A DUAL PHASED, MIXED METHODS APPROACH TO THE EXPERIENCE AND EFFECTS ON EMPATHY WITH A SMALL GROUP OF PARENTS OF PREADOLESCENT CHILDREN WHO PARTICIPATED IN CHILD PARENT RELATIONSHIPS THERAPY TRAINING

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Counseling and Educational Psychology

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Abstract

This dual phased, mixed methods designed examined the experiences and the effects of empathy and acceptance on six parents with preadolescent children who participated in Child and Parent Relationship Therapy (CPRT) training. Parents from an experimental and control group participated in a 10-week filial therapy training. The results of the posttest scores of the experimental parent group were compared to the pretest scores of the control group on the Measurement of Empathy in Adult and Child Interactions (MEACI) and the Porter Parental Acceptance Scale (PPAS). Following the training period for both groups parent participants were interviewed regarding their experiences. Parental acceptance of self-direction, involvement and acceptance were shown in the interview responses to be responsible for relationship growth and improved interactions for these parents. Parents were recalled and four out of the original parent participants were interviewed 16 weeks after the completion of their respective training sessions had lapse in order to participate in a closing interview. A narrative inquiry was presented to impart the experiences of these four parents who had participated in filial therapy training with their preadolescent child.
Dedication

This has truly been a journey of self and academic discovery and I have so many to thank for getting me through. I would first like to thank them all for their patience and tolerance of me while I walked this path. I have been completely supported in my efforts this entire way, they lifted me up when I thought I was broken and couldn’t finish and they have cheered me on when I was on a roll. I cannot express enough gratitude for my family for their ongoing support. Next, I would like to thank my chair, without her expertise and guidance this process would have been all the more daunting. She has been a source of academic and personal strength every step of the way and it was her passion for her profession that was the spark to mine. She is the ultimate example of teacher, mentor and therapist and I am better for having known her. Lastly, I would like to thank, very graciously, my entire committee for their continued support and patience on my endeavor to change the world. They allowed me to push a little farther but set appropriate boundaries so I could stay on track and not lose sight of the immediate task. This has been a grueling and enlightening process and I am proud of the person I am for having completed it.
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Chapter One – Introduction

“An ounce of prevention is worth a pound of cure.” – Benjamin Franklin

Introduction

As children develop into adolescents, the influence of the family begins to wane as they place importance on friendships and socioemotional functioning (DuRant, Cadenhead, Pendergrast, Slavens, & Linder 1994). This process begins during the stage of preadolescence. The developmental phase of childhood that is preadolescence can be a tumultuous time for both the child and parents. Kohen-Raz (1971) characterized preadolescence as the peak and terminal point of a child’s development toward adolescence. There is evidence too that sustained patterns of behavior problems occurring across childhood into adolescence can be linked to experience configurations in late elementary school years (Bergman & Magnusson, 1997; Cairns & Cairns, 1994). The preadolescent child vacillates between the desire for autonomy and a very real emotional, social, and physical dependence on the adults in preadolescent’s lives (Packman & Solt, 2004). Preadolescents struggle with their desire to be independent and their varying ability to be and this can create frustration for them and for their parents.

Parents can often feel a loss of their “child” during this stage of development marked with a definite increase in their preadolescent’s abilities toward independence and can do one of two things: (a) try to keep them from gaining autonomy or (b) expect much more from them than is developmentally possible. This can create a great deal of tension in the parent/child relationship. Tension between the parent and the preadolescent can often create behavior changes or acting out on the part of the child. Parents can quite often lose confidence in their parenting
abilities and fear a loss of connection with their preadolescent child during this period of development (Packman & Solt, 2004).

Many parents struggle with the job of being a parent and there have been many studies on the efficacy of parent trainings that address child behavior. Some look at the effects of cognitive/behavioral approaches in parent training (Gavita & Joyce, 2008), or are qualitative studies around behavioral approaches (Farooq, Jefferson & Flemming, 2005; Patterson, Mockford & Stewart-Brown, 2005; Taylor & Biglan, 1998). These studies focus on addressing the behavior of the child and very minimally address the relationship inherent in the parent/child dynamic. Furthermore, there is a dearth of research examining effective parent training with the specific focus of families with preadolescent children (Kottman, Strother, & Deniger, 1987).

Many of the parent trainings discussed focus on changing child behavior while only suggesting changes in parent responses and behavior except in cases of abusive parenting styles (Lau, Fung & Yung, 2010; Sanders, Cann & Markie-Dadds, 2003). While there are many studies aimed at illustrating the efficacy of parent trainings as a means of changing child conduct there is little that address changing the relationship by modification of parent behaviors (Hawes & Dadds, 2006). Filial Therapy training, which is designed to address the relationship more than the child’s target behaviors, looks to improve the relationship, and in so doing, change interactions and perceptions (Landreth, 1991; Vanfleet, 1994; Watts & Broaddus, 2002). The process of filial therapy helps parents understand and respond to their child’s needs aside from the child’s behavior and provides a skill set to improve relationships as a way of indirectly improving child behavior (Watts & Broaddus, 2002; Landreth, 1991).

Filial therapy was developed by Bernard and Louise Guerney in the early 1960s with close ties to the practice of play therapy (Landreth & Bratton, 2006). Building on the work of the
Guerneys (2000), Landreth developed a more condensed, 10-session parent training format based on his observations that time and money availability may be a concern for parents who would otherwise participate in a longer parent training (Landreth & Bratton, 2006). For this reason, Landreth and Bratton (2005) created a 10-session training format calling it Child Parent Relationship Therapy (CPRT, Landreth & Bratton, 2006). There is a significant pool of research aimed at looking into the efficacy of parent trainings and filial therapy with diverse populations across specific child behaviors and disabilities (Chacko et al., 2009; George, Kidd & Brack, 2011; Landreth, 1991; Sanders, Markie-Dadds, Tully & Bor, 2000; Vanfleetc, 1994; Wade, Llewellyn & Matthews, 2008; Watts & Broaddus, 2002). With the many studies in the literature, the focus seems to be on studies with young children or adolescents rather than on studies aimed at parents participating in parent trainings with preadolescent children.

Statement of Problem

Because the business of raising a child and especially navigating the phase of development that is preadolescence can be difficult for parents it is important to consider family interventions that include the parents and children in a developmentally appropriate way. If the children are present during therapy but are not able to participate fully because the approach does not meet their developmental needs then the therapeutic process may be hindered (Bratton, Ray, Rhine, & Jones, 2005; Topham & VanFleet, 2011). There is little research outside the study of filial therapy that employs an approach designed specifically to address the relationship rather than target child behaviors (Bratton, Ray, Rhine & Jones, 2005; Landreth, 1991; Landreth, Baggerly & Tyndall-Lind, 1999; Landreth & Bratton, 2006; Vanfleetc, 1994; Topham & Vanfleetc, 2011; Watts, Broaddus, 2002).
According to research taking an approach that values developmental needs and accepts the unique position of children is more appropriate for success in family therapy than traditional talk therapy or family systems approaches not considering the developmental needs of children (Bratton et al., 2005; Landreth, Baggerly & Tyndall-Lind, 1999; Landreth & Bratton, 2006). The challenge with most family therapy approaches lies in the reliance on verbal exchanges. Children are often excluded from the process because children do not have the full cognitive abilities to verbalize feelings and thoughts like adults do (Landreth, 2002). While there is extensive research across many populations and situations there is still little investigation how the approach of filial therapy, which employs a developmentally sensitive relationship and play–based method, can provide a holistic intervention for families. It is a much understudied population and therefore the focus of this proposed research.

**Purpose of Study**

The purpose of this study is to determine the effectiveness of Child Parent Relationship Therapy (CPRT) training and the experiences of those parents participating in such a training. The researcher is interested in seeing how this training is experienced by the participants and to see how CPRT addresses parent perceptions of preadolescent behavior while focusing on the parent child relationship rather than on the preadolescent’s behavior. This mixed methods design will examine the effectiveness of filial therapy in, (a) easing difficult parent-child interactions, (b) increasing parental empathy with the preadolescent child, (c) enhancing the parent-child relationship, (d) increasing the level of parental acceptance regarding their preadolescent child’s behavior (e) helping the researcher better understand the experience of the parents as they move through the process and how that relates to their individual outcomes.
This study will examine the effects on empathy and the experiences of parents with preadolescent children participating in a 10-week Child Parent Relationship Therapy training. Although there are a great many parent trainings available to parents with children of varied ages, the implications of CPRT and the impact the training has on the relationship is the focus for this proposed research. Changing specific behaviors are not the focus of CPRT. If it happens that interactions and patterns may change but this is not a behavioral approach aimed at changing behavior. It may be though, that parental perceptions of behavior change as a result of participation in a CPRT training. The study is aimed at enhancing the relationship between the parent and child by helping parents learn empathy and acceptance while looking deeper into the experience of the parent participants in order to better understand this process from their perspectives.

Design and Theoretical Framework

The quantitative data of this mixed design explored the use of CPRT with families with preadolescent children and investigated its effectiveness compared to a waitlisted control of parents not participating in CPRT. The purpose of this exploration was to determine the use of filial therapy as an effective parent training intervention. The ultimate goal of this research was to provide evidence of the efficacy of filial therapy as both an intervention and prevention for families with any age child with a comparison of the quantitative and the qualitative data collected to better understand how this process works for the parents who participate.

This mixed methods design, was aimed at comprehensibly exploring the experience of each of the parents who participated in the ten-CPRT training by comparing the scores from the Measure of Empathy of Adult Child Interactions (MEACI) and the Porter Parental Acceptance
Scale (PPAS) of both the experimental and waitlisted control group parents with their individual experiences of the process. The parents’ experience of the training was assessed by performing a single exit interview along with the researcher’s observations of the training which worked to inform the parent’s phenomenology. The purpose of combining the quantitative and qualitative methods was to develop a deeper understanding of the experience of the parent participants and how that experience relates to their empathy and acceptance. This researcher used a sequential explanatory design by collecting the quantitative data first which was supported by the qualitative data which was collected later. The data was integrated and compared at the point of interpretation following the quantitative analysis and the interview data was compiled. Through the use of the MEACI, PPAS and interviews, a more comprehensive story and a more complete understanding of the effects of empathy and the parental experience emerged.

**Research questions**

This study investigated the following three research questions:

1. What is the differential effect on parental empathy when parents of preadolescent children (ages 9 to 11 years old) participate in filial therapy versus parents who do not participate in filial therapy training?

2. What is the differential effect on parental acceptance when parents of preadolescent children (ages 9 to 11 years old) participate in filial therapy versus parents who do not participate in filial therapy training?

3. What are the individual experiences of the parents participating in a CPRT training? The conceptual framework for Question Three focuses on the individual experiences of
parents participating in filial filial therapy training. The findings will offer insight into possible common perspectives and experiences across the parents.

Rationale

Several research studies have been published showing the effectiveness of filial therapy in several different populations including homeless families (Kolos, Green, & Crenshaw, 2009); with parents who have children with severe behavior problems (Rennie & Landreth, 2000); parents of children in other cultures and single parents, (Bratton & Landreth, 2009; Guo, 2005); parents who have children with chronic illness (Waldman, Zimmerman, & Landreth, 1992); and young children (Topham & VanFleet, 2011). Even with the amount of research that exists with a focus on family therapy, little, if any, addresses the specific needs of parent with preadolescents, even though there is evidence that interpersonal competence patterns of preadolescence have been evidenced with later adjustment difficulties that include school dropout, teen parenthood, substance use, and criminality (Estell, Farmer, Irvin, Crowther, Akos, & Boudah, 2007; Farmer, Goforth, Leung, Clemmer, & Thompson, 2004; Roeser, Eccles, & Freedman-Doan, 1999). The transitional time of preadolescents can be filled with turbulent interactions between parent and preadolescent and the relationship may suffer as a result.

Family therapists have a responsibility to provide developmentally appropriate care that encourages participation from all members of the family. This seems particularly important for the developmental stage of preadolescence because of the struggle between dependence and independence (Packman & Solt, 2004; Wentzel, Weinberger, Ford, & Feldman, 1990). Preadolescents may resent not being able to participate in the process and may feel invalidated as a member of the family if their needs or ideas are not being considered (Vuchinich, Vuchinich, & Wood, 1993). Along with the sentiment that all members should be involved in the process is
the idea that there is strength in having parents become active agents of change because of the inherent relationship that exists between themselves and their child, that which a play therapist would have to take time to develop.

The review of literature of play and filial therapy suggests that conventional talk therapy is not appropriate for children (Landreth & Bratton, 2006; Rennie & Landreth, 2000). Often children and even preadolescents do not have the cognitive development to express themselves verbally. Instead, with the use of play, which is the child’s language (Landreth, 1991), children can be free to project thoughts and emotions onto toys using their natural language of play. When a parent plays the role of play therapist the parent becomes immersed in the process rather than staying a bystander to the process otherwise performed by a play therapist.

There are however, indications that the process of intentionally and academically mixing quantitative and qualitative data can provide strength to research results (Greene, Caracelli, & Graham, 1989). Greene (1989) identified a number of reasons how mixed methods can be used in credible ways to support research results. Greene (1989) describes the process as complementary when the quantitative and qualitative methods can be combined and the use of the results from one method work to elaborate on results from the other method.

More recently, it has been suggested that the use of mixed methods research design may help researchers better understand a research problem by converging numeric trends from quantitative data and specific details from qualitative data; work to help identify variables or constructs that may be measured subsequently through the use of existing instruments or aid in the development of new ones (Newman, Ridenour, Newman, & DeMarco, 2003, & Punch, 1998). Further, the use of mixed methods research designs can provide researchers with statistical, quantitative data and results from a sample of a population whereby they can use this data to identify individuals who may expand on the results through
qualitative data results and it is further suggested that mixed methods research results can convey the needs of individuals or groups of individuals who are marginalized or underrepresented (Newman et al., 2003; & Punch, 1998).

**Definition of terms**

The following is a list of operational definitions as they apply to the terms used in this study. Operational definitions provide the framework for future replication and lend themselves to the meaningful data comparisons across studies (Isaac, & Michael, 1995).

Allowing the Child Self-Direction – a subscale of the Measure of Empathy in Adult and Child Interactions (MEACI) measures the adults’ behavioral willingness to allow the child self-direction in behavior rather than attempting to control the preadolescent’s behavior.

Child-Centered Play therapy – Landreth (2002) play therapy that has the philosophy that child-directed play is essential to children’s healthy development, where play gives concrete form and expression to children’s inner words, and where emotionally significant experiences are given meaningful expression.

Child Parent Relationship Therapy (CPRT) training – a 10-week filial therapy training that teaches parents the key skills of child-centered play therapy, such as reflecting feelings, returning responsibility, and crediting the child’s effort, helping the parent better understand the world of the child as viewed by the child. Parents learn how to create a non-judgmental, understanding, and accepting environment which enhances the parent/child relationship and facilitates personal growth and change for the parent and child (Landreth, 1991, 2002).
Child of focus – a child between the ages of 9 and 11 years of age chosen by the parent’s

Filial therapy – a unique relationship-based approach whereby professionals who are trained in play therapy help parents become therapeutic agents in their children’s lives (Landreth, 2002).

Communication of Acceptance - a subscale of the Porter Parental Acceptance Scale (PPAS) which provides a measurement of the adults’ verbal expression of acceptance-rejection of the preadolescent’s feelings and behavior in spontaneous play with the child (Porter, 1954).

Empathy – refers to parents’ sensitivity to their children’s feelings and to the parents’ ability to verbally communicate this understanding to their children and as measured by their total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, Guerney, & O’Connell, 1971). Secondarily, empathy can be described as the ability of an individual to identify emotions of others, taking the perspective of that other person and being able to communicate that understanding to the other person (Rogers, 1961).

Involvement – a subscale of the MEACI that is operationally defined as a measure of the adults’ attention to and participation in the preadolescent’s activities.

Loves Child Unconditionally – a subscale of the PPAS which is operationally defined as the love the parent shows toward a child without placing conditions or minimum standards on the preadolescent’s behavior in order to receive that love. For the purpose of this study, loves the preadolescent unconditionally (Porter, 1954).
Play Therapy: The Association of Play Therapy (2001) – states that "Play therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (p.20).

Porter Parental Acceptance Scale (PPAS) – developed by Blaine R. Porter in 1954 is a 40-item self-report inventory type questionnaire. The acceptance scale is designed to measure parental acceptance of children as revealed in the behavior and feelings parents express toward, with, or about their child. The PPAS involves four dimensions of acceptance: (a) respect for the child’s feelings and right to express them, (b) appreciation of the child’s uniqueness, (c) recognition of the child’s need for independence and autonomy, and (d) unconditional love.

Preadolescent – a child between the ages of 9 and 11 years old participating in Child Parent Relationship Therapy training.

Recognition of the Child’s Need for Autonomy and Independence – a subscale of the PPAS which describes the parents’ understanding of the preadolescent’s need to differentiate and separate from his parents in order to achieve his own identity (Porter, 1954).

Respect for the Child’s Feelings and Right to Express Them – a subscale of the PPAS that describes the parent’s willingness to allow the child to express feelings and to show acceptance for the child (Porter, 1954).

Measure of Empathy with Adult and Child Interactions (MEACI) – observational scale developed by Stover, B. Guerney, and O’Connell (1971) and modified by Bratton (1993) to operationally define empathy as related to adult-child interactions. Bratton (1993)
made modifications that involved the organizing of the content of the instrument into a form so it could be used to score videotapes for research purposes.

Limitations

A limitation of this study is the sheer numbers of required subjects. It will be necessary for the researcher to facilitate five to six training sessions per week for the 10-weeks required for Child Parent Relationship Therapy training. This may affect her effectiveness at training which may impact the experience of the experimental parent group. This may also create the potential for researcher bias. The researcher will make every attempt to address this by practicing self-care and seeking appropriate supervision and consultation as necessary for relief and assistance.

Another limitation may be the nature of the parents who choose to participate; it may be their willingness and motivation to participate in the training that is a factor in the results. That being said, the length of the training may also be a limitation that leads to attrition which may reduce the power in the analysis of results. The challenges associated with mixed methods design can be described in terms of representation, legitimation, integration, and politics (Onwuegbuzie & Johnson, 2006). Firstly, the challenge of representation refers to the difficulties researchers encounter in capturing lived experiences via their social texts (Denzin & Lincoln, 2005). This is intensified in the case of mixed methods as both the qualitative and quantitative components of studies bring their own unique limitations. Denzin and Lincoln (2005) further define the challenge of representation as the difficulty of capturing the lived experiences using text in general and words and numbers in particular. Onwuegbuzie & Johnson (2006) posit that the challenge of legitimation refers to the difficulty of obtaining credible, trustworthy, dependable, transferable, and/or confirmable findings and intern being able to make
inferences about those findings. In these terms Onwuegbuzie and Johnson (2006) suggest that
credibility in mixed methods research may be seen as a replacement term for internal validity,
transferability for external validity, dependability for reliability and conformability as a
replacement for objectivity. In these terms they suggest a shift in the paradigm to
reconceptualize the idea of how research or more specifically mixed methods research can be
legitimized or valid.

The concept of integration centers around the question of how much weight should be
placed on qualitative data as compared to quantitative data. This is to say how does the
researcher decide the best way to describe the relationship between the quantitative data and the
qualitative data or how best to relate the respective data to the other. Lastly, Onwuegbuzie and
Johnson (2006) describes politics as a challenge for mixed methods research as referring to the
difficulty of persuading consumers, including stakeholders and policy makers, to value the findings
stemming from both the qualitative and quantitative phases of a study.

Delimitations

This study included six parents with preadolescent children between the ages of 9-11
years of age who are attending 4th and 5th grade in two Western United States school districts.
Composition of the experimental group was not limited by age, gender or marital status. Both
the experimental parent group and the subsequent control group one consisted of three parents.
Control group parents were offered the filial therapy training at the conclusion of the training for
the experimental parent group. Interviews for both groups occurred at the convenience of the
individual parents. In phase I two of the interviews occurred in the home of the participants at
their request, two were conducted in the office of the researcher behind closed doors and with
confidentiality and comfort in mind, and one interview was conducted at the office of the
participant at her request. The office was a private office and the door was shut for confidentiality. The last interview of phase I occurred in the training room used for the CPRT training sessions with the door closed.

As a means of member checking during the interviews the researcher made several attempts during the interviews to check in with the participants by asking clarifying questions and reference to their statements in order to check for accuracy and decrease the incidence of incorrect data and the incorrect interpretation of data, with the goal representing the responses with authenticity (Creswell, 2007; Moustakas, 1994). As a further attempt at representing the sentiment and responses of the parent participants the researcher videotaped and transcribed each video.

Summary

There is a unique relationship between parents and their preadolescent child. A great many things are happening during this stage of development both, for the preadolescent and for the parent. The preadolescent child is struggling between a very real dependence on his parents while wishing for and working toward a new level of autonomy. This struggle is felt and often mirrored by the parent who is often trying to decipher when to expect independence from their child and when to accept dependence or vice versa.

While the processes are evolving in the areas of parent training and family mental health little has been done to address the developmental needs of children in the therapeutic process and the struggles of their parents. Even less has been done to address the unique needs of families with preadolescents. Other literature reviews have indicated a clear need for further outcome
research in the area of developmentally sensitive therapeutic interventions for preadolescents (Packman & Solt, 2004).

Whereas the research suggests that most parent trainings and family therapy interventions rely on verbal interactions and focus on problem solving, filial therapy provides a developmentally appropriate approach and focuses on the parent-child relationship and play/activities rather than at changing target behaviors. Preadolescents are on the cusp of developmental progress and an approach that can meet them where they are developmentally and assist parents in recognizing their unique needs may help smooth the transition and keep the parent-child relationship intact.
Chapter Two – Review of Literature

The following literature review provides a theoretical lens with which to frame the examination of Child Parent Relationship Therapy (CPRT, Landreth & Bratton, 2006) as an appropriate intervention program for parents with preadolescent children. The areas of exploration include (a) preadolescent development, (b) history of play therapy, (c) history of filial therapy, (d) Child and Parent Relationship Therapy, (e) efficacy of filial therapy.

Preadolescent Development

The developmental stage of preadolescence can generally be described as chaotic. Preadolescents are trying to navigate the road between adolescence and childhood—between dependence and independence. There are several ways to conceptualize development during preadolescence, as there are several components working. These components include socioemotional, psychosocial and cognitive development.

Socioemotional Development. The socioemotional stage of preadolescence is marked by an expansion of the preadolescent’s social world and how preadolescents begin to navigate these new experiences. In preadolescence, children begin to explore the notion that other people beyond their family, particularly their peers are influential in the way they think and act (Bratton & Ferebee, 1999; Packman & Solt, 2004). In preadolescence, children become more aware of, and are starting to be influenced more by, the opinions of other people beyond their family, particularly their peers (Bratton & Ferebee, 1999).

This awareness of others is needed to have meaningful relationships. Holder and Kirkpatrick (1991) commented on the fact that children with learning disabilities often have difficulty identifying emotions from facial expressions and other non-verbal cues, which
contributes to their social ineptitude. Learning the appropriate responses to social situations begins in the home and is fostered by early interactions with parents. This being said, even preadolescents with normal development are still learning to interpret the world outside familial interactions. By the period of preadolescence, children are generally able to be introspective about their own psychological functioning (Harter, 1983) in a consistent way (Weinberger, 1989).

Preadolescents are faced with increasing social context demands (Eccles, 1999; Rubin, Bukowski, & Parker, 1998). Even while they have achieved a great deal developmentally there is still a fluctuation in the needs of preadolescents and behaviors that goes back and forth between dependence and autonomy. Interpersonal competence problems in preadolescence have been shown to be associated with later adjustment difficulties (Estell, Farmer, Irvin et al., 2007; Farmer et al., 2004; Roeser, Eccles & Freedman-Doan, 1999). While they are exploring external relationships at this stage of development, it is still characterized by close family ties.

**Psychosocial Development.** The psychosocial development of children has been described by Erickson (1980), who identified eight stages of psychosocial development that greatly impacts the socioemotional world of the preadolescent child. The stages are not discreet, but unresolved issues in one stage can continue to pose challenges in the following stages. According to Erickson (1980), preadolescents operating in the stage of industry versus inferiority are categorized by having an increasing desire to broaden their world. Preadolescents begin to believe that they are what they learn and industry is manifested in the desire to make things (Erickson, 1980, Packman & Solt, 2004).
According to Erickson (1980), this stage of socioemotional growth can be characterized by the development of industry versus inferiority, which consists of learning the rules of society. While learning the rules of society does not eliminate feelings of inferiority, understanding and abiding by societal rules facilitates appropriate interactions with others because the preadolescents are becoming more aware that they are not singular entities (Packman & Solt, 2004). They either become industrious and learn the rules of society or perceive themselves as inferior. Failure at becoming industrious can create a great deal of anxiety and depression and can create a negative self-image (Packman, 2002). Even perceived failure can result in feelings of inferiority for the preadolescent child. Becoming industrious speaks to the preadolescent’s desire to be useful, to provide something and participate in decisions. It is important to be part of how problems are solved whether as part of the family unit, at school or in the preadolescent’s social interactions.

Cognitive Development. Piaget (1977) divided cognitive development into four stages. The sensorimotor phase extends from birth to 2 years old and is characterized by the movement from reflexive responses to goal-directed responses. In the preoperational stage, ages 2 to 7, children lack the concept of conservation or the ability to recognize that matter is the same regardless of what form it takes. The classic example uses a glass of water. Younger children do not recognize that the volume of water is the same no matter what shape or size the container is. Children at this stage of development rely on what they see to interpret their world. Furthermore, preoperational children can only think of one aspect of a problem and lack the capacity to verbalize difficulties. Instead, they act out their emotional stressors and their perception of the problem via play (Landreth, 1991). While preadolescents can exhibit more sophisticated cognitive abilities, they still process information differently and so it is important
for parents to understand that keeping in mind that their preadolescent is not a “little kid” but not yet nearly an adult. Developmentally, preadolescents are driven by their perceptions. What they see provides more information to their sensibilities than reality.

Piaget (1977) further explained that around the age of 7, children move from preoperational to the concrete operational stage of cognitive development. Typically, at this stage they have little problem with the concept of conservation and have mastered reversibility. Reversibility means they have the ability to understand that changing the appearance of the vessel does not change the volume of the liquid within (Gruber, Vonéche, & Piaget, 1977). They understand that if the action was reversed it would in fact be the same volume.

Children in the concrete operational stage respond to inferred reality, form concepts, and see relationships between object and situations. With this increased insight into concepts and movement toward abstract thinking, a child at the concrete operational stage can see the perspectives of others and move away from egocentrism (Packman, 2002). According to Kholberg, (1969) preadolescents are starting to empathize with other people’s experiences and consider others when making decisions. By understanding new views of the world and by expanding their perceptions, preadolescents have the capacity to reorganize their experiences.

By the time children reach preadolescence they have developed many skills and are competent in the area of language, motor and ego functioning, and are fairly competent in exploration beyond the family as they begin engaging in more complex interactions (Hartup, 1984; Maccoby, 1984). The issue of co-regulation and effortful control become evident during preadolescence as preadolescents strive toward autonomy from the family relationship even while they are not always sure how to go about it (Maccoby, 1984, Shulman, Collins, & Dital,
Preadolescents are continually renegotiating their roles and relationships (Bosacki, Elliot, Bajovic, & Akseer, 2009).

**Preadolescent Development and Parental Interactions**

A growing body of research on cognitive development indicates strong links between the quality of parent-child interactions which have been seen as predictive of a variety of intellectual outcomes including IQ, specific cognitive abilities and aptitude (Baumrind, 1973; Bing 1963; Estrada, Arsenio, Hess, & Halloway, 1987; Hess, Holloway, Dickson, & Price, 1984; Hess & McDevitt, 1984; Radin, 1972). The connection between parent interactions and a child’s development are becoming increasingly understood. This is especially true during preadolescence. Parental discord effects children’s cognitive development as well (Feldman & Wentzel, 1990).

Montemayor, Adams, & Gulotta (1990) suggested that as autonomy begins to become salient in preadolescence it may be frustrating for a child to go up against a parent coalition that dominates cooperative problem solving. That is to say that if parents consistently oversee problem solving without considering the perspective and input of the preadolescent it may cause the preadolescent to act out or withdraw. It is important for the preadolescent to be an active part of the problem-solving process to the extent that it is developmentally appropriate to the situation.

It will be important for parents to become more flexible in regard to their perception of their preadolescent’s increasing desire toward autonomy, detachment, self-reliance, and task-persistence (Shulman et al., 1993). Preadolescent children tend to act out or withdraw when parents allow for independence in certain situations then relinquish independence by regulating
the child in situations where preadolescents feel like they are competent or in control. Parental insensitivity to the preadolescent’s developmental needs and growing sense of autonomy will impede the relationship and create interaction problems. Preadolescents’ perceptions of parental attitude are at least as important as the actual sentiment of the parent’s behavior or words. Therefore it is important that genuine empathy and acceptance be conveyed in a way that can be accurately perceived by the preadolescent.

**History of Play Therapy and Child-Centered Play Therapy**

Anna Freud (1928) and Melanie Klein (1932) were the first who are generally acknowledged as the originators of play therapy in lieu of talk therapy for children (Bratton Ray, Rhine, & Jones, 2005). In 1955, with the use of play materials to induce catharsis, Hambidge (1955), marked the next expanse toward play therapy. Axline (1947), a student of Carl Rogers, used play therapy and applied a non-directive therapeutic approach in her work with children. Her work is considered a significant development because of the natural mode of expression and her inherent trust in children’s capacity to resolve their own problems through their play (Bratton et al., 2005). Many studies built on Axline’s work and contributed to the acceptance of play therapy as it is currently recognized and as a result are credited with the development of play therapy (Ginott, 1961; Guerney, 1983; Kottman, 2003; Moustakas, 1953, 1997; Landreth, 2002; O’Connor, 2000).

Child-Centered Play Therapy (CCPT), (Johnson & Chuck, 2001; Landreth, 2002; Ray Blanco, Sullivan & Holliman, 2009) is a humanistic approach that relies on an empathetic relationship between the therapist and the child. CCPT has been researched across many modalities and with several populations: with preadolescents with learning disabilities (Axline,
1949; Mundy, 1957; Packman, 2002); socially maladjusted children (Schmidtchen & Hobrucker, 1978; Thombs & Muro, 1973); children who exhibit withdrawn or depressed behavior (Clement & Milne, 1967; Dogra & Veeraraghevan, 1994; Johson & Nelson, 1978); children with anxiety and fear (Burroughs, Wagner, & Johnson, 1997; Schmidtchen & Hobrucker, 1978). Child Centered Play Therapy has also been found to address and reduce aggressive behavior because of the relationship that is built between therapist and child. This relationship works to increase the child’s expression of empathy through his use of play (Ray et al., 2009; Trotter, Eshelman & Landreth, 2003). The empathic relationship inherent to CCPT is the key to resolution of aggressive behaviors (Ray et al., 2009; Trotter et al., 2003).

The humanistic/non-directive approach has demonstrated a large effect size of up to .93 as compared to .75 for all other approaches, including cognitive/behavioral approaches this implies that the child-centered approach, which aims to create and enhance a therapeutic relationship rather than problem solve, had a greater impact on the child’s outcomes (Ray, Bratton & Rhine, 2001). Large effect sizes were found across modalities, age and gender, clinical and non-clinical populations. Two main factors seemed to increase its effectiveness - parent involvement and duration of sessions (Ray et al., 2001). Parental involvement was also a significant predictor of successful play therapy outcome ($p = .008$) especially in filial cases when parents had direct involvement (Ray et al., 2001).

Significance of Play Therapy.

Research has shown that interventions like group play therapy, play therapy or filial therapy can impact the emotional well-being of preadolescent children as a preventative measure aimed at addressing interactions and relationships. Minuchen (1995) highlighted the importance
of considering developmental issues in the application of family systems theory. Intervening at this stage of development may impact future development and interactions as these children enter middle school and beyond. Helping preadolescents gain an emotional language may help them in their transition to adolescence. Assimilation through play for an older child involves an emerging awareness of thought processes that correlate with significant change (Wilson & Ryan, 2005; Robinson, 2001). This is especially important when creating the play activities for parents and children participating in filial therapy.

Play therapy provides children with a developmentally appropriate and comfortable means of expressing feelings and experiences (Bratton & Ferebee, 1999; Ginot, 1975; Landreth, 1991; Packman & Solt, 2004; Schiffer, 1969; Slavson, 1945). Play therapy is most effective when the practitioner or play therapist has a solid developmental understanding of children (Ray, Muro, & Schumann, 2004). This is because such an understanding allows the play therapist to effectively assist the child and the developmental stage the child happens to be in. This further assists the play therapist to align their expectations more appropriately to the child’s developmental capabilities.

Because the children who have not yet reached concrete operations and because they are more apt to behave thoughts and feelings rather than speak them, play is useful in helping them express themselves. Words are abstractions. When teaching children to speak, anchoring the abstraction (words) in the concrete (objects) facilitates the process of learning. Using this principal, toys are substitutes for words. This will help assist the child in progressive development (Ray et al., 2004). Landreth (2002) suggests that toys are children’s words and play is their language. He goes on to say that a child’s play may contain more meaningful content than words and it is the job of the observer (play therapist) to find this meaning, embrace it and
help communicate it to the child so the child can gain understanding of it feeling acceptance and empathy (Landreth, 2002; Ray, 2004).

For children, emotional experiences are safely and comfortably expressed through symbols and representation (Landreth, 2002). As has been previously mentioned play is a child’s language and toys their words. By extension, the symbols and representation of the child’s thoughts and emotions create a safe way for the child to communicate and effectively deal with these thoughts and emotions. Thus, play and play therapy provide adults with a way to see those experiences from the perspective of the child and communicates understanding in a developmentally appropriate way (Landreth, 2002). The child knowing, that he is accepted and understood, can experience feelings safely rather than be afraid or unclear about them. In so doing, the child can regain responsibility and a sense of empowerment over those feelings.

The idea that the play therapist genuinely believes the child is capable of figuring things out commensurate to their developmental capabilities is key. The accepted founders of play therapy including suggest a play-based process of specific set of skills both non-verbal and verbal aimed at addressing the therapeutic needs of children (Axline, 1947; Guerney, 1983; Kottman, 2003; Landreth, 2002; Moustakas, 1997; O’Connor, 2000). Non-verbal skills are described as leaning forward, appearing interested, seeming comfortable, applying a tone congruent with the child’s affect, and applying a tone congruent with the therapist’s response (Ray, 2004). Verbal skills include the ability to deliver quality verbal responses, to track the child’s behavior, reflect content and emotion, facilitate decision-making, creativity, and esteem building. All of these skills are aimed at facilitating a safe and accepting relationship (Landreth, 2002; Ray, 2004).
Therefore, the non-verbal skills of the play therapist are an essential part of the process. Leaning forward, appearing interested and seeming comfortable set the stage for the child to understand the play therapist is engaged and focused strictly on the child’s activity and needs. The processes of play therapy provide preadolescents with both verbal and nonverbal means to develop relationships and to work toward resolving conflicts. (Bratton & Ferebee, 1999; Ginott, 1961; Kottman, Strother, & Deniger, 1987; Packman & Solt, 2004; Schiffer, 1952; Slaveson, 1945).

Being present, being focused on the child and his experiences in the play room, is essential for the child as he may not have experienced such a thing in an interaction with another adult. The tone of the therapist is best served when it matches the affect of the child. This is to say that a therapist may be inclined to be over animated in his desire to help the child have fun. A more appropriate and genuine approach would be to truly mirror the child’s level of activity and affect and follow the highs and lows of the activity as directed by the child (Ray, 2004).

According to Ray (2004) the verbal skills that the therapist should maintain are succinct interactive responses with an appropriate rate of response that matches the flow of the child’s play. Tracking is an important and basic skill of the play therapist. Like the non-verbal skills that convey presence, tracking the child’s activity correctly helps them to know the play therapist is actively engaged, interested and accepting of them (Landreth, 2002; Ray, 2004). Reflecting content validates how the child perceives his experience and may clarify the child’s understanding of himself (Ray, 2004). A deeper reflection, such as “reflecting the feeling”, opens the door for the child to understand and gain an emotional language for future interactions or deeper personal understanding (Landreth, 2002; Ray, 2004).
The job of the play therapist is not to problem-solve or direct the play of the child. Rather, it is to facilitate decision-making and return responsibility to the child. Allowing the child to do for himself, problem solve, or make decisions helps the child learn empowerment by way of experience (Ray, 2004). It is very rare that children have any real part in making decisions that are important to them. Play therapy provides such a situation. When the play therapist is open to the creativity and expression of the child, the child becomes responsible for his own choices (Ray, 2004; Landreth, 2002). The essential function of play in play therapy is the changing of what is unmanageable for the child in reality to manageable situations through symbolic representation that provides the child with learning opportunities that will enable coping mechanisms through self-directed exploration (Landreth, 2002). Regardless of the reason for referral, the play therapist has the opportunity to enter the child’s world through the child’s experiences, actively dealing with issues the child brings to therapy (Ray, 2004). The play therapist understands that the child will engage in activities that help him express his thoughts, needs and emotions so the play therapist lets the child drive the interactions.

The play therapist assists the child in building self-esteem by encouraging the child to feel better about himself using phrases like “You knew just how to make that work” or “You worked really hard on that” (Ray, 2004). Validating the child’s efforts rather than conditionally praising the child helps the child gain an internal locus of control and move toward self-efficacy which is not dependent on external motivations. The last of the basic skills of play therapy is the facilitation of the relationship by using relational responses (Ray, 2004). Relational responses are responses that express to the child how much the therapist cares about and values the child.

While the above play therapy skills are essential, another skill that enables the freedom inherent to the play room is the ability of the play therapist to set appropriate limits.
Communicating sensitivity, understanding and acceptance conveys freedom and responsibility because the child starts to understand himself and his own boundaries in a way that he can take genuine ownership of his actions and responses as they relate to social and personal relevance (Landreth, 2002). It is continually noted in the literature that children need boundaries- they need to know the rules to feel safe, valued and accepted (Landreth, 2002; Landreth & Bratton, 2006). When the relationship or interaction is inconsistent and without boundaries or predictability the child cannot get his bearings and my act out as he searches for what is or isn’t acceptable.

Play therapy limits need to be predictable and necessary. Landreth and Sweeney (1997) suggest that limits should only be set in situations when a child’s behavior is dangerous or harmful to himself or others or it is disruptive to the play room environment, socially unacceptable or revolves around inappropriate displays of affection. Play therapists should be reasonable, rational, consistent, comfortable and unconditionally accepting when setting realistic, neutral and only necessary limits (Axline, 1969; Bixler, 1949; Guerney, 1983; Landreth, 2002). Limits should never be punitive.

Play therapy is not only an intervention but can also be preventive in nature (Ray, Muro, & Schumann, 2004). Benson (2002) reported that group play therapy facilitates a child’s sense of universalism while at the same time promoting interdependence and social skills, which are a strong factor of resiliency for overcoming aversive life events. Packman (2002) and Liles (2009) have explored the processes of group play/activity therapy. Improvement was shown in children with learning disabilities and freshmen success in high school respectively.

Play Materials and the Importance of Play
Play materials and activities are used to facilitate the development of a therapeutic relationship with children in a non-threatening environment (Packman & Solt, 2004). The materials in the playroom can be described in the following ways:

1. Nurturing toys: baby dolls, kitchen items, medical kit
2. Aggressive toys: handcuffs, punching bag, toy soldiers, aggressive puppets
3. Communication toys: balls, a soft bat, telephone
4. Mastery toys: chalk and chalk board, Velcro darts, school supplies, blocks (Landreth, 2002).

Toys should lend themselves to the objective of play and align with the rationale of play therapy (Bratton et al., 2011). They should also be culturally sensitive to the experience of the child. Toys should facilitate (a) a positive relationship with the child; (b) the expression of a wide range of feelings; (c) should encourage exploration of real experiences; (d) allow for the testing of limits; (e) allow for an experience of a positive self-image; and (f) should foster self-understanding for the child to redirect behavior that is unacceptable to others (Landreth, 2002).

This arrangement of toys should follow the precepts of play therapy with younger children but with a consideration of the transitional period of preadolescents. Preadolescents should still have the opportunity to play without feeling like they are being treated like “little kids”. Proven interventions that are developmentally appropriate and that target the emotional, social, and behavioral needs of children and families are critical (Packman, 2002). Play allows children to extend themselves into areas they would have difficulty entering verbally (Landreth, 2002). As noted in the literature, the child will likely spend more time engaged in non-verbal exploration of play. Additionally, the child will likely feel more comfortable with non-verbal
interaction and it is important for the play therapist to be able to mirror the child’s affect in an air of joining and acceptance.

Activity Therapy

Even though preadolescent children have gained a great deal of cognitive and psychosocial ground, they are still in a developmental gray area between childhood and adolescence. For this reason, because preadolescents do not reason like adolescents or adults preadolescents and can benefit greatly from participating in activity therapy which does not rely on verbal communication, but does allow for developmentally appropriate interactions (Bratton & Ferebee, 1999). Slavson (1944) developed group activity therapy for preadolescents, advocating that the transition characterized by this stage of development could be fostered by an expansion of their interactive experiences.

Gladding (2005) suggested that the use of expressive arts as a therapeutic intervention offers a nonthreatening symbolic means of exploration to engage in self-awareness. Expressive modalities can engage preadolescents in self-expression, active participation, imagination, and mind-body connection (Malchiodi, 2005). Expressive activities facilitate the process of creative self-development which can be sustained long after termination of treatment while providing preadolescents with inner resources to draw on and then be better able to handle future challenges (Rubin, 1984).

The results of Packman and Bratton (2003) suggested that preadolescents who participated in a 12 week group play therapy program which employed structured and unstructured expressive activities such as collages, drawing, clay, sandtry, and puppetry saw a significant reduction in total problem and internalizing problem behaviors. As preadolescents learn to assume responsibility in interpersonal relationships they are able to transfer such
learning to interactions outside of the group (Landreth, 2002). Additionally, it is important to keep in mind, preadolescents will not process expressive activities as long or with as much depth of thought or emotion as adults because their abstract thought process is not fully developed (Bratton, Ceballos, Ferebee, 2009).

*Play Therapy with Preadolescent Children*

Working with preadolescent children in the play room requires a few adjustments to both the approach and the play materials. A major argument for modifying the play room activities and toys is that preadolescents might find the toys of a conventional playroom juvenile (Ginott, 1961, 1994; Packman & Bratton, 2003). It is suggested that the need for specialized treatment for preadolescents, one that provides a setting and activities consistent with their developmental needs is essential to the progress of play and filial therapy (Bratton & Ferebee, 1999; Krall & Irvin, 1973; Schiffer, 1969).

Preadolescent socio-emotional growth is dependent on development of industry over inferiority (Erickson, 1980). Play therapy helps to bridge the gap between concrete and abstract verbalization (Ginott, 1961). With a new understanding of himself the preadolescent child can choose to modify his behavior in order to engage fully in new relationships even outside the play room environment. The approach takes a special interest in the very specific developmental needs of any child. Preadolescents are in a sort of developmental holding pattern, stuck between childhood and adolescence. Therefore, the language used, the materials provided, and the activities selected must be developmentally sensitive to the age group. This is important as it will address this struggle between dependency and a striving toward cognitive, psychological, moral and physical independence, (Packman, 2002).
Preadolescent children will benefit from being accepted and understood as they struggle toward greater independence (Packman & Solt, 2004). Preadolescents are able to reason logically and organize thoughts coherently, manipulate ideas and accept logical society rules (Ray, 2004). At this stage preadolescents are still however, unable to navigate abstract reasoning or express complex emotions. Play helps bridge the gap between concrete experiences and abstract thought for children in the concrete stage (Piaget, 1959, 1962; as referenced in Ray, 2004; Rennie & Landreth, 2000).

Play therapy as a preventive approach, not simply as an intervention has helped to identify symptoms early and the use of developmentally appropriate interventions provides information for professionals and parents making it possible for them to be a catalyst in assisting the child in a lifetime of meaningful interactions (Packman & Bratton, 2003). Within an environment of acceptance and safety, like the one fostered in play therapy, the preadolescent is more apt to tap into his innate capabilities for growth and change. While preadolescents are hovering on the cusp of the ability for greater abstract thought, they may still not be ready for traditional talk therapy which makes play therapy an important and appropriate segue for intervention as it allows for flexibility; the preadolescent can play or talk or play and talk.

*History of Filial Therapy*

Filial therapy was developed as a new and innovative method of treating emotionally disturbed children, 10 years of age and younger, by Guerney, and his colleagues (Guerney, 1964; Geurney, Guerney, & Andronico, 1966; Stover & Guerney, 1967). This approach uses parents as the therapeutic agents and the professional functions in the role of therapist-educator. Traditionally, psychiatric services have focused on the child as the problem, while parents are
seen separately by another therapist, if at all. Filial therapy broadens the “help” net when parents can act as the agents for therapeutic change. This can be ongoing therapy for both the child and the parent, something that would not be feasible or even appropriate for traditional forms of therapy (Ginsberg, 1976). Filial therapy has as its basic model client-centered play therapy (Axline, 1969; Rogers, 1951). Filial therapy employs the skills of play therapy. In an accepting environment, preadolescents explore and role play which has been shown to generalize from multiple interactions.

Bernard and Louise Guerney were the first to develop a training model for parents to develop child-centered play therapy skills for use with their own children (Bratton et al., 2005; Guerney, 2000) and Landreth (1991, 2002) condensed the Guerneys’ filial therapy training to a 10-week protocol as a means for making the process a bit more accessible to parents. He introduced this time-limited structured filial therapy training and formalized it as Child Parent Relationship Therapy (CPRT) (Landreth & Bratton, 2006; Landreth et al., 2000) and as a treatment model (Bratton, Landreth, Kellam, & Blackard, 2006). The use of CPRT has been researched in school settings as one component of a comprehensive program to address mental health in children by encouraging involvement of parents and teachers (Baggerly & Landreth, 2001; Hekler, 2007; Jones & Landreth, 2002; Kale & Landreth, 1999; Landreth et al., 2009; Morrison, 2007; Smith & Landreth, 2004).

Filial/family play therapy is a method by which both parents and children can receive help and move toward healthier relationships. And the need for a developmentally appropriate intervention, which filial therapy is by nature, opens the possibilities for parents with preadolescents. The nature of the parent-child relationship is of primary importance to the present and future mental health of children (Ray, Bratton, & Brandt, 2000) along with the
increase of empathic responding and unconditional acceptance. Stover, Guerney, and O’Connell (1971) indicated that developing high levels of empathy was critical to the success of filial parent training and imperative in impacting significant changes in child behavior. Parental acceptance is a core element in the expression of parental empathy which is another condition fostered by filial parent training which facilitates a child’s development of positive worth (Bratton & Landreth, 1995; Harris & Landreth, 1997; Rennie & Landreth, 2000).

A sentiment found in the literature is that often times the family therapy movement, which views the child only as the identified patient with the problems residing in the larger context of the family does not take a systemic or organic approach to the problem. Filial therapy adds significantly to the services that a community of mental health can offer because it focuses on present-day functioning and its improvement and enhancement (Ginsberg, 1976). As such, filial therapy directs itself to the teaching of skills to parents to change present pathological patterns, as well as provide skills for the future (Ray, Bratton, & Brandt, 2000). Filial therapy is a relationship-oriented model. The “client” is the parent-child relationship, not the child or the parenting.

Play therapy and filial therapy have in their foundation the means to help children experience, name and master their own feelings. These feelings are accepted and acknowledged by the therapist or parent respectively. Filial therapy literature suggests that the most significant other, in the world of a child is its parent and uses the power of that interaction to create profound and sustainable change to the relationship as well as the perceptions of both the parent and the child. Filial therapy training takes place in a support group format where parents learn basic child-centered play therapy principles and skills for use with their children in special weekly play sessions (Guerney, 1977; Guerney & Guerney, 1989).
The combination of didactic instruction, coupled with supervision in a supportive atmosphere, provides a dynamic process that sets filial therapy training apart from other parent training programs, the majority of which are exclusively educational in nature. Strategies and experiences in the playroom tend to externalize and generalize outside the playroom to “real world” situations and interactions. When the child sees that they “can” in the playroom or in the case of filial therapy in the play session, they find that they “can” in expanded settings and situations (Landreth & Bratton, 2006).

Significance of parents as agents for change for their own children

Filial therapy as described in the literature is founded on the notion that parents as change agents are stronger influences for children because of the level of relationship that already exist between parent and child (Bratton et al., 2006; Guerney, 2000; Landreth, 2002, Landreth & Bratton, 2006). The crux of play therapy is that the therapist creates an environment of acceptance for the child and an air of permissiveness so the child can explore the play room and his own emotions. Having parents in this role puts them at an advantage as they have already established relationship. All that is left is providing them the skills of play therapy. Filial therapy is an extension of play therapy in which parents learn to duplicate some of the behaviors of the child-centered play therapist (Guerney, 1976). The parent serves as the primary change agent under the supervision of a professional after being trained in play therapy skills and child-socializing skills (Guerney et al., 1985)

The filial therapy training groups are dynamic and didactic, providing an opportunity for parents to discuss their feelings and to receive support and encouragement of other group members (Andronico, Fidler, Guerney, & Guerney, 1967). Role playing, demonstration,
homework, and supervision are all part of the structure. Group dynamics become a major factor in the effectiveness of a filial therapy group (Bratton et al., 2006). The unique element in filial therapy and especially Child Parent Relationship Therapy training (CPRT) (Landreth & Bratton, 2006; Landreth et al., 2000) is the participation of the parent in structured weekly play sessions with the child. Several research studies using Landreth’s 10-week program have shown this time-limited approach to be highly effective with a variety of populations (Bratton & Landreth, 1995; Glass 1986; Glover, 1996; Harris 1995; Lobaugh, 1991).

The most effective parent training programs are found to be those which are group based and behaviorally oriented (Barlow, 1997), providing parents with both education from therapists in how to manage their children’s behavior and emotional support from group peers. This is exactly the format for CPRT filial therapy training. Comparisons of filial therapy to other play therapy modalities or control groups, consistently found increases in the quality of parent-child relationships, enhancement of parenting skills, and decreases in the child’s problem behaviors when filial therapy was the treatment modality (Landreth & Bratton, 2005).

The play session provides the parent with a practical situation in which to view the child’s problems and reactions and the parent’s problem and reactions (Geurney et al., 1970). Guernsey (1979) described the typical course of events in the play sessions as: “moving from negative feelings toward the self and others to positive feelings, from dependence toward independence, from impaired impulse control to acquisition of greater self-regulation” (p. 244). Both parent and child gain skills of interaction in the play session. Filial therapy is part parenting education, part interactive because parents and children are involved in weekly play sessions with parents (Guerney, et al., 1985). Also important during the learning process for the parents is learning a feeling vocabulary they can then teach their child during the play sessions, learning
also to the power and importance of play in the lives of children. Lastly, learning what is appropriate to the age and development of children will assist the parent in engaging in play that or having expectations that match the child’s individual developmental level.

**Efficacy of Filial Therapy**

There are many studies that show the efficacy of filial therapy and the ability of the process to help parents gain empathic understanding with their children by developing empathy and acceptance (Bratton et al., 2005; Landreth, 1991; Landreth & Bratton, 2006; Topham & VanFleet, 2011; VanFleet, 1994; Watts & Broaddus, 2002). These studies span many populations and situations, including homeless families (Kolos, Green, & Crenshaw, 2009); with parents who have children with severe behavior problems (Rennie & Landreth, 2000); parents of children in other cultures and single parents (Bratton & Landreth, 2009; Edwards, Ladner, & White, 2007; Guo, 2005); parents who have children with chronic illness (Waldman, Zimmerman, & Landreth, 1992); and young children (Topham & VanFleet, 2011). The effectiveness of filial therapy has also been documented by using both quantitative and qualitative research paradigms (Baggerly & Bratton, 2010; Bratton et al., 2005; Foley, Higdon, & White, 2006; Glazer & Stein, 2010).

The foundation of filial therapy and child-centered play therapy is the presence and practice of empathy (Landreth, 1991; Rogers, 1989). The extent to which one can understand and know the experience of another person and be able to communicate that understanding is paramount to the process of filial therapy. When parents develop a working empathic language they begin to understand the world of their child thereby creating change without directly addressing behavior (Landreth, 1991). Landreth (2000) further identified filial therapy as an
effective approach to supporting parental empathy, acceptance, self-esteem, diminished parental stress, and the development of more cohesive family characteristics. The success of filial therapy is predicated on the belief that parents are more effective therapeutic change agents than mental health professionals (Guerney, 1964). This is largely speculated to be true because of the relationship inherent in the parent child relationship.

Filial therapy is designed to impart knowledge and skills in dealing with children that will help parents create an optimal growth atmosphere in the family (Guerney, 1976) this is accomplished by teaching parents the facilitative conditions of empathy, genuineness, and positive regard (Levant, 1983). They are further taught the elements of play therapy and develop skills in reflecting feelings, in becoming accepting of their child’s feelings, and in setting limits on the child’s behavior in a caring and non-punitive fashion (Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Levant, 1983). Filial therapy can be a strategy for relationship building while teaching the parent(s) skills in communication, discipline, and enhancing self-esteem. Filial therapy’s strength lies in the direct involvement of the parent and the child by enhancing the relationship between parent and child. It can help both parents and children cope with life’s transitions (Glazer & Kottman, 1994).

Filial therapy succeeds in training parents to acquire reflective listening skills, to allow children self-direction, to demonstrate involvement in children’s emotional expression and behavior, and to maintain these skills for up to six months (Guerney & Stover, 1971) while positive changes do sustain themselves in the long term (Sensue, 1981). It increases measures of parents’ empathy toward and acceptance of their children (Lobaugh, 1992; Lobaugh & Landreth, 1998), decreases parents’ reports of problem behaviors in their children (Bratton & Landreth, 1995; Sywulak, 1977), improves children’s feelings of self-confidence (Bratton & Landreth,
1995), increases children’s expression of emotions (Glass, 1986). This finding, coupled with the reduction in parenting stress scores (Bratton, 1994; Bratton & Landreth, 1995; Logaugh, 1992), and indicates that filial therapy can enable parents to become better equipped to handle a range of emotional expressions in their children, while gaining personal emotional regulation as well (Johnson, 1995).

Ray and Bratton (2000) reported 7.1 years of age as the mean age of the majority of play therapy research with the greatest number of the studies focusing on children under the age of ten. Additionally, interventions tend to focus on cognitive-behavioral and directive approaches (Ray & Bratton, 2000). This is also reflected in the research on parent-child interactions. Typically the research has centered on addressing challenging behaviors of the children rather than examining the parent-child relationship (Gavita & Joyce, 2008). Family therapy has been focused on younger children or adolescents; little has been explored with the preadolescent population. Filial research suggests that parents may gain a better developmental idea about their child and their child will experience having their specific needs (cognitive and social-emotional) as being met appropriately.

One of the reasons filial therapy, as a process of play therapy where parents are the change agents, is impactful is in the development of therapeutic skills such as, empathic responding and the allowance of interactions and play to be child directed. This will enhance the interactions and enable growth in the relationship (Landreth, 2002). In the case of filial therapy, when a parent can learn to believe the child is capable of figuring things out to their developmental ability, there can be lasting positive effects on the parent-child relationship (Landreth, 2002). Regardless of whether it is a play therapist or parent, the relationship can
grow when the expectations of the adult matches the abilities of the child and the adult can communicate acceptance and understanding.

According to VanFleet (1994) filial therapy can be used for healthy and unhealthy families alike. Healthy families can benefit from filial therapy as a preventive means for strengthening their interactions even when they are not encountering any significant difficulties. In other words, something does not have to be wrong for filial therapy to improve parent-child interactions, increase parental empathy and acceptance, and enhance parent-child relationships.

Guerney (1976) suggests that the establishment and maintenance of an optimal relationship between parents and their children must include the following objectives of filial therapy:

1. To enhance the emotional and interpersonal development of children
2. To impart knowledge and interpersonal skills in dealing with children that will help them create an optima growth atmosphere in the family
3. To train the parent(s) in such a way that the skills become a permanent part of behavior so that consolidation and growth continue after the end of the program
4. To help the parent(s) identify and act appropriately on their own needs in relationship to their children
5. The promotion of the parent-child relationship with the goal of creating a more harmonious and mutually satisfying relationship between parent and child (Guerney, Guerney, & Cooney, 1985).

Furthermore, it is suggested that parent’s warmth and their ability to express that warmth in response to a child’s expression of emotion and accurately labeling those expressions leads to
a child’s ability to respond with appropriate empathy (Dix, 1991, Dunn & Brown, 1994; Zahn Wexler, 1991). This is a skill gained and an aim of filial therapy training for parents. The crux of play therapy is that the therapist creates an environment of acceptance for the child and an air of permissiveness so the child can explore the play room and his own emotions, having parents in this role, puts them at an advantage having already established a relationship. All that is left is providing them the skills of play therapy and that is the cornerstone of filial therapy training.

While some studies have reported the use of parents as therapists with their own children, most are in the area of behavioral modification (Furman & Feighner, 1973; Staughan, 1964). Filial therapy is somewhat separate from these approaches as it stresses the improvement of the parent-child relationship as the therapeutic variable, though behavior modification concepts can and often do enter into the treatment (Landreth, 2002). The idea is that relationship enhancement equals behavior change rather than a behavioral change creating relationship enhancement. Focusing on the relationship, is a focus on the interaction between the parent and child not on the child’s behavior so the family can get out of the rhythm of poor interaction patterns making it possible to sustained effective changes (Ginsberg, 1976). Filial therapy is an intervention that has repeatedly been shown to be effective in reducing parenting stress, empowering parents, enhancing parent-child relationships, and ameliorating children’s behavioral and adjustment problems (Ray, Bratton, & Brandt, 2000).

If the parent can be taught to execute the essentials of play therapy, the parent could conceivably be more effective than a therapist because of the already existing and presumably stable relationship (Guerney et al., 1970). Because the interaction is performed in a natural environment with a trusted adult the relationship already intact, will not impede expedited progress. Changing the way the parent and child interact together may also generalize outside
their special play sessions becoming part of their behavior set in other settings (Glazer-Waldman et al., 1992). One objective is that the skills will become an integral part of the behavior of the parents and the behaviors will generalize from the play sessions to daily living and will continue after the parent-child play sessions terminate (Guerney, 1976).

Beyond the improvements in the parent-child relationship, couples have reported improved parent-child communication, improved partner communication, and improved child behavior (Bavin-Hoffman, 1994; Bavin-Hoffman, Jennings, & Landreth, 1996,); and even with others outside the family as a result of filial therapy (Lahti, 1992). Further improvements include, improved interpersonal boundaries, more differentiated relating between family members, an increase in communication, increased acceptance, understanding, and empathy, and more realistic and flexible expectations of children (Lahti, 1992; Wineck et al., 2003).

Modification of filial therapy for preadolescent children

It was first suggested by Slavson (1945) that there is a need for a specialized treatment for preadolescents, one that provides a setting and activities consistent with the developmental needs of this age group (Bratton & Ferebee, 2009; Krall & Irvin, 1973; Packman & Solt, 2004; Schiffer, 1969). Therapeutic goals for children include a reduction of symptoms, increased self-worth and confidence, and a more positive perception of their parents. This is important for preadolescent children given the dependence/independence struggle. Parents learn to better interpret their child’s needs, abilities and developmental struggles.

Landreth (2002) maintained that because play is developmentally appropriate as a medium of communication and expression for children, the incorporation of special toy kits enable parents to relate to the child at the child’s level which is a specific consideration for this
proposed research and an important consideration as to the toys and activities presented to the preadolescent population. Landreth (2000) further concluded that while filial therapy does support parenting power it is also an effective intervention for supporting the adjustment and self-concept of children whereby he discovered a diminishing in behavior problems.

Following are suggested modifications for play/activity therapy materials for play kits for preadolescents:

1. Nurturing toys: dolls, medical kit, kitchen items
2. Aggressive toys: handcuffs, toy soldiers
3. Toys of social life: people, police, cars, paper money
4. Communication toys: phone
5. Mastery toys: balls, paper, paint, play dough, chalk and chalk board, scissors, pens

Broad therapeutic goals for parents include a greater understanding and acceptance of their child’s emotional world, the development of more realistic and tolerant perceptions and attitudes towards both themselves and their children the development of more effective parenting skills based on developmentally appropriate strategies, a reduction of parental stress, and, last but not least, assistance for parents in recapturing the “magic” of parenting (Ray, Bratton, & Brandt, 2000).

Traditional filial therapy models (Guerney, 1976; Landreth, 2002; VanFleet, 1994) and the Parent Adolescent Relationship Developmental Model (Ginsberg, 1997), address the unique developmental needs of children and adolescents respectively, but preadolescents are a unique population and require a different approach to their developmental needs. Filial therapy
interventions with parents with children who are preadolescents will help parents gain a better awareness of what is developmentally appropriate both emotionally and behaviorally. This phase of development is minimally researched in the filial therapy literature but with this type of intervention parent expectations and perceptions can be better aligned and realistic. While preadolescents desire to be independent and self-reliant in some circumstances, they also tend to engage in childhood play and express dependency on parents. Because of the characteristics of this developmental phase, parents often struggle in determining how they should go about relating, disciplining, and caring for their preadolescent (Packman & Solt, 2004). They may also find it difficult to understand how they should be “playing” with their preadolescent.

Little research exists on the therapeutic use of play and activity therapy with preadolescent children (10-12 years of age), individually or in groups the same seems true in regard to filial therapy research (Packman & Solt, 2004). It is critical to establish proven interventions that are developmentally appropriate and that target the emotional, social, and behavioral needs of children and families. A shortage of mental health professionals who work with children and families makes it impossible to provide direct services for all who would benefit from them (VandenBos & DeLeon, 1988).

Overview: Rogerian Person-Centered Theory

Rogerian Person-Centered Theory in counseling is based on enhancing the relationship between the therapist and their client in order for the client to find a safe, accepting place to generate personal growth (Rogers, 1989, Sharf, 2004). The strength of filial therapy lies in the gaining of understanding about the importance of the relationship along with a greater understanding of the emotional precursors to behavior (Watts & Broaddus, 2002; Landreth, 1991).
Filial therapy was essentially founded by Bernard and Louise Guerney in the early 1960s with close ties to the practice of play therapy (Landreth & Bratton, 2006). Building on the work of the Guerneys (2000), Landreth developed a more condensed, 10-session parent training format based on his observations that time and money availability may be a concern for parents who would otherwise participate in a longer parent training (Landreth & Bratton, 2006). For this reason, Landreth and Bratton (2005) created a 10-session training format calling it Child Parent Relationship Therapy (CPRT) (Landreth & Bratton, 2006).

The tenants of person-centered theory are present in the processes of filial therapy making it an appropriate fit for this investigation. Rogerian person-centered theory was founded by Carl Rogers (Rogers, 1989; Sharf, 2004) and provided a foundation to his psychotherapeutic practice. Rogers was directly influenced by Otto Rank for his thoughts about non-directive psychotherapy (Sharf, 2004). Sharf (2004) describes the development of Rogerian Person-Centered therapy as developing across four stages. The four stages include: the developmental stage; which describe Roger’s early professional life, the non-directive stage; marked the start of theoretical development where he shifted his emphasis to understanding the client and communicating that understanding, the client-centered/theoretical stage; the beginning of theoretical development of personality and psychotherapeutic change with a continued focus on the person rather than on technique, and finally the person-centered stage; marked by a move away from individual psychotherapy into the areas of marriage counseling, group therapy and political activism (Sharf, 2004). Rogers considered the phenomenology of the therapist as an agent of change for the patient but not as a direct force (Rogers, 1989).

Rogers contends that individuals know what “hurts” but also have within themselves the ability to see and fix their own pain, but it is through the processes of the therapeutic relationship
that they can be safe enough to start the process (Rogers, 1989). It is through the building of congruence or the process whereby the therapist accurately experiences and is aware of the communication of the patient that he (the therapist) can start to understand and communicate the psychological experiences of the other and be “in tune” with them (Rogers, 1989). Rogers goes on to express how it is with an attitude of deep respect and full acceptance of the client and his potentiality, suffused with warmth that transforms the relationships to allow for the level of communication whereby the client perceives that his feelings and experiences are understood and accepted (Rogers, 1989).

This is not unlike what filial therapy aims to enhance in the parent-child relationship. When children feel safe and accepted and parents understand and accept their child, changes in the dynamic of the relationship can be initiated. Rogers (1989) says it is the accepting of each fluctuating aspect of the other person, a concept that can be applied to the parent-child relationship, that is the basis for change and growth. The “helping relationship”, whether it is a therapist-client or parent-child relationship, through the person-centered lens is fostered by this acceptance and how it grows within trust and safety (Rogers, 1989). Further the relationship is characterized by transparency, the ability of one person to make evident his feelings of acceptance and care, along with empathic understanding, which enables that person to see the other’s private world from their perspective (Rogers, 1989)

*Genuineness*

The processes of being genuine starts with being able to express our own thoughts and feelings, knowing they exist in ourselves and should not be suppressed in a helping relationship (Rogers, 1989). The concept of genuineness, a core concept of person-centered theory and a foundational concept of the process of filial therapy should be evidenced in the relationships that
will be the focus of this case study research. From the relationships of the trainer/researchers and parents to the relationships of the parents and children the concept of genuineness plays a crucial part in the growth of child and parent through the filial therapy process. Rogers (1989) describes the process of being genuine as a way of being internally consistent. I, too, am an individual who brings my own feelings and understandings to the relationships and observations, and working toward genuineness, being internally consistent is a goal of the person-centered theorist/practitioner. Helping build a foundation of safety and acceptance for the parents during the filial process is crucial to their transfer of those concepts to their children (Rogers, 1989; Watts & Broaddus, 2002; Landreth, 1991).

Genuineness means he has the ability to not only gain understanding but also to express that understanding to the other individual (Rogers, 1989). This expression of genuineness lends itself to providing me with the tools to engage parents in this case, both as trainer and researcher recognizing their needs with empathy both as a means of creating a sound research relationship but also as a way of teaching by way of modeling the concepts of filial therapy for them to experience with their child (Kensit, 2000; Poyrazli, 2003; Schnellbacher & Leijssen, 2011). The concept of genuineness in the context of therapy relates to the efficacy of filial therapy as an appropriate parent training because it relates so concretely to the parent-child relationship. Schnellbacher and Leijssen (2011) also discussed the idea that genuineness always goes together with sincere involvement and that it is a relational experience and interpersonal process. This concept is indicative of the processes of this study as well as being particular to the skills that will be addressed in the filial therapy training for parents and their children.
Acceptance or Unconditional Positive Regard

The second concept described connecting person-centered theory to the current research proposal and the filial therapy process is that of acceptance and or unconditional positive regard (Rogers, 1989; Sharf, 2004). Rogers (1989) describes this concept as warm regard for the other as a person of unconditional worth and value no matter the context. For the context of this research this concept is directly tied to me as a trainer in the relationship with the parent trainees as a basis for building a trust relationship through the processes of filial training. The purpose of the training is to build or rebuild this in the parent-child relationship and the filial process has been shown in many studies to create this type of relationship between parents and their children (Braton et al., 2005; Chacko, et al., 2009; George, et al., 2011; Landreth, Baggerly & Tyndall-Lind, 1999; Landreth & Bratton, 2006; Landreth, 1991; Vanfleet, 1994; Sanders, et al., 2000; Topham & VanFleet, 2011; Wade, Llewellyn & Matthews, 2008; Watts & Broaddus, 2002).

Rogers (1989) suggests and filial therapy supports that when individuals feel safe and free because they feel unconditionally accepted they can grow and change both parents and children in the specific case of filial therapy training. This is the goal with the filial process and from a person-centered perspective I will aim to embody these concepts as a means of creating a safe environment where parents feel they can be open about their experiences. As reported by Topham and VanFleet (2011) an integrated approach to filial therapy that is conducted in accordance with the principals of non-directive play therapy (Axline, 1947) and concepts of Rogerian person-centered therapy helps parents learn how to create acceptance, non-judgment and respect for their children by way of experiencing such concepts themselves as facilitated by the filial therapy process.
**Congruence**

The next concept that threads through the literature as an important idea of both the person-centered perspective and filial therapy is the concept of congruence, which according to Rogers (1989) is the ability to experience feelings, having access and knowledge of them, live these feelings and finally to be able to communicate them as appropriate. Poyrazli (2003) describes congruence as the correspondence between one’s thoughts and one’s behavior, relating it in the context of therapy. My ability to be ever aware of this as the researcher/trainer will be helpful in building relationships but will also be what is being taught to the parents. Helping them become more congruent with themselves they can enhance their relationships with their children. Having access to themselves will also allow them to be more expressive of their experiences as they go through the processes of filial therapy training. Ray et al. (2000) also reports that filial therapy is a method by which both parents and children receive help as they move to a healthier relationship because the process is not about changing overt behaviors but is directed at changing the relationship by way of increasing understanding and acceptance.

The concept of congruence can also be described in terms of authenticity and when the relationships between individuals, specifically in this case parents and their children, presumes openness for both individuals; for themselves and for the other this concept can manifest in a changing relationship (Schnellbacher & Leijssen, 2011).

**Empathy**

Empathy refers to the ability to view the world view of another from their perspective and relates to cognitive and neurophysiologic processes (Light, Coan, Zann-Waxler, Frye, Goldsmith & Davidson, 2009; Pyschogiou, Daley, Thompson & Sonuga-Barke; 2008). It is the cornerstone of child-centered play and filial therapy. Further, empathy addresses the ability of
an individual to identify emotions of others, taking the perspective of another person while also communicating that understanding to the other person (Rogers, 1961). Rogers (1961) also describes empathy as the ability of a therapist to “enter freely” into his client’s world of emotion and personal experience and gain meaning while curtailing the desire to evaluate and judge it.

This concept is the underlying precept for child-centered play therapy and filial therapy. The research indicates that when a parent can fully escape from the desire to evaluate a child’s perspective, behavior or expression of emotion the interaction between parent and child improves (Bratton et al., 2005; Gurney et al., 1970; Landreth, 1991; Landreth & Bratton, 2006; Topham & VanFleet, 2011; VanFleet, 1994; Watts & Broaddus, 2002). In the interest of creating healthy individuals and families it is important that both parents and children know how to deal effectively with emotions, both theirs and the emotions of others (MacQuiddy, Maise, & Hamilton, 1987). The development of empathy and working emotional language is essential to interactive and prosocial experiences conversely the lack of empathy can impede social development which stands to affect interpersonal and social interactions (Hogan, 1969).

It is with the development of genuine empathy and the ability of the parent to communicate this empathy that prepares the way for the child to learn and understand empathy for himself. Parental empathic understanding is a factor to be considered in many aspects of a child’s social development as well as a factor that affects their emotional expressiveness (Eisenberg, Fabes & Losoya, 1997; Roberts & Strayer, 1996; Saarni, Mumm, & Campos, 1998; Strayer, 1987). In their classic study, Mehrabian & Epstein (1992) found that subjects who scored low on measures of empathy administered more shocks than did those who were found to score higher on measures of empathy. Many studies have shown that children of parents who use a mostly inductive parenting style have higher internalized norms, more guilt associated with
unacceptable social behavior and higher empathic responding (Eisikovits & Sagi, 1982; Hoffman, 1975a, 1975b, 1979; Hoffman & Saltzstein, 1967; Kravans & Gibbs, 1996; Lopez, Bonenburger, & Schneider, 2001). It can be seen that even minor use of corporal punishment can be a predictor of low levels of emotional empathy (Lopez et al., 2001; Hoffman, 1994).

Feshbach (1975) suggested that empathy can be viewed as both a cognitive and affective process composed of three related elements including the ability of an individual to distinguish among and label the thoughts and feelings of another, the ability to take another’s perspective, and finally the ability to become emotionally responsive to another’s feelings.

It is not simply the ability to recognize the emotional world of another but also to feel something about it and then communicated it effectively. Additionally, Feshbach and Feshbach (1969) suggested that parents who have limited ability to perceive their child’s needs, feelings, and intentions tend to respond punitively out of a lack of understanding, especially if the interaction is perceived as being confrontational on the part of the parent. The ability then, of the parent to perceive the world from the point of view of their child is fundamental to sensitive parenting (Ainsworth, Bells, & Strayton, 1971; Pschogiou, Daley, Thompson, & Sonuga-Barke, 2008). Fostering empathy is dependent on the ability of the parent to accurately identify and label a child’s emotion (Dunn & Brown, 1994).

Roberts (1999) supposed that empathic parents would accurately assess and respond to their child’s emotion which in turn encourages the child. While Strayer, Fraser, & Roberts (2004) found little connection between parental empathy and children’s empathy they did not discount its importance recognizing that the lack thereof has the potential for creating behavior problems in the child. Hoffman (2000) and Snow (2000) conceptualize affective empathy as involving the vicarious experience of emotions consistent with those of others and the cognitive...
component as the understanding of other’s feelings. Bateson (2004) suggests an extension to the
definition of empathy saying that empathy development is an ongoing process that is essential
for human development that is continuously learned and re-learned by way of loving, nurturing
parent-child interactions.

While the aim of play, activity and filial therapy is to develop empathy in the child and
parent respectively, empathy itself has been shown to be foundational to moral development. A
fundamental proposition on how moral development occurs is based on the idea that empathy
inhibits aggression while promoting prosocial behavior (Hogan, 1969). The development of
empathy is also linked to the ability of children to express emotion which is further linked to
social and familial interactions (Eisenberg, Fabes & Losoya, 1997; Roberts & Strayer, 1996,
Saarni et al., 1998; Staryer et al., 2004; Strayer, 1987).

Feshbach (1987) and Zahn-Waxler (1991) linked empathy development to the ability of
parents to more accurately read their child’s emotional cues and to consequently be motivated to
respond with warmth. The strongest evidence of this link is reported by Trommsdorff (1991)
who found a correlation of .61 within a sample of German mothers and their children. This idea
makes a strong argument for the use of filial therapy not simply as an intervention but certainly
as a preventive or assessment model aimed at enhancing parent-child interactions as a means of
impacting the development of empathy in the child while enhancing the empathy of the parent.

There is a certain quality of parental empathy that research suggests to be important to
consider when endeavoring to train parents to be empathic change agents for their children. That
concept is mental flexibility which refers to the cognitive ability to learn about what is affecting
others and to be able to effectively imagine what it would be like to be in their place, thus
requires abstract thought (Gerdes, Segal, & Lietz, 2010). So it stands to reason then, that while some see empathy as simply a reflective empathic rapport, it is also a communicative attunement or the ability to express empathic understanding in a way that can truly be received by others (Elliot, Bohart, Watson, & Greenberg, 2011).

A most interesting advancement of the study of empathy even as the debate around a concrete definition is brewing, is the neurological work that has been done to physiologically define empathy. Decety and Ickes (2009) and Elliot et al., (2011) introduced the idea that the processes of empathy are very much associated with the brain and much is being discovered as to precisely which parts of the brain deal with empathy.

“Mirror neurons” found in the motor cortex and which may be the foundation of empathic accuracy (Gerdes et al., 2010) having been discovered, have begun to expand the understanding of human empathy (Decety & Lamm, 2009). “Mirror neurons create physiological mimicking. If you have ever seen somebody yawn and moments later yawned yourself, that is the work of mirror neurons and this seemingly simple neurological response, as the literature indicates, is considered to be correlated with the very complex notion of empathy.

The neurological research suggests that the prefrontal cortex organizes information from the limbic and sensory system, the emotion center of the brain, and uses the information to orchestrate thought, emotion, and motor actions in accord with internal goals (Light et al., 2009). The research further indicates that empathy as a neurobiological process (Eisenberg & Eggum, 2009) consists of, (a) emotional simulation which mirrors the emotional elements of another’s bodily experience centered in the limbic system (Decety & Lamm, 2009); (b) a conceptual role taking localized in the prefrontal and temporal cortex (Shamoy-Tsoory, 2009); (c) an emotion-
regulation process used to soothe personal distress when pain is perceived of another which facilitates helping behavior likely found in the orbitofrontal, prefrontal and right parietal cortex (Decety & Lamm, 2009). The existence of physiological evidence of the process is a huge advancement of the study of empathy because being able to localize it may bring us closer to understanding precisely how to grow or enhance it while also leading us toward answers about why some people seem to lack empathy all together. Thus far, client-centered therapy is one of only two approaches most focused on empathy as a therapeutic agent (Selman, 1980; Elliot et al., 2011).
Chapter Three – Research Methodology

Phase I

Purpose

The purpose of this phase of the study was to use a mixed methods design to evaluate the effectiveness of Child and Parent Relationship Therapy (CPRT) in enhancing the parent-child relationship between parents and their preadolescent children as measured by the Measure of Empathy in Adult and Child Interactions (MEACI) and the Porter Parental Acceptance Scale (PPAS) while examining the experiences of the parents attending the CPRT training. The MEACI measures empathic interactions between parent and preadolescent. The PPAS is designed to measure the level of acceptance parents show their children. A mixed methods design was used to determine effectiveness using a posttest of the experimental and a pretest from the waitlisted control group along with interviews which conducted to expand the researchers understanding of the experience of the parent participants.

Additionally, the researcher examined the experiences of the parents participating in the Child Parent Relationship Therapy training using exit interviews. With a sequential exploratory strategy the researcher integrated qualitative data with quantitative data at the point of interpretation. The purpose of this approach was to test the efficacy of the parent training as it relates to the actual experiences of the parents who participated and may help to generalize both sets of data to different samples (Chase, 2005).

The study addressed the following research questions:
1. What is the differential effect on parental empathy when parents of preadolescent children (ages 9 to 11 years old) participate in filial therapy versus parents who do not participate in filial therapy training?

2. What is the differential effect on parental acceptance when parents of preadolescent children (ages 9 to 11 years old) participate in filial therapy versus parents who do not participate in filial therapy training?

3. What are the individual experiences of the parents participating in a CPRT training?

The conceptual framework for Question Three focuses on the individual experiences of parents participating in filial therapy training. The findings will offer insight into possible common perspectives and experiences across the parents.

*Researcher Background*

The researcher has worked for over 25 years in the field of Early Childhood Education as both a classroom teacher and for the last 12 years as the director of a community college child development center. The researcher’s interest in these relationships was piqued as she moved through her doctoral studies. The purpose of this approach was to better understand the experience of parents participating in a Child Parent Relationship Training (Landreth, 1991) to gain insight on how they perceive the experience and in the end how that experience relates to their eventual empathy and acceptance scores as measured by the MEACI and PPAS and beyond that, the impact the experience had on the parent/preadolescent relationship. The researcher plays a dual role for the study, that of researcher and trainer. This is to say the researcher will be conducting the case study research while also instructing the filial training process. As part of her studies, the researcher has practiced play therapy and activity therapy for three years in the context of counselor and supervisor. The researcher has worked with several children and
preadolescents in a university clinic. Her theoretical perspective revolves around the tenants of child-centered play therapy in her work as a therapist. These tenants incorporate the beliefs about how to interact with children and are listed below:

1. Children are not miniature adults.
2. Children are people.
3. Children are unique and worthy of respect.
4. Children are resilient.
5. Children have an inherent tendency toward growth and maturity.
6. Children are capable of positive self-direction.
7. Children’s natural language is play.
8. Children have a right to remain silent [or not play].
9. Children will take the therapeutic experience where they need it to be.
10. Children’s growth cannot be sped up [or slowed]. (Landreth, 2002, p.54)

*Participants-Phase I*

The demographics for the schools are based on the 2010-2011 school year data from the Institute of Education Science, National Center for Educational Statistics. The total number of students in the Washoe and Carson County City School Districts was 3,413 of which 2.17% were listed as Native American Indian, 2.02% Asian or Pacific Islander, .05% Black, 43.69% Hispanic, 48.73% White, and 2.82% two or more races. Of the total number of students enrolled 57.04% were male and 48.96% female. The number of children eligible for free lunch services was 50.63% and 7.47% were eligible for a reduced lunch program.
The researcher contacted the Carson City School District’s main office to request approval to access the six public schools in the Carson City area and Washoe County to request approval for 4 of the public schools in that district. The researcher communicated with the respective principals to gain permission to disseminate information and interest packets to the 4th and 5th grade classrooms which was sent home in the children’s take-home folders for parent review.

The researcher sent out 1500 parent packets to six Carson City School District schools, held four parent orientation meetings and 450 parent packets to four Washoe County schools, where she held another four parent orientation meetings. The recruitment packets included: a letter of invitation to participate and a brief overview of the processes of Child and Parent Relationship training which includes: a description of the time commitment of 1-2 hour of training per week for a ten-week period; the requirement of a 30 minute play/activity session with their child once a week; and a description of the study requirements including videotaping which includes instructions about: videotaping format, videotaping consent and videotape destruction. Parents also received an invitation to an informational meeting lasting approximately 2 hours, researcher contact information for questions and RSVP instructions, a qualification checklist (see Appendix A), and a brief demographic survey to be submitted if they consent to participate (see Appendix B).

At the initial information meeting, parents were randomly selected to participate in either the experimental group or the waitlisted control group by drawing names out of a jar at the beginning of the meeting. Parents selected to participate in the experimental group participated in a 10-week Child and Parent Relationship Therapy training beginning one week after the initial
meeting. Pretest data was not be necessary because the groups were randomly assigned to the experimental or the waitlisted control group.

A total of 7 parents of preadolescent children between the ages of 9 and 11 years old committed to the research study. One parent dropped out prior to the first meeting of the experimental group training. Participants included one father and five mothers. The experimental group consisted of three parent participants all of which were married. The control group was made up of three mothers, two were married and one was divorced. All of the parents in the experimental group had multiple children choosing only one child for the purposes of this study who qualified under the age requirements. The parents of the control group also had multiple children of which there were two sets of twins. The two mothers in the control group chose one of the twins each for the play sessions. Ethnicities included Asian and Caucasian. Regarding the education of the parent participants, one parent, had earned an Associate’s degree, four with Bachelor’s degrees and one parent with a Juris Doctor degree. The demographic information was completed using the initial demographic survey completed at the information meeting along with the demographic survey that is part of the PPAS. The distribution of demographics for the six parent participants is displayed in Table 1.

Table 1

<table>
<thead>
<tr>
<th>Demographics of Parent Participants</th>
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<tbody>
<tr>
<td>Total number of parent participants (N=6)</td>
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<tr>
<td>Gender</td>
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<tr>
<td>Female</td>
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Table 1 continued

*Demographics of Parent Participants*

<table>
<thead>
<tr>
<th>Total number of parent participants (N=6)</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Age of Participant’s Child</td>
<td></td>
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<tr>
<td>9-years-old</td>
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<tr>
<td>10-years-old</td>
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</tr>
<tr>
<td>11-years-old</td>
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<tr>
<td>Gender of Participant’s Child</td>
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</tr>
<tr>
<td>Widowed</td>
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<td>Separated</td>
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<tr>
<td>Ethnicity/Race</td>
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<tr>
<td>Black or African American</td>
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</tr>
<tr>
<td>One or more years of college, no degree</td>
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Table 1 continued

Demographics of Parent Participants

<table>
<thead>
<tr>
<th>Total number of parent participants (N=6)</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Associates Degree</td>
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</tr>
<tr>
<td>Master’s Degree</td>
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</tr>
</tbody>
</table>

During the parent orientation meetings parents, were presented with a power point presentation outlining the study and explaining the processes of CPRT therapy. The parents were also given participant consent forms for the study (see Appendix C), video consent forms (see Appendix D) and assent forms (see Appendix E). At the end of the orientation meeting parents were given the option of turning in the consent forms and confirming their participation in the study or taking the documentation home for further review. Each parent who attended the parent orientation meetings drew a number out of a covered jar for randomization purposes. Parents pulled either a one (1) or a two (2) representing the experimental group and control group respectively. The outcome of the two parent orientation meetings held in the Carson City School district was four experimental group members and three waitlisted control group members. The orientation meetings held in Washoe County did not produce any parent participants.

In order to be eligible to participate in the study, parents must have met the following criteria:

1. The parent must have a preadolescent child (between 9-11 years of age).
2. The parent must have signed and returned the consent forms; including the consent to participate, the videotaping consent form and the assent form for their minor child.

3. The parent must have consented to participate in at least 80% of the 10-week parent training and to provide all the data including the completion of the Porter Parental Acceptance Scale (PPAS), a video tape for scoring with the Measure of Empathy in Adult and Child Interactions (MEACI) and interviews.

The experimental group was initially made up of four parents, however, one parent dropped out prior to the start of the experimental group training sessions. The continuing group members in the experimental group consisted of one father and two mothers. The control group consisted of three mothers and retained their group make-up for the duration of their training sessions. The demographics of the two groups are in Table 2.

Table 2

Demographics of Group Members

<table>
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<th>Experimental group (n=3)</th>
<th>Waitlisted Control (n=3)</th>
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<tbody>
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<tr>
<td>Age of Participant’s Child</td>
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<td></td>
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<tr>
<td>9-years-old</td>
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</tr>
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<td>10-years-old</td>
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<td>1</td>
</tr>
<tr>
<td>11-years-old</td>
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<td>0</td>
</tr>
<tr>
<td>Gender of Participant’s Child</td>
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</tbody>
</table>
Table 2 continued

*Demographics of Group Members*

<table>
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<tr>
<th></th>
<th>Experimental group (n=3)</th>
<th>Waitlisted Control (n=3)</th>
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</thead>
<tbody>
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<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>2</td>
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<tr>
<td>Single</td>
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<td>Divorced</td>
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<td>1</td>
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<tr>
<td>Widowed</td>
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<tr>
<td>Separated</td>
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<td>Ethnicity/Race</td>
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<tr>
<td>White</td>
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<td>Education</td>
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<tr>
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<td>One or more years of college, no degree</td>
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<td>Bachelor’s Degree</td>
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<tr>
<td>Doctorate Degree (Attorney)</td>
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</tr>
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</table>
There was one incident of attrition occurring prior to the first session of the experimental group; one parent decided that she would not be able to make the 10-week commitment because of work and family responsibilities. Both of the groups maintained their respective three members each for the duration of the two 10-week training sessions.

Experimental group parent participants were asked to provide their PPAS self-study surveys which included a short demographic survey, and a videotape for review with the MEACI at the end of their training. Interviews were not scheduled until after the start of the control group trainings began, which was approximately four weeks after the experimental group had concluded their training sessions. Control group training sessions commenced four weeks after the conclusion of the experimental group training. Control group parents were asked to provide a completed PPAS and a videotape for review with the MEACI prior to the start of their training sessions.

Setting - Phase I

The 10-week Child and Parent Relationship Therapy (CPRT) training was held on the Carson campus of the local community college. Play sessions occurred in the respective homes of the both groups of parent participants. Due to the nature of the CPRT training which uses a didactic and educational group format, having smaller groups was ideal for cohesion of the group in the time allotted for the training, each of the training groups consisted of three parents respectively. (Landreth, 2002; Packman & Solt, 2004).

Interviews for both groups occurred at the convenience of the individual parents. Two of the interviews occurred in the home of the participants at their request, two were conducted in the office of the researcher behind closed doors and with confidentiality and comfort in mind,
and one interview was conducted at the office of the participant at her request. The office was a private office and the door was shut for confidentiality. The last interview occurred in the training room previously mentioned with the door closed.

_Treatment-Phase I_

_The Measurement of Empathy in Adult and Child Interactions._ The Measurement of Empathy in Adult and Child Interactions (MEACI, Stover et al., 1971) was used to measure the study’s second research question and hypothesis, addressing the participation of parents of preadolescent children in filial therapy training, as well as the differential effects of this training on parental empathy. The MEACI is used to measure empathic interaction of adults and children (Stover et al., 1971). Stover et al., (1971) established reliability coefficients for each of the three subscales of the original instrument. With average reliability correlation coefficient for the Communication of Acceptance subscale measured at .92. Both, the Allowing the Child Self-Direction subscale and the Adult Involvement subscale had medium coefficients of .89.

Concurrent validity was established by correlating .85 with a previously developed measure of empathy and offered measures of three other relatively independent variables. The results of an examination of a population of 51 mothers participating in a research project on the efficacy of filial therapy were used to establish construct validity for the total empathy score. The study examined the empathic responses of a group of 5th grade students. Because of the observational nature of the instrument, there is no age range used to define “adult” (Robinson, Landreth, & Packman, 2007).

_The Porter Parental Acceptance Scale._ The Porter Parental Acceptance Scale (PPAS, Porter, 1954) was used to measure the study’s third research question and hypothesis,
addressing participation of parents of preadolescent children in filial therapy training, as well as the differential effects of filial therapy training on parental acceptance of their preadolescent child. The PPAS purports to measure the levels of acceptance a parent has for his child (Porter, 1954). Developed by Blain R. Porter in 1954, it is a 40-item self-report inventory type questionnaire. The acceptance scale is designed to measure parental acceptance of children as revealed in the behavior and feelings parents express toward, with, or about their child. The PPAS involves four dimensions of acceptance: (a) respect for the child’s feelings and right to express them, (b) appreciation of the child’s uniqueness, (c) recognition of the child’s need for independence and autonomy, and (d) unconditional love (Porter, 1954, Ferrell, 2003).

The PPAS is suggested for this study because these four variables are well matched with the training objectives of filial therapy. Relatively easy to administer, the PPAS takes approximately 20 minutes to complete. Each question has five responses ranging from low to high acceptance (Ferrell, 2003). There are two dimensions of acceptance: (a) how the parent feels in a specific situation, and (b) what the parent will do in a specific situation. It is scored to yield four subscale scores and one total scale score (Ferrell, 2003). A split-half reliability correlation of .766 which rose by the Spearman Brown Prophecy formula to .865 was reported (Porter, 1954). Both coefficients are significant beyond the .01 level. Burchinal, Hawkes, and Garner (1957) reported that the PPAS is internally consistent at the .001 level of probability.

*Child and Parent Relationship Therapy.* Child and Parent Relationship Therapy (CPRT, Bratton, Landreth, Kellam, & Blackard, 2006) training is a specialized 10-week parent training program aimed at helping parents strengthen the relationship they have with their child by using a 30 minute play/activity time once a week (Bratton et al., 2006). Bratton et al., (2006) contend that play is important for children because it is their natural language which they often use to
express, explore and experience their feelings which is why it is so important for parents to learn how to play with their child and respond empathically to their child’s needs (Bratton et al., 2006). It is for this reason that it was used as the treatment for the proposed study. This researcher served as facilitator for both of the parent training groups. Along with learning empathic responding parents learned how to build their preadolescent’s self-esteem, how to help them learn self-control and self-responsibility, and help parents learn how to set therapeutic limits during the play/activity sessions (Bratton et al., 2006). Modifications of the play sessions were made to benefit preadolescents based on the recommendations of Bratton and Ferebee (1999) who suggested making adjustments for the developmental needs of children ages 9-12. As group facilitator the researcher conducted the CPRT training session with parents once a week for 60-90 minutes each for the duration of the 10-week training period.

Weekly Sessions. In the first week of training parents were familiarized with the process of filial therapy and welcomed to the group. Parents were given some of the common language that was used throughout the training such as the rule of thumb, “focus on the donut not the hole”, which is meant to encourage them to consider the preadolescent and their relationship as the focus rather than the problem (Bratton et al., 2006). They were also given to understand that play is the natural language of children because as an extension of play therapy, it will be important that parents understand the value of play for their preadolescent’s experiences. Lastly, the first week focused on providing skills including reflective responding and role play that will help them regain control as a parent which will help the preadolescent gain self-control, provide a closer more enjoyable time with their preadolescent, and give them keys to their preadolescent’s inner world (Bratton et al., 2006).
In week two parents learned the basic principles of play. These included, (a) allowing the child to take the lead and following them, (b) showing intent interest and observation, (c) being aware of their body language, and (d) joining their preadolescent when invited (Bratton et al., 2006). The emphasis for this week was to encourage parents to practice empathy with their preadolescent by seeing his experience through his play/activity and to learn better understanding of their preadolescent’s needs, feelings, and thoughts as expressed through his play/activity (Bratton et al., 2006). The parent also learned how to and the importance of communicating that understanding to their preadolescent by, (a) describing what he is doing and (b) reflecting what he is saying and feeling (Bratton et al., 2006). Lastly, parents were introduced to the modified play kits.

Week three was marked by reflection on the skills learned in week two and processing of the play sessions from the previous week. Two parents were assigned to videotape this week’s play session for review by the group the following week. Parents were also introduced to the Do’s and Don’ts of play sessions. Below are the Do’s and Don’ts that are the focus for this week’s training (Bratton et al., 2006):

Do:

1. Do set the scene
2. Do let the preadolescent lead.
3. Do join in the preadolescent’s play activity, as a follower.
4. Do verbally track the preadolescent’s play or activity.
5. Do reflect the preadolescent’s feelings.
6. Do set firm and consistent limits.
7. Do salute the preadolescent’s power and encourage effort.

8. Do be verbally active.

**Don’t**

1. Don’t criticize any behavior.

2. Don’t praise the preadolescent.

3. Don’t ask leading questions.

4. Don’t allow interruptions of the session.

5. Don’t give information or teach.

6. Don’t preach.

7. Don’t initiate new activities.

8. Don’t be passive or quiet (Don’ts 1-7 are taken from Guerney, 1972).

In week four parents watched and discussed the two videos from the previous week, and two more parents were assigned to videotape for the following week. The focus of this session was A-C-T limit setting which stands for: **Acknowledging the feeling**, **Communicating the limit**, and **Targeting the alternatives** (Bratton et al., 2006).

Week five is formatted much like week four and parents will have the opportunity to review limit setting including when to appropriately set a limit. In week six the focus for parents is to learn about choice giving when setting a limit. Parents were presented with the lesson that choices should not be punitive and should be commensurate to the age of the child; in the case of this study it was a preadolescent who should be able to accept more involved choices. The choices must be equally acceptable to the parent and the preadolescent (Bratton et al., 2006).
Week seven, like the previous three weeks, followed the same format of reviewing parent group videotaped play sessions. For this week the focus though was on self-esteem building for the preadolescent. The pertinent rule of thumb for this week was, “Never do for a child that which a child (preadolescent) can do for themselves” (Bratton et al., 2006).

The theme of week eight was to encourage the efforts of the preadolescent rather than praise the product (Bratton et al., 2006). That is to say parents were approached with the idea that encouragement will foster internal loci of control as opposed to praise which is an externally motivating sentiment. This is thought to contribute to the preadolescent’s ability toward self-efficacy and self-responsibility.

Week nine like weeks five, six, seven and eight was the same regarding the viewing of the videotaped play sessions. The focus for this week was aimed at helping parents move toward change in small manageable ways rather than encouraging a total overhaul of behaviors. This is to say they were encouraged not to try and change everything about themselves, their preadolescent, and their family. The group also discussed the use of limit setting outside of the play sessions. The main sentiment of this week was that consistency is equivalent to a secure relationship (Bratton et al., 2006).

All parents were required to videotape this week’s play/activity sessions for Measurement of Empathy in Adult and Child Interactions (MEACI) posttest. Parents in the waitlisted control group were contacted this week to make arrangements for videotaping and returning a videotaped play session for MEACI. Control group parents were assigned a date and time following the conclusion of the experimental group’s last session, approximately four
weeks, to take the Porter Parental Acceptance Scale and provide this to the researcher prior to the start of their training sessions.

During the final week, parents were provided with referral information if they wished to continue or if they felt like they needed additional help. Parents were given their certificates of completion. The experimental groups had an opportunity to process and reflect on their experience during the training. Both groups of parents, experimental and waitlisted control provided the Porter Parental Acceptance Scale (PPAS) for posttest data. There were no parents who missed more than three sessions.

The parent participants were interviewed after their respective training sessions concluded and were asked to reflect on the experiences of the training and how the training would relate generally to their parenting. These interviews were compared to the results of each participants PPAS and MEACI scores and the researcher constructed themes regarding the relationship of the data collected.

*Procedures- Phase I*

The nonparametric Mann-Whitney *U* Test was considered to be the most appropriate test for this analysis because of the Likert scale responses which provide ordinal data rather than interval data which is a requirement of parametric analysis (Garsen, 2008; Liles, 2009). The MEACI and the PPAS consist of 3 and 40 items respectively that provide 215 possible Likert scale responses (Mehrabian, 1994a, 1994b, Liles, 2009). Nonparametric statistical procedures as a class of statistical procedures do not rely on assumptions about the shape or form of the probability distribution from which the data were drawn. Additionally, nonparametric statistical procedures rely on no or few assumptions about the shape or parameters of the population
distribution from which the sample was drawn (Garsen, 2008). The experimental group posttest scores on both the MEACI and the PPAS were compared to the control group using a Mann-Whitney $U$ Test. Siegal & Castellan (1998) suggested that the Mann-Whitney $U$ Test is appropriate when homogeneity of variance does not exist with unequal sample sizes when the data is drawn from two independent random samples.

An apriori power analysis was conducted with G-Power to determine minimal sample size to maintain power at the .80 level for a medium effect size. This analysis determined the size of both the experimental and control group should be 53 parents per group. In order to account for probable attrition however, the researcher increased the projection to 30 more participants to have a total population (N= 130) making the individual groups (n=65). The experimental and control groups ended up consisting of three parents each for the duration of the CPRT training.

Before the video tapes were rated, inter-rater reliability was established through training sessions. A pair of graduate student interns who were not involved in the study, blind rated an anonymous training tape with a play therapist and preadolescent child following the training sessions. The graduate interns who rated the tapes did not know if the tapes they were rating demonstrated a control group or experimental group parent.

Interviews were scheduled at four weeks after the experimental group concluded their training session and at week nine for the waitlisted control group. Interviews lasted between 30-45 minutes and provided supportive anecdotal data toward inferences from the scores of the MEACI and PPAS in answering the study’s first and second research question. Interviews were analyzed for patterns and themes between the individuals.
In addition the interviews elaborated on information regarding the experience of the parents during the training in terms of how they saw their relationship and what they felt during the process, their struggles and their achievements. The interviews also provided the researcher additional information about how the parents’ might be able to extend the skills learned in the training into their daily interactions with their child/ren as well as in other situations.

**Qualitative Data Analysis.** The researcher approached the data collection from observations, videotapes and interviews as a means of identifying themes regarding the experiences of parents in the experimental and control groups keeping in mind how that experience related to the results of the quantitative data collection. The researcher made several attempts during the interviews to check in with the participants by asking clarifying questions and reference to their statements in order to check for accuracy and decrease the incidence of incorrect data and the incorrect interpretation of data, with the goal of representing the responses with authenticity (Creswell, 2007; Moustakas, 1994). As a further attempt at representing the sentiment and responses of the parent participants, the researcher videotaped and transcribed each video. In comparing parent interviews and observation of parents in each group, the researcher was able to indentify shared experiences and common threads of ideas for many of the parent participants. In addition interview data was compared to the scores for the PPAS and MEACI as a means of scaffolding these results and developing working understanding of the study’s first and second research questions.

**Integration of data.** The researcher followed the sequential explanatory design for comparison of qualitative and quantitative data which was combined at the point of interpretation. The researcher followed the model of mixed methods research as outlined by Onwuegbuzie & Teddlie (2003) including data reduction which included the process of developing themes of the parent responses to the interview; data display which describes the
process of developing visual representation of the data quantitative and/or qualitative as was appropriate; data consolidation where the quantitative and qualitative data were combined as new variables related to the themes that emerged from the interviews; data comparison which included comparing and contrasting the data from both qualitative and quantitative sources. Data integration was the final step which occurred last and developed a coherent whole of qualitative and quantitative data and presenting themes (Onwuegbuzie & Teddlie, 2003).

The qualitative data were used as a means of augmenting the quantitative data with special note that the qualitative data from the interviews were designed and intended to support quantitative results (Palmer & Cochran, 1998). The researcher designated the themes of the interviews comparing them to the results of the PPAS and MEACI. This comparison supplied the researcher with further information and understanding about the individual and cumulative experiences of the parent participants in terms of relationship with their child and how the filial training experience affected their empathy and acceptance toward their child. Themes were generated by examining the interview transcriptions over many hours. Reading the transcription along with the video-taped interview session and then adding written researcher notes and observations to describe inflection and body language. Each individual transcription was color coded for individual and collective themes. Themes were added and deleted according to relevance and where patterns emerged (Merriam, 1988).

While the PPAS and MEACI provided information to the researcher about the ability of the parent to empathize and accept his or her child, the interviews provided an enlarged picture of the experience the parents had of the CPRT training which provide a richer understanding about what those data meant to the individuals. The researcher looked at ways the data were convergent or divergent making inferences in either instance. There were instances where the
quantitative and qualitative data seemed related insofar as the results of the MEACI and PPAS however; there were instances when the parent’s perceptions of growth or success in their interactions were divergent from their individual scores on either measure.
Chapter Four – Discussion

Phase I

_Hypothesis One_

The study’s first research question asked: What is the differential effect on parental empathy when parents of preadolescent children (ages 9-11 years old) participate in filial therapy versus parents who do not participate in filial therapy training? Hypothesis one stated: Parents who participate in a CPRT training will have lower mean empathy scores on the MEACI than parents who do not participate. This hypothesis was tested using the MEACI in conjunction with individual parent exit interviews.

_Inferential measures._ The MEACI is an observational scale that measures empathic interactions between parent and preadolescent. A score of one (1) indicates the highest empathy score on where a score of five (5) indicates the lowest empathy score across three observations; (a) Communication of Acceptance of Child; (b) Allowing Child Self-Direction; (c) Adults Involvement With Child. A low score on this measure indicates a high level of empathic interaction. Parent participants in the experimental group submitted a video for observation for post-testing on the MEACI after completing the 10-week Child Parent Relationship Therapy (CPRT) training. Parent participants in the waitlisted control group supplied a video prior to their 10-week CPRT training as a pre-testing control. A Mann-Whitney U Matched Ranked Pairs Test was calculated for both groups to determine if parent’s empathy had changed as a result of participation in the CPRT training.

_Measurement of Empathy in Adult and Child Interactions._ The MEACI is used to measure empathic interaction of adults and children (Stover et al., 1971). Empathy refers to
parents’ sensitivity to their children’s feelings and to the parents’ ability to verbally communicate this understanding to their children and as measured by their total score on the MEACI (Stover, Guerney, & O’Connell, 1971). Additionally, empathy can be described as the ability of a parent to identify emotions of their child, taking the perspective of that child and being able to communicate that understanding to the child (Rogers, 1961). A low score on the MEACI indicates a higher level of empathic responding during the play sessions (Stover, Guerney, & O’Connell, 1971).

Following the completion of the training sessions for both groups, the posttest video tapes of the experimental group and the pretest video tapes of the control group were rated using the MEACI. Tapes were coded by the researcher to insure that the raters would not have prior knowledge of whether they were rating an experimental group video or a control group video. Before the tapes were rated, interrater reliability was established by using three play therapy video tapes. The three tapes used for the training and pre-coding session were designed to be examples of a beginner level, mediocre and expert example of the processes of play therapy. Two graduate students not involved with the study and with training in play therapy blind rated the tapes after the training sessions. The training session was two hours in length and included discussion and collaboration which aligned with the procedure of Stover et al. (1971). Interrater reliability was checked at the mid-point of grading as well as at the end of scoring. Chronbach’s alpha was used to calculate interrater reliability the resulting alpha is in the acceptable range and is likely representative of the small sample size. Table 3 contains the results for the reliability coefficient calculations.
Table 3

*Inter-rater reliability from the Measurement of Empathy in Adult and Child Interaction*

<table>
<thead>
<tr>
<th>Reliability Coefficients</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-coding</td>
<td>.75</td>
<td>.75</td>
<td>.75</td>
</tr>
<tr>
<td>Midpoint</td>
<td>.75</td>
<td>.75</td>
<td>.75</td>
</tr>
</tbody>
</table>

Parent participants in both the experimental and the control groups submitted tapes for review against the MEACI observational instrument. Parents participating in the experimental group provided a videotaped play session after they completed the 10-week Child Parent Relationship Therapy (CPRT) training sessions and parents in the control group submitted a videotaped play session prior to beginning their CPRT training sessions. A Mann-Whitney U Ranked Pairs Test was calculated for both groups to determine if parents’ empathic responses were different as a result of participation in a 10-week CPRT training.

In the experimental parent group, parents’ scores on the MEACI ranged from 26 to 32.4 on their posttest. The control group parents’ scores ranged from 42 to 55.5. In comparing the posttests scores of the experimental group with the pretest scores of the control group on the MEACI, the obtain $U$ was 9.00, which was not found to be significant ($z = 1.963; p = 0.247$). Therefore the study failed to reject the null hypothesis that there would be difference in the median scores of the two groups. Table 4 presents the results of this comparison.

Table 4

*Mann-Whitney U Ranked Pairs Test on MEACI*

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
</table>
Table 4 continued

*Mann-Whitney U Ranked Pairs Test on MEACI*

<table>
<thead>
<tr>
<th></th>
<th>Experimental Group</th>
<th>Control Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann-Whitney U</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Ranked Pairs</td>
<td>3</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

While the quantitative comparisons did not reveal significant differences an examination of the individual raw scores between groups show lower scores for the experimental group. These are presented in Table 5 below.

Table 5

*Raw Scores for Measurement of Empathy in Adult and Child Interactions by Training Group*

<table>
<thead>
<tr>
<th></th>
<th>Subscale A</th>
<th>Subscale B</th>
<th>Subscale C</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group</td>
<td>13.25</td>
<td>12.00</td>
<td>8.00</td>
<td>32.50</td>
</tr>
<tr>
<td></td>
<td>9.00</td>
<td>13.00</td>
<td>7.00</td>
<td>29.00</td>
</tr>
<tr>
<td></td>
<td>12.00</td>
<td>8.00</td>
<td>7.00</td>
<td>26.00</td>
</tr>
<tr>
<td>Control Group</td>
<td>16.00</td>
<td>17.00</td>
<td>9.00</td>
<td>42.00</td>
</tr>
<tr>
<td></td>
<td>15.25</td>
<td>28.00</td>
<td>12.00</td>
<td>55.50</td>
</tr>
<tr>
<td></td>
<td>16.50</td>
<td>20.00</td>
<td>13.00</td>
<td>49.50</td>
</tr>
</tbody>
</table>

Scores for subscale C which described the parents’ involvement level during the play sessions seemed to be an area of success for the parents. The scores for this subsection are lower
on average than the other subsections and reflect a high level of involvement during the individual play sessions.

Table 6

Measurement of Empathy in Adult and Child Interactions Median results by Training Group

<table>
<thead>
<tr>
<th></th>
<th>Subscale A</th>
<th>Subscale B</th>
<th>Subscale C</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental group</td>
<td>11.42</td>
<td>11.00</td>
<td>7.00</td>
<td>29.17</td>
</tr>
<tr>
<td>Control group</td>
<td>15.92</td>
<td>21.67</td>
<td>11.33</td>
<td>49.00</td>
</tr>
</tbody>
</table>

Hypothesis Two

The second research question asked: What is the differential effect on parental acceptance when parents of preadolescent children (ages 9 to 11 years old) participate in filial therapy versus parents who do not participate in filial therapy training? The second hypothesis stated: Parents who participate in CPRT training will have higher mean acceptance scores on the Porter Parent Acceptance Scale (PPAS) than parents who do not participate. The PPAS was used for inferential measurement of this hypothesis while the qualitative measures included observation and interviews.

Inferential measures. In order to examine whether the experimental group had increased acceptance scores over the control group scores on Porter Parental Acceptance Scale (PPAS) was employed. The PPAS is designed to measure the level of acceptance a parent shows his child. Effectiveness is determined using a posttest from the experimental parent group and a pretest from the waitlisted control group. Interviews were conducted in order to expand the researchers understanding of the experience of the parent participants. The PPAS developed by B. R. Porter
in 1954 is a 40-item self-report inventory type questionnaire. The acceptance scale is designed to measure parental acceptance of children as revealed in the behavior and feelings parents express toward, with, or about their child. The PPAS involves four dimensions of acceptance: (a) respect for the child’s feelings and right to express them, (b) appreciation of the child’s uniqueness, (c) recognition of the child’s need for independence and autonomy, and (d) unconditional love.

In the experimental parent training group scores on the PPAS ranged from 150 to 177 and the scores from the control ranged from 132 to 169. The Mann-Whitney $U$ Ranked Pairs Test was used to compare the scores on the PPAS of the two groups. Comparing the posttest scores of the experimental group with the pretest scores of the control group on the PPAS, the obtained $U_{97.5}$, which was not found to be significant ($z = 1.472; p = 0.070$). Therefore, the study failed to reject the null hypothesis that there would be no difference in the median scores of the two groups. The results of this comparison are presented on Table 7.

Table 7

*Mann-Whitney U Ranked Pairs Test on PPAS*

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>6</td>
<td>14.5</td>
<td>174</td>
</tr>
<tr>
<td>Control</td>
<td>6</td>
<td>10.3</td>
<td>124</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Higher raw scores were evident on the PPAS while there was no indication of a significant statistical difference between the two groups. Of note, the scores for subscale C which for both groups range from 40 to 48, and which are higher on average than the scores from
the other subscales, relates to the parents’ acceptance of the child’s desire for differentiation.

Results for this summation are presented on Table 8.

Table 8

*Raw Scores for Portal Parental Scale by Training Group*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>31</td>
<td>45</td>
<td>36</td>
<td></td>
<td>150</td>
</tr>
<tr>
<td>42</td>
<td>34</td>
<td>44</td>
<td>32</td>
<td></td>
<td>152</td>
</tr>
<tr>
<td>41</td>
<td>44</td>
<td>42</td>
<td>50</td>
<td></td>
<td>177</td>
</tr>
<tr>
<td><strong>Control Group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>36</td>
<td>48</td>
<td>42</td>
<td></td>
<td>169</td>
</tr>
<tr>
<td>26</td>
<td>26</td>
<td>40</td>
<td>22</td>
<td></td>
<td>114</td>
</tr>
<tr>
<td>25</td>
<td>32</td>
<td>45</td>
<td>30</td>
<td></td>
<td>132</td>
</tr>
</tbody>
</table>

Table 9

*Porter Parental Acceptance Scale Median results by Training Group*

<table>
<thead>
<tr>
<th>Subscale</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental group</strong></td>
<td>41</td>
<td>34</td>
<td>42</td>
<td>36</td>
</tr>
<tr>
<td><strong>Control group</strong></td>
<td>26</td>
<td>32</td>
<td>45</td>
<td>30</td>
</tr>
</tbody>
</table>

The third research question asked: What are the individual experiences of the parents participating in CPRT training? The conceptual framework for Question Three focuses on the
individual experiences of the parents participating in filial therapy training. The findings will offer insight into possible common perspectives and experiences across the parents.

Qualitative measures

*Interview data.* Parents from both groups participated in exit interviews which provided supplemental information to the researcher regarding the data reported for the MEACI and the Porter Parental Acceptance Scale (PPAS) as a means of developing a greater understanding of the experiences of the individual parents participating in the filial therapy training. The researcher conducted this interview with each parent who participated regardless of whether they were from the experimental or the control group. During these interviews parents were asked to expand on their experiences during the 10-week training period and how the experience affected their current relationships with their child of focus. For a list of the interview questions used for these interviews see Appendix F.

The interviews resulted in three themes germane to answering the first and second research questions: acceptance, involvement or being with, and allowing for self-direction or differentiation. All six parents provided responses in the exit interviews that provided the scaffolding of these three themes. Acceptance as resultant of the interviews conducted in this study is defined as the ability of the parent participant to allow their child certain freedoms during the play sessions that encouraged creativity and problem solving while also creating a safe space that was present in the play session. Providing this space may not have been limited to the play sessions.

In the interviews the six parent participants reflected on where and how important it was to allow certain behaviors or activities that they had heretofore sanctioned and how making that conscious change expressed acceptance of their respective children. As a point of example, one
of the parents from the control group stated, “One of the most significant things that I gained during the training was becoming aware of how I spoke to the kids and wanting to provide a safe environment where I followed rather than lead.” She added, “I felt embarrassment when I made mistakes [in the play sessions] and wondered if the kids…I had never felt that, and I tell my children not to feel bad when they make mistakes, so I wondered if they really, if they were getting the message that it was ok to learn new things and feel uncomfortable.”

Another parent, one from the experimental group said, “I am trying to dig deeper and find out what’s going on before going into parent mode, I am working on allowing that space.” When asked to elaborate this parent commented that it was difficult in the beginning because her son didn’t respond to the play sessions in a way that she felt was expected, “I am not the best at communicating” saying further, “I have definitely been trying to do that more, they haven’t been as willing to share, but I am working on that, on allowing that space. She described the experience of having her son be resistant to the play sessions but rather than getting angry and taking it personally she accepted that he did enjoy the time they were spending together. It was difficult for her to embrace the freedom inherent in the filial approach to interaction, even when working on allowing that space, it is possible her son’s resistance was born out of her inconsistency. This is to say that she may have been sending mixed signals which he was unable to interpret appropriately and so, responded with resistance.

During week four of the training sessions, a mother shared a story about her first videotaped play session. She mentioned to the group that her son had exhibited very violent behavior in a drawing activity that he chose during that week’s session. She was surprised first of all that her son behaved this way, saying, “When you mentioned that you provide aggressive toys in the toy boxes and that sometimes children are violent, I was thinking my kids are not like that,
but, boy did he.” She continued saying, “I wanted to ask a million questions but I didn’t.” This was a good example of her acceptance of the child’s behavior that was incongruent with what she would have expected and with self-admission during the group meetings was leery of. She allowed him the freedom to explore this behavior without sanctioning or questioning it. When asked in her exit interview if she ever revisited the behavior outside the play session she, said no she had just, “left it.”

During her interview another mother shared an interaction with her son that both upset her and caused her to reflect deeper on her interactions with him. Her son had come to her during the time she was participating in the training and said to her that sometimes he felt like she was yelling at him. In instances where she perceived were benign parenting moments, he was seeing her as angry and yelling. She commented that while this caused her to pause and think about her tone she had been pleased that her son had felt “safe enough” and accepted by her to share that and that she was able to allow him to tell her this without “reacting”. She said, “I was upset, I didn’t want him to remember me as the one who was yelling all the time, but I was glad he felt safe enough to tell me.” This was a powerful awareness for her to be able to recognize that her son’s perception of the interactions was valid; for her to be accepting of it and consider making adjustments to her behavior or at the very least reflecting on the interaction.

The second theme that resulted from the interviews was involvement or “being with” which is described as the intentional and joint participation between the parents and their children where the focus is clearly on the immediate interaction and the attention of the parent is aimed directly at the child and what they are doing. One of the parents said regarding this concept, “I made a commitment to making the time for the play sessions. I made sure to carve out that special space in time, it was important that we set aside time just for us.” She further
commented, “I learned that she really takes in that one-on-one focus, to continue that is really important.” After making these comments, this mother shared during her interview how difficult it was to maintain that “focus” saying, “It wasn’t that I didn’t want to focus on her or pay attention, I found my mind would (gesturing with her hand to indicate wondering), I had to purposely direct myself to give her the feedback.” She continued saying, “Watching is much different than being with.” She recognized here that being next to, in the same room as, does not necessarily mean one is being with. She came to value this difference and commented that her daughter did as well. Another parent said of her son, “I liked that [he] felt special.” The same parent who had shared that her son had not been as receptive to the play sessions added in her interview that, “He really knew I was really trying to spend time with him and communicate with him.”

This was a similar experience for another parent who said, “This attention was [for] her; I don’t know if it was the time frame but she needed it more, she is having the hardest time with what’s going on with her dad.” She continued saying, “She was not verbalizing it but I could see it in her body expressions and in her face.” This family was struggling with the dad’s terminal illness. During the course of the training period, he had been moved home under hospice care and this was a predominant topic of conversation during the group sessions for this parent.

This parent showed that she was paying particular attention to how the special play sessions were affecting the interactions between her and her daughter and how the play sessions also seemed to be affecting her daughter’s behavior. She said, “I realized it was real easy to turn off her negativity by just a little attention, one-on-one attention.” She realized how important it was to provide her daughter with a safe personal interaction without discounting her feelings, but rather, provided her with a forum where she could express her fear, anger or sadness without
judgment. She said later in the interview, “Going through this process made that pronounced for me.” As a way to let her daughter know that she wanted to “be with” her even when they weren’t physically with each other this mom decided to slip her a note in her folder for school saying, “I just told her I was thinking of her, I thought she might just need a little encouragement.”

The concept of involvement seemed to be a central theme for all of the parents, while it was often difficult for them to create the time they all mentioned the importance of doing so and reaping the reward. This was also an area where the experimental group scored highest on the MEACI with scores ranging from 6 to 8 as opposed to, the control group who scored between 9 and 13. One of the fathers commented that, “The best what I did was try to take time to spend time with my kid, especially doing that 30 minute play session.” This family seemed to always be incredibly busy. Each week this father showed up right on time or a few minutes late to class and was often out of breath. He was the cub leader in his son’s Boy Scout group and he often commented while in group, on the very hectic schedule that they kept but also that he did all he could to make the special play time happen each week. He recognized that even while he was “with” his son during the scouting events this was a very different experience for them both as compared to the play sessions. He said, “It was challenging to make the commitment, but it was important to do my best to keep the commitment to this time.”

Lastly, the final theme generated from the individual exit interviews was allowance of self-direction or acceptance of the child’s desire for differentiation. This was a particularly poignant theme for this group which may be representative of the age group of the children. The study focused on CPRT with parents and preadolescent children, so the fact that this seemed to be a theme that ran through the majority of parent interviews was telling insofar as it was a typical reaction to very developmental appropriate behavior on the part of the preadolescent
children. This was also the highest score for the experimental group on the PPAS with scores ranging from 32 to 50 as compared to the scores of the control group which were between 22 and 42.

As previously mentioned, one of the parents commented that, “One of the most significant things that I gained during the training was becoming aware of how I spoke to the kids and wanting to provide a safe environment where I followed rather than lead.” And while this statement does illustrate her desire to be accepting of her children and being more cognizant of how she interacts with them, the other sentiment relates to letting her child lead whether in their interactions or in her child’s independent activities. She went on to say, “I think I will be better at letting go, letting them lead and me follow,” and that she finds herself addressing her children’s requests for help differently saying, “They initially ask for help and I find myself stepping back more and seeing if they can figure it out.” She recognizes that her children have power and while she maintains that she was not prone to caudle the children, she found they are very capable, and while it may take a few more tries, they are better for figuring it out on their own.

Another mother said, “I need to not always become some sort of coach and teacher all the time and step back.” She continues about the awareness, “It helps me analyze why I feel like I need to crack down, like the example of the size of the cookie, I mean who cares?” Allowing her child to have some control provided her with a calmer sense of her own control as parent. This mother further commented, “I want to be with instead of leading; I have taught them to be leaders, and I am still there trying to lead in those moments.” She recognized that they have the skills to make decisions, to solve problems, and to create great things, and she does not need to be leaning over their shoulder for that to happen and that she, “didn’t have to crack down on this
little aspect of what they were doing.” One of the other mothers said, “I had a hard time letting go I always wanted to intervene, but during the training I realized how essential that is and maybe how much stronger our relationship will become before she hits the teen age years.” She mentioned that she is working on letting go and allowing her daughter to, “explore for herself and do the stumbling that she needs to without [mom] intervening.” She said, “I am trying not to tell her how to do something, letting her discover.”

During the final training session, this mother told a story about a current situation with her daughter getting into some trouble at school because of a relationship with another child. She wanted very much to tell her daughter to stop hanging out with this other child but instead talked about what was happening and gave her daughter “permission” to make choices of her own on how to work this situation out. At her exit interview, she reflected on how she was contented with the way she had dealt with this situation, she had not wanted to just dictate a solution to her daughter and as she put it, “be like my mom,” and was so far pleased with the way her daughter had been dealing with the other child and managing her own behavior.

Finally, one of the fathers said, “The parent doesn’t have to be a leader you could be more like a friend, so we can understand, understand their frustration.” This example not only speaks to a parent allowing a child to self-direct but it also exemplifies this parent’s ability to recognize and respect his child’s right to feelings. He understands that frustration is a valid response to some situations, and while it can sometimes impede progress or created undesirable behavior, his son has the right to those feelings, and it is more productive and conducive to a stronger relationship when a parent can step back and allow for those feelings. Joining the child rather than dictating a solution seemed to him to create a better interaction. He mentioned to this effect, “I like the way he was transforming and trying to make decisions and trying to come up
with solutions; he was very creative.” The interviews provided insight into the experiences of the parents as they moved through the training process, but also provided information as to how they were becoming more aware of how their interactions exemplified empathy.

The interview responses along with the observations of shared experiences among the individual participants during their respective training groups reflect changes in ways of thinking, communicating and interacting. The parents collectively commented on their desire to pull back in situations to allow their children the opportunities to explore and discover their own ways of problem solving. This was expressed in the parents’ desire to allow the child to lead as related to their time in the play sessions but also in other situations like interactions with other children or family members as well as with situations of decision making.
Methods: Phase II

*Expanded Case Study and Narrative*

“When seeking essences, philosophers always seek the most universal essence, that is, those characteristics without which the object would not be what it is”. (Giorgi, 2009, p. 101)

As a means of enhancing the initial findings as reported in phase I, the researcher re-administered the MEACI and PPAS measures to four of the six original parent participants. These four parent participants were contacted via email and by phone and asked to provide an additional play session video and PPAS at a point of 16 and 20 weeks after the conclusion of their respective training sessions. Additionally and by means of either email or phone, these four parents were asked to participate in a final interview within this same time frame. The interviews were conducted at the convenience of the participants according to their schedules and venue preferences. Three were conducted in the homes of the participants and one was conducted in the office of one of the participants. All interviews were conducted with comfort and confidentiality in mind. The interviews for phase II were between 45 to 60 minutes long. The additional longitudinal data was used in conjunction with the final interview in order to gain deeper understanding of the experiences of the individual participants after an amount of time had passed since the completion of their training sessions.

During this phase of the project, the researcher expanded the case study investigation in order to gain a more in-depth understanding of the parent’s experiences regardless of their respective and subsequent scores on either the MEACI or PPAS. The efficacy of play therapy having been well researched, this new investigation became focused on how the experience of
the CPRT training influenced the parents and how that in turn related to their perception of their relationships with their children. It was also important for this researcher to better understand what drove parents to the training, why they made that commitment and what the experience meant to them. It was apparent at the conclusion of phase I that it might be important to look more closely at the point at which these four parent participants became aware that change was being affected or if they perceived change and in so doing, perceived a shift in their respective relationships with their preadolescent children. Lastly, the investigation was aimed at understanding how the parents perceived the transition, whether that was the transition of their child moving into and away from preadolescence and the significance of that experience; or transitions that would be described as familial structure change.

For phase II the study refocused at addressing two additional research questions:

1. Do parents experience a lasting effect of CPRT on parental empathy with parents of preadolescents after a period of time following the completion of the training?

2. What are the experiences of parents of preadolescent children who participate in CPRT training when examined over time, and what relationship does that experience have with their level of empathy or perception of their subsequent relationships with their preadolescent children?

Expanding the case study analysis for the second phase of this research project allowed the parent participants and me to more deeply examine their varied and individual experiences having participated in CPRT training. The perceptions of the parent participants create the foundation of their experiences and an analytical exploration of these perceptions was used as a means of expressing information about their experiences and in so doing create meaning and understanding for both the participants and the researcher.
Case study through narrative emphasizes story telling (Lichtman, 2011). The story becomes more than just a story at the point where meaning can be derived from individual or collective understanding of an experience. Husserl argued that social science is best served by focusing on the “life world” as experienced by its members (1970). This is to say that the experience of the members of the world creates truth from their experiences and that that truth creates their meaning. Examining these experiences makes it possible to view the whole process or the “hows” by which a separate empirical world becomes an objective reality for its members.

For this reason I endeavored to expand the case study approach and gain a deeper understanding of the individually perceived gains, challenges, and changes of four of the parent participants who had completed CPRT training in the first phase of the research study. With a great deal of research having already established the widely accepted efficacy of CPRT, I became more interested in examining the individual meaning of each participant as they experienced it. I aimed to delve into the phenomenon of the parent’s experience of CPRT and parent/child relationship through their narrative.

The stories or narratives of the parent participants, which utilizes many analytic lenses and approaches, both traditional and contemporary and which dictated the particular of lived experience was the general focus of analysis in phase II (Chase, 1995). Each narrative provided a means of taking retrospective meaning and shaping and ordering past experiences, while assisting me in understanding both my own and the actions of others, organizing this understanding into a meaningful whole (Blauner, 1989; Gubrium & Holstein, 1997; Hinchman & Hinchman, 2001; Laslet, 1999, Polkinghorne, 1995). More specifically, the narratives of this case study provided a means of taking retrospective meaning from the parent participant’s recollections of their experiences in the training and at home helping to shape and order these
past experiences. The thorough examination of these narratives provided me a means of better understanding the parent participants’ experiences.

The experience of my position as trainer/researcher and participant/observer (Glesne, 2006) worked to help me remain authentic to the representation of the participants’ experience and required my continued diligence in employing rigorous bracketing to separate my experience from theirs. It created however, the ability for me to establish and maintain a rapport with each allowed us to have an open relationship with comfortable and open communication.

Bracketing was required in order to suspend my own beliefs and experiences in order to retain the reality of the parent participants’ individual perceptions of their experience (Creswell, 2007; Giorgi, 2009; Moustakas, 1994). Holstein and Gubrium (2000), as reported in the Handbook of Qualitative Research, suggested that narrative can move away from the factual nature but there is still truth’s essence within the narrative that describes the narrators’ perceived experience. This is to say that the experience is their own, their own responsibility and it is the responsibility of the narrator/researcher to maintain her own credibility while representing that perceived truth to create credibility of the story. This requires constant and continued introspection and exclusion of personal biases.

While the main focus was on the individual experiences of the parent participants it remained important to also consider the shared experiences. Therefore, I aimed to acknowledge that while each instance of narrative was particular it was useful to the process to attend to both similarities and differences across narratives. (Chase, 2005 from the Qualitative Handbook) Chase (2005) found, that in order to accomplish this it is necessary as narrator/researcher to listen for and to each participant’s subjective positions, maintain authentic interpretive practices,
and to pay reverence to the ambiguities and complexities in each story. The narrative process made it possible to see clearly with respectful understanding of the perspectives and contexts of the participants (Hayes, 1998).

I used semi-structured interviews, a particular kind of discourse or communicative event from which narratives can be both discouraged and encouraged (Briggs, 1986, 2002 & Mishler, 1986) in order to elicit the experiences of the part participants. The questions were used as scaffolding during the interviews to help maintain the flow of conversation and can be found as Appendix I. While the interview questions were meant to provide a general framework, open communication was encouraged. As previously mentioned, having been with each participant both individually and as the group’s leader, I had established a semblance of my role as “insider” (Creswell, 2007). This helped to create a level of rapport that encouraged collaboration especially during the interview process as it created an environment that facilitated open and sincere communication between me and the participants. This also reinforced however the importance of continued introspection and bracketing on my part in order to remove my own biases from coloring the interaction (Creswell, 2007; Giorgi, 2009; Moustakas, 1994). With this careful consideration of my own experiences and beliefs about adult/child interactions set aside, not absent but place aside, I was able to bring clarity to my conceptualizations while maintaining objectivity of the understanding of the parent participants (Moustakas, 1994). This meant I was also cognizant of removing my biases from the individual and collective contexts of the participants (Nicholas, 2014 an unpublished manuscript).
Participants: Phase II

The participants were drawn from the original two groups from phase I of this research study. Each parent participant was asked to participate in this final phase of data collection. Four of the original six agreed to offer their time toward this endeavor. These four parents, or in this case, four mothers, were asked to complete a final PPAS and to provide a video tape of one last play session with their original child of focus for scoring on a final MEACI. Lastly, they were each asked to participate in a final closing interview. The small sample size was ideal for maintaining an in-depth examination of the varying experiences (Dukes, 1989; Huber & Whelan, 1999; Nicholas, 2014; Polkinghorne, 1989; Smith & Osborn, 2003). This study presents the multiple narratives of four mothers around their experiences of CPRT training.

Four of the six original parent participants agreed to provide the follow up MEACI and PPAS data along with agreeing to a final interview. Of these parents one volunteered from the previous experimental group and the other three had participated in the control group from phase I of the study. All the participants for this phase were independently interviewed therefore prior group affiliation was not an issue. At the point of the interview and their submission of additional MEACI and PPAS data, each member had completed their respective CPRT training sessions. This final group consisted of four mothers of two girls and two boys. The demographics of this final group are in Table 10.

Table 10

<table>
<thead>
<tr>
<th>Demographics of Parent Participants: Phase II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of parent participants (N=4)</td>
</tr>
</tbody>
</table>
Table 10 continued

**Demographics of Parent Participants: Phase II**

<table>
<thead>
<tr>
<th></th>
<th>Total number of parent participants (N=4)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age of Participant’s Child</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-years-old</td>
<td>3</td>
<td>75</td>
</tr>
<tr>
<td>10-years-old</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td><strong>Gender of Participant’s Child</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Single</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>50</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Separated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Ethnicity/Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Asian</td>
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<td>0</td>
</tr>
<tr>
<td>Black or African American</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
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<td></td>
</tr>
<tr>
<td>White</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School graduate</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Participating Parents

The participants for this phase, as previously mentioned were all mothers of preadolescent children. Each participant had completed their respective CPRT training. One participant was drawn from the experimental group and the remaining three had participated as members of the control group. The names of each of the parents, their spouses and children have been changed for purposes of maintaining confidentiality. Following is a brief introduction to each of the four participants. The information is provided as objective data that was collected through demographic surveys and through conversations or interactions occurring during the processes of the study.

Julie Mills. Julie is the mother of a set of twin girls, Heather and Hanna, age 10 years. The twins had a birthday following the completion of the CPRT training sessions. Julie was a member of the control group in the initial phase of this research project. Julie and her husband were separated at the beginning of her training sessions and remained as such for the duration of the 10 weeks. This separation ended in divorce following Julie’s completion of the CPRT training sessions and between the time of the initial interview and her final closing interview.
Julie and her husband had been married for 10 years. Julie works in marketing for a mental health facility in her community. Julie chose Heather as her child of focus for the CPRT training sessions.

Julie valued education and growth and that seemed to be a major deciding factor for her to participate in the CPRT training. In hind sight, it also seemed that the impending divorce motivated her as well in order to create a more effective way of communicating and interacting with both of her daughters but most specifically Heather as she was most concerned with what was happening with her parents at the time. Julie was a dedicated “student” and came each week very eager to participate, arriving early to most sessions and always willing to receive feedback. Julie was engaged and determined to assimilate as much as she could each week. As with her counterparts Julie was beginning to become apprehensive about her daughters becoming teenagers and was hoping the training would provide her with the skills she deemed necessary to navigate this transition by improving the communication and interactions with her children before they “pulled away” as she described it in their teen years.

Kate Brown. Kate is the mother of two children, Matthew, age 11 and Katherine age 8. Matthew was 10 years old during the initial phase of the study when Kate was participating in the CPRT training and turned 11 prior to the final interview. Kate was a member of the experimental group in the first phase of this research study project. Kate is a teacher at a specialized elementary school. Kate has been married to her husband for fourteen years. Sean, her husband is a general manager for a machine shop. Kate chose Matthew as her child of focus during the CPRT training.
As a teacher herself, Kate was a strong proponent for continued education and growth. It was important for Kate to keep up and be ready each week spending time outside the training sessions to prepare and maintain pace with the materials. As the training progressed Kate also found the material and strategies useful in her classroom, maybe even more so than with her son with whom she struggled in the play sessions. Kate was tenacious in her pursuits throughout the training period and worked hard to master the language and processes.

There were no significant happenings for this family over the course of the training sessions, neither life or system changes nor individual changes that impacted the process. Kate’s desire to participate seemed largely connected to continued growth and development rather than to address a specific familial need. As the training sessions progress it did become apparent though that Kate was desirous of better understanding her son’s development and what that meant to their relationship.

**Anna Black.** Anna is the mother of three children, John, age 12 and a set of twin girls, Sara and Samantha, age 11. The twins had a birthday following Anna’s training sessions. Anna was a member of the control group for the first phase of this research study project. Anna is an education consultant for the charter school district office in her community. Anna’s husband Frank was terminally ill and under hospice care for the period that Anna was participating in her CPRT training. Frank passed away in the space of time between the completion of her training and the final closing interview. Anna chose one of her twin girls, Sara as her child of focus for the CPRT training.

Anna, who was very dedicated to the process, came every week despite the very anxious state of her family situation. If not a little breathless, she was always prepared and ready to
participate. Anna enjoyed the company and respite the training sessions provided describing the time as “therapy”. Even in her worry for her husband Anna remained engaged and developed relationships with her group members. Anna felt comfortable to share about her current situation and often took comfort in being able to talk with me and her group about how the impending loss of her husband affected her and her relationships with her children.

Martha White. Martha is the mother of three children, two boys Ben and Daniel ages 10 and 11 respectively, and a daughter, Jenny age nine. Martha was a member of the control group in the initial phase of this research study project. Martha is divorced from her husband and the father of her three children; they have been divorced for six years. Martha is a district attorney in her community. Her ex-husband Lloyd is also an attorney. Martha chose Ben as her child of focus for the CPRT training sessions.

Martha chose Ben for this project because she was beginning to realize she was having the biggest struggle with him of late. Martha describes all three of her children as extremely bright, top of their class but sees Ben as the one she butts head with. Martha was particularly skeptical of the processes of play as described the CPRT training and how that was going to affect change or growth in her relationship but was willing to go through the process in order to develop new skills.

Site-Phase II

Interviews for phase two were conducted with comfort and confidentiality in mind. Much like the initial closing interviews, two were conducted in the parent participants’ own residences at their request while another was performed in the researcher’s office with the same
considerations of confidentiality and comfort in mind. The last participant requested that her interview be conducted in her office.

As a means of maintaining objectivity which allows for the meaningful understanding of others (Girogi, 2009; Moutstakas, 1994; Patton, 2002), I made sure there was a period, prior to each interview when I reflected anew on my beliefs around the process of CPRT training, my beliefs about parent/child interactions and relationship, my understanding of the importance of play, and the implications of filial therapy training. This, as Glesne (2006) suggested helped me to consciously guard against ethical dilemmas. Each individual interview being its own separate exercise, an individual experience for me and for my co-researchers respectively, it was important that each interaction was initiated with the same respect as the previous one. To this end I also checked myself while in the interviews to avoid the outright solicitation of information, to be mindful of authentically hearing and representing the words, values and attitudes of each participant, and to accurately interpreting those words, actions and or attitudes even or especially when they were contradictory to mine (Glesne, 2006).

For phase II the interviews were the focus of the investigation. This is to say that with this small group, the important aspects of discovery were directly tied to the individual experiences of the parents as they participated in the CPRT training. The researcher was interested in looking at how that experience was perceived as being related to their empathic interactions or relationships with their children rather than if it was related in some way. In this way the researcher, while still examining how the qualitative and quantitative data were convergent and/or divergent, made inferences about the overall experiences of the parent participants and what was important to them individually regarding their current parent/preadolescent child relationships.
Interviews were scheduled, MEACI play session videos were requested and PPAS were disseminated at 16-20 weeks respectively following the phase I exit interviews and after additional IRB approval had been obtained for this new investigation. Interviews lasted between 30-45 minutes and were used to gain experiential understanding of the parent participants in support of, or despite their final MEACI and PPAS scores.

In addition to the original body of information as provided by the initial exit interviews in phase I of the study, the phase II interviews provided information around the parent participants’ experiences of maintenance of skills learned; understanding around their perceptions of the experience as it related to the age of their children – preadolescence; and their experiences of transition during the process. The idea of transition surfaced in experiences of the parent participants either as a description of their dealing with their child’s developmental transitions, and/or their experience of transitions within the structure of the family.

**Data Sources and Data Gathering Procedures**

I explored the individual experiences of four mothers through semi-structured interviews, demographic surveys, PPAS and MEACI scores. Each of these data sources were collected at around 16 weeks following the conclusion of their respective CPRT training sessions had been completed. The semi-structured interview questions were reviewed by experts in qualitative investigation and CPRT training procedures for evaluation of the projects research questions and to establish constancy at obtaining information regarding the experiences of each of the parent participants. It was important to the process to use semi-structured questions to create some structure to the interactions while still allowing for flow of conversation. The professionals reviewing the interview questions helped me create the opportunity for open responses and an
environment that fostered discussion centered on the processes of CPRT training and how each of the parents experienced it.

The interviews were videotaped for transcription purposes as with the interviews from the previous phase of this research project. Transcription occurred over many hours of observation of the videotaped interviews, and following the creation of the typed transcription each interview was reviewed again against the video tape to check for accuracy. Notations of inflection and non-verbal cues were noted in the textual representation. This helped to more accurately comment on the contextual underpinnings of the interview sessions. This repetitive process was paramount in my continued move toward better understanding of the meaningful experiences of the parent participants through their individual narratives. My own notes and comments were added to the typed transcription as means of interpretation and as a way for me to identify and organize the individual and shared narrative themes that were description of the individual and shared experiences of the four parents participating in CPRT training. Once again, emerging themes were color coded for ease of identification during analysis. Themes were deleted or added during analysis depending on relevance to the parent experiences.

Findings

The purpose of this phase of the study was to understand the experiences of parents of preadolescent children after 4 months had passed from their successful completion of a 10-week CPRT training. Each parent’s narrative account evoked, shaped and worked to explain their individual retrospective experiences of moving through their respective training sessions and lives during that time period and after. The results are represented as both individual and collective experiences of four mothers of preadolescent children.
The data consisted of a demographic survey, the results of a third PPAS, a second MEACI, and a final closing interview which provided open-ended and authentic responses, and the observations of the researcher both during the training period and during the interviews. The topics of the semi-structured interviews included but did not end up being limited to investigations into the experiences of the parents of the processes of CPRT training, the experience of comfort as related to the training, the experiences of changes or not in the parent/child relationships, and finally, the experience of the impact of CPRT training on the family unit.

Following are the MEACI results for the four parents who participated in phase II of the research study project. These results as presented in Table 11 indicate the raw scores from the final tests that directly followed the participant’s respective training sessions and the scores that were collected after 16 weeks following their completed training sessions:

Table 11

MEACI Test Results: Phase I and Phase II

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Subsection of MEACI</th>
<th>Phase I</th>
<th>Phase II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Brown</td>
<td>A</td>
<td>16.0</td>
<td>18.0</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>17.0</td>
<td>20.0</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>9.0</td>
<td>11.0</td>
</tr>
<tr>
<td></td>
<td>TOTAL SCORE</td>
<td>42.0</td>
<td>49.0</td>
</tr>
<tr>
<td>Kate Brown</td>
<td>A</td>
<td>9.0</td>
<td>11.0</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>13.0</td>
<td>10.3</td>
</tr>
</tbody>
</table>
Table 11 continued

*MEACI Test Results: Phase I and Phase II*

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Subsection of MEACI</th>
<th>Phase I</th>
<th>Phase II</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C</td>
<td>7.0</td>
<td>9.0</td>
</tr>
<tr>
<td></td>
<td>TOTAL SCORE</td>
<td>29.0</td>
<td>30.0</td>
</tr>
<tr>
<td>Anna Black</td>
<td>A</td>
<td>15.5</td>
<td>11.0</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>28.0</td>
<td>12.0</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>12.0</td>
<td>7.0</td>
</tr>
<tr>
<td></td>
<td>TOTAL SCORE</td>
<td>55.5</td>
<td>30.0</td>
</tr>
<tr>
<td>Martha White</td>
<td>A</td>
<td>16.5</td>
<td>17.0</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>20.0</td>
<td>11.0</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>13.0</td>
<td>21.0</td>
</tr>
<tr>
<td></td>
<td>TOTAL SCORE</td>
<td>49.5</td>
<td>49.0</td>
</tr>
</tbody>
</table>

The following outlines the MEACI results for the four parents who participated in phase II of the research study project. These results on Table 12 indicate the raw scores from the final tests that directly followed the participant’s respective training sessions and the scores that were collected after 16 weeks following their completed training sessions:
### Table 12

**PPAS Test Results: Phase I and Phase II**

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Subsection of PPAS</th>
<th>Phase I</th>
<th>Phase II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Julie Brown</td>
<td>A</td>
<td>43</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>36</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>48</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>TOTAL SCORE</td>
<td>169</td>
<td>158</td>
</tr>
<tr>
<td>Kate Brown</td>
<td>A</td>
<td>32</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>42</td>
<td>31</td>
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<tr>
<td></td>
<td>C</td>
<td>34</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>44</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>TOTAL SCORE</td>
<td>152</td>
<td>131</td>
</tr>
<tr>
<td>Anna Black</td>
<td>A</td>
<td>22</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>26</td>
<td>27</td>
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<tr>
<td></td>
<td>C</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>TOTAL SCORE</td>
<td>114</td>
<td>135</td>
</tr>
<tr>
<td>Martha White</td>
<td>A</td>
<td>30</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>25</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>32</td>
<td>40</td>
</tr>
</tbody>
</table>
Table 12 continued

**PPAS Test Results: Phase I and Phase II**

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Subsection of PPAS</th>
<th>Phase I</th>
<th>Phase II</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>45</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL SCORE</strong></td>
<td><strong>132</strong></td>
<td><strong>145</strong></td>
<td></td>
</tr>
</tbody>
</table>

Following are the narrative results from each of the four mothers. These data show how each participant interacted within her family while participating and following the completion of her respective CPRT training period. Each participant’s summary is represented as an individual narrative examination which describes both structural and textural experience of each mother and the resulting impact on the family’s maintenance or not of equilibrium (Moustakas, 1994).

Throughout the narrative there are also discussion of the parent participant’s experiences as they relate to the numerical data collected as a means of drawing comparisons between the test results and the individual experiences of gains or struggles. It is hoped that the collaborative comparison of the narrative and numerical data will create a holistic picture of the individual and collective experiences of these four parents. These narratives were also informed by the collective researcher reflections and interpretations during the interviews and while participating in the CPRT training sessions.

**Julie Mills.** “I wanted to learn how to be a better parent… to learn about my child’s behavior at this age”. Julie was concerned about what the future looked like for her family. Her twins were moving through preadolescents and changes had begun in their family. Julie felt like this was the time when it would be most important for her to learn what she could about the
special stage of development that was preadolescents and that she thought this training might help her to, “normalize things that she might struggle with”. She was very interested in gaining a better understanding about what preadolescence would mean in regard to her child and hoped the new skills offered by the CPRT training would improve her interactions with her daughter. She said, “I knew it would be good for me, um to help me with my parenting skills.”

Julie was beginning to see her children make the transition from child to preadolescent, and while she seemed very aware of what those changes meant developmentally, she was making an effort to learn more about how to best navigate that transition. Preadolescence is marked by a desire of the child to become more independent and to move outside the purview of the family. With this, Julie was worried she would lose opportunities to develop open communication with her daughters. Her desire to take this course was spurred by her desire to create that channel of communication and to gain skills that would help her maintain appropriate interactions by better understanding her preadolescent daughter/s by better understanding their changing needs.

Transitions-Divorce. While we were talking about what the transition of preadolescence meant to her insofar as the projected struggles she may have with the twins through preadolescence but even more frighteningly into being teenagers, Julie said she wanted to do what she could to benefit her family. There as a distinct pause at this point in the conversation, Julie shifted and looked pointedly at me and said, “You know… the other thing is, that we were in the middle of a divorce, and so if there was anything, any skills I could pick up, anything that would help all of our family members, then I was willing to do whatever.” Julie settled back into her chair; I remember reflecting that there had been no indication that this might have been brewing during our time together in the training.
There was always a very authentic sharing of information, but she had never brought this up. I commented on this and she apologized, to which I told her that was not necessary at all, this was her process, this was her journey and my comment was only made to illustrate how stressful that must have been for all of them. The added stress of separation and in the case of this family, divorce changed Julie’s motivation to a certain extent. Initially she wanted to learn about the processes of CPRT as a means of learning how to better communicate with her preadolescent daughter, but with the impending family changes she knew there would be more to address. She said, a bit more relaxed now for having said it out loud, “I knew this was coming; we were sort of in the beginning stages of being in the midst of it, and I thought how do I best parent these children through this major transition?” Julie was clearly very interested in making sure she provided an environment for both of her daughters that was open and accepting of what they might be going through as their family went through this change.

Transition was a major theme throughout Julie’s story. She was concerned about her children’s transitions from being children to preadolescent while also being aware that their family was going through a major life change. She believed it would be a time of struggle so she welcomed the possibility of “absorbing” new knowledge around the interactions she had with her children. She said, “I had children right at the age range of the study, and I thought it would be really valid,” and that she would be able to, “pick out what was normal and where I should be frustrated, or where they were testing and what maybe was a product of additional stress in our family.” She was noticing that the girls were, “more emotional”, and she wanted to “allow them and to make it normal that they are going through this, she’s going through this”. Through her experience in the training, she was learning to acknowledge this emotionality and accept it as very valid. This is to say she was learning to be respectful that emotional reactions came from a
deeper place and in this case she was learning to be open to it. She continues, “I let her lead me to, and whatever comes out comes out. A lot of times I just find out she is exhausted and she needs to sleep but she…in that way it’s vital for us getting through this.” Julie believed it was of great importance that she learned how to deal with each layer appropriately and believed that was what the CPRT training had to offer her.

“The family has shifted and everything that comes with that it, that is a loss, however, I think the skills for me, in a way allowed them… I think we will just be closer or more connected because of it”. Julie was very cognizant of what a divorce meant for the family and was working very hard to maintain homeostasis in the midst of it. She wanted to make sure she was in a space where she could recognize the changing needs of her children and work out what was normal or typical preadolescent behavior and what may be a result of the changes in their family dynamic.

“We will get through the transition in a more smooth way because I am leaving the door open, and again, so vital because it wasn’t just, this transition was such a big thing that has happened, unfortunately but it has happened, so I think the skill became even more weighted because it is such a stressful transition”. Julie was learning to be more in tune with her children during this transition. “Their life was just turned upside down, and I want to be mindful that their life was turned upside down”. This was definitely one of the reasons Julie decided to participate and decided to commit. “Kids are going to have challenges no matter what, even if a family is not going through what our family went through, and this experience, I would tell people that it is worth the commitment”. Julie found a great deal of value in the process in spite of what was happening in her family at the time of the training.
Regarding a different kind of transition, and a common theme that was present for all of the moms who participated in the second phase of the study, was the transition between children and preadolescence. As previously mentioned this stage of development brings with it a dichotomy of child behaviors that vacillate between dependence and autonomy and maturity and immaturity. The key for these participants seemed to be how they navigated these polar opposites in their children.

Allowing for independence when appropriate and being supportive in the same turn. “She is ready for the things, she’s been ready, and I am grateful that I did this now so that I could recognize that I could give her the opportunity”. Julie was starting now to realize that her daughters were capable of more independence and in need of less guidance. Julie said, “I think the training made me realize that I didn’t need to lead them, that it is very important for them to learn how to lead themselves…it refocused me anyway so that it, so I could allow them a different way to grow.” She realized they were no long little girls who needed her to constantly dictate to them how they should be, how they should react, how they should solve problems.

Julie said this realization came from the “rules of thumb” that were part of each week’s lesson. “I remember things like, grant in fantasy what can’t be granted in reality, and those things go through my mind, or you don’t have to fix this for them, you know let them lead me…I am trying not to lead them, standing back and allowing them to explore; it is becoming obvious that they want more reign, they want to experience more things and with that comes learning from your mistakes”. Mistakes are not the enemy, failing is not always a bad thing; Julie was starting to look at the process of growth and independence with a better understanding that learning is more profound if the right amount of frustration is applied. This is to say that she was finding value in letting her children explore and get lost if that is what needed to happen for them
to solve a particular problem or simply have the ability to make a choice and be responsible for the outcome.

*Struggling with change: Making Mistakes.* Learning new skills, making changes, these experiences can often create person or systemic disequilibrium. It is how the individual or system responds and resolves this discord that is important and provides meaning to the experience. There is no formula, either failure or success can be a response or a resolution but meaning is the outcome either way. Julie experienced disequilibrium throughout her participation in the CPRT training. The impending and eventual divorce created a stunning backdrop of disequilibrium within the family and parallel to her experience while participating in the training. She commented that she aimed to create “normalcy” in the family’s schedule all the while acknowledging that her daughter’s world had been, “turned upside down”. Even at this junction, or as a product of retrospective reflection, she was aware that she wanted to keep the family whole, in whatever form that was to be and hoped the training would offer her some support to that end.

Julie maintained a very introspective process throughout our conversation and this allowed her to gain access to her fears and failings as she saw them. Julie described several instances of discomfort as it related to the training material saying, “There was a newness level, you know, of trying it and then sort of fumbling and not really being sure what to say.” She saw this as an issue saying, “I am the parent; I should know what’s going on here.” She knew how to interact with her children; she had been doing it for 9 years. She knew how to communicate effectively; she was in tune with their needs. She didn’t fully understand that she was in the process of learning a new language, not at first.
With further discussion and introspection however, she realized that her fumbling was very much part of the process and she was able to say, “I was learning something new in a different way to think about it.” This realization came as she was describing the interactions between her and her fellow group members; it became normal to “fumble” to “struggle” when she was able to see that the other parents were “fumbling and “struggling” too. Connection to the group allowed her to normalize her struggle and described that experience saying, “When you hear other people, other parents, you realize you are all kind of learning pace so you go, oh okay!” Within this community, her discomfort transitioned into understanding which was powered by very sincere desire to learn these new skills and this new language in order to create openness in her relationship with her daughter.

A central tenant to CPRT is to help parents gain empathy through the acknowledgement of feelings. This concept does not simply lie in the parent’s ability to recognize but also to find value in or respect that the child has the right to these feelings no matter the situation. This process is linked to the parent’s empathy development and is key for improving parent/child interactions. Part of this process is to acknowledge that validating another’s feelings may in some situations be difficult or frustrating especially when considering the parent/child dynamic.

Julie’s results on both the MEACI and PPAS were higher at the completion of her training but still indicative of growth when examined for the second phase of this project. The subsections of these two measures provide a glimpse into Julie’s progress and that are best supported by her recalling of the experience are subsection (A) communicating acceptance on the MEACI and subsection (A) of the PPAS which describes an acceptant parent as one who regards his/her child as a person with feelings and respects the child’s right and need to express them. While the effects of the training seemed more profound closer the to the completion of her
training sessions, her recollection of the process and a re-visiting of the experience seemed to bring it all back up to the fore once more.

*Play is important.* Information about a child’s feelings is rarely expressed verbally, often it manifests in other ways; behavior, outbursts that seem incongruent to the present situation; and through play. Julie recognized that she was improving on her ability to access these feelings by assimilation of the skills from her training sessions while reflecting on her play sessions. She said to me, “As a mom, you sometimes forget to play with your kids and you forget to hear what their play is saying, and you forget that their play is telling you something and that it is really valid; it’s their work, like my work is my work”. She experienced the notion that play is important and was open to “hearing” what her daughter might be saying through her play. Julie said that play was very important in her family and that through the processes of the training she was learning how much more important it could be for her and her children.

Julie told me that paying attention to her daughter’s play both during their play sessions and out, gave her a “heightened sense of awareness”. If her daughter wasn’t talking to her directly about her feelings she could observe and be present during their play sessions and she was learning “to at least be able to recognize that there’s other stuff going on here”. Her new found or at least newly fostered ability to be open created the opportunity for her to practice paying closer attention and be present to which she said, “I am picking up on things a little better, so I am certainly not a therapist, but I am open enough to receive the information…that is a good direction”.

Being open is certainly a move toward effective communication between parent and child. This awareness, that of what’s behind the behavior, the words, the play, allowed Julie to
also recognize how questions can be a barrier to communication especially questions that bear expectations. Child will always answer the question. Julie had begun to understand however that instead of asking “How are you?” and receiving the pat response “I’m fine”, she had another way of gleaning an authentic response by withholding the question. Instead she remained open to her daughter’s world of play. This opened up to other situations outside the play sessions as well. In being open and respecting the process she was learning that her daughter not only had the right to feelings and the need to express them, but that those feelings were worthy of respect and imparted a great deal of important information for her.

Making this shift was an important indication that Julie was benefiting from the CPRT process and had learned the value of letting her children know she was paying attention; she was present and therefore didn’t need to ask the question, knowing that doing so sometimes undermines the relationship. This is to say if she can show her children that she understands and hears their message the question is unnecessary, and in just letting them know she can see what they need and provide support toward that need then she creates a gateway of trust in the relationship and for future communication. This shift for Julie had a side-effect. She had begun to notice that she was becoming less directive. She commented on the fact that it had somewhat to do with the fact that her girls were getting older, “they aren’t two anymore”, but it seemed more broadly to be a recognition of their emergence toward greater independence even in the midst of this stressful transition.

In her constant desire to keep the family on track, “to get them from A to B”, to maintain the families normal routines, she was stopping in the midst of that to see and to allow her children to, “lead themselves”, to be responsible for themselves, and in a sense, take care of themselves. As any good mother would want to do in a time of family crisis, she recognized
how much she wanted to control all their experiences, reactions, feelings, and when she looked at this through the lens of what she had learned and very much assimilated, she was seeing now how much more important it would be for her to support rather than protect.

By empowering her children and recognizing that they were capable, she began to see them become more capable. Julie spoke to this saying, “Now when their emotions come up, now, um I’m less likely to say it’s going to be okay. I am more likely to say you seem sad or I see tears. I am more likely to just sit with them and be empathic that way instead of trying to fix it!” There is strength in feeling capable, and Julie was learning that both for herself but also how to foster that with her daughters. In this case one might be able to say she was, “teaching them how to fish” rather than just handing them a fish.

**Martha White.** “My middle child and I butt heads a lot, and I thought that any advice that I could get or training, anything might help...It has been since birth!”

Martha is a successful attorney and mother of three, and she was hoping to get some strategies to help her work with her middle child, a child who she admits is very much like her. Ben was 10 for the majority of the time Martha was taking the CPRT training; he turned 11 in the summer following her training completion and this final interview. The first theme that became apparent very early in Martha’s story was that she lives and respects the world of intellect and spending any time with her one on one it becomes very clear how much that world is where she “feels” most comfortable.

**Head versus Heart.** When the flow of the discussion moved to thoughts or feelings around certain aspects of the training or her experiences with her child, Martha’s responses centered on her thoughts, rare was the occasion where she “felt” about things. We began the discussion
around the logistics of the training sessions; time allowed, environment, materials and while it seemed that all things considered the process was comfortable for Martha, it was evident that there was something else to the story. Martha said, “It was a good amount of time, I just think my own self, I didn’t really get the play therapy part.” “It was hard for you,” I said. There was a slight pause, and crossing her arms over her chest she replied, “Yes, but I don’t think more time would have helped me, possible somebody showing me with Ben because he just seemed to outsmart me.”

The scene was set then and the discussion turned to what made the process most difficult for her. The difficulty seemed to be leading us in the direction of the existing relationship, but not just with Ben, with all of her children. Martha described the phenomenon that her “Momness” was getting in the way of implementing the skills and language of the filial therapy process and especially the language. The language, because it was so different from the predictable, or interchangeably, habitual, patterns of communication normally employed with her children was creating a barrier in the filial process. Martha said, “I don’t think I was couching the language right, because he would just call me on it. Why are you acting so strange Mom?” Martha was struggling with the implementation of the language in the play sessions; she had no problem pontificating on the words or learning the patterns, but she was struggling with being able to deflect her son’s curiosity of the process. Every time she tried to use one of the play session reflections or the follow the processes of the play session she seemed to be blocked and could find no way around it. Because this was so different from the way they usually interacted, she was struggling to make changes in her behavior. Martha was uncomfortable with the reflections because the reflections are generally meant to focus on drawing attention to the emotional state of the child as expressed through his play.
The language of play therapy is intentional; it is meant to create an environment of presence and to encourage empathic interaction between therapist and child or in the case of filial therapy, between parent and child. Martha could not find a way to counter feeling uncomfortable, nor could she find a way to respond to the feelings her son was having, which in her mind made the interaction “weird”. She was struggling, in other words, with integrating the concepts and the language, and when Ben responded to the awkwardness, she chose to shut down. She comments on this saying, “I was interested in the material, I was however frustrated with my inability to roll through the play language.” The material was learnable; she could read and digest the information, but any sign of struggle she found she was unable to translate that learned material into the play sessions. She was finding it difficult to make changes, at least initially with her patterns of communication, and Ben’s responses to her attempts reinforced that sense of awkwardness. She said of the training sessions, “I think through discussions in the class I kind of got a feel for what I should be doing but actually implementing it did not get easier, but I did change my style from the very first session.”

I asked her in what ways, to which she replied, “I didn’t pound him with so many questions,” she went on to say, “yes because he thought [the reflections] were so odd, so I took more of his lead but then there was a lot of quiet.” This, she said was also very difficult for her, to sit in the quiet, to be still. She always does a lot of talking; she always does a lot of asking questions. It seemed that because the process of filial and play therapy are more directing at gaining information and making connection through being present and not asking questions, Martha and Ben were both feeling uncomfortable with this kind of interaction; it was so different from what they were both expecting their time together to look, feel, or sound like.
Struggle with Change: This just isn’t how we do things. When we talked about her experience of awkwardness or this feeling of discomfort, I wondered what the awkwardness was saying to her. “It’s hard, I think especially with your own child…the language and that I am not real creative, I mean it just seems so…when I watched you or that other guy [Gary Landreth], it just seemed so easy, but when you mix it with the relationship, with your child that is based on something that is completely…like in my case, he’s like what are you doing?” In her case the relationship was getting in the way.

Play therapy is based on the notion that relationship is foundational to its success which is why it seems filial therapy is so successful; the relationship is already established, is already intact. Because the relationship already exists, parent and child are halfway there. Martha’s experience was that this was not the case, or at least her inability to make the shift during the play sessions made her feel like the relationship was a barrier. “I guess 9 or 10 years of history, of how we acted…I think if he was younger and that, not so smart, it would have been, it would have gone better…I would get so self-conscious.” That sense of self-consciousness was compounded by her inability by her own admission, that she was not playful. Her interactions with her children were more focused on interrogation, maybe not as intense as she might experience in the courtroom, but it definitely left little room for freedom of communication.

Playfulness or the lack thereof. There was definitely a theme evolving here around the established relationship between Martha and Ben, but there was another piece of the puzzle. Martha was really struggling with the concept of play. Playfulness was a very foreign concept for her, and it wasn’t something that was a big part of her interactions with her children. The uncomfortable feelings she was experiencing in the play sessions had as much to do with her inability to attend to Ben’s play as it was for her to grasp the language of the process. She had
been very skeptical in the first place that Ben would play during the play sessions, which may have been a projection of her fear of play. Their relationship was not playful. That being said, Martha had made the commitment to the training and started to develop an understanding of how important it might be to change the way they interacted even in the midst of her discomfort. She may not ever be described as playful, but she was learning the importance of play in the lives of her children and she was learning to be present.

She had an awareness around her beliefs about what CPRT had to offer or rather what filial therapy processes meant in parent/child interactions, to which she said, “I think that it fits in that I believe in everything you taught, and it made me intellectually aware that I am not implementing any of it, yeah… I think their dad does do this, like naturally, so with that being said, I think it made me more aware to be more like that, and I wish he would be more like me so there, so we could come to a happy medium.” I remember having the thought that Martha had a desire to be more empathic, understanding and patient but that she lived in the comfort of her intellectual world because that was what was natural to her. She recognized the importance of that emotional place, understanding at the same time how important it was for her children to have that emotional sensibility and that the parent/child relationship should have this component; she was just struggling with how to get there. She was moving in that direction; she was not static anymore and that too was causing a bit of discomfort as change often does. What she was looking for was a way to be more comfortable there and that was the reason she had continued on with the training even though it was awkward and a bit messy.

To this end, when we talked further about my reflections; she mentioned that at one point she felt demoralized at her inability to effectively implement the play therapy language but had the revelation that the training process had given her some valuable skills. Of the process
Martha said, “It kind of slowed me down on a day-to-day basis of just, you don’t have to be teaching them, you don’t always have to be quizzing to see if they know the answer, so you can just be there with them.” There was a benefit even, to making it through the play session, to pushing through the training and she was actually seeing a positive effect on the relationships she had, not only with Ben but with the other children as well. Ben may have thought the play sessions were awkward and weird, but he was enjoying the one-on-one time with his mother. Recalling her last play session, “I was just there for him; I really didn’t do anything, and I didn’t have any questions; he was very, I could tell he liked me there.” She said she felt a lot more authentic, “I, I, I am not very good at the language, so I am just going to be there and so it went well.” I then said to her that she must have felt good about that, and she responded, “Yes, and I think he did too; he liked it!”

At this point it was clear that she was seeing how her work with Ben had transferred over into her relationship and interactions with her other two children as well as Ben outside the play sessions. “The process slowed me down and I’m just, there, I am not, I just can’t believe how I would just pepper them with questions, kind of quizzing, it wasn’t always about the answer, but now I’m just quiet with them; I’m quiet and I am just there.” She had found a space that she was able to maintain; she was getting comfortable with stillness and metaphorically she was moving forward in that stillness toward empathy.

She was not a master of the filial approach, but she had been able to create a space to share with her children that was no longer like the courtroom where she spent her day examining and cross examining. “I don’t think they notice that I am not asking them a lot of questions, or if they do I don’t know, but they like it, they, especially on the trips we go on now, they want to be around me, and they want to be around me when we get home.” She was much more self-aware
at this point, and in that awareness she was able to be okay with her failings: “I don’t always implement it or stick to the language, but I feel good in that I recognize it, and I think those play dates with Ben made me realize I do not just let them talk; I am constantly questioning them and drilling them about…” she paused here and leaned forward not quite slamming her hand onto the table but hitting it for emphasis to her statement, “it is paying off…in school they are grades ahead.” Then she sat back in her chair, her body relaxing, “But that is not what life’s all about, especially in interpersonal relationships.”

Martha’s MEACI and PPAS scores may not have provided a complete picture of her growth. Empathy is not only about being aware of the emotional world of others, it starts with recognizing one’s own emotional world. One must be available first to one’s self before being open to another. Martha summed this up saying, “I am really happy about that awareness. I am really glad we did it now because if they were in high school and almost out of the house, they would be like, 'Oh my God! Mom was just like a, a drill sergeant!'” At the start of the training, Martha and I had a discussion around her chore chart at home for the children. This chart had a few small tasks that each of the children needed to complete and the time frame in which they had to complete it. By the end of the final interview it was very clear that she had been able to let go of some of that rigidity. She was beginning to be more flexible and she was happy about that shift for her and for her family.

That was not the memory she wanted planted in her children’s minds about their relationship. She wanted to move toward a different way of being with them and was taking responsibility for her role in that change. There was definitely a struggle here for Martha, to move away from such an intellectual place to one more accepting of emotional expression. Gaining empathic awareness was uncomfortable because it pushed back against her sensibilities,
but she was embracing that awareness as a valid means of improving her relationship with her children. Was empathy achieved? Maybe not in the academic sense but change was affected and there was a move toward empathy by way of increased awareness and self-reflection. In this way there was improvement in the parent child relationship which is a goal of participation in CPRT training.

**Kate Brown.** Kate, an elementary school teacher at a Montessori school in her community was very interested in participating in the CPRT training as a means of gaining parenting skills but also saw value in learning new skills she could use in her classroom. Kate was further motivated to improve her relationship with her son Matthew, an extremely bright book worm who was riding the cusp of becoming a teenager. Kate was an exceptional student; she always wanted to be prepared whether that was having done the reading or the “homework”. She was conscientious of being able to participate each week. “I didn’t want to come to class unprepared, so I kept up with the materials - you had a week to do this, it was important. I wanted to participate so I tried to make sure that I kept up with where the class was, so I could participate fully.” Kate was always prepared and made a concerted effort to be engaged. It was clear that Kate was very interested in gleaning what she could to improve her relationship with her son.

*Struggle with change.* The materials, the language, the book work - that was the easy part. The play session, the preadolescent book worm; that was where the struggle lived. “I didn’t get a chance to try this with my daughter, and that was something I thought afterwards that I wanted to see how it worked with her, to see the difference because Matt was very uninterested, and I kind of wondered if it would be different for Kathleen. I think she would have been more interested in playing with me.”
Kate perceived her relationship with her son as being healthy, but she was worried about the changes in his behavior as he moved closer to his teenage years. He was not acting out, but he was pulling away, and Kate was starting to really feel her own growing pains because of this. Some of it was that Matt was getting older, she got that, but she wanted to maintain a good relationship with him, “You know be able to talk with him and communicate through those difficult times, especially as he does approach the teen years; he’s the one who has already developed, kind of an edge.” It is very clear that Kate has a deep and complete understanding of her son; she can see who he is, she knows how he is and at this point she was trying to fit her round peg of a son into the square hole of filial therapy.

She was motivated to learn the new skills, capable of learning the material, desirous of a strong relationship with Matt…and struggling with his growing up. “I think he has always kind of been a little more of a serious child, I mean when he was young, he definitely liked to play, but he would prefer now just to sit in his room and read.” There is a sad sort of resignation here that he would rather withdraw into his books rather than spend half an hour with Mom. “I was like, think of it this way, as 30 minutes of uninterrupted time you know, that I am giving to you, your undivided attention, and he was just kind of like…” she shrugged her shoulders here indicating that he seemed quite uninterested in her proposal. They ended up playing several games of Connect Four during that play session she said, still looking dejected, but resigned to she got what she got. There was a sadness in her telling, a sadness even behind her nervous smile. She was aware of his changing needs but hadn’t fully reconciled her feelings about these changes. The growth here for Kate though lies in her ability to meet his needs despite her sadness around his lessening need for her.
The discomfort that Kate described seemed parallel to the awkwardness that Martha had described with her son. The resistance in both families seemed centered around play or playfulness; however, the difference is with whom the resistance came. In Martha’s story she was the one who resisted being playful or emotional; Kate seems almost to be mourning her son’s lack of interest in playing, and even deeper, his lack of interest in playing with her. This was further adding salt to her wounds as she described his very age appropriate but no less heartbreaking resistance to physical touch.

*Hands off Please.* “Since Matt has gotten older he really doesn’t want physical touching especially out in public, so this is one thing I keep in mind.” She says this with an “I’m almost the mother of a teenager so I knew this was coming. I respect it, but I am not sure I like it”, sort of body language. Even though it is clear she makes every effort to respect his space, she says she still tries, only at home of course to, “give him a little tap or a hug or a rub on the head, some kind of physical connection that is one of my things.” She wants very much for him to know that she loves him and while he seems to be shrugging off his need for physical touch, she does not ever want him to feel that she is withholding anything from him.

Kate showed improvement in two subsections of the PPAS, subsection (A) which states that an acceptant parent understand that his/her child has feelings and respects the child’s need to express them and subsection (B) which states that an acceptant parent recognizes and respects his/her child’s need for differentiation. These areas of improvement are evident in her experiences of growth and understanding. She also made gains on her MEACI score for subsection (B) which illustrates empathic responding to her son regarding allowing his self-direction.
Kate struggled and mourned the fact that her son was in small ways pulling away from her, a developmentally appropriate phase for preadolescent children. But that struggle did not keep her from learning even more about and growing to respect those changes in her son. She learned effectively to modulate her own needs and in so doing has allowed a safe space for Matt to go away with the knowledge that she is still there if he needs her. She created room for him to come to her if he needed it or not as the situation dictated, and while the play sessions were not as successful in her mind as she would have liked, she was gaining knowledge from them in the form of self-reflection.

**Anna Black.** “As I read through the flyer that was sent home from school, I thought maybe I could learn some skills, some parenting skills with my kids and given the dynamics of my husband being sick, I felt that my stress level…I knew it was only going to get worse as my husband was terminally ill. He passed away in the spring.”

*Transition: Where do we go from here?* Anna was calm and even smiling. There was almost a sense of relief in her telling; her husband had been ill but had not passed away since we had last seen each other. She had been working through the training sessions each week while her husband was home very sick with cancer. She was there every week, sometimes a few minutes late, but there every week and she grew in her participation in the group every week. But each week she worried: “If he was going to pass and would be gone, I wanted to follow through with that commitment, knowing that I needed those skills whether he passed or didn’t pass because I was going to have to deal with my children.” There was a lot at stake for Anna; the prospect of raising the children without their father was a major motivation for her to gain some knew skills. She knew she was not only facing the loss of her husband but that this was going to change and
impact everything in her family system. She knew this was not just her pain but her children’s pain. This was going to be a major transition.

“The amount of patience that I used to have was getting slimmer and slimmer, and the training really helped me focus on the, ‘Oh yeah I need to have more patience, because they were going through what I was going through too with their father.’ I kept going, reflect, reflect, reflect. It’s not just me going through this at home it’s them…and they don’t have a total understanding so….” The training was a lifeline, something she could grab onto to help her stay afloat during this very stressful time. Even more, this was something she could draw from as she embarked into her uncertain future. She had little that she could control except her own actions and her decisions, everything else was infuriatingly outside her purview.

As puzzle pieces started to fit together, she started gaining a footing, both in her work in the training but also in her every day at home. About six weeks in Anna said she started to feel differently, “I didn’t totally feel like a fish out of water. I felt a bit more comfortable. I was also picking up on, you know, that I was reacting to her [Sara] differently, but it wasn’t just on film, I was trying of course to use these skills along the way… it was therapy for me.” As Anna started to gain some competency she was feeling empowered in her relationships with her children and as an advocate for herself and her children with the impending death of her husband, their father.

The training helped her along the way, she said, to talk to them about what was going on, and she became very aware of how important it was for her to, “acknowledge their feelings too, I mean it’s watching him suffer and acknowledging their sadness and letting them talk.” She mentioned that they eventually had to put her husband on hospice care, which made counseling available for the whole family. The children seemed uninterested in the counselor, but each of
them gave their own reasons and alternatives. Her son said he would rather talk to his teacher, and her daughter, Sara, said, “I like playing.” Anna said this really validated that she was doing the right thing. She said, “The door was open and I opened it, for the counselor if they needed it, it wasn’t that I got everything taken care of but I got the feeling, I think they are okay, I think they are okay.”

We are We: Community is Important. The community or small group dynamic was an incredibly important aspect of Anna’s experience of the CPRT training sessions. She said of this, “I really enjoyed the fact that it was so small, we felt like we could share, and I mean really. I think we shared some very deep things, personally that was going on for me, and I think we were all learning from each other.” For Anna the dynamic of the weekly trainings provided a comfortable, predictable foundation for her to move forward and learn the processes. More than that, she was able to find strength from her group members each week because of the nurturing, safe environment that had been created. Anna had a great deal of commitment to the training and she was definitely an illustration of the idea that you get out what you put in, “it turned into more than I originally thought I was going to get from it.”

Anna gained as much from the materials as from her fellow group mates, taking from their positive experiences or struggles, a new strategy or the idea that she was on the right track. She spoke to this saying, “We are all in kind of the same place and we are all struggling with the same, very similar problems, and I started to feel a little more comfortable on film.” Feeling a sense of commodore with her fellow group mates helped to normalize her parenting experiences even in the midst of this very sad and stressful time. She did not need to be surrounded by other parents losing a spouse and co-pilot to find commonality in her experience of raising preadolescent children. For Anna that was enough to feel less alone during this period of time
and to be able to focus on the CPRT processes. Anna comments on this saying, “At first it was a little awkward, but watching you model it and seeing others, that made me feel more empowered. Okay, I am on the right track and am putting pieces together…it made sense.”

*I’m the antecedent.* Along with a set of new skills and some shiny new language, Anna was developing a sense of awareness, self-awareness and a growing awareness of her children’s inner worlds. The training was helping her reflect rather than react. She described it as stepping back and really trying to think about what was happening with her child and not be so quick to react or tell her what to do. She said she had always tried to understand, “what was the antecedent to this behavior?” But as a result of gaining a new perspective and fully embracing the new skills and embracing what was really behind them, she was learning how to, “make her child aware that she heard her, that she was going to listen and help her feel valuable and gain more self-respect.”

Anna found that this was really opening the channels of communication between her and Sara. Anna shared that Sara was a reactive and emotional child and she was prone to, “stomping off and just trying to, you know, everything was BIG, slamming doors and whatever…..” Where she used to respond punitively, addressing the seemingly incongruent outburst as simple temper tantrums, she was shifting toward empathy and instead of exacerbating the situation, she would say instead, “Hey, you know I’ll be in my room if you want to talk about this, cuz, I don’t know what is going on with you right now, but I’ll be right here if you want to…..” She said she is quicker to stop herself and say, “Wait because I’m more aware, if I say *that* what kind of reaction am I going to get…so often I realized I was the antecedent!”

She was acknowledging how much of her reactions were affecting her daughter’s behavior, that there didn’t always have to be a lesson to be learned. This shift in their
interactions was being reinforced by fewer outburst and better interactions. Anna was seeing successes in her relationships and finding strength to move her through her future. “My parenting skills have been enlightened and enhanced by this course, and I sometimes wish there was a part two. I am so fortunate to have been chosen to be part of this. I am glad I was able to help, but more than that I walked away with a lot more skills.”

Anna did walk away with a lot more skills and even more than her group mates, Anna had a profound increase in her skills set as indicated by her final MEACI and PPAS scores. Anna improved in all but one subsection of the PPAS between the completion of her training and the final interview. She not only assimilated the material but had sustained the skills in a way that was clearly reflected in her personal experiences and the changes in her relationship if not more clearly in her test results.

Chapter Five - Discussion

Statement of Problem

This study addressed the problem of improving the parent/child relationship with parents and their preadolescent children. Parents often struggle with their children at different times in their child’s development however the stage of preadolescence seems to be a particularly difficult time for the relationship. The challenge of understanding the swaying needs of the preadolescent child from dependence to independence and various iterations in between is a difficult task for parents.

This study was aimed to provide parents with an intervention that would help them development more effective ways of communicating and understanding their preadolescent
child. Other parent trainings have provided training based on cognitive/behavioral approaches in parent training (Gavita & Joyce, 2008; Man & Johnston, 2008), or are qualitative studies around behavioral approaches (Farooq, Jefferson & Flemming, 2005; Patterson, Mockford & Stewart-Brown, 2005; Taylor & Biglan, 1998).

Many parent trainings focus on changing child behavior (Lau, Fung & Yung, 2010; Sanders, Cann & Markie-Dadds, 2003). There is little research that addresses changing the relationship by modification of parent behaviors (Hawes & Dadds, 2006). Filial Therapy training addresses the relationship more than the child’s target behaviors (Landreth, 1991; Vanfleth, 1994; Watts & Broaddus, 2002). The process of filial therapy helps parents understand and respond to their child’s needs aside from the child’s behavior and provides a skill set to improve relationships as a way of indirectly improving child behavior (Watts & Broaddus, 2002; Landreth, 1991).

Results

Hypothesis one. The study’s first hypothesis stated: Parents who participate in a CPRT filial therapy training will have lower mean empathy scores on the MEACI than parents who do not participate. While the results from the MEACI alone do not support the hypothesis it can be noted that the interview responses connect the experimental and control groups to the hypothesis. The experimental group did have lower MEACI scores averaging a 20.17 which exemplifies higher empathic empathy as compared to the control group scores which showed an average of 49.00. The sample size was prohibitive in supporting statistical significance however the smaller sample size and subsequently small group sizes created an ideal situation for the examination of the experiences of this group of parents participating in filial therapy training.
Interviews with the parents provided insight into their ability to use the skills offered in the CPRT training that effectively corroborated the results from the MEACI. There were three themes that emerged from the interview responses. These themes included acceptance, involvement or “being with” and allowing for self-direction or differentiation. This was evident in the responses of the parents as they described the ways they began to interact differently with their child along with the newly gained awareness around these interactions. These results supported growth toward the first hypothesis that parents in the experimental group would have improved empathy and a move toward incorporating their child’s perspective.

While this study did not show a statistically significant result with an examination of the MEACI or PPAS, research studies have consistently revealed support for filial therapy in decreasing child behavior problems, decreasing parent–child relationship stress, and improving the empathic responsiveness of parents toward their children (Bratton, Landreth, & Lin, 2010). Wickstrom (2009) suggested also that parents participating in filial therapy training had increased awareness around how much they actually do influence their relationships with their children, and that they have the ability to create developmentally appropriate equality with children. This is to say, they recognize that they have the ability to allow the child to lead and take responsibility without losing an appropriate level of parental control.

The parent interviews illustrated their desire to reduce their own directiveness so as to allow their child to explore, create and problem solve in meaningful ways. Parents reported their desire to step back in more situations and follow their children rather than lead them and the interactions. Winek et al. (2003) offers support in an extensive qualitative study, that filial therapy highlights habituating interaction sequences between parents and children while providing useful tools for interaction that help parents identify behaviors on the part of children
and parents. They identified that parent’s “directiveness” detracted from play sessions (Winek et al., 2003).

This was a consistent observation of the parent participants in this study as they realized how following their children’s lead facilitated improved interactions in the play sessions. Winek et al., (2003) suggested that a parent’s directiveness created opposition from the child in the play sessions, further suggesting that this creates a behavior loop, where as the parent is more directive, the child is more oppositional, and as the child is more oppositional, the parent is more directive. Winek et al. (2003) showed that parents had greater success when they joined in the fantasy play led by their children and conversely that parents tended to inhibit play sessions when being too directive.

The parents in both groups reported that they were learning to be “thermostats rather than thermometers”, meaning they were taking more opportunities to respond rather than reacting and that they were finding success in their interactions with their children when employing this strategy. This was exemplified in their reported ability to step back and allow the child to problem solve and to explore creativity. CPRT training has been shown to encourage parents to ‘‘respond rather than react’’ and recognize that their ‘‘child’s feelings are not [their] feelings’’ (Landreth & Bratton, 2006). This was also evident for one of the parents who had not realized how infrequently she may have been doing this. This mother shared that her child had approached her telling her that he felt like she often yelled at him. Upon reflection she realized she had the option to respond rather than react and she found relief in knowing that this tool provided her a great deal of power as a parent. She realized that she had the power to control the interaction in a positive way. Gaining the awareness that directive interactions are less powerful than going with the child was a general sentiment among both parent groups. This
is supported by Landreth and Bratton (2006) who highlighted how parents can provide opportunities to “encourage their child’s self-direction, self-responsibility, and self-reliance” rather than always having to direct them.

The theme of involvement or “being with” has also been shown across filial therapy research. It is widely held that parents learn to “be with” their children, which clearly communicates the messages “I am here” “I hear you” “I understand” and “I care” (Landreth & Bratton, 2006). In several instances, the parents reported that they could tell their child enjoyed the play sessions or at least the time spent, that the child felt special, or that they knew the child craved that one-on-one interaction. The concept of “being with” speaks closely to empathic responding and understanding to the degree that a greater ability to “be with” presents a better opportunity toward empathy. This was a significant awareness that was cultivated among the parents in both the experimental and control groups as evidenced in their interview responses. Approximately 85% of the parents responded as having a new appreciation that it was not simply important to be spending time with their children but that the time spent needed to be intentional and with a general focus on the child from the child’s perspective.

**Hypothesis two.** The study’s second hypothesis stated: Parents who participate in CPRT training will have higher mean acceptance scores on the PPAS than parents who do not participate. The results of the analysis of the PPAS data did not support this hypothesis. As with the quantitative results of the MEACI sample size was a general impediment to finding significance. However the qualitative measures, which included interviews and observations, provided elaborated information to support the parents’ development of greater acceptance of their children in both groups.
Both parent groups reported increased acceptance of their child’s behaviors and offered examples of their ability to allow greater freedoms in the play sessions. This notion, as a means of suggesting improved parent/child relationship, is supported by the myriad research that the use of CPRT has demonstrated effectiveness in increasing parents’ acceptance of their children (Bratton & Landreth, 1995; Chau & Landreth, 1997; Costas & Landreth, 1999; Harris & Landreth, 1997; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Lee & Landreth, 2003; Tew, Landreth, Joiner, & Solt, 2002; Yuen, Landreth, & Baggerly, 2002). Feeling acceptance creates an environment of safety and support, providing the child with an invitation toward exploration and openness. Many of the parents commented that they felt it was important to provide that space for their child.

Parents are more successful at facilitated play sessions when they demonstrate behaviors of acceptance and encouragement (Winek et al., 2003). This was clear in the instance of the mother who allowed her child to take the lead and be creative when baking his cookies. She did not intervene when she saw that he was making the cookies “huge”. She accepted that this was his time and she did not, at that moment, have a good argument for why the cookies should be a certain size. It was more important to allow the behavior than set a limit or change the direction of the activity. The result for her telling of the story was a feeling of release of responsibility and pride because in the end she had encouraged the activity and as she reported the cookies were, “amazing.” And the resulting interaction did not include a fight over how big a cookie should be. It has been widely shown that CPRT-trained parents have reported feeling less responsible for or controlling of the behavior of their children (Kinsworthy & Garza, 2010; Lahti, 1992; Wickstrom, 2009).
Filial therapy can assist families in maintaining developmentally appropriate parent/child boundaries which can often translate into improved interaction between parent and child as a result of the parent’s growing awareness of and respect for the child’s changing developmental needs (Cornet, 2012). While the play sessions may at first be reflective of previous parent/child interactions, the positive interactions that are fostered in the play sessions, during the time the parent is in CPRT training can begin to be expressed outside the play sessions and in so doing create a new behavior loop of cooperation rather than opposition. This is especially poignant during the period of adolescence when the parent and child are often dancing around the child’s vacillation between dependence and independence.

**Limitations.**

There were four limitations present in this study. The first limitation related to recruitment and subsequent participant involvement. While the parents were randomly selected for participation in either the experimental or control group, all the parents who attended the orientation meetings who were eligible for the participation became the study’s parent population. This group of parents decided to participate on their own and for this reason it can be said that they were a motivated group of parents. This being said, the study was limited to studying the results of this group of motivated parents already moved to make changes or improvements with their relationships to the exclusion of other parents who may be less motivated.

The second limitation of this study was related to the prohibitively small sample size. Attendance at the parent orientation meetings did not translate into the population size desired in order to provide the power necessary for the statistical analysis. A larger sample size would have allowed for a greater possibility toward quantitative significance and generalizability of
results. While that was a quantitative limitation of this study, other research suggests that smaller group size can still provide significance of the effects of filial therapy (Bratton & Ray, 2000). Garza, Watts, and Kisnworthy (2007) provided support for filial therapy with a single case study with custodial grandparents. Bratton & Landreth (2006) suggest that smaller parenting groups benefit the didactic and dynamic learning environment provided by CPRT training.

The evidence that the smaller group size was addressed in a positive way was in the ability of the group to grow toward trust and openness. The small group sizes were conducive to providing a safe environment for the two groups respectively to share their experiences as related to the processes of the training but also in regard to their collective experiences as parents of preadolescent children. Their ability to see commonality in their experiences during the training sessions created a sense of normalcy that kept them from feeling like they were islands on their own trying to figure out how to get through this stage of development.

A third limitation of this study could have been the target age of the children. This limitation speaks to the perceptions of the parents that learning play therapy was not appropriate for their preadolescent child. This limitation may have been a block for the parents during the initial play sessions because they had stopped being “playful” with their children. This was a big concern for some of the parents, and there was some resistance to the play sessions on this account worrying that their children would find the play sessions to be juvenile (Ginott, 1994). Making the modifications in the toy kits and providing the concession for activity therapy while also providing developmentally appropriate vocabulary adjustments (Packman & Salt, 2004) seemed to partially address this issue.
A fourth limitation of this study centered on the researcher’s dual role. The researcher served as trainer and researcher for both the experimental and control parent groups. The researcher controlled for this limitation by way of supervision and consultation with her primary investigator. In addition, the researcher did not participate in the scoring of the parent videotapes for the MEACI. While this limitation had the potential to convolute the relationship between the researcher and the participants it was a definite strength in terms of the qualitative processes because the relationships had already been established with safety and trust.

Lastly, the fifth limitation centered on the fact that on more than one occasion both during the training sessions and in the final interviews, parent participants spoke about how they struggled during the play sessions because their children communicated that they were uncomfortable, they felt awkward, or that they were “talking funny”. It is suggested that possibly providing a briefing for the preadolescent group may reduce some of the “blocking” that may have occurred based on the language of filial and play therapy. Skilled play therapists are capable of skirting such issues with a child because they are adept at the language and have a means of reading why a child might be feeling uncomfortable, however, that is partly due to, at least in the first few sessions, the fact that the child would not expect them to speak or act differently.

This is to say that while it is argued and widely agreed upon, that the existing relationship of parent and child is a verifiable strength of filial therapy, this may be, at least for an older population like the preadolescent, a slight hindrance. The established pattern of interaction was significantly different, and for some this created a disconnect during the play sessions because the parents were unable to address the awkwardness in a way that helped them live in it or move past it. The established relationship, and more directly the understanding of the patterns of this
relationship, seemed to hinder the parent participants from. Even if they simply perceived awkwardness, they were handicapped in responding to it even when feeling confident in the processes and language of filial therapy.

It may be beneficial to address this in one of three ways: providing additional support in a proactive way to parents around the language, providing support around helping parents understand the idea that this interaction is much different than both parties are used to which requires different responses, or finally contriving a way during the process to “check in” with the children around what feels “awkward” or strange, and if they did in some way impede the process or if, with a bit of tenacity parent and child could surmount it.

Implications.

The results of this study indicate that filial therapy provides scaffolding for parents but that that may be less impacting than their experiences of the training. Both groups’ experiences were similar regarding their development of understanding around the needs of their preadolescent children. Although other studies have examined the use of activity therapy with preadolescents and adolescents in schools (Packman & Bratton, 2003; Paone, 2006), this is a unique study that examined the use of CPRT training with parents of preadolescent children. While results were not quantitatively significant, it provided a glimpse into the world of parenting the preadolescent child and the ways parents can improve their relationships with children of this age group. Preadolescent children are very under-represented in the play therapy and filial therapy research, and yet the implications for providing this type of intervention are far reaching. The importance of recognizing that preadolescents are at a developmental crossroads does not negate the importance of play and empathic relationships with their parents.
The presenting increase of youth violence accentuates the consequences of turning a blind eye to the unique developmental needs of preadolescent children (Packman & Bratton, 2003). Because of the unique developmental needs of preadolescents, the advocating for counseling interventions that identify this age group’s cognitive and emotional maturity is increasingly impactful (Akos & Martin, 2003; Flahive & Ray, 2007; Gerrity & DeLucia-Waack, 2007; Kulic, Horne, & Dagley, 2004; Milson, Akos, & Thompson, 2004). Filial therapy provides an opportunity for parents to create relationships with their preadolescent child that mediates this increase in developmental independence with the deeper understanding of the child’s familial needs.

Parents who participated in this study were able to gain an increased understanding of the needs of their preadolescent children to be decision makers and problem solvers. Improved parental empathy may be especially important for this population as it returns responsibility to the child and as the child moves into adolescence and pulls away from the family unit to find influence elsewhere; the foundation of a trusting relationship with parents may positively affect decision making when parents are not available for guidance. When the child understands that he is accepted and understood, the child experiences feelings safely, and in so doing, the child can regain responsibility and a sense of empowerment over those feelings. Parental acceptance which was also indicated in this study to have been improved, is a core element in the expression of parental empathy, which is another condition fostered by filial parent training which facilitates a child’s development of positive worth (Bratton & Landreth, 1995; Harris & Landreth, 1997; Rennie & Landreth, 2000). An investigation of the specific deterrents like; perceptions of “therapy”, the time commitment, or the perception that there is no need of change may be just a few items to consider when thinking about recruitment success.
Recommendations for Future Research and Practice

The results of this study were grossly limited by sample size. Therefore, it is recommended that a study of this nature be conducted with a much larger sample size. This would likely impact the potential for power. Examining the impact of filial therapy on a larger population of parents with preadolescent children would offer the study generalizability. Possible differences between the experimental and control groups would be much more evident with a larger sample size.

It was previously explained that the recruitment process may have impacted the general characteristics of the parents who chose to participate in the study limiting its examination to a population of more motivated individuals desirous of making improvements or changes to their current relationship. It is suggested then that additional research should seek to study parent participants who do not self-refer as a means of expanding the participant characteristics and providing a better picture of how filial therapy can facilitate improved relationships in parent/child relationships where the parent is not as motivated to making improvements with their preadolescent child.

Another suggestion for future research with preadolescents examines the nature of empathy. Empathy is a two way street, so while investigating the parents’ perspective is important it only tells half the story. Due to the reciprocal nature of empathy, conducting exit interviews with the children following the conclusion of the parent trainings might add strength to the conclusions regarding the relationship of increased parental empathy and improved relationship from the child’s perspective. The parent participants all described growth insofar as a gaining of awareness if not a better understanding of the changing needs off their preadolescent
children. Interviews with the children might offer support to whether changes and growth occurred in a way that was accessible to the children. Their insight into what they need and were they getting it would strengthen the interpretation of the results.

Concluding remarks

This study examined the experiences of parents of preadolescents participating in CPRT filial therapy training. Interviews with both the experimental and control group parents indicated they had gained skills to improving their relationships with their children and means to better understanding the unique developmental needs of this age group. Parents in both groups developed an awareness of the need to allow their preadolescent children to employ more self-direction and autonomy with regard to decision making, problem solving and exploration. This awareness began with an understanding that they did not have to be directive for their children to learn, rather they learned that encouragement rather than intervention facilitated smoother interactions and self-responsibility on the part of their child. Parents participating in the filial therapy training also learned the value of being involved with their children in meaningful ways where in their busy lives their child was the focus. Parents in this study also expressed the desire to continue using these tools to facilitate ongoing relationship harmony.

For a deeper understanding of the experience of parents who participated in Child Parent Relationship Therapy, the second phase of this study investigated the individual and shared experiences through narrative. As the trainer for each of the CPRT training sessions, spending 10 weeks and several hours with each of the parents who participated, it was possible to see glimpses of their successes, to see the moments when something new came to light. It was important for me to draw attention to that for them during the training, to mirror empathy, and
provide feedback on their experiences. Each of the parents who completed this final interview showed improvement in many areas. The four mothers shared struggles and success both in the way of experience and with each other every week during their respective trainings.

There were common themes that ran through the group - awkwardness, transition and community. Each of the parents expressed a sense of awkwardness; whether it was due to the way they were learning to “speak”, like fumbling to ask directions in Russian using only a book of simple translations or whether it was a sense of awkwardness that was more related to changing the way they typically interacted with their children. While the theme of awkwardness permeated throughout each parents’ experience, there was a great deal of difference in the way each parent dealt with it and how much it affected the play sessions and their individual experiences. Awkwardness did provide a catalyst toward change regardless however because each parent gained a sense of awareness around resolving or the necessity to resolve the awkwardness.

Overall, it seemed fitting the kinds of child reactions, parent reactions and experiences to the developmental stage of the children involved. Preadolescence is marked by an increased desire toward independence, a marked separation from familial influence and a rejection of “childhood”. This was evidenced in the interactions between parent and child in and out of the play sessions. There was a slight difference, according to the parents, between the girls and the boys. It was not made clear in this investigation whether that was a reflection of gender or a characteristic of the parent and subsequent parent/child interactions. Regardless, each of the parents arrived at a new awareness around the experience of awkwardness and struggle finding value in in the experience.
Transition was also a theme presented, some felt it profoundly having major life changes during and following the training sessions. Change through transition was a marked experience for the group. Some viewed the training as a foundation from which to gain strength or balance as they moved into new life situations. Others saw their children transitioning from children to preadolescents and developed ways of dealing with that in ways that allowed for a greater respect for their children if not a better understanding of what this transition meant for their children. They each saw themselves as evolving in the midst of change around them and with their family systems.

Lastly, community played a big part in the parent’s experience. The sense of community that was built in their very intimate training sessions provided each parent a feeling of normalcy. They were not struggling or fumbling alone, their children were not abnormal, their reactions and methods of interaction with their child were similar to others. This sense of shared experiences bolstered the learning for most of these parents, all commenting on how that helped in the long run. Being able to also use each other as additional sources of learning was another area of interest. They had the same materials and watched the same instructional videos, but they learned from seeing their group mates fail or succeed. Because they had developed relationships of trust and camaraderie, the impact of seeing one of their members use a specific technique or make a good reflection was more powerful than seeing an “expert” do the same thing.
References


Appendix A

MEASUREMENT OF EMPATHY IN ADULT-CHILD INTERACTION

Rating Form

<table>
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<tr>
<th>Rater:</th>
<th>Video Tape Code #:</th>
</tr>
</thead>
</table>

**Communication of Acceptance** verbal expression of acceptance / rejection

1. Verbally Conveys Acceptance of Feelings. *You're proud of…, You really like…, That makes you angry…*

2. Verbally Recognizes & Accepts Behavior Only (tracking, giving credit): *You got it that time…, Your hitting the…, You really stabbed…*

3. Social or NQ Conversation: *Mothers aren't very good at that. These are nice toys.*

4. Slight to Moderate Verbal Criticism: *No, not that way. You'll have to be more careful. That's cheating. You'll ruin the paints.*

5. Strongly Critical / Preaching / Rejecting: *You see, I told you to do it the other way, It's not nice to feel/say…, How stupid! You're being nasty.*

**Allowing the Child Self-Direction**: behavioral willingness to follow the child's lead (rather than control the child's behavior).

1. Follows the Child's Lead (no verbal comment necessary): *You'd like me to…, I'm supposed to…, Show me what you want me…(whisper tech.)*


3. Adult Takes Lead (teaching child how to do): *Are you sure that's how…, See if you can do…, Take your time and aim, It might work better…*

4. Directs or Instructs Child (initiates new activity): *Put the doll away first. Why don't you…, Let's play…, Don't put the…*
5. Persuades, Demands, Interrupts, Interferes, Insists: *No, take this one, That’s enough, I told you not to…, You’ve got to…*

**Involvement** adult’s attention to and participation in the child's activity (may not always contribute in a positive way)

1. Fully Observant (more attention to child than to objects being used): *involved verbally and with "eyes" (& physically when invited by child)*

2. High Level of Attention (attention to activity rather than child): *when adult more involved in game than attending to child’s reactions/behaviors*

3. Marginal Attention: *no joint activity, adult involved in own activity to degree that it interferes with attentiveness occasionally comments on child's activity*

4. Partially Withdraw / Preoccupied: *infrequently observes, but doesn’t comment, fails to attends to child' needs but responds when asked by child.*

5. Self-involved / Shut Off: *child ignored for prolonged period, child must repeat or prompt to get a response.*

**DIRECTIONS FOR SCORING:** A rating is made every 3 minute interval for 6 intervals (scoring is retrospective) (Highest score = 1; Lowest score = 5)
[This form was adapted by Bratton (1993) from Stover, B. Guerney, and O'Connell (1971)]
PORTER PARENTAL ACCEPTANCE SCALE

We are seeking information about parent-child relationships. You can help us by filling out the following questionnaire frankly and carefully. Sincere and honest answers are requested so that valid data may be obtained. The questionnaire does not call for any mark of identification your answers along with all others will be absolutely anonymous. Furthermore, all of the responses will be treated confidentially and will be used only for purposes of scientific research. It is essential that all questions be answered if you do not closely describe your feelings or actions.

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 9 10 11 12 1 2 3 4

     Graduate school High school College Post graduate

8. Religious Affiliation:

    ______ Protestant ______ Jewish ______ None

    ______ Catholic ______ Other ______________________

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 4,999

    ______ a city of 5,000 to 9,999 ______ a city of 10,000 to 49,999

    ______ a city of 50,000 to 99,999 ______ a city of 100,000 to 249,999
_____ a city of 250,000 or over

10. Presently family income (annual)
_____ under $15,000 _____ $15,000 to $24,999
_____ $25,000 to $34,999 _____ $35,000 to $49,999
_____ $50,000 to $74,999 _____ $75,000 to $99,999
_____ $100,000 or more

11. Husband’s occupation (Be specific such as computer specialist, CPA, salesperson, teacher, auto mechanic, lawyer, etc.) _____________________________

12. Wife's occupation (Be specific as illustrated above) _____________________________

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13. Ages of children (to nearest birthday)

Ages of boys _____; _____; _____; _____;
Ages of girls _____; _____; _____; _____;

While responding to the following questions, please think of only one child. If you have a child in the age range of 6 to 10 years, choose that one. If you have more than one child in that age range, choose the one nearest to 10. If your children are all younger than six years, choose the one nearest six. Place a circle around the age (in question 13 above) of the one which you will be thinking of while answering the questions about your child. **Be sure and refer only to this child while answering the questions.**

14. Is this child your: (circle one)

Biological child Step child Adopted child
**INFORMATION ABOUT YOUR CHILD**

Many parents say that their feeling of affection toward or for their child varies with his/her behavior and with circumstances. Please read each item carefully and place a check in the column which most nearly describes the degree of feeling of affection which you have for your child in that situation.

<table>
<thead>
<tr>
<th>Degree of Feeling or Affection</th>
<th>Much more than usual</th>
<th>A little more than usual</th>
<th>The same</th>
<th>A little less than usual</th>
<th>Much less than usual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When my child is obedient.</td>
<td></td>
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<td>2. When my child is with me.</td>
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<td>3. When my child misbehaves in front of special guests.</td>
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<td>4. When my child expresses unsolicited affection. &quot;You're the nicest mommy/daddy in the whole world</td>
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<td>5. When my child is away from me.</td>
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<td>6. When my child shows off in public.</td>
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<td>7. When my child behaves according to my highest expectations.</td>
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<td>8. When my child expresses anger and hateful things to me.</td>
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<td>9. When my child does things I have hoped my child would not do.</td>
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<td>10. When we are doing things together.</td>
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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 number 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.

************************************************************************

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

   a. feel annoyed.

   b. want to know more about what excites my child.

   c. feel like punishing my child.

   d. feel that I will be glad when my child is past this stage.

   e. feel like telling my child to stop.

12. When my child misbehaves while others in the group are behaving well, I:

   a. see to it that my child behaves as the others.

   b. tell my child it is important to behave well when in a group.

   c. leave my child alone if the others are not disturbed by the behavior.

   d. ask my child to suggest an alternate behavior.

   e. help my child find an alternate behavior to enjoy while not disturbing the group.
13. When my child is unable to do something which I think is important for him/her, I:
   a. want to help my child find success in other things.
   b. feel disappointed in my child.
   c. wish my child could do it.
   d. realize that my child cannot do everything.
   e. want to know more about the things my child can do.

14. When my child seems to be more fond of someone else (teacher, friend, relative) than me, I:
   a. realize that my child is growing up.
   b. am pleased to see my child's interests widening to other people.
   c. feel resentful.
   d. feel that my child doesn't appreciate what I have done for him/her.
   e. wish my child liked me more.

15. When my child is faced with two or more choices and has to choose only one, I:
   a. tell my child which choice to make and why.
   b. think it through with my child.
   c. point out the advantages and disadvantages of each, but let my child decide.
   d. tell my child that I am sure he/she can make a wise choice and help my child foresee the consequences.
   e. make the decision for my child.
16. When my child makes decisions without consulting me, I:
   a. punish my child for not consulting me.
   b. encourage my child to make many of his/her own decisions.
   c. allow my child to make many of his/her own decision.
   d. suggest that we talk it over before he/she makes the decision.
   e. tell my child he/she must consult me first before making a decision.

17. When my child kicks, hits, or knocks his/her things about, I:
   a. feel like telling my child to stop.
   b. feel like punishing him/her.
   c. am pleased that my child feels free to express himself/herself.
   d. feel that I will be glad when my child is past this stage.
   e. feel annoyed.

18. When my child is not interested in some of the usual activities of his/her age group, I:
   a. realize that each child is different.
   b. wish my child were interested in the same activities.
   c. feel disappointed in my child.
   d. want to help my child find ways to make the most of his/her interests.
   e. want to know more about the activities in which my child is interested.

19. When my child acts silly and giggly, I:
   a. tell my child I know how he/she feels.
   b. pay no attention to him/her.
   c. tell my child he/she shouldn't act that way.
d. make my child quit.

e. tell my child it is all right to feel that way, but help him/her find other ways of expression.

20. When my child prefers to do things with his/her friends rather than with the family, I:

a. encourage my child to do things with his/her friends.

b. accept this as part of his/her growing up.

c. plan special activities so that my child will want to be with the family.

d. try to minimize his/her associations with friends.

e. make my child stay with the family.

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

a. feel like punishing him/her.

b. am pleased that my child feels free to express his/her thoughts and feelings.

c. feel like persuading my child that my way is best.

d. realize my child has ideas of his/her own.

e. feel annoyed.

22. When my child misbehaves while others in his/her group are behaving well, I:

a. realize that my child does not always behave as others in his/her group.

b. feel embarrassed.

[c. want to help my child find the best ways to express his/her feelings.]

d. wish my child would behave like the others.

e. want to know more about his/her feelings.

23. When my child is shouting and dancing with excitement at a time when I want peace and quiet, I:
a. give my child something quiet to do.

b. tell my child that I wish he/she would stop.

c. make my child be quiet.

d. let my child tell me about what is so exciting.

e. send my child somewhere else.

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

a. try to minimize my child's association with that person.

b. let my child have such associations when I think he/she is ready for them.

c. do some special things for my child to remind him/her of how nice I am.

d. point out the weaknesses and faults of the other person(s).

e. encourage my child to create and maintain such associations.

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

a. feel annoyed.

b. feel that I will be glad when my child is past this stage.

c. am pleased that my child feels free to express himself/herself.

d. feel like punishing my child.

e. feel like telling my child not to talk that way to me.

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

a. realize my child has interests of his/her own.

b. want to help my child find ways to make the most of this interest.

c. feel disappointed in my child.

d. want to know more about my child's interests.

e. wish my child were more interested in the things I think are important for him/her.
27. When my child is unable to do some things as well as others in his/her group, I:
   a. tell my child he/she must try to do as well as the others.
   b. encourage him/her to keep trying.
   c. tell my child that no one can do everything well.
   d. call attention to the things he/she does well.
   e. help my child make the most of the activities which he/she can do well.

28. When my child wants to do something which I am sure will lead to disappointment for him/her, I:
   a. occasionally let my child carry such an activity to its conclusion.
   b. don't let my child do it.
   c. advise my child not to do it.
   d. help my child with it in order to ease the disappointment.
   e. point out what is likely to happen.

29. When my child acts silly and giggly, I:
   a. feel that I will be glad when he/she is past this stage.
   b. am pleased that my child feels free to express himself/herself.
   c. feel like punishing my child.
   d. feel like telling him/her to stop.
   e. feel annoyed.

30. When my child is faced with two or more choices and has to choose only one, I:
   a. feel that I should tell my child which choice to make and why.
   b. feel that I should point out the advantages and disadvantages of each.
   c. hope that I have prepared him/her to choose wisely.
d. want to encourage my child to make his/her own choices.

e. want to make the decision for my child.

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

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

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

   a. tell my child he/she should not disagree with me.
   
b. make my child quit.
   
c. listen to my child's side of the issue and change my mind if that seems reasonable.
   
d. tell my child maybe we can do it his/her way another time.
   
e. explain that I am doing what is best for him/her.

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

   a. realize that my child can't do as well as others in everything.
   
b. wish that my child could do as well.
   
c. feel embarrassed.
   
d. want to help my child find success in the things he/she can do well.
   
e. want to know more about the things my child can do well.

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

   a. hope that I have prepared my child adequately to make his/her decisions.
   
b. wish that my child would consult me.
c. feel disturbed.

d. want to restrict his/her freedom.

e. am pleased to see that as my child grows, I am needed less.

35. When my child says angry and hateful things about me to my face, I:
   a. tell my child it is all right to feel that way, but help him/her find other ways to express himself/herself.
   b. tell my child I know how he/she feels.
   c. pay no attention to him/her.
   d. tell my child he/she shouldn't say such things to me.
   e. make my child quit.

36. When my child kicks, hits, and knocks his/her things about, I:
   a. make my child quit.
   b. tell my child it's alright to feel that way, but help him/her find other ways of expressing him/herself.
   c. tell my child he/she shouldn't do such things.
   d. tell my child I know how he/she feels.
   e. pay no attention to him/her.

37. When my child prefers to do things with friends rather than with the family, I:
   a. wish my child would spend more time with us.
   b. feel resentful.
   c. am pleased to see my child's interests widening to other people.
   d. feel my child doesn't appreciate us.
   e. realize that he/she is growing up.
38. When my child wants to do something which I am sure will lead to disappointment, I:
   a. hope that I have prepared him/her to meet disappointment.
   b. wish that my child did not have to experience unpleasant events.
   c. want to keep my child from doing it.
   d. realize that occasionally such an experience will be good for him/her.
   e. want to postpone these experiences.

39. When my child is not interested in some of the usual activities of his/her age group, I:
   a. help my child realize that it's important to be interested in the same things as others in the group.
   b. call attention to the activities in which he/she is interested.
   c. tell my child it is all right not to be interested in the same things as others in his/her group.
   d. see to it that my child does the same things as others in his/her group.
   e. help my child find ways of making the most of his/her interests.

40. When my child shows a deep interest in something I don't think is important, I:
   a. let my child go ahead with this interest.
   b. ask my child to tell me more about this interest.
   c. help my child find ways to make the most of this interest.
   d. do everything I can do to discourage my child's interest in it.
   e. try to interest him/her in more worthwhile things.

THANK YOU VERY MUCH FOR YOUR COOPERATION
TITLE OF STUDY: Effects of Filial Therapy on Parents of Preadolescents Who Do or Do Not Participate in Child Parent Relationship Therapy Training.

INVESTIGATOR(S): Jill Packman, Ph.D., 775-682-5502; Andrea Doran, M.A., 775-445-4265

PROTOCOL #: 2013S087

SPONSOR: N/A

PURPOSE
You are being asked to participate in a research study and you have been randomly assigned to the experimental group. The purpose of this study is to look at how a filial therapy parent training effects child and parent relationships.

PARTICIPANTS
You are being asked to participate in this study because you are a parent of a child between the ages of 9 and 11 years who goes to school in the Carson City School District. During the initial parent meeting you consented to participating in the research study. Up to 65 parents are expected to participate in the research study but you will be part of a smaller group of 8 or 9 parents.

PROCEDURES
The total time commitment for the experimental parent group will be up to 12 weeks including:

- One hour once a week for 10 weeks of the Child Parent Relationship Therapy training
- 30 minute play/activity sessions per week for 9 weeks
- One 30 minute closing interview to be scheduled after the completion of the CPRT training sessions

The total time commitment for the experimental group preadolescent children will be up to 12 weeks including:

- Nine 30 minute play/activity sessions with the child’s participating parent per week
- On 30 minute closing interview to be scheduled after the completion of the CPRT training sessions
CPRT Training Sessions Procedures:

Week 1:

- Welcome and introductions
- You learn the process of filial therapy
- You will be given some of the common such as
  - the rule of thumb,
  - “focus on the donut not the hole”,
- You will also learn to understand that play is the natural language of children
- This will be important because play therapy and filial therapy, which is what you will be learning, values play even for preadolescent children
- You will also be given skills including
  - reflective responding
  - role play that will help
    - you regain control as a parent
    - your preadolescent gain self-control
    - provide a closer and enjoyable interactions with your preadolescent
    - give you keys to your preadolescent’s inner world

Week 2:

- You will learn the basic principles of play including
  - allowing the child to take the lead and following them
  - showing intent interest and observation
  - being aware of their body language
  - joining their preadolescent when invited
- The emphasis for this week will be to encourage you to practice empathy with your preadolescent by
  - seeing his experience through his play/activity
  - learning to better understand your preadolescent’s needs, feelings, and thoughts as expressed through his or her play/activity
- You will also learn how to and the importance of communicating that understanding to your preadolescent by
  - describing what he is doing
  - reflecting what he is saying and feeling
- Lastly, you will be introduced to the modified play kits.

Week 3:

- You will be asked to think about and discuss the skills you learned in week two
- You will be asked to talk about the play/activity sessions from the previous week.
- During this week you will also learn the Do’s and Don’ts of play sessions

Week 4:

- You will watch and discuss two videos from the previous week and two
- The focus of this session will be A-C-T limit setting which stands for:
  - Acknowledging the feeling
Communicating the limit
Targeting the alternatives

Week 5:
- This week’s session formatted much like week four and you will have the opportunity to review limit setting including when to appropriately set a limit

Week 6:
- This week’s focus is to learn about choice giving when setting a limit

Week 7:
- This week the focus is on helping your preadolescent with self-esteem building.

Week 8:
- This week the focus is to encourage the efforts of your preadolescent rather than praise the product

Week 9:
- The focus for this week will be aimed at helping you take bite sized steps toward change.
- All parents will be required to videotape this week’s play/activity sessions for Measurement of Empathy in Adult and Child Interactions (MEACI) posttest.

Week 10:
- You will be provided with referral information if you wish to continue or feel like you need additional help.
- You will be given certificates of completion.
- You will take the Porter Parental Acceptance Scale (PPAS) for posttest data.
- You will be asked to set a date for your closing interview and the closing interview for your preadolescent child.

**Waitlisted Control group**

The total time commitment for the waitlisted control parent group will be up to 21 weeks including:

- Waitlisted control group parent participants will be offered the Child Parent Relationship Therapy training which will start after the data completion of the experimental group training but will not be required to participate.
- Waitlisted parents will participate in the exact CPRT training as the previous group with all the same activities and responsibilities.

Data Collection for Waitlisted Control Group:

- Investigator will contact you at week nine of the experimental group’s training to make an appointment to give instructions on your play/activity session and to collect the following items:
• A videotaped play/activity session between you and your preadolescent child for data collection using the Measure of Empathy in Adult-Child Interaction.
• A completed a Porter Parental Acceptance Scale to be filled out at week nine of the experimental group’s training.

DISCOMFORTS, INCONVENIENCES, AND/OR RISKS

By participating in this research study, you may experience some discomfort, inconvenience, and risks. You may find that some of the questions asked on the survey or the interviews may make you feel uncomfortable, but may choose not to answer them. You may find that some of the activities and conversations make you feel uncomfortable when you are participating in the group interactions and conversations. You will remain with the same small cohort parent group for the duration of the 10-week training sessions and you will also have the opportunity to talk privately with the instructor about your feelings. You are always free to choose not to answer or participate at any point during the training. You may find the weekly sessions can become inconvenient at times. In addition to the above stated risks, there may be unknown or unforeseen risks associated with participating in this research study. You may choose to withdraw from this study at any time without any penalty.

BENEFITS

There may be no direct benefits to you, your child or your relationship with your child as a result of being a participant in this study. It is possible that you will benefit by developing a greater understanding of your preadolescent’s needs and ways of improving communicating with your preadolescent. You may also become more aware of how you relate to your preadolescent his or her behavior. The benefits of this study may extend to other family members and other parents. Through studying the use of filial therapy with parents of children who are preadolescents, this research study provides information about how parents interact with their children. All parents could potentially benefit from this study’s exploration of the importance of developing interventions to assist parents with interactions with their children.

CONFIDENTIALITY

Your identity will be protected to the extent allowed by law. Confidentiality will only be broken as required by law. This includes if you are going to hurt yourself or your child. You will not be personally identified in any reports or publications that may result from this study.

The investigators of this study, and the University of Nevada, Reno Social Behavioral Institutional Review Board may inspect your study records. Your records for this research study, including this permission form, your child’s assent form, and the weekly videotapes will be stored in a separate locked container from all other data and forms from this study. The final videos, which are the only videos that will be kept by the investigators, will be destroyed at the conclusion of the data analysis.
COSTS/COMPENSATION

There will be no cost to you nor will you be compensated for participating in this research study. In the event that this research activity results in an injury, treatment will be available, including first aid, emergency treatment, and follow-up care as needed. Care for such injuries will be billed in the ordinary manner to you or your insurance company.

RIGHT TO REFUSE OR WITHDRAW

You may refuse to participate or withdraw from the study at any time and still receive the care you would normally receive if you were not in the study. If the study design or use of the data is to be changed, you will be informed and your consent re-obtained. You will be told of any significant new findings developed during the course of this study, which may relate to your willingness to continue participation.

QUESTIONS

If you have questions about this study or wish to report a research-related injury, please contact Jill Packman, Ph.D. at (775) 682-5502 or Andrea Doran M.A. at (775) 445-4265 at any time.

You may ask about your rights as a research subject or you may report (anonymously if you so choose) any comments, concern, or complaints to the University of Nevada, Reno Social Behavioral Institutional Review Board, telephone number (775) 327-2368, or by addressing a letter to the Chair of the Board, c/o UNR Office of Human Research Protection, 205 Ross Hall / 331, University of Nevada, Reno, Reno, Nevada, 89557.

CONSENT/ CLOSING STATEMENT

I have read ( ) this consent form or have had it read to me ( ). [Check one.]

Andrea Doran has explained the study to me and all of my questions have been answered. I have been told of the risks or discomforts and possible benefits of the study.

If I do not take part in this study, my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty [or loss of other benefits to which I am entitled].

I have been told my rights as a research subject, and I voluntarily consent to participate in this study. I also give permission for my preadolescent child to participate in the 30 minute
videotaped play sessions each week. I have been told what the study is about and how and why it is being done. All my questions have been answered.

I will receive a signed and dated copy of this consent form.

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Appendix D

UNR Social Behavioral Institutional Review Board

VIDEOTAPE, PHOTOGRAPH CONSENT FORM

Title of Study: Effects of Filial Therapy on Parents of Preadolescents Who Do or Do Not Participate in Child Parent Relationship Therapy Training.

Investigators: Jill Packman, Ph.D., 775-682-5502; Andrea Doran, M.A., 775-445-4265

Protocol Number: 2013S087

1. PURPOSE

Video tapes are used in this study for two reasons:

1. As a participant in the control group you will be asked to videotape a 30 minute play session each week with your preadolescent child during the Child Parent Relationship Therapy training (CPRT). There will be a total of nine play sessions. The tapes are reviewed in your parent training group for the purpose of providing feedback and you allow to discuss your experiences each week and to see how the process is working.

2. As a participant in the control group you will be asked to videotape will be at the end of the training period.

3. You will provide a videotape of a play/activity session prior to your CPRT training for data collection for this study. This video will be used to score your 30 minute play session with the Measure of Empathy in Adult-Child Interaction for post-testing data collection.

2. PROCEDURES

Videotapes will show you interacting with your preadolescent child in your home or designated area. You will be videotaping your play sessions for all of the required weekly session. You will be asked to place the video camera so you and your child can be seen clearly by the investigators and/or the parent group members see. It will be important that you and your child, you and your child's face are visible and that you make sure the audio on the camera is on so the viewers can hear the verbal interactions as well. You will be sitting in a chair or another comfortable sitting device near your child. Your child can be on the floor or in a chair as well as long as it does not impede the child’s play and activity.

3. VIEWING
Members of your respective CPRT group will be viewing your videotapes in the group training. Each parent will be asked to videotape their play sessions each week for review by the group the following week. You will only be asked to submit one videotape to the investigators. This video will be submitted to the investigator prior to the start of your CPRT training and will be used for data collection for the study. The investigator will view videotaped play sessions so that the videotapes can be coded and scored on the MEACI. At least two other graduate level individuals, who are familiar with play therapy, will also be viewing the videotapes for scoring purposes. The video tapes will be anonymous and the graduate level individuals will not know whether they are from the experimental or control parent group.

4. **CONFIDENTIALITY**

You and your child’s identity will be protected to the extent allowed by law. Confidentiality will only be broken as required by law. This includes if you hurt your child or if someone else is hurting your child or another child. Your child will not be personally identified in any reports or publications that may result from this study.

The investigators of this study, the University of Nevada, Reno Social Behavioral Institutional Review Board may inspect your child’s study records. You and your child’s records for this research study, including this permission form and the interview videotapes will be stored in a separate locked container from all other data and forms from this study. The videotape will be destroyed or returned to you once it is scored.

All videotaped materials will be kept in a locked container in the investigators’ chairperson’s office when not being utilized, and will be kept until the data is analyzed. The tapes will not be used for any other purpose without your written permission. When the current research is completed, the tapes will be erased or returned to you for your discretion. You will not be personally identified in any reports, presentations, or publications that may result from this study.

6. **CONSENT/CLOSING STATEMENT**

I have read ( ) this assent form or have had it read to me ( ). [Check one.]

Andrea Doran has explained the study to me and all of my questions have been answered. I have been told of the purposes and procedures for the videotapes for this study.

If I do not take part in this study, my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty [or loss of other benefits to which I am entitled]. My child may also withdraw or decide not to participate at any time without penalty [or loss of other benefits to which he/she is entitled].
I have been told my rights as a research participant, and I have decided to volunteer to participate in this study and fulfill the needs for videotaping. I have been told what the study is about and how and why it is being done. All my questions have been answered.

I will receive a signed and dated copy of this assent form.

MY SIGNATURE BELOW INDICATES THAT I HAVE DECIDED TO VOLUNTEER TO BE

_____ (VIDEOTAPED, PHOTOGRAPHED) AND THAT I HAVE READ, I UNDERSTAND, AND I HAVE RECEIVED A COPY OF THIS CONSENT FORM.

_______________  ________________________________
DATE               SIGNATURE OF PARTICIPANT

(OR LEGALLY RESPONSIBLE PERSON)

_______________  ________________________________
DATE               SIGNATURE OF INVESTIGATOR

_______________  ________________________________
DATE               SIGNATURE OF WITNESS
Appendix E

UNIVERSITY OF NEVADA, RENO BIOMEDICAL (or SOCIAL BEHAVIORAL) INSITUTIONAL REVIEW BOARD
ASSENT TO PARTICIPATE IN RESEARCH

TITLE OF STUDY: Effects of Filial Therapy on Parents of Preadolescents who do or do not Participate in Child Parent Relationship Therapy Training.
INVESTIGATOR(S): Jill Packman, Ph.D., 775-682-5502; Andrea Doran, M.A., 775-445-4265
PROTOCOL #: [include sponsor number and UNR protocol number]
SPONSOR: NA

1. My name is Andrea Doran.

2. We are asking you to take part in a research study and you have been assigned to the control group of the study. We are trying to learn more about how parents and children your age get along. We want to know if we can help parents and children your age communicate and work better with each other.

3. If you agree to be in this you will be asked to spend 30 minutes each week with your mom or dad (who ever has decided to participate in our parent training) having a play or activity session. These play/activity sessions will be videotaped and your mom or dad will bring the videotape to their parent training each week.

4. There is little risk for you if you participate in this study but there may some differences in the way your mom or dad talk with you or in the ways that they spend time with you.

5. It is the purpose of this study to help you and your mom or dad to have a better relationship. As your mom or dad goes through the training sessions you may see that some of the things they are learning help you get along better, you may communicate better, and you find that you understand each other a little more.

6. Please talk this over with your parents before you decide whether or not to participate. We will also ask your parents to give their permission for you to take part in this study. But even if your parents say “yes” you can still decide not to do this.

7. If you don’t want to be in this study, you don’t have to participate. Remember, being in this study is up to you and no one will be upset if you don’t want to participate or even if you change your mind later and want to stop.

8. You can ask any questions that you have about the study. If you have a question later that you didn’t think of now, you can call me at 775-445-4265.
Appendix F

**TITLE OF STUDY:** Effects of Filial Therapy on Parents of Preadolescents Who Do or Do Not Participate in Child Parent Relationship Therapy Training.

**INVESTIGATOR(S):** Jill Packman, Ph.D., 775-682-5502; Andrea Doran, M.A., 775-445-4265

**PROTOCOL #:** [include sponsor number and UNR protocol number]

**SPONSOR:** N/A

**Experimental Parent Group Closing Interview Questions**

1. What were the most significant happenings for you during the training period?

2. What have you learned about yourself during this experience?

3. What have you learned about your child?

4. What feelings stood out to your over the last 10 weeks?

5. What do you think you did best over the last 10 weeks?

6. What was the most challenging part of this process?

7. What skill/s do you think you will be able to maintain?

8. Do you have any questions or concerns?
TITLE OF STUDY: Effects of Filial Therapy on Parents of Preadolescents Who Do or Do Not Participate in Child Parent Relationship Therapy Training. INVESTIGATOR(S): Jill Packman, Ph.D., 775-682-5502; Andrea Doran, M.A., 775-445-4265 PROTOCOL #: 2013S087

UNIVERSITY OF NEVADA, RENO SOCIAL BEHAVIORAL INSTITUTIONAL REVIEW BOARD CONSENT AND PARENT PERMISSION FOR CHILD TO PARTICIPATE IN A RESEARCH STUDY

PURPOSE

You are being asked to participate in **Phase II** of this research study. As previous participants you are being asked to provide additional material for an investigation of Child Parent Relationship therapy (CPRT) training over time and to participate in a more extensive interview process aimed at providing the researcher with a clearer picture of your experience of the 10 week CPRT training. The purpose of this phase of the study is to gain a deeper understanding of your personal experience and perspective of CPRT.

PARTICIPANTS

You are being asked to participate in this phase because you have just recently completed a 10-week CPRT training.

PROCEDURES

You are being asked:

- to video tape one more 30 minute play session with the same child of focus as previously used for your respective CPRT training period
- submit this video tape for a final review with the Measurement of Empathy in Adult and Child Interactions (MEACI)
- to provide responses to a second Porter Parental Acceptance Scale (PPAS)
- to participate in at least one in person, in-depth, semi-structured interview between 45 minutes to an hour. The researcher will make every effort to ask for clarification and expansion during this interview. After the interviews have been coded, however, it may be necessary for the researcher to contact you, by phone, to verify responses and ensure the researcher’s understanding of your point of view. This does will not require another meeting and may be accomplished via phone call or email, depending on your preference and availability.

*You will only be asked this one time to consent to participation, there will not be any further modifications of this research study.*
DISCOMFORTS, INCONVENIENCES, AND/OR RISKS

By participating in this research study, you may experience some discomfort, inconvenience, and risks. You may find that some of the questions asked on the survey or the interviews may make you feel uncomfortable, but may choose not to answer them. In addition to the above stated risks, there may be unknown or unforeseen risks associated with participating in this research study. You may choose to withdraw from this study at any time without any penalty.

BENEFITS

There may be no direct benefits to you, your child or your relationship with your child as a result of being a participant in this study. It is possible that you will benefit by developing a greater understanding of your preadolescent’s needs and ways of improving communicating with your preadolescent. You may also become more aware of how you relate to your preadolescent his or her behavior. The benefits of this study may extend to other family members and other parents. Through studying the use of filial therapy with parents of children who are preadolescents, this research study provides information about how parents interact with their children. All parents could potentially benefit from this study’s exploration of the importance of developing interventions to assist parents with interactions with their children. The second phase of the research study may provide a refresher and you will have access to the researcher for clarification or additional support during the interview process.

CONFIDENTIALITY

Your identity will be protected to the extent allowed by law. Confidentiality will only be broken as required by law. This includes if you are going to hurt yourself or your child. You will not be personally identified in any reports or publications that may result from this study. The investigators of this study, and the University of Nevada, Reno Social Behavioral Institutional Review Board may inspect your study records. Your records for this research study, including this permission form, your child’s assent form, and the weekly videotapes will be stored in a separate locked container from all other data and forms from this study. The final videos, which are the only videos that will be kept by the investigators, will be destroyed at the conclusion of the data analysis.

COSTS/COMPENSATION

There will be no cost to you nor will you be compensated for participating in this research study. In the event that this research activity results in an injury, treatment will be available, including first aid, emergency treatment, and follow-up care as needed. Care for such injuries will be billed in the ordinary manner to you or your insurance company.

RIGHT TO REFUSE OR WITHDRAW

You may refuse to participate or withdraw from the study at any time and still receive the care you would normally receive if you were not in the study. If the study design or use of the data is to be changed, you will be informed and your consent re-obtained. You will be told of any significant new findings developed during the course of this study, which may relate to your willingness to continue participation.
QUESTIONS

If you have questions about this study or wish to report a research-related injury, please contact Jill Packman, Ph.D. at (775) 682-5502 or Andrea Doran M.A. at (775) 445-4265 at any time. You may ask about your rights as a research subject or you may report (anonymously if you so choose) any comments, concern, or complaints to the University of Nevada, Reno Social Behavioral Institutional Review Board, telephone number (775) 327-2368, or by addressing a letter to the Chair of the Board, c/o UNR Office of Human Research Protection, 205 Ross Hall / 331, University of Nevada, Reno, Reno, Nevada, 89557.

CONSENT/ CLOSING STATEMENT

I have read ( ) this consent form or have had it read to me ( ). [Check one.]

Andrea Doran has explained the study to me and all of my questions have been answered. I have been told of the risks or discomforts and possible benefits of the study.

If I do not take part in this study, my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty [or loss of other benefits to which I am entitled].

I have been told my rights as a research subject, and I voluntarily consent to participate in this study. I also give permission for my preadolescent child to participate in the 30 minute videotaped play sessions each week. I have been told what the study is about and how and why it is being done. All my questions have been answered.

I will receive a signed and dated copy of this consent form.

__________________________________________
Signature of Participant Date

__________________________________________
Signature of Person Obtaining Consent Date
Appendix H


UNR Social Behavioral Institutional Review Board
VIDEO TAPE, PHOTOGRAPH CONSENT FORM: PHASE II

PURPOSE

Video tapes are used for Phase II of this study for the following reasons:

1. As a participant you will be asked to video tape a final play session for review with the Measurement of Empathy in Adult and Child Interactions (MEACI).
2. As a participant you will be asked to participate in another individual interview. This interview will be between you and the researcher and will be videotaped for transcription purposes.

PROCEDURES

Videotapes will show you interacting with your preadolescent child in your home or designated area. You will be videotaping your play sessions for all of the required weekly session. You will be asked to place the video camera so you and your child can be seen clearly by the investigators and/or the parent group members see. It will be important that you and your child, you and your child’s face are visible and that you make sure the audio on the camera is on so the viewers can hear the verbal interactions as well. You will be sitting in a chair or another comfortable sitting device near your child. Your child can be on the floor or in a chair as well as long as it does not impede the child’s play and activity. Videotapes of the interview will be used so the researcher can accurately record your experiences and your words without interrupting the process.

VIEWING

The investigator and the researcher team will view videotaped play sessions so that the videotapes can be coded and scored on the MEACI. The research team is made up of two graduate level individuals. The video tapes will be coded to remain anonymous.

CONFIDENTIALITY

You and your child’s identity will be protected to the extent allowed by law. Confidentiality will only be broken as required by law. This includes if you hurt your child or if someone else is hurting your child or another child. Your child will not be personally identified in any reports or publications that may result from this study.

The investigators of this study, the University of Nevada, Reno Social Behavioral Institutional Review Board may inspect your child’s study records. You and your child’s records for this research
study, including this permission form and the interview videotapes will be stored in a separate locked container from all other data and forms from this study. The videotape will be destroyed or returned to you once it is scored.

All videotaped materials will be kept in a locked container in the investigators’ chairperson’s office when not being utilized, and will be kept until the data is analyzed. The tapes will not be used for any other purpose without your written permission. When the current phase of research is completed, the tapes will be erased or returned to you for your discretion. You will not be personally identified in any reports, presentations, or publications that may result from this study.

CONSENT/CLOSING STATEMENT

I have read ( ) this assent form or have had it read to me ( ). [Check one.]

Andrea Doran has explained the study to me and all of my questions have been answered. I have been told of the purposes and procedures for the videotapes for this study.

If I do not take part in this study, my refusal to participate will involve no penalty or loss of rights to which I am entitled. I may withdraw from this study at any time without penalty [or loss of other benefits to which I am entitled]. My child may also withdraw or decide not to participate at any time without penalty [or loss of other benefits to which he/she is entitled].

I have been told my rights as a research participant, and I have decided to volunteer to participate in this study and fulfill the needs for videotaping. I have been told what the study is about and how and why it is being done. All my questions have been answered.

I will receive a signed and dated copy of this assent form.

MY SIGNATURE BELOW INDICATES THAT I HAVE DECIDED TO VOLUNTEER TO BE _______(VIDEOTAPED, PHOTOGRAPHED) AND THAT I HAVE READ, I UNDERSTAND, AND I HAVE RECEIVED A COPY OF THIS CONSENT FORM.

_________________                                  ________________________________
DATE                                              SIGNATURE OF PARTICIPANT
                                          (OR LEGALLY RESPONSIBLE PERSON)

_________________                                  ________________________________
DATE                                              SIGNATURE OF PERSON OBTAINING CONSENT
Appendix I

TITLE OF STUDY: Effects of Filial Therapy on Parents of Preadolescents Who Do or Do Not Participate in Child Parent Relationship Therapy Training.

INVESTIGATOR(S): Jill Packman, Ph.D., 775-682-5502; Andrea Doran, M.A., 775-445-4265

PROTOCOL #: 2013S087

SPONSOR: N/A

Phase II Parent Group Final Interview Questions

1. What factors influenced your decision to participate in the Child Parent Relationship Therapy training sessions?

2. Can you tell me your thoughts and feelings about how the training was organized? Can you describe whether the time, location and content were manageable and comfortable?

3. Tell me your thoughts and feeling about the time allowed for the training? Was it sufficient for being able to share and learn the material?

4. How comfortable were you with the material? Can you think of a point in the training where you started feeling that comfort level?

5. If you were describing the training to another parent, how would you do that?

6. How would you describe how this training is or was at addressing the needs in your family?

7. In what ways do you think this training did or did not fit into the values and beliefs of your family?

8. Do you think there is a relationship between this training and your ability to be empathic in your relationship with your child or other individuals? Please explain.

9. Can you describe a situation where the material of this training may have influenced the way you interacted with your child or with another individual?
10. Were there times during the training, and after when you found it difficult to use the skills being introduced in interactions with your child or other individuals? What do you think made that difficult for you?

11. Do you see yourself continuing to draw from your training sessions and the materials? Please explain.

12. How would you describe the differences in your relationship with your child after having participating in the parent training?

13. Is there anything else that you can think of, whether positive and/or negative, that was important to you about your experiences during this training?