

**A Descriptive Phenomenological Study of Parents' Experiences
with Long-Term Filial Therapy**

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Dedication

In loving memory of my grandmother, Betty Jo Helton.

In honor of my talented, beautiful, amazing son, Hunter Ryan Mynatt. You have been with me every step of the way. All this means nothing without you!

The greatest of these is love. 1 Corinthians 13:13

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Abstract

Filial therapy is an effective intervention for children and their families (Lin & Bratton, 2015). At the conclusion of filial therapy training, parents are encouraged to continue holding filial sessions with their children at home. Using descriptive phenomenology, this study sought to describe parents' experiences with long-term filial therapy. This study focused on the experience of parents who continued holding sessions for at least one year after parent training sessions terminated. The author utilized Creswell's (2007) simplified version of Moustakas's (1994) Modification of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological Data to analyze six participant interviews. The in-depth interviews yielded seven themes: reasons for coming to filial therapy; descriptions of filial sessions; filial therapy and the process of change; ending filial therapy; child benefits; parent benefits; and parent and child benefits. The author developed a textural description of the phenomenon of long-term filial therapy. The structural description of long-term therapy had four major components: realization, routine, rearrangement, and rewards. Further, the author integrated the textural and structural descriptions to create the essence of long-term filial therapy. The author discussed these findings as they relate to implications for filial therapists and provided suggestions for future research.

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Chapter One: Introduction

Introduction

Childhood development experts in the United States realize that children experience a myriad of mental health concerns and life stressors. Each year in the United States, 13-20% of children under 18 years of age will be diagnosed with a mental health disorder (Angold, Erkanli, Silberg, Eaves, & Costello, 2002; Merikangas et al., 2010; National Research Council and Institute of Medicine, 2009), however only 20-25% of those children will receive needed mental health services (Kataoka, Zhang, & Wells, 2002).

Additionally, a large number of children experience life events that cause significant amounts of stress. In the United States, approximately 7% of children are bereaved due to the loss of a parent or sibling (Understanding Childhood Grief in the U.S.: Childhood Bereavement Estimation Model, 2018). Approximately 50% of children experience parental divorce (American Academy of Child & Adolescent Psychiatry, 2011) and 21% of children are raised in poverty (Aber, Morris, & Raver, 2012). Approximately 683,000 children were reported as being abused in 2015 (Child Welfare Information Gateway, 2017). This indicates that a significant number of children are experiencing some level of stress that will impact their mental health.

Parental involvement, or participation, in a child's life is one factor that leads to improved outcomes for children. Studies have shown positive relationships between parental involvement and academic outcomes (Henderson & Mapp, 2002; El Nokali, Bachman, & Votruba-Drazl, 2010). Other studies highlight positive health benefits for children whose parents are involved (Ice, Neal & Cottrell, 2014; Lee, Cintron, & Kocher, 2014). However, 33% of parents believe they are spending insufficient time with their children. Twice as many fathers

reporting feeling they are spending insufficient time with their children, as compared to mothers (Parker & Wang, 2013). This suggests that parental involvement is positive but may need to be increased in families.

Parent involvement specifically in their child's mental health treatment has demonstrated positive outcomes (Bratton, Ray, Rhine, & Jones, 2005; Cunningham & Henggeler, 1999; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015; Hogue, Liddle, Dauber, & Samuolis, 2004). Play is one way to increase engagement in their children's lives. Studies have shown that the use of play yields positive outcomes in children's cognitive and language development (Bennett, Weigel, & Martin, 2002; Kiernan & Huerta, 2008). Additionally, children of parents who reported understanding the value of play in the home learning environment yielded greater school readiness and positive behavioral outcomes (Lamb-Parker, Boak, Griffin, Ripple, & Peay, 1999). Play provides a positive outlet in which parents can interact with their children and be involved in their mental health treatment.

Filial therapy utilizes play to strengthen the parent-child relationship and increase parental involvement (Landreth, 2002). As this relationship is improved, the entire family unit improves because family members feel valued and are able to utilize coping skills to address challenges (Garza, Watts, & Kinsworthy, 2007). While filial therapy was first developed for use with children with emotional challenges (Guerney, 1964), it is being more widely recognized as an intervention that can benefit all children and families. Filial therapy is a type of play therapy that teaches the parent to let the child lead in play sessions (Landreth, 2002). VanFleet (2014) explained the evolution of the Filial Therapy proposed by Guerney, into two major types of filial therapy. Each of these models teaches child-centered techniques in a group setting but differs

slightly on the delivery of the parent training aspect. Additionally, some parents may have received training from a filial or play therapist. Filial therapy seems to have some benefits, but more research is needed to demonstrate how it is implemented.

Filial therapy research has utilized quantitative and qualitative research methodology to explore its effectiveness. Quantitative studies have shown the general effectiveness of filial therapy (Bratton, et al., 2005; Lin & Bratton, 2015; Elling, 2003; Guerney, 1976), the improvement of problematic behaviors as demonstrated by the child (Guerney, 1976; Dematatis, 1981; Lebovitz, 1983; Johnson-Clark, 1996), positive changes as reported by filial parents (Swyulak, 1977; Payton, 1980; Packer, 1990), and positive changes in the parent-child relationship (Bratton & Landreth, 1995; Ceballos & Bratton, 2010; Tew, Landreth, Joiner, & Solt, 2002). A number of qualitative research studies have described both typical and unusual applications, discerning elements of the filial therapy process that may lead to positive outcomes (Bavin-Hoffman, Jennings, & Landreth, 1996; Wickstrom, 2009; Edwards, Sullivan, Meany-Walen, & Kantor, 2010). These studies reveal that filial therapy is an intervention that improves the child-parent relationship.

A number of the studies focus on the application of filial therapy with diverse populations. Filial therapy has been indicated to be an effective intervention with a wide range of cultural groups including African-American (Sheely-Moore & Bratton, 2010), Chinese (Chau & Landreth, 1997), Hispanic (Garza, Kinsworthy, & Watts, 2009; Villarreal, 2008), and Israeli (Kidron & Landreth, 2010). The filial therapy model may lend itself to a variety of family structures including single parents (Bratton & Landreth, 1995), custodial grandparents (Bratton, Ray, & Moffit, 1998), and blended families (Johnson, 1995). This application to diverse

populations and family types only increases its attractiveness in use with children in need of therapy.

Children who experience stress can benefit from the additional support that filial therapy provides. While the research on filial therapy suggests it may be helpful, more research needs to be conducted to demonstrate its full use. For example, no research has focused on parents who continue holding filial therapy sessions with their children for an extended period of time. Additionally, many of these studies take place during or immediately after filial training has ended. For the purpose of this study, I will utilize participants trained in group or individual models of filial therapy. I will also seek to understand the experience of parents engaging in filial therapy.

Statement of the Problem

A positive parent-child relationship is a significant predictor of positive academic outcomes (Henderson & Mapp, 2002; El Nokali, et al., 2010) and health outcomes (Richter, 2004) for children. Research indicates overwhelmingly positive outcomes for children who have engaged in filial therapy with a parent or caregiver (Ray & Bratton, 2010). The use of filial therapy has also led to positive outcomes for parents (Grskovic & Goetze; 2008; Wickstrom, 2009). The number of stressors and issues that children face today (Aber, Morris, & Raver, 2012; American Academy of Child & Adolescent Psychiatry, 2011; Child Welfare Information Gateway, 2017) along with reports that parents feel they do not engage with their children enough (Parker & Wang, 2013) indicate a need to increase parental involvement.

Qualitative research exists that examines the parental perceptions of filial therapy and their training experience (Foley, Higdon, & White, 2006; Wickstrom & Falke, 2012). In

addition, several case studies exist that highlight the experiences of individuals engaging in filial therapy with their children (Edwards, Ladner, & White, 2007). In Landreth's Child-Parent-Relationship Training (CPRT, 2002), trainers encourage parents to continue using filial therapy in weekly sessions. To date, however, no research has explored families' experiences that have chosen to engage in long-term filial therapy.

Purpose of the Study

After an extensive search through the literature, it appears few, if any, studies have explored long-term filial therapy. The purpose of this study was to describe parents' experiences of long-term filial therapy. The study included parents who held filial therapy sessions with their child for at least one year after the parent training session have ended. This study used descriptive phenomenology to capture the participants' lived experiences. The central research question is "What are the experiences of parents who engage in long-term filial therapy?"

Significance of the Study

This study adds to the limited amount of qualitative research surrounding filial therapy by exploring the meaning parents make of their experiences with long-term filial therapy. More specifically, this study will be the first to look at the phenomenon of long-term filial therapy. This study is significant to counselors who utilize filial therapy in their practices because it will assist them in building supports for and understanding challenges of parents who engage in filial therapy. This study will also provide information to parents who are considering filial therapy for their children or for parents who desire to continue filial therapy after the supervisory process has ended. Exploring parents' experiences with filial therapy can assist researchers' understanding of the impact of long-term filial therapy on childhood and adult outcomes.

Theoretical Framework

For this study, I selected phenomenology as the research methodology; however, phenomenology is also a philosophy (Vagle, 2014). Phenomenology is the study of the structures of human experience from the first-person point of view (Smith, 2008; Sokolowski, 2000). Phenomenology seeks to create an in-depth description of how individuals consciously experience specific phenomenon (Arslan & Yildirim, 2015; Gallagher, 2012). Researchers are then able to “reach at the essence of participants’ lived experience of the phenomenon” (Arslan & Yildirim, 2015, p. 3). The essence is the common features experienced by all individuals who experience the same phenomenon (Lopez & Willis, 2004).

According to Wertz (2000), phenomenology is not meant to “impose order” on its subject matter by developing or testing theories (p. 175). Husserl (1962), the founder of phenomenology, encouraged researchers to set aside prior assumptions in order to look at their subject matter without bias. The aim of this study was to provide a description of parents’ experiences with long-term filial therapy.

Definition of Terms

Child-Parent-Relationship Training (CPRT) – a 10-session group training model developed by Landreth and Bratton (2006) in which play therapy professionals “train parents to be therapeutic agents with their own children through didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere” (p.11)

Descriptive phenomenology- also known as transcendental phenomenology, a model of phenomenology introduced by Husserl and detailed by Moustakas; “focused less on

interpretations of the researcher and more on a description of the experience of the participants” (Creswell, 2007, p.59)

Filial therapy models – any model that utilizes parents and/or caregivers to provide child-centered play therapy with their children; can include Filial Therapy, Child-Parent-Relationship Training (CPRT), or parents trained individually by a filial therapist

Filial Therapy – “involves the training of parents of young children (in groups of six or eight) to conduct play sessions with their own children in a very specific way. After training, parents continue to meet weekly with the therapist to discuss results, conclusions, and inferences about their children and themselves” (Guerney, 1964, p. 305); also known as the Guerney model; the letters “F” and “T” are capitalized at the request of the founders

Long-term filial therapy – the continuation of filial therapy sessions after the parent training sessions have been terminated; for the purposes of this study, I focused on parents who continued holding sessions for at least one year after parent training sessions have terminated

Parent – any adult in a caretaking role of a child or children between the ages of 0-18

Limitations and Delimitations

This study has limitations due to research procedures, sampling procedures, and researcher bias. Although not the goal of qualitative research (Creswell, 2007), I acknowledge that the results of this study are not generalizable due to the phenomenological research design and small sample size. The method in which participants were recruited is also a limitation to this study. Some participants in the study were referred by practicing filial therapists. More than likely, these filial therapists trained the participants. While participation was completely voluntary, the participants could feel obligated to participate in the study. Finally, this study

utilized interviews for data. Interviews are dependent on the participant to express themselves (Giorgi, 2009) and on the skill of the interviewer (Brinkmann & Kvale, 2015).

Qualitative research also includes the limitation of researcher bias. This study is particularly prone to researcher bias due to the fact that I have engaged in filial therapy with my child for a period of time. In order to reduce researcher bias, I employed several strategies including bracketing, reflective journaling, using multiple data analysts, and member checking.

The delimitations of this study include focusing on only the experiences of parents who conduct long-term filial therapy with their child. In this study, long-term filial therapy was defined as filial therapy sessions continuing for at least one year after parent training sessions have ended. This study may not accurately represent the experiences of parents who conducted filial therapy sessions with their child for under a year or parents who sought alternative forms of mental health treatment for their child.

Organization of the Study

This chapter provided a comprehensive overview of children's mental health issues, filial therapy, and the research proposal. Chapter Two reviews the literature on filial therapy. Chapter Three describes the methodology used in this study, including a description of the research questions, participants, and method of data collection. Chapter Four details the results of the study as related to qualitative analysis. Chapter Five summarizes the study, discusses the results, and provides recommendations and implications for counseling professionals and future researchers.

Chapter Two: Review of Literature

Introduction

The purpose of this chapter is to review relevant literature pertaining to filial therapy. It explores the role of play in child development and the impact of parental involvement on children's mental health. Included in this review is an overview of child-centered play therapy and the two major models of filial therapy; the Guerney model of Filial Therapy and Child Parent Relationship Therapy (CPRT).

Children and Play

A wide variety of definitions exist for play across a range of academic disciplines (Fromberg, 1992; Cass, 1971). Curtis (1994) described play as self-motivating, pleasurable, and imaginative. Docket and Perry (2010) defined play as “a special mode of thinking and doing...includ[ing] the exercise of choice, non-literal approaches, multiple possible outcomes and the acknowledgment of the competence of players” (p. 716). According to Fromberg (1992), play is:

Symbolic, in that it represents reality with an “as if” or “what if” attitude
 Meaningful, in that it connects or relates experiences
 Active, in that children are doing things
 Pleasurable, even when children are engaged seriously in an activity
 Voluntary and intrinsically motivated, whether the motives are curiosity, mastery, affiliation, or others
 Rule-governed, whether implicitly or explicitly expressed
 Episodic, characterized by emerging and shifting goals that children develop spontaneously. (p.43)

Finally, Landreth (2002) defined play as “spontaneous, enjoyable, voluntary, and non-goal directed” (p. 10).

Play is a universal experience for children across all cultures (Samuelsson & Carlsson, 2008; Almon, 2003). Cultures express various perspectives towards play which impact the patterns of the child's play and the involvement of children's parents in play (Gaskins, Haight, & Lancy, 2007). Current research has examined the cultural attitudes towards risk and its effect on children's play (Whitebread, Basilio, Kuvalja, & Verma, 2012). Heavily urbanized cultures report higher levels of parental supervision and indoor play. Children in more rural areas are less supervised by parents and report higher levels of outdoor play. This study also revealed that parents in industrialized countries reported insufficient time to play with their children.

Play in early childhood education has historically been supported. Research indicates that play impacts children's physical, social, emotional, cognitive, and language development (Bergen, 2002; Casby, 2003; Garvey, 1993; Piaget & Inhelder, 1969; Vygotsky, 1976). However, current educational attitudes are turning away from play-based learning in favor of academically-oriented curriculum, assessment, and accountability (Gray, 2011; Stipek, 2006; Whitebread et al., 2012). Additionally, the amount of time children engage in free play at school is declining due to more highly organized activities and decreased time for recess (Gray, 2011; Stegeline, Fite, & Wisneski, 2015). This reduction in play has been associated with children's mental health problems, including an increase in anxiety and depression, reduced sense of person control, and increased narcissism (Gray, 2011).

Play in children is an important part of development and seems to be similar across cultures. While play has historically been part of early childhood education, societal factors such as industrialization, changes in education requirement, and changes in the structure of children's days indicate a decrease in the amount of spontaneous play children engage in. Notably, reduced

play may negatively impact children's mental health. These findings indicate the importance of play despite recent reductions in the amount of play children experience.

Parent Involvement

Parental involvement is discussed regularly in educational environments and is beginning to be explored in mental health treatment. While parental involvement has been mentioned in various reauthorizations of the *Elementary and Secondary Education Act* (1965), the *No Child Left Behind Act* (2004) clearly defined parental involvement and tied federal funding to specific parental involvement actions and activities. Parental involvement in both settings demonstrates clear benefits for children.

Researchers have identified multiple dimensions related to parental involvement such as volunteering at school, helping with homework, communication with the teacher, and the quality of these interactions (Eccles & Harold, 1996; Epstein, 1995; Kohl, Lengua, & McMahon, 2000). The benefits of parental involvement have been associated with children's academic performance (Henderson & Mapp, 2002; El Nokali et al., 2010), social competency (Simons-Morton & Crump, 2003; McWayne, Hampton, Fantuzzo, Cohen, & Sekino, 2004; El Nokali, et al., 2010), and mental health outcomes (Wang & Sheikh-Khalil, 2014). Parental involvement has clear benefits for children.

A less clearly defined concept is parental involvement when it relates to children's mental health treatment. Parental involvement reflects the "parent's active, independent, and responsive contribution to treatment" (p. 3) and includes the following activities;

sharing opinions, asking questions, and providing one's point of view on a problem or solution, as well as participation in therapeutic activities such as games and role plays [and] parent follow-through with home action plans, such as changing one's own parenting behavior, serving as a 'co-provider' to continue intervention delivery at home,

and/or supporting the child's behavior change efforts. (Haine-Schlagel & Walsh, 2015, p.134)

Meta-analyses have demonstrated the positive relationship between parental involvement and children's mental health treatment outcomes across diagnoses (Dowell & Ogles, 2010; Karver, Handelsman, Fields, & Bickman, 2006). Other studies have also demonstrated this effect.

Recent studies of caregiver involvement within a therapeutic intervention for children and family mental health have demonstrated positive effects. Richards, Bowers, Lazicki, Krall, and Jacobs (2008) examined treatment outcomes of 47 elementary-aged seriously emotional disturbed children in relationship to caregiver involvement and family participation. The children were enrolled in a half-day, school-based therapeutic setting. Results supported higher levels of parent involvement and improved child functioning at discharge. Additionally, this study found that higher levels of parental involvement was linked to improvement in child thought processes and parents' ability to meet the emotional and social needs of their children. Another study examined parental involvement and readmission rates at residential treatment facilities. Lakin, Brambila, and Sigda (2004) defined parent involvement as parents' interactions with treatment professionals, regular participation in phone calls, visits, therapeutic absences with child, and weekly family therapy session attendance. The study included 89 children and adolescents who were diagnosed with mood, anxiety, neurodevelopmental, or psychotic disorders. A relationship was found between higher levels of parental involvement and lower readmission rates. Higher parental involvement was also related to better family functioning and less severe impairments in children's functioning at discharge. This study suggested that parental involvement should be looked at in a broader light, not just participation in family therapy sessions. Overall, research supports the involvement of parents in therapy.

Research in parental involvement in mental health treatment is limited. While parent involvement in educational settings has been explored and supported by research, including parents in mental health treatment is a relatively unexplored concept. Research in this area, however, indicates positive outcomes for parental involvement and supports including parents in therapy.

Overview of Play Therapy

The Association for Play Therapy (2015) defines play therapy as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help the clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.” Proponents of play therapy view play as the therapeutic medium for children to express themselves (Gil, 1991; Landreth, 2002). Play therapy is primarily used as an intervention for children ages 3 through 12 (Landreth, 2002), however, play therapy has been utilized with young children (Schaefer, Kelly-Zion, McCormick, & Ohnogi, 2008) and even adults (Schaefer, 2003).

Two major branches of play therapy exist, non-directive play therapy and directive play therapy (Willard, 2013). Non-directive play therapy permits the child to direct the play in the sessions. Directive play therapy is led by the therapist and focuses on the child mastering specific goals and skills. Several theoretical orientations have recognized that play is a beneficial strategy to utilize when working with children and have integrated play within their frameworks (Kaduson & Schaefer, 2000).

History of Play Therapy

Landreth (2002) described four major developments of play therapy: psychoanalytic play therapy, release play therapy, relationship play therapy, and non-directive play therapy. The different developments are defined “by a shift in theoretical basis for play therapy or a change in therapeutic technique” (Elling, 2003, p.8). The psychoanalytic development began with Freud (1959) and his involvement with the case of “Little Hans”. This development was continued with the work of Klein and Anna Freud (Landreth, 2002). In the second development, release play therapy, Levy (1932) focused more on stress with children rather than dream analysis. Relationship play therapy, the third development, again shifted from the psychoanalytic focus on the past to emphasize the present relationship (Rank, 1945). Finally, the fourth development of play therapy incorporates Rogers’ Person-Centered Therapy into a non-directive approach to play therapy (Ray, Bratton, & Brandt, 2000).

The first development in play therapy is rooted in psychoanalytic tradition (Bromfield, 2003). The first mention of play in therapy was the case of five-year-old “Little Hans” described by Sigmund Freud (1959). “Little Hans” had a phobia of horses. Though Freud had only one brief visit with Hans, he maintained regular correspondence with Hans’ father. When provided notes on Hans’ play, Freud suggested various ways for Hans’ father to respond and question his son. The first therapist to utilize play in therapeutic sessions was Hermine von Hug-Hellmuth who analyzed children’s spontaneous play during sessions (Plastow, 2011). Hug-Hellmuth questioned the effectiveness of verbal methods when working with children (Landreth, 2002). These beginnings of play therapy were expanded on further in this first development.

The psychoanalytic approach to play therapy continued with Freud's daughter, Anna Freud. During the 1920s and 1930s, Melanie Klein and Anna Freud began using play to understand and help children in therapy (Bromfield, 2003). Klein and Anna Freud stressed examining the child's history and strengthening the ego (Landreth, 2002). However, the two significantly differed on the role of play. Klein substituted play for adult's free association allowing the therapist to access the child's unconscious. Anna Freud used play to develop a therapeutic alliance between the child and therapist. As the alliance strengthened, the sessions moved to more verbal interaction. Rather than have the child engage in free association, Freud encouraged the child to engage in a feeling-level experience. This experience was characterized by the child verbalizing imaginative thoughts, daydreams, or fantasies (Bromfield, 2003). Psychoanalytic play therapy raised awareness to children's mental health issues and how their treatment needed to differ from adults (Landreth, 2002).

Release play therapy was the next major development in play therapy. While working with children with nightmares, David Levy (1932) developed a play therapy approach known as release therapy. Differing from psychoanalytic play therapy, release therapy did not seek to analyze the child's play (Landreth, 2002). Release therapy was intended to provide children a cathartic release from high stress situations. Hambridge (1955) revised Levy's work and renamed it Structural Play Therapy. The therapist utilizes play to develop a therapeutic relationship with the child. Then the therapist recreates the stressful event in the playroom with play materials so the child can release the tension from the event. Children then move to free play during which they recover from the event.

Relationship play therapy is the third major development of present day play therapy. Though Otto Rank (1945) was once a close colleague of Freud, he made a dramatic departure from psychoanalytic theory. Rank departed from focusing on the client's past and unconscious. Instead he developed a "here and now" orientation that emphasized the therapist-client relationship (Landreth, 2012). Rank's approach to therapy was adopted by Jessie Taft (1933) and Fredrick H. Allen (1942) in non-directive sessions with children. Moustakas (1959; 1997) began consistently using and analyzing non-directive play therapy sessions with children. He was one of the first to detail utilizing play therapy with parents (Blau, Bach, & Scott, 2013). Taft, Allen, & Moustakas' approach supports that children are able to take responsibility for their own growth process, allowing children more freedom to lead the play during sessions.

While these three approaches have significant differences regarding the goal of therapy, the purpose of therapy, and therapeutic techniques, all recognize that play is an effective and useful form of both expression and communication for children. Play has been adapted to various theoretical approaches. The fourth major development in play therapy will be discussed in a subsequent section.

Play Therapy Research

The effectiveness of play therapy as a treatment modality for children has been well-supported. LeBlanc and Ritchie (2001) conducted a meta-analysis using hierarchical linear modeling (HLM). The researchers included 42 play therapy studies that were completed between 1947 and 1996. Independent variables included modality of play therapy used, the participation of caregivers in the process, treatment duration, the gender and age (0-12) of participants, the presenting problem, the use of other therapies being used with play therapy, treatment format

(group or individual therapy), publication characteristics (data, source, publication status), and research characteristics (control versus comparison group and research design). Play therapy had a medium to large overall treatment effect ($d = 0.66$). Play therapy participants performed an average of 25 percentile units higher on outcome measures compared to non-play therapy participants. This study demonstrated that play therapy is as effective for children as psychotherapy is for adults.

Bratton et al. (2005) investigated the efficacy of play therapy with children. Expanding on LeBlanc and Ritchie's study, the researchers completed a meta-analysis with a random effect model. The analysis included 93 play therapy studies with 3,248 participants that were completed between 1953 and 2000. Characteristics of interest included treatment modality, treatment provider, treatment setting, treatment duration, treatment format (group or individual therapy), the presenting problem, outcome measures (type, number, source), demographics of child (gender, age, ethnicity), and study characteristics (publication status, study design, source of participants). Play therapy had a large overall treatment effect ($d = .80$).

Research on play therapy indicates significant positive effects. For example, LeBlanc and Ritchie (2001) determined that play therapy is as effective with children as psychotherapy is for adults (LeBlanc & Ritchie, 2001). In two large-scale meta-analyses (Bratton et al., 2005; LeBlanc & Ritchie, 2001), researchers found that play therapy has a large affect on treatment. Because of these findings, expanding play therapy beyond counseling to parent involvement in treatment seems to be a logical next step to continue achieving positive results with children

Overview of Child-Centered Play Therapy

Child-centered play therapy is based on Carl Rogers' person-centered therapy (Ray, Bratton, & Brandt, 2000). This approach utilizes child-centered concepts based on Rogers' work and combines this with the medium of play. This section will first provide an overview of person-centered therapy, followed by a review of child-centered play therapy. Finally, a review of the research around child-centered play therapy will be presented.

Review of Person-Centered Therapy

Rogers' approach to counseling focused on characteristics of the therapist as opposed to specific techniques and interventions. Rogers expanded the work and concepts of Otto Rank and other relationship therapists (deCarvalho, 1999). According to Rogers (1957), a therapeutic relationship between the client and therapist is the catalyst for healthy client growth and change. The core conditions or philosophical "way of being" featured in person-centered therapy are each evidenced as important factors in mental health interventions (Elliott, Bohart, Watson, & Greenberg, 2011; Farber & Doolin, 2011; Kolden, Klein, Wang, & Austin, 2011), as well as evidenced as an effective set of qualities forming therapeutic relationships (Cochran & Cochran, 2017). These core conditions include empathy, congruence, and unconditional positive regard (Rogers, 1986).

The three core conditions work together throughout the therapeutic process. Rogers (1980) defined empathy as "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view" (p. 85). Empathy involves the therapist attending to the client through active listening and reflecting the client's experiences. This allows the client to process more deeply, self-reflect, and come to a better

understanding of their experiences and themselves. Increased client understanding reduces the gap between the current self and the ideal self, thus aiding the client towards self-actualization (Cain, 2010). A positive relationship has consistently been shown between empathy and client outcomes (Watson, Goldman, & Warner, 2002). Thus, empathy continues to be an important therapist characteristic within many counseling theoretical frameworks.

The next counselor quality, congruence, or genuineness means “the therapist is what he or she seems to be” (Cain, 2010, p. 85). Genuineness is also referred to as authenticity, or transparency. This core condition builds trust between the client and the counselor. Congruence is the ability of the therapist to be aware of their own internal experience during the counseling sessions, and the willingness to communicate their internal experience with the client (Lietaer, 1993). According to Rogers (1959), congruence was the most important part of the therapeutic process because it facilitates client growth.

Finally, Unconditional Positive Regard (UPR) can be defined as “acceptance, nonpossessive warmth, lack of judgment, and affirming attitudes and responses” (Cain, 2010, p. 81). UPR is expressed in therapy sessions through “smiling, warm vocal tone, consistent eye contact, shared laughter, celebrating the client’s triumphs, looking pleased to see the client, [and] self-disclosure about something the therapist values in the client” (Cain, 2010, p. 84). UPR, along with empathy and congruence, demonstrate the three qualities that Rogers determined as being essential to bring about a therapeutic counseling relationship.

Review of Child-Centered Play Therapy

Child-centered play therapy unites the concepts of client-centered therapy and the medium of play. Children utilize play as a method for communication and self-expression rather

than spoken language (Guerney, 1964). Developmentally, children do not have the ability to engage in abstract thought or problem-solving until age 11 (Piaget, 1964). This inhibits their ability to verbally express their feelings, especially intense emotions. Play allows children to symbolically express their inner thoughts and feelings about their experiences, wants and needs, and self-perception (Cochran, Nordling, & Cochran, 2010; Landreth, 2002).

Play is also the medium that child-centered play therapists use to develop the relationship between the child and the therapist (Axline, 1947). Child-centered play therapists are not concerned with establishing specific treatment objectives for the child, focusing instead on the promoting a therapeutic relationship with the child (Axline, 1947; Landreth, 2002). Virginia Axline, a student of Rogers, developed eight major principles of child-centered play therapists:

(1) The therapist is genuinely interested in the child and develops a warm, caring relationship. (2) The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way. (3) The therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express self completely. (4) The therapist is always sensitive to the child's feelings and gently reflects those feelings in such a manner that the child develops self-understanding. (5) The therapist believes deeply in the child's capacity to act responsibly, unwaveringly respects the child's ability to solve personal problems and allows the child to do so. (6) The therapist trusts the child's inner direction, allows the child to lead in all areas of the relationship, and resists any urge to direct the child's play or conversation. (7) The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry things along. (8) The therapist establishes only those therapeutic limits that help the child accept personal and appropriate relationship responsibility. (pp. 84-85)

Axline's development of these principals is the fourth major development in play therapy (Landreth, 2002).

Child-centered play therapy is not a set of techniques that are used with children (Landreth, 2002), but a philosophical "way of being" with children that allows children to lead their journey toward self-actualization. According to Rogers (1961), self-actualization takes

place when a person's "ideal self" is congruent with their external behaviors. Additionally, child-centered play therapy sessions are unique from other therapy sessions. Therapists do not direct the child's play within the session but allow the child to self-express. Children are free to choose the toys, activities, and conversations throughout the session. This freedom allows the child to feel in control and practice decision-making (Axline, 1969; Cochran, Nordling, & Cochran, 2010; Landreth 2002).

A common misconception of child-centered play therapy is that all actions of the child are permitted. Limits do exist in child-centered play therapy, though they are few and focused as narrowly as possible, each to a specific behavior (Guerney, 2001). Axline (1969) supported the use of limits in order to "anchor the therapy to the world of reality" (p. 73). Limits also support the child's responsibility in the counseling sessions. For example, if a child was about to rip a doll's clothes, making them unusable in future sessions or by other children, the therapist could say, "The doll's clothes are not for ripping." Limits provide the child an opportunity to learn, demonstrate self-control (Landreth, 2002), develop a sense of security and prevent guilt (Axline, 1969).

The child-centered play therapist demonstrates two specific communication skills with the child, tracking responses and empathic responses (Cochran, Nordling, & Cochran, 2010). Tracking responses focus on the child's behavior in the playroom. While the child is playing, the therapist utilizes tracking responses to let the child know they are present and participating in the session. Tracking responses also let the child know their behaviors are acceptable in the playroom (Cochran, Nordling, & Cochran, 2010; Landreth, 2002). For example, if a child is carefully burying a variety of animal figurines in the sandbox, the therapist could say, "You are

covering all of them up. And you want to make sure you get every bit of them.” The actual figurines are not named unless the child has already named them.

Empathic responses “acknowledges the underlying feeling, preference, intention/motivation, belief, or relationship desire expressed in the actions of the child” (Cochran, Nordling, & Cochran, 2010, p.). Empathic responses make children feel understood, support emotional expression, and can increase the child’s awareness of therapeutic issues. If a child is pretending to feed a doll a bottle, smiles, and says “All Done!”, the therapist could say, “You are happy because the baby drank its bottle.” Tracking responses and empathic responses are used together by the therapist.

Children in child-centered play therapy progress through stages during the play therapy process (Nordling & Guerney, 1999). These stages occur in the following order, “warm up” stage, “aggressive” stage, “regressive” stage, and “mastery” stage. Children progress through these stages at different length of time. During the “warm up” stage, children “learn” the play therapy room and process. They begin to understand their role and the therapist’s role in the playroom. They begin to test limits and express themselves. The development of a trusting relationship with the therapist is crucial during this stage. The “aggressive” stage of play therapy is characterized by high energy play or assertive verbalization. Children may act aggressively towards objects in the play room, display aggressive action physically or verbally towards the therapist through role play or directly. Children demonstrate the need for control such as telling the therapist what to do and breaking limits in the playroom. During the “regressive” stage of play therapy, children work through issues such as nurturance, attachment, dependence/independence, identity and self-image, and relationships with others. Children may

also demonstrate age regression as evident by verbal communication or pretending to be a young child. The “mastery” stage of therapy focuses on the child strengthening therapeutic gains. Children may play alone or engage in role play activities with the therapist. This stage is characterized by the child attempting more challenging play room tasks independently and demonstrating higher levels of competence and control.

The arrangement of the playroom does matter in child-centered play therapy. Landreth (2002) compared the playroom to a “well-worn, warm sweater” (p. 125). The play therapy space can range from fully-outfitted play rooms in private agencies to modified settings such as a corner of a classroom with a traveling therapy kit. No matter the space, play therapists intentionally utilize specific toys and materials that encourage expressive and imaginative play. “Toys are children’s words and play is their language” (Landreth, 2002, p. 132).

The assortment of toys should allow energy release, artistic expression, and role-play (Cochran, Nordling, & Cochran, 2010). Toys that encourage energy release include a bop bag, wild animal figurines or puppets, and foam ball/basketball set. Sand and water trays, art supplies (art easel, paper, crayons, scissors, paper, pipe cleaners), Legos, and small musical instruments assist the child with artistic expression. Role-playing toys include a doctor’s kit, doll house with multiethnic dolls, generic figurines, transportation vehicles, cash register, play food with dishes and cookware, cleaning supplies (small broom, dustpan), play money, play telephone, sunglasses, hats, and scarves. Children often use toys for multi-purposes. Toys should be well-organized, developmentally-appropriate, and easily accessible to children (Landreth, 2002).

Child-Centered Play Therapy Research

Child-centered play therapy research has supported its effectiveness (Bratton, et al., 2005; Lin & Bratton, 2015; Ray, Armstrong, Balkin, and Jayne, 2015). As discussed in a previous section, Bratton et al. (2005) conducted meta-analysis of play therapy outcomes. Play therapy yielded a large overall treatment effect ($d = 0.8$). When comparing treatment modalities, humanistic therapies such as child-centered play therapy demonstrated a larger treatment effect than other types of play therapy ($d = .92$).

Lin & Bratton (2015) conducted a meta-analysis to examine the effectiveness of child-centered play therapy. The analysis included 53 studies with 1,848 child participants that were completed between 1995 and 2010. Individual study characteristics included publication dates, demographics of child participants, family demographics, treatment setting, study population, presenting problem, clinical level of participants, source of participants, research design, treatment model, treatment format, sample size, duration and frequency of treatment, therapist demographics, randomization, and treatment integrity. Child-centered play therapy had a moderate treatment effect ($d = .47$).

In another meta-analysis, Ray et al. (2015) examined the effectiveness of child-centered play therapy in the elementary school setting. The researchers completed a meta-analysis with a random effect model. The analysis included 23 play therapy studies with 1,106 child participants that were completed between 1975 and 2011. The studies were coded based on sample size, number of sessions, participant demographics, publication year, type of publication, treatment assignment, treatment integrity, play therapy provider (mental health provider or school counselor), treatment modality (individual or group), and statistical data for each construct.

Additionally, outcome constructs were organized into six categories, including internalizing, externalizing, total problems, self-efficacy, academic, and other (includes social skills, attitude toward school, and teacher-child relationship). Rather than provide a single effect size for the study, the researchers compared the outcome constructs across studies. Outcome constructs with a small effect size included internalizing outcomes ($d = .21$) and self-efficacy ($d = .29$). Outcome constructs with a small to medium effect size included externalizing outcomes ($d = .34$), total problem behaviors ($d = .34$), academic outcomes ($d = .36$), and other outcomes measures ($d = .38$). Overall, this research found that play therapy does have a small to moderate impact on a variety of outcome constructs.

Further research studies have demonstrated the effectiveness of child-centered play therapy on a variety of issues. Child-centered play therapy has improved children's general behavioral problems (Kot, Landreth, & Giordano, 1998; Raman & Kapur, 1999; Shashi, Kapur, & Subbakrishna, 1999), externalizing behavioral problems (Garza & Bratton, 2005; Kot, et al., 1998; Ritzi, Ray, & Schumann, 2017), and internalizing behavioral problems (Packman & Bratton, 2003). Child-centered play therapy has improved children's self-efficacy (Fall, 1994) and self-concept (Kot, et al., 1998). It has been utilized effectively with specific presenting problems such as enuresis and encopresis (Cuddy-Casey, 1997), anxiety (Baggerly, 2004; Shen, 2002; Stulmaker & Ray, 2015), somatization symptoms (Schottelkorb, Swan, Jahn, Haas, & Hacker, 2015), aggression (Cochran, Fauth, Cochran, Spurgeon, & Pierce, 2010; Wilson, 2016), highly disruptive behavior (Cochran, Cochran, Fuss, Nordling, 2010), and ADHD symptoms (Robinson, Simpson, & Hott, 2017; Schottelkorb & Ray, 2009).

Benefits of child-centered play therapy have also been demonstrated in the school setting. Child-centered play therapy has been shown to improve academic achievement (Blanco, Holliman, Muro, Toland, & Farnam, 2017; Blanco & Ray, 2011; Blanco, Ray, & Holliman, 2012). Other studies have demonstrated improvements in teacher-child relationship stress (Ray, 2007; Ray, Henson, Schottelkorb, Brown, & Muro, 2008).

The use of child-centered play has been advocated as a culturally-responsive treatment (Lin & Bratton, 2015), as well as applicable with clients of special populations. Decreased hyperactivity and irritability has been reported in children with intellectual disabilities (Swan & Ray, 2014; Swan & Schottelkorb, 2015). Children with autism have demonstrated gains in social competency, self-regulation, and empathy (Balch & Ray, 2015). Children with speech impairments have shown improvement in language skills (Danger & Landreth, 2005). Positive outcomes have also been achieved with various populations such as African-American children (Taylor, 2016); Hispanic Spanish-speaking children (McGee, 2010), homeless children (Baggerly, 2004; Baggerly & Jenkins, 2009), Chinese earthquake victims, (Shen, 2002), and children residing in domestic violence shelters (Kot, et al., 1998).

Child-centered play therapy appears to demonstrate positive impacts with children. Two large meta-analyses demonstrated the effectiveness of play therapy interventions (Lin & Bratton, 2015; Ray et al., 2015). Additionally, multiple studies have established the impact of play therapy on a range of issues from behavioral problems to anxiety to ADHD symptoms. Finally, child-centered play therapy has been shown effective with children from diverse backgrounds. These findings suggest that child-centered play therapy is a useful, effective treatment option for many children with many issues.

Overview of Filial Therapy

Filial therapy is an integrative form of family therapy that “harnesses the power of play therapy within the family context to empower children, parents, and the family as a whole” (VanFleet, 2014, p. 2). Filial therapy strengthens familial relationships and improves adjustment and family functioning. In the 1960s, Bernard Guerney introduced Filial Therapy to help parents work with their emotionally disturbed children (Stover & Guerney, 1967). As Guerney’s model has evolved, it has been known by several terms including Child Relationship Enhancement Family Therapy (CREFT), Filial Play Therapy, and Filial Family Therapy (Van Fleet, 2014). For the purposes of this study and in respect of the founder, the model of filial therapy developed by Guerney will be referred to as Filial Therapy.

Guerney was inspired by the work of several predecessors that informed the development of Filial Therapy. Dorothy Baruch (1949) was a psychologist who encouraged parents to conduct play sessions at home based on Axline’s (1947) play therapy. These play sessions allowed children the opportunity to self-express and enhanced the parent-child relationship. Natalie Rogers Fuchs, daughter of Carl Rogers, used Axline’s (1947) model for nondirective play therapy with her daughter to help with toilet training issues. While Moustakas did not develop a specific model, Moustakas (1959) provided the first description of play sessions between parents and child. He encouraged parents to use child-centered play therapy sessions with their well-adjusted children to strengthen the parent-child relationship.

Filial Therapy is characterized by several features that distinguish it from other play-oriented modalities (VanFleet, 2014). These features include

- (1) The importance of play in child development is highlighted, and play is seen as the primary avenue for gaining greater understanding of children.
- (2) Parents are

empowered as the change agents for their own children. (3) The client is the relationship, not the individual. (4) Empathy is essential for growth and change. (5) The entire family is involved whenever possible. (6) A psychoeducational training model is used with parents. (7) Tangible support and continued learning are provided through live supervision of parents' early play sessions with their children. (8) The process is truly collaborative. (pp. 9-15)

VanFleet (2011) pointed out that the presence of all these features is what defines Filial Therapy.

Filial therapists train parents in the principles of child-centered play therapy in a psychoeducational, small group setting (VanFleet, 2014). Small groups consist of 6-8 parents and initially include children. Originally, Filial Therapy lasted approximately 6 to 18 months, but Guerney (2000) shortened the approach to 5 to 6 months. Before Filial Therapy begins, typically a three-step assessment process occurs (VanFleet, 2014). First, the Filial therapist meets with the parents to obtain a thorough history of the child(ren), family, and presenting problem(s). Any assessments are administered during the initial meeting. The second step involves a family play observation. Finally, the Filial therapist meets with the parents to discuss the family play observation.

Child-centered play therapy skills are taught to parents through play session demonstrations, direct instruction, and mock play sessions for approximately two months (Guerney & Guerney, 1987; VanFleet, 2014). The Filial therapist stresses four major skills including structuring, empathic listening, limit-setting, and child-centered imaginary play (VanFleet, 2014). After parents have successfully demonstrated the four major skills in mock play sessions with the therapist, parents conduct at least five play sessions with their children under the live supervision of the Filial therapist. Initially, play sessions are 20 minutes long, and increase to 30 minute sessions. After each play session, the Filial therapist discusses the session in detail with the parents. Initially, sessions focus on parents' skill development, but then shift to

therapeutic issues. Therapists encourage parents to begin play sessions at home with their child when the parents demonstrate confidence in conducting live play sessions. The Filial therapist assists the parents in transferring the play sessions to home and continues to supervise parents' progress and results with their children (Guerney, 1964, Guerney, 1991). As families make progress towards therapy goals, the Filial therapist assists the parents plan for the termination (VanFleet, 2014). Reasons for termination include lack of fit between Filial Therapy and the family's issues, resolution of presenting problem, children's reduced interest in the play session, and when the parents have developed the understanding and skills to conduct play sessions independently.

Therapeutic goals exist for children and parents in Filial Therapy (VanFleet, 2014). The three basic goals aim to

- (a) eliminate the presenting problems at their source, (b) develop positive interactions, attachments, and relationships between parents and their children, and (c) increase families' communication, coping, and problem-solving skills so they are better able to handle future problem independently and successfully (p. 17).

Ultimately, these goals paired with the structure of the approach create an effective intervention for parents to implement with their children.

Early Filial Therapy Research

After Guerney (1964) described Filial Therapy, the psychological community had concerns regarding the appropriateness of parents utilizing psychological methods and skills. Therefore, initial studies on Filial Therapy examined whether parents were capable of conducting play therapy sessions with their children. Early research on Filial Therapy suggests that trained parents could effectively conduct play therapy with their children.

The first studies considering the effectiveness of Filial Therapy focused on parent abilities. Stover and Guerney (1967) conducted the first study on Filial Therapy. The researchers assessed twenty-eight mothers' ability to utilize child-centered play therapy skills after receiving Filial Therapy training. Mothers demonstrated improvement in non-directive, active listening skills after four play sessions. In another study, Andronico & Guerney (1969) continued to assess parents' ability to conduct nondirective play therapy sessions. The skill levels of therapists and parents trained in Filial Therapy were compared. Trained observers blindly observed play sessions and rated them on specific behavioral measures. There were no significant differences between therapist and parent skills levels. These two studies (Andronio & Guerney, 1969; Stover & Guerney, 1967) quieted the psychological community's concerns regarding the ability of parents to engage in Filial Therapy.

In the next wave of research, researchers focused on the children's behaviors. Stover and Guerney (1971) conducted a study with mothers whose children had been referred for serious emotional problems. Fifty-one mothers completed the 12-18 month long Filial Therapy small group format. Researchers found the children's problematic behaviors decreased by 66% as reported by behavior checklists, including a reduction in aggressive behaviors. All children demonstrated improved social adjustment, with 18 children demonstrating statistically significant gains. Mothers reported increased satisfaction with their children and increased levels of empathy. In another study, Oxman (1972) compared the outcomes of the 51 mothers who participated in the Stover and Guerney (1971) study to a non-treatment control group of 77 mothers with similar demographic data. Mothers in the Filial Therapy group reported higher levels of improvement in their child's behavior and higher levels of satisfaction with their

children than the mothers in the control group. Another follow up study was conducted with the mothers in the Stover and Guerney study (1971). Guerney (1975) surveyed 42 mothers of the original sample and found the majority of mothers continued to report improvement in their child's behaviors and reported high levels of satisfaction with their children. Mothers believed these improvements were related to their ability to understand their child. Eighty-six percent of the social adjustment gains were maintained one to three years after termination of Filial Therapy. This study demonstrated the positive long-term effects of Filial Therapy. These studies indicated that Filial Therapy was also improving the behaviors of the children involved.

A final round of research also supported the effectiveness of Filial Therapy through improved in child adjustment and parental relationships. Sywulak (1977) conducted a study of filial therapy with 32 parents utilizing a repeated measures design. Parents completed problem checklists four times during Filial Therapy; 4-months before treatment, at the beginning of treatment, after 2 months of treatment, and after 4 months of treatment. There were statistically significant improvements in child adjustment and specific presenting problems as Filial Therapy continued. Parents also reported improved parent-child relationships, parental acceptance, and communication skills. Three years later, Sensue (1981) completed a follow-up study of Sywulak's (1977) study. Sensue added a non-treatment comparison group. The improvements in child adjustment and parental acceptance three years after the study were still significant when compared to before training data. Sensue also found that Filial parents reported higher parental acceptance than the non-treatment group. Finally, the maladjusted children who received Filial Therapy in the initial study were as well-adjusted as the normal children in the control group.

This research indicates that Filial Therapy is also effective with issues of adjustment and family communication.

Studies have also shown that Filial Therapy is an effective intervention with culturally diverse children and families. This includes children with intellectual disabilities (Boll, 1972), children with learning disabilities (Gilmore, 1971), children who stutter (Andronico & Blake, 1971), foster parents (Ginsberg, 1976; Guerney & Gavigan, 1981), single parent families (Ginsberg, 1976), and families with various socioeconomic status (Ginsberg, 1976). This research indicates that Filial Therapy can be effective with a wide range of populations.

Research on Filial Therapy is dated. However, the research demonstrates multiple important findings. First, parents can effectively do play therapy with their children (Andronio & Guerney, 1969; Stover & Guerney, 1967). The next line of research indicates that children do show improvements in behaviors with Filial Therapy (Guerney, 1975; Stover & Guerney, 1971; Oxman, 1972). The third findings indicate that Filial Therapy is useful with more issues than just child behaviors. Sensue (1981) and Sywulak (1977) found improvements in areas such as child adjustment, parent-child relationships, and communication skills. Finally, Filial Therapy is useful with a variety of diverse populations (Boll, 1972; Gilmore, 1971; Ginsberg, 1976). This historic research indicates a clear need for further studies on Filial Therapy

Child Parent Relationship Therapy (CPRT)

Child Parent Relationship Therapy (CPRT) is an off-shoot of Guerney's Filial Therapy model (Landreth & Bratton, 2006). CPRT was developed by Gary Landreth to shorten the time and structure the approach initiated by Filial Therapy (Landreth & Bratton, 2006). This section will review the CPRT approach and then consider the research associated with this intervention.

Overview of Child Parent Relationship Therapy (CPRT)

Child Parent Relationship Therapy (CPRT) is a successful intervention for children with behavioral and mental health challenges (Bratton, Landreth, Kellam & Blackard, 2006; Landreth & Bratton, 2006). Gary Landreth was an advocate of child-centered approaches and began utilizing Filial Therapy in the 1970s. Landreth developed CPRT in response to his concerns that very few families would be able to commit to the time frame in Guerney's Filial Therapy model (Landreth & Bratton, 2006). He also believed that client change could occur in a shorter timeframe than Guerney proposed. In his private practice, Landreth experimented with the reducing the number of filial therapy sessions (Landreth & Bratton, 2006). This resulted in a highly structured, manualized, 10-session model (Bratton, et al., 2006). The CPRT approach shares similarities with Filial Therapy, but also makes significant changes.

Landreth & Bratton (2006) support that the philosophies of CPRT and Guerney's Filial Therapy are largely the same. According to CPRT, filial therapy is

a unique approach used by professional trained in play therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration lay session, required at-home laboratory play session, and supervision in a supportive atmosphere. Parents are taught basic child-centered play therapy principals and skills including reflective listening, recognizing and responding to children's feeling, therapeutic limit setting, building children's self-esteem, and structuring required weekly play session with their children using a special kit of selected toys. Parents learn how to create a nonjudgemental, understanding, and accepting environment that enhances the parent-child relationship, thus facilitating personal growth and change for child and parent. (p. 11)

Instead of focusing on the problems of the child or parents, CPRT focuses on the growth of the parent-child relationship. Thus, the underlying theoretical approach to Filial Therapy and CPRT are the same.

CPRT sessions are conducted in a weekly, 2-hour, small group format with five to eight parents. During the first three sessions, parents learn the tenants and skills of child-centered play therapy. Parents are trained in reflective listening and empathy. The needed toys and materials needed to create the at-home play session toy kit are demonstrated and discussed. After the third training session, parents start conducting and videotaping 30-minute play sessions with their child(ren) at home on a weekly basis. During the fourth through ninth sessions, parents are trained in tracking, limit-setting, and choice-giving skills. Additionally, videotapes are reviewed in the group setting each week. Parents learn vicariously through the videotapes and the processing of the play session experience. During the final session of CPRT, parents review the last videotape, discuss the improvements they have noticed in themselves and their child, and evaluate the training. Parents are also asked to commit to continuing play sessions with their child (Bratton, et al., 2006). CPRT is more structured and offered in a shorter time frame than Filial Therapy.

Child Parent Relationship Therapy Research

CPRT research has supported its effectiveness (Bratton, Landreth, & Lin, 2010). While not specifically focusing on CPRT, two meta-analyses demonstrate the effectiveness of parents in the therapeutic process. As discussed in a previous section, Bratton et al. (2005) compared 93 controlled outcomes studies exploring play therapy and filial therapy. Studies in which parents provided filial therapy yielded a large overall treatment effect ($d = 1.15$). Studies in which a mental health professional provided play therapy resulted in a medium to large treatment effect ($d = 0.72$). When these treatment effect sizes were further analyzed, the difference was statistically significant ($p < 0.1$). Another meta-analysis (Lin & Bratton, 2015) demonstrated

larger treatment effects ($d = .59$) when parents conducted filial therapy than professionals conducting play therapy ($d = .33$). Only one meta-analysis has specifically examined CPRT (Bratton, et al., 2010). Utilizing the data in the Bratton et al. (2005) meta-analysis, data was recoded to analyze CPRT studies. CPRT studies resulted in a large effect size ($d = 1.25$) and an even larger effect size for parent-only CPRT studies ($d = 1.30$).

CPRT has been demonstrated to be a culturally appropriate therapeutic intervention with a wide-range of parent populations, ethnic groups, and clinical populations (Lin & Bratton, 2015). CPRT is an effective intervention with specific parent populations, including single parents (Bratton & Landreth, 1995), incarcerated parents (Harris & Landreth, 1997; Landreth & Lobaugh, 1998), and grandparents (Bratton, Ray, & Moffit, 1998). Additionally, the efficacy of CPRT has been demonstrated with various ethnic groups, including Chinese families (Chau & Landreth, 1997; Yuen, Landreth, & Baggerly, 2002), Hispanic families (Ceballos & Bratton, 2010; Garza, Kinsworthy, & Watts, 2009; Sangganjanavanich, Cook, & Rangel-Gomez, 2010), Native American families (Glover & Landreth, 2000), Korean families (Jang, 2000; Lee & Landreth, 2003), and Israeli families (Kidron & Landreth, 2010). CPRT appears to be a useful approach with a wide variety of populations.

Researchers have identified positive outcomes with various clinical populations in children including sexually abused children (Costas & Landreth, 1999), children who have witnessed domestic violence (Smith & Landreth, 2003), chronically ill children (Glazer-Waldman, Zimmerman, Landreth & Norton, 1992; Tew, et al., 2002), adopted children (Carnes-Holt & Bratton, 2014), children with learning difficulties (Kale & Landreth, 1999), ADHD (Kale & Landreth, 1999), anxiety (Abbasi, Amiri, & Talebi, 2016; Kale & Landreth, 1999), and autism

(Beckloff, 1997; Sullivan, 2011). CPRT is not only effective with diverse populations, it is also useful with a variety of clinical populations.

Finally, positive effects of the application of CPRT have been evidenced with individuals other than parents. These include high school students conducting play sessions with elementary students with adjustment difficulties (Jones, Rhine, & Bratton, 2002), teachers-trainees (Brown, 2000), Head Start teachers with low-income preschool children with behavioral difficulties (Morrison Bennett & Bratton, 2011), and teachers of deaf or hard of hearing students (Smith & Landreth, 2004).

Research on CPRT demonstrates its effectiveness. A meta-analysis specifically considering the CPRT approach validates its usefulness (Bratton et al., 2005). As CPRT is a variation of Filial therapy, research looking at the Filial Therapy model also supports the impact of CPRT (Bratton et al., 2005; Bratton, Landreth, & Lin, 2010). Finally, research considering the use of CPRT with various diverse populations, many clinical populations, and with individuals other than parents has supported its positive effect.

Summary

Filial therapy is a treatment invention that has been an effective intervention with children and their parents under a wide-range of presenting problems, family structures, and populations (Bratton, et al., 2005). While studies have described long-term outcomes of filial therapy interventions (Guerney, 1975), no studies have examined the experience of parents providing long-term filial therapy with their children. The CPRT model of filial therapy encourages parents to continue their sessions with children after the parent training component

has ended (Bratton, et al., 2006). A further investigation of this phenomenon is needed. Chapter Three will describe the research methods used throughout this study.

Chapter Three: Methodology

Introduction

As more attention is being brought to the issue of children's mental health concerns, it becomes important to bring family members into their treatment (McKay & Bannon, 2004). Filial therapy is an intervention that has been documented as an effective treatment in the literature (Landreth & Bratton, 2006; VanFleet, 2014). Filial therapy literature encourages the continuation of parent-child play sessions after the parent trainings sessions have ended (Landreth, 2002). However, the experiences of parents that continue in long-term filial therapy have not been examined. It would be beneficial to understand the experiences of parents who have utilized long-term filial therapy with their children in order to provide information to filial therapists who work with these families and parents who intend to use filial therapy. This chapter will address the qualitative study design, the descriptive phenomenological methodology, guiding research questions, researcher reflexivity, and the methods used to collect and analyze data.

Qualitative Design

I selected a qualitative design to guide this study for several reasons. First, Creswell (2007) supports the use of qualitative design to explore areas where little to no research exists. Second, qualitative design is useful when the researcher seeks to capture the detailed, stories of the participants (Creswell, 2007). Finally, Glazer and Stein (2010) advocated for the use of qualitative design in play therapy (the predecessor of filial therapy) research as a natural extension of the therapeutic process. Specifically, this study utilized descriptive phenomenology to explore long-term filial therapy.

Phenomenology

Phenomenology is a research methodology that has grown out of German phenomenological philosophy. Husserl developed phenomenology as a reaction to empirical methods for describing objective truth (Stewart & Mickunas, 1990). The goal of phenomenology is to explore a specific phenomenon experienced by an individual, or group of individuals in their everyday life, or ‘lifeworld’ (Creswell, 2013). Phenomenology seeks to describe the meaning that individuals attribute to these everyday experiences. (Christensen, Johnson, & Turner, 2010). Phenomenology examines structures of consciousness from a first-person point-of-view (Giorgi, Giorgi, & Morley, 2017).

According to Grbich (2007), three major schools of phenomenology exist: descriptive, hermeneutic, and existential. Each school is interested in the individual’s conscious perception of a phenomenon of interest and its description (Reiners, 2012). However, differences exist between philosophical assumptions, research questions (Reiner, 2012), and the role of the researcher (Creswell, 2007). For the purposes of this study, I used Husserl’s descriptive phenomenological approach, as described by Moustakas in *Phenomenological Research Methods* (1994). I selected this approach because descriptive phenomenology is most suited for studies when little research exists (Penner & McClement, 2008). I also selected descriptive phenomenology in order to capture a rich description of long-term filial therapy that has not yet been described. Finally, I selected descriptive phenomenology because I felt comfortable conducting interviews to obtain participant data (Glazer & Stein, 2010).

Descriptive Phenomenology

Descriptive phenomenology is a qualitative research method that examines the psychological structures of human experience (Giorgi, Giorgi, & Morley, 2017). Descriptive phenomenology returns to individuals' experiences in order to identify the essential features present in the experience or phenomenon (Moustakas, 1994). These essential features are the essence of the phenomenon (Lopez & Willis, 2004). Husserl believed that "these essential features would transcend the particular circumstances of appearance and might then illuminate a given experience for others" (Smith, Flowers, & Larkin, 2009, p. 12).

Husserl argued that to focus on the basic structure, or essence, of individuals' experiences, one should "go back to the things themselves" (Husserl, 1935/1970, p. 252). Husserl stressed the taking on of the transcendental phenomenological attitude. The phenomenological attitude involves an intentional focusing on our perception of everyday experiences (Smith, et al., 2009). Husserl (1927) described this process as "a turning about of a glance which has previously been directed elsewhere" (p. 323). For Husserl, the implicit description of the meaning of the experience through patterns embodies the gestalt of the phenomenon. The critical question was, "What do we know as persons?" (Reiners, 2012, p. 1).

The overall aim of descriptive phenomenology is to provide a description of a phenomenon based on the "first-person reports of life experiences" (Moustakas, 1994, p. 84). To achieve this goal, descriptive phenomenology is based on four major conceptual tasks, as identified by Husserl (1927) utilizing specific techniques (Moustakas, 1994). This examination consists of four broad steps: epoché, phenomenological reduction, imaginative variation, and synthesis.

The first task of the examination of conscious experiences is epoché. Descriptive phenomenology requires an attitude of “not knowing” and undergoing the “process of setting aside predictions, prejudices, and predispositions” (Moustakas, 1994, pp.85). Epoché allows the researcher to describe their own feelings and experiences with the phenomenon (Moustakas, 1994). To do so, researchers bracket themselves during the research process.

Bracketing is “the task of sorting out the qualities that belong to the researcher’s experience of the phenomenon” (Drew, 2004, p. 215). The bracketing interview gives the researcher insight to her own understanding and bias towards the topic under investigation. The researcher can then suspend her preconceived understanding when describing the participants’ experiences (Chan, Fung, & Chien, 2013).

Phenomenologists tend to disagree when bracketing should occur. Some argue that bracketing should begin at the initial development of the research process (Glaser, 1992). Others support bracketing as an ongoing process throughout the data analysis (Rolls & Relf, 2006). Drew (2004) emphasized that bracketing is not limited to a one-time event, but should serve as a process of discovery and self-awareness. Bracketing can take the form of memo writing (Cutcliffe, 2003); interviewing (Rolls & Relf, 2006); and maintaining a reflective journal (Ahem, 1999). While the specific process and procedure of bracketing has a general lack of consensus, the overall goal is for the researcher to “perceive [the data] freshly, as if for the first time” (Moustakas, 1994, p. 34). I decided to combine both approaches to bracketing for this study because I did not want my previous experience with long-term filial therapy to impact the phenomenological interview or data analysis. I participated in a bracketing interview before I conducted interviews to bring awareness to my own

understanding of long-term filial therapy. I also maintained a reflexive journal that captured my thoughts and feelings while analyzing data in order to bring awareness to potential bias.

The second task is phenomenological reduction, or eidetic reduction (Moustakas, 1994). It requires the “continually returning to the essence of the experience to derive the inner structure or meaning in and of itself” (Merriam, 2009, p. 26). In this step, the irrelevant data is eliminated in order to “reveal the core”, or meaning structure (Lin, 2013, p. 471). It is completed through several strategies that are specific to phenomenology. Horizontalization is the process of “laying out all the data for examination and treating the data as having equal weight” (Merriam, 2009, p. 26). Interview data are divided into sentences and phrases that indicate separate thoughts regarding the phenomenon. These sentences and phrases are also known as meaning units. Meaning units that are repetitive or over-lapping are removed. The remaining meaning units are known as the invariant constituents.

Imaginative variation is the third task of the phenomenological process. The goal of imaginative variation is to identify the primary components of the phenomenon by altering aspects of the experience. This involves viewing the data from multiple perspectives, positions, roles, or functions to determine which components are essential or non-essential (Lin, 2013). A component is considered essential when its removal causes the phenomenon to “collapse.” When the essential components are realized, the meaning of the participants’ lived experiences can be constructed.

The fourth task of the phenomenological process is synthesis. Using the essential components, synthesis forms a descriptive paragraph of the phenomenon or essence. This description serves as the “essential, invariant structure” of the phenomenon (Creswell, 2007, p.

62). This structure is based on the textual and structural descriptions derived from the themes (Creswell, 2007).

Research Question

The central research question was:

1. What are the experiences of parents who engage in long-term filial therapy?

Participants

The participants for this study were parents who engaged in long-term filial therapy. This study utilized purposive sampling (Creswell, 2007). The criteria for purposeful sampling included: that participants have first-hand experience with long-term filial therapy; be willing to participate in one-on-one interviews in person, over the phone, or videoconferencing software; give permission to be recorded; provide consent and sign the Institutional Review Board-approved informed consent document; and agree that the data could be published when their name was replaced with a pseudonym.

Two major perspectives exist regarding the minimum number of participants needed for a phenomenological study. The first perspective includes qualitative researchers who provide specific guidelines regarding sample sizes. Polkinghorne (1989) suggested that the phenomenological sample consist of 5-25 people, while Creswell (2013) suggested 3-10 people. The second group of qualitative researchers believe the focus should be on the quality of data collected and that no specific number exists regarding sample size (Merriam, 2009). This perspective focuses on data saturation. Data saturation occurs “when no new information seems to emerge during coding” (Strauss & Corbin, 1998, p. 136).

I combined both perspectives and aimed to interview at least six parents, with the understanding that interviewing would continue until data saturation was accomplished. I sought six parents because it was in the low to midrange of sample size suggestions (Creswell, 2013; Polkinghorn, 1989). The number of parents who have experienced long-term filial therapy is relatively small, as compared to phenomenon of interest in other studies. If two parents in the same family participated in the study, they would count as separate participants because their experiences would be different.

I recruited participants four ways. Each method relied on potential participants contacting me after being indirectly notified of the study. The first method of recruitment was by sending an email (Appendix A) to filial therapists with whom the researcher was informally acquainted. The letter described this study and provided information for their clients to contact me regarding study participation. This method of recruitment provided four potential participants, all four of whom agreed to participate.

The second method was an open solicitation of participants by making a posting on the CESNET, a listserv for counselor educators and supervisors (Appendix B). This solicitation was aimed at practicing filial therapists who would distribute the research request to their clients. This recruitment strategy provided two potential participants, one of whom agreed to participate.

The third method was an open solicitation on a closed (private) Facebook site for individuals with interest in filial therapy (Appendix C). This recruitment strategy provided zero participants.

The fourth method was snowballing sampling. At the end of each interview, I told the participant that if they knew of other long-term filial therapy parents, I would appreciate them

sharing my information with them. This recruitment strategy provided one potential participants, who agreed to participate.

After potential participants made initial contact with me, I responded with an email (Appendix D) and provided an informed consent (Appendix E). The email thanked them for their willingness to participate in the study and asked them to provide contact information. Immediately upon completion of the interview, I emailed the participant a \$15 Amazon eGift card to thank them for their participation in my study.

Data Collection

For this study, I interviewed participants to obtain data. I conducted interviews face-to-face, over the phone, or through videoconference with parents who engaged in long-term filial therapy with their children. Interviews lasted from 33 minutes to 68 minutes. I opened the interview by collecting demographic information and basic information about their filial therapy background to ensure they met study criteria (Appendix F). I utilized an open-ended prompt, “Tell me about your experiences with filial therapy” to elicit responses from participants. As the participants shared information, I provided additional prompts such as “Tell me more about....” If I needed to clarify a participant’s response, I asked follow-up questions. All interviews were audio recorded. Once the participant left, I spoke into the audio recorder after each interview to provide my initial impressions about the interview. I also maintained a reflective journal during the study and made notes in it before, after, and during each interview. I transcribed each recording into a Word document that was then uploaded to OneDrive.

Data Analysis

There are varying methods in phenomenology that detail specific steps regarding data analysis (Creswell, 2007). In order to analyze data in light of descriptive phenomenological methodology, I utilized Creswell's (2007) simplified version of Moustakas's (1994) Modification of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological Data. The steps are described below. Figure 1 shows an example of the data analysis process.

The first step is to describe the researcher's experience with the phenomenon under investigation. To begin this process, I participated in a bracketing interview. The bracketing interview is a dialogue regarding personal experiences, biases, and knowledge about the phenomenon under investigation (Chan, Fung, & Chien, 2013). I completed my bracketing interview with my faculty advisor before I interviewed participants. He followed the same interview protocol that I used with participants. The results of my bracketing interview are included in Chapter Four.

The second step of the data analysis method requires the "horizontalization" of the data. After reading through the interview transcripts several times to get a sense of the whole, I developed a list of significant statements, or meaning units. The meaning units were from the verbatim transcripts of the participants. Any statement that was irrelevant or repetitive to the experience of long-term filial therapy was deleted. I entered meaning units into a Microsoft Word document and noted meaning units by inserting a line break between each one. Each meaning unit was held in equal value.

Next, I clustered each meaning unit into themes. Themes were identified within each

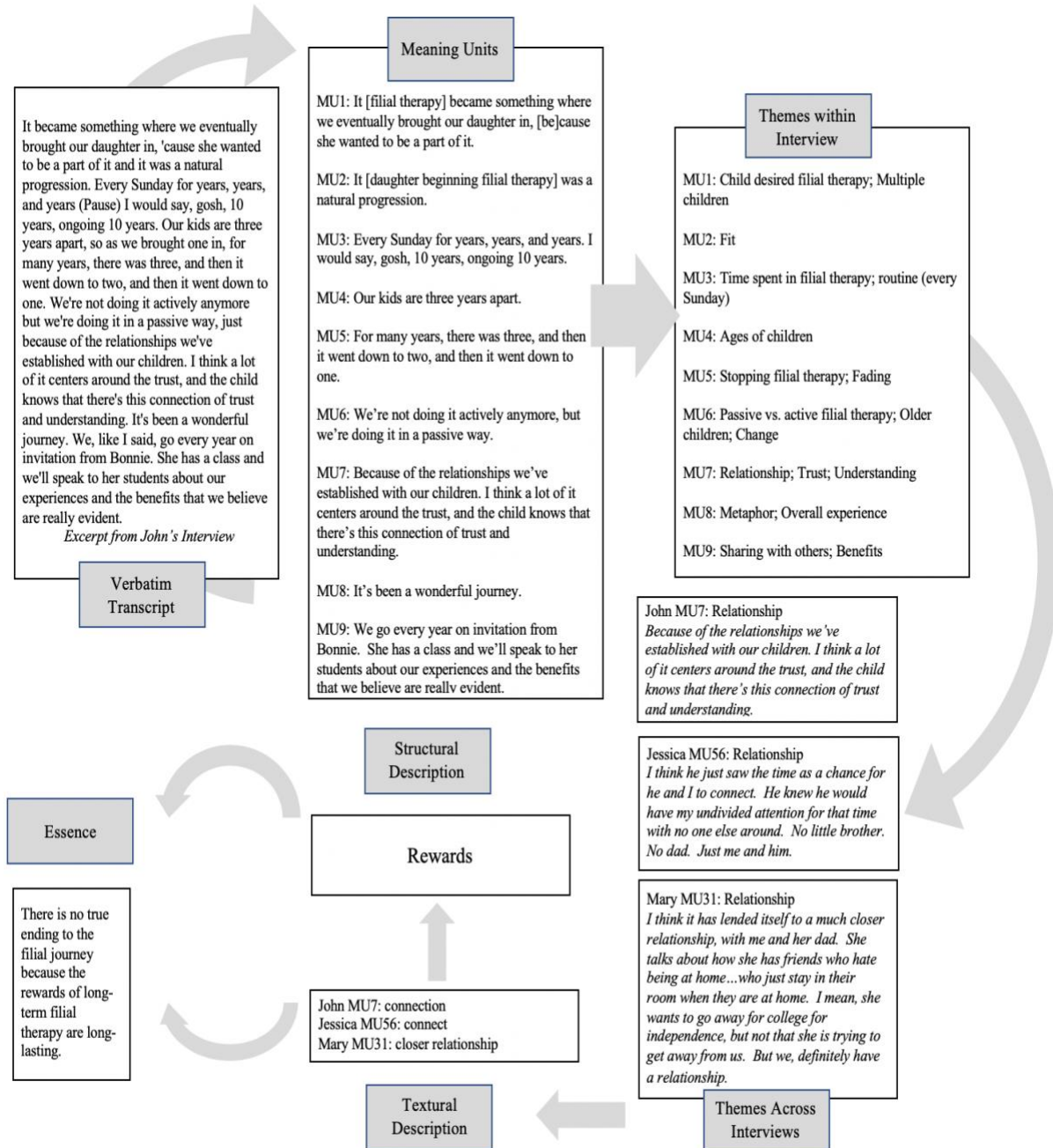


Figure 1: Data analysis process

transcript. Then I compared themes across every transcript. This process was cyclical and completed each time an as interview was conducted (Creswell, 2007).

Then, I synthesized the meaning units and themes into a textural description of long-term filial therapy, using the participants' verbatim examples. This narrative describes "the what," meaning what parents experience in long-term filial therapy (Yüksel & Yildirim, 2015).

The fifth step of data analysis focused on the creation of a structural description of the participants' experiences with long-term filial therapy. The structural description describes "the how," and describes the setting or context in which long-term filial therapy occurred (Yüksel & Yildirim, 2015).

Finally, using the textural and structural descriptions, I constructed a composite textural-structural description of the phenomenon. The composite textural-structural description describes "that what" and "the how." The blending of these descriptions captures the essence of the collective experience of long-term filial therapy.

Trustworthiness

Trustworthiness refers to the level of confidence in the quality and rigor of a qualitative research study (Lincoln & Guba, 1985). Lincoln and Guba (1985) describe the four major criteria utilized to determine trustworthiness: credibility, transferability, confirmability, and dependability. Credibility focuses on the confidence of the accuracy, or "truth" of the research findings. Transferability is the degree to which the findings of a qualitative study can be applied to other contexts or settings. Confirmability is the degree to which the results of a qualitative study can be verified by other researchers. Finally, dependability is the degree to which the findings are consistent over time (Lincoln & Guba, 1985).

Four major techniques enhanced the trustworthiness of the data in this study. I utilized deep, rich descriptions of participant experiences, continual discussion of my own experience, multiple data analysts involved in a negotiated analysis, and member-checking (Lincoln & Guba, 1985). In order to elicit participants' thick, rich descriptions during the interview process, I allowed the participants plenty of time to think before responding (Glesne, 2006). I asked probing question to elicit more details regarding the phenomenon. Furthermore, participants' contradictory statements were clarified immediately following the contradiction (Glesne, 2006). I also used the participant's own words to illustrate each of the themes that were generated from data analysis. This technique enhanced the transferability of the study (Lincoln & Guba, 1985).

The continual discussion of my own experience enhanced the confirmability of the study. By participating in a bracketing interview and analyzing my bracketing interview data, I was aware of my own biases and assumption regarding long-term filial therapy. While it was important to consider my relationship with the phenomenon under investigation, it was also important for me reflect on my role as a researcher. I kept a reflective journal throughout the data collection and analysis process, writing before, after, and during each interview. I reflected on my own subjectivity and impressions throughout the research process (Glesne, 2006). Before analyzing each transcript, I reviewed my reflective journal to be aware of feelings and reactions that could possibly impact analysis. I also shared my reflexive journal with the data analysis team so they could also point out potential bias.

Triangulating analysts analyzed the data which involves "having two or more persons independently analyze the same qualitative data and compare findings" (Patton, 2002, p. 560). Analysts reviewed the meaning units of participants and determined if there was a match

between the themes and the content of the meaning unit. The analysis team was composed of my faculty advisor and a member of my dissertation committee. Both had experience with phenomenological research, and one had extensive experience with filial therapy. They independently reviewed the transcripts to determine if the themes I generated were an accurate description of the participants' lived experiences. After I transcribed each interview, I uploaded it into my password protected, university-provided OneDrive account. Both analysts were given access to the account which was also password-protected. One analyst read each interview and provided her thoughts regarding emerging themes and impressions. The analyst organized her thoughts into a Word document and uploaded it into OneDrive. I did not access this document until after I had already analyzed each interview. I compared the themes that we saw emerging. The other research analyst read each interview transcript and compared his impressions to the themes I provided. He provided agreement, disagreement and other considerations. This technique strengthened the dependability of the study.

Finally, to enhance credibility, I presented findings to participants for member checking (Merriam, 2009). At the end of the study, I provided participants with a copy of the research findings. Participants had the option to provide feedback and ensure that they were comfortable with the data that was presented. This ensured that the findings accurately and ethically represented their experiences with long-term filial therapy. Of six participants, three provided feedback about the findings. One of the participants asked me to remove some information that could possibly identify her or her children. The three participants agreed with the findings I presented to them.

Limitations and Delimitations

As with most phenomenological studies, descriptive phenomenology typically utilizes interviews to deeply explore specific phenomenon. As with any qualitative method utilizing interviews, descriptive phenomenology is dependent on the ability of the participants to recall and provide personal information. Interview data is subject to issues with memory and accuracy (Giorgi, 2009). Quality interviews are also dependent on the relationship developed between the researcher and the participant (Brinkmann & Kvale, 2015).

Another limitation involved the sampling technique to obtain participants. This study depended on filial therapists referring potential participants to the researcher for consideration. It is assumed that in most cases the referring filial therapist was the individual who provided filial training to the participant. This could cause a potential participant to feel an obligation to participate in the study.

Another limitation of the study included the possibility of researcher bias. As part of the descriptive phenomenological tradition, the researcher is also an active participant in the research. This is especially true due to my experience with filial therapy with my child. The use of a deliberate and intentional data analysis method addressed limitations in this study. By participating in a bracketing interview, I brought my own beliefs, knowledge, and experiences with filial therapy to light. These presuppositions were analyzed and then set aside when analyzing further data. The use of techniques such as multiple data analysts and member checking also addressed the study's limitations.

The delimitations of this study included how I defined my population of interest. By focusing on only the experiences of parents, I did not capture the experiences of other caregivers

or individuals who conducted filial therapy. I also defined long-term filial therapy as sessions continuing for at least one year after parent training sessions have ended. This study did not portray the experiences of parents who held filial therapy sessions for under a year.

Additionally, this study did not represent the experiences of parents who utilized alternative long-term mental health interventions or treatments for their child.

Research Ethics

The goal of the study was to improve understanding of parents who engage in long-term filial therapy. To safe guard the well-being of each participant, I completed the Collaborative Institutional Training Initiative (CITI) before completing the dissertation proposal. The study followed the guidelines of The University of Tennessee's Institutional Review Board (IRB). Each participant received a copy of the consent form that detailed the study's purpose, benefits and risks, and confidentiality before participating. Participants also had the right to withdraw from the study anytime without penalty.

Maintaining participant confidentiality was a potential risk to my study. In order to protect participant confidentiality, I took several measures. Once I transcribed the interviews, I erased the recording and assigned a pseudonym to each participant. All potential identifiers were removed from the transcript or were provided a pseudonym. For example, if the participant mentioned a child's name, a pseudonym was provided for the child's name. I also returned the transcript to each participant for them to read to ensure their identity was protected. Transcripts were analyzed on a password protected computer. All transcripts were stored on my password protected OneDrive account. Finally, data analysts were required to sign a Confidentiality Agreement (Appendix J) before given access to the transcripts.

Finally, I developed a protocol if a participant appeared to experience emotional distress (Appendix I). This protocol was not required during this study. If it was needed, a referral would have been made to a mental health professional in their area. First, I would have referred the participant to the filial therapist with whom they trained. If the filial therapist was not accessible to the participant due location, etc., I would have provided a list of counselors in their area using the Find a Therapist feature on the *Psychology Today* website.

Summary

This study utilized descriptive phenomenology to understand the experience of parents that engage in long-term filial therapy. The researcher engaged in the four major tasks of the phenomenological approach including epoché, phenomenological reduction, imaginative variation, and synthesis. I utilized Creswell's (2007) simplified version of Moustakas's (1994) Modification of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological Data to analyze participant interviews. Throughout the research process, the researcher sought to maintain trustworthiness while treating the participants in an ethical manner. Chapter Four will detail the data analysis and results of this study that describe the participant's experiences of long-term filial therapy.

Chapter Four: Findings

Introduction

This chapter presents the findings of the descriptive phenomenological study on parents' experiences with long-term filial therapy. First, I introduce each of the six participants and provide demographic information, information about their child (or children), how they were trained in filial therapy, and their interview format. I then present the findings from my bracketing interview. Then I present each of the seven themes and their subthemes derived from data analysis. Following that, I provide the textural description and the structural description of the participants' experiences. Finally, I conclude the chapter with the textural-structural description, or the essence of long-term filial therapy.

Participants

Six parents participated in this study of long-term filial therapy. To be considered for this study, individuals had to have conducted filial therapy for at least one year after filial therapy training had ended. The participants consisted of five females and one male. Five family structures were represented in this study, as two parents participated in separate interviews from one family. Participants selected their pseudonym and the pseudonym(s) for their children. Participants will be introduced in the order in which they were interviewed.

Participant 1 – Jessica

Jessica is a 51-year-old, Caucasian female. She is the mother of two boys currently aged thirteen and nine. She started conducting filial therapy sessions with her eldest son when he was six years old. She held filial sessions for approximately three years. Jessica is a therapist specializing in treating children at a private mental health agency. While she did not have

specific training on filial therapy, she felt competent to conduct filial therapy because she is a trained play therapist. She has attended professional development sessions on filial therapy at conferences and workshops. She discussed the filial process with her son in peer supervision on a regular basis (approximately twice monthly). The interview was held face to face.

Participant 2 – Hannah

Hannah is a 36-year-old, Caucasian female. She is the mother of a six-year old daughter, Lucy. Hannah started conducting filial sessions two years ago and is still conducting sessions. Hannah was trained by a filial therapist in the CPRT model while she was a graduate student in Texas. She is currently an educational consultant and an adjunct professor of early childhood education. She travels out of town approximately eight days per month. Hannah was referred to the study by a colleague who shared the CESNET listserve post with her. The interview was conducted over Zoom.

Participant 3 – Mary

Mary is a 46-year-old, Caucasian female. She is the mother of three children, currently aged 19, 17, and 14. Mary held filial therapy sessions with her middle daughter, Anna, beginning when she was three years old. Mary and Anna continued having filial therapy sessions for six years. Mary's oldest daughter, Katherine, has Down Syndrome, and her youngest son, Ryan, was diagnosed with autism when he was three. Mary was referred to a play/filial therapist while the family lived in Virginia. The play/filial therapist conducted the training in approximately six private sessions with Mary and Anna. Mary was referred to this study by a filial therapist who forwarded the post on the CESNET listserve. The interview was conducted over Zoom.

Participant 4 – Sarah

Sarah is a 55-year-old, African American female. She is a single mother to two adopted daughters, Devon and Kathleen. Sarah adopted the sisters from foster care when they were almost two years old and four years old. Sarah held filial sessions with her daughters for eight years. The girls are currently 17 and 20 years old. Sarah is a play therapist in a private mental health agency. She was trained in play therapy during her graduate training in Florida. Sarah was referred to the study by Jessica (Participant 1). The two of them have collaborated on play therapy cases for over eight years. The interview was held face to face.

Participants 5 and 6 – Nancy and John

Nancy is a 43-year-old, Caucasian female and John is a 49-year-old Caucasian male. They have three children, Kyle (20), Luke (17), and Molly (14). Nancy and John started conducting special play time with their oldest son when he was eight years old and continued holding special play time with their children for over a decade. Luke has a diagnosis of autism, and Molly has multiple diagnoses, as well as being adopted. Nancy and John were trained in filial therapy by a play therapist in a 10-session, couple's format. Nancy and John's separate interviews were held over the phone.

Bracketing Interview

Bracketing is a detailed description of my experience with long-term filial therapy. Bracketing is done to bring the personal judgment and biases to light with the intent to set them aside so that the focus can remain on the study participants (Creswell, 2007). To minimize the impact of my experience, I attempted to suspend my beliefs about long-term filial therapy to the

best of my ability. I held a bracketing interview with my dissertation chair over Zoom before I started collecting any participant data. The interview lasted 40 minutes.

My experience with long-term filial therapy is personally meaningful because I conducted special play time with my son. After taking a play therapy course, I was eager to utilize my skills with Hunter at home. I also decided to begin play therapy because my schedule was about to significantly shift from being predictable to the hectic nature of graduate school. We started our play therapy journey with a bag of toys that we kept on the laundry room shelf. Our sessions ranged from 30 to 40 minutes and were usually held on Friday's because that was my day off from graduate assistant responsibilities.

At first, Hunter questioned the nature of my communication during our special play times. He would frequently ask, "Why are you talking like that?" in response to the reflective, non-directive communication skills I was using. This caused some discomfort for me because I thought he did not enjoy the time. After both of us fumbling through the beginning sessions of our special play time, Hunter and I got into a comfortable routine. We spent about six years having our weekly time together. Over these six years, Hunter moved several times, changed schools, and experienced his parent's divorce. Despite these challenges, Hunter has been a well-adjusted, happy child. I believe that our special play times have been a protective factor for him.

When Hunter was about nine years old, I noticed that his play was beginning to change. He was wanting to play with specific toys more and less with the toys in the toy kit. At first, this created some concern for me because this was uncharted territory. I worried that I was diverting from the usual filial format. Typically, filial sessions are conducted with a single set of toys (a filial play kit) that is often stored in a portable box or plastic bin. These toys are selected to meet

a range of play activities and a range of areas of expression, such as power and control, and giving and receiving nurturing. Normally the filial toys are only used in filial sessions and no other toys are brought into the filial session. Further, the sessions are most often held in the same place, often a bedroom of which a door can be shut for privacy. However, I also worried that if I kept to strict protocol, it might hurt the relationship we had built. So I decided to give him the freedom to select the toys and even the setting in which to hold our special play time. I found that “as the toys fell away, the skills remained the same.”

The communication skills and the unique way of “being with” my son in special play time became “a pattern” in our relationship. It defined how we responded to one another in many of our interactions. Special play time helped create a special bond between us. We have freedom to communicate with one another, and we enjoy being in each other’s company, even now that he is almost a teenager!

Themes

This section describes the themes attained from interviews conducted with six parents who engaged in long-term filial therapy for at least one year after filial therapy training has ended. Seven themes emerged from the data to describe the phenomenon: (1) reasons for coming to filial therapy, (2) descriptions of filial sessions, (3) change, (4) ending filial therapy, (5) child benefits, (6) parent benefits, and (7) parent and child benefits. To use the participants’ words within the data represented, filial therapy sessions are sometimes referred to as special play time, play time, or play sessions.

Theme 1: Reasons for Coming to Filial Therapy

Every parent provided specific reasons for seeking filial therapy for their child. Oftentimes parents had multiple reasons for coming to filial therapy. The subthemes include: (1) behavioral issues, (2) disability, (3) to rebuild or build parent/child relationship, and (4) meet parents' emotional needs.

Subtheme 1: Behavioral issues. All parents sought filial therapy as a response to their children's behavioral challenges. Before beginning filial therapy, participants described that their children had temper tantrums, defiance, and symptoms of anxiety. Most participants provided specific examples regarding a situation in which their child's behavior proved to be a challenge.

Nancy described her son's behavior which included, "swinging doors... talking back...swearing and yelling." Sarah explained that her daughter, Devon, had tantrums in response to her attempt to "putting those structures, those routines into place" when she transitioned into her home from foster care. Hannah described her daughter, Lucy, as "overstimulated all the time." Lucy displayed distress in situations that had "a lot of activity" and had "meltdowns."

Mary described her daughter's behaviors as having had "constant tantrums over things, like little things. You know not getting what she wanted for breakfast or you know, just things that were just exhausting to deal with as parents." Mary went on to detail her daughter's former behavior.

Her behavior was absolutely out of control (pause). We could not take her anywhere. Not even to church. She actually got kicked out of Sunday School when she was 3. I think that may have been the breaking point for us. She was just extremely defiant. She was all over the place...up, down...super excited about everything, happy,

all over the place, or just constantly crying, angry. We took her to a behaviorist to make sure there was nothing wrong with her. And they said she is an extremely emotional kid. She wasn't going to be ignored. We knew that children around the ages of two and three, tend to be in that terrible twos stage, but this was way, way, way, beyond that.

Parents also discussed their children having had symptoms of anxiety. Jessica expressed that her son, Will as “a bit more anxious and high-strung. John said Kyle’s “anger and temper, and frustration and his anxiety was going up, and we couldn’t account for it.” Nancy described that Kyle’s anxiety had hit him like “a train wreck.”

Subtheme 2: Disability. Multiple participants said their child having a disability or having a child in their family with a disability was a reason for pursuing filial therapy. Nancy and John have two children with disabilities that participated in long-term filial therapy. Their middle son, Luke has a diagnosis of autism and their youngest daughter, Molly has a developmental disability, reactive attachment disorder, learning disability, and attention deficit hyperactivity disorder. Sarah’s oldest daughter, Devon has a learning disability.

Families also explained utilizing long-term filial therapy with their child without a disability to help them manage having siblings with disabilities. Mary described her reasoning for continuing filial therapy with Anna was due to both of her siblings being diagnosed with disabilities, Down Syndrome and autism. She explained that “Life just sort of revolves around them [her children with disabilities].” Nancy described a similar issue with her oldest son, Kyle

he was noticing how our family was changing. Molly got all these diagnoses, and Luke was diagnosed with something, and he [Kyle] took on some added stress of being the normal kid. Which was a diagnosis in itself for him. And he put on this persona of I have to be different. I have to be better. I have to show the way. And I think a lot of times, first kids do that. It became ridiculously clear to me that this kid had taken on way too much responsibility. He would ask me, ‘Mom, how are you going to handle this without me? How are you going to do this?’ and I would be like ‘Dude, (laughter) you are taking on way too much. Like you don’t need that. That’s not your problem. I am the parent.’

Subtheme 3: Rebuild or build parent/child relationship. Parents spoke about their desire for filial therapy having been to build or rebuild the parent/child relationship. Sarah expressed her hope that filial therapy would help build a relationship with both of her daughters because they were adopted. She explained that she hoped their play times “would help us bond. Would help the girls see that they could have a constant adult. Someone who cared about them.”

Jessica and Hannah explained their hope for filial therapy having been to help them reconnect with their child. Jessica was away from the home a lot due the demands of graduate school when her son, Will was young. She also described her role as the parent with the responsibility of helping Will with academic work while he was struggling in school. Jessica explained “Our relationship was not bad, but we were missing something. We just needed a positive connection. Something good. We needed a way to ‘re-find’ each other. With my school and his school issues, we just needed something to bring us back together.”

Hannah travels approximately eight days a month for work. Hannah said that holding filial sessions helps Lucy cope with the schedule changes and her absence. She explained, “Being able to have that time with her before I, you know, leave for work is important. And then trying to have that time with her as soon as I come home, to reconnect is also very important.”

Nancy described a sudden change in the relationship with her son, Kyle, as a reason for seeking filial therapy. Before beginning filial therapy, she was proud of the strong connection she had with her son.

I was really, really on track with my kid. I was a stay at home mom at the time. So, I just really felt connected to my kiddo. There wasn’t a lot that I didn’t know going on in his life. And for me, that was a gauge of how well I was connected with him.

However, due to behavioral changes that occurred she felt a disconnect from him. These sudden changes caused her to lose confidence in her parenting ability. She felt worried, which motivated her to find a way to re-establish a connection with Kyle. She said, “I was like ‘This is not my child!’ It seemed like night and day.” Her hope for filial therapy “was to unite with our child. To meet them [children] where they were at.”

Subtheme 4: Meet parents’ emotional needs. Parents also looked to filial therapy to help meet their emotional needs. Parents expressed feelings of guilt, helplessness, gratitude, and curiosity. Jessica described feeling guilty about missing some of Will’s early years due to the demands of graduate school.

I was gone a lot while I was in grad school. With classes, teaching, working at Counseling Care Center. We were very fortunate during this time to have our parents living near us. Both of our mothers were retired and were able to give us a lot of help with the boys. But I still feel like I missed out on a lot time that I should have been with them, especially Will.

Nancy described her feeling of helplessness when her relationship with Kyle suddenly changed after he started demonstrating intense behaviors. She said, “I would call my husband and I would cry, and I would say, I don’t know what’s wrong with him. I don’t know what I did. I don’t know what he did.” Mary echoed this feeling of helplessness, describing a sense of desperation for anything to help her daughter, Anna’s intense behaviors. She described being at “rock bottom with Anna” and at her “wits’ end.”

John and Nancy’s son Kyle participated in play therapy sessions with a therapist. John explained his gratitude for the changes he had seen in Kyle during his time in play therapy led him to pursue filial therapy training. Nancy also explained that her sense of curiosity also led her to filial therapy. “I was like I want to know what she’s [play therapist] doing. I have to know.

This worked for our son. He is different. He changed! I don't know how they did it, but I want to learn."

Summary. Each parent described specific reasons for coming to filial therapy. Each subtheme describes a specific reason for seeking filial therapy in more detail. The subthemes include; behavioral issues, disability, to rebuild or build the parent/child relationship, and to meet parental emotional needs. Most parents described multiple reasons for seeking filial therapy for their child, but it appears that the primary reason was to resolve behavioral challenges that the child was exhibiting at home.

Theme 2: Descriptions of Filial Sessions

Parents described qualities, actions, children's processing, and challenges within the work. The parent descriptions provide a view of what the sessions looked like. John succinctly said, "The special playtime in filial therapy created a space where they (children) learned that they were in charge, that they could be heard, that they were the ones that could decide what they do with that time." The subthemes include (1) consistent, (2) child activities during filial sessions, (3) child processing during filial sessions, and (4) challenges with filial sessions.

Subtheme 1: Consistent. Parents discussed the logistics surrounding their filial sessions. Jessica described how she and Will had sessions at home, and then moved them to her office. At the start of their filial sessions, they had sessions "about three times per week," but dropped the sessions to once a week when Will returned to school.

Nancy explained that she held a 20-minute filial session with each of her children on Sundays. She explained that she and her husband collaborated together to each have a session

with each child. They held “special play time” in their bedroom. She went into detail about how their toys were stored

We had a box with our special play time stuff. It was a huge Tupperware box. It lived under our bed and a blanket that went on top of it. And when it was special play time, we took out the box and we put the blanket on the floor. And then they came in, and if they wanted to open the box, and use the toys that were in the special play time box. That was just those toys for that time.

Sarah stressed the consistency of holding filial sessions with her daughters stating, “I can probably count on two hands how many play times we missed while they were growing up.”

John also shared that each filial session began with a disclaimer, “We would always start the sessions with like, ‘If there's anything you can't say or do, we'll let you know. Otherwise, what happens in special playtime is special playtime.’”

Subtheme 2: Child activities during filial sessions. Parents described a variety of activities that their child engaged in during filial sessions. Parents described frequent imaginative play, including playing dolls and playing school. Parents also described their children playing with animal and dinosaur figurines. Parents utilized various toys such as a sand tray, a dollhouse, and dress up clothes.

Children tended to utilize a lot of art materials during the filial sessions. Parents detailed their children drawing, painting, and modeling with Play-doh. Parents also discussed the need to frequently add new art supplies in their play therapy materials.

A common experience that children tended to play out was family play. Hannah describes an experience with Lucy.

I was a mommy dinosaur and she was a baby dinosaur. We were on some sort of journey or something. We were going on in the sand. She was also a T-Rex or something that was chasing us on our sand journey. We spent a lot of time escaping the T-Rex.

Eventually he got us in the end. Well, at least me. The T-Rex ate my dinosaur. She is a violent little thing. (Laughter)

Parents also described their children engaging in high energy activities during their play sessions. Jessica explained, “He [Will] loved my punching bag. Often times, he would come in from school and just let loose on that punching bag for a few minutes. Then he would sort of settle and play. I think part of it was just an ability to let out some frustration with the school day (Pause), letting out some big energy.” Mary also explained that Anna also liked high energy play and “was never sitting. She was standing, she was jumping on one leg while rolling out a snake [with Play-doh].”

Finally, parents spoke about games their children would play during filial sessions. Some of these games were traditional. For example, John said his children played card games. Other games were child-created and could get rather elaborate. Mary described playing games that Anna developed. Nancy detailed an intricate game that one of her sons created.

We had marbles in this box. The way that the Tupperware lid went together...there was this way that my son...created this way, this whole new game where we would, with the marbles. [We would] try to get them back and forth and hit a marble against another marble. One day we would be trying to get them in this section, and the next day we would be trying to tip the box.

Subtheme 3: Child processing during filial sessions. Parents noticed their children processing various events or situations during their filial sessions. Common events were death, self-concept or confidence, and family issues.

Jessica and Sarah described their children processing death during their filial sessions. Jessica described how Will processed the death of one of his teachers. She described him burying figures in the sand and covering them up. Even though he had never been to a funeral, she believed that Will was acting out what he thought a funeral might be like. Sarah described

how her daughters processed the complicated death of their biological mother. She admits to being honest with her daughters surrounding their biological mother's death and they engaged in play for a period of time that reenacted her death. Nancy, John, Mary, and Hannah also described their children "killing things" during their play sessions.

Jessica and Sarah also describe how their children utilized play to build their self-concept or confidence. Jessica said Will played school a lot. She attributed this to his frustrations with school and the need to feel in control of his school environment and academic struggles. Sarah described Devon attempting to build her self-concept through affirmation. She explained that Devon often struggled in school due to a learning disability. She describes that Devon took on the role of the class clown which would sometime lead to minor trouble at school. Sarah explained that Devon needed to build her confidence even if school could be challenging.

She would draw something [or] create something. She would often seek affirmation She would want me to say 'That's good.' or something positive. She would prompt me to say it. Eventually, she moved to just creating things [and] she did not need me to affirm her anymore. Not in the play sessions.

Parents also reported their children working through family issues. Hannah described how her daughter made sense of a close family member's divorce, how she worked through conflict with her cousin, and her mother's travel schedule. Jessica also noted how Will worked through conflict with his younger brother in play sessions. She noted that he had "a hard time letting their little arguments and stuff go." and "his little brother [the character he created for his little brother in play sessions] got in trouble a lot in the play sessions." Mary described how Anna worked through some issues surrounding her siblings with disabilities. She went on to explain

She did a lot of parent play. She was the mom and the baby was (Pause) well, her baby. (Laughter). This was sort of a constant thing that she would come back to over and over during our play. When she was a little older, she would try to parent Katherine and Ryan. She was sort of their third parent, especially Ryan. She was almost his mini-parent. (Pause) We did not want her to take on this responsibility. We still don't. But by this time, my husband and I had majorly lost all expectations for how we expected our kids to behave if we were anywhere in public (Laughter). But she would still attempt to parent them especially when she was old enough to understand, she would be embarrassed by their behavior which is ironic. (Laughter).

Mary believed that special play times helped prepare Anna for a move to a new state.

While she did her best to prepare her for the move, Anna still had a significant amount of anxiety surrounding this change. Anna would engage in activities like packing and moving the objects in the dollhouse.

We did a lot of things to prepare. We came and visited her school before she moved. We knew the school she was going to attend, so we did our best to prepare her. To talk to her about that, but there was a lot of play during our sessions about the move. I think she had a lot of worry about it. Maybe more about how everyone else [her siblings with disabilities] would handle it.

Subtheme 4: Challenges with filial sessions. During special play time, parents described having challenges or struggles regarding some of the play in which their children were engaging. Further, parents also described personal challenges they faced during their play. While most parents dealt with these struggles independently, some parents contacted their filial therapist for assistance.

Nancy shared that sometimes she felt tired during her children's play sessions. She described struggling to stay awake.

And there were many days, on the cold windy days in February when it is dark, and you know you finally allow yourself in a week as an adult...a full hour of nothing. You are like, I am tired. I am going to struggle to just stay awake for this, right? It wasn't always perfect. There were times I was like, 'Whew!, you [husband] gotta' take a turn because I am like falling asleep here.'

To combat this, she and her husband would openly communicate and would “tag team” so the other parent could have “an opportunity to rest.” While one parent would hold a filial session with one of their children, the oldest child would be responsible for doing an activity (Legos or a craft) with a younger sibling. This would provide the other parent a chance to rest for approximately 40-50 minutes.

Additionally, at the beginning of special play time, Nancy experienced difficulty juggling the special play time with her children while also completing house work and managing the schedule.

And he [John] would be like ‘I know, I know, I know.’ It’s not easy. It’s not fun to make this choice. And how are we going to fit this in? It’s so and so’s birthday. And you know it was something like that all the time, and we would keep each other going. We had that accountability to each other.

Again, the support that she and John provided for each other helped them navigate these challenges. She also described that while one parent was playing with one child, the other parent may have helped out with chores around the house.

John shared his challenge of shifting to a new way of interacting through his filial therapy experiences. He described his personality as “more directing and controlling.” He described his natural tendency to try to help his children and complete tasks for them. For example,

The kids wanted to shuffle some cards, I would grab it from them and help them. I was helping them. It was instructional based. It was like, ‘Let me show you how. Let me do this for you. Watch me.’ I didn’t get the whole idea that it was ... the fundamental shift that I didn’t get right away was ... or, the fundamental principle, rather, that I didn’t get right away, was just be present in the moment and provide the child a space where they can speak and act freely without any concerns of anyone telling them what to do or how to do it. Basically, it was like, I had to learn how to really listen, truly listen, and be present, and without judgment, without directing.

He described recording his sessions with his children and reviewing them with the filial therapist for corrections in order to master the attentive communication of filial therapy.

Nancy described a phase with Luke that involved him violently beating stuffed animals during their play. She described the play as being “alarming” and unsettling. She shared her concerns with their filial therapist (Bonnie) who encouraged her to set a boundary with Luke if it was upsetting her that much. Bonnie also assured Nancy that play like this was normal. The two decided that Nancy would allow the play that had alarmed her to continue for two more sessions. Ironically, he shifted from beating stuffed animals when Nancy entered the next two play sessions calmer and less worried. The difference in her reaction, from worry to acceptance, seemed to Nancy to be what he needed in order to move on to his next play themes.

Mary described the beginning of her and Anna’s play as “very chaotic.” When Mary and Anna started their play sessions, Anna “was just everywhere with all the toys. It was almost like a mania or something. She could not even really settle at first to really begin playing with anything at all. It was not fun at first.” Mary believed that once Anna understood that the filial sessions would consistently occur, she was able to engage in focused, thematic play instead of just picking up toys and running around the room.

She just was not as rushed. She was able to attend to things during the sessions, like sometimes she was able to stick with one or two things she would focus on for a while, for the whole time. Like she may actually play with the baby dolls for 15 minutes or 20 minutes or something, not like, 2 seconds. So that really stands out. Just sort of settled into the time.

Once Anna settled into the routine, Mary started enjoying their time together.

Summary. The second theme of this study was descriptions of filial sessions. The subthemes of this section were consistent, child activities during filial sessions, child processing

during filial sessions, and challenges with filial sessions. Parents described their children participating in common play activities and processing similar problems. Most parents described challenges surrounding their filial sessions and how they overcame them.

Theme 3: Change

All parents described changes while they engaged in long-term filial therapy with their children. The subthemes include (1) changes occurred in filial sessions, and (2) changes occurred outside of filial sessions.

Subtheme 1: Changes occurred in filial sessions. Parents described allowing the structure of their filial therapy sessions to expand and loosen as their children grew and changed, and parents described their children's play also changing as they grew up.

Hannah described that in order to help her remain consistent with her filial sessions, she has "relaxed some things around our sessions." This includes holding sessions outside and without the filial play kit. While at first, she held sessions on a weekly schedule, now "we don't plan to have our sessions at a certain day or time or anything like that, other than making sure we have the time before and after my work trips (Pause), but we just do it."

Mary described how she and Anna's filial sessions moved outdoors as well. She also described allowing Anna to bring preferred toys into the sessions especially as she got older. She justified this because Anna was growing tired of the items in their play kit. She explained, "I wanted her to enjoy the time with me and if she needed Littlest Pet Shop toys to do so, then so be it."

Nancy highlighted how she gave her daughter freedom to select the setting as she got older and allowed the session length to increase. Molly also started requesting novel and unique experiences.

Around 11 or 12, that's when she started, 'You know I'd rather do special play time outside and dig a hole and pour mud in it.' And we'd be like, 'okay!' We said change out of your Sunday clothes and get into your shorts and a t-shirt. And then we'd go outside. And we'd apply all those same principals to the mud bath. Um, basically it was 20 minutes and it got to be a little longer with her, so it probably got stretched to about half an hour. And, and then we'd just watch.

Nancy also explained that both of her sons became interested in Legos. Since 20 minutes was too short to complete a Lego project, she combined her sons' play times to extend the session to 40 minutes.

Parents also described changes in how their child played during the sessions. Hannah went on to say

I think one of the biggest changes has been how Lucy plays. When we first started, she did a lot of repetitive behaviors, sensory things. Now she will still do those things, but not as much as she used to. Instead of doing some of those things, she will pretend a lot more. She wants me to pretend a lot more with me.

John explained that his son, Luke went through a limit testing stage during their filial sessions.

Luke began cursing during the play sessions. John allowed his son to go through this phase and then it naturally extinguished when John and Nancy did not react to it.

My middle child, when he realized that he could swear in special playtime, and we told him, "Now, you can't say this out of special playtime." He did it to try to get a reaction. He did it to try to see if, how far he could push the envelope. And he was the most interested in pushing envelopes. Like, just how far will you let me go before you tell me no? Let's test to see if you really do, you know, if this is what, if what you're saying that, this is a safe space. But we didn't say this is a safe space. But he wanted to test the boundaries. And so, he went on a swearing streak for a while. And when he realized that the novelty had worn off, and he was not getting a reaction out of us, it went away.

Subtheme 2: Changes occurred outside of filial sessions. Parents noticed that the skills they practiced in their play sessions started to generalize outside of the play sessions. Parents also noticed that their children were transferring skills that were once contained in filial sessions into their everyday lives. Nancy explained that the empathic responses and listening skills started to permeate all of her interactions with her children. Nancy said, “You can’t help but bring those techniques that you are cementing day after day after day when you are sitting there 20 minutes at a time every week. You can’t help but bring that into your life. You can’t help it.”

Hannah started “noticing more opportunities to play” with her daughter throughout the day. As the two engaged in spontaneous play, Hannah would begin utilizing filial therapy techniques.

We may be playing and then she will tell me what to do, you know sort of how we let them do during our play sessions. So I just sort of go there with her...not every time, but sometimes I will just back off, and let her lead the play.

Mary noticed that when Anna got older, she was doing more talking about her issues outside of the filial sessions as she played them out. She explained “there was a lot more of that...more of that talk it out, play it out, talk it out, play it out.” Things that Anna may have only expressed through play were coming out in conversations throughout their day.

According to Jessica, Will would attempt activities in filial sessions that he would not do outside of the sessions. Jessica told the story of Will refusing to jump rope at school and at home. However, he would jump rope in their filial sessions. When Will felt confident in his ability to jump rope, he then transferred that skill into “real life.” Jessica also noted finding “other little ways to play” outside of the play sessions with Will.

Summary. Change was common to parents' experience with long-term filial therapy.

The subthemes for this theme are changes occurred in filial sessions, and changes occurred outside of filial sessions. Parents described how their filial sessions with their children became more relaxed as their time went on. They may have played outdoors or allowed their child to bring outside toys into their play sessions. Parents also described how their child started playing in a different way during their sessions whether that was by engaging in more pretend play or testing limits. Parents also described changes that they noticed occurring outside of filial therapy. Parents began transferring the communication skills used in filial sessions outside of sessions. Parents also noticed how their child was able to work through challenges inside of sessions and demonstrate mastery outside of the sessions. Finally, parents began noticing more opportunities to play with their children.

Theme 4: Ending Filial Therapy

This theme is unique to five of the participants because one of the parents is still conducting play sessions with her daughter. Subthemes include (1) allowing the child to take the lead in deciding when to end filial therapy sessions, (2) age, (3) goal attained, and (4) a feeling of sadness,

Subtheme 1: Allowing the child to take the lead in deciding when to end filial therapy sessions. Mary described her daughter wanting to end sessions early. When Anna questioned whether or not her and her mother would have sessions, Mary responded, "And I would ask her...well, so you want to have them? And a lot of time, she would say no." Nancy echoed a similar experience with one of her sons

We would say Luke, we are done with Molly's special play time, do you want to go? And he would say yes or no. And sometimes he said yes and sometimes he said no. And

eventually the no's got more and the yes's got less. And when we had more no's than yes's, we just stopped asking. And he never said anything, and it was just sort of done.

Nancy also shared that her other son, Kyle would spend time during his special play time drawing, and not really interacting with either of his parents. When they asked if he still wanted to have special play time, "he was like, no I think I am good. And he just never came back."

John described ending special play time with his daughter Molly. He explained that Molly would often have sessions with his wife first. When it was time for her session with him, she would sometimes say no. John understood that "she had gotten the connection and attention she needed during her special play time with her mother."

Subtheme 2: Age. Parents also attributed the end of special play times with their children due to the child's age. Mary explained, "We had been on this routine for almost six years. I think age had a lot to do with it." Sarah also mentioned the developmental aspect of filial therapy and how it is uniquely meant for children. She said, "It just didn't fit anymore. You don't see adults going to play therapy (laughter). It's for children. So part of it was developmental." By "developmental," she meant that the work was a fit for a younger age, but no longer a fit as her children grew older. John provided a contrast with the example of his daughter. His daughter continued having filial sessions for a year or two longer than her brothers did when they were of similar ages. John attributed this to her developmental delays.

Subtheme 3: Goal attained. Long-term filial therapy parents said part of the reason they ended filial therapy was because their child had met the goals they had hoped for. Jessica said, "I think that we had worked through a lot. Will was not struggling in school anymore. My goal of he and I reconnecting had happened. As the sessions faded away, I did not see a huge negative

impact for Will. Will had accomplished what he needed to accomplish in our sessions together.”

John explained that Kyle learned to use drawing as a coping skill to manage his anxiety.

He would draw a lot towards the end. And that’s what he did in his quiet spot if he just needed to be alone... and then we noticed that there wasn’t a lot going on with us [in filial sessions]. He had this way of sort of centering himself, and he didn’t need us.

Mary and Sarah mentioned that their children were now able to verbally communicate with them, and filial therapy sessions were not really needed anymore. When Anna was in fourth grade, Mary ended the filial sessions. Mary said, “I think by that time...she was able to communicate with me and her dad just whatever she needed to. She was just comfortable with the talk.” Sarah also said, “That [play] was not how they communicated anymore. They could verbally communicate. They could make sense of the world around them. Put it into words.”

Subtheme 4: A feeling of sadness. Parents and children described a sense of sadness or wistfulness in regard to the ending of their filial therapy sessions. During the interview, Nancy cried several times while she was reflecting on her experience with long-term filial therapy. She was surprised that she was so emotional about it. John described, “When it [special play time] started to end with them, there was a bit of sadness, to be honest. It was like, ‘Oh, you don’t want to.’ I would feel a little bit of this let down.” Sarah said that she and her daughters “mourned a little” when their play time ended. She goes on to explain “We refer back to our play times. We speak of them fondly. We sort of reminisce. My girls are grown now, and we still talk about our play times.”

Summary. Parents described how their filial therapy sessions with their children ended. The subthemes included allowing the child to take the lead, age, goal attainment, and a feeling of sadness. Most children began questioning whether or not they had to have sessions or responded

that they did not want to have filial sessions when their parent asked them. Parents also believed that age and the fact that they felt their child had met their goals were reasons for the play sessions ending. Parents described a sense of sadness when discussing their filial sessions ending. This theme was only applicable to five of the parents because Hannah is holding filial sessions with her daughter, Lucy.

Theme 5: Child Benefits of Long-term Filial Therapy

Each parent described positive changes their child was making in long-term filial therapy. Some of these changes were immediate, while some took longer. Subthemes include (1) resolution of presenting problem, and (2) prevented problems.

Subtheme 1: Resolution of presenting problem. Parents described personal issues for their children being resolved through the parent-child work of filial therapy. Most parents said that this improvement occurred fairly early in their play sessions.

Hannah described how her daughter engaged in sensory activities to soothe herself during their filial sessions. She detailed her daughter doing repetitive actions such as “rubbing her hands through the rice over and over.” Lucy was then able to transfer some of those sensory skills. Hannah explained that this play “provided the opportunity for her to learn how to soothe herself when she was in situations that were stressful for her.” Hannah went on to say that Lucy also demonstrated improvement in her oversensitivity and was able to understand the emotions of others.

She seems to be able to understand emotions better now, the emotions of others. At first, it was all about her feelings. Now when I see her play, she is able to play with multiple figures and have them take on different emotions and perspectives.

Before beginning play sessions, Jessica described how Will had a pattern of non-compliance. Requests for non-preferred activities would result in refusal, passive defiance, or avoidance. This behavior happened most frequently surrounding academic work. She described that this one of the first improvements after beginning their play sessions and that homework became much easier. Jessica and Will started their filial sessions during the summer, and she noted a “huge change” by the time he started back to school in the fall.

Mary described seeing improvements from their play sessions “fairly quickly.” She explained that Anna “leveled out” some after the somewhat “chaotic” start to their play sessions. Mary said, “She was just not as rushed” and was able “to attend to things during the sessions.” She described it as a “settling into the time.” She described “major, major improvements” in Anna’s tantrums.

Sarah explained the difficulty that Devon had at first with adjusting to her expectations after being in foster care. When Devon encountered a rule, she would often cry and tantrum.

She (Devon) had been raised with no schedule, no rules, living in two foster homes, which were good ones. They took good care of her and Kathleen. There was not a lot of consistency in her life, so rules were hard for Devon at first. Understanding having to come up with, a structure, with the rules. Bedtime is the same time every day. You eat your vegetables, things like that. That was new-er for her. So like most kids, when I started putting those structures, those routines into place, there was quite a bit of push back. She cried. She tantrum-ed, but it did not take long. She figured it out. She is a smart girl.

Subtheme 2: Prevented problems. Parents also described their belief that long-term filial therapy helped prevent problems and challenges that their child may have had. Jessica pointed out when they started filial sessions Will was not confident due to his difficulties with reading. He was avoiding any activity related to reading, including participating in church readings. She noticed that his lack of confidence was beginning to spread out into other areas of

his life. However, the filial sessions helped “head a lot of problems off at the pass. We kept them small and manageable, instead of them becoming big.”

Sarah explained that she started filial sessions with Kathleen and Devon as a “proactive” measure. Since the girls were removed from their mother’s custody and placed into foster care, Sarah hoped that the filial sessions would help the girls form an attachment with her.

Like I said at the beginning, she was removed from her mother’s custody when she was just a few months old. While she did have very loving and stable foster mothers, that early caregiver...her mother...that was disrupted. I think that Kathleen escaped some of the negative outcomes because I believe that Devon filled that role for that temporary time. In fact, I know she did. So anyways, I really hoped that our play sessions would protect her... would counter any negative impacts from the lack of their mother being there...In fact, I really hoped this for both of the girls.

John believed that the filial sessions with his children helped them be more “well-adjusted” teenagers. He went on to explain that his children were not that “susceptible to all the peer pressure.” He did not worry about his children “getting into trouble or drugs.” His children had an attitude of “I don’t need to fit in with the crowd.” John said, “I don’t think they were really susceptible to that because the foundational elements that were applied when they were younger were in place to where they had a better sense of their self.” He added, “I think that they’re better equipped to navigate some of the emotional and social challenges that life is gonna’ throw at them.” John came to see his children as having developed a self-confidence and coping skills through their work in filial therapy.

Hannah explained that filial sessions may have had a preventative effect on Lucy’s behaviors. She explained that she and Lucy always have sessions before and after she has to go out of town on a work trip. This helps her adjust to the schedule changes. Hannah also observes Lucy’s behaviors. If Lucy begins demonstrating oversensitivity to social situations, changes in

routine, or her sleep starts getting disrupted, Hannah will hold a filial session with her to prevent the behaviors from escalating.

Nancy also described filial sessions having a preventative effect on Molly's impulsive behaviors. As Molly got older, she started requesting to do activities inside of their filial sessions that may have been frowned upon outside of the session.

[Speaking as Molly] 'I would really like to cut the hair off all my Barbies.' It really became unique and different. And I would be like, 'We can't cut the hair off all our Barbies, but that one that the dog chewed, you could probably do that one.' Right, so her ADHD and her impulsivity had a place where she would ask permission to do stuff...she had a place to ask to do these things that were unique and different. You know, kind of edgy, right? Messy...she had a place to do that and so it worked for her.

Summary. Parents described ways their child benefitted from filial therapy sessions. This theme was composed of two subthemes; resolution of presenting problems and prevented problems. Parents said that there was an improvement in their child's behavioral problems including increased self-regulation and compliance. Parents also thought that filial sessions prevented issues from occurring, which might have otherwise been expected to arise as problems in development.

Theme 6: Parent Benefits of Long-term Filial Therapy

Each parent mentioned personal benefits that they have experienced as parents as a result of long-term filial therapy. Subthemes include (1) personal change, (2) other relationships, and (3) family of origin issues.

Subtheme 1: Personal change. Parents discussed the "way they were" before they started special play time with their child. They often described themselves in contrast to the type of parent they are now, as a result of holding play sessions with their children.

Due to her experience with her daughter, Hannah explained that she became more accepting of differences. She realized that it is more important to meet individuals where they are before jumping to a diagnosis. Hannah went on to explain that before she had Lucy

I would have said ‘Oh yeah, she has autism.’ or something like that. I would have pushed that parent to get all those services for their child, have them tested, all that. But, then, when it is your own child...somehow all that goes out the window.

Hannah explained that now her perspective has changed such that she sees that some children are “quirky” and “just need more time” before they are diagnosed. Hannah also expressed that long-term filial therapy helped her develop “an appreciation of my child. A deep appreciation of her that I may not have had.” It also helped her develop a belief that children “can work some things out on their own.”

Before Mary started filial therapy with her child, she was planning on returning back to work because she could not handle Anna’s behaviors. She did not anticipate the impact that the special time would have on Anna. Due to the positive change in Anna’s behaviors, Mary decided to remain home. Mary also described a sudden shift in understanding the importance of holding special play time. “It all sort of clicked...I was like, yes. I can do this for my daughter. She needs this.” She also described an affinity to filial therapy. “Filial just really drew me in. Something about it just resonated with me. It made sense to me.” Mary hypothesized that filial attracted her because it was so different than the types of therapy she had been exposed to through her oldest daughter, Katherine, who has a severe disability. Mary explained that Katherine’s therapies were tailored to meet her intense needs. These therapies were very directive, therapist-led, and highly structured.

Nancy described a personal transformation in how she viewed her son's behavior. She admitted that there was a "codependency there at that stage [before filial therapy] that that drove me as if my behavior was somehow based on that way he was reacting. Instead of allowing him to have his own feelings." She explained that there was not "enough separation in my parenting to realize that I had a unique human being here and I needed to focus on what he needed." After being trained on filial therapy, Nancy described difficulty reconciling her "Type A personality" and the need to get "stuff done" with pausing to have special play time with her children. However, she also credited her personality to helping her persist in holding special play times. She described their special play time as being a "holy space" where she could be "available" for her children. She also credited filial therapy as her ability to parent "without guilt."

Subtheme 2: Other relationships. Parents described benefits that occurred in other relationships as a result of long-term filial therapy. The communication and listening skills used during filial sessions transferred out of the play sessions and into other relationships. Nancy said, "It was a fantastic gift from God that I have been able to apply to my life everywhere. As a friend, as a wife, as a daughter, everywhere."

Nancy and John expressed that filial therapy benefitted their marriage. Nancy said, "It mattered in our marriage. Oh my gosh, did it matter in our marriage. We didn't know how to talk and listen to each other. And we needed to be taught that." She went on to describe the logistics surrounding her and John's filial therapy sessions also required them to depend on each other and work together. John expressed that "learning [what] to do with my children, I would do too...listen and be present with my wife." He went on to say,

And in my marriage, like with the filial therapy, it's like I said, I learned to be, to (Pause) Listening and hearing are two different things. I heard what you said, but I really didn't

listen to the words, or I really didn't understand what you meant. And sometimes, what I had to learn, too, is when someone's talking to you, sometimes they just want you to listen. And sometimes they, hopefully when they tell you when they want your solicited feedback.

Jessica explained that her relationship with her son who did not participate in long-term filial therapy also benefitted. She stated that filial therapy created an “atmosphere of openness, and trust....it has made a difference with [both] the boys.” She confidently explained that “both of my boys can talk with me about just anything. And with their dad too.” Her husband did not engage in filial sessions, but the sessions created an opportunity for their children to trust him too.

Nancy also described how her relationship is different with her nieces and nephews as a result of filial therapy. Her brothers and sisters notice that their children are willing to do things for Nancy that are difficult at home. She provided examples such as the children going to bed on time and being willing to have a diaper change.

The biggest thing is probably the fact that we are not these other people's parents. Right? That matters. But the way that we approach the situation is also uniquely different because we know how to play with these kids where they are at.... It was different. Yeah, no one could put a name on it because they can't associate it with special play time, but that's what it is.

John explained that the non-judgmental, accepting attitude that is learned in filial therapy has been beneficial to him in his workplace. He provided an example of how special play times with his children carried over into his relationships with his co-workers.

Because you know, when you go to work and there's that one co-worker that just drones on and on and on. Instead of being annoyed by it or being put off by it, I could just be present in the moment and let them have their space, without judgment. Not necessarily encouraging it, but to be less affected by it.

Subtheme 3: Family of origin. Parents described a longing that their parents had interacted with them in a similar way. Mary explained, “Parents just did not play with their children like I was playing with Anna. I remember thinking while we were working with Dr. Smith...whoa! I would have loved if my parents had played with me like that.” John described a difference in how he communicated with his parents compared to how his children communicate with him.

The oldest, will share with us things that would blow my mind, because I would never have talked about those things with my parents, never would've approached them about those things. I was too embarrassed or awkward. Not that I didn't think my parents would ultimately support me, but it just wasn't the way things ... I didn't think that was the way things were done, like talking about sex and girls and things like that. It was like, "No way. Talk to my mom? No way."

Other parents described long-term filial therapy as a way to resolve family of origin challenges. Nancy described how long-term filial therapy impacted her relationship with her parents. She explained that in her family of origin she “never felt heard.” When she learned about filial therapy, she exclaimed that “little tiny Nancy was just yes (emphasized)! This is what you needed, right? It filled this gaping, open hole of my own childhood because I was like, ‘I needed this.’” She explained that filial therapy allowed her to move past her parents’ shortcomings and has given her peace and acceptance. “For a long time, I thought my parents did so much wrong, I couldn’t see the right that they did.” She went on to describe the change. “For a long time with my parents, it was, ‘You did this, you did that, you did the other thing. You weren’t available, you weren’t’...and I have switched gears back to that openness and opportunity.”

Summary. Parents detailed benefits as a result of providing long-term filial therapy to their children. The subthemes included personal change, other relationships, and family of

origin. Parents described changes regarding how they viewed their child and areas of their life they wanted to improve. Parents explained improvement in relationships with other people in their life including their spouse, other children, and coworkers. Finally, parents described that they wished their parents had engaged with them using filial skills. One parent also described how filial therapy helped her resolve significant family of origin issues.

Theme 7: Parent and Child Benefits

Each parent highlighted benefits that were experienced in the parent/child relationship. The subthemes include (1) relationship and (2) communication.

Subtheme 1: Relationship. Parents described a positive change in the relationship between them and their child as a result of long-term filial therapy. Hannah said, “I think that it has really just created a great bond between me and her...I really enjoy being around her. I think that trusting my gut and going the filial route helped develop this.”

Jessica described the last year of her and Will’s play time. She believes that Will was not working through huge issues during this last year, however he still prioritized the sessions with his mother. “I think he just saw the time as a chance for he and I to connect. He knew he would have my undivided attention for that time with no one else around. No little brother. No dad. Just me and him.” Jessica also noticed that Will sought to have time with her outside of filial sessions. “We still found opportunities to spend time together. You know? It was just sort of informal. We may find little times here and there to play or to do something.”

Nancy described “a closeness” with her children that she would have not had if it were not for their special play times. She explained

What I do notice is a difference in my relationships with my children. And I have had many, many people comment on that. On the kinds of conversations that we have.

Because I have older children that have done things that I would have never done in a million years with my parents. And things that other people are like ‘No way. Your kids did not do that’.

John described his now older children making family time a priority. They have regular family dinners. His children initiate activities on a regular basis to spend time with him and his wife (Nancy, Participant 5). He described his oldest child finding unique recipes to cook with Nancy. The two of them shop for ingredients and cook a meal together. John explained that although Kyle is an adult, “That’s like their special playtime.” John believes that Kyle’s desire to spend time with Nancy stems from their filial sessions. John said that even though Molly has aged out of filial sessions, she still seeks time with her parents. She often asks them to play games with her or watch a show with her.

Mary attributed filial therapy to the closeness of the relationship between her and Anna. Mary and Anna notice a difference between the relationship that peers have with their parents.

I think it has lend[en]d itself to a much closer relationship, with me and her dad. She talks about how she has friends who hate being at home...who just stay in their room when they are at home. I mean, she wants to go away for college for independence, but not that she is trying to get away from us. But we, definitely have a relationship.

Sarah also described that her hope for her daughters was to form an attachment with her as a result of their filial sessions. Sarah said, “I can say a lot of the things I worried about when they were young, it’s all turned out fine.” She went on to say, “Many children who have attachment issues...don’t turn out like that.”

Subtheme 2: Communication. Parents describe an ease of communication with their children that they attribute to the listening and communication skills learned in filial therapy. Jessica explained that “some of the things [filial therapy communication skills] go with you.

How I talk with him...it is just my style of parenting.” She described a recent issue that Will was having in school.

Will shared about some conflict with some boys at school. Instead of me telling him what to do, I just listened to him...asked some questions about his actions...what he thinks he should do...Try not to give my ten cents unless he really needs it. But I trust that he knows what to do. He may just need a space to figure that out. Or run it by someone first.

She went on to describe that there is “open communication at our home.” This “atmosphere of openness, and trust” extends to the both of her children, even though only one of them participated in filial therapy. She went on to say that her children are willing to approach her and her husband with challenging issues, even ones that she believes other children may not share with their parents.

Mary described the communication skills she utilized within filial therapy sessions with her daughter.

It was really just letting her be her. Just being open...maybe like, I see you are mad at that Barbie. I think that was the biggest thing, telling her what I saw her doing or telling her what I saw she was feeling, or what the toys were doing. Or whatever she was playing with. ...I also remember not telling her what things were...keeping the options open. Letting her decide things.

Mary believes that she retained the communication skills that she learned during her filial therapy experience. She said, “I think I really kept that language, that way of talking. I think that will always sort of be part of my communication.” Mary went on to describe the frequent communication she has with her daughter about the challenges of having two siblings with disabilities.

We have had to have those conversations with her. You are not the third parent. Like, that’s not your role. Sometimes she has to have those conversations with us if she is feeling like the third parent and we have to make adjustments. We can make changes

accordingly rather than have her resent it. So, I feel like this has created an opportunity for her to be able to have these hard conversations and we have had to have a lot of them.

She also discussed that the ease of communication is noticed by Anna's friends when they are visiting.

There is a comfortable place in our home. It is funny. Even with her siblings, our house is the hang out house. Her friends don't mind talking about whatever is going on...you know, who likes who, who is doing what, right in front of us. So, they see something too. I think, just something different from what they may see at home.

Sarah discussed the impact that filial therapy had on the communication with her daughters. In current conversations with them, she described conveying acceptance and understanding, especially in difficult situations. "If they sound upset about something, I acknowledge that. I let them notice when I see how they are feeling." She admits that she struggles conveying listening skills all of the time, and she recognizes that is not beneficial to her daughters.

No one is perfect. I am still a human. I have the tendency to tell my girls what to do. I can get in that mode. But really, that does not help them. Now listening, really listening to them... trusting them to make the best decisions for themselves, that goes a lot further to me, and to them too.

Textural Description

The textural description of a phenomenological study is a narrative that describes the participants experiences of a phenomenon (Yüksel & Yildirim, 2015). The textural description utilizes verbatim quotations from the participants to provide an understanding of "what" the participants experienced. The textural description of parents' experiences with long-term filial is as follows.

Parents who engaged in long-term filial therapy with their children came to filial therapy as a result of their children's behavioral challenges. Parents cited temper tantrums as the primary

challenge. Mary said, “The hardest part was just the daily behaviors. Constant tantrums over things, like little things. You know not getting what she wanted for breakfast or you know, just things that were just exhausting to deal with as parents.” Parents had secondary reasons for coming to filial therapy. Parents came to filial therapy to support their children with disabilities Nancy said,

My middle son is on the autism spectrum, so he’s got needs that are different than my oldest son. My daughter because we adopted her, she’s got even more demanding needs. She has reactive attachment disorder, she has a learning disability, she has ADHD that’s so high off the charts.

Parents of children with disabilities sought filial therapy to support their child without a disability. Parents described the non-disabled child as taking on too many responsibilities related to their siblings. Nancy said,

He (Kyle) would ask me mom how are you going to handle this without me? How are you going to do this, and I would be like dude, (laughter) you are taking on way too much! Like you don’t need that. That’s not your problem. I am the parent.

Parents with adopted children hoped that filial therapy would build a secure attachment between them and their child. Parents had circumstances that created a distance between them and their child. They hoped that filial therapy would bring them back together. Jessica said,

Our relationship was not bad, but I just feel like we were missing something. We just needed a positive connection. Something good, you know. We needed a way to sort of re-find each other. With my school and his school issues. We just sort of needed something to bring us back together.

Finally, parents hoped filial therapy would resolve their own feelings of guilt and helplessness.

Parents also participated in filial therapy to ease their curiosity and in response to their gratitude.

Parents described what occurred during their filial sessions. At the onset, parents held sessions with their children once a week for 20-30 minutes. Parents used the same play kit each

week with a variety of toys including art materials, Play-doh, dolls, animal figurines, dress up clothes, a dollhouse, and a sand tray. Children engaged in art activities such as drawing and sculpting. Parents also explained that their children enjoyed high-energy play. Jessica said Will frequently would “let[ting] out some big energy.” Mary echoed that Anna “was never sitting. She was standing. She was jumping.” Children had the opportunity to be creative and create their own games in sessions. John said, “We created a new game with some of the toys, you know, like a new type of game.” Parents also described their children engaging in imaginative play such as family play. Mary said Anna “did a lot of parent play. She was the mom.” Parents observed their children processing events such as death. Sarah described her daughters “reenacting some of her [biological mother] situation that they could understand surrounding her death.” Children frequently processed family issues. Jessica described Will working through conflict with his brother during sessions, and Hannah discussed Lucy working through a family member’s divorce. Hannah said,

She [Lucy] is doing a lot of family play, dollhouse play, right now. I think this is just her way to figure this [divorce] out. She is close with her cousin, and so she has been doing a lot of things like pretending to help her cousin.

Parents also described their children using the sessions to build their self-confidence. While completing art projects, Sarah said her daughter would

often seek affirmation. She would want me to say, “That’s good.” or something positive. She would prompt me to say it, you know. Eventually, she moved to just creating things. She did not need me to affirm her anymore, not in the play sessions.

Parents cited challenges they faced in their filial sessions. Parents mentioned being “tired” and “bored” during their filial session. It was also difficult for parents to set aside time from household duties and the demands of the family schedule to hold filial sessions. It was also

difficult for parents to acquire the nondirective skills required for filial sessions. John said, “I was fighting my whole...nature. My whole design as a being. My natural inclination is to direct and control.” Parents also admitted struggling through their child’s play. John said, “Well, they did things that were not always like, honestly enjoyable to sit through.” When Mary and Anna started their filial sessions, Mary admitted not liking the sessions because Anna’s play was “so chaotic.” Parents worked closely with their filial therapist to resolve these challenges.

Parents also recognized changes in their children that occurred inside play sessions and outside of play sessions. After a significant amount of time, parents reported that the sessions became more “relaxed.” Hannah said, “It doesn’t have to be as rigid as I feel like I was being at first.” Parents said that their session length got longer, and they moved their play sessions outdoors. Oftentimes, parents would have filial sessions without the play kit. Parents allowed the child to bring preferred toys into the session or select novel activities. Hannah and Lucy engaged in outdoor play with a gardening set. Nancy said,

Around 11 or 12, that’s when she [Molly] started, ‘You know I’d rather do special play time outside and dig a hole and pour mud in it.’ And we’d be like, ‘okay!’ We said change out of your Sunday clothes and get into your shorts and a t-shirt. And then we’d go outside. And we’d apply all those same principals to the mud bath. Um, basically it was 20 minutes and it got to be a little longer with her, so it probably got stretched to about half an hour. And, and then we’d just watch.

Communication skills that parents practiced during filial sessions started to generalize outside of sessions. Nancy said, “You can’t help but bring those techniques that you are cementing day after day after day when you are sitting there 20 minutes at a time every week. You can’t help but bring that into your life.” Parents started “noticing more opportunities to play” with their children outside of filial sessions. Children generalized activities that they practiced in filial sessions into “real life.”

Parents allowed their child to take the lead when ending filial therapy sessions. Children started showing disinterest in filial sessions. They asked their parent if they had to have the session or stopped interacting with the parent within the session. When parents asked the child if they wanted to have the session, the child said “No, I think I am good. And...just never came back.” Parents attributed the ending of filial therapy to their child’s age and to the child meeting their goals. Parents experienced a feeling of sadness when the sessions ended. Sarah said,

So when it ended, we all sort of mourned a little. We would refer back to our play times. We would speak of them fondly. We would sort of reminisce, sort of like a person. So that was unexpected. My girls are grown now, and we will talk about our special play times.

Parents described the benefits of filial therapy extending to children and parents, and enhancing the relationship between child and parent. Parents described children benefit by a resolution of the presenting problem. Parents reported a reduction in tantrum behaviors “fairly quickly” after starting filial sessions. Children also became more aware of their emotions and emotions of others. Hannah said, “She seems to be able to understand emotions better now, the emotions of others.” Parents believe that long-term filial therapy was “proactive.” Jessica said filial therapy helped “head a lot of problems off at the pass. We kept them small and manageable, instead of them becoming big.”

Parents described benefits in themselves from long-term filial therapy. Parents experienced personal change as a result of filial therapy. Parents came to an acceptance and appreciation of their child. Parents reported a greater understanding of what their child needed. Mary said, “Yes. I can do this [filial therapy] for my daughter. She needs this.” Parents experienced positive improvements in other relationships. Nancy said, “I have been able to apply [it] to my life everywhere. As a friend, as a wife, as a daughter, everywhere.” Parents also

reported that filial therapy resolved family of origin challenges. Parents echoed that they wished their parents had interacted with engaged with them in a filial manner. John said

I would tell Bonnie's [filial therapist] students that I wanted to give my kids something I never had. Not that I'm a better parent, by any means, than my father, but that that's what I wanted from him, so that's what we gave them. Give them what I needed.

Benefits experienced between the parent and child include a closer relationship and better communication. Filial sessions helped create a “bond” and “connection” between the parent and child. Parents of older and adult children report that these benefits extend far after the filial sessions have ended. Older children seek opportunities to spend time with their parents. John said these opportunities are “like their special playtime.” Filial therapy enhanced the communication between the parent and child. Parents maintained the filial communication skills in daily conversation with their family members. Mary said, “Think I really kept that language, that way of talking. I think that will always sort of be part of my communication.” Parents also reported “open communication” which allowed children to approach them with challenging issues.

Structural Description

The structural description of a phenomenological study depends on imaginative variation to describe “how” the participants experience a particular phenomenon (Yüksel & Yildirim, 2015). This requires the researcher to utilize imagination to explore the phenomenon of interest from multiple perspective until discovering the shared meaning (Moustakas, 1994). Parents in this study, experienced filial therapy through realization, routine, rearrangement, and rewards.

Realization

Parents began their filial therapy experience with a realization that their child needed help to address behavioral challenges. Parents recognized a need to connect or unite with their children. Parents realized that filial therapy was a different way of being with their child that was in stark contrast to their previous way of parenting. Within a short amount of time, parents saw a positive change in their child's behavioral challenges that they attributed to filial therapy. Parents realized that filial therapy also met an emotional need for them.

Routine

Parents got into a routine with their filial sessions. Parents regularly held filial sessions for several years. During this time, children played! Parents demonstrated an attitude of non-judgement, openness, and empathy. Children processed various events going on in their lives including death and family issues. Parents reported internal challenges they had regarding their filial sessions. Parents continued the sessions because they saw a positive impact they had on their child and deemed the time important.

Rearrangement

After dedicating a significant of time to the filial therapy routine, parents noted a rearrangement in their sessions. Children started asking for changes in their sessions. Sessions became less structured and more spontaneous. Parents allowed the children to have sessions outdoors, allowed them to bring items in the sessions that were not part of the play kit, or agreed to the child doing unique experiences. Parents experienced filial therapy generalizing into their everyday life. Parents started seeking opportunities to play with their child throughout the week, and integrated filial communication skills in daily conversation. By the time children aged out of

filial therapy, the filial attitudes and skills were a part of the family culture. While the filial sessions ended, the atmosphere of empathy, openness, and non-judgement remained.

Rewards

Parents experienced rewards as a result of long-term filial therapy. First, parents described rewards that their children experienced improvement in the challenging behaviors that brought them to filial therapy. Parents believed that filial therapy also had a preventative effect on their children. Parents experienced rewards that they attribute to filial therapy. They described changes that occurred in their perception of their children and improved parenting skills. Parents described improvements in relationships with their spouse, co-workers, and other family members due to the listening and communication skills that generalized from filial therapy. Finally, parents described a close relationship with their children marked by open communication.

Essence

Long-term filial therapy is a journey. The experience is marked by a clear beginning when parents come to a realization that their child needs an intervention for their challenging behaviors. There is also a realization that the parent/child relationship could be improved. For years, the journey continues. Parents and children continue to “show up” and regularly hold filial sessions. While this part of the journey seems uneventful, it is the most crucial part of the journey. This time can be tiring and challenging, but it is this routine that begins to cement filial skills which begin to generalize into “real life.” The journey experiences rearrangement when parents and children become more flexible with the “parameters” surrounding play sessions. While the toys and setting may change, the skills remain the same. Following the child’s lead,

there is another rearrangement when the filial sessions end. There is no true ending to the filial journey because the rewards of long-term filial therapy are long-lasting.

Summary

This chapter presented the findings of the descriptive phenomenological study on parents' experiences with long-term filial therapy. After I introduced the participants, I presented the findings from my bracketing interview. Each of the themes and their subthemes were presented from the data analysis. The seven themes that described long-term filial therapy were (1) reasons for coming to filial therapy, (2) descriptions of filial sessions, (3) filial therapy and the process of change, (4) ending filial therapy, (5) child benefits, (6) parent benefits, and (7) parent and child benefits. The textural and structural description of the participants' experiences was developed. Finally, the textural-structural description, or the essence of long-term filial therapy was presented. Chapter Five will discuss the findings from the study.

Chapter Five: Discussion

This chapter presents an overview of parents' experiences with long-term filial therapy. I describe the limitations of the study. Then, I offer a discussion of the study's findings and connect them to the current literature. Additionally, I include my reflections on the data analysis of the study. Next, I discuss the implications this study has for practice. Lastly, I offer suggestions for future research on filial therapy.

Overview of the Study

This study explored the lived experiences of parents who engaged in long-term filial therapy with their children. For the purposes of this study, long-term filial therapy was defined as conducting filial therapy for at least one year after filial therapy training had ended. At the end of filial training, parents are encouraged to continue holding filial sessions with their children. Literature supports the efficacy of filial therapy, but research has not looked at the experiences of parents on a long-term basis. This study used a descriptive phenomenological methodology to answer the research question: What are the experiences of parents who engage in long-term filial therapy? To explore this question, I interviewed six parents who met the study's criteria. Using Creswell's (2007) simplified version of Moustakas's (1994) Modification of the Stevick-Colaizzi-Keen Method of Analysis of Phenomenological Data, I analyzed the interview transcripts. Seven themes emerged from the data which were used to build a textural and structural description of the parents' experiences. Finally, using the textural and structural descriptions, the essence of the experience of long-term filial therapy was developed.

Connections to Previous Literature

My research supports previous filial therapy research in several areas. The findings from this study encourage the use of filial therapy for behavioral challenges. This study also supports positive parental outcomes as a result of filial therapy. Previous research regarding positive improvements in relationships is also supported. Finally, this study also supports the use of filial therapy as a preventative approach for children.

Challenging, disruptive behavior is the most common reason for mental health referrals for children (Neary & Eyberg, 2002). Participants in this study described coming to filial therapy as a result of their child's behavioral challenges. Participants indicated their children demonstrated improvements in the area of uncontrolled outbursts, oversensitivity, and non-compliance. Filial therapy is an effective intervention for these challenging behaviors. A number of previous filial therapy studies demonstrate a decrease in children's problematic behaviors (Ceballos & Bratton, 2010; Lin & Bratton, 2015; Opiola & Bratton, 2018; Villarreal, 2008). Specifically, in a qualitative study (Bavin-Hoffman, et al., 1996) parents reported improvements in child aggression and an improvement in self-control. Parents reported that these positive changes continued for 1-3 years after filial sessions ended. This study supports previous research regarding challenging behaviors being the primary reason for seeking filial therapy. This study also supports previous research regarding the improvements children demonstrate as a result of filial therapy.

This study supports previous filial therapy research that demonstrated additional benefits that children and parents experience as a result of filial therapy. Participants reported personal changes such as a greater acceptance and appreciation of their child. Previous quantitative

research has demonstrated improvements in parental acceptance of their child and increases in parental empathic responses (Bratton & Landreth, 1995; Ray, 2003; Sparks, 2010).

Supporting previous research, participants in this study cited positive improvements in the relationship with their spouse and family of origin after participating in long-term filial therapy. When parents generalize the skills and techniques of filial therapy into other relationships, positive changes occur. Other studies (Bavin-Hoffman et al., 1996; Wickstrom, 2009) have also supported positive changes in the marital relationship after filial therapy. The studies showed improved communication and higher levels of marital unity. Wickstrom's (2009) study also showed that the application of filial skills and techniques positively impacted parents' relationships with their own parents.

Participants in this study also believed that long-term filial therapy was "proactive" and prevented possible negative outcomes. Long-term filial therapy promotes this preventive effect due to the emphasis on the parent/child relationship and parent communication, both of which have been shown to be protective factors for children (Martinez -Torteya, Bogat, Von Eye, & Levendosky, 2009). Overwhelmingly, parents who conduct filial therapy with their child report an improved relationship with their child, as well as better communication with their child (Bratton & Landreth, 2005; Garza et al., 2009; Kidron & Landreth, 2010; Solis et al., 2004; West, 2010).

New Findings

This study contributes several new findings to the body of filial therapy research. First, this study provides a detailed understanding of how filial therapy sessions change as children age. This suggests the need for additional phases to be added to the filial therapy process.

Additionally, this study provided new insight on the use of filial therapy for children who have a sibling with a disability.

Changes in Filial Therapy Sessions

A significant finding of this study was how parents described their filial sessions evolving after conducting filial sessions with their child for a considerable amount of time. At the beginning of filial sessions, parents followed the structure they learned from their filial therapist. These sessions were once a week, lasted from 20-30 minutes, and utilized a play kit with specific toys. As the play continued, parents became more flexible. This did not occur until at least a year into the filial sessions, and some parents did not make this change until even later. Parents described their sessions becoming more spontaneous and did not always require the play kit. Sessions also moved outdoors. Parents allowed their child to select other toys to bring into the session or allowed the child to select novel experiences.

This finding suggests that additional phases should be added to the long-term filial therapy experience. After parents have completed training with a filial therapist, parents move through two phases; generalization and maintenance (Ginsberg, 2012). Lastly, the filial therapist moves to a consulting role with the parents. Two additional phases known as rearrangement and cessation could be added to these phases.

Rearrangement phase. While regular filial sessions can still occur, rearrangement allows the child freedom to alter aspects of the play session such as moving the play to a different setting and incorporating different toys or experiences in the filial sessions. This phase is also marked by the parent spontaneously playing with the child in a filial manner. This phase is flexible and is dependent on the filial skills being mastered and practiced by the parent for a

considerable amount of time. Participants in this study had been holding sessions for at least one year before rearrangement occurred. For some parents, rearrangement did not occur for at least five years. Rearrangement could include small, subtle changes such as allowing the child to bring Legos into the filial session. Larger more novel experiences could also occur such as the child asking to hold a filial session outside so they could create a garden for a doll.

Cessation phase. The cessation phase is marked by the end of filial sessions with the child. This phase is completely child-led. This cessation may be abrupt with the child saying that they do not want to have the filial sessions anymore, or it may gradually phase out. Children in cessation have mastered the language development that allow them to communicate through talk. A meaningful, trusting parent/child relationship has been firmly established. The communication skills learned in filial therapy are being used in most aspects of everyday life. In this study, children started moving towards the cessation phase from age nine to fourteen. This phase is also marked by the child and parent finding ways to “play” that may be more developmentally appropriate. For example, a teenager may ask his parent to wash the car with him.

Siblings of Children with Disabilities

Another finding was the use of filial therapy for siblings of children with disabilities. While parents did use filial therapy with their child with a disability, some parents intentionally focused on the sibling without a disability. Research on children of siblings with disabilities is mixed. Some studies support that siblings are at a higher risk for behavioral problems (Verté, Roeyers, & Buysse, 2003) and internalizing behaviors such as anxiety (Gold, 1993). Other research supports that having a sibling with a disability is not the singular factor that causes these

issues but is more related to a variety of family factors (Tudor & Lerner, 2014). The participants in this study felt that there were benefits for the sibling, especially in regard to helping them manage their role and responsibilities as a sibling. Filial therapy may be a useful intervention for families with children with disabilities to improve outcomes for the non-disabled sibling.

Limitations of the Study

As initially discussed in Chapter Three, limitations associated with this study are: the use of interviews for data, sampling methods, researcher bias, and the transferability of the results. Additional limitations of the study included the definition of long-term filial therapy. I will go into more detail regarding the specific limitations of this study. Data for this study came in the form of interview transcripts. Interviews require the participants to be willing and able to provide information regarding the phenomenon of interest (Flinders, 1997; Giorgi, 2009). Interviews also require the participant to recall information. In this study, five participants had not provided filial therapy for their children for a number of years. Recall of past experiences is subject to greater levels of inaccuracy making it less reliable (Hassan, 2006).

Phenomenological interviews are also dependent on the ability of the interviewer to probe the meaning that participants make of the phenomenon of interest instead of focusing solely on factual information (Brinkmann & Kvale, 2015). This requires a level of trust between the researcher and participant. In this study, I co-created a positive relationship with each participant. This was evidence by their willingness to provide information and specific examples when asked. Participants also expressed interest in the results of the study when it concluded and expressed a hope that more research was done on filial therapy. Looking back over the transcripts, there were opportunities I should have asked questions that focused more on the

meaning of the participant's experience. However, at the end of each interview, I looked back over my notes. If I missed the original opportunity to ask a question, I would simply ask the participant for more information. For example, after reviewing my notes I may have said, "Can we go back to something you said earlier. I realize that I want to know more about your experience allowing Lucy to play outdoors. Can you tell me a little more about what that looked like?" I also gave the participants ample time to think before I moved to the next question, and at the end of each interview I asked if there was anything the participant would like to add.

The method in which participants were recruited was also a limitation to this study. Of the six participants, three were referred to the study by the filial therapist with whom they worked. Therapists may have only recommended participants that they knew were successful. Also, these participants could have felt obligated to participate in the study. Another participant in the study was recruited by the snowball method. While the person that referred her was not her filial therapist, she was engaged in peer supervision with her. This could have also caused a feeling of obligation.

Inherent in phenomenological research, there exists the limitation of researcher bias. Filial therapy is personal to me as I engaged in long-term filial therapy with my son. I attempted to minimize researcher bias by bracketing my experience, using reflective journaling, using multiple data analysts, and member checking. I will discuss my reflections in a later section.

An important component of trustworthiness in qualitative research is transferability (Lincoln & Guba, 1985). Transferability refers to the application of findings to other contexts or settings. This study had a threat to transferability. Two participants in this study are also play therapists. Additionally, another participant was formerly a teacher and holds a doctorate in

early childhood education. These parents' participation could limit transferability because they have more experience in play therapy or they have a greater knowledge of child development than a parent normally would. These participants may have experienced more success with filial therapy due to these factors.

Another limitation of this study was how I defined long-term filial therapy. For this study, long-term filial therapy was defined as the continuation of filial therapy sessions after the parent training sessions have been terminated. While filial therapy is successful for many families (Bratton, Landreth, & Lin, 2010), it should be considered that parents who continued long-term filial therapy for at least one year would only do so if they were being rewarded by successes.

Role of the Researcher

This section will describe my reflections during the research process. I will discuss issues surrounding data analysis. Finally, I will describe how I arrived at the essence of the long-term filial therapy experience.

I was brought to this study because of my own meaningful experience with long-term filial therapy. As previously mentioned, my son and I engaged in long-term filial therapy sessions for almost six years. During my doctoral program, I maintained a small black notebook of questions and wonderings that came up in classes and while reading articles. One of the questions that came up was in response to a passage in Landreth's (2005) chapter on filial therapy. It said that during the last parent training session, the filial therapist was instructed to encourage parents to continue holding filial sessions with their child. I made a note, "What about the parents that keep going with filial therapy?"

Several years later, I was looking back through my notebook, found this note and realized, I was a parent that just kept going with filial therapy! I wondered what other parents' experiences looked like. As noted in my bracketing interview, I recognized changes that were occurring in our play sessions that were not mentioned in filial training. I reflected on these changes. Were they unique to my experience or were they common to other parents? These wonderings and reflections brought my dissertation topic to life.

Data Collection

During the data collection phase, I found myself intrigued by the level of passion and conviction that parents expressed regarding filial therapy. At times it was hard to not share in participants' enthusiasm. During data collection, a few challenges arose. First, one of my face-to-face interviews was difficult to schedule. The participant and I settled for an interview scheduled during a lunch break. This interview felt rushed compared to other interviews. However, when the interview ended and we were leaving the location, the conversation that ensued was extremely meaningful to the participant's filial experience. This conversation was not recorded.

Another challenge was the interview method. One of the interviews held over Zoom had a significant lag for a portion of the interview. When I looked back over my reflections on this interview, I had noted that the participant seemed closed off at the beginning of the interview. As the interview proceeded, she seemed more comfortable. Now I believe the technical issues with the Zoom platform made her appear to be more uncomfortable at the beginning of the interview.

Finally, while preparing transcripts, I followed up with one participant via email and asked her to clarify a statement she made about her son attempting new skills during filial sessions. Her response was added to her transcript for analysis. When I provided the transcripts to the participants for member checking, one participant asked me to strike some identifying information. I deleted this information and followed up again to ensure her request was honored.

Essence

While I was trying to capture the participants' experiences, likening the long-term filial therapy experience to a journey made sense. As I was reading through the transcripts, this quote stood out, "As far as the journey goes, [I am] grateful that I've been on this journey. Wouldn't trade it for anything." This parent had just finished discussing some challenges that he and his son had been having in filial therapy before he made this statement. He was still sure to mention his gratitude for the journey as a whole. Another parent described filial therapy as a path that her family was going down. A different parent said that her experience with long-term filial therapy had "its ups and down."

The use of metaphors in qualitative research is useful when providing a meaning to participants' experiences (Carpenter, 2008). The way in which participants described their filial experience beginning and ending, as well as changes, challenges, and benefits along the way reminded me of journeys described in literature and in travel. What stuck out the most was that although journeys end, the personal rewards gained from the journey, much like the rewards of long-term filial therapy last far beyond the journey's conclusion.

Implications for Practice

The findings of this study support previous research regarding the benefits of filial therapy for parents, children and the parent/child relationship. This study provides important information to filial therapists regarding their clients. Parents who provide long-term filial therapy with their child need to be aware that the experience is truly a journey! As the filial therapist moves into more of a consulting role, they should prepare parents for the eventual changes that may come up in the rearrangement stage of the filial therapy process. Filial therapists will also have to prepare parents to notice the child's lead when ending filial sessions. During cessation, filial therapists must encourage parents to notice how their child initiates activities with them as a replacement for the filial therapy sessions. These activities are developmentally appropriate and could include engaging in hobbies, completing household tasks, or planning family events. If the child does not initiate these activities, the parent may need to provide various opportunities for their child to have meaningful, one-on-one time with them.

It is important for filial therapists to build a relationship with parents that promotes consultation. Parents will continue to experience challenges along the way even after their child has moved to a mastery stage of play (Nordling & Guerney, 1999). Several parents in this study returned to their filial therapist for assistance when issues arose in filial sessions. Filial therapists should intentionally structure a collaborative relationship with filial clients that allows for scheduled check ins, support, and encouragement.

In a study of parents' perceptions of the filial therapy process, some parents said they needed additional support to continue having filial sessions with their children (Bavin-Hoffman, et al., 1996). Filial therapists are encouraged to provide this support for their clients by

providing refresher sessions. Parents could also seek this support through other parents who provide long-term filial therapy for their children. Because filial therapy is not a common experience, parents could also seek this support through online support groups.

Future Research

This study provided more information about parents' experiences with long-term filial therapy. Additional research can further explore this phenomenon. First, the experiences of children who have participated in long-term filial therapy could be examined. These studies would be retrospective, focusing on the benefits that adults perceive as a result of their childhood experience of long-term filial therapy. Research examining the long-term effects of filial therapy could provide more information on the process and outcomes. Most filial therapy research is completed soon after filial sessions have been ended or shortly after parent training. Long term studies could show further impacts on child, parent, and parent/child outcomes. These studies could also examine impacts on other relationships such as outcomes for the non-filial child or family members. Other research could focus on the consultative role of the filial therapist and how parents seek assistance for issues in filial therapy after the training has ended. Finally, the efficacy of filial therapy for the siblings of children with disabilities could be explored.

Summary

The purpose of my study was to describe parents' experiences with long-term filial therapy. I used a descriptive phenomenological design to answer the central research question: what are the experiences of parents who engage in long-term filial therapy? Seven themes emerged from the interview data that described the phenomenon of long-term filial therapy: (1) reasons for coming to filial therapy, (2) descriptions of filial sessions, (3) filial therapy and the

process of change, (4) ending filial therapy, (5) child benefits, (6) parent benefits, and (7) parent and child benefits. Each theme had a number of subthemes. The textural and structural description of long-term filial therapy was described, and the essence of long-term filial therapy was developed. Major findings from this study include how the play changes over the course of long-term filial therapy. This causes consideration for additional phases to be added to filial therapy. Other findings include the use of filial therapy for children of siblings with disabilities.

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Appendices

Appendix A

Request to Filial Therapists for Participants

Dear (Filial Therapist),

I am conducting my dissertation about the lived experiences of parents who engage in long-term filial therapy. I am writing this email to ask for your help in recruiting participants for this research project. If you have any clients or former clients who have provided long-term filial therapy for their children, I would greatly appreciate if you could pass on my information to them so they can contact me.

For the purpose of this study, long-term filial therapy is defined as “parent/child sessions that continue taking place for *at least one* year after formal supervision/training from the filial therapist has ended.” I will conduct a 45-90 minute interview with the parent regarding their experiences. Interviews will be recorded, and the recordings will be erased after they are transcribed. No identifying information will be used in any materials created from these transcripts.

There will be no direct benefit to you if you choose to share my contact information with your clients/former clients, however your assistance will contribute to the body of knowledge surrounding filial therapy. Participants will receive a \$15 Amazon eGift card upon completion of the interview.

Please provide this sheet to your client/former client. My contact information where they can contact me is below. Thank you for your time!

Blair Sumner Vincent, Ed.S., NCC
Doctoral Candidate
The University of Tennessee
(865) 805-4994
bmynatt@vols.utk.edu

Appendix B

Request to CESNET and American Counseling Association List serves for Participants

Dear _____,

I am conducting my dissertation about the lived experiences of parents who engage in long-term filial therapy. I am writing this email to ask for your help in recruiting participants for this research project. If you have any clients or former clients who have provided long-term filial therapy for their children, I would greatly appreciate if you could pass on my information to them so they can contact me.

For the purpose of this study, long-term filial therapy is defined as “parent/child sessions that continue taking place *for at least a year* after formal supervision/training from the filial therapist has ended.” I will conduct 45-90 minute interview with the parent regarding their experiences. Interviews will be recorded, and the recordings will be erased after they are transcribed. No identifying information will be used in any materials created from these transcripts.

There will be no direct benefit to you if you choose to share my contact information with your clients/former clients, however your assistance will contribute to the body of knowledge surrounding filial therapy. Participants will receive a \$15 Amazon eGift card upon completion of the interview.

Please provide my contact information to your client/former client. Thank you for your time!

Blair Sumner Vincent, Ed.S., NCC
Doctoral Candidate
The University of Tennessee
(865) 805-4994
bmynatt@vols.utk.edu

Appendix C

Facebook Post

Professionals and parents: I am recruiting participants for a study that examines families engaging in long-term filial therapy (defined as filial sessions continuing for *at least a year* beyond professional supervision). If you or one of your clients meet this criteria, please have them message me for further information. Participants will receive a \$15 Amazon eGift card upon completion of the interview.

Appendix D

First Email for Contact Information

Dear _____,

Thank you for demonstrating interest in my research study that examines long-term filial therapy. For the purposes of this study, long-term filial therapy is defined as “the continuation of filial therapy sessions for at least one year after parent training sessions have terminated.”

I am a doctoral candidate in the Counselor Education program at The University of Tennessee. In addition, I am also a filial parent.

Please provide the best way to get in touch with you to schedule an interview. I can conduct interviews face-to-face (if travel permits), over the phone, or via Zoom (an online meeting platform).

An informed consent form is attached to this email. Please look over it and let me know if you have any questions.

Thank you,

Blair Sumner Vincent, Ed.S., NCC
Doctoral Candidate

Appendix E

Informed Consent

Consent for Research Participation

Research Study Title: A Phenomenological Investigation of Long-Term Filial Therapy

Researcher(s): Blair Sumner Vincent, The University of Tennessee, Knoxville
Dr. Jeff Cochran, Faculty Advisor, The University of Tennessee, Knoxville

Why am I being asked to be in this research study?

We are asking you to be in this research study because you have conducted long-term filial therapy with your child. Long-term filial therapy is defined as “parent/child sessions that continue taking place for *at least one* year after formal supervision/training from the filial therapist has ended.”

What is this research study about?

The purpose of the research study is to understand parents’ experiences who conduct long-term filial therapy with their children.

How long will I be in the research study?

If you agree to be in the study, your participation will include one interview that will last for approximately 45-90 minutes.

You also have the option to provide feedback to 2 separate emails about the study within two months of your interview. This is completely voluntary and expected to take 10-20 minutes.

What will happen if I say “Yes, I want to be in this research study”?

If you agree to be in this study, I will ask you to participate in one interview about your experience with long-term filial therapy. Interviews can take place in person, over the phone, or over a Zoom conference (online meeting platform) – this will be your decision. If we agree to meet in person, you can select the location.

It is estimated that the interview will last about 45-90 minutes. I will ask you some questions about your experience with long-term filial therapy. Your responses will be recorded.

About two days after the interview, I will email a copy of the transcript from your interview to you. You can provide feedback on your transcript. This feedback can include the request to remove information and/or to verify that I have fully captured what you wanted to say in the interview. This feedback is completely optional.

At the conclusion of the study, I will provide a copy of the study results to you. You can provide feedback about the results. This is estimated to occur in April 2019. This is completely optional.

What happens if I say “No, I do not want to be in this research study”?

Being in this study is up to you. You can say no now or leave the study later. Either way, your decision won't affect your relationship with the researchers or The University of Tennessee

What happens if I say “Yes” but change my mind later?

Even if you decide to be in the study now, you can change your mind and stop at any time. If you decide to stop before the study is completed, please contact Blair Vincent at bmyntt@vols.utk.edu. Your interview data will be destroyed and not used in the study. You will have until approximately March 10, 2019 to make this decision. After this time, the research results will be finalized.

Are there any possible risks to me?

It is possible that someone could find out you were in this study or see your study information, but we believe this risk is small because of the procedures we use to protect your information. These procedures are described later in this form.

Another possible risk includes emotional distress. To minimize this risk, you have the right to only answer the questions you feel comfortable answering. If you appear to experience significant emotional distress, I will provide a list of referrals for counselors in your area. The referrals will generate from the Find a Therapist feature on the *Psychology Today* website.

Are there any benefits to being in this research study?

We do not expect you to benefit from being in this study. Your participation may help us to learn more about long-term filial therapy. We hope the knowledge gained from this study will benefit others in the future.

Who can see or use the information collected for this research study?

We will protect the confidentiality of your information in several ways:

- The digital recording of your interview will be stored on a password protected jumpdrive. The recording will be erased after the interview is transcribed. Only I, Blair Vincent, will have access to the recorded interviews.
- Your identifying information will be removed from your transcript. Only pseudonyms will be used in transcripts. Transcripts will be stored on a password protected jumpdrive. Transcripts will be shredded three years after the study is over.
- I will email you a copy of your transcript to review to make sure that all identifying information has been removed. If there is any part of your transcript that you want me to remove or change, I will.
- The research team will receive electronic copies of your transcript via email. They will only receive a copy of the transcript with pseudonyms.

- A professor and a graduate assistant from The University of Tennessee are a part of my research team. Dr. Jeff Cochran is a professor of counselor education and the chair of my dissertation committee. Ms. Mary Wynn is a graduate student who has had data analysis training.
- I will keep a copy of your informed consent in a locked filing cabinet in my home office. The research team will not have access to the informed consent. I will destroy your informed consent three years after the study is over.
- I will correspond with you from a password protected email account on a password protected laptop.
- When the research study is over, I will delete the email archive of our correspondence.
- There will be a history on my Amazon account that shows the delivery of an Amazon eGift card to your email account. I will not include the reason for the delivery of the gift card when I send it to you.

If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information or what information came from you. Although it is unlikely, there are times when others may need to see the information we collect about you. These include:

- People at the University of Tennessee, Knoxville who oversee research to make sure it is conducted properly.
- Government agencies (such as the Office for Human Research Protections in the U.S. Department of Health and Human Services), and others responsible for watching over the safety, effectiveness, and conduct of the research.
- If a law or court requires us to share the information, we would have to follow that law or final court ruling.

What will happen to my information after this study is over?

I will not keep your information to use for future research. Your name and other information that can directly identify you will be kept secure and stored separately from your research data collected as part of the study.

Will I be paid for being in this research study?

You will receive a \$15 Amazon eGift card after completing the interview for this study. The Amazon eGift card will come to you via email from Amazon.com. Your email address will be required for the delivery of the gift card.

What else do I need to know?

Number of research participants. About 6-12 people will take part in this study. Because of the small number of participants in this study, it is possible that someone could identify you based on the information we collected from you.

We use procedures to lower the possibility of these risks happening. Even so, you may still experience problems or injury, even when we are careful to avoid them. Please tell the researcher in charge, Blair Vincent, 865-805-4994 about any problems that you have during this study.

If you experience emotional distress, I will provide a referral for counselors in your area. The referral list will come from the Find a Therapist feature on the *Psychology Today* website. If you experience emotional distress outside of the study interview, please inform the researchers as soon as possible.

The University of Tennessee does not automatically pay for medical claims or give other compensation for injuries or other problems.

Who can answer my questions about this research study?

If you have questions or concerns about this study, or have experienced a research related problem or injury, contact the researchers, Blair Vincent, blairvincent11@gmail.com, 865-805-4994; OR Dr. Jeff Cochran, jcochr11@utk.edu, 865-974-4173.

For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board
The University of Tennessee, Knoxville
1534 White Avenue
Blount Hall, Room 408
Knoxville, TN 37996-1529
Phone: 865-974-7697
Email: utkirb@utk.edu

STATEMENT OF CONSENT

I have read this form and the research study has been explained to me. I have been given the chance to ask questions and my questions have been answered. If I have more questions, I have been told who to contact. By signing this document, I am agreeing to be in this study. I will receive a copy of this document after I sign it.

Name of Adult Participant

Signature of Adult Participant

Date

Researcher Signature (to be completed at time of informed consent)

I have explained the study to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to be in the study.

Name of Research Team Member

Signature of Research Team Member

Date

Appendix F

Interview Protocol

1. Please tell me your age.
2. What is your race?
3. Which word best describes your socioeconomic status?
Lower
Middle
Upper Middle
Upper
4. What is the Age or what are the ages of Child(ren) participating in filial therapy?
5. How did you learn to provide filial therapy for your child?
6. How long have you and your child participated in filial therapy sessions?
7. Are you currently still working with a filial therapist?
8. Tell me about your experience with filial therapy.

Additional prompts or questions will result from responses to this question, including:

“Tell me more about...”

“What did you mean when you said...”

“How did you feel when...”

Appendix G

Participant Transcript Review

Dear _____,

Thank you for participating in my study on long-term filial therapy. I am attaching a copy of the transcript from your interview for you to review. If there is any information you would like me to delete or change, please let me know within one week. I want to make sure I captured your experience with long-term filial therapy as accurately as possible.

With gratitude,

Blair Vincent, Ed.S., NCC
The University of Tennessee
Doctoral Candidate

Appendix H

Email to Participants Regarding Findings

Dear _____,

Thank you so much for participating in my study on long-term filial therapy. I am attaching a summary of the results from the study for you to review. If you have any input on the results, please respond within one week. Thank you for adding to the knowledge on filial therapy!

Best,

Blair Vincent, Ed.S., NCC
Doctoral Candidate
The University of Tennessee

Appendix I

Professional Referral Protocol

If a participant appears to be in emotional distress during our interview or if the participant later reports emotional distress, I will make a referral to a mental health provider.

1. I will encourage the participant to make contact with the individual who trained him or her in filial therapy.
2. I will also provide a list of at least three mental health providers in their area (zip code). I will obtain this list from the “Find a Therapist” feature on the *Psychology Today* website.
3. I will email the list of mental health providers to the participant.

Appendix J

Research Team Member's Pledge of Confidentiality

As a member of this project's research team, I understand that I will be reading transcriptions of confidential interviews. The information in these transcripts has been revealed by research participants who participated in this project on good faith that their interviews would remain strictly confidential. I understand that I have a responsibility to honor this confidentiality agreement. I hereby agree not to share any information in these transcriptions with anyone except the primary researcher of this project, his/her doctoral chair, or other members of this research team. Any violation of this agreement would constitute a serious breach of ethical standards, and I pledge not to do so.

Research Team Member

Date

Vita

Blair Sumner Vincent was born in Clarksville, Tennessee to the parents of Philip and Laura Sumner. Blair has a younger brother, Wesley. She graduated from the Clarksville Academy. Blair earned her Bachelor of Science degree in Special Education from the University of Memphis in 2003. While working as a special education teacher in the high school setting, she graduated from The University of Tennessee with a Master of Science in Counseling with a concentration in School Counseling in 2007. Blair has experience as a school counselor in the elementary and high school settings. She accepted a graduate teaching assistantship at The University of Tennessee as a career counselor for Career Services. While a doctoral student, Blair served in a variety of leadership positions including Chi Sigma Iota Leadership Intern and as the graduate student representative for the American Counseling Association. Additionally, Blair has co-authored peer-reviewed journal articles and presented at local, state, regional, and national conferences. Blair earned graduate certificates in Gerontology, Qualitative Research Methods in Educational Settings, and Evaluation, Statistics, and Measurement. Blair was admitted to the Memphis Leadership Scholars Program at the University of Memphis and graduated with an Educational Specialist degree in Education in 2017. She will graduate with a Ph.D. in Counselor Education in August 2019 and will continue serving the children at Collierville Elementary School. Blair is the proud mother of Hunter and Presley.