

EXPLORING PARENTS' PERCEPTIONS OF EXTERNALIZING AND INTERNALIZING
BEHAVIORS AND THEIR CHOICE OF THERAPY

by

Rachel Williams

March, 2017

Directors of Thesis: Andrew Brimhall, PhD

Major Department: Human Development and Family Science

Mental health problems in children, such as the prevalence of externalizing and internalizing behaviors are a growing crisis in the United States. The economic shift in recent years has resulted in many parents working increased hours and spending less time as a family, which often results in increased problematic behaviors. In response to the relationship discord and behavior problems in children, filial play therapy is recommended as an effective treatment option. Although filial play therapy is a supported treatment, societal views on play are examined, revealing that many parents disregard the importance of play for a preferred focus on academic achievement. This article reflects parent's concern of externalizing and internalizing behaviors in boys and girls based on a provided behavioral vignette. Parents' recommended therapeutic treatment based on level of concern is also explored. Suggestions are provided as to how systemic change might be implemented within these families through parent and child participation in filial play therapy, specifically when parents report reluctance towards participation in play therapy.

EXPLORING PARENTS' PERCEPTIONS OF EXTERNALIZING AND INTERNALIZING
BEHAVIORS AND THEIR CHOICE OF THERAPY

A Thesis

Presented to the Faculty of the Department of Human Development and Family Science

East Carolina University

In Partial Fulfillment of the Requirements for the Degree

Master of Science in Marriage and Family Therapy

by

Rachel Williams

March, 2017

© Rachel Williams, 2017

EXPLORING PARENTS' PERCEPTIONS OF EXTERNALIZING AND INTERNALIZING
BEHAVIORS AND THEIR CHOICE OF THERAPY

by

Rachel Williams

APPROVED BY:

DIRECTOR OF THESIS: _____
Andrew Brimhall, Ph. D

COMMITTEE MEMBER: _____
Katharine Didericksen, Ph. D

COMMITTEE MEMBER: _____
Sandra Lookabaugh, Ph. D

CHAIR OF THE DEPARTMENT
OF HUMAN DEVELOPMENT
AND FAMILY SCIENCE: _____
Sharon Ballard, Ph. D

DEAN OF THE
GRADUATE SCHOOL: _____
Paul J. Gemperline, Ph. D

ACKNOWLEDGEMENTS

I would like to express my deepest gratitude to the director of my thesis, Dr. Andrew Brimhall, for his excellent guidance, patience, motivation, and continuous support. His continued support and knowledge allowed me the opportunity for significant growth in my research and writing abilities. Thank you for continuously pushing me to always give a little more than my best.

I would also like to thank my other committee members, Dr. Katharine Didericksen and Dr. Sandra Lookabaugh, for their continued patience, encouragement, and insightful feedback.

I am thankful for the support and encouragement from my entire cohort. Thank you for continuing to encourage me when it seemed as though the end would be forever out of reach.

Most importantly I would like to thank my family. Thank you to my parents for encouraging me to continue to follow my dreams, even when it seemed as though my dreams were out of reach. You have always been my biggest fans. Finally, I am forever grateful for the support and encouragement I have received from Will. Thank you for your patience, encouragement, support, and all of the sacrifices you've made that have allowed me to succeed.

TABLE OF CONTENTS

TITLE PAGE	i
COPYRIGHT.....	ii
SIGNATURE PAGE	iii
ACKNOWLEDGEMENTS	iv
LIST OF TABLES	viii
CHAPTER 1: INTRODUCTION	1
Childhood Mental Health.....	1
Emotional and Behavioral Problems in Children	2
Gender Differences	3
Long Term Effects of Externalizing and Internalizing Behaviors	3
Filial Play Therapy.....	4
Parent Perceptions of filial play therapy.....	5
Purpose Statement.....	6
CHAPTER 2: LITERATURE REVIEW	7
Societal Factors Increasing Child Maladaptive Behaviors	7
Parents' Increased Work Hours	8
Impact on Parents' Mental Health	9
Increased Marital Tension due to Nonstandard Work Schedules	10
Externalizing and Internalizing Behaviors.....	10
Externalizing Behaviors.....	11
Internalizing Behaviors	11
Co-existing Behaviors	12

Gender Differences	13
Parental Response to Child Behaviors	14
Gender Based Response.....	15
Variations in Mothers' and Fathers' Responses	16
Effective Treatment	16
Decreasing Behaviors	17
Societal Views on Play	17
Parental Views	18
CHAPTER 3: METHODOLOGY	22
Design	22
Data Collection	24
Participants	24
Selection Criteria	24
Recruitment.....	25
Procedures.....	25
Measures	26
Demographics	26
Vignettes	26
Face Validity.....	28
Qualitative Response	28
Parental Stress Scale	28
Data Analysis	29
CHAPTER 4: RESULTS.....	31

Hypothesis 1:	31
Qualitative Analysis.....	33
Hypothesis 2:	35
CHAPTER 5: DISCUSSION.....	37
A Systemic Understanding of the Findings	37
Participants' Report of Vignette Behavior	38
Gender Differences on Level of Concern.....	39
Participants' Report of Recommended Treatment	42
Clinical Implications	43
Limitations	46
Future Research	47
Conclusion	48
REFERENCES	50
APPENDIX A: INSTITUTIONAL REVIEW BOARD APPROVAL.....	61
APPENDIX B: VIGNETTE 1 – MALE EXTERNALIZING	62
APPENDIX C: VIGNETTE 2 – FEMALE EXTERNALIZING	64
APPENDIX D: VIGNETTE 3 – MALE INTERNALIZING.....	66
APPENDIX E: VIGNETTE 4 – FEMALE INTERNALIZING	68
APPENDIX F: PARENTAL STRESS SCALE.....	70

LIST OF TABLES

1. Correlations between Variables	31
2. Ancova utilizing Vignettes	32
3. Means of Vignettes based on Parent Concern	33
4. Ancova utilizing Participant Gender.....	33

CHAPTER 1: INTRODUCTION

Childhood Mental Health

Mental health communities have focused on the need for effective interventions for young children for more than a decade (Ray, Armstrong, Balkin, & Jayne, 2014). It has frequently been declared that the need for intervention is apparent because children's mental health is a growing crisis in the United States (Ray, Armstrong, Balkin, & Jayne, 2014; Jordans, Tol, & Komproe, 2011; Jabbour et al., 2016). Despite this growing crisis, as many as 80 % of children and youth with mental health problems do not receive any mental health services (Jabbour et al., 2016). Mental health problems in young children, such as externalizing and internalizing behavior problems that remain untreated can lead to more severe problems in later childhood, adolescence, and even adulthood (Chen, 2010).

However, research confirms that when children receive treatment for externalizing and internalizing behaviors that positive change occurs and is effective in preventing these behaviors during later years (Karcher & Lewis, 2002; Edwards & Hans, 2014; Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015). Without treatment, these problems can negatively affect family relationships (Marshall, Arnold, Rolon-Arroyo, & Griffith, 2015). Specifically, internalizing problems often results in withdrawal, fearfulness, and irritability, which can often lead to isolation and loneliness (Marshall, Arnold, Rolon-Arroyo, & Griffith, 2015). Externalizing problems, such as hyperactivity and aggression, are likely to result in over reactive parenting, harsher disciplining, and subsequent aggression from the children towards the relationship (Chen, 2010).

While these are common reactions to these problems, families do not respond to all problems in the same way and it is assumed that parents might react more overtly to boys'

problems because boys tend to exhibit mental health problems more externally (Peter & Roberts, 2010). Play therapy is a developmentally appropriate approach that has demonstrated effectiveness for working with children who present a variety of concerns (Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015). When parents do seek treatment for their children, they are likely to reject some of the treatments that are recommended for externalizing and internalizing behaviors such as filial play therapy because of their negative perceptions of play (Kane, 2016; VanFleet, 2000). The following section will highlight some of the emotional and behavioral problems experienced by children, specifically in relation to gender differences.

Emotional and Behavioral Problems in Children

Strong evidence exists to support the notion that behavioral problems emerge in the first few years of life, and that these problems are exacerbated in later childhood and adolescence (Edwards & Hans, 2015; Briggs-Gowan, Carter, Bosson-Heenan, Guyer, & Horwitz, 2006; Wilens et al., 2002; Chen, 2010). Behavioral problems have been conceptualized along two broad spectrums to include internalizing and externalizing problems. Internalizing problems are expressed in intrapersonal manifestations such as anxiety, depression and withdrawal.

Externalizing problems are expressed in interpersonal manifestation such as hyperactivity and aggression (Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015). While some children may exhibit only one form of behavior, it is not uncommon for children to exhibit co-occurring problems (Edwards & Hans, 2015). Children who exhibit internalizing, externalizing, and co-occurring behaviors and do not receive interventions are more likely to experience continued behavior problems throughout their lives such as anxiety, depression, and substance abuse (Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015).

Gender differences. In addition to the significant evidence that demonstrates that children who display internalizing and externalizing behaviors experience continuous behavior problems throughout their lives, there is also evidence that there are gender differences in behavior problems. It should be noted that before age four, boys and girls show little difference in levels of disruptive behaviors, but after age four significant gender differences have been documented (Olson, Sameroff, Kerr, Lopez & Wellman, 2005). It has been reported that after age four boys tend to display externalizing behaviors more often than girls, while the rates of internalizing behaviors are relatively similar in both boys and girls (Chen, 2010). Furthermore, girls tend to display higher rates of co-occurring behavior problems than boys, by frequently expressing anger, aggression and other externalizing behaviors simultaneously with depression and other internalizing problems (De Coster & Cornell Zito, 2010; Francis, 2014).

These behavior patterns have been found to persist throughout childhood (Chen, 2010). Furthermore, girls may display fewer disruptive externalizing behaviors than boys, perhaps because they are more emotionally mature than boys in their ability to control aggression and impulsivity (Olson, Sameroff, Kerr, Lopez & Wellman, 2005). When these behaviors continue without treatment they are likely to lead to further problems in adolescence and adulthood. The long-term effects of externalizing and internalizing behaviors in children can be detrimental to their development (Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015).

Long-term effects of externalizing and internalizing behaviors. Children, who manifest problem behaviors, may continue to grow and develop believing that their problems are a characteristic of their identity and that they are irreparable (Turns & Kimmes, 2014). Behavior problems in early childhood are predictors of more serious externalizing and internalizing behaviors in later childhood and adolescence (Graziano et al., 2015). These behaviors can

include depression, substance abuse, and anxiety, and tend to remain stable throughout adulthood (Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015).

Both externalizing and internalizing behaviors seem to be predictable of developmental deficits (Karcher & Lewis, 2002). The presence of these problems demonstrates trends that may lead to rejection by peers and potential conflict with parents and other meaningful people (Olson, Sameroff, Kerr, Lopez, & Wellman, 2005). Similar to the existence of only internalizing or externalizing behaviors, evidence of co-occurring behavior problems at earlier ages also often demonstrates disruptive developmental patterns (Mardigan, Brumariu, Villani, Atkinson, & Lyons-Ruth, 2015).

Filial Play Therapy

Filial play therapy is strongly supported as an effective treatment for childhood behavioral problems (Bratton, Ray, Rhine, & Jones, 2005). Filial play therapy, first developed in the early 1960's by Bernard Guerney, is a therapeutic approach in which parents of young children are trained to be therapeutic agents of change by learning how to apply basic play therapy skills during play sessions with their children (Cornett, 2012). Prior research supports the effectiveness of filial play therapy, revealing that it has proven successful in decreasing child behavior problems, decreasing parent-child relationship distress, and improving empathic responsiveness of parents towards their children (Bratton, Ray, Rhine, & Jones, 2005; Bratton, Landreth, & Lin, 2010).

Cornett (2012) reported that filial play therapy appears to bring about change within children and parents, between children and parents, and between the relationships of others in the family system. Bratton, Ray, Rhine, and Jones (2005) reported that of 67 studies utilizing filial therapy methods, filial therapy displayed greater effectiveness than traditional play therapy. This

may be due to the incorporation of the parents as the therapeutic agents of change and due to the combination of individual child therapy and family therapy (Johnson, 1995). Filial play therapy has also been found to lead to statistically significant positive changes in child behavior problems (Cornett & Bratton, 2015).

Parent perceptions of filial play therapy. Although the importance of children's play and filial play therapy are empirically supported, the use of filial play therapy has often been scrutinized by parents (Boswell, 2014; Vanfleet, 2000). Many parents often have difficulty understanding the rationale and effectiveness of play therapy because it does not align with their own individual cultural values or lifestyles (Socarras, Smith-Adcock, & Min Shin, 2015). Parents have expressed uncertainty over their child not responding in a desired way, that the changes would not be lasting, and that the changes may not be appropriately aligned with their child's issues (Boswell, 2014).

Parental apprehensiveness towards filial play therapy is important to investigate because parents who do not understand the benefits of play therapy are more likely to end therapeutic services early (Post, Ceballos, & Penn, 2012). Eliana Gil, a registered play therapy supervisor, reported that parental misconceptions of play therapy may stem from the idea that many parents of children who receive play services have never been given the opportunity to play themselves (Christensen & Thorngren, 2000). These parents often come from backgrounds where they were the parents to their parents rather than being allowed to be a child (Christensen & Thorngren, 2000).

Parents' negative perceptions of play and subsequent concerns about filial play therapy are likely to prevent them from seeking out a service that has been shown to be effective when dealing with emotional and behavioral problems in children. Through the use of clinical

vignettes, the purpose of this study is to evaluate how parents perceive problematic behaviors in children. Specifically, the research questions are:

1. How do parents perceive problematic behaviors in their children?
2. How do parents view these behaviors based on gender and type of problematic behavior, either externalizing or internalizing?
3. How would parents respond to the recommendation of filial play therapy as an appropriate course of therapeutic treatment?

CHAPTER 2: LITERATURE REVIEW

There is adequate evidence to support the need to research childhood externalizing and internalizing behaviors, parental perceptions of these behaviors, and parental perceptions of play based therapy (Goleman, 1998; Vanfleet, 2000; Boswell, 2014). Given the need for more research understanding the link between childhood behaviors, parents perceptions of these behaviors, and how they perceive play based behaviors, this review of the literature will focus on social factors that are contributing to an increase in maladaptive behaviors and discuss how parents are reacting to those behaviors. Next it will explore the literature around problematic behaviors and highlight how they impact children. Finally it will provide an overview of how parents react to these negative behaviors and how treatment options are often influenced by parents' beliefs and assumptions surrounding play.

Social Factors Increasing Child Maladaptive Behaviors

A nationwide sample of more than two thousand American children, rated by their parents and teachers, found that children display negative behaviors on more than forty indices. In recent decades the number of homicides among teenagers had quadrupled, suicides had tripled, and forcible rapes had doubled. Children were found to be dropping in basic emotional and social skills and on average are more nervous and irritable, more sulky and moody, more depressed and lonely, more impulsive and disobedient (Goleman, 1998).

There are multiple assumptions as to why childhood maladaptive behaviors have significantly increased (Reijneveld et al., 2014; Gruhn et al., 2016). The decrease in economic stability has had an impact on the time that parents spend working and away from home, meaning that they are spending less time with their children (Goleman, 1998; Heymann & Earle, 2001; Vieira, Matias, Ferreira, Lopez, & Matos, 2016). Less time spent with children indicates

that there is less time for parents to teach basic emotional and social skills. Increased working hours and job stress have also negatively impacted a parent's mental health, which in turn impacts how they parent their children (Mistry, Vandewater, Huston, & McLoyd, 2002; Vieira et al., 2016). Negative parenting techniques have been found to lead to maladaptive behaviors (Vieira et al., 2016). Finally, an increase in divorce and family transitions has been found to lead to maladaptive behaviors including externalizing and internalizing behaviors. Understanding the impact of increased working hours, parent's mental health, and family transitions on child stress and externalizing and internalizing behaviors has become increasingly important. This section will focus on each of these factors and illustrate how they are impacting children and families.

Parents' increased work hours. Approximately sixty years ago, the standard workday was defined as 8 hours per day for 5 days a week (Strazdins, Clements, Korda, Broom, & D'Souza, 2006). No work was completed on Sunday and any work on Saturday or during evening hours required extra pay. Recent changes in the economy due to technological advances, growth in services, and economic uncertainties have required that businesses be open on the weekends, many opting to stay open 24 hours a day, 7 days a week (Strazdins et al., 2006). These new standards in hours of operation have resulted in working times that are outside of the regular nine-to-five weekday.

Two in five employees in the United States are working on the weekends, evenings, or nights. Families have embraced these new working hours as a defensive economic behavior that allows them to remain in their preferred class standing although economic uncertainties are high (Edwards, 2001). In order to adjust to these economic uncertainties, families have also resorted to becoming dual-earner families, in which both parents are employed (Strazdins, 2006). For many, the male-breadwinner family arrangement no longer makes sense when considering the

economic struggle (Edwards, 2001). Continued economic uncertainties and improvements in women's labor opportunities will continue to encourage both parents to work, specifically in jobs that are not nine to five (Strazdins, 2006).

Nonstandard work schedules have made more difficult for parents to build family closeness. Working atypical hours is often accompanied by relationship disruptions and strains. Atypical work schedules can make it more difficult to maintain family rituals, routines, and social activities that are important for family closeness. An increase in working hours may also affect the mental health of parents, the way parents interact with one another, and the way they interact with their children. These elements often have adverse effects on the children's well-being and may result in maladaptive behaviors (Mistry, Vandewater, Huston, & McLoyd, 2002, Vieira, et al., 2016).

Impact on parents' mental health. Parent mental health has been shown to be important to the child's well-being (Heymann & Earle, 2002). Depressed parents are less spontaneous and more withdrawn, angry, and sad (Strazdins, 2006; Vieira, et al., 2016). Downey & Coyne (1990) found that children of depressed parents tend to have more behavioral and emotional difficulties, poorer physical health, and more impairments in social and academic performances than children with nondepressed parents.

Work conditions, including odd work hours and increased working hours, can negatively impact parents' mental health (Strazdins, 2006). Mothers who were worn down by job stressors and economic pressures often display similar parenting behaviors as clinically depressed mothers (Downey & Coyne, 1990). These mothers were found to be preoccupied with low energy levels. Child noncompliance was avoided, with these depressed mothers more often choosing strategies that required less effort and negotiation. The negative impact of more stressful work situations

often carries over into family life in the form of irritability and withdrawal (Menaghan, 1991). Jobs affecting parental well-being also impact marriage stability and child well-being (Strazdins, 2006).

Increased marital tension due to nonstandard work schedules. The previously stated nonstandard work scheduled may also lead to increased marital tension (Presser, 2000). Marital conflict is a characteristic of distressed marriages that has been shown to predict negative child outcomes (Amato & Cheadle, 2008). These conflicts result in negativity between parents, escalated anger, and greater potential for physical abuse towards the children. The stress and frustrations of marital conflict and divorce carries over into parent interactions with their children. Children exposed to conflict between their parents frequently show signs of distress. This includes crying, covering their ears with their hands, making requests to leave, and freezing all actions. Children of divorce are frequently exposed to parental conflict long before the divorce occurs, leading to heightened aggression, impulsivity, and emotional problems (Amato & Cheadle, 2008). More specifically, aggression and abuse between partners due to high work stress, has been associated with behavioral and emotional problems in children (Amato & Cheadle, 2008).

Externalizing and Internalizing Behaviors

It is evident that parent's mental health, parenting patterns, and marital tensions due to nonstandard working hours and the weakened economy have had an impact on the emotions and behaviors that are frequently displayed in children. Children in high conflict homes due to increased stress and fatigue from nonstandard working hours are increasingly vulnerable to both externalizing and internalizing problems (Amato & Cheadle, 2008). It is estimated that approximately 10-12% children experience behavioral or emotional problems (Reijneveld et al.,

2014). These problems are likely to lead to restrictions in daily functioning and may have severe long-term effects. It is necessary to understand how externalizing and internalizing behaviors are manifested in children, how they vary between girls and boys, and how they might impact their families.

Externalizing behaviors. One of the most common externalizing problems found in young children is deviant behavior and anger (Peter & Roberts, 2010). Deviant behaviors include aggression to people or animals, property destruction, stealing or lying, and violating rules such as running away from home. Externalizing behaviors are considered aggressive, assaultive, and destructive (Maguire et al., 2015). Other behaviors associated with externalizing problems include fighting, attacking and threatening people, and temper outbursts (Achenbach, Ivanova, Rescorla, Turner, & Althoff, 2016). Children who are exposed to interparental conflict display a variety of conflict behaviors including hostility, disengagement, and uncooperativeness (Davies et al., 2016). These children have difficulty achieving emotional security and instead display fearful distress and avoidance.

Although depressive behaviors are primarily considered internalizing behaviors, there is a possibility that some depressive behaviors may manifest themselves, especially in boys, as externalizing behaviors (Peter & Roberts, 2010). Therefore it is important to clarify that for the purposes of this study, traditional withdrawing behaviors were considered as internalizing behaviors rather than focusing on the behaviors that fit within certain diagnostic criteria.

Internalizing behaviors. Internalizing behaviors most frequently include depressive symptoms and anxiety disorders (Peter & Roberts, 2010). Depressive symptoms in the United States were found to be the strongest correlate of suicidal ideation, attempt, and completion in children and adolescents (Peter & Roberts, 2010). Other common internalizing behaviors among

children are: a) panic disorders; b) specific phobias (i.e., social, etc); c) obsessive-compulsive disorder; d) posttraumatic stress disorder; and e) stress disorders (i.e. acute, generalized, etc.). Symptoms may also manifest as social withdrawal, somatic complaints with no apparent cause, and insecurity (Achenbach et al., 2016; Davies et al., 2016). Sadness, withdrawal, fear, and physical distress are internalizing behaviors related to child insecurity (Davies et al., 2016). Internalizing behaviors have been further characterized as contributing to relationship difficulties and isolation from peers (Marshall, Arnold, Rolon-Arroyo, & Griffith, 2015).

These behaviors seem to be connected to those children who have been neglected and feel as though they have no control in what happens to them (Maguire et al., 2015). More specifically, increased involvement in family conflicts increases child insecurity (Davies et al., 2016). This insecurity seems to be a defense mechanism against parental and family conflict that often leads to fear, withdrawal, and anxiety.

Co-existing behaviors. Although some children display only externalizing or internalizing behaviors, it is also common for some children to exhibit co-occurring problems (Edwards & Hans, 2015). Previous family risk factors including parental conflict, aggressive parenting, and parent's mental health may have an impact on the development of these co-occurring problems. Children who experience co-existing internalizing and externalizing problems are at especially high risk for experiencing adverse outcomes (Fanti & Henrich, 2010). Children with co-occurring problems are expected to have poorer social, emotional, and behavioral adjustment in adolescence (Fanti & Henrich, 2010). These children are often regarded as more annoying by their peers and do not have the social skills necessary to associate with peers (Fanti & Henrich, 2010). Externalizing, internalizing, and a combination of both behaviors

have been found in both boys and girls (Reijneveld et al., 2014). However, there is evidence of gender variations between externalizing and internalizing behaviors (Olson et al., 2005).

Gender differences. Research has shown that serious externalizing and internalizing behaviors can be identified in the toddler and preschool years and that child gender is a powerful moderator in the development of these behaviors (Olson et al., 2005). More specifically, boys and girls show few differences in disruptive behaviors before age 4 with substantial differences in behaviors after age 4 (Keenan & Shaw, 1997). However it is also supported that boys tend to display more externalizing problems in response to adverse parenting than girls and that girls tend to display more internalizing problems in response to intrusive and withdrawn parenting (Olson et al., 2005; Gruhn et al., 2016).

Daughters have been found to be at a greater risk for developing depression, anxiety, and low self-esteem (Marshall, Arnold, Rolon-Arroyo, & Griffith, 2015; Peter & Roberts, 2010). Girls frequently display significantly higher rates of depressive symptoms (Wade et al. 2002). They are also twice as likely to exhibit symptoms of anxiety when compared to boys (Silverman & Carter, 2006). Finally, girls have higher odd ratios for suicide ideation and attempt (Peter & Roberts, 2010). Specifically, 1 in 10 girls reported making some form of a suicidal attempt compared to only 1 in 25 boys (Peter & Roberts, 2010).

There is also evidence that girls tend to be worriers (Cummings, Pepler, & Moore, 1999). In addition to worrying, depression and self-blame may exist as a girl's response to stressful family events. These symptoms often exist because girls tend to feel more responsible for resolving inter-parental conflicts (Cummings, Pepler, & Moore, 1999). The higher maturity level found in girls may contribute to their ability to maintain control over aggressive and impulsive behaviors, often resulting in more internalized behaviors (Olson et al., 2005).

Whereas girls have been found to score higher on internalizing problems, boys score higher on externalizing problems (Achenbach et al., 2016). Evidence suggests that conduct disorder and deviant behaviors are higher among boys compared to girls (Peter & Roberts, 2010). It was estimated that the rate of conduct disorder was between six and 16 percent for boys compared to only two and nine percent for girls. Finally, boys tend to be more physically aggressive overall while girls tend to display more relational aggression (Maguire et al., 2015). Peter and Roberts (2016) suggest that perhaps boys tend to display more externalizing behaviors because they have social expectations in which they are not supposed to feel depressed or be anxious and they do not know how to counter this belief.

Preschool boys tend to show more externalizing behavior problems than girls (Javo, Heyerdahl, & Rønning, 2000). Boys have repeatedly obtained higher behavior problem and externalizing scores on behavior checklists than girls (Javo, Heyerdahl, & Rønning, 2000; Kumpulainen et al., 1999; Chen, 2010). Boys have also repeatedly scored lower on internalizing behaviors than girls. The higher externalizing scores in boys may be a result of parents being less tolerant of deviant behaviors (Javo, Heyerdahl, & Rønning, 2000).

Parental Response to Child Behaviors

Parental understanding of and response to externalizing and internalizing behaviors is as equally important as understanding how the behaviors themselves are manifested in children. It is up to the parents to determine the treatment that their children receive depending on how they view various behaviors. Gruhn et al. (2016) suggested that parents respond differently to their sons and daughters behaviors. This suggestion may exist based on the evidence that parents tend to view externalizing behaviors in boys more negatively than internalizing behaviors in girls (Gruhn et al., 2016).

Parents often report more negatively on the more observable externalizing behaviors than the less observable internalizing behaviors (Madigan, Brumariu, Villani, Atkinson, & Lyons-Ruth, 2016). Children displaying externalizing behaviors are more likely to be warned or punished when compared to other children (Wright, Zakriski, & Drinkwater, 1999). It seems as though externalizing problems often result in greater parent response because they are more obvious and noticeable.

Although externalizing behaviors garner more attention, this is not to say that internalizing behaviors are entirely unnoticed. Internalizing behaviors tend to be behaviors that do not disturb others and therefore are not as easily noticed (Kumpulainen et al., 1999). Children exhibiting internalizing behaviors may not be punished as often as children who exhibit externalizing behaviors, but parents of children with internalizing behaviors have been found to be more likely to hold negative beliefs about their child (Laskey & Cartwright-Hatton, 2009).

Gender based response. On most of the internalizing scales girls have a higher level of internalizing symptoms than boys (Sourander, Helstelä, & Helenius, 1999). This may be a result of internalizing problems being more easily hid from the parents' view and are therefore less likely to be recognized by the parents. Lower levels of parenting response to internalizing behaviors in girls may also be due to the fact that parents who rate their child low on externalizing problems also rate their child low on internalizing problems (Chen, 2010).

Mothers specifically react with anger towards their sons' risk-taking or externalizing behaviors (Chen, Seipp, & Johnston, 2008). They often feel unable to control these behaviors. In contrast, mothers respond to their daughters' risk-taking or externalizing behaviors with disappointment and concern because they feel as though their daughters should know better.

Fathers similarly rated boys more highly than girls on externalizing behaviors (Olson et al., 2005). However, fathers do not differ in the response to boys and girls internalizing problems.

Variations in mothers' and fathers' responses. Research suggests that mothers and fathers are not likely to differ on their responses to externalizing and internalizing behaviors in their children (Kumpulainen et al., 1999; Chen, Seipp, & Johnston, 2008). It is suggested that the gender of the parent does not affect the observations that the parent makes at home.

However, Javo, Heyerdahl, & Rønning (2000) report that fathers' attitudes towards their sons' aggressive behaviors tend to be more lenient than mothers'. Fathers were also found to have less tolerance for their daughters' sulkiness than mothers (Javo, Heyerdahl, & Rønning, 2000).

Effective Treatment

Parents who have children experiencing emotional and behavioral problems will often seek therapy to help improve their child's behaviors. One of the treatment models that has been shown to be effective is filial play therapy. According to the research filial play therapy has a long history of effectiveness in decreasing child behavior problems and parental stress. In addition, it has also been found to increase child confidence and parent-child connection with a variety of populations, family structures, and presenting problems (Cornett & Bratton, 2015; Ginsberg, 2002).

More specific benefits of filial play therapy are reduction in child anxiety and assistance in regulating emotions, processing stressful experiences, and developing life skills (Willis, Walters, & Crane, 2014). Bratton, Ray, Rhine, and Jones (2005) reported that of the 67 studies involving parents using filial play therapy methods, filial therapy demonstrated greater effectiveness than traditional play therapy methods. This meta-analysis established that play

therapy, specifically filial play therapy, is a statistically viable intervention and an agent in changing behaviors in children (Bratton, Ray, Rhine, & Jones, 2005).

Decreasing behaviors. Play therapy has been found to be beneficial for children regardless of whether they were being treated for externalizing or internalizing behaviors (Bratton, Ray, Rhine, & Jones, 2005). Moreover, filial play therapy is generally supported as having a positive impact on the behavior of children (Cornett & Bratton, 2015). Parents often report positive changes in their child's behavior following participation in filial play therapy (Bavin-Hoffman, Jennings, & Landreth, 1996). Parents stated that their children had gained an ability to control aggressive behaviors and were generally much calmer (Bavin-Hoffman, Jennings, & Landreth, 1996).

The Filial Problem Checklist has also been utilized to measure the effectiveness of participation in filial play therapy on externalizing and internalizing behaviors. Decreased problematic behaviors were a consistent finding in the earliest filial play studies (Cornett & Bratton, 2015). Child symptoms have been found to be reduced by as much as 66% on behavior checklists (Guerney, 2000). In fact, the children who participated in filial play therapy displayed an increase in their ability to respond appropriately and a decrease in aggression. Their play patterns at termination were found to be similar to those children without emotional or behavioral problems (Guerney, 2000).

Societal Views on Play

Although filial play therapy is recognized as an effective approach for decreasing externalizing and internalizing behaviors in children, decreasing parental stress, increasing child confidence, and increasing parent-child connections, it is important to consider societal and parental views on play. A better understanding of how play is viewed and accepted will provide

greater insight into how filial therapy may be accepted by families. Recognizing how parents view their child's treatment can be an invaluable resource as parents play such a vital and important role in deciding if treatment will be considered, and if so, what type of treatment to pursue (Boswell, 2014).

Over the last several decades the amount of time that children spend in unstructured play has consistently declined (Hofferth & Sandberg, 2001). Preschoolers are largely sedentary or they spend a great deal of time participating in highly structured activities rather than engaging in active free play (Copeland, Sherman, Kendeigh, Kalkwarf, & Saelens, 2012; Hofferth & Sandberg, 2001). The emphasis on accountability and student achievement that stems from programs such as *No Child Left Behind* has created a climate that favors success and achievements (Kane, 2016).

Copeland et al. (2012) found that academic programs in U.S. preschools is increasingly replacing play. Greater achievement in academic skills outweigh the importance of play in modern society (Kane, 2016). However, this is not an entirely new debate. Although the majority of childhood educators recognize the importance of play, there is much disagreement about the exact definition of play and the specific benefits that come from play (Rothlein & Brett, 1987). Throughout the last century early childhood educators have stated their beliefs on play including the notion that play has no ulterior benefits, play is an aimless expenditure of energy, and that play consists of activities that are not performed for any result other than to simply play (Rothlein & Brett, 1987).

Parental views. Considering the importance that society has placed on educational achievement and overall progress, it is understandable that parents' beliefs about play seem to be based on the role it has in preparing children for academic success. Parental beliefs about play

often evolve from their own cultural experiences and contextual trends. A mother who believes that children learn best through direct instruction rather than through unstructured play often does so because of her own experiences as a child and her own observations of children (Fisher, Hirsh-Pasek, Golinkoff, & Gryfe, 2008).

Parental understanding of play is likely linked to societal education policies such as *No Child Left Behind*. Educational standards that children face increase parent expectations for school readiness and their anxieties about their child's future success in uncertain economic times (Kane, 2016). Based on the expected educational norms, parents have reported that recognizing letters and numbers is the most important quality in a child care setting as opposed to play and peer interaction (Kane, 2016).

Many parents do not regard play as important for young children (Rothlein & Brett, 1987). Based on parents' definitions of play, they seem to distinctly separate play from learning (Rothlein & Brett, 1987). Parents define play as imaginative, fun, and active, while they define learning as gaining new knowledge and the ability to apply it (Cooney, 2004). Structured activities are viewed as setting the best foundation for academic success and value this time more so than unstructured play, while unstructured play is considered extra and not a pathway to learning (Kane, 2016).

Based on the evidence, it seems as though many parents do not have a clear perception of play and what it means for children (Socarras, Smith-Adcock, & Shin, 2015). In an interview on the importance of integrating play in family therapy Eliana Gil explained that she has found that many parents had never actually had the opportunity to play themselves (Christensen & Thorngren, 2000). These parents come from backgrounds where they may have been made to take on a parental role to their own parents and not given the freedom to act as the child

(Christensen & Thorngren, 2000). With this in mind, it is understandable that parents believe that children do not need playtime except as a break from work (Rothlein & Brett, 1987).

Based on the presented views of the importance of academic success and achievement it is understandable that speculation exists about parental acceptance of play therapy techniques. VanFleet (2000) speculated that parents may be resistant to the idea of play therapy because of their value on independence and self-efficacy. It was proposed that parents might view participation in play therapy as a sign that something is wrong with the parents or that they are too weak to handle their own problems (VanFleet, 2000).

Given the parental and societal views presented on the understanding of play, it is necessary to further research the value that parents place on filial play therapy for children that present with internalizing and externalizing behavior problems based on gender.

Therefore, the purpose of the current study is to evaluate how parents perceive problematic behaviors in children. Specifically, the study will measure how parents view the child's behavior based on their gender and type of problematic behavior, either externalizing or internalizing. It is anticipated that parents will rate boys' behaviors most negatively with externalized behaviors as most negative. Based on these interpretations parents will be asked to rate their level of concern and how they would feel about recommending filial play therapy as an appropriate course of therapeutic treatment. Based on the research question and the reviewed literature we anticipate the following hypotheses:

1. Parents will rate the severity of the child's behavioral problems in the following order (most severe to least severe):
 - a. boys with externalizing problems as the most severe;
 - b. girls with externalizing problems;

- c. boys with internalizing problems;
 - d. girls with internalizing as least severe.
2. Parents will prefer a talk-therapy approach to play therapy recommendations.

CHAPTER 3: METHODS

Design

The literature review of externalizing versus internalizing behaviors and parent perceptions of those behaviors supported the need to further investigate parent perceptions of these behaviors and their subsequent therapy recommendations. A mixed methods design was utilized in order to collect both qualitative and quantitative data. Both the qualitative and quantitative data were integrated into the design analysis by embedding the qualitative portion into the quantitative portion. Since the primary purpose of the open-ended questions was to provide clarification, qualitative responses were included whenever additional data was necessary to understand participants' responses.

A concurrent nested mixed methods design was utilized so that the qualitative forms of data were nested within the larger quantitative forms of data (Creswell, 2014). This approach allowed for a broader perspective in which the qualitative data enriched the description of the quantitative data and the quantitative data enriched the results of the qualitative data. A concurrent nested mixed methods design allowed for a consistent quantitative model of the study while simultaneously gathering the otherwise limited qualitative information within the study in greater detail (Creswell, 2014).

In accordance with a concurrent nested mixed methods design, the study utilized a survey that included more quantitative components including demographic information, a collection of parental stress, relationship and adverse experience scales, and responses to behavioral vignettes. The behavioral vignette portion of the survey also included a qualitative open-ended response box that was intended to further explore parent perceptions of problem behaviors in children

based on gender. The qualitative data was collected simultaneously with the quantitative data as the information was provided within the same survey.

Behavioral vignettes were utilized in order to thoroughly assess for parent's perceptions on externalizing and internalizing behaviors in young boys and girls and how likely they were to recommend play therapy for a child that exhibits similar behaviors. The vignettes included a variety of examples of internalizing and externalizing behaviors as exhibited by boys and girls in order to help determine if differences in recommendation differ based on presented behavior and gender. Vignettes are often based on simulations of real events from which to collect data and are a valuable technique for exploring peoples' perceptions, beliefs, and meanings of specific situations (Barter & Renold, 1999).

Vignettes have also been found to have value in exploring the nature of various behaviors and are commonly used to assess for the influence of biases (Jenkins, Bloor, Fischer, Berney, & Neale, 2010; Garb, 1997). The vignettes in this study assisted in the control of potential bias in parent perception of childhood behaviors. If parents were directly asked if they treat boy behaviors more negatively than girl behaviors, they would likely say no because the parents may feel as though it is the socially desirable answer. Most parents would not admit that they show favoritism towards certain types of behaviors in children. As a result the vignettes attempted to minimize this potential bias by asking the same question in a less direct way that did not ask the parents to comment specifically on their own parenting behaviors, while continuing to allow for a collection of parents beliefs about how they might parent their own child with similar behavior problems.

Data Collection

Participants.

Selection criteria. The targeted parent population included one parent with primary custody from each household with at least one child living in the home between the ages of 3–12 years. The age of the child in the home was significant because the study focused on childhood behaviors within this age group and their participation in filial play therapy. Filial play therapy is recommended for children between ages 3-12. Finally, parents with children in this age group were targeted because the behavioral examples in the vignettes fall within this age range.

The target sample included all parents, irrespective of whether or not they have sought clinical treatment for their child(ren). While it seems important to include all parents it is also understood that a clinical population may influence the parental perception of childhood behaviors and their recommendations for filial play therapy. As a result, whether or not they have sought clinical treatment was used as a control variable in order to account for how their recommendation for play therapy might have been influenced by previous experiences.

An a priori power analysis was conducted using G*Power with a medium effect size anticipated (.50), α set at 0.05, and two groups, mothers and fathers. The analysis suggested a target population of 64 mothers and 64 fathers. In order to have confidence that the findings were not simply due to chance, a combined total of mothers and fathers suggested approximately 128 participants. In the end, we obtained a total sample size of 241 participants. However, of those 241 respondents, several participants ($n = 33$) started the survey but did not provide any answers, leaving the entire response blank. Of the remaining 208 responses that began the survey, several participants ($n = 63$) did not complete the entire survey. The incomplete responses were not included in the total sample of responses ($n=145$). An analysis was run to compare the non-

completers with the completers and no significant difference existed. As a result the non-completers were dropped from the sample, resulting in a final sample of 208. Participant demographics of the final sample were as follows: The mean age of participants was 35 with a standard deviation of 6.9 ($n = 145$); the sample was 62.8% female ($n = 91$) and 37.2% male ($n = 54$). The participants demographics were as follows: ($n = 145$) M age = 35, 62% female ($n = 91$), and 89.0% ($n = 129$) White, Non-Hispanic. The final sample demographics included 6.9% African American/Black ($n = 10$), 0.7% Asian American ($n = 1$), 2.1% Hispanic ($n = 3$), 0% Native American ($n = 0$), 89.0% White, Non-Hispanic ($n = 129$), and 1.4% other ($n = 2$). Of the two participants who chose other to identify race and ethnicity, one participant wrote in “Black and white,” while the other was described as “Mixed Asian and white.”

Recruitment. The participants were parents who were recruited through several different means. Parents were recruited from a university childcare center, several Facebook sites (including a Facebook site specifically devoted to mothers, 2 sites designated to Father’s, and several Facebook sites of friends and families who were asked to post the invitation to participate on their site). Administrators of these sites were given a flyer to post on their sites inviting those affiliated parents affiliated with their sites to participate. Finally, given the low enrollment of fathers in the study, students from an undergraduate HDFS class were given extra credit if they referred a father who completed the survey. Based on the information provided in the survey, the participants self-selected their participation in the study.

Procedures. Participants were provided with an electronic invitation that provided a description of the study and a link to an online survey. The invitation was presented online to participants through Facebook sites. If electronic access was not available, a hardcopy of the

flyer was provided. The hardcopy flyer included a QR code that allowed parents to conveniently access the online survey utilizing a mobile device.

The online survey consisted of questions related to demographics, a variety of assessments, and one of four clinical vignettes. Participants were informed through the electronic invitation that participation in the study would allow for further understanding of their perceptions of childhood behaviors and subsequent treatment recommendations for that behavior.

Parents who chose to participate followed the link provided in the electronic invitation in order to access the web-based survey. Each survey was randomly generated so that the participant's responses were equally distributed for each of the four vignettes (described in detail below). Each vignette described a child who engaged in a variety of either internalizing or externalizing behaviors. After reading the provided vignette, participants answered questions to assess their understanding of the child's behavior and their response to a recommendation of filial play therapy. The participants also answered a number of other questions related to their own demographics, stress, and relationships.

Measures

Demographics. Participants were asked to provide information regarding their age, race/ethnicity, gender, number of children, and other demographic variables that might impact the results. Participants were allowed to leave blank any demographic questions they did not feel comfortable answering.

Vignettes. Participants were asked to assess an individual child in one of four unique vignettes. The vignettes were designed to help assess perception of child behaviors and recommended treatment. For the purposes of this study, the vignettes were created by the

primary author, based on previous experiences working with children in daycare and preschool settings. Therefore, these vignettes were not developed based on any pre-existing vignettes in the literature. Participants were asked to assess the vignette on three criteria: 1) Based upon the vignette you read, how concerned are you about the child's behavior? (0 = not concerned at all, 10 = extremely concerned); 2) Based on your level of concern over the child's behavior, how likely would you be to seek treatment to correct the behaviors? (0 = not likely at all, 10 = extremely likely); and 3) When people decide to seek therapy there typically are several options available. Please rate how likely you are to pick the following type of treatment (0 = not likely at all, 10 = extremely likely). When rating their likelihood to seek treatment (question #3) participants were asked to rate 4 specific options. These options included: a) therapy where the therapist meets individually with your child and talks to a therapist about their behaviors/concerns; b) therapy where the therapist meets with both you and your child and talks about your behavior/concerns; c) therapy based on common play based treatments where your child attends session and plays with a therapist; d) filial play therapy where you, as the parent, are taught the skills necessary to engage in therapeutic play with your child and then you and your child go to therapy together to work through the child's behaviors/concerns. After parents were asked to rate how comfortable they are with each approach, the parents were asked which of the four types of therapy they would choose if the child in the vignette were their own child. They were also given an open ended question that asked them to describe what they would recommend that the parent do, both regarding therapy and when parenting the child at home.

The current research study utilized four vignettes. Two of the vignettes were an identical representation of externalizing behaviors (Appendices B and C) and two of the vignettes represented internalizing behaviors (Appendices D and E). The identical externalizing vignettes

and the identical internalizing vignettes differed only by child gender (male or female). An example of a vignette to be used in the study appears below (all vignettes are provided as appendices):

George is a four-year-old male. George attends a local daycare center every day from mid-morning to late afternoon. One afternoon during outdoor playtime, a classmate takes away the ball that George is playing with. George runs after his classmate, shoves the child to the ground, and calls the child, “Stupid.” George’s teacher has often reported that he does not follow the class rules, disturbs his classmates, and is highly aggressive. George also frequently displays these behaviors at home. He is often aggressive towards his two-year-old brother. George yells at him and hits him when he becomes upset. George also uses aggressive language towards his parents.

Face validity. In order to ensure that the vignettes had face validity, several parents of a child between the ages of 3 and 12 read through the vignettes to ensure that they were relatable and understandable. Six parents volunteered to preview the vignettes by reading them and offering any feedback concerning their ability to understand the behaviors presented in the vignettes. One parent provided feedback stating that she felt as though the behaviors presented in the internalizing vignettes were not quite as drastic as the behaviors presented in the externalizing vignettes. Upon receiving this feedback, the internalizing vignettes were changed so that the extremity of the behaviors was more adequately balanced between both the externalizing and internalizing vignettes.

Qualitative response. In order to enrich the qualitative results, each participant was asked to provide an open-ended response following the four questions about level of concern and recommendations for treatment. Open-ended text boxes were provided after each of the four questions following the vignettes. These boxes allowed the participants to further explain their perceptions regarding externalizing and internalizing behaviors in children and why they provided the responses they did regarding treatment options. The final question was an open-

ended question designed to assess what they would do if they found themselves in a similar situation with their own child.

Parental stress scale. The Parental Stress Scale is an 18 item self-report scale that assesses parental stress for both mothers and fathers of children with and without clinical problems (Berry & Jones, 1995). The 18 items represent positive themes as well as the more negative components of parenthood. Participants respond to each item using a 5-point Likert scale that ranges from 1, strongly disagree, to 5, strongly agree.

Berry and Jones (1995) found this scale to have adequate reliability. Scores of the Parental Stress Scale were compared to the Perceived Stress Scale and the Parenting Stress Index. The 18-item version of the Parental Stress Scale was found to have a coefficient α of .83 for the total sample and a test-retest correlation of .81 over a period of six weeks (Berry & Jones, 1995). No significant difference was found between mothers' and fathers' responses (Berry & Jones, 1995).

Data Analysis

In order to answer each specific research question, quantitative analyses were run for each of the independent hypotheses. Each hypothesis will be discussed individually including the analysis that was used.

Hypothesis 1: Parents will rate child behavioral problems in the following order: boys with externalizing problems as the most severe; girls with externalizing problems would be next; followed by boys with internalizing problems; and girls with internalizing as least severe. The parental response data required that the following three steps be completed. First, the correlations between each set of variables were checked. A 2x2 ANCOVA (vignette type X level of concern) was completed, controlling for parent's age and parental stress. Respondent's age and stress level

was selected as the covariates of older parents or parents who experience less stress might have been more relaxed or even less achievement based. Finally, due to the significance found from running the first ANCOVA, a second 2x2 ANCOVA (participant gender x level of concern) was completed, again controlling for parent's age and parental stress.

Hypothesis 2: Despite literature that says play therapy techniques tend to be more effective for children, parents will prefer a talk-therapy approach to play therapy recommendations. Specifically, the parents will be least likely to choose filial play therapy as an appropriate treatment for the child. Data for determining which type of treatment parents prefer was analyzed using a multinomial logistic regression. The type of preferred treatment was the dependent nominal variable with parental gender and the vignette used in the survey being the independent variables.

CHAPTER 4: RESULTS

The correlations between each of the variables, along with the means and standard deviations, are presented in Table 1.

Table 1.
Correlations between Variables

Measure	Mean	SD	1	2	3	4	5	6	7
1. Participant Age	35	6.9	-						
2. Participant Gender	1.5	.49	-.20*	-					
3. Level of Concern	7.8	1.9	-.29**	.21*	-				
4. Vignette Gender and Behavior	2.7	1.1	.04	-.00	.08	-			
5. Recommended Treatment	1.1	1.2	-.08	.15	.20*	.08	-		
6. Participant Stress Level	48.3	12.6	-.01	.04	-.08	.06	-.04	-	
7. Previous Mental Health	1.6	.49	.01	-.23	-.02	.05	-.13	-.25**	-

Notes: * $p < .05$, two-tailed. ** $p < .01$, two-tailed.

Hypothesis 1: Parents will rate child behavioral problems in the following order: boys with externalizing problems as the most severe; girls with externalizing problems would be next; followed by boys with internalizing problems; and girls with internalizing as least severe.

A one-way between groups analysis of covariance (ANCOVA) was conducted to compare the relationship between participant concerns of behaviors in children based on the vignette type (gender x behavior). The independent variable was the vignette presented in the survey either male externalizing, male internalizing, female externalizing, or female internalizing, and the dependent variable was the participant's level of concern. The participants' total scores on the Parental Stress Scale and participant age were used as covariates in this analysis.

Preliminary checks were conducted to ensure that there was no violation of the assumptions of normality, linearity, homogeneity of variance, homogeneity of regression slopes,

and reliable measurement of the covariate. Given that each of these assumptions were met, the ANCOVA was run and results indicated that, while holding parental stress and age constant, that a significant relationship exists between vignette type and parents' level of concern, $F(3, 122) = 2.15, p < .05$ (see Table 2). It also appears that the relationship between vignette type and parents' level of concern accounts for approximately 12.3% of the variance.

Table 2.
Analysis of Covariance (ANCOVA) for Level of Concern as a Function of Vignette Type

Variable	<i>df</i>	MS	F	Sig.
Corrected Model	5	11.4	3.4	.006
Age	1	41.8	12.5	.001
Stress Level	1	7.2	2.1	.15
Vignette	3	4.7	1.4	.24

Note: R Squared = .123 (Adjusted R Squared = .087)

When the specific means of each vignette were explored, parents' scores indicated that parents actually rated internalizing female behaviors as the most concerning followed by internalizing males, externalizing females, and last by externalizing males (see Table 3). Although internalizing females were viewed by participants as more concerning, the results suggest that all of the vignettes were seen as potentially concerning. On average parents rated the female internalizing behaviors as .84 points more concerning than male externalizing behaviors. Specifically, the mean levels of concern were as follows: internalizing female $M = 8.08, SD = .30$, internalizing male $M = 8.02, SD = .33$, externalizing female $M = 7.66, SD = .40$, and externalizing male $M = 7.24, SD = .33$. Therefore, although a significant relationship exist between vignette type (child gender and behavior) and parent's level of concern, the original hypothesis that parents would rate male externalizing behavior as most negative was not supported.

Table 3.

Mean Scores of Participant Concern Level Based on Vignette Type

Vignette	Mean	Standard Deviation
Externalizing Male	7.24	.33
Externalizing Female	7.66	.40
Internalizing Male	8.02	.30
Internalizing Female	8.08	.33

Notes: Covariates appearing in the model are evaluated at the following values: What is your age?: 35.0, total parent stress scale score = 48.36

Due to the significance found between vignette type and parent’s level of concern a second one-way between groups analysis of covariance was conducted to compare the relationship between participant gender and level of concern (Table 4). The independent variable was participant gender and the dependent variable was level of concern. The participant’s total scores on the Parental Stress Scale and participant age were used as covariates in this analysis. Results indicated that a significant relationship was also found between participant gender and level of concern, $F(1,124) = 5.07, p < .05$. The association between participant gender and level of concern accounted for approximately 10.9% of variance.

Table 4.

Analysis of Covariance (ANCOVA) for Level of Concern as a Function of Participant Gender

Variable	df	MS	F	Sig.
Corrected Model	3	16.9	5.1	.002
Age	1	29.9	8.96	.003
Stress Level	1	6.2	1.9	.18
Participant Gender	1	7.7	2.3	.13

Notes: R Squared = .109 (Adjusted R Squared = .088)

Qualitative analysis. A review of the qualitative data provides further explanation for the level of concern expressed by participants towards each of the vignettes. The qualitative

responses seemed to focus on specific themes for externalizing behaviors in boys, externalizing behaviors in girls, internalizing behaviors in boys, and externalizing behaviors in girls. The primary theme for externalizing behaviors in boys centered on the theme that this behavior seemed normal for a four-year-old boy. One participant reported that there was little concern for the externalizing male vignette due to the notion that, “He is only four and is still learning.” Similar responses included, “A lot of boys that age show aggression,” “I am not concerned if he is aggressive at home,” “Not out of the norm for this age,” “His age made me less concerned,” and “Might just be a phase, not concerned.”

Responses related to the externalizing behaviors in girls centered on the theme that the child’s actions are a reaction to other concerning issues that should be addressed. Specifically, one participant reported, “Behavior problems at this age are a symptom of larger issues, possibly within the family system.” Similar responses included, “Something is bothering Elizabeth internally,” and “Aggressive behaviors can be caused by an underlying issue.” Other responses about the externalizing female behaviors centered on the theme that the child has not learned to appropriately express herself. These responses included, “It seems as if she doesn’t know how to control her frustration,” and “It is less about the structure the child is in and more about the child’s difficulty expressing herself in an appropriate manner.”

On the other hand, many participants expressed much concern for the internalizing behaviors. The participant responses for both male and female internalizing behaviors seemed to overlap on the same central themes. The theme that occurred the most often centered on the notion that the child was experiencing some form of social anxiety, “She is anxious,” “She seems to be having serious social issues,” “He seems full of social anxiety,” and “He seems to be having difficulty with anxiety.” A second theme centered on the notion that this behavior did not

seem normal for a child, “Children are inherently social creatures and I worry about his need to be alone,” “I would be worried because that is unusual of children,” and “ Not sure why she doesn’t like other kids.” Other responses centered on the themes that there was a concern that the behaviors were a possible response to abuse. The answers that related to abuse included the following: “Concerned about something going on at home/safety issues,” “Is the child being abused emotionally, physically, or sexually,” and “Something is going on at home and he is not safe.”

Hypothesis 2: Parents will prefer a talk-therapy approach to play therapy recommendations.

Data for determining whether or not parent gender and the presented vignette impacted participant recommendation of therapeutic treatment was analyzed using a multinomial logistic regression, with chosen course of therapeutic treatment as the dependent measure. Participant gender and vignette (child gender and behavior) were the independent variable while previous participation in mental health treatment was used as a covariate in this analysis. Of the total participants, 25 did not provide an answer that fit within one of the therapies recommended. Several participants did not provide an answer (n = 21), others reported that they would not recommend therapeutic services based on the child’s behavior in the vignette (n = 3), and one participant answered other (n = 1). However, the one participant who put other did not provide enough information to properly categorize the answer into one of the other groups.

Due to the limited number of participants in some of the therapies recommended, it was necessary to consolidate some of the groups in order to do a proper analysis. As a result, filial therapy was used as the referent group because according to the literature it is the most effective treatment for children with externalizing and internalizing behaviors (Bratton et al., 2013).

However, given parent's lack of familiarity with filial play therapy and their reliance on talk therapy, it was assumed that parents might be more likely to recommend talk therapy. As a result, talk therapy was listed as the first option and play therapy was listed as the second option. Finally, a combination of play and filial play therapy was listed as the third option due to the number of participants that chose a combination of these two recommended therapies ($n = 26$).

The results using the multinomial logistic regression were not significant ($p = .140$). While the trend for parents was to recommend talk therapy over filial therapy (2.61 times more likely) the fact that it was not statistically significant means that the hypothesis that parents were more likely to recommend talk therapy versus a play based approach, specifically comparing it to filial play therapy, was not supported.

A review of the qualitative data suggested trends in participant recommendation. Many participants expressed that they were unfamiliar with filial play therapy and therefore uncomfortable with the filial play therapy option. One participant explained that she might have recommended filial play therapy if her pediatrician recommended it, but that otherwise she would recommend talk therapy. Several other participants reported that they felt as though the parent may be the main stressor for the child and that the child may therefore be more willing to open up to a therapist through individual talk therapy. Finally, parents seemed to rate internalizing female behaviors as the most concerning and although parents seemed to recommend talk therapy in lieu of other treatment options, these recommendations for therapy were not statistically significant. The importance of these findings and how they contribute to the preexisting literature will be discussed in the discussion section.

CHAPTER 5: DISCUSSION

The purpose of this article was to evaluate how parents perceive problematic behaviors in children based on child gender and type of behavior, either externalizing or internalizing. Results indicated that parents viewed the child's behavior in each vignette as problematic, but they viewed some behaviors as more problematic than others. This section will specifically discuss these findings in the context of existing literature; and, in some cases, highlight where these findings might make a contribution to the preexisting literature.

A Systematic Understanding of the Findings

Recent changes in the economy require that changes be made within the family system so that many parents are embracing new working hours (Strazdins, 2006). Mothers are more likely to take responsibility for managing the household responsibilities and the disciplining of children, while fathers are likely to be more lenient because their time with their children has become so limited (Vieira et al., 2016; Strazdins et al., 2006). Additionally, nonstandard work schedules have made it harder to build family closeness, resulting instead in relationship disruptions and strain (Mistry, Vandewater, Huston, & McLoyd, 2002; Vieira, 2016). Parents ability, or inability, to balance their work and family roles due to the economic changes and increased working hours is directly associated with the quality of the parent-child relationship, which is in turn linked to internalizing and externalizing behaviors in children (Vieira et al., 2016).

In order to understand the finding that mothers reported higher levels of concern than fathers, we need to understand societal messages around parenting and how these messages relate to how childcare is often split between parents. Women are often expected to be in charge of children and other household tasks as well as being in charge of defining the problems in the

context of relationships (Vieira et al., 2016). As a result, women often find themselves in the role where they are doing the double shift, which might result in women being more involved in their children's lives (Vieira et al., 2016; Strazdins et al., 2006). More involvement in the child's life might influence their negative response. Likewise, fathers might not be as involved, resulting in experiencing their children less negatively.

Participants' Report of Vignette Behavior

Based on the reviewed literature it was suggested that male externalizing behaviors would be rated more negatively, closely followed by female externalizing behaviors (Chen, 2010; Olson, Sameroff, Kerr, Lopez & Wellman, 2005). The literature implied that parents often report more negatively on the more observable externalizing behaviors and that children who displayed these externalizing behaviors are more likely to be punished compared to children displaying less observable behaviors (Madigan, Brumariu, Villani, Atkinson, & Lyons-Ruth, 2016; Wright, Zakriski, & Drinkwater, 1999). Although the literature reports that externalizing behaviors are often viewed more negatively by parents, this sample seemed to rate female internalizing behaviors as the most concerning, closely followed by male internalizing behaviors, with externalizing behaviors in both males and females as least concerning.

Although the previous reviewed literature does not support the results from the analysis, other studies have found that during the preschool years, aggressive, hyperactive, and compliance behaviors are relatively common and can be viewed as relatively normal (Beernink, Swinkels, & Buitelaar, 2007). This study found that more than 70% of parents recognized externalizing behaviors in their children, and in turn justified this as normal behavior in young children (Beernink et al.).

Several participants expressed less concern for the male externalizing behaviors. Considering the explanations provided by participants for their lack of concern about the externalizing behaviors, in addition to the notion that externalizing behaviors are normal for boys this age, it is understandable that participants rated the internalizing behaviors as more concerning. Boys are often thought to be more deviant and more specifically, masculinity has become a catch all phrase to explain all male behaviors of being tough, noisy, and deviant (Peter & Roberts, 2010; Mac an Ghail & Haywood, 2012). With this in mind, it seems as though boys are expected to behave in aggressive manners. Although the previously reviewed literature suggests otherwise, it seems as though the participants in this sample considered externalizing behaviors to be normal behaviors at this age for both males and females.

The participants may have also been less concerned by the externalizing behaviors because the vignette primarily focused on some of the more common acting out and aggressive behaviors. In turn, the vignette fails to address some of the more severe externalizing behaviors such as hurting animals, lack of remorse, property destruction, stealing or lying, and truancy (Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015; Peter & Roberts, 2010). Furthermore, the responses towards the vignette were focused on the level of concern participants feel in the presented behaviors and did not focus on how likely the participant would be to punish the child for exhibiting those behaviors. While lack of concern may be understood separately from need to punish a child based on certain behaviors, some behaviors have been found to lead to parents adopting negative beliefs about the child, which may increase the likelihood of a parent selecting harsh or punitive discipline strategies (Laskey & Cartwright-Hatton, 2009).

Gender differences on level of concern. The majority of the concern focused on the female internalizing behaviors. The qualitative responses provide a greater understanding of the

participants' rationale in having more concern for the internalizing behaviors, explaining that many participants felt as though the internalizing behaviors were not socially normal for a child and that the behaviors may be due to social anxiety or even as a result of experiencing abuse. Laskey and Cartwright-Hatton (2009) provide another view on parents' understanding of internalizing behaviors that support the current findings. Children with internalizing behaviors are more likely to experience negative parental beliefs, which may increase the displayed internalizing behaviors, eliciting further unsupportive parenting and creating a negative feedback loop (Laskey & Cartwright-Hatton, 2009).

The reviewed literature also suggested that mothers and fathers are not likely to differ on their responses to externalizing and internalizing behaviors in children (Kumpulainen et al., 1999, Chen, Seipp, & Johnston, 2008). However, the one-way analysis of covariance between participant gender and level of concern suggested that mothers viewed all behaviors more negatively. Although this differs from the presented literature, one study found that mothers often score higher than fathers when rating behaviors (Javo, Heyerdahl, & Rønning, 2000). Another study reported similar results, stating that mothers rated both externalizing and internalizing behaviors higher than fathers (Chen, Seipp, & Johnston, 2008).

Javo, Heyerdahl, & Rønning (2000) hypothesized that differences in scores might represent differences in tolerance of behaviors due to parent gender, suggesting that fathers' attitudes on aggressive behaviors tend to be more lenient than mothers' attitudes. Fathers have also been found to have a stricter attitude than mothers on items such as clumsiness, restlessness, and hyperactivity (Javo, Heyerdahl, & Rønning, 2000). These findings directly relate to the systemic understanding of the findings, mother's increased amount of time spent with their children may negatively influence their reaction towards behaviors, while the opposite may be

true for fathers. A review of the qualitative responses further validated father leniency and provided explanations such that one participant stated that he felt as though it would not be out of the norm for a young boy to be hyper at that age. Another father stated that he did not feel concerned because kids may be kids, while another father stated that his level of concern was zero, although he provided no reasoning behind this answer.

The qualitative responses also supported mothers' tendency to be less lenient than fathers. One mother stated, "Too rough, uses ugly language. Needs to practice other ways to express his feelings." "Being aggressive at school concerns me," "He needs to be taught another outlet," and "Concerned about the language and trying to hurt little brother" were additional responses towards the externalizing behaviors made by mothers. Therefore, although some of the reviewed literature proposes that mothers and fathers do not differ vastly on their understanding of externalizing and internalizing behaviors in children, there is also evidence to support our finding that mothers tended to have more concern overall about the presented behaviors than fathers (Javo, Heyerdahl, & Rønning, 2000; Chen, Seipp, & Johnston, 2008).

The findings on parents' level of concern about problematic behaviors in children differed from what was presented from the preexisting literature. This may be due to the participants responding to a vignette that does not specifically address how the parents would react if the child were their own. The abstract quality of the vignettes may have encouraged parents to provide an answer that they felt would be viewed as morally sound. Additionally, participants may have responded differently due to the vignette being based on a written reaction, meaning that parents might react differently if they were to encounter these behaviors in person rather than on paper.

Participants' Report of Recommended Treatment

Although the multinomial logistic regression found no significance between parent genders, the presented vignette, and recommended treatment, trends did emerge in participant recommendations. Talk therapy seemed to be the preferred recommended treatment with participants explaining that they felt as though the parents may be a main source of stress for the child, resulting in the child's unwillingness to open up to a therapist if the parents were involved. Although this idea seemed to be endorsed by many of the parents in this study and some resistance to therapy is natural, therapy has also proven to assist parents in becoming more unified in the parenting skills they use with their children and the amount of disharmony between parents and children has been found to decrease following participation in parent child therapies, particularly filial play therapy (Cornett, 2012; Van Fleet, 2000; Bavin-Hoffman, Jennings, & Landreth, 1996).

While parents were concerned that parent involvement in therapy would limit the opportunity for change in the child's behavior, lack of parent involvement would leave the child in an isolated therapeutic setting. This lack of parental involvement may result in the child consistently being reintroduced to the same problematic system because change would only be occurring on one level, thus diminishing therapeutic potential (Cornett, 2012). The purpose of therapy is to help the entire family system change, with filial play therapy provoking change by training parents to be the "therapeutic agents" of change within the family, enhancing the parent-child relationship through increased family interactions, and through increased feelings of affection, warmth, and trust (Cornett, 2012). Therefore, although parents are concerned that parental involvement may impede the child's progress in therapy, parent involvement has been found to be a significant predictor of successful play therapy outcomes for the entire family

(Cornett, 2012; Van Fleet, 2000) These outcomes of filial play therapy include positive changes in child behaviors, improved marital relationships, improved sense of shared power between parents, and improvements in parent-child communication (Cornett, 2012; Bavin-Hoffman, Jennings, & Landreth, 1996).

The results presented from the analyses showed significance in the relationship between vignette type and parent level of concern and significance in the relationship between parent gender and level of concern, although the hypotheses were not supported. Parents seemed to be concerned about each of the vignette types and were only slightly more concerned by the internalizing female behaviors. Furthermore, responses varied by parent gender, suggesting that mothers were more concerned by each of the behaviors than fathers. This may be due to mothers being less lenient towards negative behaviors in children. Finally, parents seemed to recommend talk therapy over any form of play therapy. It is suggested that parents would be more likely to choose talk therapy because of their lack of knowledge about filial play therapy and because of their uneasiness about the possibility of being the stressor behind the problematic behaviors in the child.

Clinical Implications

The results of the analyses generate several concepts for consideration in clinical practice. It is important to consider the clinical implications of the findings that mothers tend to rate all behaviors more negatively and fathers tend to be slightly less concerned about the same behaviors. Although the parents tended to rate the behaviors differently, it is important to understand and validate both views when addressing behavior problems in children (Javo, Heyerdahl, & Rønning, 2000). Primarily, it is important for therapists to listen without judging family members' reactions in order to maintain open communication and to invite both parents to

express all that is on their minds (Van Fleet, 2000). Listening and validating both parents and each of their concerns will establish a trusting relationship between the parents and therapist, which would allow for a partnership that is essential for positive outcomes (Van Fleet, 2000).

In order to address both mothers' and fathers' views in a clinical setting it may be beneficial to explain to parents the cognitive, emotional, and behavioral capabilities of young children (Wyatt Kaminski, Valle, Filene, & Boyle, 2008). Normalizing age appropriate behaviors may increase mothers' understanding of childhood behaviors so that they are more tolerant and less concerned by typical behaviors (Wyatt Kaminski, Valle, Filene, & Boyle, 2008). This normalizing process may also prove beneficial in encouraging fathers to be more wary of childhood behaviors that are abnormal, rather than slightly less concern over these concerning behaviors (Wyatt Kaminski, Valle, Filene, & Boyle, 2008). Specifically involving parents in filial play therapy would allow both mothers and fathers to gain a new way of understanding behaviors in children (Wickstrom, 2009). Many parents that have participated in filial play therapy report that therapy decreased the focus on the child's behavior and increased awareness of the child's needs and feelings (Wickstrom, 2009). filial play therapy also altered parents' tendencies to fix things for their children by allowing them to set more developmentally appropriate expectations of their children (Wickstrom, 2009).

Additionally, the suggestion that mothers and fathers differ slightly in their concern of the presenting behaviors is important to consider in a clinical setting. The results did find that mothers seem to be more concerned about all of the behaviors, but only marginally. From a research perspective this marginal difference is rather important, but from a clinical perspective it may present as though all parents seem concerned by all four vignette descriptions. A systemic perspective takes note of what happens when people tend to focus on the differences rather than

looking at the similarities (Wickstrom, 2009). In a clinical setting, if the clinician is able to point out the many similarities without focusing on the differences, then perhaps the parents can be united against the behaviors rather than working from opposite directions (Wickstrom, 2009).

It is also important to focus on how mothers and fathers are reacting towards negative behaviors in their children. While fathers' increased working hours often result in greater leniency with behaviors in children because time with their children is limited, mothers often take on the responsibility of disciplining the children (Vieira et al., 2016; Strazdins, 2006). Increased work hours directly results in less time spent with children teaching them emotional and social skills and may also negatively impact a parent's mental health, which in turn impacts their parenting (Mistry, Vandewater, Huston, & McLoyd, 2002; Vieira et al., 2016). The systemic nature of filial play therapy provides a way to assess and intervene within family interactions with a focus on the importance of the child subsystem, the parent subsystem, and the overall family system so that problematic behaviors in children decrease, parent-child relationships improve, and marital relationships improve (Cornett, 2012; Wickstrom, 2009).

It is also important to consider the participants' tendency to recommend talk therapy treatment options in lieu of play therapy options due to their lack of awareness of play therapy and due to them being uncomfortable about the parent being the possible stressor and cause of the problematic behaviors in the child. When parents are reluctant to participate in play therapy, clinicians should first show genuine empathy for the parent's point of view in order to validate their reluctance (Van Fleet, 2000). The clinician might also inform the parents explicitly how filial play therapy will meet their needs by educating them on the skills that the parents will learn and on the benefits of filial play therapy as opposed to talk therapy approaches (Van Fleet, 2000). When parents question the value of play, it might be encouraging to have parents reflect

on their own experiences with play as a child in order to help them understand that play is the primary way that children learn about the world, communicate their feelings, and develop life skills (Van Fleet, 2000).

Limitations

Although this study found significance between participant level of concern and presented vignette type as well as between participant gender and level of concern, limitations in the study do exist. The final sample exceeded the targeted effect size of 128, but fell just short of its goal of including 64 males (n=54). Instead, the final sample of completed surveys was predominantly female (n = 91; 62%) and heavily White, Non-Hispanic (n = 129; 89%).

A second limitation exists in the methodology behind the utilization of the behavioral vignettes. The authors created the included vignettes without knowledge about the expected difference in responses. Bradbury-Jones, Taylor & Herber (2012) suggested that care must be taken when vignettes are constructed solely on real-life experiences. The use of more concretely constructed vignettes, as opposed to vignettes based entirely on experience, may also provide responses that more closely resemble real judgement in daily life rather than responding to more abstract vignettes (Dülmer, 2016). The vignettes may be further improved upon by including suggestions from previous research findings, literature reviews, and even by depicting a broader range of behavioral situations (Bradbury-Jones, Taylor, & Herber, 2012).

Finally, the vignettes did not ask participants to rate their level of concern as if the child presented in the vignette were the participant's own child. Therefore, it is assumed that participants may have responded differently to the vignettes if the vignettes were less abstract and asked questions specifically as if the presented child were the participant's own (Bradbury-Jones, Taylor, & Herber, 2012). The use of vignettes has been found to assist participants in

disclosing sensitive information related to morally-charged issues, such as appropriate childhood behaviors and appropriate disciplining practices (Bradbury-Jones, Taylor, & Herber, 2012).

Asking the parents to express their concern over the vignette as if the child were their own, might have resulted in a wider variety of the levels of concern and recommendations because of the distance between researcher and participant that vignettes provide (Bradbury-Jones, Taylor, & Herber, 2012).

Future Research

Based on the presented limitations it is suggested that future research involving parents' understanding of child behaviors and recommended treatment include a larger, more diverse sample. The current study does not provide enough data to accurately suggest how a sample of more racially diverse parents would view these behaviors in children and what type of treatment they might recommend. Parents from different cultures may be more or less tolerant of deviant behaviors and while tolerance for behavior problems may be similar in some cultures, the threshold for seeking therapeutic treatment may be higher in certain ethnic groups (Javo, Heyerdahl, & Rønning, 2000). It is also important to include a highly diverse population of parent participants because parental tolerance of child behavior in boys and girls may differ more in some cultures than in others (Javo, Heyerdahl, & Rønning, 2000). Furthermore, some cultures may have different feelings about play in general and in filial therapy. Specifically, African American families have historically placed a higher value on academic achievement and school readiness and often rate academic skills as more important than other approaches to learning, such as engagement (Tamis-LeMonda, Sze, Ng, Kahana-Kalman, & Yoshikawa, 2013). The findings in a future study that includes a more diverse sample may better reflect the different norms and values between various ethnicities and cultures.

This study also does not provided adequate male participation, thus suggesting that fathers be more heavily targeted in future studies. Although the target population of males was 64, males completed a total of only 54 responses. Due to male participation remaining stagnant for a large amount of time, the current study was expanded to offer extra credit to any students who were able to refer a male participant. This increased the male participation drastically. While this was beneficial in increasing the sample size, it also introduces the possibility that some participants were involved simply to help a friend, and as a result may not have been as invested in the process, or in some extreme cases that a student may have simply taken the survey on their own. While we have no way of knowing whether or not this was indeed the case, it does introduce the possibility and as such should be considered when interpreting these results.

Finally, in order to have more confidence in the behavioral vignettes, it is suggested that parents who have experience with these externalizing and internalizing problems manifesting in their own children be sought out rather than focusing on the views surrounding more abstract vignettes. Participants who respond to hypothetical vignettes are more likely to respond in a hypothetical manner, rather than basing their answer on experience (Bradbury-Jones, Taylor, & Herber, 2012). When participants are faced with vignettes that are not relatable they often struggle to rate the presenting behaviors and ask for more detailed information in order to make their decisions (Bradbury-Jones, Taylor, & Herber, 2012). Therefore, it is assumed that if parents were more familiar with the behaviors in the vignette and could relate the vignettes to their own experiences, they may respond in a more realistic and truthful manner.

Conclusion

The need for effective interventions for young children has become increasingly important as the amount of children with mental health problems that do not receive mental

health services continues to grow (Ray, Armstrong, Balkin, & Jayne, 2014; Jordans, Tol, & Komproe, 2011; Jabbour et al., 2016). It is evident that the weakened economy has affected parental working hours, which has in turn affected parental mental health, parenting strategies, and marital satisfaction (Menaghan, 1991). Each of these components have had an impact on child behaviors, leading to externalizing and internalizing problems in children. When these problems are allowed to continue without treatment, later problems in adolescence and adulthood are likely to exist (Meany-Walen, Kottman, Bullis, & Dillman Taylor, 2015).

Although filial play therapy is supported as an effective treatment for childhood behavior problems, the parents in this study reported that they were more likely to recommend some form of talk therapy, specifically without the inclusion of the parents (Bratton, Ray, Rhine, & Jones, 2005; Kane, 2016). Although these recommendations were not found to be significant, parents did seem to prefer talk therapy over other options. Providing an awareness of the systemic change that results from participation in filial play therapy is likely to improve parent understanding of behaviors in their children, improve parent-child relationships, and improve marital relationships (Cornett, 2012; Wickstrom, 2009).

Finally, the significant finding between the presented vignette type and the participant's level of concern increases the understanding of the need to increase parent awareness of appropriate and inappropriate behaviors in children and whether or not these behaviors are cause for concern. The incorporation of filial play therapy, with the parents acting as the "therapeutic agents" of change is likely to result in improving child behaviors, confidence in parenting ability, and an improvement in overall family bonding (Cornett, 2012). The continued implementation of filial play therapy provides a systemic context of therapeutic action within the family system as a whole that results in systemic change within the entire family.

REFERENCES

- Achenbach, T. M., Ivanova, M. Y., Rescorla, L. A., Turner, L. V., & Althoff, R. R. (2016). Internalizing/externalizing problems: Review and recommendations for clinical and research applications. *Journal of the American Academy of Child and Adolescent Psychiatry, 55*(8), 647-656. doi:10.1016/j.jaac.2016.05.012
- Amato, P. R., & Cheadle, J. E. (2008). Parental divorce, marital conflict and children's behavior problems: A comparison of adopted and biological children. *Social Forces, 86*(3), 1139-1161. doi:10.1353/sof.0.0025
- Barter, C., & Renold, E. (1999). The use of vignettes in qualitative research. *Social Research Update, 25*, 1-4.
- Bavin-Hoffman, R., Jennings, G., & Landreth, G. (1996). Filial therapy: Parental perceptions of the process. *International Journal of Play Therapy, 5*(1), 45-58. doi:10.1037/h0089109
- Beernink, A. E., Swinkels, S. N., & Buitelaar, J. K. (2007). Problem behavior in a community sample of 14- and 19-month-old children: Common versus uncommon behaviors, structure, and stability. *European Child & Adolescent Psychiatry, 16*(4), 271-280. doi:10.1007/s00787-007-0600-9.
- Berry, J. O., & Jones, W. H. (1995). The parental stress scale: Initial psychometric evidence. *Journal of Social and Personal Relationships, 12*(3), 463-472. doi:10.1177/0265407595123009
- Boswell, J. N. (2014). The use of child parent relationship therapy and common parent concerns: Voices from the community. *The Family Journal: Counseling and Therapy for Couples and Families, 22*(4), 382-389. doi:10.1177/1066480714548162

- Bratton, S. C., Ceballos, P. L., Sheely-Moore, A. I., Meany-Walen, K., Pronchenko, Y., & Jones, L. D. (2013). Head start early mental health intervention: Effects of child-centered play therapy on disruptive behaviors. *International Journal of Play Therapy*, 22(1), 28-42. doi:10.1037/a0030318
- Bratton, S. C., Landreth, G. L., & Lin, Y. D. (2010). Child parent relationship therapy: A review of controlled outcome research. In J. N. Baggerly, D. C. Ray, & S. C. Bratton (Eds.) *Child-centered play therapy research: The evidence base for effective practice* (pp. 265-293). Hoboken, NJ: Wiley. <http://dx.doi.org/10.1002/9781118269626.ch15>
- Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36(4), 376-390. doi:10.1037/0735-7028.36.4.376
- Briggs-Gowan, M. J., Carter, A. S., Bosson-Heenan, J., Guyer, A. E., & Horwitz, S. M. (2006). Are infant-toddler social-emotional and behavioral problems transient? *Journal of the American Academy of Child and Adolescent Psychiatry*, 45, 849-858. <http://dx.doi.org/10.1017/S0954579409000285>
- Charmaz, K. (2003). Grounded theory. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*. (pp. 81-110). Thousand Oaks, CA: Sage Publications.
- Chen, J. J. (2010). Gender differences in externalising problems among preschool children: Implications for early childhood educators. *Early Child Development and Care*, 180(4), 463-474. doi:10.1080/03004430802041011
- Chen, M., Seipp, C. M., & Johnston, C. (2008). Mothers' and fathers' attributions and beliefs in families of girls and boys with Attention-Deficit/Hyperactivity Disorder. *Child Psychiatry and Human Development*, 39(1), 85-99. doi:10.1007/s10578-007-0073-6

- Christensen, T. M., & Thorngren, J. M. (2000). Integrating play in family therapy: An interview with Eliana Gil, Ph.D. *The Family Journal: Counseling and Therapy for Couples and Families*, 8(1), 91-100. doi:10.1177/1066480700081017
- Cooney, M. H. (2004). Is play important? Guatemalan kindergartners' classroom experiences and their parents' and teachers' perceptions of learning through play. *Journal of Research in Childhood Education*, 18(4), 261-277. doi:10.1080/02568540409595040
- Copeland, K. A., Kendeigh, C. A., Saelens, B. E., Kalkwarf, H. J., & Sherman, S. N. (2012). Physical activity in child-care centers: Do teachers hold the key to the playground? *Health Education Research*, 27(1), 81-100. doi:10.1093/her/cyr038
- Cornett, N. (2012). A filial therapy model through a family therapy lens: See the possibilities. *The Family Journal: Counseling and Therapy for Couples and Families*, 20(3), 274-282. doi:10.1177/1066480712449128
- Cornett, N., & Bratton, S. C. (2015). A golden intervention: 50 years of research on filial therapy. *International Journal of Play Therapy*, 24(3), 119-133. doi:10.1037/a0039088
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks: SAGE Publications.
- Cummings, E. M. (1994). Marital conflict and children's functioning. *Social Development*, 3(1), 16-36. doi:10.1111/j.1467-9507.1994.tb00021.x
- Cummings, J. G., Pepler, D. J., & Moore, T. E. (1999). Behavior problems in children exposed to wife abuse: Gender differences. *Journal of Family Violence*, 14(2), 133-156. doi:10.1023/A:1022024702299
- Davies, P. T., Hentges, R. F., Coe, J. L., Martin, M. J., Sturge-Apple, M. L., & Cummings, E. M. (2016). The multiple faces of interparental conflict: Implications for cascades of

- children's insecurity and externalizing problems. *Journal of Abnormal Psychology*, 125(5), 664.
- De Coster, S., & Cornell Zito, R. (2010). Gender and general strain theory: The gendering of emotional experiences and expressions. *Journal of Contemporary Criminal Justice*, 26(2), 224-245. doi:10.1177/1043986209359853
- Downey, G., & Coyne, J. C. (1990). Children of depressed parents: An integrative review. *Psychological Bulletin*, 108(1), 50-76. doi:10.1037/0033-2909.108.1.50
- Dube, S. R., Williamson, D. F., Thompson, T., Felitti, V. J., & Anda, R. F. (2004). Assessing the reliability of retrospective reports of adverse childhood experiences among adult HMO members attending a primary care clinic. *Child Abuse & Neglect*, 28(7), 729-737. doi:10.1016/j.chiabu.2003.08.009
- Dülmer, H. (2016). The factorial survey: Design selection and its impact on reliability and internal validity. *Sociological Methods & Research*, 45(2), 304-347. doi:10.1177/0049124115582269
- Edwards, M. E. (2001). Uncertainty and the rise of the work-family dilemma. *Journal of Marriage and Family*, 63(1), 183-196. doi:10.1111/j.1741-3737.2001.00183.x
- Edwards, R. C., & Hans, S. L. (2015). Infant risk factors associated with internalizing, externalizing, and co-occurring behavior problems in young children. *Developmental Psychology*, 51(4), 489-499. doi:10.1037/a0038800
- Fisher, K. R., Hirsh-Pasek, K., Golinkoff, R. M., & Gryfe, S. G. (2008). Conceptual split? Parents' and experts' perceptions of play in the 21st century. *Journal of Applied Developmental Psychology*, 29(4), 305-316. doi:10.1016/j.appdev.2008.04.006

- Francis, K. A. (2014). General strain theory, gender, and the conditioning influence of negative internalizing emotions on youth risk behaviors. *Youth Violence and Juvenile Justice*, 12(1), 58-76. doi:10.1177/1541204013477428
- Garb, H.N. (1997). Race bias, social class bias, and gender bias in clinical judgment. *Clinical Psychology: Science and Practice*, 4(2), 99-120.
- Ginsberg, B. G. (2002). The power of filial relationship enhancement therapy as an intervention in child abuse and neglect. *International Journal of Play Therapy*, 11(1), 65-78. doi:10.1037/h0088857
- Goleman, D. (1998). Foreward. In J. Gottman & J. DeClaire. *Raising an emotionally intelligent child*. (pp. 13-14). New York: NY: Simon & Schuster.
- Graziano, P. A., Bagner, D. M., Slavec, J., Hungerford, G., Kent, K., Babinski, D., Derefinko K., Pasalich, D. (2015). Feasibility of intensive parent–child interaction therapy (I-PCIT): Results from an open trial. *Journal of Psychopathology and Behavioral Assessment*, 37(1), 38-49. doi:10.1007/s10862-014-9435-0
- Gruhn, M. A., Dunbar, J. P., Watson, K. H., Reising, M. M., McKee, L., Forehand, R., . . . Compas, B. E. (2016). Testing specificity among parents' depressive symptoms, parenting, and child internalizing and externalizing symptoms. *Journal of Family Psychology : JFP : Journal of the Division of Family Psychology of the American Psychological Association (Division 43)*, 30(3), 309-319. doi:10.1037/fam0000183
- Guernsey, L. (2000). Filial therapy into the 21st century. *International Journal of Play Therapy*, 9(2), 1-17. doi:10.1037/h0089433

- Heymann, S. J., & Earle, A. (2001). The impact of parental working conditions on school-age children: The case of evening work. *Community, Work & Family*, 4(3), 305-325.
doi:10.1080/01405110120089369
- Hinshaw, S. P., Han, S. S., Erhardt, D., & Huber, A. (1992). Internalizing and externalizing behavior problems in preschool children: Correspondence among parent and teacher ratings and behavior observations. *Journal of Clinical Child Psychology*, 21(2), 143-150.
doi:10.1207/s15374424jccp2102_6
- Hofferth, S. L., & Sandberg, J. F. (2001). How American children spend their time. *Journal of Marriage and Family*, 63(2), 295-308. doi:10.1111/j.1741-3737.2001.00295.x
- Jabbour, M., Reid, S., Polihronis, C., Cloutier, P., Gardner, W., Kennedy, A., . . . Cappelli, M. (2016). Improving mental health care transitions for children and youth: A protocol to implement and evaluate an emergency department clinical pathway. *Implementation Science: IS*, 11(1), 90. doi:10.1186/s13012-016-0456-9
- Javo, C., Heyerdahl, S., & Rønning, J. A. (2000). Parent reports of child behavior problems in young Sami children: A cross-cultural comparison. *European Child & Adolescent Psychiatry*, 9(3), 202-211. doi:10.1007/s007870070044
- Jenkins, N., Bloor, M., Fischer, J., Berney, L., & Neale, J. (2010). Putting it in context: The use of vignettes in qualitative interviewing. *Qualitative Research*, 10(2), 175-198.
doi:10.1177/1468794109356737
- Jordans, M., Tol, W., & Komproe, I. (2011). Mental health interventions for children in adversity: Pilot-testing a research strategy for treatment selection in low-income settings. *Social Science & Medicine*, 73(3), 456-466. doi:10.1016/j.socscimed.2011.06.004

- Kane, N. (2016). The play-learning binary: U.S. parents' perceptions on preschool play in a neoliberal age. *Children & Society, 30*(4), 290-301. doi:10.1111/chso.12140
- Karcher, M. J., & Lewis, S. S. (2002). Pair counseling: The effects of a dyadic developmental play therapy on interpersonal understanding and externalizing behaviors. *International Journal of Play Therapy, 11*(1), 19-41. doi:10.1037/h0088855
- Kumpulainen, K., Räsänen, E., Henttonen, I., Moilanen, I., Piha, J., Puura, K., . . . Almqvist, F. (1999). Children's behavioural/emotional problems: A comparison of parents' and teachers' reports for elementary school-aged children. *European Child & Adolescent Psychiatry, 8*(S4), S041-S047. doi:10.1007/BF03159641
- Laskey, B. J., & Cartwright-Hatton, S. (2009). Parental discipline behaviours and beliefs about their child: Associations with child internalizing and mediation relationships. *Child: Care, Health and Development, 35*(5), 717-727. doi:10.1111/j.1365-2214.2009.00977.x
- Mac an Ghail, M., & Haywood, C. (2012). Understanding boys': Thinking through boys, masculinity and suicide. *Social Science & Medicine, 74*(4), 482-489. doi:10.1016/j.socscimed.2010.07.036
- Madigan, S., Brumariu, L. E., Villani, V., Atkinson, L., & Lyons-Ruth, K. (2016). Representational and questionnaire measures of attachment: A meta-analysis of relations to child internalizing and externalizing problems. *Psychological Bulletin, 142*(4), 367-399. doi:10.1037/bul0000029
- Maguire, S. A., Williams, B., Naughton, A. M., Cowley, L. E., Tempest, V., Mann, M. K., . . . Kemp, A. M. (2015). A systematic review of the emotional, behavioural and cognitive features exhibited by school-aged children experiencing neglect or emotional abuse:

- Systematic review of school-aged neglect/emotional abuse. *Child: Care, Health and Development*, 41(5), 641-653. doi:10.1111/cch.12227
- Marshall, N. A., Arnold, D. H., Rolon-Arroyo, B., & Griffith, S. F. (2015). The association between relational aggression and internalizing symptoms: A review and meta-analysis. *Journal of Social and Clinical Psychology*, 34(2), 135-160.
doi:10.1521/jscp.2015.34.2.135
- Meany-Walen, K. K., Kottman, T., Bullis, Q., & Dillman Taylor, D. (2015). Effects of Adlerian play therapy on children's externalizing behavior. *Journal of Counseling & Development*, 93(4), 418-428. doi:10.1002/jcad.12040
- Menaghan, E. G. (1991). Work experiences and family interaction processes: The long reach of the job? *Annual Review of Sociology*, 17(1), 419-444.
doi:10.1146/annurev.so.17.080191.002223
- Mistry, R. S., Vandewater, E. A., Huston, A. C., & McLoyd, V. C. (2002). Economic well-being and children's social adjustment: The role of family process in an ethnically diverse low-income sample. *Child Development*, 73(3), 935-951. doi:10.1111/1467-8624.00448
- Olson, S.L., Sameroff, A.J., Kerr, D.C.R., Lopez, N.L., & Wellman, H.M. (2005).
Developmental foundations of externalizing problems in young children: The role of effortful control. *Development and Psychopathology*, 17(1), 25-45.
doi:10.1017/S0954579405050029
- Peter, T., & Roberts, L. W. (2010). 'Bad' boys and 'sad' girls? Examining internalizing and externalizing effects on parasuicides among youth. *Journal of Youth and Adolescence*, 39(5), 495-503. doi:10.1007/s10964-009-9498-5

- Post, P. B., Ceballos, P. L., & Penn, S. L. (2012). Collaborating with parents to establish behavioral goals in child-centered play therapy. *The Family Journal: Counseling and Therapy for Couples and Families*, 20(1), 51-57. doi:10.1177/1066480711425472
- Presser, H. B. (2000). Nonstandard work schedules and marital instability. *Journal of Marriage and Family*, 62(1), 93-110. doi:10.1111/j.1741-3737.2000.00093.x
- Ray, D. C., Armstrong, S. A., Balkin, R. S., & Jayne, K. M. (2015). Child-centered play therapy in the schools: Review and meta-analysis. *Psychology in the Schools*, 52(2), 107-123. doi:10.1002/pits.21798
- Reijneveld, S., Wieggersma, A., Ormel, J., Verhulst, F., Vollebergh, W., & Jansen, D. (2014). Adolescents' use of care for behavioral and emotional problems: Types, trends, and determinants. *Plos One*, 9(4), e93526. doi:10.1371/journal.pone.0093526
- Rothlein, L., & Brett, A. (1987). Children's, teachers; and parents' perceptions of play. *Early Childhood Research Quarterly*, 2(1), 45-53. doi:10.1016/0885-2006(87)90012-3
- Sibley, C. G., Fischer, R., & Liu, J. H. (2005). Reliability and validity of the revised experiences in close relationships (ECR-R) self-report measure of adult romantic attachment. *Personality and Social Psychology Bulletin*, 31(11), 1524-1536. doi:10.1177/0146167205276865
- Sibley, C. G., & Liu, J. H. (2004). Short-term temporal stability and factor structure of the revised experiences in close relationships (ECR-R) measure of adult attachment. *Personality and Individual Differences*, 36(4), 969-975. doi:10.1016/S0191-8869(03)00165-X
- Socarras, K., Smith-Adcock, S., & Shin, S. M. (2015). A qualitative study of an intensive filial intervention using child–parent relationship therapy (CPRT). *The Family Journal:*

Counseling and Therapy for Couples and Families, 23(4), 381-391.

doi:10.1177/1066480715601681

Sourander, A., Helstelä, L., & Helenius, H. (1999). Parent-adolescent agreement on emotional and behavioral problems. *Social Psychiatry and Psychiatric Epidemiology*, 34(12), 657-663. doi:10.1007/s001270050189

Strazdins, L., Clements, M. S., Korda, R. J., Broom, D. H., & D'Souza, R. M. (2006). Unsociable work? Nonstandard work schedules, family relationships, and children's well-being. *Journal of Marriage and Family*, 68(2), 394-410. doi:10.1111/j.1741-3737.2006.00260.x

Silverman, W. K., & Carter, R. (2006). Anxiety disturbance in girls and women. In J. Worell & C.D. Goodheart (Eds.), *Handbook of girls' and women's psychological health*. Oxford: Oxford University Press.

Tamis-LeMonda, C. S., Sze, I. N., Ng, F. F., Kahana-Kalman, R., & Yoshikawa, H. (2013). Maternal teaching during play with four-year-olds: Variation by ethnicity and family resources. *Merrill-Palmer Quarterly*, 59(3), 361-398.
doi:10.13110/merrpalmquar1982.59.3.0361

Turns, B. A., & Kimmes, J. (2014). "I'm NOT the problem!" Externalizing children's "Problems" using play therapy and developmental considerations. *Contemporary Family Therapy*, 36(1), 135-147. doi:10.1007/s10591-013-9285-z

VanFleet, R. (2000). Understanding and overcoming parent resistance to play therapy. *International Journal of Play Therapy*, 9(1), 35-46. doi:10.1037/h0089439

Vieira, J. M., Matias, M., Ferreira, T., Lopez, F. G., & Matos, P. M. (2016). Parents' work-family experiences and children's problem behaviors: The mediating role of the parent-

- child relationship. *Journal of Family Psychology*, 30(4), 419-430.
doi:10.1037/fam0000189
- Wade, T.J., Cairney, J., & Pevalin, D. (2002). Emergence of gender differences in depression during adolescence: National panel results from three countries. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41. 190-198.
- Wickstrom, M. F. T. A. (2009). The process of systemic change in filial therapy: A phenomenological study of parent experience. *Contemporary Family Therapy*, 31(3), 193-208. doi:10.1007/s10591-009-9089-3
- Wilens, T. E., Biederman, J., Brown, S., Monuteaux, M., Prince, J., & Spencer, T. J. (2002). Patterns of psychopathology and dysfunction in clinically referred preschoolers. *Development and Behavioral Pediatrics*, 23, S31-S36.
<http://dx.doi.org/10.1097/00004703-200202001-00006>
- Willis, A. B., Walters, L. H., & Crane, D. R. (2014). Assessing play-based activities, child talk, and single session outcome in family therapy with young children. *Journal of Marital and Family Therapy*, 40(3), 287-301. doi:10.1111/jmft.12048
- Wright, J. C., Zakriski, A. L., & Drinkwater, M. (1999). Developmental psychopathology and the reciprocal patterning of behavior and environment: distinctive situational and behavioral signatures of internalizing, externalizing, and mixed-syndrome children. *Journal of Consulting and Clinical Psychology*, 67(1), 95-107. doi:10.1037//0022-006X.67.1.95
- Wyatt Kaminski, J., Valle, L. A., Filene, J. H., & Boyle, C. L. (2008). A meta-analytic review of components associated with parent training program effectiveness. *Journal of Abnormal Child Psychology*, 36(4), 567-589. doi:10.1007/s10802-007-92

APPENDIX A: IRB APPROVAL



EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
4N-70 Brody Medical Sciences Building · Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** · www.ecu.edu/irb

Notification of Exempt Certification

From: Social/Behavioral IRB
To: [Andrew Brimhall](#)
CC:
Date: 1/31/2017
[UMCIRB 16-002210](#)
Re: Exploring parents' perceptions of externalizing and internalizing behaviors and their choice of therapy

I am pleased to inform you that your research submission has been certified as exempt on 1/31/2017. This study is eligible for Exempt Certification under category #2.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

The UMCIRB office will hold your exemption application for a period of five years from the date of this letter. If you wish to continue this protocol beyond this period, you will need to submit an Exemption Certification request at least 30 days before the end of the five year period.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418

IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418

APPENDIX B: VIGNETTE 1 – MALE EXTERNALIZING

George is a four-year-old male. George attends a local daycare center every day from mid-morning to late afternoon. One afternoon during outdoor playtime, a classmate takes away the ball that George is playing with. George runs after his classmate, shoves the child to the ground, and calls the child, “Stupid.” George’s teacher has often reported that he does not follow the class rules, disturbs his classmates, and is highly aggressive. George also frequently displays these behaviors at home. He is often aggressive towards his two-year-old brother. George yells at him and hits him when he becomes upset. George also uses aggressive language towards his parents.

Please answer the following questions:

1. Based upon the vignette you read, how concerned are you about the child’s behavior? (0 = not concerned at all, 10 = extremely concerned). _____

Explain:

2. Based on your level of concern over the child’s behavior, how likely would you be to seek treatment to correct the behaviors? (0 = not likely at all, 10 = extremely likely). _____

Explain:

3) When people decide to seek therapy there typically are several options available. Please rate how likely you are to pick the following type of treatment (0 = not likely at all, 10 = extremely likely); a) therapy where the therapist meets individually with your child and talks to a therapist about their behaviors/concerns; b) therapy where the therapist meets with both you and your child and talks about your behavior/concerns; c) therapy based on common play based treatments where your child attends session and plays with a therapist; d) filial play therapy where you, as

the parent, are taught the skills necessary to engage in therapeutic play with your child and then you and your child go to therapy together to work through the child's behaviors/concerns.

4) Which of the four types of therapy would you choose if the child in the vignette were your child? In detail, please explain the reason for your answer.

5) Describe what you would recommend that the parent do, both regarding therapy and when parenting the child at home.

APPENDIX C: VIGNETTE 2 – FEMALE EXTERNALIZING

Elizabeth is a four-year-old female. She attends a local daycare center every day from mid-morning to late afternoon. One afternoon during outdoor playtime, a classmate takes away the ball that Elizabeth is playing with. Elizabeth runs after her classmate, shoves the child to the ground, and calls the child, “Stupid.” Elizabeth’s teacher has often reported that she does not follow the class rules, disturbs her classmates, and is highly aggressive. Elizabeth also frequently displays these behaviors at home. She is often aggressive towards her two-year-old brother. Elizabeth yells at him and hits him when she becomes upset. Elizabeth also uses aggressive language towards her parents.

Please answer the following questions:

1. Based upon the vignette you read, how concerned are you about the child’s behavior? (0 = not concerned at all, 10 = extremely concerned). _____

Explain:

2. Based on your level of concern over the child’s behavior, how likely would you be to seek treatment to correct the behaviors? (0 = not likely at all, 10 = extremely likely). _____

Explain:

3) When people decide to seek therapy there typically are several options available. Please rate how likely you are to pick the following type of treatment (0 = not likely at all, 10 = extremely likely); a) therapy where the therapist meets individually with your child and talks to a therapist about their behaviors/concerns; b) therapy where the therapist meets with both you and your child and talks about your behavior/concerns; c) therapy based on common play based treatments where your child attends session and plays with a therapist; d) filial play therapy where you, as

the parent, are taught the skills necessary to engage in therapeutic play with your child and then you and your child go to therapy together to work through the child's behaviors/concerns.

4) Which of the four types of therapy would you choose if the child in the vignette were your child? In detail, please explain the reason for your answer.

5) Describe what you would recommend that the parent do, both regarding therapy and when parenting the child at home.

APPENDIX D: VIGNETTE 3 – MALE INTERNALIZING

William is a four-year-old male. He attends a local daycare center every day from mid-morning to late afternoon. William usually plays alone at the daycare and does not initiate play with his classmates. He often appears sad and has difficulty concentrating during the class circle time. William frequently complains of headaches and stomachaches to his parents and teacher. He also displays similar behaviors at home on a regular basis. While at home, William often plays alone and runs to hide when he is upset. He chooses not to spend time with his parents or younger sister and appears fearful often.

Please answer the following questions:

1. Based upon the vignette you read, how concerned are you about the child's behavior? (0 = not concerned at all, 10 = extremely concerned). _____

Explain:

2. Based on your level of concern over the child's behavior, how likely would you be to seek treatment to correct the behaviors? (0 = not likely at all, 10 = extremely likely). _____

Explain:

3) When people decide to seek therapy there typically are several options available. Please rate how likely you are to pick the following type of treatment (0 = not likely at all, 10 = extremely likely); a) therapy where the therapist meets individually with your child and talks to a therapist about their behaviors/concerns; b) therapy where the therapist meets with both you and your child and talks about your behavior/concerns; c) therapy based on common play based treatments where your child attends session and plays with a therapist; d) filial play therapy where you, as the parent, are taught the skills necessary to engage in therapeutic play with your child and then you and your child go to therapy together to work through the child's behaviors/concerns.

4) Which of the four types of therapy would you choose if the child in the vignette were your child? In detail, please explain the reason for your answer.

5) Describe what you would recommend that the parent do, both regarding therapy and when parenting the child at home.

APPENDIX E: VIGNETTE 4 – FEMALE INTERNALIZING

Charlotte is a four-year-old female. She attends a local daycare center every day from mid-morning to late afternoon. Charlotte usually plays alone at the daycare and does not initiate play with her classmates. She often appears sad and has difficulty concentrating during the class circle time. Charlotte frequently complains of headaches and stomachaches to her parents and teacher. She also displays similar behaviors at home on a regular basis. While at home, Charlotte often plays alone and runs to hide when she is upset. She chooses not to spend time with her parents or younger brother and appears fearful often.

Please answer the following questions:

1. Based upon the vignette you read, how concerned are you about the child's behavior? (0 = not concerned at all, 10 = extremely concerned). _____

Explain:

2. Based on your level of concern over the child's behavior, how likely would you be to seek treatment to correct the behaviors? (0 = not likely at all, 10 = extremely likely). _____

Explain:

3) When people decide to seek therapy there typically are several options available. Please rate how likely you are to pick the following type of treatment (0 = not likely at all, 10 = extremely likely); a) therapy where the therapist meets individually with your child and talks to a therapist about their behaviors/concerns; b) therapy where the therapist meets with both you and your child and talks about your behavior/concerns; c) therapy based on common play based treatments where your child attends session and plays with a therapist; d) filial play therapy where you, as the parent, are taught the skills necessary to engage in therapeutic play with your child and then you and your child go to therapy together to work through the child's behaviors/concerns.

4) Which of the four types of therapy would you choose if the child in the vignette were your child? In detail, please explain the reason for your answer.

5) Describe what you would recommend that the parent do, both regarding therapy and when parenting the child at home.

APPENDIX F: PARENTAL STRESS SCALE

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided.

1 = Strongly disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly agree

- ___ 1. I am happy in my role as a parent.
- ___ 2. There is little or nothing I wouldn't do for my child(ren) if it was necessary.
- ___ 3. Caring for my child(ren) sometimes takes more time and energy than I have to give.
- ___ 4. I sometimes worry whether I am doing enough for my child(ren).
- ___ 5. I feel close to my child(ren).
- ___ 6. I enjoy spending time with my child(ren).
- ___ 7. My child(ren) is an important source of affection for me.
- ___ 8. Having child(ren) gives me a more certain and optimistic view for the future.
- ___ 9. The major source of stress in my life is my child(ren).
- ___ 10. Having child(ren) leaves little time and flexibility in my life.
- ___ 11. Having child(ren) has been a financial burden.
- ___ 12. It is difficult to balance different responsibilities because of my child(ren).
- ___ 13. The behavior of my child(ren) is often embarrassing or stressful to me.
- ___ 14. If I had it to do over again, I might decide not to have child(ren).
- ___ 15. I feel overwhelmed by the responsibility of being a parent.
- ___ 16. Having child(ren) has meant having too few choices and too little control over my life.
- ___ 17. I am satisfied as a parent.
- ___ 18. I find my child(ren) enjoyable.