean score on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST), the Child Behavior Checklist (CBCL) Withdrawn subscale score, the Child Behavior checklist (CBCL) Somatic Complaints subscale score, the Child Behavior Checklist (CBCL) Anxious/Depressed subscale score, the Child Behavior Checklist (CBCL) Delinquent Behavior subscale score, the Child Behavior Checklist (CBCL) total Internalizing Behavioral Problems mean score, the Child Behavior Checklist (CBCL) total Externalizing Behaviors mean score, and the Child Behavior Checklist (CBCL) Total Behavior Problems subscale score.

Data for the MEACI was collected by videotaped analyses of parent-child interaction, which had been videotaped during the pre-test and post-test parent-child play

times, each 20 minutes in length, in the designated room with a selection of toys and play materials comparable to those used in the Kot (1995) and Tyndall-Lind (1999) studies.

Following the collection of the pre-test and post-test data, the two self-report instruments were blind-scored by a research assistant and double checked by a second research assistant. The pre and post-training videotapes of parent-child play sessions were not rated until completion of the study to insure that the raters did not know whether they were rating a pre-training or post-training session. Two doctoral students with advanced course work and training in play therapy and filial therapy blind scored the videotapes over a two-week period. Inter-rater reliability for the two raters was established during a 2-hour training session. Training included discussions and collaborative rating sessions, following the procedures outlined by Stover et al. (1971). Inter-rater reliability was also checked at the end of the scoring as suggested in the Manual for Coders (Muehl, 1961). Kendall's Coefficient of Concordance \underline{W} was used to calculate inter-rater reliability.

<u>Variables of the MEACI</u>	<u>Kendall's Coefficient W</u>	
	<u>Pretest</u>	<u>Posttest</u>
Communication of Acceptance	1.000*	.740
Allowing Self-Direction	.818*	.481
Parental Involvement	.866*	1.000*

P<.01*

Because of the small number of raters, and a relatively small sample size, inter-rater reliability was calculated to determine the correlation of how each rater coded each individual item. Out of 16 items on the MEACI, the raters only varied slightly on coding items in the posttest on the Allowing Child Self Direction variable, resulting in a low correlation of .481.

For the purpose of statistical analysis, data from all filial therapy training groups conducted at each of the two shelters involved was pooled to form the treatment group. The resulting data was keyed into the computer and analyzed by the researcher using SYSTAT: The System for Statistics (Wilkinson, 1990)

An analysis of covariance (ANCOVA) was computed to test the significance of the difference between the experimental group, the non-treatment comparison group/control group and the comparison treatment groups on the adjusted posttest means for each hypotheses of scores as measured by the Joseph Pre-school and Primary Self-Concept Screening Test (JPPSST) and the Child Behavior Check List. In each case, the posttest specified in each of the hypotheses was used as the dependent variable and the pretest as the covariant. ANCOVA was used to adjust the group means on the posttest on

the basis of the pretest, thus statistically equating the control, comparison and experimental groups. Significance of difference between means was tested at the .05 level. On the basis of the ANCOVA, the hypotheses were either retained or rejected.

In a comparison of the pretest and posttest means of three individual subscale scores and a total combined score as measured by the Measurement of Empathy of Adult-Child Interaction (MEACI) scores of the experimental group, an independent t-test was performed on this data. Significance of difference between means was tested at the .05 level.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents a description of the statistical analyses performed, the specific results of each hypotheses, consistent trends identified in the analysis of the data, a discussion of the potential meaning and implications of the findings, and recommendations for future research.

Results

The results of this study are presented in the order of the hypotheses were tested. Analyses of covariance were performed on hypotheses 1-18 an independent t-test was preformed on hypotheses 19-22. A level of significance of .05 was established as a criterion for either retaining or rejecting the hypotheses.

Hypothesis 1

There will be no significant difference in self-concept mean scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

Table 1 presents the pre and posttest means and standard deviations for the experimental and intensive individual play therapy groups. Table 2 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive individual play therapy groups' posttest mean scores.

Table 1

Mean scores of the intensive filial and intensive individual play therapy groups for the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

	<u>Experimental Group (n=11)</u>		<u>Intensive Individual Play Therapy Group (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	23.1818	25.6364	22.8182	27.0000
<u>SD</u>	4.7501	4.0063	3.7899	2.7928
Total cases =	22			

Note. A increase in the mean score indicates an increase in self-concept.

Table 2

Analysis of covariance data of the filial therapy and intensive individual play therapy groups for the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

Source of Variation	Sum of Squares	df	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	89.558	1	89.558	25.617	.000***
Covariates	277.030	1	277.030	79.2241	.000
Error	66.425	19	3.496		
Total cases =	22				

** $p < .001$

Table 2 shows the F ratio for the main effects was significant at the $< .001$ level indicating a significant increase in the intensive individual play therapy group's self-concept as measured by the JPPSST. On the basis of this data, hypothesis 1 was rejected.

Hypothesis 2

There will be no significant difference in self-concept mean scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive sibling group play therapy group .

Table 3 presents the pre and posttest means and standard deviations for the experimental and intensive sibling group play therapy groups. Table 4 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive sibling group play therapy groups' posttest mean scores.

Table 3

Mean scores of the intensive filial and intensive sibling group play therapy groups on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

	<u>Experimental Group (n=11)</u>		<u>Intensive Sibling Group Play Therapy Group (n=10)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	23.1818	25.6364	22.4000	26.0000
<u>SD</u>	4.7501	4.0068	3.9777	2.4944
Total cases =	21			

Note. An increase in the mean score indicates an increase in self-concept.

Table 4

Analysis of covariance data of the intensive filial and intensive sibling group play therapy groups for the mean scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F
Main effects	3.563	1	3.563	.741	.401
Covariates	129.992	1	129.992	27.033	.000
Error	86.554	18	4.809		
Total cases =	21				

Table 4 shows the F ratio for the main effects was not significant at the $< .05$ level indicating that there was not a significant difference between the experimental group and intensive sibling group play therapy group's self-concept as measured by the JPPSST. On the basis of this data, hypothesis 2 was retained.

Hypothesis 3

Subjects whose mothers receive intensive filial therapy training will attain a significantly higher mean score on self-concept as indicated by the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST) posttest than will subjects in the non-treatment comparison group .

Table 5 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison group. Table 6 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores.

Table 5

Mean scores of the filial therapy and non-treatment comparison groups on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

	<u>Experimental Group (n=11)</u>		<u>Non-Tr. Comp. Group (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	23.1818	25.6364	24.8182	22.9091
<u>SD</u>	4.7501	4.0068	4.0204	4.2768
Total cases =	22			

Note. An increase in the mean score indicates an increase in self-concept.

Table 6

Analysis of covariance data of the filial therapy and non-treatment comparison groups for the mean scores on the Joseph Pre-School and Primary Self-Concept Screening Test (JPPSST)

Source of Variation	Sum of Squares	df	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	14.378	1	14.378	4.770	.042*
Covariates	181.275	1	181.275	60.139	.000
Error	57.271	19	3.014		
Total cases =	22				

* $p < .05$

Table 6 shows the F ratio for the main effects was significant to the $< .05$ level indicating a significant difference in the experimental group's self-concept as measured

by the JPPSST when compared to the non-treatment comparison group. On the basis of these data, hypothesis 3 was retained.

Hypothesis 4

There will be no significant difference in Total Behavior Problems mean scores on the subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

Table 7 presents the pre and posttest means and standard deviations for the experimental and intensive individual play therapy groups. Table 8 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive individual play therapy groups' posttest mean scores.

Table 7

Mean scores of the intensive filial and intensive individual play therapy groups on the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems.

	<u>Experimental Group (n=11)</u>		<u>Intensive Individual Play Therapy</u>	
	Pretest	Posttest	<u>Group (n=11)</u> Pretest	Posttest
Mean	49.9091	31.2727	28.6364	21.1818
<u>SD</u>	38.6224	29.5232	19.8760	16.6542
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in total behavior problems.

Table 8

Analysis of covariance data of the intensive filial and intensive individual play therapy groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems.

Source of Variation	Sum of Squares	<i>df</i>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	37.992	1	37.992	.158	.695
Covariates	6924.352	1	6924.352	28.817	.000
Error	4565.466	19	240.288		
Total cases =	22				

Table 8 shows the F ratio for the main effects was not significant at the $< .05$ level indicating that there was not a significant difference between the experimental group and the intensive individual play therapy group's Total Behavior Problems as measured by the CBCL. On the basis of this data, hypothesis 4 was retained.

Hypothesis 5

There will be no significant difference in Total Behavior Problems mean scores of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive sibling group play therapy group.

Table 9 presents the pre and posttest means and standard deviations for the experimental and intensive sibling play therapy group. Table 10 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive sibling group play therapy posttest mean scores.

Table 9

Mean scores of the intensive filial and intensive sibling group play therapy groups on the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems.

	<u>Experimental Group (n=11)</u>		<u>Intensive Sibling Group Play Therapy Group (n=10)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	49.9091	31.2727	56.2000	35.1000
<u>SD</u>	38.6224	29.5232	33.1186	22.4274
Total cases =	21			

Note. A decrease in the mean score indicates a decrease in the total behavior problems.

Table 10

Analysis of covariance data of the experimental and intensive sibling group play therapy groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	.345	1	.345	.001	.973
Covariates	7981.698	1	7981.698	27.307	.000
Error	66.425	19	3.496		
Total cases =	21				

Table 10 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental group and the intensive sibling group play therapy group's Total Behavior

Problems as measured by the CBCL. On the basis of this data, hypothesis 5 was retained.

Hypothesis 6

Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Total Behavior Problems subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the non-treatment comparison group.

Table 11 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 12 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores.

Table 11

Mean scores of the filial therapy and non-treatment comparison groups on the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems.

	<u>Experimental Group (n=11)</u>		<u>Non-Tr. Comp. Group (n=11)</u>	
	<u>Pretest</u>	<u>Posttest</u>	<u>Pretest</u>	<u>Posttest</u>
Mean	49.9091	31.2727	42.8182	45.5455
<u>SD</u>	38.6224	29.5232	15.0254	15.8957
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in total behavior problems.

Table 12

Analysis of covariance data of the filial therapy and non-treatment comparison groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Total Behavior Problems.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	1927.517	1	1927.517	9.106	.007**
Covariates	7221.070	1	7221.070	34.114	.000
Error	4021.839	19	211.676		
Total cases =	22				

**p < .01

Table 12 shows the F ratio for the main effects was significant at the < .007 level indicating a decrease in the mean score on the Total Behavior Problems scale of the CBCL when compared to the non-treatment comparison group. On the basis of this data, hypothesis 6 was retained.

Hypothesis 7

There will be no significant difference in Internalizing Behaviors mean scores on the subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

Table 13 presents the pre and posttest means and standard deviations for the experimental and intensive individual play therapy groups. Table 14 presents the analysis

of covariance data showing the level of significance of the difference between the experimental and intensive individual play therapy group's posttest mean scores.

Table 13

Mean scores of the intensive filial and intensive individual play therapy groups on the Child Behavior Checklist (CBCL) subscale: Internalizing Behaviors.

	<u>Experimental Group (n=11)</u>		<u>Intensive Individual Play Therapy Group (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	14.8182	8.0909	6.0000	4.3636
<u>SD</u>	14.9587	11.5278	4.1713	3.5291
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in total behavior problems.

Table 14

Analysis of covariance data of the intensive filial and intensive individual play therapy groups for the Child Behavior Checklist (CBCL) subscale: Internalizing Behaviors.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	20.068	1	20.068	.930	.347
Covariates	1043.264	1	1043.264	48.324	.000
Error	66.425	19	3.496		
Total cases =	22				

Table 14 shows the F ratio for the main effects was not significant at the $< .05$ level indicating that there was not a significant difference between the experimental group and the intensive individual play therapy group's Internalizing Behaviors as measured by the CBCL. On the basis of this data, hypothesis 7 was retained.

Hypothesis 8

There will be no significant difference in Internalizing Behaviors mean scores on the subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive sibling group play therapy group.

Table 15 presents the pre and posttest means and standard deviations for the experimental and intensive sibling group play therapy groups. Table 16 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive sibling group play therapy groups' posttest mean scores.

Table 15

Mean scores of the intensive filial and intensive sibling group play therapy groups for the Child Behavior Checklist (CBCL) subscale: Internalizing Behaviors.

	<u>Experimental Group (n=11)</u>		<u>Intensive Individual Play Therapy</u>	
	Pretest	Posttest	<u>Group (n=10)</u> Pretest	Posttest
Mean	14.8182	8.0909	17.7000	10.8000
<u>SD</u>	14.9587	11.5278	12.2751	9.5778
Total cases =	21			

Note. A decrease in the mean score indicates a decrease in internalizing behaviors.

Table 16

Analysis of covariance of the intensive filial and intensive sibling group play therapy groups for the Child Behavior Checklist (CBCL) subscale: Internalizing Behaviors.

Source of Variation	Sum of Squares	<u>Df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	3.787	1	3.787	.102	.753
Covariates	1486.868	1	1486.868	40.087	.000
Error	667.641	18	37.091		
Total cases =	21				

Table 16 shows the F ratio for the main effects was not significant at the < .05 level indicating that there was not a significant difference between the experimental

group and the intensive sibling group play therapy group's Internalizing Behaviors as measured by the CBCL. On the basis of this data, hypothesis 8 was retained.

Hypothesis 9

Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Internalizing Behaviors subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the non-treatment comparison group.

Table 17 presents pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 18 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores.

Table 17

Mean scores of the filial therapy and non-treatment comparison groups for the Child Behavior Checklist (CBCL) subscale: Internalizing Behavior Problems.

	<u>Experimental Group n=11</u>		<u>Non-Tr. Comp. Group n=11</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	14.8182	8.0909	9.9091	10.0000
<u>SD</u>	14.9587	11.5278	5.1856	5.7096
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in internalizing behavior problems.

Table 18

Analysis of covariance data of the filial therapy and non-treatment comparison groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Internalizing Behavior Problems.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	147.692	1	147.692	6.281	.021
Covariates	1208.130	1	1208.130	51.378	.000
Error	446.779	19	23.515		
Total cases =	22				

*p < .05

Table 18 shows the F ratio for the main effects was significant at the < .05 level indicating a decrease in the mean scores on the Internalizing Behaviors scale of the CBCL when compared to the non-treatment comparison group. On the basis of this data, hypothesis 9 was retained.

Hypothesis 10

There will be no significant difference in Externalizing Behaviors subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers received intensive filial therapy training and subjects in the intensive individual play therapy group.

Table 19 presents the pre and posttest means and standard deviations for the experimental and the intensive individual play therapy groups. Table 20 presents the analysis of the covariance data showing the level of significance of the difference

between the experimental and intensive individual play therapy groups' posttest mean scores.

Table 19

Mean scores of the intensive filial and intensive individual play therapy groups for Child Behavior Checklist (CBCL) subscale: Externalizing Behavior Problems.

	<u>Experimental Group n=11</u>		<u>Intensive Individual Play Therapy Group n=11</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	14.5455	9.3636	12.3636	10.2727
<u>SD</u>	14.9587	6.6674	9.5841	9.1114
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in externalizing behavior problems.

Table 20

Analysis of covariance data of the intensive filial and intensive individual play therapy groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Externalizing Behavior Problems.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	23.265	1	23.265	.563	.462
Covariates	489.800	1	489.800	11.856	.003
Error	784.927	19	41.312		
Total cases =	22				

Table 20 shows the F ratio for the main effects was not significant at the $< .05$ level indicating that there was not a significant difference between the experimental group and the intensive individual play therapy group's Externalizing Behaviors as measured by the CBCL. On the basis of this data, hypothesis 10 was retained.

Hypothesis 11

There will be no significant difference in Externalizing Behaviors on the subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive sibling group play therapy group.

Table 21 presents the pre and posttest means and standard deviations for the experimental and intensive sibling group play therapy groups. Table 22 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive sibling group play therapy groups' posttest mean scores.

Table 21

Mean scores of the intensive filial and intensive sibling group play therapy groups on the Child Behavior Checklist (CBCL) subscale: Externalizing Behavior Problems.

	<u>Experimental Group (n=11)</u>		<u>Intensive Sibling Group Play</u>	
	<u>Pretest</u>	<u>Posttest</u>	<u>Therapy Group (n=10)</u>	
			<u>Pretest</u>	<u>Posttest</u>
Mean	14.5455	9.3636	18.5000	13.2000
<u>SD</u>	14.9587	6.6674	14.6761	8.8292
Total cases =	21			

Note. A decrease in the mean score indicates a decrease in externalizing behavior problems.

Table 22

Analysis of covariance data of the intensive filial and intensive sibling group play therapy groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Externalizing Behavior Problems.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	17.086	1	17.086	.696	.415
Covariates	704.132	1	704.132	28.674	.000
Error	442.013	18	24.556		
Total cases =	21				

Table 22 shows the F ratio for the main effects was not significant at the $< .05$ level indicating that there was not a significant difference between the experimental group and the intensive sibling group play therapy group's Externalizing Behavior Problem as measured by the CBCL. On the basis of this data, hypothesis 11 was retained.

Hypothesis 12

Subjects whose mothers receive intensive filial therapy will attain a significantly lower mean score on the Externalizing Behaviors subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the non-treatment comparison group.

Table 23 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 24 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores.

Table 23

Mean scores of the filial therapy and non-treatment comparison groups on the Child Behavior Checklist (CBCL) subscale: Externalizing Behavior Problems.

	<u>Experimental Group (n=11)</u>		<u>Non-Tr. Comp. Group (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	14.5455	9.3636	18.7273	20.0909
<u>SD</u>	14.9587	6.6674	7.4174	6.8477
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in externalizing behavior problems.

Table 24

Analysis of covariance data of the filial therapy and non-treatment comparison groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Externalizing Behavior Problems.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	354.398	1	354.398	14.648	.001*
Covariates	453.756	1	453.756	18.754	.000
Error	459.698	19	24.195		
Total cases =	22				

* $p < .01$

Table 24 shows the F ratio for the main effects was significant at the $< .01$ level indicating a decrease in the mean score on the Externalizing Behavior Problems scale of

the CBCL when compared to the non-treatment comparison group. On the basis of this data, hypothesis 12 was retained.

Hypothesis 13

There will be no significant difference in Anxious/Depressed mean scores on the subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

Table 25 presents the pre and posttest means and standard deviations for the experimental and intensive individual play therapy groups. Table 26 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive individual play therapy groups' posttest mean scores.

Table 25

Mean scores of the intensive filial and intensive individual play therapy groups on the Child Behavior Checklist (CBCL) subscale: Anxious/Depressed.

	<u>Experimental Group (n=11)</u>		<u>Intensive Individual Play Therapy Group (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	9.2727	4.3636	2.9091	2.5455
<u>SD</u>	8.1252	5.8047	2.7002	2.3817
Total cases =	22			

Note. A decrease in the mean scores indicates a decrease in anxiety and depression.

Table 26

Analysis of covariance data of the intensive filial and intensive individual play therapy groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Anxious/Depressed.

Source of Variation	Sum of Squares	<u>Df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	4.204	1	4.204	.465	.503
Covariates	143.598	1	143.598	15.893	.001
Error	171.674	19	9.035		
Total cases =	22				

Table 26 shows an F ratio for the main effects was not significant at the $< .05$ level indicating a decrease in the experimental group's and the intensive individual play therapy group's anxiety and depression as measured by the CBCL. On the basis of this data, hypothesis 19 was retained.

Hypothesis 14

There will be no significant difference in Anxious/Depressed mean scores on the subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy and subjects in the intensive sibling group play therapy group.

Table 27 presents the pre and posttest means and standard deviations for the experimental and intensive sibling group play therapy groups. Table 28 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive sibling group play therapy groups' posttest mean scores.

Table 27

Mean scores of the intensive filial and intensive sibling group play therapy groups on the Child Behavior Checklist (CBCL) subscale: Anxious/Depressed.

	<u>Experimental Group (n=11)</u>		<u>Intensive Sibling Group Play Therapy Group (n=10)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	9.2727	4.3636	9.5000	6.3000
<u>SD</u>	8.1252	5.8047	6.2937	5.4375
Total cases =	21			

Note. A decrease in the mean scores indicates a decrease in anxiety and depression

Table 28

Analysis of covariance data of the intensive filial and intensive sibling group play therapy groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Anxious/Depressed.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	17.381	1	17.381	1.174	.293
Covariates	258.255	1	258.255	17.450	.001
Error	266.391	18	14.799		
Total cases =	21				

Table 28 shows the F ratio for the main effects was not significant at the $< .05$ indicating there was not a significant difference between the experimental group and the intensive sibling group play therapy group's Anxiety/Depressed as measured by the CBCL. On the basis of this data, hypothesis 20 was retained.

Hypothesis 15

Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Anxious/Depressed subscale of the Child Behavior Checklist (CBCL) posttest than will subjects in the non-treatment comparison group.

Table 29 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison groups. Table 30 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores.

Table 29

Mean scores of the filial therapy and non-treatment comparison groups on the Child Behavior Checklist (CBCL) subscale: Anxious/Depressed.

	<u>Experimental Group (n=11)</u>		<u>Non-Tr. Comp. Group (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	9.2727	4.3636	6.7000	6.9000
<u>SD</u>	8.1252	5.8047	5.0343	5.2799
Total cases =	22			

Note. A decrease in the mean scores indicates a decrease in anxiety and depression.

Table 30

Analysis of covariance data of the filial therapy and non-treatment comparison groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Anxious/Depressed.

Source of Variation	Sum of Squares	df	Mean Square	F Ratio	Significance of F
Main effects	81.512	1	81.512	6.868	.017*
Covariates	295.816	1	295.816	24.925	.000
Error	213.629	18	11.868		
Total cases =	22				

*p < .05

Table 30 shows the F ratio for the main effects was significant at the < .05 level indicating a decrease in the mean score on the Anxiety/Depression scale of the CBCL when compared to the non-treatment comparison group. On the basis of this data, hypothesis 21 was retained.

Hypothesis 16

There will be no significant difference in Aggressive Behaviors mean scores on the subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive individual play therapy group.

Table 31 presents the pre and posttest means and standard deviations for the experimental and intensive individual play therapy groups. Table 32 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive individual play therapy groups' posttest mean scores.

Table 31

Mean scores of the intensive filial and intensive individual play therapy groups on the Child Behavior Checklist (CBCL) subscale: Aggressive Behaviors.

	<u>Experimental Group (n=11)</u>		<u>Intensive Individual Play Therapy Group (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	11.9091	7.8182	10.1818	8.9091
<u>SD</u>	7.3818	5.7934	7.8590	8.1173
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in aggressive behaviors.

Table 32

Analysis of covariance data of the intensive filial and intensive individual play therapy groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Aggressive Behaviors.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	24.149	1	24.149	.778	.389
Covariates	404.798	1	404.798	13.041	.002
Error	589.748	19	31.039		
Total cases =	22				

Table 32 show the F ratio for the main effects was not significant at the $< .05$ level indicating that there was not a significant difference between the experimental

group and the intensive individual play therapy group's Aggressive Behaviors as measured by the CBCL. On the basis of this data, hypothesis 34 was retained.

Hypothesis 17

There will be no significant difference in Aggressive Behaviors mean scores on the subscale of the Child Behavior Checklist (CBCL) posttest between subjects whose mothers receive intensive filial therapy training and subjects in the intensive sibling group play therapy group.

Table 33 presents the pre and posttest means and standard deviations for the experimental and intensive sibling group play therapy groups. Table 34 presents the analysis of covariance data showing the level of significance of the difference between the experimental and intensive sibling group play therapy groups' posttest mean scores.

Table 33

Mean scores of the intensive filial and intensive sibling group play therapy groups on the Child Behavior Checklist (CBCL) subscale: Aggressive Behaviors.

	<u>Experimental Group (n=11)</u>		<u>Intensive Sibling Group Play</u>	
	Pretest	Posttest	<u>Therapy Group (n=10)</u>	
			Pretest	Posttest
Mean	11.9091	7.8182	14.7000	11.3000
<u>SD</u>	7.3818	5.7934	10.8236	8.0973
Total cases =	21			

Note. A decrease in the mean score indicates a decrease in aggressive behaviors.

Table 34

Analysis of covariance data of the intensive filial and intensive sibling group play therapy groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Aggressive Behaviors.

Source of Variation	Sum of Squares	<i>df</i>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	15.822	1	15.822	.900	.355
Covariates	609.358	1	609.358	34.669	.000
Error	316.379	18	17.577		
Total cases =	21				

Table 34 shows the F ratio for the main effects was not significant at the $< .05$ level indicating that there was not a significant difference between the experimental group and the intensive sibling group play therapy group's Aggressive Behaviors as measured by the CBCL. On the basis of this data, hypothesis 34 was retained.

Hypothesis 18

Subjects whose mothers receive intensive filial therapy training will attain a significantly lower mean score on the Aggressive Behaviors subscale of the Child Behavior Checklist (CBCL) post-test than will subjects in the non-treatment comparison group.

Table 35 presents the pre and posttest means and standard deviations for the experimental and non-treatment comparison group. Table 36 presents the analysis of covariance data showing the level of significance of the difference between the experimental and non-treatment comparison groups' posttest mean scores.

Table 35

Mean scores of the filial therapy and non-treatment comparison groups on the Child Behavior Checklist (CBCL) subscale: Aggressive Behaviors.

	<u>Experimental Group (n=11)</u>		<u>Non-Tr. Comp. Group (n=11)</u>	
	Pretest	Posttest	Pretest	Posttest
Mean	11.9091	7.8182	16.2000	17.7000
<u>SD</u>	7.3818	5.7934	6.7132	6.3430
Total cases =	22			

Note. A decrease in the mean score indicates a decrease in aggressive behaviors.

Table 36

Analysis of covariance data of the filial therapy and non-treatment comparison groups for the mean scores on the Child Behavior Checklist (CBCL) subscale: Aggressive Behaviors.

Source of Variation	Sum of Squares	<u>df</u>	Mean Square	<u>F</u> Ratio	Significance of <u>F</u>
Main effects	245.803	1	245.803	13.677	.002*
Covariates	374.236	1	374.236	20.823	.000
Error	323.500	18	17.972		
Total cases =	22				

* $p < .01$

Table 36 shows the F ratio for the main effects was significant at the $< .002$ level indicating a significant decrease in the mean score on the Aggressive Behaviors subscale

of the CBCL when compared to the non-treatment comparison group. On the basis of this data, hypothesis 35 was retained.

Hypothesis 19

The parents who receive intensive filial therapy will attain a significantly lower mean posttest score on the Total Empathy scale of the Measurement of Empathy in Adult-Child Interaction (MEACI) than will be attained on the mean pretest score.

Table 37 presents the pretest and posttest means for the Total Empathy scale of the Measurement of Empathy in Adult-Child Interaction (MEACI) and the pretest and posttest means of the three subscales on the MEACI: (a) Communication of Acceptance, (b) Allowing the Child Self-Direction, and (c) Involvement. Table 37 includes the standard deviations for each of the four dimensions of the MEACI, the t-scores, and the significance of difference between the posttest mean scores and the pretest mean scores.

Table 37

Analysis of t-test for the equality of mean scores of the Total Empathy, Communication of Acceptance, Allowing the Child Self-Direction, and Involvement of the Measurement of Empathy in Adult-Child Interaction (MEACI)

	Mean	SD	t-value	Df	P
Total Empathy					
N = 11			4.746	10	.001 *
Pretest	56.5455	8.82846			
Posttest	38.8864	8.1174			
Communication of Acceptance					
N = 11			4.522	9	.001 *
Pretest	18.2750	1.5021			
Posttest	13.4250	2.8772			
Allowing the Child Self-Direction					
N = 11			4.493	9	.002 *
Pretest	21.1500	3.7642			
Posttest	14.1500	4.0670			
Involvement Subscale Score					
N = 11			1.686	9	.126
Pretest	16.7000	6.1292			
Posttest	12.1500	3.9585			

*p < .01

Note: A decrease in the mean score indicates an increase in that area.

Table 37 shows the t-scores for the main effects was significant at the .001 level indicating that there was a significantly lower mean posttest score on the Total Empathy subscale of the MEACI as compared to the mean pretest score. On the basis of this data, hypothesis 19 was retained.

Hypothesis 20

The parents who receive intensive filial therapy will attain a significantly lower mean posttest score on the Communication of Acceptance subscale of the Measurement of Empathy of Adult-Child Interaction (MEACI) than will be attained on the mean pretest score.

Table 37 presents the pretest and posttest mean scores on the Communication of Acceptance of the Measurement of Empathy in Adult-Child Interaction (MEACI), the standard deviations, the t-scores, and the significance of difference between the posttest mean scores and the pretest mean scores.

Table 37 shows the t-scores for the main effects were significant at the .001 level indicating that there was a significantly lower mean posttest score on the Communication of Acceptance subscale of the MEACI as compared to the mean pretest score. On the basis of this data, hypothesis 20 was retained.

Hypothesis 21

The parents who receive intensive filial therapy will obtain a significantly lower mean posttest score on Allowing the Child Self-Direction of the Measurement of Empathy in Adult-Child Interactions (MEACI) than will be attained on the mean pretest score.

Table 37 presents the pretest and posttest mean scores on the Allowing the Child Self-Direction of the Measurement of Empathy in Adult-Child Interaction (MEACI), the standard deviations, the t-scores, and the significance of difference between the posttest mean scores and the pretest mean scores.

Table 37 shows the t-scores for the main effects was significant at the .002 level indicating that there was a significantly lower mean posttest score on the Allowing the Child Self-Direction subscale of the MEACI as compared to the mean pretest score. On the basis of this data, hypothesis 21 was retained.

Hypothesis 22

The parents who receive intensive filial therapy will attain a significantly lower posttest mean score on the Involvement subscale of the Measurement of Empathy on the Adult-Child Interaction (MEACI) than will be attained on the mean pretest score.

Table 37 presents the pretest and posttest mean scores on the Involvement subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI), the standard deviations, the t-scores, and the significance of difference between the posttest mean scores and the pretest mean scores.

Table 37 shows the t-scores for the main effects was not significant at the .05 level indicating that there was not a significantly lower mean posttest score on the Involvement subscale of the MEACI as compared to the mean pretest score. On the basis of this data, hypothesis 22 was rejected.

Discussion

The results from this study point to the effectiveness of intensive filial therapy in a variety of areas with mothers functioning in a therapeutic role with their children who are witnesses of domestic violence. Significant results were found on each of the six hypothesis comparing intensive filial therapy to the non-treatment comparison group. Possibly the most profound result was the lack of significant difference between the experimental group versus the comparison groups on 10 of 11 variables as measured by the Child Behavior Check List. These findings indicate that intensive filial therapy as facilitated by the mothers was as effective in producing a comparable reduction in problematic behaviors in the children as was achieved through intensive individual play therapy and intensive sibling group play therapy which were facilitated by professional therapists. The experimental group (intensive filial therapy) and the comparison treatment groups (intensive individual play therapy and intensive sibling group play therapy) each facilitated improvement in children's self-concepts at a statistically significant level as measured by the Joseph Preschool and Primary Self Concept scale. There was a statistically significance difference among the treatment groups in favor of intensive individual play therapy.

In a comparative analysis, the children who received the experimental treatment, intensive filial therapy, or a comparison treatment, either intensive individual play therapy or intensive sibling group play therapy, produced improvement on 9 of 12 variables as measured by the JPPSST and the CBCL. Appendix A gives a visual comparison of a positive trend maintained by the experimental treatment and the two

comparison treatments in facilitating positive results in the children as compared to the decline or lack of gain of the children in the non-treatment comparison group, as measured on the JPPST and the CBCL.

The results of this study are discussed in the following order: (1) improvement of children's self concepts, (2) the reduction of children's behavioral problems, (3) the ability of the mothers to function in a therapeutic role with their children, (4) the unique components of the model and pertinent challenges inherent in the study, (5) the comparative analysis of intensive filial therapy, intensive individual play therapy and intensive sibling group play therapy, and (6) a concluding presentation of implications for future application and research.

Self Concept

The children in the filial therapy group demonstrated a significant increase ($p < .042$) in self-concept as measured by the Joseph Preschool and Primary Self-Concept Screening Test (JPPSST) in comparison to the non-treatment comparison group.

These findings substantiate B. Guerney and L.Guerney's original premise that parents have a "uniquely powerful influence" on their children's development and a "genuine motivation to be a positive force in their children's lives in the great majority of cases" (L. Guerney & B. Guerney, Jr., 1989, p. 345). B. Guerney hypothesized in 1964, during the formation period of Filial Therapy, "that parents are so important in their children's lives that acceptance from them might be as [if not more] meaningful for the children" than from a therapist (Guerney, 1997, p. 136).

Poor self-concept has been documented as a lingering legacy of children who have witnessed domestic violence, a debilitating factor that is fundamental to many of the emotional, psychological, relational and behavioral problems, which tend to follow child witnesses into adolescence and adulthood (Carlson, 1991; Kilpatrick et al., 1998; Spaccarelli et al., 1995). Self-concept is not developed in a vacuum, but rather within a context of family relationships over an extended period of time (Cicchetti, Toth & Lynch, 1995; B. Guerney, 1964, Moustakas, 1955).

“DeMaria and Cowden...suggested that changes in self-concept cannot be made directly. Instead, change in self-concept must be impacted through the child’s experiences, activities and environmental reactions” (Tyndall-Lind, 1999, p. 81)

Children who are egocentric and not yet able to abstract and objectify experiences, particularly frightening ones, are more likely to personalize trauma, often deciding it was their fault or somehow they were to blame (Gill, 1991; Terr, 1994). The child’s assumed sense of responsibility may contribute to guilt, shame, fear and rage, which may contribute to the child’s negative picture of self. It seems to not be as scary for a young child to decide that he/she is the *bad one* rather than consider the *badness* is really within his/her parents.

In contrast to children with chronic low self-concepts, children with positive self-concepts have been shown to be more able to access social systems, build positive relationships and utilize their abilities to achieve, all of which are believed to help counterbalance the negative messages inherent in families of domestic violence (Tyndall-Lind, 1999). Jasinski and Williams (1998) asserted that “Children with a high self-concept are less likely to internalize personal blame for family violence” (Jasinski &

Williams, 1998, as cited in Tyndall-Lind, 1999, p. 80). The findings of this study suggest that intensive filial therapy is an effective intervention to improve the self-concepts of child witnesses of domestic violence.

Behavior Problems

Children in intensive filial therapy group demonstrated a significant decrease ($p < .007$) in Total Behavior Problems as measured by the Child Behavior Check List (CBCL) in comparison to the non-treatment comparison group at the time of posttesting. The significantly lower mean score on Total Behavior Problems indicated a reduction of overall behavioral problems as perceived by the children's mothers. The CBCL score of Total Behavior Problems is a composite score of eight subscales: (a) Internalizing Behaviors, (b) Externalizing Behaviors, (c) Withdrawn Behaviors, (d) Somatic Complaints, (f) Anxious/Depressed, (g) Social Problems, (h) Thought Problems, (i) Attention Problems (j) Delinquent Problems, and (k) Aggressive Behaviors. These findings suggest that the overall well being and emotional adjustment of the children in the intensive filial therapy group were significantly improved as a result of the intensive filial therapy treatment. Shelter staff observed fewer behavior problems in the children and, also, reported having observed improved parenting skills in the mothers, particularly when the mothers were responding to children's acting out behavior.

Some researchers have suggested that mothers' reports of their children's behavior may be modified by stress influences (Brody & Forehand, 1986; Hughes, 1988, Hughes & Barad, 1983; Hughes et al., 1989). Hughes and Barad (1983) found that mothers under stress had a tendency to be more judgmental of their children and

postulated that mothers' stress was manifested in greater frustration with their children's negative behaviors. "This implies that any positive change noted by the mothers has a potential to be an underestimation of the actual behavior change exhibited by the child" (Tyndall-Lind, p. 83, 1999). That being the case, the mothers' identification of fewer problem behaviors suggests that the improved child behavior as perceived by the mothers may indeed be a result of the experimental treatment.

The fact that the non-treatment comparison group demonstrated an increase on Total Behavior Problems on the CBCL posttest suggests that intensive filial therapy is an effective treatment modality in reducing overall problem behaviors. It is noteworthy that the children who received intensive filial therapy treatment with their mothers as facilitators and the children who received intensive individual play therapy and intensive sibling group play therapy treatment with professional therapists as facilitators made comparable changes.

Children in the intensive filial therapy group demonstrated a significant decrease ($p < .021$) in Internalizing Behaviors as measured by the CBCL in comparison to the non-treatment comparison group at the time of posttesting. Children in intensive individual play therapy showed a decrease, though not at a level of statistical significance, and children in the intensive sibling group play therapy demonstrated a significant decrease ($p < .058$) in Internalizing Behaviors as measured by the CBCL in comparison to the non-treatment comparison group at the time of posttesting. The Internalizing Behavior scale of the CBCL consists of the three subscales of Withdrawn Behaviors, Somatic Complaints and Anxious/Depressed which are combined to formulate

the Internalizing Behaviors score. Each of these subscales represents a unique type of internalizing behavior.

By definition, internalizing behaviors are those behaviors in which the individual uses a defensive mechanism of turning emotional distress inward, described as a depressing or condensing of problems into the privacy of self. Internalizing behaviors are identified by some researchers as precursors of Post Traumatic Stress Disorder and other anxiety and depressive disorders prevalent within child witnesses of domestic violence (Kilpatrick & Williams, 1998). Whereas externalizing behavior problems tend to invite attention from parents, internalizing behaviors are less noticeable.

Kot (1995) proposed that a plausible explanation for the insignificant difference between the intensive individual play therapy group and the control group in her study was the mothers' stress which may have made them insensitive to changes in the children's internalizing behavior problems. Tyndall-Lind (1999) postulated that the significant decrease in internalizing behaviors evidenced in intensive sibling group play therapy treatment may have been facilitated by the shift of focus from intrapersonal to interpersonal patterns of communication in the group sessions. In relation to the significant decrease ($p < .021$) in the intensive filial therapy group, the focused attention and empathic, reflective listening responses the children received from their mothers during the parent-child play sessions may have contributed to the reduction of internalizing behaviors. The child-centered approach would seem to be even more impactful in the presence of a parent or perhaps a sibling than a professional. In addition, as the mothers communicated more understanding and acceptance for their children, the

children may have felt safer and freer to express themselves more openly with less of a need to internalize.

Children in the filial therapy group demonstrated a significant ($p < .001$) decrease in Externalizing Behavior Problems as measured by the CBCL in comparison to the non-treatment comparison group at the time of posttesting. This means the children's mothers in the filial therapy group perceived a significant reduction in externalizing behavior problems in their children. The Externalizing Behavior score is derived from the Aggressive Behaviors subscale and the Delinquent Behavior subscale of the CBCL. In light of the fact that research has repeatedly shown that child witnesses of domestic violence demonstrate increased levels of aggressive behaviors (Carlson, 1991; Kilpatrick & Williams, 1998; Rossman, 1998), justify their use of physical force to resolve conflicts and demonstrate increased acting out behaviors, the significant reduction in externalizing and aggressive behaviors achieved with intensive filial therapy, intensive individual play therapy and intensive sibling group play therapy is noteworthy.

In examining the roots of externalizing symptomatology in children, the role of attachment and dysfunctional parent-child relationships have been implicated (Greenberg, Speltz, & DeKlyen, 1993, as cited in Cicchetti, Toth & Lynch, 1995). Cicchetti et al. (1995) identified some externalizing behavior problems as being a result of caregivers' negative or unrealistic expectations of children, while other externalizing problems are a result of negative attachment patterns with the children's caregivers (Cicchetti et al., 1995). Attachment difficulties have been shown to be manifested as externalizing behaviors when children's relationships are characterized by anger,

mistrust, chaos and insecurity, as is the case of families experiencing domestic violence (Greenberg, Speltz & DeKlyen, 1993, as cited in Cicchetti et al., 1995). Greenberg (1993) found that the “warm, supportive presence” of the parent helped children “develop confidence in the caregiver and in the self, thereby preventing the emergence of externalizing symptomatology” (Greenberg, 1993, as cited in Cicchetti et al., 1995, p. 26). From an attachment perspective, the reduction in externalizing behavior in the experimental group as opposed to the non-treatment comparison group may have been directly related to the consistent focused attention of the mothers on their children in the one-on-one parent-child play times.

An illustration of one seven-year-old boy and his mother who were in the filial therapy group at the domestic violence shelter is a case in point. Upon entry into the shelter, the shelter staff immediately classified this child at *high risk* of severe clinical problems. During the first few days at the shelter, his mother had little to no control over him and his behavior. The treatment plan for him was two fold: (1) the mother’s implementation of the therapeutic limit setting techniques that are core to the filial therapy model, and (2) her beginning by the second day conducting daily parent-child play sessions with him.

The following is a verbatim of an actual scene in the shelter dining room, witnessed by the facilitator, in which this mother implemented the principles of therapeutic limit setting, which are a crucial component of the filial therapy model.

Mother: “Kids, it is time to take your plates to the trash. Then you can go out to the playground while Mommy goes to her play class.”

Seven Year Old : “I’m KING!!! (said with an air of authority interlaced

with sarcasm). Clean-up is only for girls! You are my servant (said to his six year old sister, as he motioned to her) You clean up it up!”

Mother: “I know, _____, you don’t want to clean up your dirty plate, but it is time to the playground. Your plate and cup go in the trash.”

Boy (to his mother): “I’m not cleaning up. Kitchen work is for women”, (a repeat of a familiar refrain he had heard his father say on many occasions).

Mother (firmly and calmly): “_____, I know you don’t think cleaning up is your job. If you choose to clean up your plate, then you choose to go to the Playground with the other kids. If you choose to not clean up your plate, then you are choosing to sit in the hallway outside of my play class. Which do you choose?”

As he pouted, the mother cleared the table and stationed him in a boring hallway, just outside the doorway of the filial therapy class.

During this boy’s first parent-child playtime, all of the good animals died trying to slay the monster dragon. As his play theme unfolded in subsequent sessions, he expressed his inner yearning to slay the “mean, bad dragons” (the prehistoric and surreal monster-type animals) and to save the “good ones” (the jungle, forest, farm and domestic type animals). Gradually, fewer and fewer of the “good animals” were killed “trying to save their babies”. Ironically, never did he let any of the baby or young animals be killed. Finally, all of the “good animals” found their way to the same “big house,” a “safe hiding place” from the “bad, mean dragon.” He crowded all of the jungle animals into an upper bedroom, the farm animals in another, the domestic animals in another. In his final play session before the conclusion of the study, the “worst thing happened that had never, ever happened before...the bad monster and all of his mean friends found the big house. Hurry, hurry, hide all of the babies...they are coming...they are coming to kill us.” (Tragically, the boy’s father had threatened to kill all of them in an 100 mile an hour race

through city streets). The victory was not to be without casualty, however, finally all of the different kinds of animals joined in “one big attack” by all the “good mama and daddy animals” and the “the Baddest One and all of his friends were killed. They are dead forever and forever,” he shouted. “And now let’s have a great, big party. And they all lived happily ever after in the big, big house. The End.”

It was the mother’s and the facilitator’s opinion that this child was truly battling to release deep emotional pain that was buried under all of his defiant behavior. Many experts in the field of trauma confirm that children who have experienced trauma are often able to gain relief through the symbolic expression of aggression within the safety of a therapeutic relationship and play therapy (Gill, 1991; Pynoos & Eth, 1986; Terr, 1994).

Children in the filial therapy group demonstrated a significant decrease ($p < .017$) in anxious and depressed feelings as measured by the CBCL in comparison to the non-treatment comparison group. This means that children who participated in filial therapy decreased behavior associated with feelings of sadness, loneliness, nervousness, guilt, fear, helplessness and hopeless. The children in the non-treatment comparison group showed no similar decrease in anxiety and depression. These results are encouraging in light of the unusually high prevalence of anxiety and depression in child witnesses of domestic violence that continues into adolescence and adulthood (Kilpatrick & Williams, 1998).

Depression and anxiety in children are often manifested in distressed moods (i.e., irritability, negative attitudes, defensiveness, hyper vigilance, phobic-type reactions), physiological reactions (i.e., hyperactivity, enuresis, encopresis, nail biting, thumb sucking) and/or dysfunctional behaviors (i.e., obsessiveness, separation anxiety, controlling in the form of bossiness/bullying, perfectionism, over-adaptive ness) (Kilpatrick & Williams, 1998; Pynoos & Nader, 1990). A plausible explanation for the intensive filial therapy group's significant reduction ($p < .017$) of problems with anxiety and depression and the significant reduction ($p < .058$) in these same areas by the intensive sibling group play therapy group as compared to the lack of significant reduction in the intensive individual play therapy group may be related to the intimate involvement of a family member in the therapeutic process. The children in the filial therapy group received the treatment intervention from their own mothers. The children in intensive sibling group play therapy were involved in the group experience with a sibling and the therapist. The children in the intensive individual play therapy received treatment from a non-family member, a person trained to function as a therapist. Behavioral changes within the course of the filial therapy treatment that were believed to be related to anxiety and depression included a seven year old boy's discontinuation of frequent soiling, a four-year-old girl's shifting from pull-ups to panties, a five-year-old boys' becoming able to move about the shelter rather than stay by his mother's side, a ten-year-old girl's ability to stop breaking shelter rules which had been a continual threat of expulsion from the center.

The children in the intensive filial therapy group demonstrated a significant decrease ($p < .002$) in posttest mean scores versus the non-treatment comparison group on the Aggressive Behavior subscale of the Child Behavior Check List. In light of the prevalence of the intergenerational transmission of violence, the reduction of aggressive behaviors in child witnesses is encouraging. The children in the non-treatment comparison group increased their aggressive behaviors, as measured by the Aggressive Behavior subscale of the CBCL. Several mothers in the intensive filial therapy group admittedly knew their yelling, threatening, slapping, spanking, scolding was adding to their children's problems with anger, but they did not previously have the knowledge or skill to respond differently. This was particularly true of the mothers of sons who expressed concern that they were afraid their sons would be like their fathers and they tended to overreact with anger whenever their sons acted out with anger. It was the researcher's observation and the mothers' conclusion that the mothers' learning to set limits in a non-threatening, non-punitive way contributed to their children being less aggressive.

Empathic Behavior: A Function of Communication of Acceptance, Allowing the Child Self Direction and Parent Involvement with the Child

The mothers in the intensive filial therapy experimental group showed a significant decrease ($p < .001$) on the Overall Empathy subscale posttest on the MEACI in comparison to their pretest score. For this scale, a decrease in the mean score indicates an increase in the desired behavior. Overall Empathy is a total score of three subscales of the MEACI: Communication of Acceptance, Allowing the Child Self-Direction and

Involvement. These findings suggest that the filial therapy training enabled the mothers in the experimental group to significantly improve their ability to: (a) convey empathy to their children, (b) communicate acceptance to their children, and (c) allow the child to be self-directive which entailed following the child's lead rather than controlling or directing the child.

Communication of Parental Acceptance: A Dimension of Empathy

The mothers in the intensive filial therapy experimental group demonstrated a significant decrease ($p < .001$) on the Communication of Acceptance subscale of the MEACI in comparison to their pretest score. This indicates that the mothers made significant improvement in their ability to communicate genuine acceptance of their children's feelings, thoughts and behaviors during the observed play times. According to Stover, B. Guerney, and O'Connell (1971), the verbal expression of acceptance is the major element in the communication of empathy. Although it is common knowledge that children need approval and acceptance from adults, parents seldom verbalize statements of acceptance while spontaneously interacting with their children (Stover et al., 1971). During the initial pretest parent-child play time, not one parent made a positive reflection of feeling response, the primary behavioral indicator of communication of acceptance on this scale. The participating mothers unanimously agreed that knowing how to communicate acceptance of their children seemed to help their children feel better about themselves and, most definitely, had helped the mothers feel better about themselves as a parent.

Rather than continue to parent from a perspective of external locus of control, the mothers gradually began to report feeling much more in control of themselves and their parenting, no longer experiencing that dreadful, entrapped feeling of being out of control that was so predominant when they entered the shelter. As the mothers became more adept at using the new therapeutic skills learned in filial therapy, a new inner confidence (internal locus of control) emerged. As stated by one mother, herself a victim of severe abuse as a child and in her marriage,

I hated myself for loosing my temper with my four-year old. But I'd just get so mad I'd just pop off an' smack her before I knew it. I swore I'd never beat my kids like my folks whipped me, but I was beginning to be just like 'em...screamin' like my mom, hitting like my dad.

But you all [the other mothers] would have been so proud of me the other day at Wal Mart. She was having one of her screamin' fits. Instead of smacking her right then and there, I just kept on reflecting her feelings. I didn't loose my cool and yell or spank her either. I've only spanked her once in over a week.

The following excerpts from a pretest parent-child play session in which the mother was caustic, bossy, critical and intrusive, followed by excerpts from the same mother's posttest session illustrate the type of dramatic shifts the mothers made from communicating a preponderance of negative remarks to an abundance of affirming responses.

Six-year old boy begins to explore the toys at the beginning of the pretest play session....picking up two or three puppets...

Mom: Why you pickin' that one? Why don't you play with that mean lookin' red one...

Boy: I don't know.....This one? You like this one, Mama?

Mom: No...that one has teeth.... Are you mad? What you mad about?

What is that one?

Boy: It's a dog.

Mom: No it's not. It's a bull. Bulls fight....make it mad...make it fight.

Boy moves on to explore the bop bag...

Mom: Don't mess with that...

Boy: Why not? She said I could....

Mom: Don't matter what she said...I'm your boss. Oh, well, go ahead and hit it...No, not that direction...Don't you see the video camera over there?

Boy: Yeah...I won't hit it.

Mom: Oh, yes you will. You're always breaking something. Why you quit hitting that thing. You need to get your mad out...then you won't take it out on your brother and me. Why you playin' with that thing?

The entire session was filled with criticisms, corrections and negative putdowns until the mother withdrew and became preoccupied with her fingernails, applying nail polish that was with the play make up and dress-up things.

The posttest session was as positive in many respects as the pretest session was negative.

Boy: Hey, mama, hey mama, look at me. Who do you think I am? (He begins to playfully try on a high top sparkle hat, a flat toy straw hat, a Cat in the Hat tall felt hat....)

Mom: Wow! Look at you...Your somethin' else strutting in that hat! Wow... Look at you jivin'...You got *rhythm 'n blues*. Look at you go.... (She begins moving in rhythm to the sounds and dancing he is making.)

Boy discovers a new cloth monster-type cloth figure, about 18 inches high.

Boy: Oh, know I know who I'se gonna be...Mama, I'm the Rock....I'm the World Champion Wrestler. You be the audience.

Mom: I'm in the audience. Okay, I got a ringside seat. I'm here to see My hero...The Rock. (Mom cheers and claps as the world famous wrestler [the boy with a boxing glove on each hand] comes prancing into the imaginary boxing ring.

(Boy steps out of role of wrestler momentarily) Boy: Oh, Mama, get those two little babies. Wrap them up with that there blanket. Don't let them get cold.

Mom: Oh, okay. Come here babies. I'll take real good care of you! (Mother follows his direction and wraps up the two little twin babies in a flannel baby blanket and cuddles them on her lap.)

Boy enters as a champion who enters the rink, arms raised in acknowledgement of the crowd, bowing to the cheering crowd, prancing and taking swings in the air as through he is anxious for the fight to begin."

As the boxing match fires up, the boy pretends to knock out his opponent. The mother is so attuned to her son's play that she intuitively becomes the referee, standing over the imaginary boxer and counting to ten. The scene ends with the mother, pretending to be the sports announcer, introducing "the reigning World Champion Wrestler...The Rock wins again". Her son beams as he takes his victory bows to the roaring crowd.

In the closing roundtable evaluation session in which the mothers viewed each other's pretest and posttest videotaped play sessions, a fellow classmate turned to this mother and said, "Girl, that's hot stuff. You come a long way, baby!" The mother beamed, mirroring the same pride in her smile that her son expressed as he took his victorious bows before the cheering crowd.

Allowing the child self-direction: A dimension of empathy. The mothers in the intensive filial therapy group showed a significant decrease ($p < .002$) on the Allowing the Child Self-Direction subscale posttest in comparison to their pretest score on the MEACI. For this scale, a decrease in the mean score indicates an increase in the desired behavior. Filial therapy is based on a basic philosophy that there is within each child an

innate human capacity to move toward growth and maturity and an abiding ability within the child to be constructively self-directing (Landreth & Sweeney, 1997, p. 17). From this philosophical premise, the mothers in the intensive filial therapy group were guided to allow their children to follow their own initiatives during the parent-child play times.

The Allowing the Child Self-Direction subscale measures the parents' progress in learning to replace judgmental, evaluative and directive statements with responses that allow the child the freedom to select his/her own pathways of play. In order to do this, parents were taught to permit and encourage the child's self-expression and freedom in choosing activities and to withhold the familiar habit of telling children what to do and how to do it, every minute of the day, as was aptly stated by one of the filial therapy mothers. The mothers reported with surprise that their children did indeed

“...respond very differently in play sessions than in real life and reveal[ed] wishes, fears, and so on that would not be openly expressed in real life. The parents, as party to this process, indeed creators of it, have [had] a special vantage point in observing it as therapist/parent (L. Guernsey & B. Guernsey, Jr., 1989, p. 349).

For purposes of illustration, one mother reported a play scene in which her eight-year-old son placed a mid-sized, toy alligator in the sand tray. He kept adding a variety of animals until the tray was getting very crowded. The boy happened to accidentally drop a tiny plastic fish in a cup of water, which was strategically placed in the corner of the sand tray. The alligator dived head first into the water. Just as the mother was about to say, “Guess that little fish was a tasty supper!,” she noticed how her son had the alligator ever so carefully rescue the baby fish from the bottom of the cup of water. Rather than eat the baby fish, the alligator took it to some of the other animals and told them to “dry him off

and keep him safe and warm.” The mother watched in wonder as the subsequent scenes unfolded. The big alligator busied himself to make room for all sorts of “good” animals as they asked, “You got any room? Can we come in, too?” Within moments, the shoebox of sand was nearly overflowing with newcomers. Suddenly the alligator spoke loudly and harshly to some “bad” animals that were trying to sneak into the sand tray. He angrily threw the “bad animals” out of the sandbox. “Don’t worry,” the alligator reassured the other animals, “Me won’t let any bad ones come in here for nothing.”

As the mother finished sharing her son’s play scene with the other mothers in the class, she suddenly got quiet; her eyes filled with tears. Her son’s story suddenly spoke to her...

“Oh, my goodness” she whispered. “My son is telling me that now he’s feeling safe at the shelter. Maybe I did make the right decision, bringing me and my boys to the shelter. He still misses his daddy, but he don’t have to worry no more about what his daddy might do to us when he comes home drunk.”

Although the MEACI instrument does not have a separate subscale for therapeutic limit setting, there were many examples of therapeutic limit setting in the filial therapy groups’ posttest videotapes. Contrary to the mothers’ harshness in correcting their children (i.e., “Say that again and you’re getting your mouth washed out with soap,” “You just got yourself a whippin’,” “Quit acting like a fool...I don’t want nobody to

know you're my kid") prior to training, the post test videos of parent-child play sessions showed the mothers effectively using the therapeutic skills for setting limits while still conveying an attitude of acceptance and empathy for the child.

Parental involvement: A dimension of empathy. Stovall et al. (1971) have defined parental involvement as the parent's focused attention on the child, while participating in his/her play activities, physically (when appropriate), verbally and emotionally, as opposed to distancing or withdrawing from the child or becoming distracted and/or preoccupied with self. Although the mothers in the experimental group demonstrated improvement in their ability to stay focused and involved with their children as measured by the Involvement subscale of the MEACI, their progress did not reach a level of statistical significance. The way involvement is measured on the MEACI, a parent could obtain a very good score for being involved, even though not all involvement is positive. Critical, blaming behavior may rank high in involvement, but could be low in the communication of acceptance or allowing the child self-direction. Ironically, the facilitator observed that as the mothers stepped back from being so overly involved with their child, they went through a period of less involvement in an attempt to rebalance into a position of interested involvement without being intrusive. Also, sometimes learning new skills restricts parents as they are thinking about how to respond to a child. Perhaps with more time, there would be greater improvement in the mothers' measurable involvement.

Baumrind (1975) identified *warmth* and *involvement* as vital components of parental behavior that dramatically impacts a child's positive or negative outcome.

Nurturance refers to...those parental acts and attitudes that express *Warmth* and *involvement* and are directed at guaranteeing the child's physical and emotional well-being. By *warmth* is meant the parent's love and compassion for the child, expressed in sensory stimulation, verbal approval, and tenderness of expression and touch. By *involvement* is meant pride and pleasure in the child's accomplishment, as manifested by words of praise and interest, and by conscientious protection of the child's welfare (Baumrind, 1975, p. 11).

It was understandably difficult for the mothers in this study to sustain high levels of involvement with their children because they were experiencing high levels of stress, anxiety, depression and fatigue. Increased levels of anxiety, depression, somatic complaints and other psychological difficulties have been verified as co morbid with victims of domestic violence (Carlson, 1991). It was the researcher's opinion that all of the mothers in the experimental group, without exception, were incredibly dedicated to learning and, yet, they could not help but bring their depression, anxiety, stress, and exhaustion with them to class and the *Special Play Times*. It took an inordinate amount of resourcefulness for these mothers to find enough energy to maintain emotional and physical presence with their children throughout the play times. The raters who viewed and scored the pretest and posttest videotapes seemed puzzled by the apparent contradiction of the mother's being empathic toward their children, yet appearing so exhausted. The raters penciled in several notations on the scoring sheets (i.e., "Mom seemed involved, but sure did yawn a lot," "yawned loudly...often," "sure looked sleepy"). Little did the raters know what commitment it took for these mothers to stay

awake, not zone out, doze off, or become distracted with the many worries in the back of their mind during class and play times.

Therapeutic Process and Implications

The quantitative results of the use of intensive filial therapy in this study have substantiated positive changes, at a statistically significant level, within the children in the experimental group and within their mothers who facilitated the therapeutic treatment. Trend charts depicted a visual representation of a steady, consistent trend of positive improvement, as measured across all variables of the JPPSST and CBCL, within the children who received intensive filial therapy, intensive individual play therapy (Kot, 1995) and intensive sibling group play therapy (Tyndall-Lind, 1999). Intensive filial therapy has been shown to be a treatment with comparable effectiveness to intensive individual play therapy and intensive sibling group play therapy.

Filial therapy has already been shown by other researchers to not only impact change within the child and the parent, but to positively impact the parent-child relationship and the dynamics within the family (Hoffman et al., 1991; Lebowitz, 1982; Lahti, 1993). As a comprehensive model capable of simultaneously facilitating intrapsychic, interpersonal, and family system changes, intensive filial therapy could potentially become a mediating factor for interrupting dysfunctional patterns that, if allowed to continue, have been shown to negatively impact members of violent families across their life span.

Responsiveness to the Emotional Needs of Mothers. The facilitator's daily presence at the shelter seemed to speed up the process of developing a trusting relationship with the mothers. The mothers who initially seemed less trusting of the facilitator appeared to look forward to chance meeting with the facilitator and came around for attention and encouragement, even on nights they were not able to attend class or have play sessions. The filial model clearly meets the criteria, verified by research, for effective parent programs with *high risk* parents: (a) *child centered*, focusing on the needs of the child, (b) *parent focused*, giving supportive attention to the personal needs of parents, (c) *voluntary*, in participation, and (d) *neighborhood-based*, which evolved among the mothers in this study who actually were neighbors, though temporary, living within the community of the shelter (Reppucci et al., 1997).

Because there was so much to accomplish in the condensed class times, the facilitator arranged additional time before and after class to give mothers a few minutes of personal support and concern, sometimes in the presence of other mothers, sometimes during a few moments of privacy (i.e., a mother's room, an empty hallway, a bench on the shelter playground). The communal living arrangement at the shelter seemed, in some ways, to be advantageous, and in other ways, to be a disadvantage. By living within the shelter together, the mothers were an ever-present source of encouragement for one another in learning the model; yet on the other hand, the communal living sometimes felt intrusive, lacking in privacy (i.e., all residents sharing one pay telephone in an open hall area). The issue of confidentiality was, at times, more delicate in this study than is usual

in filial classes in which parents do not know one another and see each other only within the context of the filial therapy class sessions.

Implications. This study has shown the Landreth (1991) model of filial therapy to be effective in facilitating change within the target population of victims of domestic violence and their children who are known to be at *high risk* for less than optimal parenting and poor child outcome. Considering the shortage of mental health services offered and the limited number of professionals available, the use of mothers as a component of their children's therapeutic treatment could potentially provide clinical services to a much larger number of child witnesses who, otherwise, run the risk of receiving either no treatment intervention or a very brief period of therapy.

Intensive filial therapy, intensive individual play therapy and intensive sibling group play therapy were shown to produce comparable results with only one exception in which intensive individual play therapy was more effective at improving children's self concepts as measured by the JPPSST. Given a larger sample size, these trends may have shown even more statistical power. Children who received intensive filial therapy showed change at a higher level of statistical significance than the children who received intensive individual play therapy and intensive sibling group play therapy versus the non-treatment comparison group on the following post test scores: Total Behavior Problems, Internalizing Behaviors, Externalizing Behaviors, Anxious/Depressed, and Aggressive Behavior as measured by the CBCL. The information associated with these trends may be helpful to the professional within shelters to determine which treatment would be likely to be more helpful for individual children. A review of the improvement trends (as

depicted in Appendix A) as related to the types of improvement the children made suggests that intensive filial therapy may be more effective than the intensive individual play therapy and intensive sibling group play therapy with issues of emotional difficulties and related behavioral manifestations.

Aside from the statistical trends, several additional implications for intensive filial therapy in the future are as follows:

(a) Intensive filial therapy was shown to effectively prepare parents to relate therapeutically with their children, particularly, by increasing the mothers' ability to convey empathy and acceptance to their children. The mothers demonstrated that, even though they were under extreme stress, the model equipped them to relinquish undue control of their children, allowing the children to become more self-directive and self-expressive. Parents demonstrated effectiveness in shifting from an authoritarian type of punishment to a set of therapeutic limit setting skills shown to foster self-discipline and self-responsibility within the child. In intensive filial therapy, the mothers developed a new confidence in their ability to be a positive parent, capable of fostering healthy parent development in their children. A new level of closeness and understanding evolved between parents and their children. The model facilitated a reduction in emotional and behavior problems. The results of this multiplicity of change imply that filial therapy is a very efficient, cost effective and comprehensive treatment model, capable of facilitating various therapeutic changes within families of domestic violence.

(b) Intensive filial therapy has the potential of having a more prolonged impact than treatment with a shelter clinician because it is not time limited to the child's

residence at the shelter. In light of the shortage of accessible and affordable clinical services for families with limited resources, intensive filial therapy appears to promise the continuation of therapeutic work past a family's short stay at a shelter facility.

Families in crisis are often transient and chaotic; therefore, the results of this study imply that filial therapy may be a treatment of choice for families living in a shelter so as to increase the continuity of therapeutic support, regardless of where the family lives in the future.

(c) Filial therapy was shown to be a multi-level therapeutic intervention with the potential to impact change within individual family members and within the family dynamics. The results of this study, particularly in light of the reduction of behavioral problems (externalizing behaviors, internalizing behaviors, anxious and depressed behaviors and aggressive behaviors) known to be characteristic of families of domestic violence, posits filial therapy as a multi-level therapeutic intervention that has the potential to assist in interrupting the intergenerational transmission of violence. Therapies that change individual family members but do not impact change within the family system are lacking in power to alter a system that supports the intergenerational transmission of dysfunction and violence.

Recommendations for Future Research

Based on the results of this study, the following recommendations for application and research are offered:

(a) Incorporate intensive filial therapy into the standard program for victims residing in domestic violence and homeless shelters and other settings serving families in crisis.

(b) Provide intensive filial therapy through the public schools, particularly those serving families living with *high risk* factors and circumstances known to impair healthy child development.

(c) Provide intensive filial therapy at subsidized childcare centers that serve *at risk* families and their children.

(d) Provide intensive filial therapy at community service centers within or near subsidized housing projects where *at risk* families come regularly for various types of assistance.

(e) Investigate continuation of intensive filial therapy training, begun in the crisis shelter on the intense daily schedule and then following the mothers to the shelter's transitional housing facilities in which the training would transition to weekly and bi-monthly training and supervision for a period of three to six months.

(f) Compare the provision of intensive filial therapy in lieu of parent education and mothers' support groups for domestic violence and homeless shelter residents to determine the effectiveness of intensive filial therapy in facilitating therapeutic change within the children and the mothers.

(g) Increase the number of subjects in a replication of this study and compare the effectiveness of intensive filial therapy with mothers residing in the domestic violence shelter with mothers residing in the homeless shelter, all of who are victims of domestic violence.

(h) Replicate the study with a larger population and provide three month, six month and twelve month follow up testing to compare the results of intensive filial therapy with mothers and children who return to the perpetrator with mothers who do not reunite with the perpetrator.

(i) Provide qualitative research of the intensive filial therapy model to determine the process of change through self-report, studying of videotapes of class sessions and parent-child play sessions and assessment of modifications made in the model to adjust for use with families living in a shelter facility.

(j) Investigate and compare the effects of the support component and other group interactional aspects of intensive filial therapy, by comparing the effectiveness of parents trained in a filial therapy group with parents trained individually.

Concluding Remarks

Violence in any form is frightening to adults and children; but when violence occurs between children's parents, the very ones they rely on to keep them safe and secure, the effects are often damaging and traumatic for children. Domestic violence occurs within the context of the family; therefore, preparing mothers to be central components in the children's treatment, through the use of filial therapy, may be a crucial step toward changing the whole constellation of family relationships. In this study, filial

therapy effectively utilized the existing bond between mother and child during a time of crisis as a unique *window of opportunity* to begin the healing process. Through the use of filial therapy, the mothers developed the therapeutic skills to initiate emotional stabilization and increased mental health within their children; therefore, filial therapy should be given serious attention by mental professionals, parent educators, teachers, and social service professionals as a preventative and therapeutic intervention with child witnesses of domestic violence and other families living with *at risk* circumstances. The maternal bond residing in most mothers in this study proved to be an invaluable resource of compassion and concern on which they began their children's return to healthy development and wholeness.

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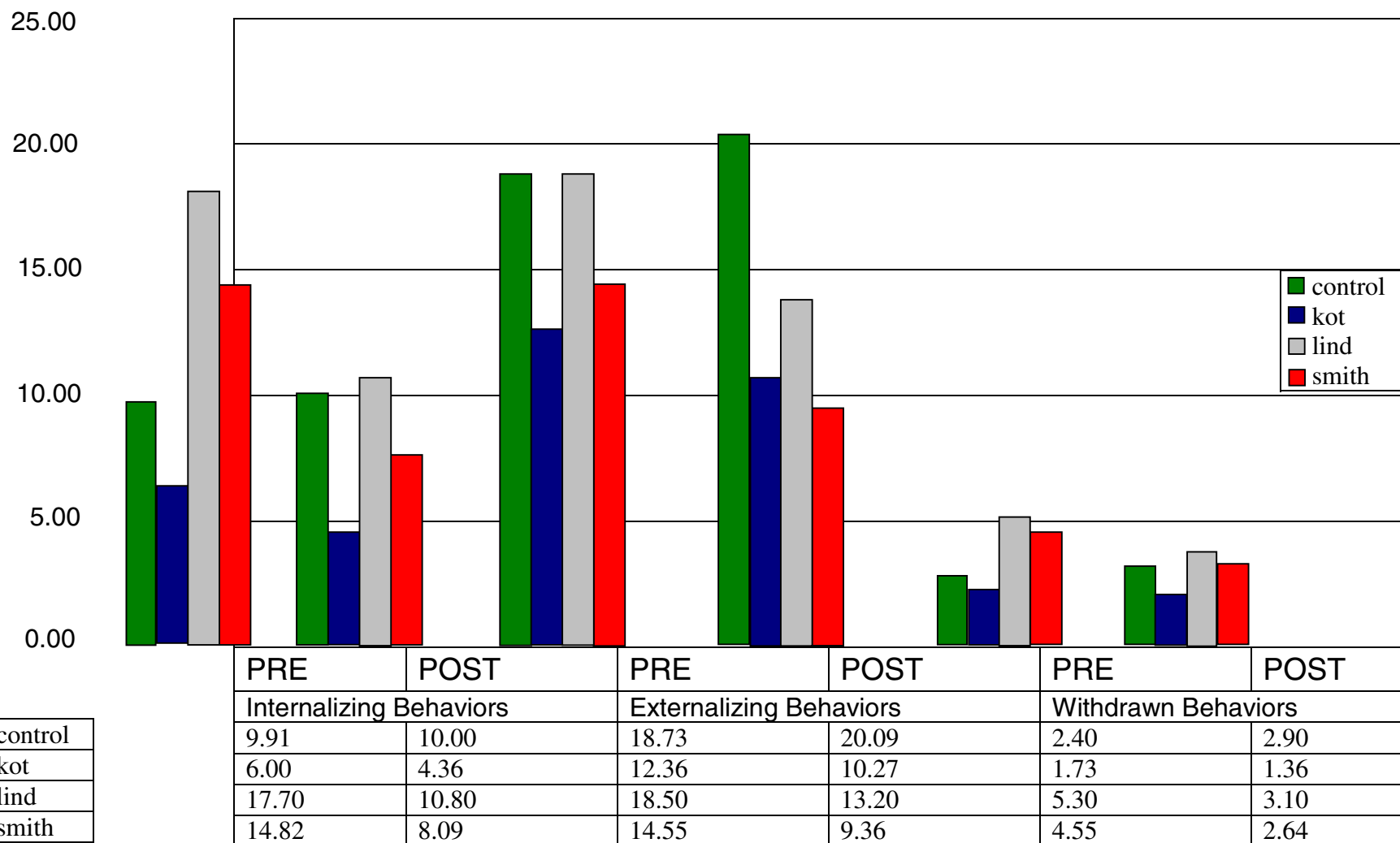
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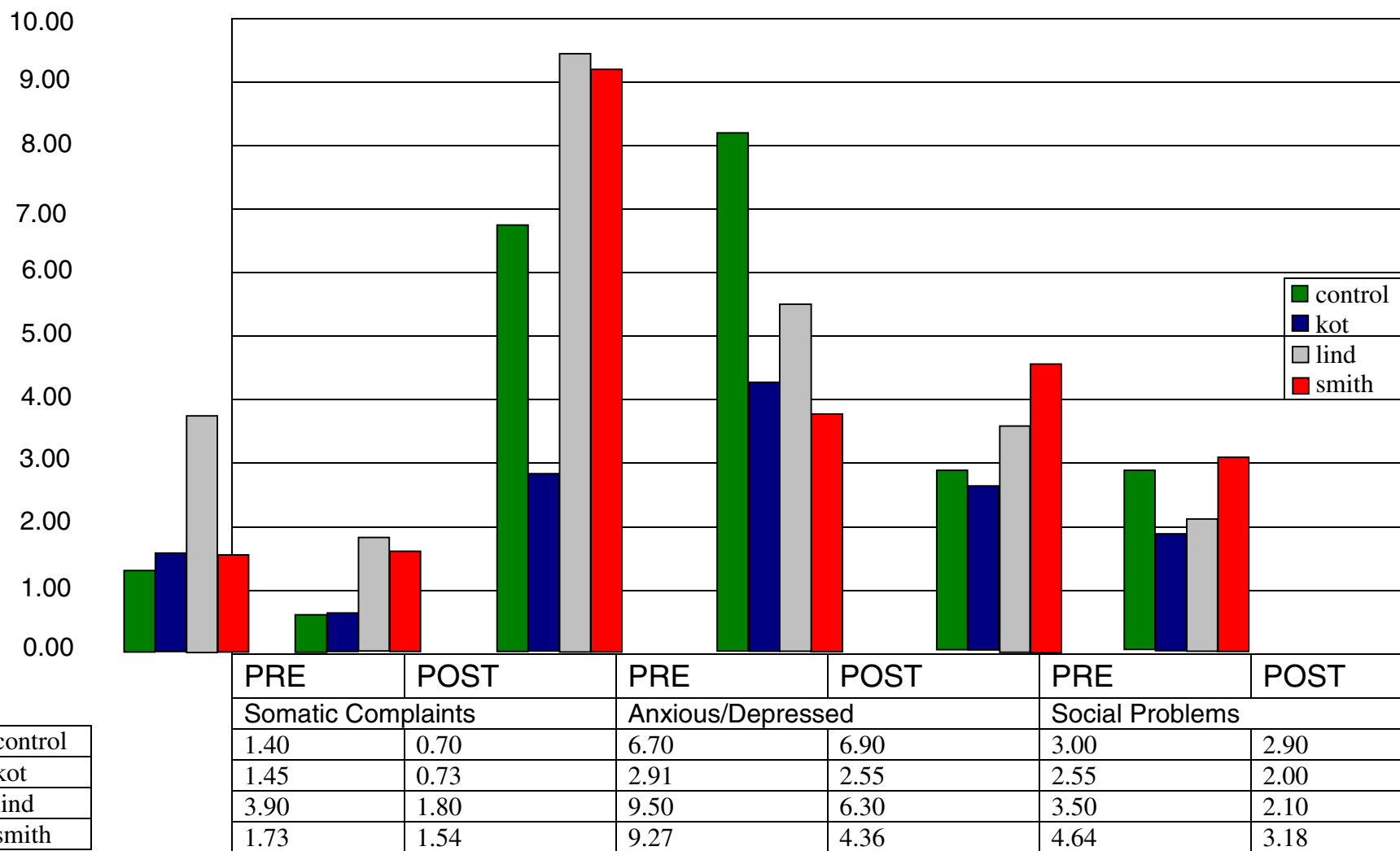
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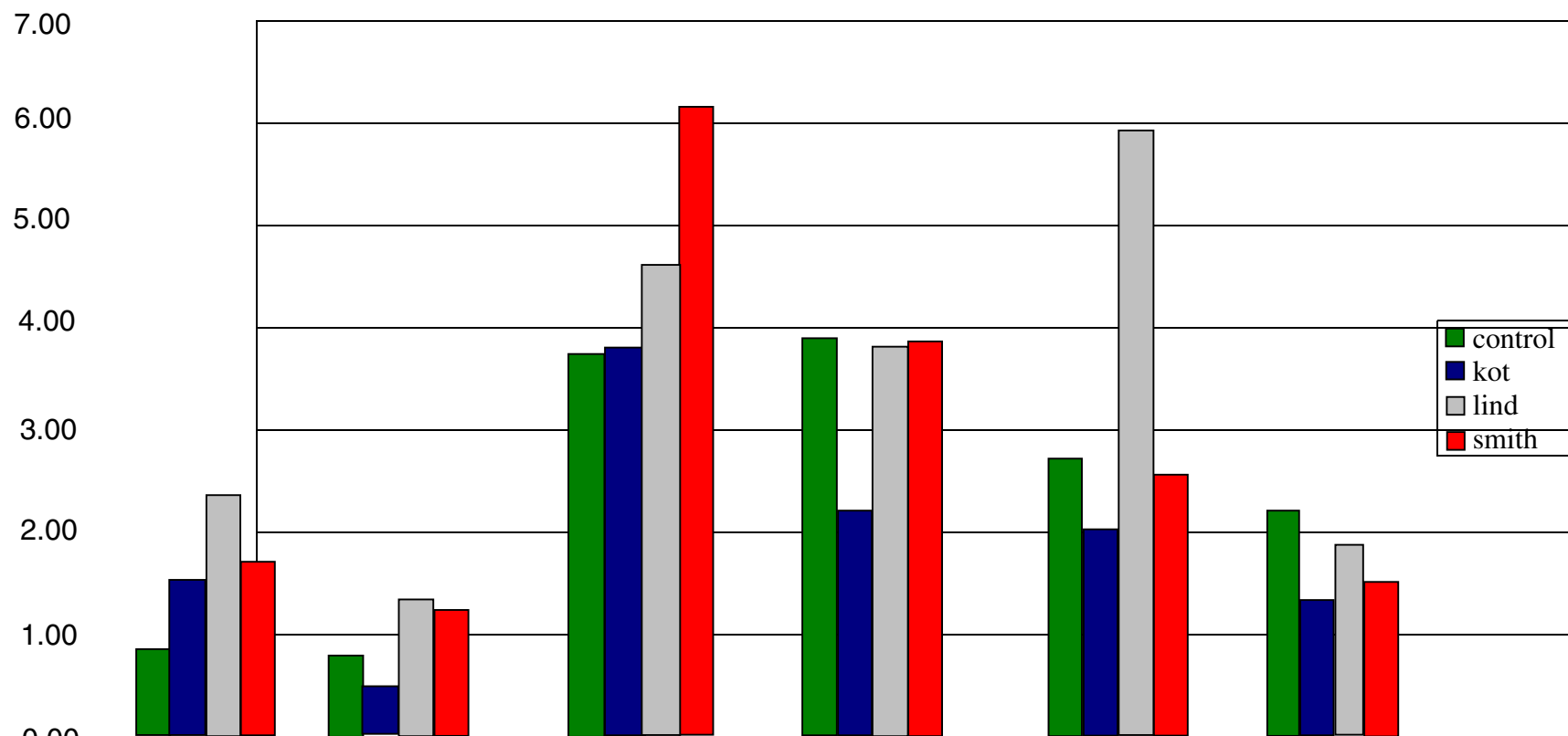
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Appendix A

Trend Tables

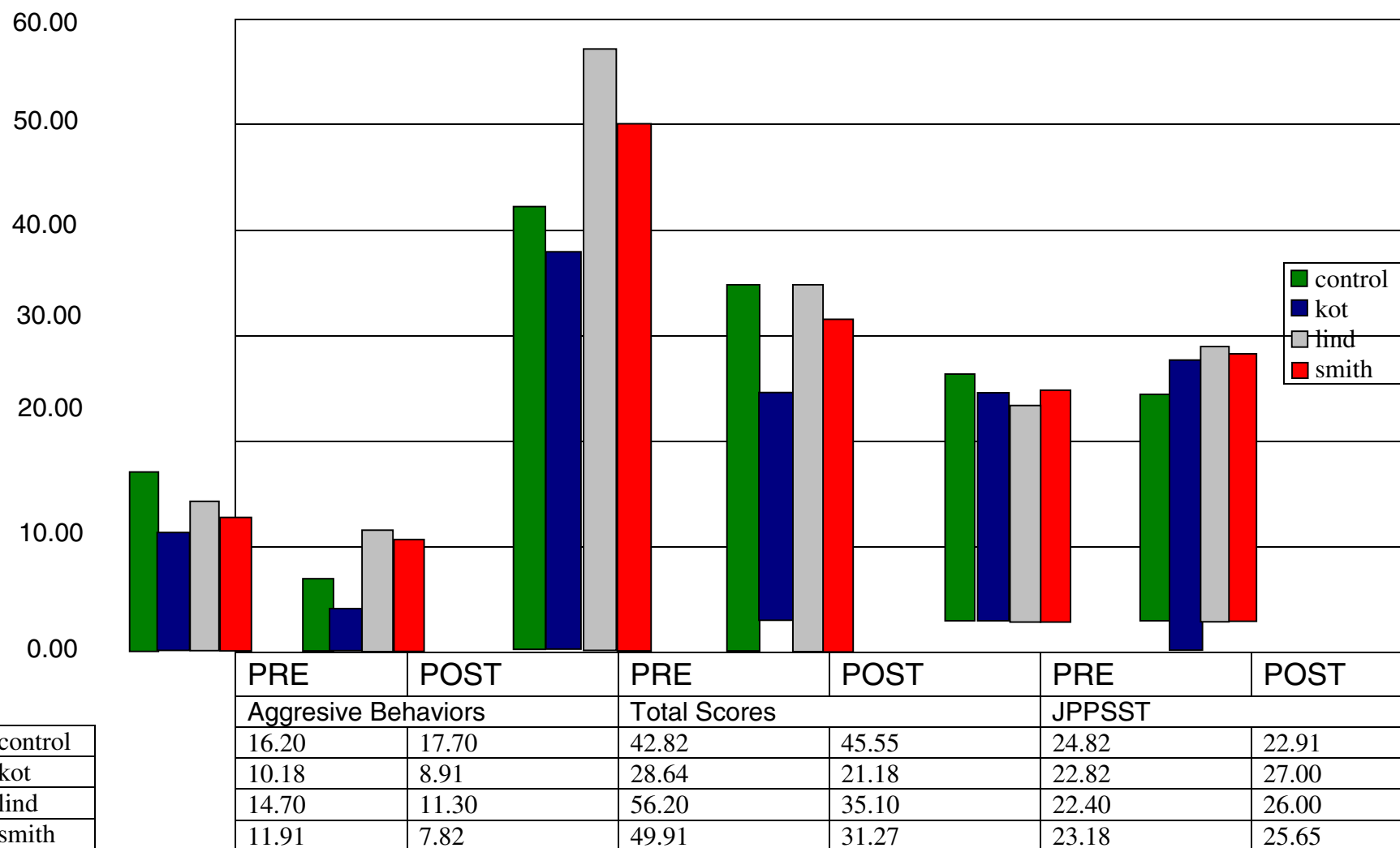






	PRE	POST	PRE	POST	PRE	POST
	Thought Problems		Attention Problems		Delinquent Behaviors	
control	0.70	0.80	3.80	3.90	2.70	2.20
Kot	1.36	0.27	3.82	2.09	2.00	1.27
Lind	2.40	1.30	4.60	3.80	5.90	1.90
smith	1.73	1.27	6.09	3.82	2.64	1.55

control
Kot
Lind
smith



Appendix B
Filial Therapy Play Kits

Filial Therapy Play Kits

Toys and play materials for parent-child playtimes are carefully selected to facilitate children's self-expression, symbolic play and interactive play with their parent.

Standard Kit: Three- to Eight-Year-Olds

Modified Kit: Nine- to Twelve-Year-Olds

Colored markers and crayons
 Pad of newsprint and colored paper
 Glue stick and small bottle of glue
 Colorful pipe cleaners and glitter
 Blunt scissors
 Scotch tape
 Play dough
 Jar of bubbles

Watercolors and oil pastels
 Sketch pad and colored paper
 Glue stick and small bottle of glue
 Colorful pipe cleaners and glitter
 Youth scissors
 Scotch tape
 Colored plastic clay
 Jar of bubbles

Handcuffs and key
 Rubber knife, plastic sword
 Toy phone or walky talky type
 Toy soldiers and army vehicles
 Three or four vehicles
 Rescue vehicle
 Dart gun, rubber darts
 Piece of cotton rope (not included)

Handcuffs and key
 Rubber knife, plastic sword
 Cell type phone
 Micro soldiers and vehicles
 Three or four mini vehicles
 Rescue vehicle
 Miniature dart board for wall
 Piece of cotton rope (not included)

Small baby doll (ethnic match)
 Baby bottle, receiving blanket
 Plastic dishes
 Some toy food
 Medical kit, bandaids, ace bandage

Small baby doll (ethnic match)
 Baby bottle, receiving blanket
 Cups and white paper plates
 Deck of playing cards
 Bandaids, ace bandage

Play make-up
 Small mirror

Lipstick, nail polish, glitter lotion
 Small mirror, colorful eye shadow

Small hair brush and clips	Small hair brush and clips
Play jewelry, sun glasses	Costume jewelry, sun glasses
Hats and accessories – girls/boys	Hats and accessories – girls/boys
Basketball hoop for door	Basketball hoop for door
Nerf ball	Nerf ball, nerf football
Blow up bob bag	Blow up bob bag
Black half mask	Black half mask
Large, medium and small animals:	Large, medium and small animals:
Prehistoric animals	Prehistoric animals
Wild animals – jungle/forest	Wild animals – jungle/forest
Farm animals	Farm animals
Domesticated animals	Domesticated animals
Sack puppets, tame and fierce	Sack puppets, tame and fierce
Cardboard lid, tapped off for rooms	Cardboard lid, taped off for rooms
Small family of people (ethnic match)	Small family of people
Small plastic doll furniture	Small family of people
Light weight hammer, nails	Light weight hammer, nails
Masking tape	Masking tape
Small scraps of wood	Small scraps of wood
Sand/plastic container with lid	Sand/plastic container with lid
Several paper lunch bags	Several paper lunch bags
Tooth picks/ colored Popsicle sticks	Tooth picks/ colored Popsicle sticks
Small plastic bottle with water	Small plastic bottle with water

Similar types of toys are put together in ziplock plastic bags to make it easy for arranging toys according to the type of toys. A colorful plastic cloth was included to spread on the floor to contain messiness and to “mark the Spot” for *Special Play Times*.

Appendix C
Assent Form

Assent Form

I understand that my mother is learning play therapy with Ms. Nancy Smith and that she will have special play times with me as a part of her homework. I understand that I am a volunteer and that I can choose to stop participating by telling my mother and Nancy Smith.

Name

Date

Nancy R. Smith, LMFT

(214) 750-1086

Garry Landreth, Ed.D.

(940) 565-2916

Appendix D
Adult Consent Form

PLAY THERAPY TRAINING FOR PARENTS:

PARENTS HELP THEIR CHILDREN

THROUGH *FILIAL THERAPY*

Research Information for Parents

“Toys are the words and play is the language of children.”

Virginia Axline (1947)

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

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

Parent Classes and Parent-Child Play Times: You will attend a daily parenting class with a small group of other mothers residing at the shelter for a total of 10 to 12 sessions. The class time will vary in length between one and one and a half-hours a day (depending on the size of the group). Make-up classes will be made available due to occasional scheduling conflicts. To help you learn to use the new skills and to simultaneously help your *child*, you will conduct daily private parent-child play times, 40 minutes in length, with your child for a total of 12 play sessions within a 2-3 week time frame. You will be given a set of toys and play materials to use during the *Special Play Times* and will exchange child-care with another class member, so that each of you can have one-on-one uninterrupted play times with your child.

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

Confidentiality: The information you and your child answer on the questionnaire will be kept confidential. Your name and your child's name will not be disclosed in any publication or discussion of the material. Information from the questionnaires will be coded with only the researcher, Nancy Smith, having a list of the participants' names. At the end of this study, the list of participants' names and the videotapes will be destroyed.

If you agree to participate, please fill out and sign the consent form attached to this page. For further information, please contact Nancy Smith, 214-750-1086 (work) or 214-503-8302 (home). Thank you very much for your time, cooperation and your participation.

Sincerely,

Nancy Smith, LMFT
Researcher
214-750-1086

8330 Meadow Rd. Suite 114
Dallas, Texas 75231

Major Professor:
Garry Landreth, Ed.D.
Department of Counseling, Development, and Higher Education
940-565-2916

University of North Texas
Stovall Hall
Denton, Texas

**PLAY THERAPY TRAINING FOR PARENTS:
INTENSIVE FILIAL THERAPY**

Informed Consent

You are making a decision whether or not to participate in this study. You should not sign until you understand all of the information presented to you on the front of this form and until all of your questions about the research have been answered to your satisfaction. You understand that participation is voluntary and you and/or your child may choose to withdraw at any time during the study. Your signature indicates that you meet all of the requirements for participation as explained by Nancy Smith and have decided to participate, having read the information on the front of this form.

Signature of Parent

Date

Name of Child

Date

Signature of Witness

Date

Researcher/Instructor:

Nancy R. Smith, LMFT
Center for Family Care
8330 Meadow Rd., Suite 114
Dallas, Texas 75231

Supervising Professor:

Garry Landreth, Ph.D.
Counseling and Higher Ed.
University of North Texas
Stovall Hall
Denton, Texas 76203
940-565-2916

Appendix E
Curriculum Materials

REINFORCE CHILD'S SETTING LIMITS

FOR

SELF-CONTROL & SELF RESPONSIBILITY

Acknowledge Feelings (with genuine empathy).

Communicate the limit (a statement, not a command.)

Target Alternatives/Choices

COMMON PROBLEMS IN FILIAL THERAPY

Originally developed by Garry Landreth, Ed.D., adapted by Sue Bratton, Ph.D.

(Session #6 Handout)

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

A: _____

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

A: _____

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

A: _____

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

A: _____

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

A: _____

8. **Q: My child wants to be in playtime longer. Should I extend the session?**

A: _____

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

A: _____

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

A: _____

Just Playing

When I'm trying on dress up clothes, having a tea party or caring for baby dolls,
don't get the idea I'm "Just Playing.."

For you see, I'm learning as I play; I may be a mother or father someday.

When you see me up to my elbows in paint, or standing at an easel, or modeling or
shaping play dough; please don't let me hear you say, "He is Just Playing.."

For you see, I'm learning as I play; I'm expressing myself and being creative; I
may be an artist or inventor someday.

When you see me "reading" to an imaginary audience, please don't laugh and think
"I'm just playing.."

For you see, I'm learning as I play; I may be a teacher someday.

When you ask me what I've done today and I say, "I just played." Please don't
misunderstand me.. For you see, I'm learning as I play. I'm learning to enjoy and
be successful in my work; I'm preparing for tomorrow,

Today, I am a child and my work is my Play.

LEARNING TO BE PERFECTIONISTIC*

I believe that perfectionism may be in part learned from a child's interactions with perfectionistic parents. This is the way I see the process working: a child is regularly rewarded with love and approval for outstanding performance; when the parents react to one child's mistakes and failures with anxiety and disappointment, the child is likely to interpret that as punishment or rejection. The perfectionistic parent often feels frustrated and threatened when a child is having difficulties in schoolwork or in relationships with peers. Because the parent is unrealistically self-critical, he or she personalizes the child's difficulties by thinking, "This shows what a bad mother (or father) I am." Because the parent's self-esteem is contingent on the child's success, the parent puts great pressure on the child to avoid failure. Consequently, when the troubled child turns to the parent for reassurance or guidance, the parent reacts with irritation, not love, and the child is flooded with shame.

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

* Excerpted from: Burns, D. D. (1980). The perfectionist's script for self-defeat. Psychology Today, November.

WHEN “SETTING THE LIMIT” DOESN’T WORK...

You have been careful *several times* to: (1) reflect the child’s feelings, (2) set clear, fair limits, and (3) give the child an alternate way to express 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 television instead of going to bed, then you choose to give up television 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 choice 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 an 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.”

LISTENING

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

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

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

Ueland, B. (1974). Tell me more. The Ladies' Home Journal. November, 51, 53.



HOMEWORK

 **LOOK** FOR...

**...some physical characteristic in your child
you have not noticed before.**

 **THINK** ABOUT...

...your child's feelings during the week.

WRITE ABOUT...

...the feelings you have observed.

“PARTNERS IN PLAY”

(unspoken)

Parental Message: “I’m here.”

I hear you.
I understand.
I care.

Rather than the message:

I agree with you.
I’ll make you feel good.
I’ll solve your problems.

“SPECIAL PLAY TIME”

1. Put collected toys in box,
 2. Choose a place where you will be **uninterrupted**; not the child’s room, not a lovely carpeted area. **NO PHONE, NO FAMILY, NO DOOR ANSWERING.**
 3. Let your child know when the play time will be – BE THERE!
 4. Tell your child: “We have 30 minutes in which you can play and do *most* of the things you want to.” Then sit on the floor or low chair and WAIT (30 minutes).
 5. Comment (no questions or directions) on what the child is *doing, feeling, or thinking.*
 6. *Follow* child’s directions, without your directing or leading. (FOLLOW-NO DIRECTIONS!)
 7. Set limits this way (in statement form, not declarations):
 - a. “The lamp is not for shooting. You may shoot the wall or ceiling.”
 - b. Wait and see what happens.
 - c. “If you *choose* to _____, then you’ll choose not to use the dart gun any more today.” (Child shoots lamp or you anyway.)
 - d.
 - e. “Oh, I see you’ve chosen to give up playing with the dart gun today.” (Child promises and begs.)
 - f. “I know you are sorry and hope I’ll give you another chance. Next play time you may choose again.”
- (SET LIMITS, ENFORCE THE CHILD’S CHOICE)
8. Give 5 minutes-notice before ending play time.
 9. Stop *on time!* You, not the child, clean up.
- (PARENTS CLEAN UP PLAY AREA. STOP AT 0 MINUTES)

Πλαψ ις Ιμ πορταντ
το Χηιλδρεν
Βεχαυσε ιτ ις

* τηειρ σψμ βολχ λανγυαγε
οφ σελφ-εξπρεσσιον

* τηειρ νατυραλμ εδιυμ
οφ χομ μ υνιχατιον

* ηοω χηιλδρεν οργανιζε
τηειρ εξπεριενχεσ,
ηελπινγ τηεμ φεελμ ορε ιν
χοντρολ
οφ τηειρ λιπες

* α χονχρετε φορμ οφ
εξπρεσσινγ α χηιλδ σ
ιννερωορλδ

* ηοω τηεψ εξπρεσσ τηειρ
εξπεριενχεσ οφ
τηεωορλδ ανδ τηειρ
φεελινγσαβουτ ιτ

* ηοω χηιλδρεν εξπρεσσ
τηειρ ωισηεσ,

REFLECT

Child to the Child

For

SELF-UNDERSTANDING & SELF-ESTEEM

TRACK BEHAVIOR

REFLECT FEELINGS

**REFLECT MEANING
OF PLAY, TALK, & BEHAVIOR**

RESPONDING & TRACKING

Originated from G. L. Landreth, Ed.D.
Adapted by Nancy Renfer Smith, LMFT

OUR RESPONSES SHOULD FACILITATE:

1. freedom for the child
2. decision making and self-responsibility
3. spontaneity and creativity
4. a feeling of being understood
5. healthy self-concept

WE ARE CALLED TO:

1. track the child's behavior
2. track the child's feelings
3. look for the theme of play
4. stroke the effort not the product

FACILITATING REFLECTIVE COMMUNICATION

G. L. Landreth (Ed.D)

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

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

Response: _____

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

Response: _____

3. Child: (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.)

Response: _____

4. Boy child: (Undressing a Barbie doll.) Wow! Look at her butt!

Response: _____

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

Response: _____

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

Response: _____

ROLES & RESPONSIBILITIES OF A FACILITATING ADULT

G. L. Landreth, Ed.D. (1991)

1. To be non-evaluative.
2. To be permissive within a safe structure.
3. To be consistent (emotionally, cognitively, and physically).
4. To be focused on the child.
5. To be emotionally present.
6. To be non-directive.
7. To be a reflector (not a director).
8. To be an encourager of the child's effort (not to praise the child's product or production).
9. To convey the messages:
 - a. I'm here.
 - b. I hear you.
 - c. I understand.
 - d. I trust your ability.
 - e. I care.

SAFE PERSON, SAFE PLACE, SAFE PROCESS!

Originated by G.L. Landreth, Ed.D.
Adapted by Nancy Renfer Smith, LMFT

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

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

“As the adult reflects back understanding and acceptance of the child’s play the child (a) feels understood and accepted, and (b) gains self-awareness and self understanding.”

THE SAFE PROCESS

G. L. Landreth, Ed.D. (1991)

1. Child leads.
2. Adult stays in a therapeutic role.
3. Adult stays focused on objectives to foster:
 - ◆ A healthy self-concept.
 - ◆ A sense of self-responsibility.
 - ◆ Emotional expression and self-control.
 - ◆ Autonomy.
 - ◆ Capacity for emotional closeness and meaningful relationships with adults and children.

SETTING THE LIMITS

EXAMPLES

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

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

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

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

5. Jennifer starts to pull the head off a \$20.00 doll. Response:

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

SPANKING

From Your Child's Self-Esteem
(Dorothy Corkle Briggs)

What are some of our methods for control? And what effect do they have? When children are young, spanking is a familiar device to show who's boss. It seems effective because it usually produces immediate results. Yet, we all know parents who say, "I could spank Henry till he was black and blue and he still wouldn't mind."

Every spanking fills a child with negative feelings that may be translated into further misbehavior. Whether the resulting anger is turned outward or inward, the fact remains that children have feelings about being spanked, and these feelings work against the best interest of the parent and child.

Spanking does not teach inner conviction. It teaches fear, deviousness, lying, and aggression. No matter how we slice it, spanking is a physical assault of a bigger person on a smaller one. And yet we tell children they shouldn't hit someone smaller or weaker.

We can all smile at the apparent contradiction of the mother who slaps her child, saying, "I'll teach you not to hit!" Yet studies show that youngsters subjected to overt parental aggression are far more likely to be physically aggressive and hostile in their reactions with others.

THE **3** Rs

Of

**A LIFE-GIVING RELATIONSHIP
WITH CHILDREN**

that prepares them for....

***R*eading, w*R*iting, & a*R*ithmetic...**

***R*eflect...**

Child to the Child

***R*eturn responsibility...**

to the Child

***R*einforcing Child's**

Setting Limits

THE NATURE OF LIMIT SETTING

In Play Therapy, limits should be:

1. Reasonable
2. Minimal: set a limit only when a limit is needed.
3. Rational: a logical reason.
4. Necessary to carry on therapy.
5. Consistent.
6. Firm, but kind: Once we set a limit we should become a brick wall.
7. Unconditional: There are no partial limits in the playroom.
8. Neutral: not emotional charged.
9. Comfortable for the therapist.

PRINCIPLE: Set the limit as soon as it is needed.

CHARACTERISTICS OF THE THERAPEUTIC PROCESS

1. brief and interactive
2. allow the child to lead
3. helpful responses are personalized
4. touch feelings
5. avoid asking questions
6. helpful responses help the child to go
7. non-evaluative
8. do not praise
9. return responsibility to the child
10. track behavior, reflect feelings, affirm decisions, and affirm effort rather than the product.

From workshop: G. L. Landreth, Ed.D. (1995). Making contact with children through play therapy.