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By

Chris G. Dematatis

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ABSTRACT

A COMPARISON OF THE TRADITIONAL FILIAL THERAPY PROGRAM TO AN INTEGRATED FILIAL-IPR PROGRAM

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The purpose of this study was to design and evaluate modifications in a particular method of intervention into the parent-child relationship known as Filial Therapy. In Filial Therapy parents are taught methods of client-centered play therapy so that they may function as psychotherapeutic agents to their own children. It was hypothesized that the introduction of important elements from Kagan's Interpersonal Process Recall (IPR) training model would enable a crucial dimension of the parent-child relationship, the parents' own emotional conflicts, to be therapeutically addressed in a more systematic and reliable manner.

The two components of Kagan's model which were integrated into the traditional Filial program are affect simulation and videotape recall. In affect simulation parents were shown filmed vignettes of a variety of interpersonal scenes. The goal was to familiarize parents with their own emotional responses to stressful interpersonal situations. As parents become familiar with the concept of interpersonal fears and started to become familiar with their own, the videotape recall component of the IPR model was introduced. The goal here was to systematically familiarize parents with the specific interpersonal fears which they encountered in their interactions with their children, the

manifestation of those fears in behavior, and the impact of that behavior on their children. In the recall process, parents confront their own fears when they are ready rather than when the clinician thinks that they are ready, as is the case in the traditional Filial Therapy program.

The experimental design of this study was a pretest/posttest control group design, with the traditional Filial Therapy model serving as the control group to the integrated Filial-IPR model. The sample for this study consisted of 32 volunteer parents of children with emotional or behavioral problems. Parents were members of the military who were referred by their Family Practice and Pediatric physicians at Dewitt Army Hospital at Ft. Belvoir, Virginia. Subjects were randomly assigned to one of the two treatment methods and to one of the two leaders. There were four groups, two treatment and two control, with eight members in each group. The leaders were the experimenter and a school psychologist experienced with play therapy and parent training groups. The groups met for two hours each session for a total of sixteen weeks.

In order to compare the effectiveness of each of the programs the following dependent variables were studied: (a) parental acceptance, (b) affect sensitivity, (c) play therapy skills, and (d) child adjustment. The specific measures used to assess these variables were the Porter Parental Acceptance Scale, the Affect Sensitivity Scale, the Filial Problem List, the Parent Check List, and videotape ratings of communication of acceptance, allowing self direction, and involvement.

Seven specific research hypotheses were formulated to test for differences between each method. Each research hypothesis related to

each of the dependent measures. Each of the hypotheses predicted no differences in gain scores, pre to post, between the two different measures. Each hypothesis was tested for differences with two different ANCOVA computer analyses. The ANCOVA was employed to adjust for initial pretest differences between groups by using the pretest scores as the covariate. One analysis examined method x leader x interaction effects. The second, more powerful analysis combined leaders and analyzed only differences between methods. Significance was set at the .05 level.

The results of the analyses showed significant differences on only one of the dependent measures, the parent play therapy skill communication of acceptance. This difference was in favor of the IPR method and was supported by both ANCOVA analyses. Significant differences were not found on any of the other major hypotheses.

A secondary analysis was independently carried out on each training method. Two hypotheses were stated, one for each method, predicting pre to post positive raw score differences on each measure for each method. Each hypothesis was tested for pre to post raw score differences using the parametric matched pairs t-test and the nonparametric Wilcoxon signed-ranks test. Hypotheses were stated directionally in favor of pre to post improvement on each measure. Significance testing was carried out at the .05 level. The results indicated that both methods achieved significant pre to post gains on most of the variables considered.

To my wife Anne--
For her love, encouragement, and
invaluable contributions to this study

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1

PURPOSE

The purpose of this study is to evaluate the effectiveness of modifying a particular method of intervention into the parent-child relationship. This method employs the basic structure of an existing strategy for intervening in the parent-child relationship, called Filial Therapy, and integrates crucial components from another methodology, Interpersonel Process Recall (IPR), which uses videotape and stimulus film techniques. The effectiveness of this integrated Filial Therapy-Interpersonal Process Recall model will be assessed by comparing it to the traditional Filial Therapy program without IPR methodology.

Need for the Study

Since the 1960s, several writers (Hobbs, 1963; Albee, 1968; Guerney, 1969; Miller, 1969) have stated that the conventional "medical" model is not meeting society's needs for preventive and remedial services. It is becoming increasingly clear that there is a need for greater and more efficient utilization of manpower and wider dissemination of available information in order to meet society's mental health needs. Therefore, an important area of investigation is the possibility of training para-professional parents, teachers, police, etc. to deliver effective psychological services through the use of educational programs and para-professional training (Kagan, 1973; Archer, 1971; B. Guerney, L. Guerney, Stollack, 1971).

One important area of application of this idea is the education of parents to be psychotherapeutic agents to their own children. Several writers on personality development, including Rogers (1951), Sullivan (1953), and Erickson (1968) have stressed the importance of the parent-child relationship to the personality development of the child. These writers have discussed the central role that an unhealthy parent-child relationship plays in the creation of emotional problems in children. Once such problems become relatively fixed, even massive expenditures of professional time may fail to be of use (Guerney, B., 1954). Consequently, a logical place to focus either remedial or preventive interventions in the battle against emotional disturbance is the parent-child relationship.

Starting in 1909, when Freud described the case of "little Hans," but especially since 1950, there have been a growing number of efforts to use parents in the treatment of their own children. One of the most promising efforts to emerge in this direction is Filial Therapy (see Chapter 2, Review of Literature). This approach trains parents to function as psychotherapeutic agents, while the professional functions in the role of therapist educator. Developed by Bernard Guerney (1964), this was the first systematic effort to so train parents. In Filial Therapy, parents are taught to do client-centered play therapy with their own children in order to alleviate present concerns and conflicts as well as to develop parenting skills for future use. The efficacy of Filial Therapy in dealing with the problems of emotionally disturbed children has been established in three research studies (B. Guerney,

et al., 1971; Oxman, 1971; Sywulak, 1978). However, while the Filial Therapy program has been proven to be both an effective therapeutic intervention which aims to improve the parent-child relationship and an effective para-professional program which provides more efficient use of professional time, it is only a beginning. Questions still remain about the best ways to help parents improve the mental health of their children.

Statement of the Problem

As Kagan (1973) points out, "the most basic issue confronting mental health today is reliability, not validity." (p. 44) The question is no longer is psychotherapy works, but which patient, therapist, and technique variables are important in influencing client growth. According to Strupp and Bergin (1969) new and more effective techniques need to be developed and evaluated.

The problem addressed by this study is whether elements of two different training models can be effectively combined so that a crucial dimension of the parent-child relationship, the parents' emotional conflicts, are therapeutically addressed in a more systematic and reliable manner. The primary structure of this new intervention is derived from the Filial Therapy program (B. Guerney, 1964). Integrated into this structure are crucial components of the Interpersonal Process Recall (IPR) model, developed by Norman Kagan and colleagues (1963). While a more detailed description and rationale for both interventions will be offered later in this chapter (see Definitions and Theoretical Considerations), the rationale for the addition of IPR to the traditional Filial Therapy model is presented here.

The goal of Filial Therapy is to help parents acquire basic play therapy skills such as active listening, communication of acceptance and understanding, limit setting, and allowing the child to be self-directed. Another goal is the elimination of certain parental behaviors which are inconsistent with the principles of non-directive play therapy and which prove to reinforce maladaptive behavior and emotional conflict in the child. The current model attempts to achieve these goals through a number of strategies, including modeling, didactic presentations, social reinforcement, and the use of observational feedback.

A premise of the Filial model is that most childhood problems are a consequence of an unsatisfactory parent-child relationship (B. Guerney, 1964). Since difficulties in the parent-child relationship likely result from emotional conflicts within the parent, sufficient attention must be paid to the emotional conflicts experienced by parents in their relationships with their children. In this regard, B. Guerney (1964) writes: "It is emphasized to the parent that the specific techniques will be meaningless, or worse, if they are applied only mechanically and not as a reflection of a genuine attempt at empathy." (p. 307) How does Filial Therapy help the parent whose own conflicts severely hamper his/her ability to be genuinely empathic? B. Guerney proceeds by saying: "A parent's very difficulty in learning to play such a role may be a valuable source of material for examination and eventual insight. . . .It is anticipated that this will be a catalytic force for group therapy of parents that will be of significant value." (p. 308) Specifically addressing how parental problems are dealt with, Andronico, Fidler, B. Guerney, and L. Guerney (1967) write: "The

therapist uses his clinical judgment to determine when to make appropriate shifts from didactic to dynamic elements." (p. 12) This exclusive reliance on leader skill and sensitivity entails some risks. The leader may miss areas of conflict; he or she may threaten parents by addressing these issues prematurely. The leader's own areas of emotional conflict may make it difficult for him/her to empathically respond to the parents, just as the parent's conflicts make it difficult for them to respond to their children. So, while the Filial Therapy model does address areas of emotional conflict for parents, it appears that these areas of emotional conflict are addressed in an unsystematic and unreliable manner, one which is highly dependent on leader skill.

Modification of the traditional Filial Therapy program will entail the integration of two components of a training model, Interpersonal Process Recall (IPR), developed by Norman Kagan and colleagues (1967) at Michigan State University. Kagan's model has been used to train para-professionals as well as professionals in the mental health field. This model shares with Filial Therapy the goal of more efficient use of professionals' time and knowledge in meeting society's preventive mental health needs. It is also built upon similar theoretical foundations (see Theoretical Considerations).

The two components of Kagan's model which were integrated into the traditional Filial Therapy program were videotape recall, the heart of the IPR training model, and affect simulation (see Definitions, this chapter). It was hypothesized that the addition of these two components would improve the Filial program by: (a) gradually introducing parents to their own emotional responses to stressful, but general, interpersonal situations through affect simulation films; (b) systematically familiar-

izing parents with the specific interpersonal fears and conflicts which they encountered in their interactions with their children, the manifestation of those conflicts in behavior, and their impact on their children; and (c) providing parents additional practice in non-directive, facilitative interaction by practicing the inquirer role (see Definitions of Terms, this chapter).

In summary, the purpose of this study was to evaluate the effectiveness of a modified Filial Therapy program which integrated elements of Kagan's IPR training model. This modified Filial Therapy program had as its control the traditional Filial Therapy program designed by B. Guerney (1964) and currently offered by L. Guerney at the Pennsylvania State University. It was hypothesized that the introduction of components of Kagan's IPR model would accelerate and heighten skill development of the parents as play therapists. It was also hypothesized that greater gains in parental acceptance and child adjustment would occur in the integrated model (see General Hypotheses, this chapter).

Definitions of Terms

Specific terms used in this study are defined as follows:

Filial Therapy: Filial Therapy is a method of treating emotionally and behaviorally disturbed children between the ages of three and ten. Developed by B. Guerney and colleagues (1964), this approach employs parents as psychotherapeutic agents with their own children. The professional functions as a therapist-educator to the parents. Filial Therapy is a highly structured training treatment program in which parents learn client-centered play therapy techniques with their own

children in order to alleviate present concerns as well as to provide parenting skills for future use. A more detailed description of the Filial Therapy program occurs in Chapter 3.

Interpersonal Process Recall (IPR): IPR is a method of training professional and para-professional counselors, therapists, and medical educators, and is used to accelerate the process of psychotherapy. IPR develops skills in interviewing techniques, affective sensitivity, and self study through videotape recall. Although parts of the model are devoted to teaching specific skills, the core activities allow trainees to determine for themselves what is important in their self study. A permissive, supportive atmosphere is created in IPR which encourages self-exploration and provides an affective and cognitive base for skill development and personal growth.

There are three basic parts in a complete IPR course:

1. Basic communication skills are developed through demonstration, practice, and discussion. The basic skills taught are exploratory, active listening, affective, and honest labelling responses.

2. The trainee is acquainted with his/her own responses to stressful situations through affect simulation films.

3. Videotaped recall is the major component of IPR. In this section, trainees are videotaped as they relate to another in a helping situation. They then sit down with a trained facilitator, called the inquirer (all trainees learn to perform this role), and review the videotape. The trainee is encouraged to re-experience and explore all of his/her thoughts, feelings, reactions, images, strategies, and fantasies which occurred in the interaction as he/she reviews the videotape. The facilitator does not stop the tape to offer criticism

or praise. Rather, he/she helps in the process of self discovery through the use of nonthreatening exploratory leads when the trainee has stopped the tapes at points which are important to him/her. IPR can be easily modified but is usually offered as a 30-hour course. It can be offered in ten three-hour sessions occurring once a week, expanded, or compressed into a weekend.

Delimitations of the Study

The following factors delimit the generalization of the results of this study:

1. The subjects used in this study were all members of the military or military dependents referred to this study by their Family Practice and Pediatric physicians at Dewitt Army Hospital, Ft. Belvoir, Virginia. Their ages ranged from 24 to 45 years.

2. Parents referred to this study had children with a variety of emotional and behavioral problems. No families were accepted to the study whose children showed signs of autism or childhood schizophrenia. None of the children of families accepted for the study evidenced overt signs of organicity.

3. Parents accepted to the study were volunteers, and were presumably motivated to help their children.

4. Both traditional Filial Therapy and integrated Filial-IPR groups ran for a period of 16 weeks. In the past, traditional Filial Therapy groups have run for 20 to 24 weeks.

5. Group leaders both attended a five-day training program in Filial Therapy. Neither leader had experience leading Filial Therapy

groups prior to the study. Both leaders were trained in IPR methodology. One leader was the experimenter who was trained in a 30 hour IPR course. The other leader was given ten hours of IPR training by the experimenter. Neither leader had prior experience with the IPR model in a therapeutic situation.

6. The study did not examine whether the treatment or control groups had differential effects on individuals with different personality and socio-economic characteristics.

Assumptions of the Study

The following assumptions were made for the present study:

1. that most childhood problems are a consequence of unsatisfactory parent-child relationships;

2. that both parents and children are capable of cognitive, emotional and behavioral growth and learning and can be helped to change in positive directions;

3. that changes in child adjustment can be reliably and validly measured by problem check lists;

4. that changes in parental acceptance, affective sensitivity, and demonstrated play therapy skills can be reliable and validly measured, and that these qualities are reflective of parental ability to function as psychotherapeutic agents with their own children; and

5. that acquisition of therapeutic skills will generalize into everyday parenting skills.

General Hypotheses

General hypotheses for this study are stated here. Specific research hypotheses are stated in Chapters 3 and 4.

1. Parents who are trained in the integrated Filial-IPR method will show greater gains in a measure of parental acceptance than parents trained in the traditional Filial Therapy method.

2. Parents who are trained in the integrated Filial-IPR method will show greater gains on a measure of affective sensitivity than parents trained in the traditional Filial Therapy method.

3. Parents who are trained in the integrated Filial-IPR method will show greater gains in videotape measures of the play therapy skills of acceptance of feelings, allowing self direction, and involvement than parents trained in the traditional Filial Therapy method.

4. Children of parents who are trained in the integrated Filial-IPR method will show greater gains on two measures of child adjustment than parents of children trained in the traditional Filial Therapy method.

Evaluation will be in the form of objective paper and pencil tests and ratings of videotapes of actual parent-child play therapy sessions. Parental acceptance, according to Porter (1954), is "one of the essential elements underlying the whole structure of the parent-child relationship." (p. 177) Affective sensitivity provides a measure of the parents' understanding of the child's feelings. Ratings of the videotaped sessions will provide measures of the parents' play therapy skills. Finally, changes in child adjustment should reflect changes in the parent-child relationship as well as the self-concept of the child.

Theoretical Considerations

In this section there will be a discussion of the theoretical underpinnings of both the Filial Therapy and Interpersonal Process Recall model. It will be demonstrated that each model shares the assumption that behavior and personality are influenced by self concept and phenomenological field of the observer. This section will begin with a discussion of the question of combining elements and techniques from different methods in order to create a new method.

Arnold Lazarus (1976) has developed a therapeutic approach called multimodal therapy. He assumes that people experience a range of difficulties across the range of modalities of human experience. These include the behavioral, affective, cognitive, sensate, and imagery modalities. This approach assumes that therapeutic change will result only if the therapist can assess the modality or modalities where the problems exist and provide the intervention best suited to that modality. The goal is to find the method that works best on a specific problem. The multimodal approach supplies a rationale for applying this "technical ecclecticism."

Different writers, including Kagan, et al. (1967), B. Guerney (1964), and Eckstien and Wallerstien (1958) point out that difficulties in learning to be therapeutic also arise. It follows that these difficulties may occur across the same modalities described by Lazarus. The same technical ecclecticism is in order for the task of discovering the most effective methods of training persons to function therapeutically.

Parents learn to facilitate the growth of self confidence, self direction, and self responsibility in their children through mastery

of the Filial methods. The use of IPR components allows parents to gain mastery of Filial methods by experiencing the same learning processes.

Filial Therapy

The theoretical model upon which Filial Therapy is based is client-centered play therapy and is derived from Roger's (1951) client-centered therapy. This theory assumes an inherent capacity in each individual for growth and self direction. The client-centered approach postulates that this capacity for growth will be released when certain definable qualities in the therapeutic relationship, such as genuineness, empathy, and unconditional positive regard, are experienced by the client. Axline (1947) applies the eight basic principles of Rogerian client-centered therapy to play therapy with children as follows:

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

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

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

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

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

6. The child leads the way; the therapist follows.

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

8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (pp. 73-74)

Filial Therapy is an intervention designed to improve the parent-child relationship by teaching appropriate parenting skills. The primary goal of Filial Therapy is to overcome the child's emotional and behavioral problems by educating the parents to serve as the psychotherapeutic agent. B. Guerney (1964), the originator of Filial Therapy, summarizes the theory behind personality change underlying the model:

> The manner in which the child's play sessions are to be conducted is intended first to break the child's perception or misperception of the parents' feelings, attitudes, or behavior toward him. Second, they are intended to allow the child to communicate thoughts, needs, and feelings to his parents which he has previously kept from them, and often from his own awareness. (This communication is mainly through the medium of play.) The children's sessions with their parents are thus meant to lift repressions and resolve anxiety-producing internalized conflicts. Third, they are intended to bring the child--via incorporation of newly perceived attitudes on the part of his parents--a greater feeling of self respect, self worth, and confidence. (p. 306)

The goal is accomplished by teaching the parents the principles and skills of client-centered play therapy as outlined by Axline above. The secondary goal is to generalize these skills to everyday parent-child relationships outside the formalized play therapy sessions conducted at home. The focus is not upon the past, or the parents'

role in creating his child's problems, but upon the present and future. The importance of skill development for preventive as well as therapeutic purposes is stressed.

The advantages of using the parent rather than a professional therapist to treat the child are many. An important advantage is that the parent has an on-going and important relationship with the child, while the building of a therapist-child relationship often takes considerable time. Quoting B. Guerney (1964), "Every bit of success that the parent achieves in successfully filling the prescribed role should have an effect many times more powerful than that of a therapist doing the same thing." (p. 308) Given the interactional nature of parent-child difficulties, any changes in the parents' contributing behavior should contribute to improving the on-going situation.

Another advantage is that the parent's involvement heightens the parent's motivation to be helped, and to be of help. This should reduce the resistance to treatment so common when the child is seen by a professional. Finally, this approach offers parents the opportunity to learn interpersonal skills which cannot only help the child work through his current problems, but also be generalized to consolidate their gains as well as be generalized to other members of the family, including the spouse. This can serve to reduce those tensions in the whole family situation which may be playing a part in sustaining symptomatic behavior in the child.

While the theory of personality change underlying the play therapy sessions is primarily derived from Rogers (1951), the method used to

teach these skills are based upon behavioral theory as well as student-centered methods. Training is accomplished through didactic presentation, modeling of play therapy skills, exercises, social reinforcement for mastery of the required principles and skills, and generalization (see Chapter 3, Filial Program). In addition, Filial leaders model client-centered skills when helping parents to explore their own areas of emotional conflict in relation to their children.

Interpersonal Process Recall (IPR)

The theoretical framework underlying the IPR model is also based primarily upon Rogerian personality theory. IPR assumes that behavior and personality are influenced by self concept and the phenomenological field of the perceiver. This idea relates to both the affect simulation films and the recall process. Kagan (1967) identified a number of interpersonal fears which limit the ability of persons to become closely and intimately involved, or which limit the ability to allow for increasing differentiation in a relationship. Briefly stated, these fears include giving and receiving affection, and expressing and receiving hostility. The affect simulation films and the videotape recall components of the IPR model both aim to help trainees to experience and begin to accept these fears. By accepting these fears they are accepting a part of themselves which may have been previously denied. This self acceptance can lead to greater self confidence and stronger self concept. It can allow them to take more interpersonal risks and learn new interpersonal behavior.

Trainees are first exposed to these fears when they view the affect simulation films. This first exposure allows the trainees to begin to experience these fears in the less risky experiencing of filmed actors. The ensuing group discussion allows parents to share their fears and learn that others have similar interpersonal fears. The second step in learning to recognize and accept interpersonal fears occurs in the videotape recall. Seeing oneself interact with another person on videotape is a powerful form of feedback. In this setting one can discover one's interpersonal fears, see their manifestation in behavior, and see the impact on the person interacted with.

The other source of learning occurring in the videotape recall component of IPR occurs in learning to function as an inquirer. It is the inquirer's job to help the person going through videotape recall in their efforts to explore their thoughts and feelings during their interaction. To do so, the inquirer must pay close attention to the verbal and non-verbal communication taking place. The inquirer role requires skills of non-judgmental, non-interpretive, and non-directive interaction with the purpose of allowing others to gain insight and experience self discovery. This leads to a sense of self responsibility for one's own learning and behavior change.

Summary and Overview

This chapter described the need for and purpose of this study which is to design and evaluate modifications of the traditional Filial Therapy program designed by B. Guerney (1964). The primary modification of the traditional program involves integration of major components of Kagan's

(1967) Interpersonal Process Recall method of training. In addition, terms were defined and limitations, assumptions, and general hypotheses were stated. The theoretical frameworks underlying each model were described and a rationale for combining elements of the two models was provided.

In Chapter 2, a three-part review of the literature examines research on parent-child relationships, the history of the use of parents as change agents for their children, and research outcomes of previous Filial Therapy and IPR research studies. Chapter 3 will contain a discussion of population characteristics, experimental design, dependent measures, and formal experimental hypotheses. A detailed description of each treatment method is also provided. Chapter 4 contains a presentation of the analysis of the data; and Chapter 5 contains the results, conclusions, and implications of the study, as well as limitations in the design and recommendations for future research.

CHAPTER 2

REVIEW OF THE LITERATURE

This chapter consists of three sections. The first section presents research findings related to the parent-child relationship. The second section is a review of the research findings in various efforts to use parents as agents of change, including research outcomes for Filial Therapy. The final section presents research outcomes for Interpersonal Process Recall (IPR).

The Parent-Child Relationship

A number of studies have examined the relationship between parental attitudes and behavior and effective psychological and social functioning in children. The review of this section is not exhaustive of the literature, but does summarize the trend of the literature in this area. Several consistent findings emerge from these studies.

Baldwin (1949) examined the dimensions of warmth, democracy, and indulgence as they occur in the home environment and related them to nursery school behavior. The factor of democracy emerged as the most significant factor in accounting for variability in the behavior of the children. Children from democratic homes were more active and socially outgoing, favored in their peer groups, and rated high on tasks requiring curiosity, originality, and constructiveness. It was also found that indulgent parents fostered physical apprehension and a lack of skill in gross motor activities.

A study by Becker, Peterson, Hellmer, Shoemaker, and Quay (1959) examined the relationship between parental behavior and personality factors, and behavior disorders in children. In families with children found to be shy, sensitive, or without self confidence a factor analysis showed a relationship with ratings of the fathers' behavior. In those families with conduct disordered children, both parents were prone to give harsh vent to emotions and tended to be arbitrary.

A second study by Becker, Peterson, Luria, Shoemaker, and Hellmer (1962) examined factors which they believed to be crucial in the development of children. Parents of 71 kindergarteners were examined on 64 to 71 scales. Among the findings: (1) there was a strong relationship between degree of parental hostility and physical punishment and aggressive behaviors in children; (2) where the father is hostile, punitive, and strict, the children show more personality problems.

In a study by Baumrind (1967) the relationship between parental child rearing practices and competencies in children was examined. In the group of children described as self reliant, assertive, self controlled, buoyant, and affiliative, the parents were found to be consistent, loving, and secure in the way they handled their children. They were also likely to provide reasons for making demands, communicate more clearly than other parents, and expect mature behavior from their children.

In the group of children who were rated to be more insecure and fearful, less affiliative with peers, less content, and more likely to

become hostile or regressive under stress, the parents were found to be less nurturant, and less involved with their children. They did exert firm control but tended to offer little support or affection. In addition, they did not use reason when giving orders. The third group of children was described as lacking in self control and self reliance. Their parents were characterized as not well organized, self effacing, and lacking confidence in their ability to influence their children. They expected less from their children than other parents and babied their children more.

Coopersmith (1967) studied the relationship between varying levels of self esteem in adolescents and child rearing practices as determined by interviews with mothers. The subjects were drawn from a school population and were measured on subjective and behavioral indices. It was found that high self esteem children experienced nearly total acceptance by their parents, clearly defined and enforced limits, and respect for differences that exist within those limits.

In a study by Miller (1971) the relationship between self esteem and the quality of communication was studied. Data was collected from three different inventories. Miller found that the general self image and social self image of the child was significantly related to the degree of empathy, genuineness, and positive regard of the mother towards the child. When there were high levels of these qualities present, the child's self esteem was high.

A number of consistent findings emerge from this review of research on the parent-child relationship. In general, parents of children who

were rated high in self esteem, self confidence, affiliativeness, popularity, and self reliance were found to be democratic, empathic, loving, consistent, involved, and able to set firm limits. Parents of children rated to be conduct disordered, withdrawn, and fearful tend to come from homes which are indulgent, arbitrary, angry, and inconsistent. It is apparent that those qualities of the parent-child relationship which are associated with positive mental health in children are the same as those relationship variables and skills taught in the Filial Therapy program. The next section will review the research literature on efforts to use parents as psychotherapeutic agents of change with their children.

Use of Parents as Agents for Change

The literature on the use of parents as psychotherpeutic agents with their own children divides into three areas: psychodynamic, behavioral, and client-centered therapies. This section of the literature review will be divided along similar lines, with research findings on the Filial Therapy method discussed under client-centered approaches.

Psychodynamic Approaches

Freud (1959) described the first reported case where a parent functioned as therapist for his child. The father of "little Hans" was enlisted in the treatment of his five year old son's phobia. Ruben (1945) concluded that the outcome was possible because the father had been analyzed and concluded that the use of this method is rare

because it requires the parent to consciously accept and use the analysts' interventions.

Jacobs (1949) described the treatment of a three year old child through involving the mother. The mother-child relationship was described as improved after five months of therapy because the mother was able to establish a strong positive relationship with the therapist.

Ruben and Thomas (1947) worked with individual mothers to resolve early developmental complications by providing information and advice to mothers on how to handle specific situations. Instruction ranged from simply changing a situation, to having mothers interpret the child's unconscious conflicts in order to bring about a change in the child's personality. Ruben and Thomas worked with over 100 cases and concluded that mothers could make appropriate analytic interpretations.

Elkish (1953) included mothers into the therapists' treatment of children. He assumed that the mother would want to imitate the therapist in an unconditional acceptance of the child. Furman (1969) concluded that for parents to be considered for participation in therapy for their child, they should be free from personal psychodynamics which might negatively influence the child. He suggested that mothers who may not benefit from inclusion in the therapy or a guidance approach are mothers who have primarily the same defenses as their child.

In summary, while many analysts claim that parents have been usefully included in the therapy of their children, the literature shows no systematic or empirical research supporting that claim. Most reports are of individual case studies which provide little reliable evidence

upon which to judge their effectiveness. The variety of approaches seem tailored to the specific problems of a particular parent or child and are not based upon a set of general skills which can be taught to a variety of parents to treat a range of childhood problems. Each of these methods is taught in the context of a specific case, so does not provide a more efficient use of professional time. In fact, Ruben and Thomas (1947) question whether their successful cases were not simply concurrent therapy of the mother and child.

Behavioral Approaches

Wahler at al. (1965) conducted one of the first well controlled experimental studies examining parental variables contributing to the maintenance and alteration of deviant child behavior. He treated three children ranging in age from three to six. Mothers were trained to use contingency management procedures, including punishment. Each child demonstrated behavior change. Wahler (1969) later trained a mother to eliminate her five year old child's stubborn and destructive behavior. A number of other writers trained parents to modify a variety of behaviors including tantrums (Hawkins, Peterson, Schweid, and Bijou, 1966), excessive scratching (Allen and Harris, 1966), self care and social interaction skills (Mira, 1970), enuresis (Shah, 1969), and fire setting behavior (Holland, 1969). In all of these cases, as well as in most cases in the literature, the authors are reporting individual cases of treatment for fairly specific problems.

In one of the few cases where more than a single set of parents were trained, Wahler (1969) trained five pairs of parents to modify inappropriate behavior of their four to six year old children. He found

that the withdrawal of attention had no effect or increased oppositional behavior for these children. When an isolation procedure was employed, undesirable behavior was reduced.

In a review of the behavioral literature related to use of parents as change agents, Frangia, Reisinger, and Ora (1977) note that the majority of studies do not explicitly state their parent training procedures. In addressing the question of how well techniques described in the literature generalize out of the clinic, these same authors indicate that the literature provides no evidence that this occurs. They also note that most studies relate to modification of a particular response or response pattern and that "the data to support generalization of techniques across classes of behavior are limited and the available findings are difficult to interpret." (Frangia, Reisinger, and Ora, 1977, p. 109)

In conclusion, the literature indicates that existing efforts to train parents to function as behavioral change agents to their children have been effective but limited to specific techniques applied to specific problem behaviors. The literature fails to show that an effective method of teaching parents a range of behavioral techniques which cover a range of problems, has yet been developed.

Client-Centered Approaches

While a number of studies, including Dorfman (1958), Moustakas and Schlacock (1955), and Axline (1964), establish the utility of client-centered play therapy procedures when practiced by a professional, few studies have been carried out on the use of parents as change agents.

In fact, the only studies to use parents in a client-centered intervention are those pertaining to Filial Therapy.

The first systematic investigation of the Filial Therapy model was conducted by L. Stover and B. Guerney in 1967 in order to explore the workability and practicality of training parents of emotionally disturbed children in the therapeutic role. The question at hand was whether parents of emotionally disturbed children could learn the skills necessary to resolve some of the interpersonal and emotional problems which they may well have had a role in creating.

Stover and B. Guerney (1967) employed two experimental and two control groups to investigate this question. Groups contained six to eight mothers and were formed by random assignment. They were drawm from a population of mothers applying for psychological services at the Psychological Clinic of Rutgers University. The study included 10 girls and 18 boys who had been previously diagnosed as emotionally maladjusted as a result of parent interviews and psychological testing. The experimental group met at the clinic for ten one and one-half hour training sessions while the control group received no training during the course of the study. The researchers reported that findings indicated Filial Therapy training did move parents toward the goal of providing the necessary climate.

A second, more comprehensive study by B. Guerney and Stover (1971) attempted to further investigate the efficacy of the Filial Therapy method. In this study, conducted at the Psychological Clinic of Rutgers University and the Huntington Psychiatric Clinic, 51 of 71 mothers were

recommended for participation. Only parents evidencing mental retardation, psychosis, or suicidal or homicidal impulses were screened out. The authors report that only mothers were included for research and practical reasons. Children were screened only for suspected organicity and if problems seemed transient or insignificant. The children included 13 girls and 58 boys between the ages of 4 and 10 years.

A weakness of the study was its lack of a control group. A one-group pretest/posttest design was used. Criteria for selection into the groups was the existence of a "serious" emotional difficulty. Therefore, problems were usually of longer standing duration and results unlikely to be exclusively accounted for by maturation. Analysis of videotape ratings indicated that mothers could be trained to acquire the play therapy skills of communication of acceptance, allowing self direction, and involvement. Tape ratings also indicated that as a result of their playroom experiences, children worked out aggressive feelings, decreased in affective displays, and dealt more realistically with their mothers in terms of conversation and sharing. Two measures filled out by clinicians indicated that children had improved significantly. Finally, children showed significant improvement on a variety of parent report inventories measuring symptomatology and psycho-social adjustment.

Oxman in 1971 attempted to compare the parents and children used in the 1971 Stover and B. Guerney study (above) to a control group. The control group consisted of 77 mother-child pairs recruited by providing free babysitting in exchange for participation in the study. Experimental and control groups were matched with respect to geography,

age of parents and children, socio-economic status, and size of family. Oxman compared the groups over a 12-month period and found significantly greater improvement in the experimental group over the control group in terms of the two variables she studied. These were child symptomatology and maternal dissatisfaction. The major weakness of her study is that the families, while matched on a number of variables, are not matched on child adjustment. Oxman may have compared two different populations.

Horner (1974) provided additional evidence that Filial Therapy may be an effective treatment intervention. Horner administered the Problem Check List (Leventhal and Stollack, 1965) to parents of 60 children prior to and at the completion of 6 months of Filial Therapy treatment. The mean number of problems checked by parents was significantly reduced from pretest levels from 22.02 to 13.88 ($p = .0001$). Again, there were no controls employed in this study.

A follow-up study by L. Guerney (1976) provided information about the lasting effects of the Filial Therapy program. A brief follow-up questionnaire was collected on 42 of a possible 51 former participants in the Filial program. The questionnaire was filled out from between one and three years after the termination of treatment. Results indicated that:

1. Only 3 of the 42 children who had participated in the program were receiving professional help at the follow-up.

2. Out of the 42 parents responding, 32 reported the child as having continued improvement since termination; 4 reported the child

as remaining the same; 4 reported the child's adjustment as deteriorating; and 1 reported their child as "worse than ever."

3. Sixty-four percent of the parents attributed their child's improved functioning to their ability to better relate to the child, in conjunction with their child having become older.

4. Parents generally responded with an overall positive evaluation of the Filial Therapy program. The results of this study suggest that the Filial Therapy program is generally effective, and that gains are maintained from one to three years.

Finally, Sywulak (1978) conducted the best controlled study of Filial Therapy to date. In this study, subjects served as their own controls during a four month waiting period which was followed by four months of participation in the Filial Therapy program. This was a major improvement over the Oxman study because it was possible to control for possible differences between families who seek professional help from those who do not. Fathers were included in a population of 13 married couples and 6 single mothers. They represented a total of 19 emotionally disturbed children. These parents were recruited from families interested in participating in the Filial Therapy program as offered by the Individual and Family Consultation Center of the Pennsylvania State University.

The effectiveness of the Filial Therapy approach was assessed by studying the variables of parental acceptance and child adjustment. Parental acceptance was measured by the Porter Parental Acceptance Scale (Porter, 1954), and child adjustment was measured by having

parents complete the Filial Problem List, the Parent Check List and the Parent Rating Scale. Parents completed these pencil and paper measures at four different points in time: (a) at intake, prior to the four month control period; (b) following the four month control period, just prior to the beginning of training; (c) after two months of treatment; and (d) after four months of treatment.

Results of this study indicate that the Filial Therapy program is significantly effective at improving both parental acceptance and child adjustment. An examination of the data at different points in time showed that parental acceptance achieved marked improvement by the second month. There was also some evidence of positive changes in child adjustment after two months. Those changes continued throughout the four months of treatment.

Overall, the Filial Therapy research conducted so far validates Filial Therapy as a method of training parents to function in a therapeutic relationship with their own children. Research findings indicate that children resolve emotional conflicts and improve in their emotional and behavioral adjustments. The literature also indicates that parents show significant gains in play therapy skills and acceptance of their children. While these results are very promising, research investigating the efficacy of the current Filial Therapy model needs to be replicated, utilizing diverse populations and better use of control groups.

Summary and Discussion

A review of the various methods of training parents to function as psychotherapeutic agents for change with their children reveals

several advantages of the Filial Therapy method over other methods. The research literature on psychodynamic approaches offers little reliable evidence to support the effectiveness of methods used. In addition, virtually all methods are tailored to specific cases and do not provide a general set of skills which can be used across a variety of problems. Because these methods are all tailored to specific cases, there is no evidence that these approaches offer a solution to the problem of more efficient use of professional time through the use of para-professionals. While the literature on behavioral methods does offer evidence that these methods are effective, these methods are limited in similar ways to the psychodynamic approaches. They tend to be limited to single cases, with parents taught specific techniques to deal with specific, usually behavioral, problems. The behavioral literature fails to show a method which deals with a range of problems, and which can be taught to a group of parents. The Filial Therapy approach has demonstrated its effectiveness in several research studies, and has the advantage of being able to treat a variety of problems, of teaching skills that are generalizable for later use in a variety of situations, and of providing a more efficient use of professional time because it is best taught to groups of parents. Also, because it focuses on the parents' relationship with the child, and because it is taught to parents in groups, it seems particularly well suited for the integration of IPR technology. A review of the literature on IPR research outcomes is presented in the next section.

IPR Research Outcomes

The research literature on IPR is quite extensive. IPR as a training method has been used in counselor education and supervision, the training of para-professionals, in both general and teacher education, and quite extensively at many medical schools to train medical students and residents in interviewing skills. In addition, the IPR method has been used to study client growth in therapy and to accelerate the process of psychotherapy. This review of the IPR literature will be focused on those areas of IPR research relating most directly to the training of parents for the role of psychotherapeutic agents to their own children. These areas will be IPR and psychotherapy, IPR and counselor education, and IPR and para-professional training. IPR research in the area of medical education and general education has been reviewed in detail elsewhere (Novick, 1978).

The earliest studies examining the use of Interpersonal Process Recall in psychotherapy were case studies of individual psychotherapy clients. While these early studies lack the controls and generalizability of larger controlled experimental research, they were crucial in the development of the IPR model. In a study (Kagan, Krathwohl, and Miller, 1963), separate client recalls were found to accelerate client growth of a female client whose individual counseling sessions of five months had yielded little growth. Therapist and client were video recorded, and a recall session of both counselor and client was conducted by a trained inquirer. During recall, the client was able to discuss previously blocked areas, and the counseling process accelerated significantly.

In another case study (Woody, Kagan, Krathwohl, and Farquahar, 1965), hypnosis was used to facilitate the recall process. Videotapes of recall sessions were studied by eight clinicians and indicated hypnosis helped the client increase his involvement in the recall procedure and improved his relationship with his therapist.

Resnikoff, Kagan, and Schauble (1970) studied a more severely disturbed 18 year old high school senior. Videotaped recall was introduced after the twelfth session of counseling. Two groups of judges who were unaware of the IPR intervention rated tapes of sessions nine through twelve on five variables: (a) ability to gain insight, (b) level of defensiveness, (c) ability to experience feelings, (d) ability to relate to the therapist, and (e) overall therapeutic relationships. Following the IPR session, ratings of both groups of judges increased over all five variables. This case suggested that progress in therapy may be accelerated by introducing videotape recall, even when a good relationship exists.

In a larger experimental study Schauble (1970) studied the responses of 12 counseling center clients to therapy using video recall of the clients' responses to the affect simulation films, and then their recall of actual therapy sessions. Schauble's study, based on a small total n, showed significant between-group differences in favor of the IPR group on three of the five dependent measures. It was concluded that the IPR method had accelerated client growth in therapy.

Van Noord (1973) replicated Schauble's study with some modifications. He retained the n of 12 students but increased the number of therapists from 2 to 12, used a MANCOVA and ANCOVA analysis, and changed 1

dependent variable. He observed no significant differences between groups on the MANCOVA, nor on separate ANCOVAs of individual measures. He did report that subjective client comments found IPR methods helpful in self exploration and exploration of the therapeutic relationship.

Both Schauble and Van Noord reported that a frequent therapist criticism had to do with the imposition of structure in the IPR treatment group. The rigid sequential use of techniques was seen as a hindrance because it did not take into account the specific needs of each client. Both researchers recommended more flexibility in the use of IPR techniques, and that the impact of IPR be studied over a longer period of time.

Tomory (1979) conducted a study evaluating the effectiveness of the IPR model in psychotherapy which attempted to improve on the earlier studies in ways suggested by their authors. IPR stimulus film techniques and videotape recall were used in conjunction with dyadic therapy and compared with traditional dyadic methods without IPR. The sample was 50 clients at a university counseling center. The therapists were three interns and two regular staff therapists. Clients were seen from 4 to 15 sessions. Each therapist saw 10 clients, 5 treatment and 5 control. Therapists were allowed to select the IPR techniques which they believed best suited their clients' needs. IPR techniques had to be used in at least five of the first ten sessions. The dependent measures included self-report questionnaires and inventories, therapist questionnaires, and tape ratings of in-therapy client verbal behaviors. The statistical analyses indicated no significant differences between treatment groups on any of the six measures. Both methods indicated statistically significant pre to post movements on some measures.

A major area of IPR research has been in the area of counselor education. Goldberg (1967) compared supervision using IPR to traditional audiotape counseling supervision. In this study all trainees interviewed their clients for 30 minutes for 6 weekly sessions. The group receiving traditional supervision received one hour of individual supervision aimed at understanding the therapeutic relationship by listening to the audiotape. The first 2 sessions of IPR supervision included a 15 minute client recall observed by the counselor and a 45 minute counselor recall. During the next two supervisory sessions, the trainees conducted recalls for each other. During the final 2 supervisory sessions, mutual recall was conducted for 60 minutes by the supervisor. The dependent measures were the Counselor Verbal Response Scale (hereafter referred to as the CVRS) and the Wisconsin Relationship Orientation Survey (hereafter referred to as WROS). The study showed that the trainees using IPR methods showed greater gains on the CVRS than the traditionally trained trainees.

Spivak (1970) compared the IPR method to a traditional classroom training approach. He found significant differences ($p < .05$) favoring the IPR method on the understanding, specific, and exploratory subscales of the CVRS in the coached client situation, and on all the CVRS scales when role playing clients were used. He found no significant differences for Carkhuff's accurate empathy scale or for the Affective Sensitivity Scale (hereafter referred to as the ASS).

Using prison counselors as trainees, Grzegorek (1971) compared two types of training with different emphases. One method was called

cognitive-intellectual and encouraged trainees to develop more effective ways of dealing with inmates. The IPR method, called experimental-accepting, encouraged trainees to become more aware of their own reactions in interpersonal situations. IPR stimulus vignettes and recall were employed. He found no significant differences in affective sensitivity as measured by the ASS. The trainees using the IPR method did make significantly greater gains in empathic understanding and on the understanding, specific, and exploratory scales of the CVRS.

Kingdon (1975) compared IPR supervisory techniques with traditional supervisory techniques. Counselors were masters level counseling students, and clients were volunteer undergraduate psychology students. Supervisors were doctoral students in counseling. The IPR treatment consisted of three videotaped counseling sessions followed by client recall and counselor recall sessions, with a mutual recall session following the third session. The control group consisted of three audiotaped sessions each followed by an hour of traditional supervision. No significant results were found on counselors' empathy level, client satisfaction, supervisor ratings, or clients' self reported inhibitions. IPR supervision did demonstrate a significant change in the clients' level of self exploration over time.

That area of previous IPR research with perhaps the most obvious relevance to this study has to do with para-professional training. Scharf (1971) examined the training of undergraduates to function as para-professional counselors. She compared an intensified IPR course with an intensive community skills program. Each program lasted 5 days

and totalled 40 hours. The community skills program was based upon Carkhuff's work with empathy training, discrimination training, role playing, group discussion, and client interviewing. The IPR model consisted of a discussion of facilitative conditions, tape rating, affective skills training, role playing, and the IPR process. Scharf examined the effects of training on six dependent variables as a post-test and eight weeks later as a follow-up. The results were inconclusive. Scharf concluded that an intensified course format (40 hours in 1 week) was not an effective way to teach, using either model.

A study by Dendy (1971) involved training undergraduate resident assistants as para-professional counselors. His treatment group consisted of 22 resident assistants who were trained over a period of six months rather than in one week, as in the Scharf study. Training occurred in two four-week phases and totalled thirty-eight hours. He compared this treatment to a similar group receiving the same training but without affect simulation films. He also compared it with the empathy training groups used by Scharf (above), and a group of eight professional counselors at the Michigan State University Counseling Center. Dendy used the same dependent variables that Scharf used. These included the Affective Sensitivity Scale (Form C), audiotapes of client interviews rated on the Carkhuff Empathic Understanding in Interpersonal Process-Revised (CE-II), and the Counselor Verbal Response Scale. Subjects were tested before and after each phase of treatment. Dendy found significant improvement in interviewing skills in both phases of treatment, significant growth in affective sensitivity, and

no loss of skills during the three-month period between training phases. Before the IPR training, there were large differences between professionals and para-professionals, in favor of the professionals. It was found after training that there were no significant differences between these groups on different measures of helping skills.

Archer (1971) studied the same undergraduates trained in Dendy's (1971) study to see if they could be used to train other undergraduates in interpersonal skills. He also examined whether methods originally developed for use in a therapeutic setting could be used by para-professionals in a growth-oriented setting, and how a structured training model using videotape recall, affect simulation, and tape rating would compare with an unstructured encounter-developmental group approach. The structured IPR approach also utilized exercises from Carkhuff's (1965) work. Also, control groups were utilized. The criterion measures used were: the ASS (Form C), a measure of affective sensitivity; the Personal Orientation Inventory, a measure of self actualization; the Wisconsin Relationship Orientation Survey (WROS), and the Barret Lennard Relationship Inventory, measures of insight and depth in peer relationships.

Results indicated that the structured IPR training model could be used successfully to train undergraduates to teach interpersonal skills to other students. The students trained in the IPR groups were found to have significantly greater interpersonal skills than those in the no treatment and encounter-developmental groups. Separate one-way ANCOVAs on each measure indicated no significant differences on all of the measures except the depth of peer relationship measure,

the Wisconsin Relationship Orientation Inventory. Archer concluded that undergraduate para-professionals using the IPR training model could train other undergraduates to have more effective interpersonal skills. He also concluded that counselor training methods could be adapted to a growth-oriented setting.

Summary and Discussion

A review of the literature indicates that IPR has proved to be an effective method of teaching helping skills and heightening affect sensitivity over a range of settings and populations. Research findings indicate that the IPR method has been effective in training counselors, accelerating client growth in therapy, in training para-professional counselors, and in the training of medical students and residents in interviewing skills. To date, there has been no direct research utilizing IPR methodology in the training of parents as effective therapeutic agents to their own children. However, because of the previous success of IPR in training of para-professionals as well as professionals, there is reason to believe that IPR methods can successfully be taught to parents in order to more effectively and reliably facilitate their acquisition of play therapy skills.

CHAPTER 3

METHODS

This chapter contains a detailed description of the participants, settings, group leaders, data collection, instrumentation, design, hypotheses, treatments, and data analyses used in this study.

Participants

All subjects were referrals from Dewitt Army Hospital at Ft. Belvoir, Virginia. Parents of children who were identified by their Family Practice and Pediatric physicians as having emotional problems were referred to the researcher for assignment to a Filial Therapy group. All subjects volunteered to be in the study.

Parents were informed that participation in the program, called the Parent Play Therapy Program, would require regular attendance at a two-hour weekly meeting for sixteen weeks, and that for the last eight weeks they would be required to conduct weekly play therapy sessions at home with their child or children. In addition, they were informed that they would be required to purchase a kit of toys for $50.00.

There were 32 parents, including 12 couples and 8 parents attending without spouses. Parents were volunteers, and presumably motivated to help their children resolve their emotional conflicts and to improve their relationships with their children. Individual subjects or couples were randomly assigned to treatment and control groups. Parents were asked their permission to be part of a research evaluation of the

Filial Therapy program and were assured that their rights as subjects would be protected.

Children accepted as candidates for participation in the Filial Therapy program ranged in age from three to ten years and were experiencing emotional and behavioral difficulties, according to parental reports.

In previous studies of Filial Therapy some researchers (B. Guerney and Stover, 1971) attempted to screen out children with problems of organicity. In another study, by Sywulak (1978), there was no attempt to screen out such children. In the Sywulak study children identified with such problems (there were four) had adjustment scores which were consistently lower and showed less change throughout the study than those of other children. In this study no attempt was made to screen these children out. There was no overt evidence of organicity and no parents reported that their children had been so diagnosed.

The Settings

There were two settings for this experiment. The parent training groups met for two hours once each week at the Family Practice Clinic at Dewitt Army Hospital. The clinic had a practice and an observation room with a one-way mirror between them to allow for observation and videotaping. The practice room was converted to a play therapy room prior to each meeting. Adjoining both these rooms was a conference room where parents could meet comfortably when not observing practice play therapy sessions. There was also a babysitting room with a baby-sitter paid by the parents. This was used by children who were in for

practice play sessions, as well as by parents whose regular babysitting arrangements temporarily broke down.

The setting for most parent-child play sessions was in the family home. Important factors to be considered in the parents' selection of a room at home are specified later in this chapter under Stages of Filial Therapy Group Process, Phase II: At-Home Sessions.

Play Therapy Group Leaders

Play therapy group leaders were the researcher and a female leader selected on the basis of her experience leading parent education groups and practicing play therapy as a school psychologist in a public school setting. Both attended a five-day conference on Filial Therapy offered by the originators of Filial Therapy, Bernard and Louise Guerney, at the Pennsylvania State University. The researcher also has experience leading training groups of various kinds, and received 30 hours of training in the Interpersonal Process Recall (IPR) model. The other leader was given ten hours training in IPR by the experimenter.

Data Collection

The testing consisted of the following pencil and paper measures: the Affective Sensitivity Scale (Form E, 1980), the Porter Parental Acceptance Scale, the Filial Problem List, the Parent Check List, and the Videotape Rating Scale. These measures are described in the next section and found in Appendices A through E. All of the measures except the ASS were given to the parents to complete at home before the first session and were turned in at the first session. They were administered again during the last week of training. The ASS was

administered during the first and last sessions of each group. Finally, an open-ended sentence completion form (Appendix J), similar to that used by Sywulak (1978), was given during the final meeting in order to obtain participant's subjective reactions to the program.

In addition, as a process measure parents were videotaped in their first and last in-clinic training sessions. These tapes were rated on Stover's (1971) three dimensions: communications of acceptance, allowing self direction, and involvement. Taping occurred through a one-way mirror so that the videotape equipment was not visible to the children in the playroom.

Instrumentation

The following instruments were selected as measures of the dependent variables being studied. Criteria involved in the choice of these measures included adequate reliability and validity. It is believed that these instruments measured the dependent variables, and that these, in turn, reflected important outcomes and process dimensions of the parent-child relationship.

Affective Sensitivity Scale

The Affective Sensitivity Scale (ASS) is an instrument designed to measure an individual's ability to detect and describe the immediate affective state of another. Developed initially by Kagan, et al. (1970 on), the scale is now in its fifth revision. The ASS consists of multiple choice items which the subject completes after viewing filmed vignettes of actual encounters in a variety of settings, including medical and psychotherapy interviews, and school, work and family settings.

The first scale, Form A, contained 86 items on 41 scenes involving 11 different clients and counselors. The test-retest reliability was between .70 and .80. A correlation between pre and post training ratings of counseling effectiveness of .49 was obtained. The second scale, Form B, consisted of 89 items. The test-retest reliability was between .58 and .75. Concurrent validity studies showed that a low positive relationship existed between scores and judgments of counselor effectiveness. A study by Danish and Kagan (1971) showed that the ASS reflects personal growth in interpersonal sensitivity.

More recent versions of the ASS have attempted to improve the scale by introducing other settings than just counseling and psychotherapy, by improving the technical quality of sound and picture clarity, and by introducing more current situations where clothing was more contemporary.

In this study, the 1980 version of Form E was used for evaluation and consisted of 55 items and takes approximately 75 minutes to complete. Because of the newness of Form E, reliability and validity data have not yet been published but is expected to be as high as in earlier versions.

Porter Parental Acceptance Scale

In order to assess a general attitude of acceptance on the part of parents involved in this study, the Porter Parental Acceptance Scale (Porter, 1954) was used. This scale is based on an operational definition of the construct of parental acceptance which consists of four dimensions or subscales. By Porter's (1954) definition, an

accepting parent is one who: (a) regards the child as a person who has feelings, and respects the child's right and need to express those feelings; (b) values the unique make-up of the child and fosters that uniqueness within the limits of healthy personal and social adjustment; (c) recognizes the child's need to differentiate and separate himself/herself from his/her parent and allows the child to become an autonomous individual; and (d) has unconditional love for the child (i.e., loves the child regardless of how well or how poorly the child behaves). In contrast, Porter defines a non-accepting parent as one who is rejecting, over-protective, or indulgent.

The form of the items selected by Porter was one which described situations where children express overt behaviors or verbalizations. Each item is repeated twice in the questionnaire, first, to see how the parent feels in the situation, and secondly, to see what the parent does in the situation. This last ten-item section was eliminated from this administration of the instrument. The responses to each item (whether measuring the parents' general way of feeling or the parents' general course of action) were written so as to build a continuum from low to high acceptance, and the items were weighted from one to five.

Using the Spearman-Brown Prophecy formula, a split-half reliability coefficient of .87 was obtained on the Porter Parental Acceptance Scale. An attempt at checking the validity of the scale was accomplished by establishing criteria against which to evaluate the items and by asking five judges to rate the items. Porter (1954) reports that there was no instance in which at least three out of five judges did not agree.

Furthermore, the greatest degree of disagreement was by a distance of only two scale points, and this disagreement occurred in only 18.67 percent of the responses.

Child Adjustment

In order to best assess child adjustment within the time constraints of this study, two separate child adjustment measures were used. These included the Filial Problem List and the Parent Check List.

Filial Problem List. The Filial Problem List was adapted by Horner (1974) from the Problem List (Leventhal and Stollack, 1965) via a factor analytic study of the original measure. The original list of 237 children's problems were derived from a survey of the literature.

Instructions for completion of the measure involved underlining those problems which apply to the child of concern and then rating the severity of the problem on a three point scale. A rating of "1" indicates that the item is true of the child, but not really a problem, a rating of "2" indicates that the item is true of the child and is a mild problem, and the rating of "3" indicates that the item is true of the child and is a serious problem. (For the purposes of this study, a rating of "1" was scored as "0," a rating of "2" was scored as "1," and a rating of "3" was scored as "2.")

Although no reliability checks have been done on the Filial Problem List to date, the original Problem List obtained a test-retest Pearson-Product-Moment Correlation of .85, representing the reliability of parents' responses after an average 17-week interval. (B. Guerney and Stover, 1971)

Parent Check List. The Parent Check List was developed at the Wichita Guidance Center by Brewer (1958). It contains short descriptions of children's behavior, subclassified by factor analysis into five problem areas: problems of learning and achievement (ten items); active behavior (ten items); passive behavior (ten items); disturbed feelings (ten items); and physiological tension (ten items). Eleven items were not scored on any factor but were included in the total score because they were discriminating in the original selection process. The total score is the number of YES responses with a maximum maladjustment score of 55. The minimum score of 0 reflects highest level of adjustment. A split-half reliability correlation of .92 was obtained on 50 cases in which odd and even numbered items were correlated. In addition, evidence of construct validity has been shown for the Wichita Parent Check List in that hypothesized results were obtained in research (B. Guerney and Stover, 1971).

Videotape Rating Scale

It was believed that by rating videotapes of each parent conducting actual play therapy sessions in the clinic playroom, direct measures of each parent's skill level in play therapy techniques could be obtained. Videotapes of each parent's first and last in-clinic practice sessions were collected. The rating scales used in this study were developed by Stover, et al. (1971) and provided measures of communication of acceptance, allowing self direction, and involvement. Each variable was rated on a continuous five point scale from very low levels of each skill to the highest levels. Each tape was rated for five three-

minute segments and a total score for each variable was determined by adding the five individual ratings together. Pre and post videotapes of each parent were mixed together and presented to raters in a double-blind fashion to assure a non-biased score. Neither the raters nor the experimenter knew which tapes were pre training and which were post training. None of the tapes were rated until the completion of all sessions. Reliability correlations for coding these scales ranged from .73 to .99. The Pearson-Product-Moment correlation on the original measure was .85 and the scales were found to be extremely sensitive measures of the behaviors in question in the original study. (See Appendix D for directions and actual scales.)

Selection and Training of Raters

The two raters for the videotape rating scales of parent play therapy skills were chosen from a population of clinical psychology graduate students who were familiar with the principles of non-directive play therapy. One rater was near the completion of her doctoral program and the other was near the completion of her masters program. Both were paid for their work as raters. Interrater reliability was determined by an analysis of variance (Ebel, 1951). Both inter-judge and intra-judge correlations are reported in Chapter 4.

Both raters completed 15 hours of training prior to beginning actual ratings of pre and post tapes. Parents were rated on five point scales along the three dimensions of communication of acceptance, allowing self direction, and parental involvement. (See Instrumentation section, this chapter.) Training consisted of having judges rate

non-experimental videotapes of actual play therapy sessions until percentage of agreement levels reached at least the 80 to 90 percent range. This experimenter trained the raters, explaining the criteria for ratings at different points on each scale, and helped identify subtle shades of behavior as belonging to one point on the continuum or another.

The Design

In this study, observations were made on all of the dependent variables except the tape ratings at the following times: (a) as a pretest prior to the beginning of the groups, and (b) as a posttest at the completion of the groups. Tapes of clinic play sessions were collected at each parent's first in-clinic training sessions and at their last in-clinic training session. The treatment group was the Filial Therapy program with integrated IPR components. The control group consisted of traditional Filial Therapy. Parents were randomly assigned to treatments and leaders so that there were four groups of eight parents each. Each leader led one treatment group and one control group. The design of this study may be diagrammed following Campbell and Stanley's (1963) notation, below:

$$\frac{O_{1-7}\ X_C\ O_{1-7}}{O_{1-7}\ X_T\ O_{1-7}}$$

(four months)

Hypotheses

While earlier research studies indicate that both Filial Therapy and Interpersonal Process Recall (IPR) are effective intervention

strategies, there was not sufficient evidence to predict directionality in the testing of the research hypotheses of this study. The following hypotheses were considered to be the primary hypotheses of the study and were tested in order to assess the relative effectiveness of these two methods of training parents to function as play therapists to their own children.

H_1: Parents trained in an integrated Filial-IPR program will show no difference in gains, pre to post, in parental acceptance than those parents trained in the traditional Filial program, as measured by the Porter Parental Acceptance Scale (alpha at .05).

H_2: Parents trained in an integrated Filial-IPR program will show no differences in gains in parents' ability to detect and describe the affective state of another, over parents trained in the traditional Filial Therapy program, as measured by the Affective Sensitivity Scale (alpha at .05).

H_3: Children of parents trained in the Filial-IPR method will show no greater improvements in child adjustment, pre to post, as measured by the Filial Problem List, than children of parents trained by the Filial Therapy model (alpha at .05).

H_4: Children of parents trained in the integrated Filial-IPR method will show no greater improvements in child adjustment, pre to post, as measured by the Parent Check List, than children of parents trained by the traditional Filial Therapy program (alpha at .05).

H_5: Videotape ratings of parents' play therapy sessions will not show greater gains, pre to post, in the play therapy skill of communication of acceptance, from one training method to another (alpha at .05).

H_6: Videotape ratings of parents' play sessions will show no differences in gains, pre to post, in the play therapy skill of allowing self direction, from one method of training to another (alpha at .05).

H_7: Videotape ratings of parents' play therapy sessions will not show greater gains, pre to post, in the play therapy skill of parental involvement, from one method of training to the next (alpha at .05).

The analytical procedures used to test these hypotheses are discussed later in this chapter.

Independent Variables

Filial Program

Role of the Group Leaders

The primary role of the leader in the Filial Therapy groups was that of parent educator or trainer. His/her task was to teach the parents play therapy skills. Filial Therapy leaders provided the parents with the rationale for play therapy and helped them acquire these skills. Additionally, Filial leaders were sensitive to parents' feelings and difficulties in dealing with their children, and offered acceptance and support for those feelings at the same time they helped parents to explore them. The Filial Therapy leader's goal was to train the parents in skills and problem-solving techniques which they could then use to both solve and prevent problems in their relationships with their children.

Training Methods

Filial Therapy training techniques employed by each therapist in training parents were classified as follows: didactic, dynamic, reinforcement, and generalization.

Didactic Methods. Didactic techniques included short lectures, modeling, demonstrations, role playing and exercises. These techniques were employed in order to teach the concepts behind client-centered play therapy, including acceptance, empathy, child leadership, genuineness, structuring, and limit setting. The same techniques were employed in teaching the skills which operationalized these concepts. In addition, Filial therapists frequently refer to a list of adult behaviors which are unacceptable in the play sessions. (See section on Play Therapy Skills.)

Dynamic Methods. Dynamic methods included a recognition of the importance of parents' feelings about their children and the Filial training. Although the didactic function is considered essential in teaching the necessary skills, it was impossible to teach parents different ways of interacting with their children without running into emotional and life problems which have so far affected the parent-child interaction.

> A conflict of old and new ideas, attitudes, and behaviors is often experienced. This requires close attention and sensitivity on the part of the leaders to subtle cues from parents indicating that they are experiencing conflict. Support must be provided for parents in their struggle to change. Since parents will often disguise a feeling of personal anxiety in the context of an intellectual question, leaders make a habit of reflecting any feeling messages that they detect along with the substantive response.
> (L. Guerney, pre-publication manuscript)

In this regard, it was important for the Filial therapist to understand the interplay between didactic and dynamic elements, and to be able to decide which method to employ at different moments during the parent groups. This issue was addressed by Andronico, Fidler, B. Guerney, and L. Guerney (1967) where they wrote:

> The group sessions are seen as a blending of these dynamic and didactic elements. The parents are told that it is expected, in the course of their learning how to conduct play periods with their children, that they will also explore their own feelings. The therapist uses his clinical judgment to determine when to make the appropriate shifts from didactic to dynamic elements. One of the times when concentration on the parents' feelings occurs is when it becomes obvious that a particular parent is unable to either understand or follow through behaviorally with a concept because of his own emotional problems. . . . Once the emotional problem is worked through, the process may return to a didactic one of discussing play periods. (pp. 13-14)

The therapist may decide that a particular parents' emotional problems are too great to focus on during the meeting and either agree to meet with the parent outside of the group or refer the parent to individual psychotherapy.

Reinforcement Method. Mastery of the principles and skills of client-centered play therapy was facilitated by the use of social reinforcement. Leaders praised individual efforts towards skill mastery. They also praised the group as a whole for regular attendance, mutual support, helpfulness, etc. By reinforcing individuals who praised and supported other group members, leaders facilitated a supportive atmosphere. Leaders communicated the expectation that each parent could master the different aspects of the play therapy, and difficulties were seen as temporary. When they did occur, leaders proceeded to reinforce small steps which gradually approximated the desired goal.

Generalization Method. Generalization of Filial Therapy skills to the outside world was often addressed specifically in Filial Therapy groups. Generalization to the outside was intentionally not addressed in the first stages unless initiated by parents. Parents themselves usually began considering ways in which they could apply these skills outside of the play sessions. This was reinforced. In the final stage of Filial Therapy, the shift of focus to "real life" is addressed deliberately. Specific assignments are made and time is allotted to discuss how it went. Focusing on dynamic issues is important here because generalization often raised many emotional issues for parents.

Necessary Attitudes of Filial Leaders

B. Guerney, L. Guerney, and Stover (1972) have addressed the importance of the attitudes of the Filial Therapy group leaders which most facilitate successful outcomes:

> The therapist--who in this context could really be called a therapeutic educator--should behave in such a way that the parent perceives him as one who (a) understands the parent's difficulties, his problems, his needs, and his emotions; (b) solicits and respects the parent's viewpoints and opinions even as he may try to persuade him to adopt or experiment with behaviors based on differing viewpoints; (c) does not blame the parent or hold him to account for any deficiencies of his child in their past relationship; and (d) sees the parent as a vital, indispensable helpmate in trying to improve the well being of his child. (p. 275)

Play Therapy Skills

Play therapy skills include empathic understanding and responding, allowing self direction, limit setting, and structuring. Parents structured each play session by informing the child that the playroom has a relatively permissive atmosphere with a minimum of limits which

were mentioned to the child at the point of transgression of those limits. These limits included physical aggression towards the parent, activities which create a danger to the child, activities which would result in expensive damage to the play area, and the reality limit of time. Rooms used for play therapy were arranged specifically for the sessions to provide as free an environment as possible. There was usually very little furniture, and expensive or breakable items were removed. Toys were chosen for the playroom on the basis that they allowed for various expressions, including fantasy, competition, mastery, and aggression.

Parents allowed self direction by permitting the child to do or say whatever he or she wanted, with the exception of the above limits. Parents communicated understanding and acceptance primarily through the skill of reflective listening. In addition, a warm and permissive atmosphere was maintained by prohibiting parents from criticizing, praising, encouraging, reassuring, questioning, leading, directing, advising, teaching, moralizing, or punishing. Sywulak (1978) comments on the results of effective play therapy:

> . . .In utilizing the play therapy techniques in an appropriate manner, the parents achieve several purposes of primary significance in the creation of a situation in which the child could become aware of the feelings he had now allowed himself to recognize. In the presence of an accepting parent, the child has the opportunity to express these feelings through play and to come to a better understanding of how to cope with these feelings. In addition, the play sessions enable the child to build a feeling of trust and confidence in the parent which, in turn, enables the child to communicate more honestly and fully with the parent. Further, play sessions enable the child to build confidence in himself, thereby allowing the child to see himself as a more worthwhile and likable person which, in turn, is expected to result in healthy emotional and behavioral adjustment. (p. 44)

Stages of Filial Therapy Group Process

Filial Therapy groups typically proceed through three stages: training, home sessions, and generalization. The first two of these are considered in detail below. The final stage, generalization, usually occurs after four or five months. In this stage, parents begin initiating discussions about outside issues and applications of the principles learned earlier. Leaders reinforce and encourage this shift in Filial groups which continue beyond four or five months. This research project did not attempt an extensive generalization stage due to limitations in time.

Phase I--Parent Training. This stage of training lasted the first eight weeks of the program. The four primary goals of this phase were: (a) to get the parents at ease with the leaders; (b) to provide the parents with a solid rationale and understanding of the Filial Therapy approach; (c) to teach the parents the skills of client-centered play therapy; and (d) to initiate the children into the play therapy experience. These goals were accomplished by following the structured format below.

Session I: This session was devoted to explaining the nature of the Filial Therapy process and the parents' role with their children. Parents were asked to explain their reasons for participating in Filial Therapy. The leaders attempted to set the parents at ease by listening empathically to parental concerns and trying to relate mastery of play therapy skills to the parents' concerns about their children. At this session, parents also watched a videotaped play session as demonstrated by the leaders in order to orient them to their task and hopefully allay anxiety about the task.

Questions and discussions followed the demonstration. This gave the leaders a chance to reinforce significant aspects of the rationale for play therapy, and to begin initial instruction in the skills necessary to conduct play therapy sessions.

Sessions II: During this session, parents again observed the leaders demonstrating play therapy skills, this time with one of their own children during a 15 minute play session. This was observed by all the parents and then discussed. Emphasis was not on the child's behavior but on the role of the leader as a play therapist. Parents then used the remainder of the session to practice the skills of reflective listening, structuring, and limit setting in preparation for their own first practice sessions in the following weeks.

Sessions III-VIII: During these remaining sessions of the Training Phase, two to three parents per week began conducting 15 minute in-lab play sessions, and then discussed them as a group. Again, the emphasis here was upon parent behavior and play therapy skills and not on the child's behavior or problems. By Session VIII, each parent had had two sessions, had begun eliminating certain negative behaviors, and began mastery of more constructive skills.

Phase II--At-Home Sessions. During the second phase of the Filial Therapy program, the groups shifted their focus from play sessions conducted at the clinic to play sessions conducted in the home. Except for the ninth session, parents also continued to bring children to the clinic to keep improving their play therapy skills.

Session IX: No play sessions were conducted so that the leaders could focus fully on establishment of the play sessions at home. Parents were asked to consider which room of their home would be most suitable for the play periods, what time and what day would be most satisfactory for both parent and child, which additional limits would be necessary to prevent unnecessary damage to the home, and how to structure play sessions so as to incorporate them smoothly into the functioning of the household. At the end of the meeting, parents purchased a $50 toy kit.

Session X and Remaining Sessions: At-home sessions were begun. The parents continued to take turns bringing their children to the clinic for play sessions. Group meetings usually began with two play sessions conducted by the parents. These helped maintain and improve the parents' skill level, although discussions began to focus on the meaning of the child's behavior as well as that of the parent. At this point, the meaning of the child's behavior as well as the parents' emotional reactions were given high priority, since by this time the children were usually using the sessions in a more expressive and meaningful manner. This gave rise to issues which required exploration of parental feelings. The leaders' ability to shift between dynamic and didactic methods was important here, as well as their ability to relate the importance of the play therapy skills to the emerging emotional issues of both parent and child. A sizable portion of each meeting was used to discuss the at-home sessions of each of the parents. In many cases, as parents further mastered the skills, emotional issues

began to resolve and parents began talking about broader application of the skills and concepts of play therapy. With sufficient time, the group would have tackled these issues in the generalization phase.

Integrated Filial Therapy-IPR Program

The integrated Filial-IPR program was structured in much the same way as the previously described Filial Therapy program, with the following changes.

1. In Sessions VII and VIII, in addition to doing a single practice session, parents were shown the affect stimulus vignettes from the IPR model. This introduced them to the notion of interpersonal fears arising in stressful interpersonal situations and helped them begin to familiarize themselves with their own emotional reactions to specific situations. The stimulus vignettes were introduced at this point because parents were just beginning to discuss their play session reactions to their children. The leaders began focusing on the at-home sessions during week eight and continued this discussion the following week. This allowed time for the additional training activities introduced during week nine.

2. In Session IX, parents began by seeing the IPR film on the inquirer's role (Mason Media, Inc., 1965). After viewing the film, they broke into groups of three and role played helping interactions and then practiced the role of inquirer with each other. The members of each triad were videotaped as they took turns playing the role of helper, helpee, and inquirer. This session attempted to build upon the previous sessions which introduced the notions of interpersonal fear

and risks. It also began to acquaint the parents with the recall process as a powerful form of feedback. Finally, in learning to serve as inquirers to each other, parents received additional practice in non-directive helping skills. Parents concluded preparations to begin their at-home sessions the next week.

3. In all the play sessions conducted at the clinic setting thereafter, parents alternated in playing the role of inquirer as the demonstrating parents reviewed their demonstration sessions on videotape. This was done in the large group where group leaders, as well as other parents, were free to respond as inquirer. The group leaders also gave feedback to parents on their performance as inquirers when this was required.

In summary, the learning of the role of inquirer, as well as the practice of actual interpersonal process recall, began in the eighth session and continued for the life of the group. This introduced into the integrated model the hypothesized benefits of the uniquely structured use of videotape feedback and self discovery, and allowed parents to play an integral part in this process. This, of course, provided parents with an additional opportunity to practice non-directive, empathic responding and to further integrate this mode into their interpersonal style.

Statistical Analysis

The statistical analysis used to test for significant differences between groups was an analysis of covariance, using the pretest scores as covariates. Analysis of secondary hypotheses was accomplished using

the Wilcoxon signed-ranks test as a nonparametric measure, and the matched pairs t-test as a parametric measure.

Summary

The sample for this study consisted of 32 volunteer parents concerned about their children's emotional and behavioral problems. There were 12 married couples and 8 parents without spouses in attendance. Parents were referred by their Family Practice and Pediatric physicians when seeking help from them. Children with very severe emotional problems and overt signs of organicity were not accepted into the study. Group leaders were this researcher and a female school psychologist with experience leading parent education groups and practicing play therapy.

The experimental design used was a pretest-posttest control group design. Individuals and couples were randomly assigned to one of four groups of eight. Two of these groups were treatment groups and two were control groups. Each leader led one treatment group and one control group. The treatment group was the Filial Therapy program with integrated IPR components. The control group was a traditional Filial program without IPR components. All groups met one evening per week for two hours over a period of sixteen weeks. All parents began at-home play therapy sessions after eight weeks.

The measures used to assess the dependent variables of parental acceptance, affective sensitivity, play therapy skills, and child adjustment were the following: the Porter Parental Acceptance Scale, the Affective Sensitivity Scale, the Filial Problem List, the Parent Check List, and videotape ratings of the play therapy skills of

communication of acceptance, allowing self direction, and involvement. Ratings on these last three were made in double blind fashion by two independent judges on videotapes from the parents' first and last in-clinic practice sessions. Data from the other measures was collected at the first and last meetings of each group. Subjective parent comments were also obtained.

The specific methods, skills, necessary roles, and attitudes of the leaders, and the structure and schedules of both the treatment and control groups were described in considerable detail.

All research hypotheses were stated nondirectionally. The .05 level of significance was used in all cases. The statistical analysis used to test for differences between groups was the analysis of covariance. The pretest scores were used as covariates. Analysis of secondary hypotheses concerned with pre to post gains for each method were analyzed nonparametrically with the Wilcoxon signed-ranks test and parametrically with the matched pairs t-test.

CHAPTER 4

ANALYSIS OF THE RESULTS

In this chapter each of the primary hypotheses outlined in Chapter 3 will be separately evaluated by an analysis of the experimental data. The primary analysis will test for differences in gains between the two methods. Two different ANCOVAs will be used in this analysis, with pretest scores used as the covariates. This will control for initial differences between groups on each measure.

A secondary analysis of the data will examine pre to post raw score differences for each method on each measure (in order to examine whether parents trained in each method show improvement pre to post training). For this purpose both a matched pairs t-test and the Wilcoxon signed-ranks test have been used.

Preceding both of these analyses will be a preliminary analysis of the relatedness of data from mother-father pairs who were reporting about the same child. This analysis was necessary in order to determine whether the scores of these pairs were independent and to be treated separately in the primary and secondary analyses.

In addition, inter-rater reliability findings for those measures based upon videotape ratings of parent play therapy skills are reported.

Preliminary Analysis

A Pearson-Product-Moment Correlation Analysis was used to compare data collected separately from mother-father pairs who were reporting about the same child. Correlation coefficients were calculated for

mother-father pairs on each measure. Two fathers had to drop out near the end of the study, thus reducing the n from 12 to 10 for the posttest. Table 4.1 lists the results of this correlation analysis for both pretests and posttests. Correlations between mother-father pairs were low and non-significant on both pre and posttests for all measures, indicating that data collected on these pairs was independent. This finding influences determination of the n size for the following analyses.

Table 4.1

Pearson-Product-Moment Correlations
of Mother-Father Scores on Each Measure

Measure	Pre (n = 12)	Post (n = 10)
Porter Parental Acceptance Scale	.49	.40
Affective Sensitivity Scale	-.22	.43
Filial Problem List	.24	.23
Parent Check List	.24	.39
Videotape Rating--Communication of Acceptance	.22	.45
Videotape Rating--Allowing Self Direction	.01	.15
Videotape Rating--Involvement	-.29	.47

NOTE: For p = .05, r must equal .532.

Primary Analysis

Each of the seven primary hypotheses relates to differences in gain scores between each method. Each hypothesis relates to a different

dependent variable. The initial ANCOVA results examine both therapist and treatment main effects. While the hypotheses are only concerned with treatment effects, the leader and interaction data are included to examine differences between leaders and to examine the possibility of experimenter bias (the experimenter, Leader I, led two of the four groups, one of each method). Results of a second more powerful ANCOVA which combined leaders are also included.

For clarity, each hypothesis is restated. The hypotheses are stated nondirectionally. Significant testing was carried out at the .05 level for each of the runs. Summary ANCOVA tables are presented, as well as tables of raw score pre and posttest means and standard deviations.

Hypothesis One (H_1): Parents trained in an integrated Filial-IPR program will show no differences in gains, pre to post, in parental acceptance, as measured by the Porter Parental Acceptance Scale (alpha at .05).

The PPAS was mailed to parents prior to the first group meeting. They were asked to complete it without conferring with a spouse or partner and to bring it to the first group meeting. As a posttest, each parent was given the PPAS at the next to last meeting and asked to complete it prior to the last group meeting. Table 4.2 lists the means and standard deviations for each method, pre to post training, as well as mean change scores. Table 4.3 is an ANCOVA table with leader, method, and interaction results. Table 4.4 presents ANCOVA results for a combined leader, method only analysis.

Table 4.2

PPAS Means, Standard Deviations, and Mean Change Scores

Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change Score
Leader I -Filial	96.85	18.44	101.66	22.34	4.81
Leader II-Filial	105.55	7.73	113.42	10.43	7.87
Leader I -Filial-IPR	105.75	10.66	114.00	16.61	8.25
Leader II-Filial-IPR	100.62	19.82	108.62	10.87	8.00

NOTE: Leader I is the experimenter in this and the following tables.

Table 4.3

ANCOVA of PPAS Scores
(Leaders x Method)

Source	df	F	P
Leaders	1	0.548	0.527
Methods	1	0.483	0.500
Interaction	1	0.179	0.190
Covariate[1]	1	0.129	0.001*
Error	23		

[1]Measures initial pretest differences between groups.

*P = .001

Table 4.4

ANCOVA of PPAS Scores
(Method Only)

Source	df	F	P
Method	1	0.349	0.566
Covariate	1	0.141	0.001*
Error	25		

*P = .001

Results: There are no significant treatment effects for either ANCOVA analysis; therefore, the null hypothesis is not rejected.

Hypothesis Two (H_2): Parents trained in an integrated Filial-IPR program will show no differences in gains, pre to post, in the parents' ability to detect and describe the affective state of another over parents trained in the traditional Filial Therapy program (alpha at .05).

This hypothesis was tested using Form E of the Affective Sensitivity Scale (ASS) originally developed by Kagan and Schneider (1970). This multiple choice scale was administered to each person during the first and last group meeting of each program. Table 4.5 lists the means, standard deviations, and mean change scores of each group's raw scores, pre and post training. Table 4.5 is the ANCOVA table for the leader x method x interaction analysis, and Table 4.7 provides results of a combined leader, method only analysis.

Table 4.5

ASS Means, Standard Deviations, and Mean Change Scores

Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change Score
Leader I -Filial	31.43	6.40	32.50	6.44	1.07
Leader II-Filial	29.66	6.00	34.57	6.05	4.91
Leader I -Filial-IPR	31.25	4.86	36.14	4.94	4.89
Leader II-Filial-IPR	29.12	4.38	31.00	5.34	1.88

NOTE: Leader I was the experimenter.

Table 4.6

ANCOVA of ASS Scores
(Leaders x Methods)

Source	df	F	P
Leaders	1	0.496	0.820
Methods	1	0.306	0.591
Interaction	1	0.368	0.064
Covariate	1	0.125	0.002*
Error	23		

*P < .01

Table 4.7

ANCOVA of ASS Scores
(Method Only)

Source	df	F	P
Method	1	0.179	0.678
Covariate	1	0.130	0.001*
Error	25		

*P = .001

Results: There are no significant treatment effects for either ANCOVA analysis; therefore, the null hypothesis is not rejected. It should be noted that the F value of the interaction effect approaches the .05 level of significance. A less significant but similar result occurred in the testing of Hypothesis 1. In both cases, Leader I achieved numerically greater gain scores for the Filial-IPR method. The implications of these leader differences will be considered with results on other measures and discussed in Chapter 5.

Hypothesis Three (H_3): Children of parents trained in the integrated Filial-IPR method will show no differences in improvement in child adjustment, pre to post, than children of parents trained by the traditional Filial Therapy model, as measured by the Filial Problem List (alpha at .05).

Parents were pretested and posttested with the Filial Problem List in the same manner as with the Porter Parental Acceptance Scale. They were asked to turn it in at the first group meeting, and again at the

last group meeting. The higher the raw score on the FPL, the greater the magnitude of the child's maladjustment. An improvement on this measure is indicated by a lower score on the posttest than the pretest. Table 4.8 lists the means and standard deviations for each method, pre and post training, as well as the mean change scores. Tables 4.9 and 4.10 describe the same analyses used to test the previous two hypotheses.

Table 4.8

FPL Means, Standard Deviations, and Mean Change Scores

Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change Score
Leader I -Filial	98.85	59.73	87.83	62.98	-11.02*
Leader II-Filial	50.55	34.31	39.71	29.90	-10.84
Leader I -Filial-IPR	84.00	62.47	54.57	48.42	-29.43
Leader II-Filial-IPR	54.50	25.58	44.25	21.80	-10.25

*A negative value on this measure indicates a positive change. A lower posttest score indicates a reduction in perceived problems.

Table 4.9

ANCOVA of FPL Scores
(Leaders x Methods)

Source	df	F	P
Leaders	1	0.272	0.612
Methods	1	0.625	0.557
Interaction	1	0.811	0.619
Covariate	1	0.521	0.0
Error	23		

Table 4.10

ANCOVA of FPL Scores
(Methods Only)

Source	df	F	P
Method	1	0.509	0.511
Covariate	1	0.678	0.0
Error	25		

Results: There are no significant treatment effects for either ANCOVA analysis; therefore, the null hypothesis is not rejected. Table 4.8 indicates that Leader 1 again appears to achieve greater gain scores for the Filial-IPR method than Leader II though Table 4.9 indicates that the differences between leaders is not significant.

Hypothesis Four (H_4): Children of parents trained in the integrated Filial-IPR method will show no differences in gains in child adjustment, pre to post, as measured by the Parent Check List (PCL), than children of parents trained in the traditional Filial method (alpha at .05).

The Parent Check List pre and posttest data was gathered in the same manner as the ASS and FPL. Parents completed the forms just prior to the first and last group meetings. As with the FPL, higher scores indicate higher levels of emotional and behavioral problems. Table 4.11 lists raw score means, standard deviations, and mean change scores, pre and post training. Table 4.12 presents ANCOVA results for a combined leader, method, and interaction analysis. Table 4.13 presents ANCOVA results for a method only analysis.

Table 4.11

PCL Means, Standard Deviations and Mean Change Scores

Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change Score
Leader I -Filial	27.28	9.82	23.28	10.10	-3.45*
Leader II-Filial	16.66	11.98	12.42	12.48	-4.24
Leader I -Filial-IPR	24.00	12.21	15.71	10.19	-8.29
Leader II-Filial-IPR	18.87	9.76	9.87	5.76	-9.00

*A negative mean change score indicates a reduction in perceived problems; hence, is a positive change.

Table 4.12

ANCOVA of PCL Scores
(Leaders x Methods)

Source	df	F	P
Leaders	1	0.252	0.122
Methods	1	0.342	0.074
Interaction	1	0.401	0.948
Covariate	1	0.437	0.0
Error	23		

Table 4.13

ANCOVA of PCL Scores
(Methods Only)

Source	df	F	P
Method	1	0.322	0.081
Covariate	1	0.558	0.0
Error	25		

Results: There are no significant treatment effects for either ANCOVA analysis; therefore, the null hypothesis is not rejected. It should be noted that the probability level in both analyses approaches significance. Differences, though not significant, favor the IPR method of treatment.

Hypothesis Five (H_5): Videotape ratings of parents' play therapy sessions will not show differences in gains in the play therapy skill of

communication of acceptance, pre to post, from one training method to another (alpha at .05).

This hypothesis, and the two following it, was evaluated by videotape ratings of parents' play therapy skills. The skill evaluated in this hypothesis is communication of acceptance. The videotape ratings were made on each parent's first and last in-clinic practice sessions (procedure described in Chapter 3) and as a process measure provide direct evidence of the parent's skill levels in play therapy techniques.

On the Communication of Acceptance scale ratings were determined by rating both the highest and lowest levels of skill observed in each three minute segment, and then averaging the scores. Ratings were made on a continuous five point scale, with the highest score, five, reflecting the lowest levels of this skill and a score of one reflecting the highest levels of skills. Ratings were made on five three minute segments, and a total score was obtained by adding the average scores for each three minute segment. The total n is three less than with previous measures because technical problems with the videotape equipment made data collection impossible in a few cases. Pre and post videotapes were presented in a double blind fashion to assure a non-biased score. None of the tapes were rated until the completion of all groups. Inter-rater reliability coefficients and a discussion of the statistical procedure used to determine them will be found later in this chapter.

Table 4.14 lists pre and post training means and standard deviations for each group, as well as mean change scores. Mean scores are determined

by adding together the total score of each rater. The ANCOVA analyses found in Tables 4.15 and 4.16 are based upon these total scores. Table 4.15 is the ANCOVA table for the leader x method x interaction analysis and Table 4.16 is the ANCOVA table for the methods only analysis.

Table 4.14

Communication of Acceptance:
Means, Standard Deviations, and Mean Change Scores

Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change Score
Leader I -Filial	20.25	3.32	19.83	3.69	-0.42*
Leader II-Filial	25.56	7.34	21.08	5.33	-2.48
Leader I -Filial-IPR	20.50	6.31	16.33	3.12	-4.17
Leader II-Filial-IPR	19.75	3.79	16.85	2.32	-2.90

*A negative mean change score reflects an improvement in play therapy skills.

Table 4.15

ANCOVA of Communication of Acceptance Scores
(Leaders x Methods)

Source	df	F	P
Leaders	1	0.280	0.607
Methods	1	0.568	0.026*
Interaction	1	0.517	0.980
Covariate	1	0.105	0.318
Error	20		

*P < .05

Table 4.16

ANCOVA of Communication of Acceptance Scores
(Methods Only)

Source	df	F	P
Methods	1	0.605	0.021*
Covariate	1	0.127	0.271
Error	22		

*P < .05

Results: Significant treatment effects were found in both ANCOVAs, in each case favoring the integrated Filial-IPR method. Therefore, the null hypothesis is rejected. Again, Table 4.14 suggests that Leader I achieved somewhat greater gain scores than Leader II.

Hypothesis Six (H_6): Videotape ratings of parents' play therapy sessions will show no differences in gains, pre to post, in the play therapy skill of allowing self direction, from one method of training to another (alpha at .05).

This hypothesis was evaluated in the same manner as the preceding hypothesis. Table 4.17 lists means and standard deviations for each group, pre to post training, and mean change scores. Tables 4.18 and 4.19 present ANCOVA results for a leaders x methods and a methods only analysis.

Table 4.17

Allowing Self Direction:
Means, Standard Deviations, and Mean Change Scores

Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change Score
Leader I -Filial	21.16	6.43	14.00	4.05	-7.16*
Leader II-Filial	21.37	8.68	18.83	7.57	-2.54
Leader I -Filial-IPR	18.57	4.57	17.00	3.79	-1.57
Leader II-Filial-IPR	21.37	5.04	17.71	2.98	-3.66

*A negative mean change score reflects improved play therapy skill.

Table 4.18

ANCOVA of ASD Scores
(Leaders x Methods)

Source	df	F	P
Leaders	1	0.185	0.186
Methods	1	0.416	0.532
Interaction	1	0.122	0.280
Covariate	1	0.210	0.159
Error	20		

Table 4.19

ANCOVA of ASD Scores
(Methods Only)

Source	df	F	P
Methods	1	0.422	0.529
Covariate	1	0.223	0.145
Error	22		

Results: There are no significant treatment effects for either ANCOVA analysis; therefore, the null hypothesis is not rejected.

Hypothesis Seven (H_7): Videotape ratings of parents' play therapy sessions will show no differences in gains, pre to post training, in the play therapy skill of involvement, from one method of training to the next (alpha at .05).

This hypothesis was evaluated in the same manner as the previous hypothesis. Ratings were made on the same videotapes and performed by the same raters. Table 4.20 lists means and standard deviations for each group's, pre and post training, and mean change scores. Tables 4.21 and 4.22 present ANCOVA results for a leaders x methods, and a methods only analysis.

Table 4.20

Involvement:
Means, Standard Deviations, and Mean Change Scores

Treatment Group	Pretest M	Pretest SD	Posttest M	Posttest SD	Mean Change Scores
Leader I -Filial	16.16	5.92	19.16	4.49	2.50
Leader II-Filial	20.62	4.95	14.50	5.28	-5.12*
Leader I -Filial-IPR	12.85	3.57	17.33	6.18	4.48
Leader II-Filial-IPR	16.50	5.31	14.42	4.72	-2.08

*A negative mean change score reflects improved play therapy skills.

Table 4.21

ANCOVA of Involvement Scores
(Leaders x Methods)

Source	df	F	P
Leaders	1	0.862	0.008*
Methods	1	0.346	0.569
Interaction	1	0.276	0.611
Covariate	1	0.945	0.006*
Error	20		

*P < .01

Table 4.22

ANCOVA of Involvement Scores
(Methods Only)

Source	df	F	P
Methods	1	0.345	0.848
Covariate	1	0.418	0.0502
Error	22		

Results: There are no significant treatment effects for either ANCOVA analysis; therefore, the null hypothesis is not rejected. It should be noted that in the leaders x methods ANCOVA, significant differences between leaders were found.

Inter-Rater Reliability

The inter-rater reliabilities in this study were calculated according to Ebel's Formula (Ebel, 1951) which employs a two-way analysis of variance technique. The reliabilities obtained were based upon the total score for each parent on each dimension, as determined by each rater. This formula employs reliability coefficients for each rater, pre to post, on each measure, as well as between raters at each point in time. Inter-rater reliability coefficients are reported in Table 4.23 below. Coefficients are reported separately on the pretest and posttest for each scale. These coefficients were sufficiently reliable for the final statistical analyses.

Table 4.23

Inter-Rater Reliability Coefficients
for Videotape Ratings of Parent Play Therapy Skills

Skill	Pretest	Posttest
Reflection of Feelings	.92	.97
Allowing Self Direction	.86	.96
Involvement	.95	.93

Summary of Primary Analysis

The primary analysis consisted of two different ANCOVAs for each of the seven hypotheses. Both ANCOVAs were concerned with differences in gain scores, pre to post, between each method. One of the ANCOVAs examined leader effects as well as treatment effects and their interaction. The other ANCOVA combined groups by method and examined differences between methods. This offered a more powerful test of differences between methods. In the case of each hypotheses, both ANCOVA analyses were in close agreement.

Of the seven different outcome measures examined, only one measure, the play therapy skill communication of acceptance, was found to be affected more by one method than the other. In this case, the integrated Filial-IPR method achieved significantly greater gains in this skill than the traditional Filial Therapy program. On one of the measures of child adjustment, the Parent Check List, significant differences were approached ($P = .073$ and $.081$) but not attained using a two-tailed test. Differences here also favored the IPR method of training.

Significant leader differences (.008) were found on the play therapy skill of involvement. These differences were independent of method, however, and do not concern our primary hypotheses.

On the hypothesis concerning affective sensitivity, the interaction effect between leader and method scores approached significance (.064) with Leader I favoring the Filial-IPR method and Leader II favoring the Filial only method. As the data has emerged, differences between group leaders became apparent. Leader I, the experimenter, achieved greater gain scores for the Filial-IPR method than with the Filial only method and achieved greater gain scores for the Filial-IPR method than Leader II. These differences are not considered in the primary or secondary hypotheses, however, and will be discussed in Chapter 5.

Secondary Analysis

While the primary hypotheses of this study were concerned with differences between the two training methods, additional informal hypotheses were formulated which predicted that parents in each training method would show pre to post improvement on each of the dependent measures considered in the primary analysis. In other words, this secondary analysis set aside the question of which method was more effective and examined whether each method was effective in its own right. It is believed that such an analysis was needed since the previous research on Filial Therapy and para-professional applications of IPR technology was not extensive. Additional evidence of the efficacy of each method should contribute to our confidence in them, as well as an understanding of the conditions under which they are most effective.

It is important to note that no non-treatment control groups or attention only placebo control groups were used to compare the results of training with no training. Results should be considered with this in mind since parent improvement may be the result of maturation or history. However, Sywulak's (1978) research on Filial Therapy found that when subjects served as their own controls over a four month period, there was no significant pre to post gain, while there was significant improvement before and after treatment. This would suggest that the factors of history and maturation have exerted a negligible effect on this study.

The analysis of pre to post differences employed both a parametric and nonparametric analysis. This was thought advisable due to the small n's. The parametric statistic was the matched pairs t-test and the nonparametric statistic was the Wilcoxon signed-ranks test. The results of the analyses for the Filial Therapy groups are listed in Tables 4.24 and 4.25 and the results of the integrated Filial-IPR analyses are listed in Tables 4.26 and 4.27. For simplicity and because the hypotheses are informal, all of the instruments used to measure each method will be considered under the single hypothesis stated for each method.

Hypothesis Eight (H_8): Parents trained under the traditional Filial Therapy model will show a significant pre to post training increase on each of the seven dependent measures.

This hypothesis was evaluated using the Porter, FPL, PCL, ASS and videotape ratings of communication of acceptance, allowing self

Table 4.24

Analysis of Pre to Post Differences for the Traditional Filial Method Using the Matched Pairs T-Test

Measures	Pretest M	Pretest SD	Posttest M	Posttest SD	df	T	p (1 tail)
PPAS	102.00	12.55	108.00	17.29	12	3.02	.0057**
FPL	71.84	56.40	61.92	52.18	12	5.74	.0001***
PCL	21.69	12.22	17.69	12.47	12	1.78	.0498*
ASS	31.69	5.90	33.61	6.06	12	1.06	.1628
Video.: CoA	21.70	6.02	20.45	4.42	11	1.97	.0381*
Video.: ASD	21.50	8.15	16.41	6.31	11	2.45	.0085**
Video.: Inv.	18.08	5.41	16.83	5.27	11	1.73	.0649

* $p < .05$

** $p < .01$

*** $p < .001$

Table 4.25

Analysis of Pre to Post Differences for the
Traditional Filial Method Using the Wilcoxon Signed-Ranks Test

	Pretest			Posttest					
Measures	Median	High	Low	Median	High	Low	n	T	p (1 tail)
PPAS	102.0	73	124.0	117.0	65	128.0	13	19.0	.032*
FPL	53.0	13	167.0	35.0	12	158.0	13	25.0	.136
PCL	20.0	6	43.0	16.0	2	38.0	13	10.5	.013*
ASS	31.0	23	43.0	34.0	25	43.0	13	23.0	.105
Video.: CoA	20.5	15	38.5	20.5	15	29.5	12	25.0	.400
Video.: ASD	20.5	10	41.0	19.0	10	32.0	12	9.0	.017*
Video.: Inv.	19.5	10	25.0	17.0	10	27.0	12	20.5	.238

* $p < .05$

direction, and involvement. Table 4.24 lists the results of the matched pairs t-test analysis and Table 4.25 lists the results of the Wilcoxon signed-ranks test. All p values are for a one-tailed test with alpha at .05.

Results: This hypothesis was fully supported by the data on the Porter Parental Acceptance Scale, the Parent Check List, and the videotape ratings of allowing self direction. There is partial support for the hypothesis on the Filial Problem List and videotape ratings of communication of acceptance. The hypothesis received no support on the Affective Sensitivity Scale and the videotape rating of involvement. In the two cases where the hypothesis received partial support the parametric analysis indicated significant gains while the nonparametric analysis did not.

Hypothesis Nine (H_9): Parents trained in the integrated Filial-IPR model will show a significant pre to post training increase on each of the seven dependent measures.

This hypothesis was evaluated using the Porter, FPL, PCL, ASS and videotape ratings of communication of acceptance, allowing self direction, and involvement. Table 4.26 lists the results of the parametric matched pairs t-test and Table 4.27 lists the results of the nonparametric Wilcoxon signed-ranks test. All p values are for a one-tailed test with alpha at .05.

Results: This hypothesis was fully supported for the Porter Parental Acceptance Scale and the Filial Problem List. The hypothesis is partially supported on the Parent Check List, the Affective Sensitivity Scale, and

Table 4.26

Analysis of Pre to Post Differences for the
Integrated Filial-IPR Method Using the Matched Pairs T-Test

Measure	Pretest M	Pretest SD	Posttest M	Posttest SD	df	T	p (1-tail)
PPAS	102.53	15.92	108.00	17.29	14	4.30	.0002***
FPL	63.20	43.58	49.06	35.65	14	6.97	.00005***
PCL	20.33	10.43	12.60	8.38	14	1.64	.0440*
ASS	30.13	4.76	33.40	5.64	14	1.33	.1120
Video.: CoA	19.88	5.20	16.61	2.61	12	1.34	.1184
Video.: ASD	20.23	4.39	17.38	3.25	12	1.38	.0982
Video.: Inv.	14.61	4.75	15.76	5.41	12	1.51	.0742

* $p < .05$

*** $p < .001$

Table 4.27

Analysis of Pre to Post Differences for the
Integrated Filial-IPR Method Using the Wilcoxon Signed-Ranks Test

Measures	Pretest			Posttest			n	T	p (1-tail)
	Median	High	Low	Median	High	Low			
PPAS	105	60	120	108	93	139	15	15	.020*
FPL	44	11	166	43	8	129	15	28.5	.037*
PCL	22	8.0	35.0	13	3	33	15	15	.0005***
ASS	31	21.0	39.0	34	23.0	43.0	15	21	.024*
Video.: CoA	20.0	15.0	34.0	20.5	13.5	22.0	13	6.5	.009**
Video.: ASD	20.0	12.0	27.0	20.0	12.0	21.0	13	12	.039*
Video.: Inv.	16.0	10.0	23.0	15.0	10.0	26.0	13	10	.254

* $p < .05$

** $p < .01$

*** $p < .001$

videotape ratings of communication of acceptance and allowing self direction. The hypothesis received no support on the videotape rating of involvement. In the four cases where the hypothesis is partially supported, the nonparametric analysis indicates significant gains while the parametric analysis does not. This is in contrast to the data examined in Hypothesis Eight, where the parametric analysis shows partial support.

Summary of Secondary Analysis

Each of the methods was analyzed independently for pre to post training gains on each of the seven measures used in the primary analysis. Because of the small n both a parametric and nonparametric statistic were used. The parametric statistic was the matched pairs t-test and the nonparametric statistic was the Wilcoxon signed-ranks test. Hypotheses were stated directionally with one-tailed tests used and alpha at .05.

Including those measures for which one but not both of the statistical analyses show significant increase, the traditional Filial program has a positive impact on five of the seven dependent measures. These include measures of parental acceptance, child adjustment, and the play therapy skills of communication of acceptance and allowing self direction. Parental acceptance, child adjustment (as measured by the Parent Check List), and the skill of allowing self direction were shown to increase in both statistical analyses. There was no significant evidence that affective sensitivity and parental involvement were improved with this method.

With the integrated Filial-IPR method, improvement was shown on six of the seven dependent measures. Parental acceptance and child adjustment (as measured by the Filial Problem List) were shown to increase significantly when analyzed both parametrically and non-parametrically. Child adjustment (as measured by the Parent Check List), affective sensitivity, parental allowance of self direction, and communication of acceptance were shown to increase significantly when analyzed nonparametrically. No significant improvement in tape ratings of parental involvement was shown by either method of analysis.

In summary, there is evidence that both methods of training proved effective.

CHAPTER 5

SUMMARY, RESULTS AND DISCUSSION

Summary

Several writers (including Hobbs, 1964; Albee, 1968; and Miller, G., 1969) have identified the importance of training para-professional counselors, parents, teachers, police, etc. to deliver effective psychological services. This has been in response to the failure of the conventional medical model to meet society's needs for preventive and remedial mental health services and the need for more efficient use of professional time. As the crucial impact of the parent-child relationship on the etiology of emotional problems in children has become better understood, that relationship has been seen as a logical place to focus remedial and preventive interventions. One para-professional program designed to train parents to function as psychotherapeutic agents is Filial Therapy (B. Guerney, 1964). In Filial Therapy parents are taught to do client-centered play therapy with their own children in order to alleviate present concerns and conflicts as well as to develop effective parenting skills for prevention of future problems.

A review of the Filial Therapy research suggests that Filial Therapy is an effective method of intervention in the alleviation of children's emotional problems. However, the need for additional controlled studies of the Filial Therapy model, as well as the need to find new ways to improve the parent-child relationship, have resulted in the current

study. Since difficulties in the parent-child relationship likely result from emotional conflicts within the parent, sufficient attention must be paid to these conflicts, the traditional Filial Therapy program relies on the clinical judgment of the therapist teaching the parents in determining when and how to focus on the parents' emotional conflicts. The risk is that the therapist will mis-time his interventions or fail to see areas of emotional conflict in parents.

The purpose of this study was to design and evaluate modifications in the traditional Filial Therapy program so that a crucial dimension of the parent-child relationship, the parents' emotional conflicts, are therapeutically addressed in a more systematic and reliable manner. To this end, two important elements of Kagan's Interpersonal Process Recall (IPR) training model have been integrated into the traditional Filial Therapy program. Kagan's IPR has been used to train para-professionals as well as professionals in the mental health field. In this regard, IPR shares with Filial Therapy the goal of a more efficient use of the professional's time. In addition, Filial Therapy and IPR are built upon similar theoretical foundations.

The two components of Kagan's model which were integrated into the traditional Filial program are affect simulation and videotape recall. In affect simulation parents were shown filmed vignettes of a variety of interpersonal scenes. The goal was to familiarize parents with their own emotional responses to stressful but general interpersonal situations. As parents became familiar with the concept of interpersonal fears and started to become familiar with their own, the videotape recall component

of the IPR model was introduced. The goal here was to systematically familiarize parents with the specific interpersonal fears which they encountered in their interactions with their children, the manifestation of those fears in behavior, and the impact of that behavior on their children. In the recall process, parents confront their own fears when they are ready rather than when the clinician thinks that they are ready. In addition, parents were taught to perform the inquirer role with each other during the recall sessions in order to provide them with additional practice in non-directive, facilitative interaction.

The experimental design of this study was a pretest/posttest control group design, with the traditional Filial Therapy model serving as the control group to the integrated Filial-IPR model. This study is seen as a partial response to the need to design and evaluate more effective methods of training parents as para-professionals, as well as a response to the need to further replicate the promising but limited research in Filial Therapy. The sample for this study consisted of 32 volunteer parents of children with emotional or behavioral problems. Parents were members of the military who were referred by their Family Practice and Pediatric physicians at Dewitt Army Hospital at Ft. Belvoir, Virginia.

In this study there were 18 females and 14 males, including 12 married couples. A total of 20 households were represented. Subjects were randomly assigned, either as couples or individuals (when the spouse was not participating), to one of the two treatment methods and to one of the two leaders. There were four groups, two treatment and two control, with eight members in each group. Each leader conducted one control and one experimental group. The leaders were the experimenter

and a school psychologist experienced with play therapy and parent training groups. The groups met for two hours each session for a total of sixteen weeks. The structure of both experimental and control groups is outlined in detail in Chapter 3. The introduction of the IPR components began during the seventh week in the experimental groups. At this point, parents were gaining mastery of basic play therapy skills and beginning to focus on their own emotional responses to their children.

In order to compare the effectiveness of each of the programs the following dependent variables were studied: (a) parental acceptance, (b) affect sensitivity, (c) play therapy skills, and (d) child adjustment. The specific measures used to assess these variables were the Porter Parental Acceptance Scale (PPAS), the Affect Sensitivity Scale (ASS), the Filial Problem List (FPL), the Parent Check List (PCL), and videotape ratings of communication of acceptance, allowing self direction, and involvement. The PPAS, the ASS, the FPL, and the PCL were completed by parents prior to the first group meeting and prior to the last group meeting. Videotape ratings were made in the first and last in-lab practice play sessions conducted by each parent.

The primary interest of the study was to compare these two methods of training. Seven specific research hypotheses were formulated to test for differences between each method. Each research hypothesis related to each of the dependent measures. Each of the hypotheses predicted no differences in gain scores, pre to post, between the two different measures. Each hypothesis was tested for differences with two different ANCOVA computer analyses. The ANCOVA was employed to adjust for initial

pretest differences between groups by using the pretest scores as the covariate. One analysis examined method x leader x interaction effects. The second, more powerful analysis combined leaders and analyzed only differences between methods. Significance testing was carried out at the .05 level. The results of the analyses showed significant differences on only one of the dependent measures, the parent play therapy skill communication of acceptance. This difference was in favor of the IPR method and was supported by both ANCOVA analyses. On a measure of child adjustment, the Parent Check List, differences favoring the IPR method approached significant levels (.081 and .073) on both ANCOVAs. In the leader x method x interaction ANCOVA of the ASS, the interaction effect approached significance (.064) but was not reached. Significant differences were not found on any of the other major hypotheses.

A secondary analysis was independently carried out on each training method. Two hypotheses were stated, one for each method, predicting pre to post positive raw score differences on each measure for each method. Each hypothesis was tested for pre to post raw scores using the parametric matched pairs t-test and the nonparametric Wilcoxon signed-ranks test. Hypotheses were stated directionally in favor of pre to post improvement on each measure. Significance testing was carried out at the .05 level. The results indicated that for the integrated Filial-IPR method, significant positive pre to post differences were found in both parametric and nonparametric analyses of parental acceptance and child adjustment as measured by the FPL. In addition, significant positive differences were found on the PCL, ASS, and videotape ratings

of communication of acceptance and allowing self direction when the nonparametric Wilcoxon was used. The $P \geq .05$ was approached but not achieved on each of the remaining measures when the data was analyzed parametrically.

The results indicated that for the traditional Filial Therapy groups, significant, positive pre to post differences were found in both analyses in parental acceptance, child adjustment as measured by the PCL, and the play therapy skill allowing self direction. In addition, significant and positive pre to post differences were found on the FPL and on videotape ratings of communication of acceptance when the parametric matched pairs t-test statistic was used. These differences were not supported in the nonparametric analysis.

Results

These results lead to several conclusions from the study. The following conclusions relate to the primary analysis:

1. Parents trained in an integrated Filial-IPR training model did not show greater gains in parental acceptance than parents trained by the traditional Filial Therapy model. According to Porter (1954), "Parental acceptance is one of the essential elements underlying the whole structure of the parent-child relationship." (p. 180)

2. Children of parents trained in an integrated Filial-IPR training model did not show significantly greater gains in child adjustment than children of parents trained by the traditional Filial Therapy model, though near significant differences ($P = .074$, 2-tailed test) favoring the integrated Filial-IPR method were achieved on one of the

measures of child adjustment. Changes in child adjustment should reflect changes in the parent-child relationship as well as changes in the self concept of the child.

3. Parents trained in integrated Filial-IPR groups did not show greater gains in affective sensitivity, an indicator of the parents' ability to identify their child's feelings, than parents trained in traditional Filial groups.

4. Parents trained in integrated Filial-IPR groups did achieve significantly greater gains in one of the three play therapy skills measured (communication of acceptance) than parents trained in the traditional Filial groups. Differences were not found on the skills of allowing self direction and involvement.

The following conclusions relate to the secondary analysis carried out:

1. Parents trained in the integrated Filial-IPR groups did show significant pre to post gains in parental acceptance, and their children demonstrated improved child adjustment. There is evidence that parents also achieved meaningful gains in affective sensitivity and the play therapy skills of communication of acceptance and allowing self direction.

2. Parents trained in the traditional Filial groups also showed significant gains in parental acceptance and the play therapy skill allowing self direction. Their children also showed improved child adjustment. There is some evidence that parents showed improvement in the play therapy skill communication of acceptance.

Discussion

The primary focus of this study was whether or not an integrated Filial-IPR program was more effective than the traditional Filial Therapy model in influencing the dependent variables of parental acceptance, affect sensitivity, child adjustment, and selected play therapy skills. A secondary focus of the study was whether each method was effective in its own right at influencing positive change on each of the same variables. With regard to the primary focus, significant differences favoring the integrated Filial-IPR groups were found on only one of the seven measures used, the play therapy skill communication of acceptance. Differences favoring the integrated Filial-IPR groups approached significance on one of the two measures of child adjustment, the Parent Check List (PCL). With regard to the secondary analysis, both methods showed significant pre to post gains on most of the measures, on either both, or one of, the two analyses employed.

It is important to note that the pre to post control group research design was not as valid as it would have been if a no treatment placebo attention control had been used. Either of these would have helped control for the effects of history, maturation, and test/retesting, particularly in the case of the secondary analysis. However, Sywulak's (1978) study, in which subjects served as their own controls for four months prior to four months of Filial Therapy, indicated that there were no significant gains over the four month control period on any of her four measures, including the PPAS, the FPL, and the PCL. There

were significant gains on these measure pre to post training. Therefore, while a no treatment or attention placebo control group would have improved the experimental design of this study, previous related research suggests that the threats to internal validity from history, maturation, and test/retesting would have been negligible. We can conclude, therefore, that while the integrated Filial-IPR groups were more effective than the traditional Filial groups at significantly influencing only one of the dependent variables, both methods were effective at positively influencing the parent-child relationship.

As indicated in Chapter 4, potentially significant differences between the group leaders became apparent as the data emerged. While there were no statistically significant interaction effects discovered in the leader x method x interaction ANCOVAs, significant interaction effects were approached on the PPAS (.190) and ASS (.065). In addition, Leader I, the experimenter, achieved greater gain scores for the integrated Filial-IPR method on five of the seven measures. Leader II achieved no differences in gain scores between methods on three of the measures. She achieved differences in gain scores favoring the integrated Filial-IPR method on two measures and differences favoring the Filial only method on the remaining two measures.

These differences were further analyzed to see if differences favoring the integrated model were statistically significant for Leader I. Because of the small n involved, the Mann Whitney U Test was chosen. The total n was not sufficiently large to conduct a multivariate analysis. Testing revealed that these differences were not statistically significant. However, these differences are impressive and need to be considered.

One possible explanation for Leader I, the experimenter, consistently achieving results favoring the integrated model while Leader II did not is experimenter bias. The experimenter did not experience this to be the case. Another possible explanation for these leader differences has to do with relative amounts of experience with the IPR methodology. The experimenter completed a 30 hour IPR course taught by Dr. Kagan at Michigan State University. In addition, he carefully read the IPR manual and trained the other group leader for approximately ten hours prior to the introduction of IPR components into the parent groups. Thus, he had 40 hours of experience with IPR. The other group leader's only exposure to IPR was the ten hours of training and a careful reading of the IPR manual. It may well be that leaders need to have more hours of experience with the IPR model before they can use it with the confidence and skill necessary to effect significant treatment differences. Tomory (1978) suggests that leaders have a full year of experience with IPR techniques before beginning research sessions. Although one advantage of the IPR model is that it can be taught to clinicians in a relatively short time, clinicians may need a great deal of practice before they have fully integrated the techniques into their working styles.

The same relative inexperience of the leaders with the Filial Therapy method may have also been a factor. Both group leaders attended an intensive five day workshop offered by the originators of Filial Therapy. In addition, both leaders had considerable experience using play therapy techniques in their clinical work. Leader II also had

conducted several Systematic Training for Effective Parenting groups. However, neither leader had run long-term Filial Therapy groups prior to this research study. While the pre to post training gains were positive for each method, they may have been stronger if the group leaders had had more experience with the Filial model.

Another factor which should be mentioned in discussing possible bias on the part of either of the group leaders is their personal relationship. The leaders had a close personal relationship and became engaged to be married before the completion of the groups. A number of possible factors related to the relationship could have been operating to bias the performance of the leaders, including: professional competitiveness, anxiety about performance, and desire to please or impress, coercion, and even a wish to sabotage. Personal discussions through the course of the experiment did indicate that there were feelings of competitiveness and anxiety about performance. However, both leaders felt that these factors were minimal and were outweighed by feelings of supportiveness and the increased opportunity to discuss difficulties and insure that the groups were following the same structure. Nonetheless, future research should include systematic procedures for controlling leader bias.

The description and rationale for Filial Therapy presented in Chapter 1 contained the concept that the goal of Filial Therapy was to teach parents play therapy skills so that they, rather than an outside professional, may be central in the amelioration of their children's behavioral and emotional problems. Among the basic Filial Therapy skills

are empathic understanding, allowing self direction, and limit setting. Under the umbrella of the skill of empathic understanding are the dependent variables of parental acceptance, affective sensitivity, communication of acceptance, and involvement.

Parental acceptance is communicated primarily through the skills of reflective listening and involvement and through the relative lack of limits, controls, or directions. Parental acceptance, as measured by the Porter Parental Acceptance Scale (PPAS), was not affected differentially by the two methods of training. However, the PPAS is a paper and pencil outcome measure. The play therapy skill, communication of acceptance, as measured by ratings of videotapes of actual parental behavior, is an in vivo process measure, and because it is a more direct measure may be more valid. What is important here is that the attitude of parental acceptance be communicated to the child. If the child fails to feel accepted by the parent even though the parent may internally feel more accepting of the child, it does the child no good. Differences between methods favoring the integrated Filial-IPR approach were found on the skill of communication of acceptance. It may be that attitudes of parental acceptance were equally affected by both methods and that only the communication of parental acceptance was favorably affected by the Filial-IPR groups. Support for this conclusion must be tempered by the fact that significant gains on the play therapy skill communication of acceptance are found on only one of the two (parametric and nonparametric) analyses for each method. Thus, there is evidence of significant improvement on this skill for each method but the evidence is not conclusive.

The dependent variable, affective sensitivity, is also a component of empathy. Affective sensitivity, as measured by the ASS, is the ability to identify what it is that another person is feeling. It does not address whether that understanding is communicated. The primary analysis indicated no differences in gains on this measure between methods. The secondary analysis showed no significant gains pre to post for either method when results were analyzed parametrically. Significant gains were shown for the IPR groups but not for the traditional Filial groups when the results were analyzed nonparametrically. The expected increases in affective sensitivity did not occur for the traditional Filial Therapy groups while evidence is mixed regarding such increases for the integrated Filial-IPR groups. Some of the factors which could account for this include: (a) a possible ceiling effect of the instrument for those parents scoring in the upper ranges of the scale at pretest; (b) questions about the validity of the newest form of the scale; and (c) resistance to taking the posttest during the last session. Many parents at the last session had a great deal of feeling about terminating the groups and last minute concerns about dealing with their children. They were resentful of giving up more than an hour when they had so many concerns. Finally, (d) the impact of seeing the same filmed vignettes a second time may have been mild compared to the real life situations encountered with their children and therefore parents may not have been motivated to respond to the testing in a thoughtful way.

Parental acceptance is also communicated through the skills of allowing self direction and involvement. In allowing self direction, the parent shows willingness to follow the child's lead without limiting, controlling, criticizing, teaching, praising, or moralizing. This enables the child to build confidence in himself as he explores new ways of being. Parental involvement has to do with being fully observant and aware of the child's feelings and behavior. An uninvolved parent is not as likely to notice what a child is thinking and feeling and will be unable to communicate acceptance to the child about important feelings, ideas, and behavior. Differences between methods were not found on either of these variables. With the skill of allowing self direction, traditional Filial groups showed significant pre to post gains when analyzed both parametrically and nonparametrically while integrated Filial-IPR groups showed significant pre to post gains when analyzed nonparametrically. The parametric analysis here did approach significance ($p < .20$). The leader x method x interaction ANCOVA for the skill of involvement failed to show differences between methods but did show significant ($p = .008$) differences between leaders. While involvement scores improved for one leader, they declined for the other leader in both groups. This finding is curious since scores for that leader's groups showed improvement on all other dependent measures. This finding might be explained by a lack of leader involvement during the posttest tape collecting phase of the group or a lack of attention or emphasis to that particular skill while emphasizing others.

A factor which may have influenced all of the process measures of play therapy skills is the tendency of Filial groups to reach a plateau (Sywulak, 1978). When the groups run for such a long period of time they enter periods of flagging interest and enthusiasm. Post-test videotapes collected during one of these periods would perhaps show an atypically low level of skills. The specific skill of involvement would seem especially likely to be so affected. Another factor which would influence pre to post training results was technical problems with the videotape equipment. This occurred more in the early stages of the groups before the leaders were fully familiar with the equipment but it did occur near the end also. In a few cases, second rather than first sessions were used as the pretest. In other cases, next to last sessions were used at the posttest. Since the groups might meet two to four times before a parent does another in-lab session, a great deal of vicarious learning may have taken place from watching other parents' practice sessions. In fact, all participants observed the leaders do two demonstration sessions before first being taped. Such learning may have given an inaccurate indication of the parents' pretraining skill level. Ideally, videotapes of some sort of intake session prior to the first group would be collected as the pretest measure of play therapy skill levels. When posttest tapes were next to the last practice sessions for a parent, measurement was taken on a shorter training period. Technical problems necessitated these modifications in six cases equally distributed over methods.

The outcome variable in this study was child adjustment. It was believed that improvements in the parent-child relationship and the working through of emotional conflicts in the presence of parental acceptance will result in improvement in behavior, greater mastery of difficult feelings and greater self confidence. The two instruments measuring this variable were the Parent Check List and the Filial Problem List. Significant differences between methods were not found on either method but differences favoring the IPR method were approached ($p < .08$ and .09) on the PCL. Consequently, there is a good possibility that the introduction of IPR components into the traditional Filial Therapy program does result in greater improvement in child adjustment than the traditional Filial method alone. This conclusion must be tempered with the fact that significance was approached on only one of the two measures of child adjustment. Another caution derives from the fact that both measures of child adjustment were completed by parents on their own children. Consequently, they are subject to parental biases to see problems as worse than they are or to deny the severity of existing problems. With the FPL, the Filial-IPR groups demonstrated significant pre to post gains when analyzed both parametrically and nonparametrically. The Filial-only groups showed significant gains only when analyzed parametrically (significant gains approached, $p < .13$, when analyzed nonparametrically). The reverse occurred with the PCL. Filial-only groups showed significant pre to post gains when analyzed both ways, while the Filial-IPR groups only showed significant pre to post gains with the nonparametric statistic. (Here again though the parametric statistic showed gains approaching significance, $p < .10$.) There is

evidence then that both methods positively influence child adjustment, but results are equivocal for each method depending on the statistic used to analyze the results. In her study, Sywulak (1978) established that the greatest gains in parental acquisition of play therapy skills occurred during the first two months of parent training, while the greatest improvement in child adjustment occurred during the second two months of training. This is logical since at-home sessions did not begin until after the eighth week. Sywulak pointed out that Filial Therapy groups typically run for six months or more. It may be that the full effects of the parent groups on child adjustment may require more time to fully manifest itself.

Although significant differences favoring the integrated Filial-IPR method were found on one of the seven dependent variables and significant differences favoring the integrated Filial-IPR groups were approached on another variable, the full impact of the introduction of IPR methodology on the traditional Filial Therapy model is difficult to assess. There are several factors which could account for this.

One area where the impact of IPR may have been considerable was on the play therapy skill of limit setting. While many parents have difficulty expressing warmth and acceptance, many other parents have their hardest time saying no to their children even when it is important to the child's physical or emotional safety. Many of these parents are eventually able to express their fear that their child will feel rejected while others are afraid of their children's anger. The importance of the stimulus vignettes and the recall process in eventually

recognizing and gaining control over these fears was great for several of the parents. However, there were no workable measures of this skill which could be used in this study. Indeed, the Filial program is designed to reduce the need for limit setting to a minimum. Transgressions of limits during play sessions usually occur infrequently and often in the at-home sessions. This makes the direct measurement of limit setting skills very difficult, if not impossible. The closest we can come to assessing this skill is in its impact on child adjustment.

As mentioned above, changes in child adjustment tend to occur later in the Filial Therapy program. Subjective comments from parents at the end of the 16 weeks indicated that they were just beginning to see changes in their children's behavior and feelings. Other parents said that they thought the program should last from a few to several weeks longer. While previous research does not indicate that parents' play therapy skills continue to increase significantly after four months, it may be that attitudes of parental acceptance and affective sensitivity would also continue to show increases over longer periods of time. If so, the positive but somewhat mixed results of this analysis might be stronger.

A related factor which may account for the failure to find more differences between methods has to do with structural differences between the traditional and integrated Filial groups. Each group met for two hours a week for sixteen weeks. However, at the seventh week IPR groups viewed stimulus films and discussed them for at least one hour. During the eighth and ninth weeks parents saw additional stimulus vignettes and a film on the inquirer role. In addition, parents spent

time practicing the inquirer role as they role played helping situations and conducted recalls with each other for the first time. While the IPR groups were getting IPR training, the traditional Filial groups were able to do more in-lab practice sessions and devote more time to emotional concerns of parents, as well as spend more time discussing the initial at-home sessions which began during week nine. This may have put the IPR groups "behind" the traditional Filial groups, and it may be that the IPR groups would need more than the remaining nine sessions after IPR introduction in order to integrate the new learnings and possibly "go ahead of" the non-IPR groups.

In addition, the timing for introducing IPR methods may have been poor. Although parents were just beginning to express their own emotional reactions to the sessions, they were also preparing to start their at-home sessions. Some parents expressed resentment at having to shift focus away from play sessions. This may have created an initial negative set towards IPR which may have persisted for a while. However, subjective comments from most participants tended to be very favorable about IPR with many parents requesting that it begin earlier.

In order to insure as much equality of conditions as possible for both treatment groups, group leaders attempted to follow the same strict schedule in introducing the IPR methodology. Both leaders reported feeling constrained by the schedule and that more flexibility in introducing and using the methodology would have allowed smoother and better timed introduction of the techniques. This finding is consistent with those of Schauble (1970), Van Noord (1973), and Tomory (1979), all of whom examined the use of IPR techniques in individual psychotherapy.

In discussing the impact of IPR techniques it is important to mention that in subjective comments from the group members exposed to IPR techniques, there was a range of reactions. Some parents seemed to benefit from IPR techniques a great deal. Some identified IPR techniques, particularly the recall sessions, as the most valuable part of their group experience. Some parents seemed to benefit a great deal from the film on interpersonal fears followed by stimulus vignettes. Many parents requested that IPR be introduced earlier into the course and be used more frequently. Only two parents exposed to the IPR methods expressed directly negative criticism of the methods. It may be that certain types of parents benefit more from IPR techniques than others. Informal observations by both group leaders suggested that parents of higher socio-economic status took to the model most eagerly, and that mothers did more than fathers.

More than one parent expressed dissatisfaction with learning the inquirer role. There was some feeling that the probing, nonreflective nature of the inquirer role was in conflict with the role of play therapist, which is non-probing and more reflecting of feelings. It was recommended that the leader function as inquirer during recall sessions so that parents could stay focused on the play therapy role.

Finally, the results of this study need to be considered in view of the specific population. The fathers were all members of the armed forces and their families were military dependents. As a number of parents pointed out and as became apparent in the group meetings, there is a strong caste system by rank in the military. This system

is formalized and in some ways reflects class factors of education and income. This appeared to be a problem particularly for the men, with the largest barrier between enlisted men and commissioned officers. As one Lieutenant Colonel put it, "I don't want some E-5 to see that I have problems handling my kids. What if I have to give him orders some day?" At times this caste system seemed to result in some difficult group dynamics. Usually the leaders' skill was able to resolve some of these problems but the effect may have been to inhibit self scrutiny for some parents. This may have particularly affected IPR groups where the focus was more clearly on the parents' own emotional conflicts.

Participants' Subjective Comments Regarding the Program

Written feedback from the parents provided much useful qualitative information about the program. Parents reported that the groups in general helped them to: (1) understand and accept how their children feel; (2) understand better their own feelings; (3) be firm in setting limits; (4) learn to enjoy spending time with their children again; (5) appreciate and respect their children more; (6) let their children be their own persons; (7) improve their relationships with their children; and (8) feel more capable as a parent.

Parents identified the following elements of the groups as most helpful: (1) doing the play sessions; (2) discussing them; (3) getting feedback from the group leaders and other parents; and (4) seeing that other parents are frustrated as well. Several parents in the integrated Filial-IPR groups reported that the recall sessions were most helpful.

Those aspects of the groups which parents found most helpful in real life situations were: (1) reflective listening; (2) allowing the child to make some of his own choices and live with the consequences; and (3) being able to set reasonable limits.

Feedback on each of the leaders was very positive. Comments showed appreciation of the leaders' "support," "caring," "understanding," "acceptance," "non-judgmental attitudes," "useful and perceptive feedback," "willingness to accept feelings and empathy," and "competence in dealing with children."

A great number of parents said they thought the program would be improved if it lasted longer. Other suggestions for improvement included more in-lab practice sessions and families from a broader variety of backgrounds. Three persons indicated that they felt some discomfort being grouped with families with different military rank. A few persons in the Filial only groups indicated that they would have liked the benefit of seeing themselves on the videotapes collected as pretests and posttests.

Specific comments collected from parents in the Filial-IPR groups recommended: (1) elimination of the inquirer role for parents; (2) beginning recall sessions earlier; and (3) more recall sessions each week.

Limitations and Suggestions for Future Research

1. A major limitation of the study was that it was only conducted for four months. It is recommended that in future research the sessions be carried on for six months or longer which is customary in Filial

Therapy. This would have allowed more time to measure the impact of each method on child adjustment, parental acceptance, and affect sensitivity. This particularly would have afforded parents more time to benefit from stimulus vignettes and recall sessions and incorporate learnings from them into their play sessions.

2. To gauge the full effect of IPR methodology on Filial Therapy, it is recommended that leaders using IPR techniques have more experience with them. Ideally, leaders should have the experience of learning from and teaching IPR techniques at least once before participating in a research project measuring the impact of IPR. The same recommendation holds in terms of leader experience with Filial Therapy.

3. It is recommended that future research on these methods employ several group leaders. With fewer leaders, interaction effects between leaders could obscure differences between methods. The use of several leaders will help control for differences in training and bias about outcome. It is recommended that the experimenter in future studies not be a group leader.

4. The small n of 27 means that relatively large differences between methods must be found in order to establish significant treatment differences. With a too small n size, it is more likely also that chance factors can influence results so that you won't know if findings are due to treatment or error. It also makes it impossible to assess for differential effects upon specific personality types. IPR techniques may work best with people who already have some facility in exploring their own feelings. Or it may work best with or have the greatest impact

on people who have difficulty expressing their feelings. It is recommended that future research include a larger n and that the differential effects on different personality types be examined.

5. It is recommended that in future research group leaders be allowed some flexibility in determining when to introduce and use IPR techniques into the Filial groups.

6. Future research should examine the effects of introducing IPR methods earlier or later in the course of the sessions. Some parents requested that it start earlier, so as not to overlap with the beginning of the at-home sessions, and/or find more time to experience recalls.

7. Some of the difficulty assessing the full impact of IPR methods may be related to the social structure of the military population. It is recommended that the impact of IPR techniques on Filial Therapy be studied on non-military families as well, and that future research on a military population divide groups on the basis of rank or other socio-economic indicators to determine if both traditional Filial and integrated Filial-IPR groups benefit differentially from each method.

8. Another limitation of this study was the failure to directly measure the skill of limit setting or to indirectly measure it by other outcome measures than child adjustment. This failure may particularly affect measurement of the impact of IPR techniques since they seem valuable at helping parents discover and learn to deal with their fears of saying no to their children. For many parents, this is

their most difficult area. It is recommended that some means of measuring the impact of IPR on this skill be devised and included in future research in this area.

APPENDICES

APPENDIX A.

PORTER PARENTAL ACCEPTANCE SCALE

APPENDIX A.

PORTER PARENTAL ACCEPTANCE SCALE

Date_____ Rater_____ Father / Mother (specify) / Other

We are trying to learn more about parent-child relationships. To do this we need the cooperation and assistance of many parents. You can help us a great deal by filling out the attached questionnaire as frankly and as carefully as possible. Sincere and frank answers are requested so that valid data can be secured.

You will note that the questionnaire does not call for any mark of identification. Thus, your answers, as well as the many others, will be absolutely anonymous. Furthermore, all of the responses will be treated confidentially and will be used only for purposes of scientific research.

Please answer all questions. If you cannot give the exact answer to a question, answer the best you can.

GENERAL INFORMATION

1. Sex: Male____ Female____ 2. Year of birth_____

3. Year of marriage _____

4. Living with spouse at present time: Yes____ No____

5. Married more than once: Yes_____ No_____

6. If married more than once, was previous marriage ended because of:

Death _____ Divorce _____ Other (please state)_____

7. Draw a circle around the number of years of schooling you have completed:

1 2 3 4 5 6 7 8	1 2 3 4	1 2 3 4	1 2 3 4
Grade School	High School	College	Post-Graduate

8. Religious Affiliation:

Protestant _____ Jewish _____ None _____

Catholic _____ Other (please state)_____

9. Was your childhood and adolescence, for the most part, spent in:

_____open country or village under 1,000

_____a town of 1,000 to 5,000

_____a city of 5,000 to 10,000

_____a city of 10,000 to 50,000

_____a city of 50,000 to 100,000

_____a city of 100,000 to 250,000

_____a city of 250,000 or over

10. Present family income (annually):

_____under $4,000

_____$4,000 to $7,000

_____$7,000 to $10,000

_____$10,000 to $13,000

_____$13,000 to $16,000

_____$16,000 to $25,000

_____$25,000 or over

11. Husband's occupation (be specific, such as Dairy Farmer, Drug Store Clerk, College Professor, Auto Mechanic, etc.)

_____

12. Wife's occupation:_____

13. Ages of children (to nearest birthday):

Ages of boys: ____;____;____;____;____

Ages of girls: ____;____;____;____;____

While responding to the following questions, please think of the <u>one child</u> you are most concerned about.

Age of this child _____

Grade in school _____

BE SURE AND REFER ONLY TO THIS CHILD WHILE ANSWERING THE QUESTIONS.

Listed below are several statements describing things which children do and say. Following each statement are five responses which suggest ways of feeling or courses of action.

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

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

Be sure that you answer every statement and mark only one response for each statement.

1. When my child is shouting and dancing with excitement at a time when I want peace and quiet, it:

   a. makes me feel annoyed;
   b. makes me want to know more about what excites him;
   c. makes me feel like punishing him;
   d. makes me feel that I will be glad when he is past this stage;
   e. makes me feel like telling him to stop.

2. When my child misbehaves while others in the group he is with are behaving well, I:

   a. see to it that he behaves as the others;
   b. tell him it is important to behave well when he is in a group;
   c. let him alone if he is not disturbing the others too much;
   d. ask him to tell me what he would like to do;
   e. help him find some activity that he can enjoy and at the same time not disturb the group.

3. When my child is unable to do something which I think is important for him, it:

   a. makes me want to help him find success in the things he can do;
   b. makes me feel disappointed in him;
   c. makes me wish he could do it;
   d. makes me realize that he cannot do everything;
   e. makes me want to know more about the things he can do.

4. When my child seems to be more fond of someone else (teacher, friend, relative) than me, it:

   a. makes me realize that he is growing up;
   b. pleases me to see his interest widening to other people;
   c. makes me feel resentful;
   d. makes me feel that he does not appreciate what I have done for him;
   e. makes me wish he liked me more.

5. When my child is faced with two or more choices and has to choose only one, I:

   a. tell him which choice to make and why;
   b. think it through with him;
   c. point out the advantages and disadvantages of each, but let him decide for himself;
   d. tell him that I am sure he can make a wise choice and help him foresee the consequences;
   e. make the decision for him.

6. When my child makes decisions without consulting me, I:

   a. punish him for not consulting me;
   b. encourage him to make his own decisions if he can foresee the consequences;
   c. allow him to make many of his own decisions;
   d. suggest that we talk it over before he makes his decision;
   e. tell him he must consult me first before making a decision.

7. When my child kicks, hits, or knocks his things about, it:

   a. makes me feel like telling him to stop;
   b. makes me feel like punishing him;
   c. pleases me that he feels free to express himself;
   d. makes me feel that I will be glad when he is past this stage;
   e. makes me feel annoyed.

8. When my child is not interested in some of the usual activities of his age group, it:

   a. makes me realize that each child is different;
   b. makes me wish he were interested in the same activities;
   c. makes me feel disappointed in him;
   d. makes me want to help him find ways to make the most of his interests;
   e. makes me want to know more about the activities in which he is interested.

9. When my child acts silly and giggly, I:

   a. tell him I know how he feels;
   b. pay no attention to him;
   c. tell him he shouldn't act that way;
   d. make him quit;
   e. tell him it is all right to feel that way, but help him find other ways of expressing himself.

10. When my child prefers to do things with his friends rather than with his family, I:

    a. encourage him to do things with his friends;
    b. accept this as part of growing up;
    c. plan special activities so that he will want to be with his family;
    d. try to minimize his association with his friends;
    e. make him stay with his family.

11. When my child disagrees with me about something which I think is important, it:

    a. makes me feel like punishing him;
    b. pleases me that he feels free to express himself;
    c. makes me feel like persuading him that I am right;
    d. makes me realize he has ideas of his own;
    e. makes me feel annoyed.

12. When my child misbehaves while others in the group he is with are behaving well, it:

    a. makes me realize that he does not always behave as others in his group;
    b. makes me feel embarrassed;
    c. makes me want to help him find the best ways to express his feelings;
    d. makes me wish he would behave like the others;
    e. makes me want to know more about his feelings.

13. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:

    a. give him something quiet to do;
    b. tell him that I wish he would stop;
    c. make him be quiet;
    d. let him tell me about what excites him;
    e. send him somewhere else.

14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:

    a. try to minimize his association with that person;
    b. let him have such associations when I think he is ready for them;
    c. do some special things for him to remind him of how nice I am;
    d. point out the weaknesses and faults of that other person;
    e. encourage him to create and maintain such associations.

15. When my child says angry and hateful things about me to my face, it:

    a. makes me feel annoyed;
    b. makes me feel that I will be glad when he is past this stage;
    c. pleases me that he feels free to express himself;
    d. makes me feel like punishing him;
    e. makes me feel like telling him not to talk that way to me.

16. When my child shows a deep interest in something I don't think is important, it:

    a. makes me realize he has interests of his own;
    b. makes me want to help him find ways to make the most of this interest;
    c. makes me feel disappointed in him;
    d. makes me want to know more about his interests;
    e. makes me wish he were more interested in the things I think are important for him.

17. When my child is unable to do some things as well as others in his group, I:

    a. tell him he must try to do as well as the others;
    b. encourage him to keep trying;
    c. tell him that no one can do everything well;
    d. call his attention to the things he does well;
    e. help him make the most of the activities which he can do.

18. When my child wants to do something which I am sure will lead to disappointment for him, I:

    a. occasionally let him carry such an activity to its conclusion;
    b. don't let him do it;
    c. advise him not to do it;
    d. help him with it in order to ease the disappointment;
    e. point out what is likely to happen.

19. When my child acts silly and giggly, it:

    a. makes me feel that I will be glad when he is past this stage;
    b. pleases me that he feels free to express himself;
    c. makes me feel like punishing him;
    d. makes me feel like telling him to stop;
    e. makes me feel annoyed.

20. When my child is faced with two or more choices and has to choose only one, it:

    a. makes me feel that I should tell him which choice to make and why;
    b. makes me feel that I should point out the advantages and disadvantages;
    c. makes me hope that I have prepared him to choose wisely;
    d. makes me want to encourage him to make his own choice;
    e. makes me want to make the decision for him.

21. When my child is unable to do something which I think is important for him, I:

    a. tell him he must do better;
    b. help him make the most of the things which he can do;
    c. ask him to tell me more about the things which he can do;
    d. tell him that no one can do everything;
    e. encourage him to keep trying.

22. When my child disagrees with me about something which I think is important, I:

    a. tell him he should not disagree with me;
    b. make him quit;
    c. listen to his side of the problem and change my mind if I am wrong;
    d. tell him maybe we can do it his way another time;
    e. explain that I am doing what is best for him.

23. When my child is unable to do some things as well as others in his group, it:

    a. makes me realize that he cannot be best in everything;
    b. makes me wish he could do as well;
    c. makes me feel embarrassed;
    d. makes me want to help him find success in the things he can do;
    e. makes me want to know more about the things he can do well.

24. When my child makes decisions without consulting me, it:

    a. makes me hope that I have prepared him adequately to make his decisions;
    b. makes me wish he would consult me;
    c. makes me feel disturbed;
    d. makes me want to restrict his freedom;
    e. pleases me to see that as he grows he needs me less.

25. When my child says angry and hateful things about me to my face, I:

    a. tell him it is all right to feel that way, but help him find other ways of expressing himself;
    b. tell him I know how he feels;
    c. pay no attention to him;
    d. tell him he shouldn't say such things to me;
    e. make him quit.

26. When my child kicks, hits, and knocks his things about, I:

    a. make him quit;
    b. tell him it is all right to feel that way, but help him find other ways of expressing himself;
    c. tell him he should not do such things;
    d. tell him I know how he feels;
    e. pay no attention to him.

27. When my child prefers to do things with his friends rather than with his family, it:

    a. makes me wish he would spend more time with us;
    b. makes me feel resentful;
    c. pleases me to see his interests widening to other people;
    d. makes me feel he does not appreciate us;
    e. makes me realize that he is growing up.

28. When my child wants to do something which I am sure will lead to disappointment for him, it:

    a. makes me hope that I have prepared him to meet disappointment;
    b. makes me wish he did not have to meet unpleasant experiences;
    c. makes me want to keep him from doing it;
    d. makes me realize that occasionally such an experience will be good for him;
    e. makes me want to postpone these experiences.

29. When my child is not interested in some of the usual activities of his age group, I:

    a. try to help him realize that it is important to be interested in the same things as others in his group;
    b. call his attention to the activities in which he is interested;
    c. tell him it is all right if he is not interested in the same things;
    d. see to it that he does the same things as others in his group;
    e. help him find ways of making the most of his interests.

30. When my child shows a deep interest in something I don't think is important, I:

a. let him go ahead with his interests;
b. ask him to tell me more about this interest;
c. help him find ways to make the most of this interest;
d. do everything I can to discourage his interest in it;
e. try to interest him in more worthwhile things.

THANK YOU VERY MUCH FOR YOUR COOPERATION.

APPENDIX B.

FILIAL PROBLEM LIST

APPENDIX B.

Date_____

Name of Rater_____

Relationship to Child_____

FILIAL PROBLEM LIST*

("FPL")

Information provided on this list is CONFIDENTIAL.

*The FPL was developed at the Individual and Family Consultation Center, Pennsylvania State University, 1974, by Peter L. Horner, M.S. Items were derived in part from Leventhal and Stollack's "Problem List," Children's Psychiatric Center, Inc., Eatontown, New Jersey.

INSTRUCTIONS

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

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

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

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

EXAMPLES

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

20. Bites nails __1__

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

20. Bites nails __3__

Please do NOT consult with your spouse; each parent should fill out this form separately. If you have any problems completing this list, please do not hesitate to call for assistance.

1. Eats too little ____
2. Not eating the right food ____
3. Wets bed at night ____
4. Gets lower grades in school than should ____
5. Does not talk plainly, poor communication ____
6. Shy with other children ____
7. Too few friends ____
8. Feels inferior to other children ____
9. Picked on by children ____
10. Has no self confidence ____
11. Nervous, tense ____
12. Sad, unhappy too often ____
13. Cries too easily ____
14. Feels helpless ____
15. Blames self too much ____
16. Gets into trouble ____
17. Destroys property of others ____
18. Steals ____
19. Lies ____
20. Bites nails ____
21. Picks nose ____
22. Always late, dawdles ____
23. Difficulty falling asleep or sleeping ____
24. Troubled restless sleep ____
25. Slow in reading ____
26. Cannot keep mind on studies ____
27. Does not pay attention to teacher ____
28. Restless in class ____
29. Stomach cramps, aches ____
30. Headaches for no physical reason ____
31. Feels different from other children ____
32. Easily led ____
33. Left out by children of own age ____
34. Never chosen as a leader ____
35. Is self-conscious about own body ____
36. "Big Shot" ____
37. Gets angry too easily ____
38. Fear of darkness ____
39. Panics when afraid ____
40. Too easily discouraged ____
41. Breaks promises ____
42. Thumb sucking ____
43. Bad table manners ____
44. Untidy ____
45. Has bad dreams ____
46. Afraid to speak up in class ____

47. Fights too much with children ____
48. Blows his top ____
49. Sulks, pouts ____
50. Gripes too much ____
51. Fear-ridden child ____
52. Unusual fears ____
53. Does not do chores ____
54. Takes advantage of people ____
55. Disobeys parents ____
56. Not close to parents ____
57. Scratches self a lot ____
58. Swears, uses dirty language ____
59. Unable to keep to a time schedule ____
60. Uses hands in poorly coordinated way ____
61. Restless, can't stay in one place ____
62. Non-athletic ____
63. Does not like to go to school ____
64. Does not spend enough time in study ____
65. Not interested in books ____
66. Always wants revenge ____
67. Irritable child ____
68. Teases excessively ____
69. Daydreams a lot ____
70. Gets too excited ____
71. Does not try to correct bad habits ____
72. Too stubborn with parents ____
73. Continued demanding of gifts, new things ____
74. Wants too much attention from parents ____
75. Careless in own appearance ____
76. Careless with clothes and belongings ____
77. Selfish, won't share ____
78. Does not complete work ____
79. Poor memory ____
80. Unsure of self in school ____
81. Has had a number of accidents ____
82. Plays too much with younger children ____
83. Bossy with brothers/sisters ____
84. Jealous of brothers/sisters ____
85. Preoccupied with own thoughts ____
86. Loses temper ____
87. Is erratic, unpredictable ____
88. No control over emotions ____
89. Fights back, talks back to elders ____
90. Too dependent upon mother, father ____

91. Inconsiderate of parents ____

92. Bumps into furniture, trips, etc. ____

93. Watches TV all the time ____

94. Trouble adjusting to a new school ____

95. Tries to get attention in class ____

96. Fights brothers/sisters ____

97. Gets people angry, provokes ____

98. Loses own possessions frequently ____

99. Gets completely out of control ____

100. Oversensitive to criticism from parents ____

101. Behind other children on dressing ____

102. Feels bad about own physical appearance ____

103. Elimination problems (e.g., diarrhea, constipation, gas, holds urine, etc.) ____

104. Dangerous habits (describe) ____

105. Sex-related problems (e.g., "peeps," exposes self, etc.) ____

106. Physical tension problems (e.g., hives, ulcers, colitis, sweats, nausea, dizziness, etc.) ____

107. Excessively passive, meek ____

108. Body movement problems (e.g., clumsy in using legs, jerky movements, lazy, apathetic, has no energy, head banging, paralyzed, moves too slowly, has twitches, rocks all the time, etc.) ____

In order to give us a more complete picture of your child, please answer the following questions.

1. If there are any problems with your child which were not included on the list, please note them here.

2. In your own words, write a brief description of your child's personality.

3. What do you think the child's best attributes are?

Below are several questions about the list you have just filled out. Your comments here will help us make the list more useful for other parents. Thank you for your help.

1. About how long did it take you to complete this list?

2. Do you think this list gives a fairly good "picture" of your child? If not, why not?

3. Other comments.

Parent's name_____ Child's name_____

Child's age_____

ALL INFORMATION ON THIS LIST IS CONFIDENTIAL.

APPENDIX C.

CHECK LIST FOR PARENTS

APPENDIX C.

CHECK LIST FOR PARENTS*

Date_____ Rater_____ Father / Mother / Other (specify)

This is a list of things that parents have said about their children. You are to read each one and draw a circle around YES if it is true or mostly true for your child, and draw a circle around NO if it is not true or mostly not true for your child. YOU MUST ANSWER EVERY QUESTION. If more yes than no, answer YES. If more no than yes, answer NO. EVERY QUESTION MUST BE ANSWERED.

Yes No 1. My child seldom finishes what he/she begins.

Yes No 2. At the slightest upset, my child's coordination becomes poor.

Yes No 3. My child is learning under force at home.

Yes No 4. He never seems happy, like other children.

Yes No 5. My child does not seem to be learning as he should.

Yes No 6. My child cannot conform to tasks in school.

Yes No 7. My child says people don't like him.

Yes No 8. My child gets over-excited in crowds.

Yes No 9. Hitting and pushing other children are usually what he does.

Yes No 10. My child cannot keep track of his toys and materials.

Yes No 11. My child is a discipline problem, at home and in school.

Yes No 12. My child is constantly irritable with the children he plays with.

Yes No 13. My child has nervous habits (like pulling at his clothes, clearing his throat often, and snuffing his nose).

Yes No 14. My child cannot make friends at school.

Yes No 15. My child cannot get interested in anything.

Yes No 16. My child has the habit of raiding the cupboard for forbidden food.

*Developed at Wichita Guidance Center, Wichita, Kansas

Yes No 17. My child refuses to pick up clothes and toys around the house.

Yes No 18. My child refuses to do things to help around the house.

Yes No 19. On the whole, my child is rebellious and resentful.

Yes No 20. My child lacks self-confidence.

Yes No 21. Often I can see the tension building up in my child.

Yes No 22. I can see that my child is becoming more unhappy all the time.

Yes No 23. My child cannot get along with my husband/wife.

Yes No 24. My child's behavior is unpredictable; I never know what he is going to do next.

Yes No 25. My child is a very poor reader.

Yes No 26. At times, my child seems to hate everybody who comes near him.

Yes No 27. In most things, my child cannot keep up with other children.

Yes No 28. Any change in the things around him disturbs my child.

Yes No 29. My child is out of step with the way of life in our home.

Yes No 30. At home, my child often refuses to answer when called.

Yes No 31. My child is constantly irritable at home.

Yes No 32. My child daydreams a great deal.

Yes No 33. My child is driving his teacher mad.

Yes No 34. He seems to have no regard for our warnings and instructions.

Yes No 35. Discipline of any kind only makes him furious.

Yes No 36. My child cries easily.

Yes No 37. My child can only make passing grades.

Yes No 38. Teachers complain that my child never finishes assignments in school.

Yes No 39. My child is not ready to do the work that is expected of him.

Yes No 40. My child becomes discouraged when he has to do something on his own.

Yes No 41. He often reacts with temper tantrums.

Yes No 42. The teacher says that my child will not respond in class.

Yes No 43. My child's grades are inconsistent; either real high or real low.

Yes No 44. My child has ability, but he won't use it.

Yes No 45. My child feels I am picking on him.

Yes No 46. Eating is a constant problem with my child.

Yes No 47. My child seems driven by either a nervous energy or a conflict to talk constantly.

Yes No 48. My child has to have everything his way and if not, he is at a complete loss.

Yes No 49. You can hold my child's attention only a very short time.

Yes No 50. My child seems to be one of those children that just can't do anything right.

Yes No 51. My child frequently gets into things that he knows he should not get into.

Yes No 52. My child often does things to attract attention even though he will be punished for doing it.

Yes No 53. My child teases and torments the other children.

Yes No 54. My child's jumping and moving around all the time worries me.

Yes No 55. They say my child is restless at school.

APPENDIX D.

VIDEOTAPE RATING SCALES

APPENDIX D.

VIDEOTAPE RATING SCALES

A. Communication of Acceptance

1. Verbal recognition and acceptance of feelings
2. Verbal recognition and acceptance of behavior only
3. Social conversation or no conversation
4. Slight or moderate verbal criticism stated or strongly implied
5. Verbal criticism: argumentative, "preaching," open rejecting feelings or behavior, abusive language

B. Allowing the Child Self-Direction

1. Shows willingness to follow child's lead
2. Child has option for lead-taking
3. Takes lead without giving child an option
4. Directs or instructs child to do something
5. Persuades, cajoles, demands, pushes, interrupts, interferes in child's activity, insists on new activity

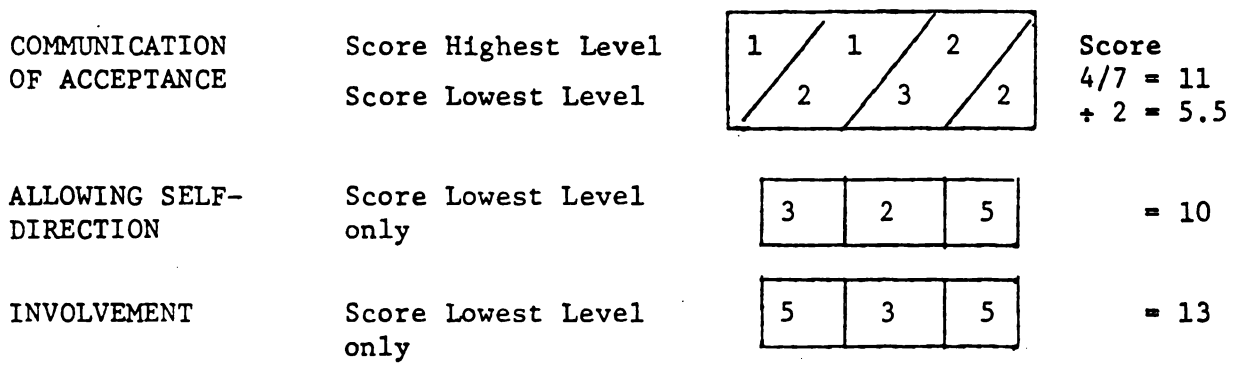
C. Involvement

1. Fully observant of child's behavior, adult gives no indication of being aware of the child's behavior
2. High level of attention
3. Marginal attention: The adult is involved in his own independent activity to a degree that interferes somewhat with attention to child.
4. Partially withdrawn or preoccupied
5. Completely preoccupied, or self-involved, or shut off.

SCORING

A rating is made for every three-minute interval on a score sheet as illustrated in Figure 1 below.

Scoring is retrospective for each three-minute interval for all categories. Thus, in each case the coder enters a score which he thinks may qualify as highest or lowest for the three-minute interval as it occurs, and changes as necessary during the remainder of the three-minute interval. To obtain a total score for Communication of Acceptance, highest and lowest scores are averaged. The lowest score only is entered for the subscales Allowing Child Self-Direction and Involvement.



The Videotape Rating Scale Scoring Sheet

Figure 1.

APPENDIX E.

THE AFFECTIVE SENSITIVITY SCALE

APPENDIX E.

THE AFFECTIVE SENSITIVITY SCALE

Forms D & E

Instructions

You will be viewing short scenes of actual encounters between two or more individuals. You are to identify what feelings the people have about their concerns or toward the person they are working with.

Although in any one scene the persons may exhibit a variety of feelings, for the purpose of this instrument you are to concentrate on identifying their last feelings in the scene.

After you view each scene ask yourself:

> If the people involved were to view this same scene, and if they were completely open and honest with themselves (i.e., if they could identify their real feelings) how would they describe their feelings?

After you decide which response comes closest to what the people are feeling, whether about their concerns or the other person they are with, fill in the space provided on your answer sheet.

Sample Items

Scene 1-1 FORMER TEACHER - 4TH GRADE STUDENT

SETTING: INFORMAL ENCOUNTER, DISCUSSING AN EARLIER INTERVIEW

Opening statement (teacher): "When we talk, we normally touch each other."

Closing statement (teacher): "You said something that really made me feel good, and I wanted to hug."

Time: 50 seconds

ITEM 1. WHAT IS THE STUDENT FEELING AT THAT POINT?

a. I'm sorta uncomfortable and uptight. I'm embarrassed.
b. I'm feeling comfortable now.
c. I'm not feeling much of anything.

ITEM 2. WHAT IS THE STUDENT FEELING ABOUT THE TEACHER AT THAT POINT?

a. I'm afraid. I don't want to be touched right now.
b. I feel good about you. I'd like to hug you, too.
c. I'm really scared. What are you going to do next?

Scene 1-2 FORMER TEACHER - 4TH GRADE STUDENT

SETTING: INFORMAL ENCOUNTER, DISCUSSING AN EARLIER INTERVIEW

Opening statement (teacher): "Did you feel it was different?"

Closing statement (teacher): "We didn't sit on pillows this time, did we?"

Betsy (student): "No."

Time: 25 seconds

ITEM 3. WHAT IS THE STUDENT FEELING AT THIS POINT?

a. I'm a little happier now, but not much.
b. I wish we had brought some pillows. I would have liked that.
c. I'm really uncomfortable, but I'm scared to show it.

ITEM 4. WHAT IS THE STUDENT FEELING ABOUT THE TEACHER AT THIS POINT?

a. I'm still not really relaxed. I still don't trust you.
b. I'm relieved. She didn't change the subject.
c. I feel safe now. We like each other.

APPENDIX F.

LETTER TO PARENTS

APPENDIX F.

LETTER TO PARENTS

March 31, 1980

Dear

As you know, you have been selected to participate in the Parent Play Therapy Program. As I explained to you, you will also be participating in a research project. We are trying to discover the most effective ways to teach parents play therapy skills.

We need your help in this endeavor. Would you please complete the enclosed forms and bring them with you to the first group meeting next week? On the forms which ask you about your children, fill out the forms for the child whose behavior or problems are of the greatest concern to you. If both parents are participating in the program, be sure that both parents fill the form out for the same child, even if you intend to spend weekly play therapy time with more than one child. When both parents are participating, be sure to complete the forms independently. Do not discuss the answers with your partner until after you have turned your forms in.

In addition, please read and sign the Parent Consent form. If you have questions or concerns regarding the form, please contact me individually or raise them in the first meeting.

I will contact you again this week to notify you of the day, time, and place of your regular group meeting. Thank you for your cooperation.

Sincerely,

Chris G. Dematatis
Program Director
Parent Play Therapy Program
517-7171 or 664-6047 (days)
765-1950 (evenings)

Enclosures

APPENDIX G.

PARENT CONSENT FORM

APPENDIX G.

PARENT PLAY THERAPY PROGRAM

Parent Consent

1. I understand that participating in the Parent Play Therapy Program at the Dewitt Army Hospital at Ft. Belvoir, my child and I will also be participating in a research project. Data obtained from questionnaires or educational or training sessions will be employed for evaluation and research purposes.

2. I also understand that audio or video taping of the sessions in which I participate will be played for the purposes of research data collection.

3. No names or descriptions of families or individuals will be made in reporting results of the research in a manner that would permit a reader to identify anyone concerned.

4. Participants have the opportunity to assist training of a few other professionals by allowing the investigator to use the data and tapes for this purpose. Presentation to a larger group will require a signed consent for this specific purpose.

5. The Parent Play Therapy Program has been outlined in detail for me along with a description of the benefits to be expected from the program and any alternative procedures that may be more advantageous for the participant. Furthermore, I understand that I am free to withdraw my consent and to discontinue participation at any time.

6. I understand that there will be a cost of approximately $50.00 for materials for this program, that this cost must be paid by me and is not reimbursable from federal funds, and that I am responsible for obtaining the materials directly from the supplier.

7. Any questions I may have had concerning this project have been answered satisfactorily. I agree to full participation in the Parent Play Therapy Program and authorize the project to use research data and tapes for such purposes.

_____ _____

Date Signature of Mother

_____ _____

Date Signature of Father

Participating Children

_____

_____

APPENDIX H.

PLAYROOM GUIDELINES FOR PARENTS

APPENDIX H.

PLAYROOM GUIDELINES FOR PARENTS

Introductory Message

_____, this is a very special room. You can do almost anything you want to do in this room. If you cannot do something, I will tell you.

Departing Message

Give two time warnings as to the session's end. One time warning is to be given at five minutes before the end of the play time and the last warning is to be given at one minute before the end.

Examples: "Johnny, we have (five, one) minute(s) more to play today."

At the end of the play time, firmly, but pleasantly say: "Our time is up for today. We have to leave now."

Resistance: If the child is reluctant to leave the room, reflect his feelings and restate that the session is ending. Use your body and voice to stress your message and insistence:

1. Stand straight up from your kneeling position on his level.
2. Take him gently by the shoulder and guide the child in the direction of the door.
3. Go directly to the door and open it.
4. Change the tone of your voice from acceptance to a firm and clear intention.

Remember first to reflect the child's feelings before attempting to enforce his leaving.

Limits

Definition

A limit is a rule or guideline for behavior which is defined and enforced by imposing consequences or results if the limit is broken.

Rationale

Children need help to define their boundaries and to feel safe and yet able to explore their environment and to try out more adult behaviors.

Children learn that what happens to them is a direct consequence of their behavior. They can begin to take responsibility for their actions by the proper use of limits and consequences.

Guidelines to consider before making a limit

1. Is this limit necessary for the safety of the child?

2. Is this limit necessary for the safety of others?

3. Is this limit necessary for the protection of valuable property?

4. Is this limit enforceable?

Reasons for setting as few limits as possible

1. Children cannot be expected to remember a great number of rules.

2. If few bounds are imposed, the child can explore the situation as much as possible and he can lead the way.

3. Since consistency is important (you want to be viewed as a person who does what he says), the fewer the limits imposed, the more likely it is that the limits will be enforced every time they are broken.

Steps in setting limits

1. Determine if a limit is necessary. Limits in the playroom are:

    a. Nothing should be thrown at the mirrors, camera, or windows.

    b. No crayons on the blackboard.

    c. No sharp objects or kicking should be directed to the bop bag.

    d. The room should not be left during the session except for one trip to the bathroom.

    e. Mass destruction of the toys is not allowed.

    Leaving the room for a bathroom trip:

    a. Reflect the need.

    b. State the limit.

    c. Structure the leaving.

Example: "Johnny, you want to go to the bathroom." (reflection)

"You can only leave this special room when you want to go to the bathroom. We can leave now." (stating the limits as to when leaving is allowed)

Upon re-entry into the room, reintroduce the child to the situation: "We are now in the special room again."

The bathroom trip can be avoided mainly by structuring the situation before the session begins by simply asking the child if he needs to go to the bathroom.

2. State the limit to the child.

a. Be brief and clear.

b. Phrase the limit in a forceful but pleasant tone. Change your voice from the acceptance level to one of authority.

c. In this order, catch the child's attention; reflect his desire to do the prohibited action; then state the limit.

Example: "Billy, you want to hit the mirror with the dart. Remember, I told you if there was something you couldn't do, I would tell you? One of the things you cannot do in this room is shoot darts at the mirror."

d. Next, give the child an alternative structure to allow him to open up again and redirect his own play.

Example: "One of the things you cannot do is shoot the dart at the mirror, but you can shoot it almost anywhere else in the room."

This statement provides a limit and a structure without restricting play too much and allowing the child to make his choice as to where to shoot the darts.

e. If the child persists in asking why, reflect his question, and then answer him with a simple reason.

Example: "You want to know why you cannot shoot the mirror. Because it might break. If the mirror breaks, it will cost too much money to be replaced."

3. Warning.

If the child breaks the limit you have just set (the second time this occurs in the session), remind him of the first warning and re-establish

the limit and state what will happen if the limit is broken again. A warning is given so that the child knows beforehand what will happen if he breaks the limit and can decide for himself whether he will risk the consequences.

Example: "Johnny, remember I told you that you could not shoot the darts at the mirror? If you shoot the darts at the mirror again today, we will have to end the play time for today."

4. Enforcement of consequences

Restate the rule and follow through with the consequence you warned him about. Use a firm but pleasant tone. Perhaps stand up immediately or guide him to the door to help him clearly distinguish your insistence that he now leave because he has broken a limit.

Example: "Johnny, remember I told you if you shot the mirror again, you would have to leave the play room for today? Since you choose to shoot the mirror, we have to leave today right now."

A child will begin to learn that he is responsible for what happens to him when he makes a choice to break a limit when he has been warned previously and knows what the result will be.

For each subsequent session, start at the warning stage and progress to enforcement of consequences if necessary. For only the first time, do you state the limits. After each limit is stated when it comes up, go to the warning stage.

APPENDIX I.

TOYS FOR THE PLAYROOM

APPENDIX I.

TOYS FOR THE PLAYROOM

Inflated plastic bop bag (at least four feet high)

Dart gun with darts

Rubber knife

Non-hardening modeling clay

Plastic cowboys, Indians, soldiers

Family of puppets

Doll family (mother, father, brother, sister, baby)

Baby bottle

Bowl for water

Crayons, paints

House box for doll furniture and family

Cups and saucers

Drawing paper

Tinker toys or similar construction toys

APPENDIX J.

COMMENTS ON PARENT PLAY THERAPY PROGRAM

APPENDIX J.

COMMENTS ON PARENT PLAY THERAPY PROGRAM

Please complete the sentences below with a brief comment.

1. **The course helped me to**

2. **I think I got the most from the**

3. **It would have been more helpful if**

4. **One thing I learned from the play sessions that I think is useful in real life is**

5. **I would like to have had more**

6. **The best thing about the leader was**

7. **It would have been better if the leader had**

8. **I felt that my child regarded the play sessions as**

9. **The course would be improved if**

10. **If a friend or neighbor asked me about the class, I would**

11. **Insofar as change in my relationship with my child goes, I would say that it has**

12. Additional comments please. Use back side if necessary.

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BIBLIOGRAPHY

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