`FILIAL THERAPY WITH ADOLESCENT PARENTS:

THE EFFECT ON PARENTAL EMPATHY, ACCEPTANCE, AND STRESS

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Filial Therapy with Adolescent Parents:

The Effect on Parental Empathy, Acceptance, and Stress

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ABSTRACT

Cathy Ford Sparks. FILIAL THERAPY WITH ADOLESCENT PARENTS: THE EFFECT ON PARENTAL EMPATHY, ACCEPTANCE, AND STRESS. (Under the direction of Dr. Kathie Morgan) School of Education, April 2010.

The purpose of this study was to investigate the relationship of filial therapy training on adolescent parents' parental empathy, acceptance, stress, and attainment of educational goals. It used a quasi-experimental, non-randomized sample drawn from a population of adolescent parents from three different high schools, pretest/posttest design, to measure the effectiveness of filial therapy. Each parent completed a ten week training period using either a filial therapy model or a typical parenting education model. Data included pretest and posttest questionnaires and videotaped sessions of play with their child. Statistical analyses showed a significant difference in seven of the thirteen areas. Parents in the filial therapy group showed significant increases in empathy and acceptance of their child. Decreases in stress were not statistically significant. Both experimental and control groups showed evidence that providing programs that support adolescent mothers in the school setting increases the chances that they will remain in school. Suggestions for further research are also included.

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To my Lord and Savior, Jesus Christ, I extend all of the glory, honor, and praise for all that has been accomplished in my life, for without Him, I can do nothing.

DEDICATION

This project is lovingly dedicated to the memory of my parents, George and Billie Ford. They always provided for me love, encouragement, and support for anything that I ever tried to do. They instilled in me love for God, love for family, and love for learning. Without their love and encouragement, this dream would have never become a reality.

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Chapter One: Introduction

Adolescent pregnancy is a serious problem in the United States. Each year in the United States, about one million girls become pregnant, and only 13% of those pregnancies are intended (Maynard, 1997). According to Berlin, Brady-Smith, and Brooks-Gunn (2002), the United States still has the highest teen pregnancy rates of all the industrialized nations, even though rates are down at this time. Teen parents and their children present many concerns. Historically, children born to teenage mothers are at increased risk for medical, psychological, developmental, and social problems (American Association of Pediatrics, 2008). Adolescent parents are more likely to rate their children as having at-risk levels of behavioral difficulties (Sieger & Renk, 2007). Further, adolescent parents are less likely to complete high school, advance education, or to be employed.

Theoretical Background of the Problem

Teenage pregnancy has been identified as the most common reason that adolescent girls drop out of high school (Caulfield & Thompson, 1999; Mathes & Irby, 1993). Adolescent mothers are more likely to be single, receive welfare, and live in poverty (Berlin et.al, 2002). Research indicates that teenage parents are at increased risk for depression, low self-esteem, unrealistic developmental expectations, and poor parenting skills. The American Association of Pediatrics (2008) reports that adolescent mothers are less likely to vocalize, touch, or smile at their infants. They are also less sensitive to, and accepting of, their infants' behaviors as compared to older mothers. In addition, adolescent mothers have less realistic expectations regarding the developmental

capabilities of their children than older mothers (American Association of Pediatrics, 2008), are less prepared for the challenges of parenting, and have relatively high rates of depression (Black, Papas, Hussey, Hunter, Dubowitz, Kotch, & Starr, 2002). Obviously, both adolescent mothers and their children struggle with some difficult challenges.

The Children. The children of adolescent parents face certain risks. Children of adolescent parents have been shown to have more academic and behavioral problems than children of older mothers (Berlin et. al, 2002). The children have increased risk of developmental delays, cognitive deficits, and health complications (Mathes & Irby, 1993). Children of teen mothers perform less well than their peers on preschool measures of cognitive competence and tend to score lower on achievement tests during elementary school (Luster, Bates, Vandenbelt, & Nievar, 2004). School grade failure (Luster, et al, 2004) and behavior problems (Black, et al, 2002) are also more common among this population. According to Lambert (1998), children born to teenage mothers are 1.4 times more likely to die in infancy than children of adult mothers. This could be due to adolescent parents' lack of knowledge about child development and appropriate parenting practices. The American Academy of Pediatrics (2008) suggests that developmentally immature adolescent mothers may put more time into the relationship with their partner than with their child. The adolescent parents lack of knowledge concerning child development and appropriate parenting techniques may also increase the risk of child neglect and abuse.

Filial Therapy. Filial therapy was developed by Bernard Guerney (1964) as a structured treatment modality for children with emotional problems. It is a form of intervention by which parents are taught to engage in child-centered play therapy with

their children. The objective of the approach is to help the parent become a therapeutic agent for change in the child's life. Filial therapy, according to Guerney (1964), uses play to facilitate interaction and build the relationship between parent and child.

Parents are trained in basic principles and skills of child-centered play therapy in a small group format of six to eight parents. Instructional techniques used in the group sessions include demonstrations of play sessions and role-playing. After the training, the parents begin conducting thirty minute play sessions once a week at home while continuing to attend the small group to receive feedback and support. Through the training sessions, parents learn to recognize and respond to children's feelings, listen reflectively, build children's self esteem, and set limits therapeutically (Landreth, 2002). The rationale is that if the parents are taught these skills, they conceivably could be more effective parents. Filial therapy is well suited as a preventative method since the skills can be presented in the context of education (Guerney & Stover, 1971). When using this approach as a preventative method, focus is placed on new knowledge and skills that can help the parent to become more confident and effective (Guerney, 1991).

Child-centered play therapy is a therapeutic intervention developed by Virginia Axline in which the therapist demonstrates genuine interest and unqualified acceptance of a child and allows the child the freedom to explore and express his or her feelings (Landreth, 2002). The therapist communicates to the child a belief in the child's capacity to act responsibly by reflecting the child's feelings and setting appropriate limits (Johnson, Bruhn, Winek, Krepps, & Wiley, 1999). In filial therapy, the focus is shifted from the relationship between the therapist and the child to that of the relationship between the parent and child.

The goals of filial therapy include the following: (a) enhance the emotional and interpersonal development of children; (b) impart knowledge and interpersonal skills to parents in dealing with children that will help them create an optimal growth atmosphere in the family; (c) train the parent in such a way that the skills become a permanent part of behavior so that growth will continue after the end of the program; (d) improve overall parenting skills by teaching reflective listening, structuring, and limit-setting skills to parents, and (e) help the parent identify and act appropriately on their own needs in relationship to their children (Glazer & Kottman, 1994).

Filial therapy has been successful in training parents to acquire reflective listening skills, to demonstrate involvement in children's emotional expression and behavior, and to maintain these skills at six months follow-ups (Guerney & Stover, 1971). In addition, filial therapy has been shown to be effective in increasing parents' empathy toward and acceptance of their children (Lobaugh, 1991), decreasing reports of problem behaviors in children (Bratton & Landreth, 1995), improving children's feelings of self confidence (Bratton & Landreth, 1995) and increasing children's expression of emotions (Glass, 1986). The practice of filial therapy has also been linked to reductions in parenting stress (Bratton, 1993; Lobaugh, 1991).

Empathy and Acceptance. Parental empathy and parental acceptance are two qualities that are considered significant indicators of positive parenting (Gordon, 1970; Reder & Lucey, 1995). Many parent education programs such as *Systematic Training for Effective Parenting* (Dinkmeyer & McKay, 1989) and *How to Talk so Kids Will Listen* (Faber & Mazlish, 1980) focus on developing these skills. The main objective of filial therapy is to teach the therapeutic skills of empathy and acceptance. According to Poon

(1998), parental empathy refers to a parent's acceptance of the child's feelings, independent development, and need for autonomy. Parental acceptance refers to acceptance of the child's uniqueness and the belief that the child can assume responsibility for himself.

Stress. According to Landreth (2006), parents who are experiencing a significant amount of stress have difficulty meeting the needs of their children. Adolescent parents may face stress due to emotional immaturity, lack of education, lack of societal support, poor coping mechanisms, and instability in relationships (Birch, 1998). According to Abidin (1983), it can be critical to the child's emotional and behavioral health when there is stress in the parenting system during the first three years of a child's life. In filial trained parents, research has shown a significant reduction in stress related to parenting (Bratton & Landreth, 1995; Chau & Landreth, 1997; Landreth & Lobaugh, 1998: Sweeney, 1996).

Purpose of the Study

According to the National Association of School Nurses (NASN, 2008), evidence suggests that many of the problems associated with adolescent parenting could be diminished through social support and school based programs that provide education about child development and parenting. NASN suggests that supportive programs offered through the school increase the likelihood that the adolescent will complete high school and delay a second pregnancy. The American Association of Pediatrics (2008) also suggests that factors positively associated with long term success for adolescent parents include active participation in a parenting program that provides health care and information on child development.

Filial therapy has been shown to be effective in both prevention and intervention. This study is designed to determine the effectiveness of a parenting program that uses filial therapy as a preventative treatment approach with adolescent parents. The purpose of the study is to investigate the relationship of filial therapy training on adolescent parents' parental empathy, acceptance, and stress. By providing a supportive program in the school setting that increases parental empathy and acceptance and reduces parental stress, adolescent parents may be more likely to improve their parenting and communication skills, may increase their understanding of their children, may increase their confidence as a parent, may be more likely to reach their educational goals, and may have results that are longer lasting or permanent.

Research Hypothesis

To carry out this study, the following hypotheses have been formulated:

Hypothesis 1: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Porter Parental Acceptance Scale than will the adolescent parents in the control group. .

Hypothesis 2: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Respect for the Child's Feelings and Right to Express Them subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Hypothesis 3: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Appreciation of the Child's Unique Makeup subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Hypothesis 4: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Recognition of the Child's Need for Autonomy and Independence subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Hypothesis 5: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Unconditional Love subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Hypothesis 6: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, B. Guerney, & McConnell, 1971) than will the adolescent parents in the control group.

Hypothesis 7: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Communication of Acceptance subscale of the MEACI than will the adolescent parents in the control group.

Hypothesis 8: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Allowing the Child Self-Direction subscale of the MEACI than will the adolescent parents in the control group.

Hypothesis 9: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Involvement subscale of the MEACI than will the adolescent parents in the control group.

Hypothesis 10: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Parenting Stress Index (PSI) (Abidin, 1983) than will the adolescent parents in the control group.

Hypothesis 11: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Parent Domain of the PSI than will the adolescent parents in the control group.

Hypothesis 12: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Child Domain of the PSI than will the adolescent parents in the control group.

Hypothesis 13: Adolescent parents in the experimental group will attain their educational goals including passing grades in coursework, passing to the next grade, and completion of high school or attainment of a GED at a higher rate than parents in the control group.

Definition of Terms

Adolescence is defined as the period between childhood and adulthood. Adolescent mothers would be parenting teens between the ages of 12 and 19 years of age.

Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model by Garry Landreth (2006) is defined as a therapeutic notebook organized by treatment sessions. This notebook contains session outlines, parent handouts, homework, and worksheets. It is designed to work with small groups of parents.

Child Centered Play Therapy is defined as a play session in which the child is in charge of the play. The child centered therapist shows acceptance of the child's feelings and actions through empathic listening (Van Fleet, 1994). The child's feelings are reflected back in a manner that allows the child to gain insight. An open atmosphere is created with few rules or limits. The therapist sets and enforces limits therapeutically so that the child understands the boundaries and learns to take responsibility for his or her actions (Van Fleet, 1994).

Filial Therapy is defined as a unique approach used by play therapists to train parents in basic child-centered play therapy principles and skills so that they can become therapeutic agents of change for their child (Landreth, 2006)). Parents are taught skills which include: reflective listening, recognizing and responding to the feelings of their child, building children's self-esteem, and therapeutic limit setting. Parents are required to have structured weekly play sessions with their child using selected toys. The therapist educates the parents through instruction, role-playing, small group discussion, and supervision.

Measurement of Empathy in Adult-Child Interaction (Stover et.al. 1971) is described as a direct observational scale which measures three specific parental behaviors identified as major aspects of parental empathy: communication of acceptance, allowing the child self-direction, and involvement.

Parental Acceptance refers to the parent's belief that the child can assume responsibility for himself and acceptance of the child's uniqueness. Parental Acceptance will be operationally defined as the parent's score on the Porter Parental Acceptance Scale (1954).

Parental Empathy according to Poon (1998), refers to the parent's acceptance of the child's feelings, independent development, need for autonomy, and the parent's willingness to communicate acceptance of the child. Parental Empathy will be operationally defined as the parent's scores on the Measurement of Empathy in Adult-Child Interaction (Stover et al. 1971).

Parental Stress is defined as the degree of stress in the parent/child relationship as defined by the parents. Parental stress will be operationally defined by the scores on the

Parenting Stress Index (Abidin, 1983).

Parenting Stress Index (Abidin, 1983) is defined as a test instrument containing 120 test items that measures parent-child systems to determine which systems are under stress and at risk for the possible development of dysfunctional parenting behaviors.

Porter Parental Acceptance Scale (Porter, 1954) is defined as a 40 item self-report test instrument that is designed to measure parental acceptance as revealed by the following subscales: respect for the child's feelings and right to express them, appreciation for the child's unique makeup, recognition of the child's need for autonomy and independence, and unconditional love.

Special Play Time is defined as a structured thirty minute period once a week in which the parent plays with the child in an empathic manner, using a kit of specially selected toys, in their own home. The child directs the play and is allowed to express feelings and creativity. The objectives of special play are as follows: (a) to allow the child to express feelings, thoughts, and needs to the parent through play; (b) to facilitate the child's development of positive self-esteem; (c) to help the child become more self-directing and self-responsible, and develop problem solving skills; (d) to help the child change negative perceptions of the parent and; (e) to reduce or eliminate behavior problems (Landreth, 2006)

Therapeutic limit setting is defined as a way to provide consistent limits so that the child can feel safe and secure. Therapeutic limit setting teaches children self-control and responsibility for their own behavior by allowing them to experience the consequences of their choices (Landreth, 2006). Limits are set for four basic reasons: (a) to protect the child from hurting himself or the parent; (b) to protect property; (c) to

maintain the parent's acceptance of the child, and: (d) to provide consistency in the play session (Landreth, 2006).

Importance of the Study

Both adolescent mothers and their children struggle with enormous challenges that are exacerbated by lower-socioeconomic status. Due to the high rates of adolescent pregnancy and the challenges faced by young mothers and their children, more information is needed to determine ways to provide support leading to positive outcomes for these young families. According to Byers (2005), evidence suggests that many of the problems faced by adolescent parents can be diminished through school-based programs that provide counseling, health care, health education, education about child development, and parenting skills.

Chapter Two: Review of the Literature

According to Mary's Shelter (2008), one million teenage girls become pregnant every year, resulting in 520,000 live births, 405,000 abortions, and 80,000 miscarriages. Approximately 40% of adolescent girls will become pregnant before age 20. The fastest growing group of parents in the United States, according to Lowenthal and Lowenthal (1997), is girls between the ages of ten and fourteen years of age. Although teen pregnancy rates have declined since 1990 by 36% (Guttmacher, 2006), adolescent pregnancy and parenting presents many challenges. Even with this decline, the United States has the highest rate of teen pregnancy of all Western industrialized countries.

Between five to seven billion dollars in state and federal money is spent annually on services to teen parents. Three out of every ten adolescent mothers go on welfare within three years of their child's birth. According to Sylvester (1994), 53% of the cost of AFDC, food stamps, and Medicaid is attributed to adolescent parents. Many teen parents and their children live in poverty, tend to be less educated, and are more likely to experience family instability (Furstenberg, Brooks-Gunn, Morgan, 1989). It is difficult for adolescent girls to complete their education because they have to raise a child and provide childcare. Adolescent mothers are also more likely to hold lower-paying jobs, be on welfare, and to be single parents than adult mothers (Hayes, 1987).

Adolescence

Adolescence is a period of significant growth and change. The role of parent may complicate this difficult time and place significant pressure on the adolescent parent. The

brain of a teenager shows most of the activity in the limbic area where emotions develop. The frontal cortex, not yet fully developed in the adolescent, is the area that is responsible for decision making, controlling emotions, and making good judgments (Klass, 2003). Adolescents are often egocentric which is in direct conflict with the requirements of being a parent. Egocentrism is defined as the inclination to perceive, understand and interpret the world in terms of self (Meece, 2002). Children require a lot of attention, and teen parents may not be able to separate these needs from their own needs. They may project their own feelings and wants onto their child (Wasik & Bryant, 2001).

Adolescent parents are expected to have the knowledge and skills of adult parents, even though they have not had the experience or developed the maturity to gain these skills. Many times they come from homes that are filled with violence, conflict, substance abuse, poverty, and chaos. Sommer, Whitman, Borkowski, Schellenbach, Maxwell, and Keogh (1993) found that parenting adolescents were less cognitively prepared to parent, experienced more stress in the parenting role, and were less adaptive in their parenting style than adult parents. Adolescents may not have learned to think abstractly and may not have developed the problem solving skills necessary for their role as parent which may cause them to have unrealistic expectations for their child or difficulty in planning for the needs of their child (Wasik & Bryant, 2001). Adolescent mothers who have been less prepared for their role as a parent tend to view that role as more stressful and their children as more difficult (O'Callaghan, Borkowski, Whitman, Maxwell, Keogh, 1999).

Negative Outcomes

Many negative outcomes occur due to adolescent pregnancy and parenting. Seventy percent of teenage mothers do not receive adequate prenatal care (Mary's

Shelter, 2008; NASN, 2008). The National Association of School Nurses (2008) identified the following risks associated with adolescent pregnancy and parenting: 9% have low birth weight babies, 30 – 50% will have a second pregnancy, and 25% will have a repeat birth within two years.

Mothers. Negative educational outcomes also exist for adolescent girls who become pregnant. Teenage pregnancy is the most common reason that adolescents drop out of school (Caulfield & Thompson, 1999; Mary's Shelter, 2008; Mathes & Irby, 1993). Approximately 80% of all teen mothers drop out of school, and 40% of females who get pregnant before age 15 do not finish the 8th grade (Mary's Shelter, 2008). One of the primary reasons that adolescent mothers often drop out of school is difficulty with providing childcare (Byers, 2005). According to Strunk (2008), the main predictor of a child's life outcome is the mother's level of education. If the mother does not complete high school, the child has a much greater risk of being reared in poverty.

Research indicates that teenage mothers are at increased risk for depression, low self-esteem, unrealistic developmental expectations, and poorer parenting skills. Adolescent mothers are less likely to vocalize, touch, and smile at their infants, and they may be less sensitive to and accepting of their child's behaviors compared to older mothers (Berlin et al. 2002). In addition, adolescent mothers have less realistic expectations regarding the developmental capabilities of their children than older mothers (American Association of Pediatrics, 2008), are less prepared for the challenges of parenting, and have relatively high rates of depression (Black, Papas, Hussey, Hunter, Dubowitz, Kotch, & Starr, 2002). Adolescent mothers may be less sensitive to their child's feelings, less supportive, and more detached than older mothers (Berlin et al,

2002; AAP, 2008). Adolescent mothers often demonstrate less knowledge about child development and parenting skills (Karraker & Evans, 1996).

Fathers. The American Association of Pediatrics (2008) has identified the following statistics concerning fathers of children born to adolescent mothers: between 50 – 75% of fathers of infants born to teen mothers are adult men, 30 – 50% involve adolescent fathers who are more likely to live in poverty, 80% of unwed adolescent fathers live away from their child, 30% of fathers of children born to adolescent mothers are in jail, and eight out of ten adolescent fathers do not marry the mothers of their first child. In adolescent pregnancies, the father is nearly always older. Typically, the younger the mother, the greater the age difference between father and mother (Mary's Shelter, 2008). Teenage fathers are less likely to pay child support for their children, usually have lower rates of educational attainment, and lower lifetime earnings (Brien & Willis, 1997).

Children. Research also shows negative consequences for the children born to teen mothers. According to the American Association of Pediatrics (2008) infants born to teen mothers are at risk for low birth weight, developmental disabilities, and deficits in cognitive and social development. In a study by Maracek (1979), it was reported that children of adolescent parents performed less well on the Bayley Developmental Scales at eight months of age, the Stanford Binet at four years of age, and the WISC at seven years of age than children of adult mothers. The children also have more health complications, hospitalizations due to accidental injuries, and academic problems later in life (Mathes & Irby, 1993; Thomas & Looney, 2004).

Children of teen mothers perform less well than their peers on preschool measures of cognitive competence and score lower on achievement tests during elementary school

(Luster, Bates, Vandenbelt, & Nievar, 2004). School failure is also more common among this population (Luster, et al., 2004) as are behavioral problems (Black et al., 2002). Maracek (1979) also found that young children of adolescent mothers were overly conforming and uncommunicative, while older children of adolescent mothers were more aggressive, hostile, and disrespectful of authority.

In addition, children of teenage mothers have been found to be at increased risk of child maltreatment in the form of physical or sexual abuse and/or neglect. The children are also more likely to experience changes in their primary caregiver. Daughters of teen mothers are more likely to become teen mothers themselves. It is estimated that 75% of pregnant teens had mothers who were pregnant as adolescents (Mary's Shelter, 2008). Obviously, both adolescent parents and their children are struggling with some difficult challenges.

A study by Sommer et al. (1993) determined that adolescent mothers lack knowledge about the range of skills possessed by their infants, expecting either "too much, too soon," or "too little, too late." In the same study, Sommer et al. (1993) found that adolescent mothers were less prepared to parent than adult mothers and had more authoritarian parenting styles. Adolescent parents are more likely to rate their children as having at-risk levels of behavioral difficulties (Sieger-Renk, 2007).

According to the National Association of School Nurses (NASN, 2008), strong evidence suggests that many of the negative outcomes associated with adolescent parenting can be diminished by strong social support and school based programs that provide health care and parent education. It has been found that school based intervention programs encourage parents to focus on their educational achievement (Byers, 2005). If

these adolescent parents maintain a connection with teachers, school nurses, and counselors, they are more likely to finish high school and delay a second pregnancy (NASN, 2008). School based intervention programs have reported improvement in achievement of educational goals such as promotion to the next grade, improved grade point averages, graduation, and job placement (Field, Widmayer, Stringer, & Ignatoff, 1980). It has been found that equipping adolescent mothers with knowledge about parenting and child development improves their ability to parent effectively (Byers, 2000).

One of the factors positively associated with long term success for parenting adolescents is active participation in a parenting program designed to support them in their educational endeavors so that they may in turn support their children (American Association of Pediatrics, 2008). Adolescent mothers who are able to stay in school or complete their GED are more likely to delay a second pregnancy. Adolescent mothers, who have been cognitively prepared during their pregnancy or shortly after the birth of the child, also have more positive outcomes (Miller, Heysek, Whitman, & Borkowski, 1996). School based programs that support parenting adolescents have been shown to encourage ongoing participation in school, improve the health of the adolescent and the child, and provide support skills needed to be a more effective parent (Stiles, 2005; Barnes, Courtney, Pratt, & Walsh, 2004).

Providing mental health services to parenting adolescents should be a priority because the lives of their children are affected also. The World Health Organization has estimated that by 2020 psychiatric disorders in children will have increased by 50% compared to other disorders. This increase will make mental health issues one of the five

leading causes of illness, disability, or death in children. According to Rogers-Larke (2006), this increase may be blamed on increased stress in children and their families and may be addressed through intervention and prevention programs that address parenting skills. The way that a parent feels about herself has an effect on her interactions with her child. Teenage mothers may have doubts about their adequacy as a parent which may in turn have an effect on the child's development. Providing these services may promote optimal outcomes for the adolescent parents and their children (Milan, Kershaw, Lewis, Ichovics, & Meade, 2004).

Early intervention can be important in reducing problems later in childhood. In a study by Sommer et al. (2000), results showed that by three years of age, many children of adolescent mothers are at high risk for dysfunctional development. Less than 30% of their sample showed normal cognitive development, emotional functioning, and adaptive behavior at three years of age, even though they were healthy at birth (Sommer, et.al, 2000).

A report released by the United States Surgeon General (2001) titled "A National Action Agenda for Children's Mental Health" described a shortage of appropriate mental health services for children and adolescents as a major health crisis in the US. One in ten children and adolescents suffer from a mental illness which is significant enough to cause some level of impairment, but it is estimated that only one in five receive treatment. The lack of professionals to meet these mental health needs of children has been documented for a number of years (Guerney, 1964; Albee, 1969; Felner & Abner, 1983; & Kazdin, 1993). A priority for mental health professionals should be to provide innovative programs that help the adolescent parent with skills that promote healthy parent-child

interactions as well as programs to support their efforts to stay in school and continue their education.

Filial Play Therapy

Play is the fundamental language of children's communication. Play therapy allows adults to enter the child's world of communication. Play therapy had its beginnings with the work of Anna Freud in 1926 and Melanie Klein in 1932. Melanie Klein is considered to be the founder of play therapy. Both Freud and Klein used the concept of free association in adult psychoanalysis and substituted it for the child's tendency to play. Klein and Freud proposed that play is the child's way of free associating by uncovering unconscious conflicts (Gil, 1994).

The child guidance movement, which focused on the work of Alfred Binet, was a multidisciplinary approach that assisted with diagnosis and treatment of children by encouraging treating both the child and their parents (Prout & Brown, 1999). This movement introduced the need to work with the entire family, rather than just the child.

Filial Therapy is a unique form of parent training developed by Bernard Guerney in 1964. This innovative approach was developed in response to the increased demand for mental health services for both children and families. Guerney recognized a shortage of professionals qualified to meet the growing needs of mental health services for children. He developed a treatment approach that would train the parents to create a therapeutic system. The term "filial" is derived from the naturally existing bond between a child and his/her parent. Sweeney reports that "the word filial comes from the Latin words filius meaning 'son', or filia, meaning 'daughter'" (Sweeney, 1997, p.165). Filial therapy as first defined by Guerney (1964) is "the training of parents of small children (in groups of

six to eight) to conduct play sessions with their own children in a very special way" (p.305). In this approach, parents are trained in a small group format to use client centered play therapy principles and skills (Landreth, 2006). The focus is on the parent-child relationship rather than the therapist-child relationship. By using filial therapy, parents may be able to develop a greater understanding of their child. Because the parents are usually the most significant adults in a child's life, they are likely to have a greater impact on their child than a therapist could (Van Fleet, 1994).

Filial therapy is based on the principles of child-centered play therapy, which is based on the principles of Carl Rogers, including genuineness, unconditional positive regard, and empathy (Rogers, 1951). The success of the therapy depends on the relationship developed between the therapist and the client. In 1947, Virginia Axline developed eight basic principles for child-centered play. These principles are as follows:

1. The therapist must develop a warm, friendly relationship with the child in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to the child in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.

6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the real world of reality and to make the child aware of his responsibility in the relationship (pp. 73-74).

The goals of child-centered play therapy according to Van Fleet (1997) include helping the child to develop an understanding of his/her feelings, expressing feelings in ways that his/her needs can be met, developing problem-solving skills, reducing maladaptive behaviors, and increasing self-confidence. Axline (1947) distinguished between directive and nondirective play therapy. She stated that play therapy may be directive in form when the therapist assumes responsibility for guidance and interpretation. It may be nondirective when the therapist leaves responsibility and direction to the child. Child centered play is not a typical playtime, but a time when the child leads and the therapist follows.

The basic tenets for relating to children in play therapy, according to Garry Landreth (2002), are as follows:

1. Children are not miniature adults and the therapist or parent does not respond to them as if they were.
2. Children are people and are capable of experiencing deep emotional pain and joy.
3. Children are unique and worthy of respect.

4. Children are resilient and possess tremendous capacity to overcome obstacles and circumstances in their lives.
5. Children have an inherent tendency toward growth and maturity.
6. Children are capable of positive self-direction and dealing with their world in creative ways.
7. The natural language of children is play and this is the medium of self expression with which they feel most comfortable.
8. Children have a right to remain silent, and the therapist or parent should respect their decision not to talk.
9. Children will take the therapeutic experience where they need to be. The therapist or parent does not attempt to determine when or how a child should play.
10. Children's growth cannot be speeded up. The therapist or parent is patient with the child's developmental process.

The skills of filial therapy are appropriate not only for parents who are experiencing difficulty with their child or parents of children with serious mental health issues, but for every parent. The skills enable them to improve the parent-child relationship, encourage positive changes in behavior, and connect with their child in a positive manner. Filial therapy is more cost efficient than family therapy and gives parents tools to address parenting issues they may face in the future

Guerney's approach helps the parents to become therapeutic agents of change by: a) utilizing parents as psychotherapeutic agents to help their children overcome problems; b) helping to prevent future problems by establishing healthy parent-child interactions;

and c) enhancing the relationship between the parent and child (Guerney & Guerney, 1989). Guerney (1964) believed that the individual attention the child received from the parent during filial play therapy would have a positive effect in enhancing the child's feelings of self-worth and belonging.

Guerney (1964) outlined five major arguments for using filial therapy as an appropriate treatment modality: (a) children's problems often result from the parent's lack of knowledge and skills that are perpetuated through dysfunctional interpersonal relationships and are not usually a result of parental pathology; (b) therapeutic play time provides children with a way to express their thoughts and feelings and promote positive parent-child interactions; (c) a precedent has been set to motivate parents to help their children by other client-centered therapists who have experienced success in implementing parent-child interactions in play therapy; (d) motivation and investment in the therapy process may increase when parents join with the therapist and are given the primary role in the treatment of their child; and (e) the parent-child relationship is usually the most significant in the child's life; therefore, positive changes that the child experiences will be exemplified and the effort by the parent will be more therapeutic than the effort by the therapist (Guerney, 1964; Guerney, Guerney, & Andronico, 1966; Guerney, 2000).

According to Stover and Guerney (1967), an advantage of using filial therapy over traditional play therapy methods is that it avoids fear and rivalry that may develop as the child decreases dependence on the parent and increases dependence on the therapist. Guerney (1964) also believed that if the parent could be taught the skills that are usually applied by the therapist, the parent could possibly be even more effective than the

professional because the parent is very influential in the child's life. The rationale is based on the assumption that parents have more emotional significance to the child than the therapist and are instrumental in the emotional well-being of their child (Landreth & Lobaugh, 1998). The goal is for the parent to be able to generalize these skills outside the play session and into daily life so that they may function more adequately in their parental role.

Some parents may be resistant to therapy due to the fear of being blamed for their child's behavior. Filial therapy gives the parents needed skills to help them help their own child. It can also reduce the feelings of guilt and helplessness that a parent may feel because they have had to seek outside treatment for the child (Stover & Guerney, 1967). Filial Therapy provides benefits to both the child and the parent. It allows children to be heard which can increase their self-esteem, self-confidence, and problem solving skills. It allows the child to express their feelings in an open and safe manner. Filial therapy promotes a cohesive family atmosphere that fosters balanced child development (Rogers-Larke, 2006). Healthy child development includes social, emotional, physical, intellectual, and spiritual growth (Van Fleet, 1994). According to Ginsberg (2002) the parent-child relationship can be changed through filial therapy to create a safer more secure context for the child.

Filial therapy, according to Guerney (1964), may be described in three stages. Parents receive training through didactic instruction, role-playing, viewing video tapes, and supervision. The first stage is instruction and practice and involves an explanation of the benefits for the child and the parent. Parents are informed of the goals which include the following: allowing the child to determine the play activities within limits, developing

empathic understanding of the needs and feelings of the child, communication to the child that he/she is understood and accepted, and allowing the child to learn to accept responsibility for his/her actions. Parents are taught a specific way to interact with their child at special times and in a special place set aside for this purpose (Guerney, 1964). During stage one, parents observe the therapist demonstrating client-centered play, and parents attempt to role play with other parents in the group the skills that they have learned. The parents also play with their child under the observation and supervision of the therapist. Parents are taught the appropriate way to set limits in the play session which may help them to become more consistent with their discipline. By setting limits, the parents provide the child with boundaries which may help the child to feel more secure (Van Fleet, 2004).

In Guerney's (1964) model, the second stage begins after six to eight weeks of training. At this stage, the parents begin their play sessions at home with their children. They have gathered play materials to be used specifically during the play sessions. Parents are encouraged to video tape the play sessions to be used in small group for discussion and feedback. The final stage occurs when the therapist determines there is no more need for therapy. At this point, the parent should be able to note the effects of the play sessions on their children and how this can transfer and generalize outside the playroom.

The typical format for filial therapy training, according to Landreth's *Child Parent Relationship Treatment Manual (2006),* occurs in a 10 week support group setting in which parents learn the basic child centered play therapy principles to use with their children in their own weekly special play therapy sessions (Landreth & Lobaugh, 1998).

The filial therapy parenting program combines didactic instruction with required parent child play sessions and supervision (Landreth, 2002). According to Landreth (2002):

> Parents are taught basic child centered principles and skills, including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self esteem, and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a nonjudgmental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for both child and parent (p. 370).

Research indicates that filial therapy has been successful in training parents to acquire reflective listening skills, to demonstrate involvement in children's emotional expression and behavior, and to maintain these skills at six month follow-ups (Guerney & Stover, 1971).

According to Landreth and Lobaugh (1998), the combination of didactic instruction paired with supervision in a supportive environment provides a process that sets filial therapy training apart from most other parent training programs that are just educational in nature. There are many differences in the filial training model and a typical parent education model. In a typical parent education model, communication is based on verbal interaction and parent-child discussions to solve problems. In a filial training model, communication is play based. Typical parent education models emphasize the parent being in charge of solving problems as they occur. The filial model places emphasis on the child developing problem-solving skills, self-responsibility, and self-control.

The filial approach is primarily experiential. Parents develop skills, practice skills, and experience skills in 30 minute special play sessions with their child. In typical parent education models, parents are expected to go home and deliver their newly acquired skills 24 hours a day, which can lead to discouragement. In the filial approach, the goal is to change the parent. In a typical model, the goal is to change the child. Filial therapy focuses on strengths rather than weaknesses. It focuses on the parents' accomplishments rather than failures (Yuen, Landreth, Baggerly, 2002).

Supervision is a part of the training that is unique to filial. The supervisor actually watches the parents in play sessions with their child either by video or live supervision. Parents can then receive feedback from the supervisor and the support group.

Finally, filial differs in the goal of the parenting education. In typical parent education programs the goal is to find solutions to problems. In filial training the goal is to improve the relationship between the parent and their child. In an interview recorded in 2002, Dr. Garry Landreth stated: "filial therapy does not focus on correcting specific problems but focuses on building the kind of relationship where the child feels safe enough to play out problems" (Watts & Broadus, 2002, p.379).

Filial therapy provided to adolescent parents in a school setting is an efficient and economical way to provide services to families who have limited resources. Filial training provides both intervention and prevention which can hopefully move adolescent parents toward healthier parent-child interactions. The system is an intervention because it enhances and strengthens the parents' relationship with their child. It is preventative because it helps to prevent children's future problems (Guerney, & Guerney, 1989). Because it provides both intervention and prevention, filial therapy has been deemed

appropriate “for parents of all children, not just children who are experiencing emotional and behavioral difficulties” (Sweeney, 1997, p.172). Filial play sessions provide a non-threatening atmosphere that provides parents with a way to deal with their own issues as they relate to their child (Van Fleet, 1994).

Filial therapy training utilizes play as a fun and developmentally appropriate way to encourage interaction between the parent and child. Play, which is an integral part of a child’s life, is the main vehicle that they use to express their thoughts and feelings and to work through issues (Bratton, Ray, & Moffitt, 1998). Children are limited by verbal skills in expressing emotion. Play allows them to act out emotions and issues in a symbolic way. Parents involved in the program begin to move away from spanking, yelling, and screaming as methods of discipline to being able to set limits therapeutically and calmly. They are able to give choices, respond consistently, and allow children to experience the consequences of their choices (Landreth, 2002).

Parental Stress

Research suggests that adolescent parents are at an increased risk of emotional, financial, and parenting problems (Berlin et al, 2002; NASN, 2008; Sweeney, 1996). Adolescent parents are more likely to experience problems with parental stress, parental empathy, and parental acceptance. Stress is defined as an elevated or heightened mental or physiological state. According to Abidin (1990):

> The task of parenting is a highly complex one that often must be performed within very demanding situations, with limited personal and physical resources, and in relation to a child who by virtue of some mental or physical attribute may be exceedingly difficult to parent (p. 298).

Adolescent parents may be particularly prone to stress due to lack of social support, relationship difficulties, emotional immaturity, financial issues, and lack of knowledge of child development and parenting techniques (Birch, 1998). According to O'Callaghan et al. (1999), adolescent parents are less prepared for parenting and are more likely to view their parenting role as stressful, their children as difficult, and are typically less responsive to their children.

According to Sweeney (1996), there is a relationship between parental stress and parental perception of children's behavioral problems. He suggested that when parents participate in the filial therapy group, they may realize that they are not alone in their parenting struggles, their stress level may decrease, and their perception of behavior problems my change.

Parental Empathy

Parental empathy is defined by Miliora (1993) as "the capacity to step into another's experience toward using the understanding thus obtained in ways that are intended to benefit the other" (p.108). Fesbach (1987) suggested that parental empathy facilitates the development of adaptive behavior in children and a lack of empathy is associated with child maltreatment. Ainsworth (1979) reported that parental empathy is positively related to secure attachment in children, which is crucial in infants' early emotional development. On the contrary, low levels of parental empathy are associated with parents who are insensitive to the needs of their child (Poon, 1998).

A characteristic of adolescence is a lack of empathy (Byers, 2005). According to Winstanley, Myers, and Florsheim (2002), the ability to take the perspective of another cognitively and emotionally is a major milestone in adolescent development. If the

adolescent parent fails to meet the empathic needs of the child, it may result in low self-esteem (Coopersmith, 1967), difficulty repressing impulses (Oppenheim, Sagi, Lamb, 1988), and overdependence for the child (Baker & Baker, 1987).

Filial therapy has been found to be an effective way of building empathy in parents. According to Coopersmith (1967) the most important contribution to the development of healthy self-esteem is the amount of acceptance and empathic treatment received from significant others. The self-esteem of a child has also been shown to be highly correlated to parental acceptance or rejection (Eisman, 1981; Cox, 1970). Parental rejection has been related to aggression in children (Kagen & Moss, 1962) and lower scores on intelligence tests (Hurley, 1967). Parpal and Maccoby (1985) found that three and four year olds who had empathic parents were more likely to obey commands and comply with parents' instructions. Rothbaum, Rosen, Pott and Beatty (1995) conducted a longitudinal study and determined that children with empathic mothers were less likely to have behavioral problems five years later.

Parental Acceptance

Porter (1954) developed the Porter Parental Acceptance Scale, and defined parental acceptance in the following way:

> Parental acceptance may be defined as feelings and behavior on the part of the parents which are characterized by unconditional love for the child, a recognition of the child as a person with feelings who has a right and a need to express those feelings, a value for the unique make-up of the child, and a recognition of the child's need to differentiate and separate himself from his parents in order that he may become an autonomous individual (p. 177).

According to Coopersmith (1967), parental acceptance occurs when the parent accepts the child regardless of appearance, abilities, or behavior, while being sensitive to the child's needs, desires and interests.

Rogers (1967) defined acceptance as warm regard for the other person's unconditional self-worth, no matter how the other person may behave or feel. Research shows a correlation between parental acceptance and adjustment and self-concept in children (Cox, 1970; Eisman, 1981). Low levels of parental acceptance are associated with externalizing behavior problems, hostility and aggression, low self esteem, juvenile delinquency, and emotional instability (Kroupa, 1988; Patterson & Bank, 1989; Rohner, 1986). Rohner (1986) also found that when parents were warm, accepting, and nurturing, their children exhibited more positive social skills. Hower and Edwards (1976) found that parents who are accepting have children with more highly developed moral character.

Educational Goals

Adolescent pregnancy and parenting is associated with high rates of dropping out of school. One of the primary social concerns resulting from adolescent pregnancy is the cost to society due to the adolescent mothers' lack of education. According to the National Campaign to Prevent Teen Pregnancy (2007), it is estimated that the annual cost to taxpayers due to teenage childbearing is about seven billion dollars annually. More than two thirds of all teens who have a baby will not graduate, 75% will end up on welfare, and only 1.5% will earn a college degree by age 30 (Teen Pregnancy Statistics, 2009). A child's chance of growing up in poverty is nine times greater if they have a mother who is an adolescent.

According to the National Campaign to Prevent Teen Pregnancy (2007), successful programs for pregnant and parenting adolescents include three components that have long term impacts on the lives of both the mother and child: prenatal care, continuing educational support, and postpartum family planning. Research shows that adolescent mothers are less likely to achieve educationally than older mothers (Furstenberg, Brooks-Gunn, Morgan, 1987). However, the same study found that if educational support services were provided, the mothers were more likely to return to school and restrict further childbearing. Some studies have found that adolescent girls who have poor school performance and a poor relationship with the school setting are more at-risk for a premature pregnancy (Abrahamse, Morrison, & Waite, 1988, Olson & Worobey, 1984). School absenteeism is a strong predictor of drop-out rates. It was found in a study by Barnet et.al. (2004), that both absenteeism and drop-out rates were reduced when pregnant adolescents received school-based prenatal care.

One of the most common reasons for teenage girls to drop out of school is pregnancy. After the baby is born, lack of child care may prevent the mother from returning to school. According to Barnet et al. (2004), once the girl makes the decision to drop out of school, she is more likely to require public assistance and to live below the poverty line. A study by Campbell, Bretmayer, and Ramey (1986) found that adolescent mothers who had access to high quality day care had an increased likelihood of finishing high school, attending post-secondary education, and becoming self-supporting.

Results of long term studies support that most teenage mothers will finish high school and find employment if they are provided with appropriate support (Furstenberg et al., 1987, Horwitz, Klerman, Kuo, & Jekel, 1991). However, school budgets across the

country are being greatly reduced. Due to these reductions, programs to support adolescent parents are being condensed or eliminated and parents are left without access to positive support services (SC Campaign to Prevent Teen Pregnancy, 2009).

It is equally disturbing that only 77% of children born to adolescent mothers will earn their high school diploma (Maynard, 1997). Children born to adolescent mothers are 50% more likely to repeat a grade and have lower performance on standardized tests (National Campaign to Prevent Teen Pregnancy, 2009). Some research also suggests that teen fathers have lower levels of education, are more likely to drop out of school, and have lower annual earnings than teens that do not father children (Teen Pregnancy Statistics, 2009).

Filial Research

Many studies have been conducted to determine the effectiveness of filial therapy with a variety of populations. The first significant study on filial therapy was conducted in 1966 by Guerney and Stover through a grant from the National Institute of Mental Health. In this early study, Stover and Guerney (1967) found that mothers trained in filial therapy had significant increases in the use of reflective statements and decreases in directive statements, as compared to mothers without filial training. In the same study, Stover and Guerney (1967) found that children's behaviors were positively affected by the changes in the behavior and positive interaction with the mothers. Only mothers were used in this study since mothers were most likely to bring children to therapy. In the study, 75% of the mothers remained in treatment which lasted about one year. Of the children who remained in the study, all showed gains on standardized rating scales of behavior (Guerney, 2000).

A comparison study was conducted by Oxman in 1972, which demonstrated that parents who participated in filial therapy reported greater improvements in their child's behavior along with increased satisfaction with their children. Measures that were developed for this study have proven reliable and valid and have continued to be used for other filial therapy studies. Guerney (1975) conducted a follow-up study and found that the mothers who had participated reported positive effects of filial therapy three years after the training had ended.

Guerney, Guerney, and Stover (1972) studied therapist attitudes and qualities that facilitate filial therapy training. They found that the necessary conditions needed included the therapist's motivation, cooperativeness, and good rapport with parents and children. They also found that the therapist needed to be perceived by the parents as understanding of the parent's feelings and difficulties; respectful of the parent's point of view; not blaming of the parent; and seeing the parents as an indispensable helpmate for the child (Guerney, Guerney, & Stover, 1972).

Stover et al. (1971) developed a rating scale to be used in filial therapy research to measure the level of empathic responses that parents display during filial therapy sessions. This was developed because parental empathy is one of the primary goals of filial therapy. Stover (1971) and Guerney (1964) concluded that a high level of empathic responses was a necessary condition for successful change in children's behavior. This rating scale was adapted by Bratton (1993) in her study using filial therapy with single parents, to become the Measurement of Empathy in Adult/Child Interaction (MEACI), and has been used in many recent filial therapy studies to measure the amount of empathy displayed during play sessions.

Ray, Bratton, Rhine, and Jones (2001) conducted a meta-analysis of the effectiveness of filial therapy and found it to be an effective treatment for children's problems. It has been shown to be effective in decreasing reports of problem behaviors in children (Bratton & Landreth, 1995), improving children's feelings of self-confidence (Bratton & Landreth, 1995) and increasing children's expression of emotions (Glass, 1986). Studies of the effectiveness of filial therapy with specific children's problems include: stuttering (Andronico & Blake, 1971; learning disabilities (Kale & Landreth, 1999; Gilmore, 1971); sexually abused children (Costas & Landreth, 1999), children who are chronically ill (Tew, Landreth, Joiner, & Solt, 2006), and children who have witnessed domestic violence (Smith & Landreth, 2003).

In the study with chronically ill children (Tew, Landreth, Joiner, & Solt, 2006), it was found that the parents reported a decrease in stress, an increase in accepting attitudes, a reduction in their children's behavior problems, and an increase in the ability to adopt a more therapeutic role with their child. The children in the study were able to express emotions and solve problems in a safe, accepting environment and were able to build a sense of mastery and confidence. According to VanFleet (1992), the greatest advantage of filial therapy in working with families of chronically ill children, is that it enhances the parent-child bond and strengthens family cohesiveness, which is related to adjustment to chronic illness.

Filial therapy has been shown to be effective in increasing parents' empathy toward and acceptance of their children (Lobaugh, 1991) and has also been linked to reductions in parenting stress (Bratton, 1994; Lobaugh, 1991). Guerney (1975) surveyed forty two former filial therapy participants one to three years after treatment to determine

long term changes in behavior as a result of their training. Thirty two of the parents responded that they had seen continued improvement in their children since treatment was terminated.

Bavin-Hoffman, Jennings, and Landreth (1996) conducted a study to investigate parents' perceptions of filial therapy. The parents in this study reported that they believed their families had improved because of the filial therapy training. It was also reported that the parents believed they had internalized the skills and applied them not only to their children, but also in their relationship as a couple. This unexpected result brought increased unity between the parents and confidence in their parenting skills. The parents reported that they were more understanding and accepting of their children's play.

Cleveland and Landreth (1997) conducted a study to determine children's perceptions of filial therapy training. This was the first study to try to capture a child's opinion of the training. Five children, ranging in age from three to eight, were interviewed after filial training ended. The researchers were not very successful in getting the children to verbalize their thoughts or feelings. However, there was evidence displayed of a significant change in the behavior of the children as a result of the training.

Glass (1986) compared the effects of parents in the Landreth 10-week filial therapy training model with a control group and found significant differences in parents increased understanding of the meaning of their children's play, increased demonstrations of unconditional love, and less conflict in the parent-child relationship. Glass (1986) also noted increases in self esteem of both parents and children as well as closeness in the parent-child relationship.

Bratton, Ray, and Moffitt (1998) conducted a study using filial therapy with custodial grandparents and their children. Children in the custody of their grandparents often need help in adjusting to their new environments and the loss of their parents. They concluded that the therapy helped the grandparents to foster a healthy parent-child relationship by equipping them with skills to provide needed emotional support to their grandchildren.

In a study with incarcerated fathers, Landreth and Lobaugh (1998) found that the fathers demonstrated significant increases in parental acceptance and decreases in parental stress. The children in the treatment group demonstrated decreases in problematic behavior and increases in self-esteem. In a similar study with incarcerated mothers, Harris and Landreth (1997) reported significant changes in empathic interactions with their children. The same mothers also reported a decrease in behavior problems with their children.

Costas and Landreth (1999) used filial therapy as an intervention with non-offending parents and their children who had experienced sexual abuse. The experimental group demonstrated a significantly increased level of parental empathy and acceptance, as well as a decrease in parental stress.

In a qualitative study by Foley, Higdon, and White (2006), six parents reported on their experiences in a filial therapy program. They reported a decrease in parenting stress. They also reported a belief that the changes they had made in relating to their children facilitated changes in their children's self-confidence and self-awareness in social interactions. Foley et al. (2006) reported that practicing the play skills in front of the small group and receiving feedback was a motivating factor in encouraging the parents to

apply the new skills. In another qualitative study by Packer (1990), parents trained in filial therapy perceived themselves as having attained skills that positively impacted their children as well as themselves. The parents in this study reported fewer acting out behaviors by their children as well as an increase in acceptance of the parents as authority figures (Packer, 1990).

Rennie and Landreth (2000) reviewed the research in filial therapy and found that it was a powerful intervention that increased "parental acceptance, self-esteem, empathy, and created positive changes in family environment, and the child's adjustment and self-esteem while decreasing parental stress and the child's behavioral problems" (p.31).

Several studies have focused on training non-parents in filial therapy. In a study by Robinson (2001), fifth grade students were trained to conduct special play sessions with at-risk kindergarten students. In the beginning of the training, the fifth grade students had difficulty with being non-directive in the kindergarten students play. During the course of training, they were able to allow the children to lead and were able to demonstrate the child-centered play therapy skills (Robinson, 2001). When compared to the control group, the fifth grade students in the filial group demonstrated an increase in empathic responses to the kindergarten students, showing that they had effectively learned the play therapy skills.

Brown (2000) conducted a study with undergraduate student teacher trainees. The trainees demonstrated significant increases in their empathic interactions with children as compared to the control group who received traditional training. Two studies were conducted with high school students who were interacting with at-risk kindergarten students (Rhine, 2000; Jones, 2001). All of the studies found that the high school students

and student teachers trained in filial therapy increased their empathic responses, were more accepting of children's feelings and behaviors, and they were more willing to follow the children's lead rather than trying to control his/her behavior. A benefit of the study with high school students was that it was determined that the model could be used by school districts and school counselors to maximize time and resources by using peer mentors trained in filial therapy to assist with younger students.

In another study by Goetz and Grskovic (2009) in Germany, older peer tutors were used to tutor younger children in a special school for students in grades one through ten with learning handicaps. The Child Behavior Checklist was used to measure changes in the student's behavior. They found that although parents did not note a behavior change, teachers did report significant changes in inappropriate school behavior. It was also reported that the tutors showed a marked and maintained increase in empathic responses over time.

Ginsberg (1976) examined the effects of filial therapy with single parents, foster parents, and families with different socio-economic status and determined that all of the groups reported positive results in the areas of reduced parental stress and increased parental acceptance.

Lebovitz (1983) compared the effectiveness of a filial therapy group, a supervised play therapy group, and a control group. It was found that the children in the filial therapy group and supervised play group had fewer behavioral problems than the control group. In the filial therapy group, the parents communicated more acceptance of the children's feelings, were more involved in the children's play, and allowed the children more self-direction.

In a phenomenological study by Kinsworthy and Garza (2010), participants in a filial therapy group expressed feeling more tolerant of themselves as parents. They also identified that they felt less pressure to be perfect parents. In this study, parents stated that the skills they learned were useful in the real world of parenting.

A study by Kolos, Green, and Crenshaw (2009) used filial therapy with homeless parents and their children. The researchers stated that it was a way to improve parent interactions with their children even under extreme stress or crisis situations such as homelessness. Kolos and Green (2009) stated that "filial therapy offers empowerment to the parent and safety and structure to the child during a time when they feel most disempowered" (p. 373).

The filial therapy approach has been used successfully with a variety of populations of parents including: incarcerated fathers (Landreth & Lobaugh, 1998), incarcerated mothers (Harris & Landreth, 1999), Head Start families (Johnson et al, 1999), non-custodial parents (Glazer & Kottman, 1994), single parents (Bratton, 1993; Ray et.al, 2001), divorced parents (Bratton, 1998; Glazer & Kottman, 1994), mothers of mentally retarded children (Boll, 1972), grandparents raising their grandchildren (Bratton, Ray, & Moffit, 1998), foster and adoptive parents (Ginsberg, 1989, Van Fleet, 1994), disadvantaged parents (Andronica & Guerney, 1967; Johnson, Bruhn, Winek, Krupps, & Wiley, 1999), missionary parents (Moncrief, 2006), parents in shelters for domestic violence (Barabash, 2003; Smith & Landreth, 2003), and adolescent mothers in foster care (Celaya, 2001).

Studies have also been conducted using filial therapy with parents of various cultures including: Chinese parents (Chau & Landreth, 1997; Yuen et.al, 2002), Korean

parents (Jang, 2000; Lee, 2003), Native American parents (Glover & Landreth, 2000), Israeli parents (Kidron, 2004) and Jamaican parents (Edwards, Ladner, & White, 2007). Glover (2001) stated that teaching parents of other cultures to do child-centered play therapy can provide the following positive results:

> The intent of child-centered play therapy is to allow the child the freedom to be who the child is, thus providing the basis for a culturally sensitive relationship. It is exactly this accepting and respectful relationship that makes child-centered play therapy an ideal intervention for children who are of a different culture than the therapist (p.32).

Since filial therapy teaches client-centered play therapy skills to parents, and the parent becomes the therapeutic agent of change, the parents may keep their traditional cultural values and beliefs but adopt a more accepting parent-child relationship during the special thirty minute, weekly play sessions.

One cultural study by Yuen, Landreth, and Baggerly (2002) used filial therapy with thirty-five immigrant Chinese families in Canada. Typically, Chinese families will not seek out mental health services due to the stigma. They do not believe that outsiders or strangers should know about their problems. Also, the principles of Confusius play a great role in the parenting practices, including parental control, obedience, and strict discipline. After the filial therapy training, the participants in this study scored significantly higher on empathic behavior during observed play sessions with their children. According to Yuen (2002), Chinese parents typically think that playing is wasting time. However, after the training, the parents were more willing to be involved in their children's play.

Gus Yuging (2005) conducted a review of studies that used filial therapy with other cultures to explore whether filial therapy would be effective in mainland China. He reported that children in China were experiencing behavioral problems such as: aggression, immaturity, and dependence due in part to parents' over-involvement, harsh discipline, and lack of knowledge of parenting skills. Yuging (2005) reported that play time is reduced, and emotional development is ignored, because so much emphasis is put on academic achievement. Filial therapy is especially appropriate because of the "one child" policy in China. The children do not have siblings with which they can play, so parents or grandparents must step into that role. Yuging's report indicated that filial therapy was culturally sensitive and was an effective intervention with families in mainland China.

Conclusion

Filial therapy has been found to be useful for a wide range of children's problems and may also be used as a preventative approach. However, there are populations that may not be best for this treatment modality. It is not advisable to use filial therapy with parents who are not intellectually capable of understanding the skills that are taught. It may not be appropriate for parents who are so overwhelmed with their own problems and needs that they cannot focus on the needs of their child. Third, filial therapy may not be appropriate for families in which the parent is the perpetrator of abuse on the child (Van Fleet, 1994).

Filial therapy was introduced by Guerney in 1964, but it did not become widely accepted until the 1990's. Guerney (2000) hypothesized reasons that the model was not applied before this time. He stated that at the time filial therapy was introduced, family

therapy was still new, and work with multiple family members was still considered suspect. He also believed that many people felt that children's problems were the result of pathology of the parent. In the 1980's the Association for Play Therapy was formed, but it was not until the 1990's that the field of filial therapy was widely accepted as a valid approach for working with families. Since that time, there has been much research from the University of North Texas and Dr. Garry Landreth. Dr. Landreth developed the ten session filial therapy model called Child Parent Relationship Therapy (Landreth, 2006) that has been used in much of the filial therapy research in recent years.

In an interview with Garry Landreth (2002) he stated: "filial therapy holds great promise for changing the world by strengthening families" (Watts & Broaddus, 2002, p. 379). Daniel Sweeney (1997) stated: "parent training is one of the most powerful tools, if not the most powerful tool, in ministering to the needs of children" (p.163). When adolescent mothers are equipped with knowledge about parenting and child development, and they develop skills to improve their relationship with their child, their ability to parent effectively and strengthen their family may be improved.

Chapter Three: Methodology

A quasi-experimental, non-randomized control group, pretest posttest design was utilized to measure the effectiveness of filial therapy with adolescent parents. Subjects participating in the experimental group were parenting adolescents from two area high schools who were participating in an existing program which provides parenting classes. The control group was made up of parenting adolescents from another high school who received all components of the intervention except filial therapy. Only the experimental group received instruction in filial therapy.

Selection of Subjects

The study was conducted at a community center that is a part of a school district. The center provides classrooms for the parent training and observation rooms with one way mirrors for parents to demonstrate the filial therapy skills. The adolescent parents from this school district were allowed to participate in the existing program as long as they met the following requirements: remain in school to complete their secondary education, participate in parenting classes, agree to case management, do not experience a second pregnancy, and engage in Parent and Child Together (PACT) in which the parents are observed working and interacting with their child,. These adolescent parents were able to choose to participate in the experimental group. The control group was a "treatment as usual" comparison group of parenting adolescents from a school that also provides parenting classes for adolescent mothers.

Parents selected to participate in the study met the following criteria: (1) must be parenting adolescents; (2) must be 19 years old or younger; (3) must have full or joint

custody of their child; (4) must be able to attend 10 weeks of parenting classes at scheduled times; (5) must agree to participate in the weekly 30 minute play session with their child; and (6) must sign the consent to participate form. Participants who were under 18 years of age were required to have their parent or legal guardian sign the participation agreement as well. To encourage participation, all participants were eligible to receive incentives for attending the parenting classes. The size of the experimental group was 25 adolescent parents. The size of the control group was 21 participants. Although adolescent fathers were invited to attend, only adolescent mothers were in the groups.

Instrumentation

Parental attitudes including empathy and acceptance were measured by the Porter Parental Acceptance Scale (PPAS) (Porter, 1954). This 40 item inventory was designed to measure parental acceptance and empathy related to attitudes and feelings of parents toward their children. These attitudes include: (1) appreciation for the uniqueness of the child; (2) respect for the child's feelings; (3) respect for the child's right to express his/her feelings; (4) recognition of the child's need for independence; and (5) feelings of unconditional love for the child (Porter, 1954). The Porter Parental Acceptance Scale was selected for use in this study because these attitudes are related to the objectives of Filial Therapy and the Porter Parental Acceptance Scale has been used in other studies on filial therapy. The PPAS takes approximately 20 minutes to complete. The items on the PPAS have multiple choice responses that range from low acceptance to high acceptance. There are two dimensions of acceptance that are measured: (1) a parent's feelings in a specific circumstance; and (2) how the parent will react in a certain circumstance. The instrument is scored to yield a total scale score and four subscale scores.

Porter (1954) reported a split-half reliability correlation of .76 raised by the Spearman Brown Prophecy formula to .86. The validity of the PPAS was established by using five expert judges to rank responses on a continuum of one to five with one representing low acceptance and five representing high acceptance. There was agreement on all items among at least three of the five judges. These finding suggest that the PPAS is a valid measure of parental acceptance (Porter, 1954).

The Measurement of Empathy in Adult-Child Interaction (Stover, B. Guerney, & O'Connell, 1971), a direct observational scale, was used to measure parental empathy. This scale measures three specific behaviors of parents that have been identified as major aspects of empathy. They include: (a) communication of acceptance; (b) allowing the child self-direction; and (c) involvement. The scale provides a score on each subscale and a total empathy score. Scoring is based on observed interactions between the parent and child at five minute intervals. The average score of the intervals is calculated providing an overall empathy rating for a session. Items are rated on a five-point Likert scale. The scale is bipolar, with the highest level of a parent's empathic responses and behaviors at one extreme and the least empathic, highest self-involvement behavior at the other extreme (Guerney, B., Stover, L. DeMeritt, S., 1968)

The Communication of Acceptance subscale measures the parent's acceptance or rejection of the child's feelings and behaviors during play sessions. In another study, Stover et al. (1971) found that acceptance of feelings and behavior did not normally occur in interactions between parents and their children although it is an important variable in positive, healthy parent-child relationships. The Allowing the Child Self-Direction subscale measures the willingness on the part of the parent to follow the

direction of the child rather than attempting to control the child's behavior. The Involvement subscale measures the parent's participation and attendance to the child's play.

The MEACI was chosen for this study because the behaviors measured by this instrument are closely related to the primary objective of filial therapy in enhancing the parent-child relationship. Reliability coefficients were established for the three subscales by having six pairs of coders independently rate play sessions after they had been trained. The average reliability correlation coefficient for the Communication of Acceptance subscale was .92; the Allowing the Child Self-Direction subscale was .89; and for Parental Involvement was .89 (Stover et al. 1971). Construct validity was demonstrated in a study with 51 mothers who participated in filial therapy training (Guerney & Stover, 1971).

The Parenting Stress Index (PSI) (Abidin, 1983) was used to measure the amount of stress parents perceive in the parent/child relationship. It is a 101 item self-report instrument divided into two domains, child and adult. Test items have five possible responses that range from strongly disagree to strongly agree. The stress index measures the amount of stress that the parent perceives in their parenting skills, competence, attachment, depression, health, and parenting style. This index also measures the stress that parents feel in regards to their child's behavior, moods, distractibility, adaptability, and personality. Summing the subscales together produces a Total Stress score. Raw scores on the subscales and the Total Score are converted to percentile ranges. The percentiles are plotted to see patterns in the participant's profile. Normal ranges are between the 15^{th} and 80^{th} percentile. High scores occur at or above the 85^{th} percentile.

The PSI can be completed in less than 30 minutes and is easily administered. The test-retest method was used to determine a coefficient of reliability (Zareski, 1983), which produced coefficients of .69 on the parent domain, .77 on the child domain, and .88 for the total score. Alpha reliability coefficients were calculated to determine internal consistency which reported .93 on the parent domain, .89 on the child domain, and .95 on the total score. These finding indicate a high degree of internal consistency (Hauenstein, Scarr, & Abidin, 1986).

This scale was appropriate for use in this study because the scales are related to the parents' ability to accept their child. If the parent/child relationship is improved through filial therapy, it is possible that a reduction in the level of parental stress could occur.

Achievement of educational goals were monitored by a tracking form that included the following: obtaining passing grades, passing to the next grade, graduation from high school, or passing the GED.

Procedure

The researcher met with each participant who met the criteria to explain the purpose and requirements of the study, discuss confidentiality, and answer questions before consent forms (appendix A) were signed. The experimental group was comprised of 25 adolescent mothers who ranged from 16 to 19 years of age. The population in the experimental group included ten Caucasian, eleven African American, two Hispanic, one Asian, and one biracial parent. All parents were attending high school or GED classes. The control group included 21 adolescent mothers who ranged from 15 – 19 years of age. The population in the control group included six Caucasian, nine African American, four

Hispanic, and two Asian parents. All parents in the control group were also attending high school or GED classes.

The experimental group was divided into four small groups of eight to ten mothers and the control group into two small groups of ten or eleven mothers. On the first week, the parents completed the following: (a) Parental Stress Index, (b) Porter Parental Acceptance Scale and (c) were observed and videotaped playing with their child. The videos were later rated using the Measurement of Empathy in Parent Child Interaction.

The Landreth (2006) ten session filial therapy model was used in the experimental group parenting classes. This model utilizes a small group format in which parents are trained in basic child-centered play therapy principles and skills (Landreth, 2006). Parenting classes were taught by the researcher and two assistants. The researcher is a Licensed Marriage and Family Therapist, Licensed Professional Counselor, Registered Play Therapist and instructor in both filial and child-centered play therapy. The assistants were Licensed Marriage and Family Therapists who had completed instruction in filial and child-centered play therapy. Posttests were administered to both the experimental and control groups after the last training session. The control group parents were scheduled to begin filial therapy training the week after they completed the posttest as an incentive for participating in the study.

Treatment

The 25 parents in the experimental group were divided into four small groups of six to eight participants, based on school scheduling requirements. Each group met weekly for ten consecutive weeks.

Training Session One

In training session one the parents introduced themselves and described their child. The facilitator explained the goals of the filial therapy program. The session focused on reflective responding and responding with empathy. The facilitator demonstrated the skills through role-playing and encouraged the participants to practice empathic responses in role-plays. Homework was assigned which asked the parents to identify four different emotions in their child in the coming week.

Training Session Two

Session two began with a review of homework. The facilitator gave an overview of the basic principles of play sessions. The goals of the play session were explained and discussed including: allowing the child to express feelings, strengthening the parent/child relationship, and increasing the level of playfulness and enjoyment between the parent and child. Examples of toys to be used in special play sessions were displayed and the rationale for specific toys was given. A video of a play session was shown and discussed.

Training Session Three

The facilitator discussed handouts, "Eight Basic Principles of Play Therapy" and "Basic Rules for Filial Therapy" (Landreth, 2006). Parents were prepared for their first home play session. After a demonstration by the instructor, the parents role-played the skills with each other. The facilitator instructed the parents to tell their children that they were going to have a time of special play. The homework assigned was to set up and begin the special play sessions at home once a week for 30 minutes. Play sessions were to be video-taped if possible. Play sessions were also set to occur at the community center so that they could be observed and videotaped by the researcher and research assistants.

Training Session Four

A discussion of the first home play session began the session. Parents were encouraged and given feedback on their experiences. Video-tapes of the play sessions were watched by the group. Information on limit-setting was introduced. A video was shown that demonstrated the correct way to set limits in a filial play session. Parents were given the opportunity to role-play situations in which limits could be set.

Training Session Five through Ten

The last five sessions followed the same general format as the first sessions. Each parent reported on her home play sessions and presented videotapes of the sessions. The group and the facilitator provided encouragement, suggestions, and instructions in a supportive atmosphere. Common problems were discussed and skills were reviewed. Parents were reminded of the skills of reflective listening, limit-setting, and giving choices.

Training Session Ten

The final session was used to review all of the skills and to discuss what was most important to each participant. Each participant was given the opportunity to tell what skills they believe will be most helpful in their relationship with their child.

Control Group

The control group was made up of 21 adolescent parents from another high school that provided parenting classes for pregnant and parenting teens. The group was divided into two smaller groups according to school scheduling requirements. The group was administered the pretests the week before the program began. Each week, the facilitator had a prepared parenting lesson. The topics included the following: self-esteem,

depression, discipline, dressing for success, coping with stress, boundaries, child support, how to have a positive relationship with the father of the baby, importance of the father in the child's life, dating violence, and importance of education for success in life. After the ten weeks, posttests were given. Filial therapy classes were provided to the control group after the ten week research period as an incentive and appreciation for participating in the research study.

Research Hypothesis

To carry out this study, the following hypotheses have been formulated:

Hypothesis 1: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Porter Parental Acceptance Scale than will the adolescent parents in the control group. .

Hypothesis 2: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Respect for the Child's Feelings and Right to Express Them subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Hypothesis 3: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Appreciation of the Child's Unique Makeup subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Hypothesis 4: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Recognition of the Child's Need for Autonomy and Independence subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Hypothesis 5: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Unconditional Love subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Hypothesis 6: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Measurement of Empathy in Adult-Child Interaction (MEACI) (Stover, B. Guerney, & McConnell, 1971) than will the adolescent parents in the control group.

Hypothesis 7: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Communication of Acceptance subscale of the Measurement of Adult Child Interaction (MEACI) than will the adolescent parents in the control group.

Hypothesis 8: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Allowing the Child Self-Direction subscale of the MEACI than will the adolescent parents in the control group.

Hypothesis 9: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Involvement subscale of the MEACI than will the adolescent parents in the control group.

Hypothesis 10: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Parenting Stress Index (PSI) (Abidin, 1983) than will the adolescent parents in the control group.

Hypothesis 11: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Parent Domain of the Parenting Stress Index than will the adolescent parents in the control group.

Hypothesis 12: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Child Domain of the PSI than will the adolescent parents in the control group.

Hypothesis 13: Adolescent parents in the experimental group will attain their educational goals including passing grades in coursework, passing to the next grade, and completion of high school or attainment of a GED at a higher rate than parents in the control group.

Analysis of Data

Following the collection of the data from the pretest and posttest of the PSI and PPAS, the two instruments were scored by a research assistant and double checked by a second research assistant. The video tapes of parent-child play were scored by three raters after the completion of the study so that the raters were unaware whether they were rating a pre-training or post-training session. Raters were research assistants with graduate course work and training in play therapy.

ANCOVA was used to test the significance of the difference between scores on the pretest and posttest for the experimental group and the control group for each hypothesis. On the basis of ANCOVA, the hypothesis was either retained or rejected.

Significance of the Study

Dr. Sue Bratton (1993) stated in her study of filial therapy with single parents that further research should be conducted using this approach with adolescent parents. This study made available to the target population of teenage mothers a program that encourages parental involvement, facilitates parent/child communication, reduces parental stress levels, and teaches limit setting skills. The study worked in collaboration and cooperation with existing high school programs that provided support services to

adolescent parents. The study was designed to determine (a) the effectiveness of filial therapy training in increasing adolescent parents' acceptance of their child; (b) the effectiveness of filial therapy training in increasing adolescent parents' empathic behaviors with their child; (c) the effectiveness of filial therapy training in decreasing adolescent parents' stress in relationship to parenting; and (d) the effectiveness of filial therapy in helping adolescent parents achieve their educational goals. This study did not investigate the impact on the children, however, typically the children as well as the parents benefit from the filial therapy training because the method is effective in both intervention and prevention.

Chapter Four: Results

This chapter presents the results of the analysis of the data for each hypothesis tested in this research study. An analysis of covariance (ANCOVA) was computed to test the significance of the difference between the adjusted posttest means for each hypothesis for the experimental and control groups. For each hypothesis, the posttest specified was used as the dependent variable and the pretest was used as the covariant. ANCOVA was used to adjust the means on the posttest for each group on the basis of the pretest. This method statistically equated the control and experimental groups. Significance was tested at the .05 level for the difference between the means. On the basis of ANCOVA, the hypothesis was retained or rejected.

In order for the mathematical calculations to be valid for comparing two groups in an experiment, one of the necessary assumptions is that subjects be randomly assigned to treatment and control groups. In this project, it was not possible to randomly assign subjects because the adolescent mothers were assigned according to the school that they attended. In the absence of random assignment, the results could be attributed to pre-existing differences between the two groups. A comparison was made of the two groups before treatment with the following results. The two groups were similar in age, ethnicity, grade level, and socioeconomic status. A t-test was run on the before scores on the three main indices used in the study with the following results.

The PSI total "before" scores were as follows:

Control Group n = 21	Experimental Group n = 25
Mean Pretest = 237.4, SD 45.0	Mean Pretest = 240.9, SD=42.9

The P value of 0 .789 indicates that the difference of scores on the pretest of the PSI between the two groups due to preexisting conditions was not significant. There is no evidence that the two groups differed with respect to the PSI prior to the start of their parenting programs.

The PPAS total "before" scores were as follows:

Control group n = 21 Experimental group n = 25

Mean Pretest = 129.7, SD = 9.9 Mean Pretest = 132.9, SD = 14.5

The P value of .396 indicates that the difference of scores on the pretest of the PPAS between the two groups due to preexisting conditions was not significant. There is insufficient evidence to conclude that the two groups differed with respect to the PPAS prior to the start of their parenting programs.

The MEACI total "before" scores were as follows:

Control group n = 21 Experimental group n = 25

Mean Pretest = 56.8, SD = 14.8 Mean Pretest = 62.1, SD = 17.8

The P value of .384 indicates that the difference of scores on the pretest of the MEACI between the two groups due to preexisting conditions was not significant. There is insufficient evidence to conclude that the two groups differed with respect to the MEACI prior to the start of their parenting programs.

Hypothesis 1: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Table 1 presents the pretest and posttest scores for the total score of the Porter Parental Acceptance Scale.

Porter Parental Acceptance Scale Total Scores

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
129	130	145	173
130	134	129	121
102	110	141	144
129	128	106	155
133	136	120	146
126	142	143	168
150	151	156	168
125	130	151	173
128	131	137	134
122	141	134	156
134	135	153	157
122	124	145	156
123	118	143	159
121	122	115	114
131	148	119	121
132	138	130	135
135	130	139	146
143	146	123	127
128	131	138	150
143	144	132	169
138	140	126	132
		106	126
		153	147
		115	134
		123	139

Table 1

Control Group n = 21	Experimental Group n = 25
Mean Pretest = 129.7, SD = 9.9	Mean Pretest = 132.9, SD = 14.5
Mean Posttest = 133.8, SD = 10.2	Mean Posttest = 146.0, SD = 17.4
Mean Change = 4.0, SD = 6.3	Mean Change = 13.1, SD = 13.6
Adjusted Mean = 135.12	Adjusted Mean = 144.86

Table 2 presents the analysis of covariance data for the mean total scores on the Porter Parental Acceptance Scale

Analysis of Covariance for the Mean Total Scores on the Porter Parental Acceptance Scale.

Source of Variation	Sum of Squares	df	Mean Square	F-ratio	P
Between	1064.87	1	1064.87	9.23	0.0040
Within	4960.00	43	115.37		
Total	6025.85	44			

Table 2

The P value of 0.004 indicates that the difference in posttest scores is highly significant, even when controlling for the covariate of the pretest scores. Therefore, the null hypothesis is rejected. The P value of 0.004 indicates that there is strong evidence of a significant increase in the experimental group adolescent parents' perceived acceptance of their child which supports the research hypothesis.

Hypothesis 2: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Respect for the Child's Feelings and Right to Express Them subscale of the Porter Parental Acceptance Scale than will the parents in the control group.

Table 3 presents the pretest and posttest scores on the Respect for the Child's Feelings and Right to Express Them subscale of the Porter Parental Acceptance Scale.

PPAS subscale A: Respect for the Child's Feelings and Right to Express Them

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
31	30	43	45
40	41	39	38
24	26	35	44
30	31	25	38
34	38	35	44
35	43	48	41
41	41	45	47
37	36	41	42
43	45	32	34
36	36	39	39
32	39	33	42
32	30	35	37
26	37	38	39
33	27	32	36
33	40	32	38
28	30	42	44
40	38	29	38
32	33	34	32
31	39	32	33
32	41	37	45
37	40	22	26
		24	26
		34	38
		31	35
		29	31

Table 3

Control group n = 21	Experimental group n = 25
Mean Pretest = 33.7, SD = 4.9	Mean Pretest = 34.6, SD = 6.4
Mean Posttest = 36.2, SD = 5.4	Mean Posttest = 38.1, SD = 5.6
Mean Change = 2.6, SD = 4.3	Mean Change = 3.4, SD = 4.3
Adjusted means = 36.60	Adjusted Means = 37.78

Table 4 presents the analysis of covariance data for the mean scores on the Porter Parental Acceptance Scale subscale Respect for the Child's Feelings and Right to Express Them.

Analysis of Covariance data for the mean scores on the Porter Parental Acceptance Scale: Respect for the Child's Feelings and Right to Express Them.

Source of Variation	Sum of Squares	df	Mean Square	F-ration	P
Between	15.79	1	15.79	1.01	0.3205
Within	671.97	43	15.63		
Total	687.76	44			

Table 4

The P value of 0.321 indicates that the difference in posttest scores is not significant. For this subscale of the PPAS, there is insufficient evidence to support the research hypothesis that the mean increase for the posttest of the experimental group is higher than that of the control group. On the basis of this data, it cannot be concluded that the parents in the experimental group increased their respect for their child's feelings.

Hypothesis 3: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Appreciation of the Child's Unique Makeup subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Table 5 presents the pretest and posttest scores for the Porter Parental Acceptance Scale subscale: Appreciation of the Child's Unique Makeup.

PPAS Subscale B: Appreciation of the Child's Unique Makeup

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
29	28	29	39
30	41	37	25
29	32	31	35
38	37	34	43
34	34	30	34
38	38	29	42
39	40	38	33
30	33	40	44
35	37	30	28
36	36	42	31
31	31	40	38
33	34	31	30
36	35	32	39
35	31	32	29
33	35	31	35
29	30	27	29
34	35	35	32
42	43	30	29
38	34	35	32
29	28	40	45
33	32	38	34
		28	32
		33	37
		28	39
		22	28

Table 5

Control group n = 21

Mean Pretest = 34.3, SD = 3.9

Mean Posttest = 34.5, SD = 4.0

Mean Change = 0.2, SD = 1.9

Adjusted Means = 34.09

Experimental group n = 25

Mean Pretest = 32.9, SD = 4.9

Mean Posttest = 34.5, SD = 5.5

Mean Change = 1.6, SD = 6.3

Adjusted Mean = 34.81

Table 6 presents the analysis of covariance data, showing the significance of difference between the experimental and control groups' posttest mean scores.

Analysis of Covariance data for the mean scores on the Porter Parental Acceptance Subscale: Appreciation of the Child's Unique Makeup.

Source of Variation	Sum of Square	df	Mean Square	F-ratio	P
Between	5.74	1	5.74	0.30	0.587
Within	818.07	43	19.02		
Total	823.81	44			

Table 6

The P value of 0.587 indicates that the difference in posttest scores is not significant. Therefore, the evidence does not support rejecting the null hypothesis. For this subscale, the data did not indicate an increase in the experimental group adolescent parents' appreciation for their child's uniqueness. On the basis of this data, there was insufficient evidence to support the research hypothesis.

Hypothesis 4: Adolescent parents in the experimental group will attain a significantly greater mean total score on the Recognition of the Child's Need for Autonomy and Independence subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Table 7 presents the pretest and posttest scores on the Porter Parental Acceptance Scale subscale: Recognition of the Child's Need for Autonomy and Independence.

PPAS Subscale C: Recognition of the Child's Need for Autonomy and Independence

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
33	35	45	47
31	34	33	38
23	26	41	41
41	40	29	36
39	39	43	40
33	37	39	41
40	40	41	44
33	34	38	41
40	39	31	30
36	37	35	36
43	39	36	47
35	37	43	43
35	36	43	44
38	37	29	29
43	45	34	30
37	38	33	35
34	32	39	38
41	43	41	40
39	44	35	39
40	43	38	43
40	38	32	38
		32	38
		40	42
		36	38
		28	36

Table 7

Control group n = 21

Mean Pretest = 36.9, SD = 4.7

Mean Posttest =37.8, SD = 4.3

Mean Change = 1.0, SD = 2.2

Adjusted Means = 37.64

Experimental group n = 25

Mean Pretest = 36.6, SD = 4.9

Mean Posttest = 39.0, SD = 4.8

Mean Change = 2.4, SD = 3.5

Adjusted Means = 39.1

Table 8 presents the analysis of covariance data showing the significance of difference between the posttest mean scores of the experimental and control groups.

Analysis of Covariance data for the mean scores on the Porter Parental Acceptance Subscale: Recognition of the Child's Need for Autonomy.

Source of Variance	Sum of Squares	df	Mean Square	F-ratio	P
Between	23.07	1	23.07	2.99	0.091
Within	332.01	43	7.72		
Total	355.08	44			

Table 8

The P value of .091 indicates that the difference in posttest scores is not significant. Therefore, the evidence does not support rejecting the null hypothesis. For this subscale, there is insufficient evidence to support the research hypothesis that the increase for the experimental group is higher than that of the control group. The data did not indicate that there was an increase for the experimental group parents' recognition of the child's need for autonomy.

Hypothesis 5: Adolescent parents in the experimental group will attain a significantly greater mean posttest score on the Unconditional Love subscale of the Porter Parental Acceptance Scale than will the adolescent parents in the control group.

Table 9 presents the pretest and posttest scores on the Porter Parental Acceptance Subscale: Unconditional Love.

PPAS Subscale D: Unconditional Love

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
36	37	28	42
20	18	20	20
26	26	34	24
20	20	18	38
26	25	12	28
20	24	27	44
30	30	32	44
25	27	32	46
10	10	44	42
14	32	18	50
28	26	44	30
22	23	36	46
26	10	30	37
15	27	22	20
22	28	22	18
38	40	28	27
27	25	36	38
28	27	18	26
20	14	36	46
42	32	17	36
28	30	34	34
		22	30
		46	30
		20	22
		44	44

Table 9

Control group n = 21

Mean Pretest = 24.9, SD = 7.8

Mean Posttest = 25.3, SD = 7.7

Mean Change = 0.4, SD = 6.8

Adjusted Mean = 26.18

Experimental group n = 25

Mean Pretest = 28.8, SD = 9.8

Mean Posttest = 34.5, SD = 9.7

Mean Change = 5.7

Adjusted Mean = 33.72

Table 10 presents the data showing the significance of difference between the posttest mean scores for the experimental and control groups.

Analysis of covariance for the mean scores on the Porter Parental Acceptance Scale subscale: Unconditional Love

Source of Variance	Sum of Squares	df	Mean Square	F-ratio	P
Between	618.19	1	618.19	9.48	0.004
Within	2802.71	43	65.18		
Total	3420.90	44			

Table 10

The P value of 0.004 indicates that the difference in posttest scores is highly significant, even when controlling for the covariate (pretest scores). Therefore, on the basis of this data, there is sufficient evidence to reject the null hypothesis. For this subscale, there is strong evidence to support the research hypothesis that the increase in the score for unconditional love for their child is significantly higher for the experimental group parents than the score for the control group parents.

Hypothesis 6: Adolescent parents in the experimental group will attain a significantly lower mean score on the Measurement of Empathy in Adult-Child Interaction posttest than will the adolescent parents in the control group.

Table 11 presents the pretest and posttest total scores on the Measurement of Empathy in Adult-Child Interaction.

MEACI (total score)

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
57.5	58	71	59.5
36	30	84	50
52.5	45.5	106	64.5
40.5	32.5	41	31
83	78	48	43.5
54	51	62	38
72.5	68	60	48
65	64	47	45
60	57	107	58
38	36	54	39
81	80	81.5	41.5
70	67	39.5	40
40.5	38.5	46	40
42	43	64.5	55
61	63	70	56
69	68	76.5	69
55	56	48	38
78.5	69	52	42
42	39	48.5	39.5
45	48	54	50
49	41.5	67	57
		53.5	46
		57	44.5
		59	47
		54.5	45

Table 11

Control group n = 21

Mean Pretest = 56.8, SD = 14.8

Mean Posttest = 54.0, SD = 14.9

Mean Change = 2.8, SD = 3.4

Adjusted Mean = 55.666

Experimental group n = 25

Mean Pretest = 62.1, SD = 17.8

Mean Posttest = 47.5, SD = 9.2

Mean Change = 14.6, SD = 12.9

Adjusted Mean = 46.04

Table 12 presents the analysis of covariance data, showing the significance of the difference for the posttest mean scores for the experimental and control groups.

Analysis of Covariance data for the mean total scores on the Measurement of Empathy in Adult-Child Interaction

Source of Variance	Sum of Squares	df	Mean Square	F-ratio	P
Between	1030.16	1	1030.16	19.59	<0.001
Within	2260.79	43	52.5		
Total	3290.95				

Table 12

The P value of <.0001 indicates that the difference in posttest scores is highly significant, even when controlling for the covariate (pretest scores). Therefore, the null hypothesis is rejected. There is strong evidence to support the research hypothesis that the parents in the experimental group experienced an increase in empathic responses with their children during observed play sessions.

Hypothesis 7: Adolescent parents in the experimental group will attain a significantly lower mean posttest score on the Communication of Acceptance subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) than will the adolescent parents in the control group.

Table 13 presents the pretest and posttest scores for the Measurement of Empathy in Adult-Child Interaction subscale: Communication of Acceptance

MEACI Subscale A: Communication of Acceptance

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
20	21	32	19.5
14	10	28	19
16.5	15.5	54	16.5
12.5	13.5	19	11
30	28	15	14.5
19	20	20	16
22.5	20	20	18
24	22	15	14
21	21	52	18
13	13	18	13
25	25	27.5	14.5
28	28	10.5	11
17.5	17.5	14	12
15	14	19.5	19
20	21	29	20
21	22	22.5	21
19	20	14	12
27.5	25	16	15
16	15	13.5	11.5
14	15	19	18
17	14.5	23	21
		18.5	16
		16	14.5
		18	15
		17.5	15

Table 13

Control group n = 21 Experimental group n = 25

Mean Pretest = 19.6, SD = 5.1 Mean Pretest = 22.1, SD = 10.9

Mean Posttest = 19.1, SD = 5.0 Mean Posttest = 15.8, SD = 3.11

Mean Change = 0.4, SD = 1.8 Mean Change = 6.4, SD = 9.6

Adjusted Mean = 19.44 Adjusted Mean = 15.51

Table 14 presents the analysis of covariance data, showing the significance of the difference between the posttest mean scores of the experimental and control groups.

Analysis of covariance data for the mean scores for the Measurement of Empathy in Adult Child Interaction subscale: Communication of Acceptance.

Source of Variation	Sum of Squares	df	Mean Square	F-ratio	P
Between	173.14	1	173.14	14.58	<0.001
Within	510.63	43	11.88		
Total	683.77				

Table 14

The P value of <.001 indicates that the difference in posttest scores is highly significant, even when controlling for the covariate (pretest scores). Therefore, the null hypothesis is rejected. There is strong evidence to support the research hypothesis that the decrease in posttest scores on the MEACI Communication of Acceptance subscale for the experimental group indicates a significant increase in parents' verbal expression of acceptance of their children's behavior and feelings during observed play session.

Hypothesis 8: Adolescent parents in the experimental group will attain a significantly lower mean posttest score on the Allowing the Child Self Direction subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) than will the adolescent parents in the control group.

Table 15 presents the pretest and posttest scores for the MEACI subscale: Allowing the Child Self-Direction.

MEACI Subscale B: Allowing the Child Self-Direction

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
19.5	19	23	21
8	12	29	17
16	14	27	27
19	9	12	10
28	28	18	15
17	16	21	14
20	18	22	17
23	22	18	17
21	18	28	25
15	13	18	14
28	27	27	17
25	23	20	14
11	10	16	13
15	15	21	16
22	22	21	20
24	22	24	24
22	21	18	14
26	23	17	15
14	12	20	15
16	15	18	17
17	14	24	20
		18	16
		20	14
		22	18
		19	15

Table 15

Control group n = 21 Experimental group n = 25

Mean Pretest = 19.4, SD = 5.4 Mean Pretest = 20.8, SD = 4.0

Mean Posttest = 17.8, SD = 5.4 Mean Posttest = 17.0, SD = 4.24

Mean Change = 1.6, SD = 2.4 Mean Change = 3.8, SD = 2.9

Adjusted Means = 18.43 Adjusted Mean = 16.44

Table 16 presents the analysis of covariance data, showing the significance of the difference between posttest scores for the experimental and control groups.

Analysis of covariance for the mean scores on the MEACI subscale: Allowing the Child Self-Direction.

Source of Variance	Sum of Squares	df	Mean Square	F-ratio	P
Between	44.30	1	44.30	6.57	0.014
Within	289.84	43	6.74		
Total	334.14				

Table 16

The P value of 0.014 indicates that the difference in posttest scores is significant, even when controlling for the covariate (pretest scores). Therefore, the null hypothesis is rejected. There is strong evidence to support the research hypothesis that the mean decrease in posttest scores on the MEACI Allowing the Child Self Direction subscale indicates a significant increase in the experimental group parents' willingness to allow the child self-direction during observed play sessions.

Hypothesis 9: Adolescent parents in the experimental group will attain a significantly lower mean posttest score on the Involvement subscale of the Measurement of Empathy in Adult-Child Interaction (MEACI) than will the adolescent parents in the control group.

Table 17 presents the pretest and posttest data for the MEACI subscale: Involvement.

MEACI Subscale C: Involvement

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
18	18	16	19
14	8	27	14
20	16	25	21
9	10	10	10
25	22	15	14
18	15	21	8
30	30	18	13
18	20	14	14
18	18	27	15
10	10	18	12
28	28	27	10
17	16	9	15
12	11	16	15
12	14	24	20
19	20	20	16
24	24	30	24
14	15	16	12
25	21	19	12
12	12	15	13
15	18	17	15
15	13	20	16
		17	14
		21	16
		19	14
		18	15

Table 17

Control group	n = 21	Experimental group	n = 25
Mean Pretest = 17.8, SD = 5.9		Mean Pretest = 19.2, SD = 5.2	
Mean Posttest = 17.1, SD = 5.8		Mean Posttest = 14.7, SD = 3.5	
Mean Change = 0.7, SD = 2.3		Mean Change = 4.5, SD = 5.1	
Adjusted Mean = 17.55		Adjusted Mean = 14.30	

Table 18 presents the analysis of covariance data showing the significance of difference between posttest scores for the experimental and control groups.

Analysis of Covariance for the Mean Scores on the MEACI subscale: Involvement

Source of Variation	Sum of Squares	df	Mean Square	F-ratio	P
Between	118.25	1	118.25	10.19	0.003
Within	498.95	43	11.60		
Total	617.20				

Table 18

The P value of 0.003 indicates that the difference in posttest scores is highly significant, even when controlling for the covariate (pretest scores). Therefore, the null hypothesis is rejected. There is strong evidence to support the research hypothesis that the mean posttest decrease in the MEACI Involvement subscale indicates a significant increase in the experimental group parents' participation in their child's play during the observed play sessions.

Hypothesis 10: Adolescent parents in the experimental group will attain a significantly lower mean posttest total score on the Parenting Stress Index than will the adolescent parents in the control group.

Table 19 presents the Pretest and Posttest total scores on the Parenting Stress Index.

Parenting Stress Index (total score)

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
291	282	228	225
219	199	186	202
299	299	217	198
230	230	199	201
261	241	245	260
177	191	234	236
237	297	202	203
239	231	188	165
158	155	311	233
240	227	233	220
199	198	217	186
294	272	229	292
195	186	185	178
286	278	319	274
230	235	229	231
260	271	256	227
262	253	273	265
190	184	190	188
191	188	272	257
323	324	283	259
204	196	201	207
		326	262
		231	265
		285	243
		284	268

Table 19

Control group n = 21 Experimental group n = 25

Mean Pretest = 237.3, SD = 45.0 Mean Pretest = 240.9, SD = 42.9

Mean Posttest = 235.1, SD = 46.3 Mean Posttest = 229.8, SD = 34.2

Mean Change = 2.3, SD = 17 Mean Change = 11.1, SD = 29.3

Adjusted Mean = 236.56 Adjusted Mean = 228.57

Table 20 presents the analysis of covariance data showing the significance of the difference between posttest mean scores of the experimental and control groups.

Analysis of Covariance for the Mean Total Scores on the Parenting Stress Index

Source of Variation	Sum of Squares	df	Mean Square	F-ratio	P
Between	728.13	1	728.13	1.45	0.235
Within	21579.80	43	501.86		
Total	22307.93				

Table 20

The P value of 0.235 indicates that the difference in posttest scores is not significant. Therefore, there is insufficient evidence to reject the null hypothesis. There is insufficient evidence to conclude that the mean decrease in posttest scores on the Parental Stress Index for the experimental group is significantly larger than that of the control group. It cannot be concluded that there was a difference in the parents perceived level of stress from parenting.

Hypothesis 11: Adolescent parents in the experimental group will attain a significantly lower mean posttest score on the Parent Domain of the Parenting Stress Index than will the adolescent parents in the control group.

Table 21 presents the pretest and posttest scores on the Parenting Stress Index subscale, Parent Domain.

Parenting Stress Index (Parent Domain)

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
153	147	125	120
112	98	83	106
175	168	117	96
128	124	101	106
125	120	135	144
98	100	134	128
126	182	106	108
125	120	90	94
79	77	177	134
138	132	114	120
108	105	132	104
158	140	118	178
97	95	87	82
151	148	184	148
127	130	128	123
135	140	142	121
131	132	159	152
105	98	93	93
87	88	145	145
181	178	162	141
103	97	109	112
		183	139
		102	147
		171	129
		159	162

Table 21

Control group n = 21 Experimental group n = 25

Mean Pretest = 125.8, SD = 27.3 Mean Pretest = 130.2, SD = 31.0

Mean Posttest = 124.7, SD = 29.5 Mean Posttest = 125.3, SD = 23.8

Mean Change = 1.1, SD = 14.1 Mean Change = 5.0, SD = 24.9

Adjusted Means = 126.31 Adjusted Mean = 123.94

Table 22 presents the analysis of covariance data showing the significance of difference between the posttest mean scores for the experimental and control groups.

Analysis of Covariance for the Mean Scores on the PSI subscale: Parent Domain

Source of Variation	Sum of Squares	df	Mean Square	F-ratio	P
Between	63.25	1	63.25	0.19	0.665
Within	510.63	43	11.88		
Total	683.77				

Table 22

The P value of 0.665 indicates that the difference in posttest scores is not significant. Therefore, there is insufficient evidence to reject the null hypothesis. On the basis of this data, there is insufficient evidence to conclude that the mean posttest score on the PSI Parent Domain for the experimental group is significantly lower than that of the control group. It cannot be concluded that there was a perceived decrease in the level of stress related to their attitudes and perceptions of themselves as parents.

Hypothesis 12: Adolescent parents in the experimental group will attain a significantly lower mean posttest score on the Child Domain of the Parenting Stress Index than will the adolescent parents in the control group.

Table 23 presents the pretest and posttest scores on the Child Domain of the Parenting Stress Index.

Parenting Stress Index (Child Domain)

Control Group Pretest	Control Group Posttest	Exper. Group Pretest	Exper. Group Posttest
138	135	103	105
107	101	103	96
124	131	100	102
102	106	98	95
136	121	110	116
79	91	100	108
111	115	96	95
114	111	98	71
79	78	134	99
102	95	119	100
91	93	85	82
136	132	111	114
98	91	98	96
135	130	135	126
103	105	101	108
125	131	114	106
131	121	114	113
85	86	97	95
104	100	127	112
142	146	121	118
101	99	92	95
		143	123
		129	118
		114	114
		125	106

Table 23

Control group n = 21 Experimental group n = 25

Mean Pretest = 111.6, SD = 20.0 Mean Pretest = 110.7, SD = 15.2

Mean Posttest = 110.4, SD = 18.9 Mean Posttest = 104.5, SD = 12.6

Mean Change = 1.2, SD = 6.3 Mean Change = 6.2, SD = 11.0

Adjusted Mean = 110.01 Adjusted Mean = 104.83

Table 24 presents the analysis of covariance data showing the significance of the difference between the posttest mean scores for the experimental and control groups for the Parenting Stress Index subscale Child Domain.

Analysis of Covariance for the Mean Scores on the PSI: Child Domain

Source of Variation	Sum of Squares	df	Mean Square	F-ratio	P
Between	305.40	1	305.40	4.44	0.041
Within	2960.27	43	68.84		
Total	3265.67				

Table 24

The P value of 0.041 indicates that the difference in posttest scores is significant, even when controlling for the covariate (pretest scores). On the basis of this data, the null hypothesis is rejected. There is evidence to support the research hypothesis that the lower mean posttest scores on the PSI child domain for the experimental group are significantly larger than those of the control group. This indicates a significant decrease in the perceived level of stress related to their children's behavior by the parents in the experimental group.

Hypothesis 13: Adolescent parents in the experimental group will attain their educational goals including passing grades in coursework, passing to the next grade, and completion of high school or GED at a higher rate than adolescent parents in the control group.

In the experimental group of 25 adolescent mothers, the following results were tracked at the end of the semester:

13 students were promoted with passing grades

2 students received failing grades, remained in school, but were repeating their grade level

7 students graduated from high school

1 student passed her GED

2 students dropped out of school

Out of the 25 students in the experimental group six students entered post-secondary school. Two students reported second pregnancies during the course of the program.

In the control group of 21 adolescent mothers, the following results were tracked at the end of the semester:

10 students were promoted with passing grades

0 students receiving failing grades or were retained in a grade level

6 students graduated from high school

1 student passed her GED

4 students dropped out of school

Out of the 21 students in the control group, three students entered post-secondary school and one student reported a second pregnancy.

There is insufficient evidence to support the hypothesis that adolescent mothers in the experimental group will obtain their educational goals at a higher rate than the adolescent mothers in the control group due to the sample size. The drop-out rate was 8% in the experimental group and 19% in the control group. There were two adolescent

mothers in the experimental group who did not achieve passing grades and were retained but they remained in school.

Although there was insufficient evidence to support the hypothesis that adolescent mothers in the experimental group will obtain their educational goals at a higher rate than the adolescent mothers in the control group, the findings do suggest that providing programs that support adolescent mothers in the school setting do increase the chances that they will remain in school. According to Mary's Shelter (2008) the drop-out rate for adolescent parents is typically 80%. For this project, the drop-out rate was 8% in the experimental group and 19% in the control group which is a highly significant difference.

Chapter Five: Discussion

This study used a quasi-experimental, non-randomized control group, pretest posttest design to measure the effectiveness of filial therapy with adolescent parents. The research question was to determine the effectiveness of filial therapy on adolescent parents' parental empathy, acceptance, and stress. It was also to determine the effect of the treatment on the attainment of educational goals by the experimental group parents.

The method used to test the research question was Landreth's (2006) *Child-Parent Relationship Therapy Treatment Manual: A Ten Session Filial Therapy Model for Training Parents.* Pretest and posttest measures included the Porter Parental Acceptance Scale (Porter, 1954), the Measurement of Empathy in Adult-Child Interaction (Stover, et.al. 1971), and the Parenting Stress Index (Abidin, 1983). These instruments were selected because they measure the attitudes that are related to the objectives of filial therapy training.

The subjects for the experimental and control groups were adolescent parents from three different school districts. The subjects participated by meeting the following criteria: being 19 years of age or younger; being a parenting adolescent with custody of their child; being able to participate in ten weeks of parenting classes; and agreeing to participate in weekly 30 minute play session with their child.

The parenting class met weekly for ten weeks. The classes were facilitated by three Licensed Marriage and Family Therapists who had completed specialized training in filial and child-centered play therapy.

Summary of Results

One of the primary objectives of filial therapy is to improve the parent-child relationship by teaching the parents new skills that will help them to become therapeutic change agents in the life of their children. The results of this study point to the effectiveness of filial therapy with adolescent parents. The parents were able to learn and demonstrate new ways to interact and play with their children. Significant results were found for seven of the thirteen hypotheses. A summary of these results is discussed below.

***Parental Acceptance*.** The parents in the experimental group showed a significant increase (P = 0.004) in the total score of the Porter Parental Acceptance Scale. The parents in the experimental group also reported highly significant increases (P = 0.004) on the subscale for feelings of unconditional love for their child. The parents in the experimental group showed gains of 9.1 points higher than those of the control group.

Although gains were not statistically significant on the Porter Parental Acceptance Scale subscales for respecting the child's rights and need to express feelings, valuing the unique makeup of the child, and recognizing the child's need to separate from parents; when asked to comment on the training during the final session, parents in the experimental group reported positive gains in understanding and accepting their children's feelings and uniqueness.

Although the adolescent parents did not score significantly higher on all subscales of the Porter Parental Acceptance Scale, the results support earlier studies in filial therapy (Bratton, 1993; Lobaugh, 1991; Poon, 1998; Sweeney, 1996) that show increases in parental acceptance following training in filial therapy. These findings

suggest that the ten week filial therapy training program (Landreth, 2006) is an effective treatment for increasing parental acceptance in adolescence parents.

Parental Empathy. The parents in the experimental group showed a highly significant decrease in the total score of the Measurement of Empathy in Parent Child Interaction. A decrease in the score indicates an increase in the desired behavior. The experimental group's mean score decreased by 15 points while the control group's mean score decreased by only three points. The experimental group displayed the largest difference in the Communication of Acceptance subscale with a pretest to posttest mean score difference of 6.26 points. The control group showed a difference of .50 points.

The creators of the MEACI, Stover, Guerney, & O'Connell (1971) stated that verbal expressions of acceptance were one of the major elements in the communication of empathy. They stated that this behavior did not typically occur in spontaneous interaction between children and parents. In the pre-training observations of the adolescent parents, no parent in the experimental or control group made reflection of feeling responses, which are the primary behavioral indicators of communication of acceptance on the MEACI.

The Measurement of Empathy in Adult-Child Interaction is an instrument that uses direct observation rather than self-reports. The adolescent parents were observed applying the skills that they had learned during the ten-week training. These results suggest that the ten week filial therapy training program is an effective treatment for increasing empathy in parent-child interactions in adolescent parents.

Parental Stress. A review of the literature showed that adolescent parenting is associated with high levels of stress. In a study by Passino, Whitman, Borkowski,

Schellenbach, Maxwell, Keogh, and Rellinger (1993) that examined differences in adjustment between pregnant and parenting adolescents and pregnant adults, the adolescent parents reported higher levels of stress. The adolescent parents in the study saw themselves as more depressed, less competent, and less attached to their children. They also viewed their children as more demanding, less adaptable, and less reinforcing to them as a parent. A similar study by Schellenbach (1991) also found that adolescent mothers experienced more stress than adult mothers on the Child Domain and Parenting Domain of the Parenting Stress Index.

The results of the study by this researcher did not support the hypothesis that filial therapy has an effect on parental stress as measured by the Parenting Stress Index total score. However, there was a significant decrease on the Child Domain score for the experimental group. The Child Domain measures the following areas: distractibility/hyperactivity, adaptability, reinforces parent, demandingness, mood, and acceptability. Normal scores are in the range of the 15th percentile to 80th percentile. The mean scores for participants in this study were above the 85th percentile for distractibility/hyperactivity. According to Abidin (1983), high scores on this subscale may be associated with unreasonable parental expectations. The mean scores for parents in the experimental group decreased on this subscale from the 85th percentile to the 75th percentile while scores for the control group remained the same. There was also a noticeable decrease on the acceptability subscale from the 50th percentile to the 40th percentile. High scores on this subscale may be the result of a poor parent-child relationship (Abidin, 1983). A contributing factor to the decrease in scores on the Child Domain of the PSI may have been the result of the parents' learning skills in giving

choices and limit-setting. These findings support the evidence that filial therapy helps to build the relationship between parents and their children.

There was no significant decrease in scores on the Parent Domain of the Parenting Stress Index. The Parent Domain measures the following areas: competence, isolation, attachment, health, role restriction, depression, and spouse. According to Abidin (1983), young parents tend to earn higher scores on the Parent Domain and may feel overwhelmed and inadequate as parents. The adolescent parents in this study earned significantly high scores in the areas of competence, isolation, attachment, and health. This supports the research that parents who are lacking in knowledge of child development and child management tend to score high in these areas (Abidin, 1983). The mean score for the competency subscale for parents in the experimental group showed a decrease from the 60^{th} percentile to the 50^{th} percentile which could indicate that they gained some helpful parenting skills during the course of treatment. The control group showed no change in this area.

Although the average decrease in stress for the experimental group was not significantly higher than the average decrease in stress for the control group, it does not mean that the experimental program was ineffective. A one-sample t-test on the results for the experimental group by itself did show significant results, with parents in the experimental group having a significant change of $P = .035$. There was a large standard deviation in the results for all groups. This indicates a great deal of variability in the scores and in the decreases themselves. Some of the adolescent mothers had decreases in stress, but there were also several very large increases in stress from pretest to posttest. Many of the adolescent mothers in both experimental and control groups discussed

stressful life events including; difficult relationships with the father of their child, difficult relationship with their own parents, financial strain, feelings of isolation, and lack of time for social activities. Others discussed challenges and stressful issues with school. Still others reported instances of having to miss school due to illness of their child. The school districts involved would not allow these absences to be excused absences, and therefore, were counted against the student's attendance which affected their grades.

It would be beneficial to try to identify some of the factors that led to those increases in stress. A qualitative study could investigate with follow-up interviews to determine possible causes for the dramatic increases in stress. Stress reduction exercises could be included to deal with issues that are causing additional stress for the adolescent parents.

Meeting Educational Goals. Adolescent parenting is associated with high rates of dropping out of school. According to Barnet et al. (2004), the main predictor of a baby's life outcome is the mother's level of education. The chances of being raised in poverty increase dramatically if the mother does not finish high school

There was insufficient evidence to support the hypothesis that filial therapy helps adolescent parents to meet their educational goals due to the sample size. However, the results from both the experimental group and control group seem to suggest that providing support through the school system encourages pregnant and parenting adolescents to stay in school and complete their education. According to Mary's Shelter (2008), the average drop-out rate for pregnant and parenting adolescence is 80%. The drop-out rate for the experimental group was 8%, and the control group was 18% which

shows that there can be a significant improvement in retaining adolescent mothers when they are provided with some type of supportive program offered through their school district.

Limitations/Delimitations

This study has certain limitations that need to be addressed when considering the contributions of the study. The pregnant and parenting adolescents who were used in this study were not recruited randomly, but were recruited from a group already receiving services through the school districts and community agencies. These adolescents may already be receiving more support than the typical parenting adolescent.

Another limitation could be in the use of different instructors to teach the parenting classes. A total of three instructors, all with similar education and training in play therapy were used to lead the filial therapy training classes. The use of the different instructors may have had an effect on the internal validity of the study.

The instruments used for the study could be a limitation because they may not accurately measure the variable if parents were guarded in answering the questions on the surveys or felt pressured to answer in a way that would please the instructor.

Recommendations

Based on the results of this study, the following recommendations are suggested:

1. Filial therapy may be seen as a viable intervention and prevention for adolescent parenting programs.
2. Follow-up research with the subjects from this study could investigate the long-term effects of the treatment to determine if the adolescent parents are still utilizing the skills at six months and one year.

3. Further research might examine the impact of the filial therapy training on the children of the adolescent parents.
4. Further research might be conducted involving adolescent fathers.
5. Further research is needed to determine ways to decrease parental stress in adolescent parents.
6. Further research could be conducted comparing three groups: a filial therapy group, a traditional parenting group, and a group of adolescent parents who are receiving no support services from the school, to determine if providing support services encourages adolescent parents to complete their educational goals.

Concluding remarks

This study adds to the body of literature on the effects of filial therapy on the parent-child relationship. A search of the current literature revealed no studies that specifically examined the effects of filial therapy on the relationship between adolescent parents and their children.

The significant results of this study support the Landreth (2006) ten-week filial therapy training model as an effective prevention and intervention for adolescent parents. The research suggests that this method is an effective way of providing training and support for adolescent parents in the school or community center setting. The filial therapy facilitators in the study reported that the adolescent parents were able to learn the basic filial therapy skills during the ten-week training period and were able to demonstrate the skills at an effective level.

The adolescent parents in the experimental group reported that they found value in the training. They reported that one of the most beneficial skills learned from the ten

week training program was therapeutic limit-setting. The adolescent parents stated that learning to give choices and set limits helped them to feel more "in control" as a parent and gave options for discipline other than spanking or yelling at their child.

Schools and communities have a responsibility to provide services to adolescent parents in an effort to keep them in school and provide better opportunities for their children. According to Sweeney (1996), the future mental health of children may be impacted by the parent-child relationship. Because there is a shortage of mental health professionals to provide these services, filial therapy is one method that can help adolescent parents and their children to receive help and move toward healthier relationships. Filial therapy provided in the school setting is a cost efficient way to provide mental health services to adolescent mothers and their children who could not otherwise afford these services.

Additional research is needed to determine the long term effects of filial therapy training for both adolescent parents and their children. Longitudinal studies should be conducted to investigate whether parents continue to use the play therapy skills and whether the positive relationships continue over time.

The transition to parenthood can provide a major disruption in the life of an adolescent. Many adolescent parents feel ill-equipped to meet the demands of parenting and can benefit from parent training that focuses on child development and parenting techniques. Filial therapy provides the opportunity for adolescent parents to be equipped with healthy parenting skills that promote a strong relationship with their child. Filial therapy focuses on strengths rather than weaknesses, and accomplishments rather than failures. The small group format allows the parent the opportunity to have emotional

support from, and to interact with, other adolescent parents with similar concerns. As the adolescent parents participate in the small group, they realize that they are not alone in their parenting struggles and may receive support from the group.

The results of this study may have implications for others who may wish to use filial therapy for prevention or intervention with adolescent parents and their children. Filial therapy offers significant possibilities for promoting the well-being of adolescent parents and their children by empowering them to handle stress more effectively, equipping them with skills to enhance the parent-child relationship, and encouraging the parent in ways to build their children's self-esteem, problem-solving skills, and self-control.

Meyers (1998) found that the perceptions that mothers have of the support that they receive has a great impact on their ability to express empathy and warmth for their children. The social support and parenting skills gained from the filial therapy training may serve as a deterrent to harmful or inappropriate parenting practices and an encouragement to effective parenting techniques.

Finally, the educational level of the adolescent mother serves as a predictor or her life outcome as well as that of the child. Harris and Franklin (2003) reported four factors that serve as predictors of how well adolescent mothers will perform in the future: parenting, social relationships, employment, and education. Harris et al. (2003) stated that education is a well-researched predictor of long-term success. The best predictor of high school graduation for adolescent parents is maintaining grade level and regular school attendance. By providing support in the school setting, the adolescent mothers are given the opportunity to remain in school and learn effective parenting skills and

techniques. The filial therapy model shows potential for addressing the underserved mental health needs of adolescent mothers in the school setting.

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APPENDIX A

Middle Tyger Community Center
Adolescent Family Life Program
Research Consent Form

Principal investigator: Cathy Sparks, Ed.S

Introduction

As a parenting adolescent and participant in the MTCC Family Life Program, you are being asked to participate in a research study that will help improve programs for adolescent parents. This study is being conducted by Cathy Sparks, doctoral student at Liberty University.

Please read this form carefully. You may ask the person who gave you this form any questions you have to help you decide whether you want to participate. Please keep a copy of this form for your records.

Purpose of the study

The purpose of this study is to find out what kind of services help adolescent parents develop the assets they need to build strong relationships between parent and child.

Adolescent parents participating in the MTCC Family Life Program in either Spartanburg School District Five or in Spartanburg School District Two are eligible to participate in this study.

What You Will Be Asked To Do

If you agree to participate in this study, you will be asked to fill out some questionnaires after you are enrolled in the program, and again after ten weeks of participation in a parenting class.

The questions on the surveys are about several topics such as your feelings about your child, being a parent, yourself, and your support system.

It will probably take you about 30 – 60 minutes to fill out the questionnaires. You will be asked to mark your answers on the questionnaires. None of the service providers in the MTCC Family Life Program will be able to see your responses to these questionnaires. You will be assigned a number that will be used to track your answers without writing your name on any of the questionnaires.

Risks and Benefits of Participation

There are no known risks of participation in this study. However, some of the questions on the questionnaires migh**t** seem personal. We are going to make every effort to make sure that no one from outside the study sees your answers. The results of this study will be used to improve this program and other similar programs.

Costs

There is no cost to you to participate in this research study.

Confidentiality of Records

All of the answers you give on the questionnaires are confidential – that means that the researchers conducting the study will not share your answers with anyone outside of the study, not even the program staff at MTCC, unless the law requires us to do so. There are two reasons the law could require us to report your answers to an authority: (1) if you say you are a danger to yourself or to others, or (2) if you say that a child is being abused or neglected.

While we will make every effort to protect your confidentiality, it cannot be absolutely guaranteed. Your name will not appear on the questionnaires that you fill out, only a number that has been linked to your name. All of the information about you used in the study will be kept in a locked cabinet. No one from outside of the study will have access to the information. The results of the study may be presented at meetings or in reports but the names of the participants will not be included.

Contact Person

For more information concerning this research you may contact:

Cathy Sparks, Ed.S.
Principal Investigator
MTCC
84 Groce Rd.
Lyman, SC 29365
(864)439-7760

Voluntary Participation

Participation in this study is voluntary-that means it is completely your choice. You do not have to participate in the study in order to receive services here. If you do not choose to participate, you can skip any questions or you can stop at any time, for any reason. In the event that you do stop participating in this study, the information you have already provided will be kept confidential.

Participant Signature

I have read (or someone has read to me) this consent form and have been encouraged to ask questions. I have received answers to my questions. I agree to participate in this research study. I have received (or will receive) a copy of this form for my records.

_____ ____/____/____

Print Name Birth Date

_____

Signature of Participant Date

Parent Signature

(for participants who are under 18 years old)

I have read (or someone has read to me) this consent form and know who to contact if I have questions. I consent to my daughter's participation in this research study. I have received a copy of this form for my records.

_____

Print Parent/Guardian Name

_____ _____

Parent/Guardian Signature Date Witness Date

APPENDIX B

Child Parent Relationship Therapy (CRPT)

A 10-Session Filial Therapy Model

Garry Landreth and Sue Bratton

Routledge, Taylor & Francis Group

270 Madison Ave.

New York, NY

APPENDIX C

Parenting Stress Index (3rd Ed)

Dr. Richard Abidin

PAR Psychological Assessment Resources, Inc.

16240 N. Florida Ave.

Lutz, Fl

www.parinc.com

APPENDIX D

Porter Parental Acceptance Scale

Dr. Blaine Porter

Brigham Young University

APPENDIX E

Measurement of Empathy in Adult-Child Interactions Rating Form

(Stover, B. Guerney, & O'Connell, 1971)

APPENDIX F

Attainment of Educational Goals Tracking Scale

Semester Summary Outcome Record

Semester: _____

Name: _____

Educational Milestones Achieved

	Date	Notes
Promoted to next grade level	___/___/___	_____
Graduate from high school	___/___/___	_____
Passed GED	___/___/___	_____
Enrolled in post-secondary	___/___/___	_____
Graduated from post-secondary	___/___/___	_____

Repeated Pregnancies

Did the participant report a repeat pregnancy during the semester? Y / N