Original Research

The Effectiveness of Filial Therapy (Play Therapy Based on Parent-Child Relationship) on Oppositional Defiant Disorder in Preschool Children

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Abstract:

Background:

The aim of this research was to investigate the effectiveness of play therapy with Filial therapy techniques on preschool children with oppositional defiant dirorder in city of Falavarjan. The research method is quasi-experimental with control group pretest posttest design

Method:

The statistical population of the study included all children with oppositional defiant disorder in Falavarjan city who referred to counseling centers in Falavarjan in 2017-18 school year, and 30 of these children were selected using convenience sampling method and put into two control and experimental groups (15 in each group). The experimental group were presented with Filial therapy intervention program for 10, 1 hour sessions for 1 month, while the control group did not receive any intervention during the research process. In this study, the data collection tool was the attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder (ODD) questionnaire by Swanson, Nolan and Pelham (1980) which was used on both control and experimental group in the pretest posttest stage. Data was analyzed by analysis of covariance using SPSS 24 software package.

Result:

The results showed that Filial therapy intervention program has a significant effect on reducing children's oppositional defiant disorder ($p < 0.001$). Based on the findings of the study, it is recommended to use the Filial therapy method.

Conclusion:

Play therapy in the form of filial therapy gives children the opportunity to freely explore their surroundings and communicate with family members in an environment free from threats and fear and develop their communication skills.

Keywords: Filial Therapy, Oppositional Defiant Disorder.

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Introduction

Oppositional Defiant Disorder (ODD) is a gradual and chronic disorder that almost always interferes with the interpersonal relationships and the child's academic performance. These children usually don't have friends and human interactions are not satisfactory for them. Children with this disorder, despite having normal intelligence, don't make much progress in school and might fail due to lack of participation and resistance to external expectations and insisting on solving their problems without getting any help from others. These problems lead to low self-esteem, low endurance for failure, depressed mood and mood swings (1). The prognosis of the disorder has been poor, and diagnosed children are at risk of developing problems such as educational failure and emotional maladaptation in the future years (2). In addition to the effect this disorder has on social and academic issues and the relationship with family members, if left untreated, in more than 75% of cases turns into conduct disorder and antisocial personality disorder and other adult psychological disorders associated with aggression and violence (3). Oppositional defiant disorder is classified in the category of persecution disorders, the most important features of which are persistent patterns of repetitive negative behavior, stubbornness, defiance and vindictiveness toward authority figures that exist for at least six months, it is not adequate with development age of the child and causes significant clinical disorders in academic, social and professional activities (4). The specific behaviors of this disorder include disobeying the rules of everyday life, quarreling and throwing tantrums, arguing with superior powers, bothering others, blaming others for their problems. Also considering the fact that emotional and behavioral problems are not usually reduced naturally, there is an increasing attention dedicated to prevention and treatment of these problems. Research shows that behavioral family interventions effectively reduce and improve these problems. According to social learning theory in treatment and prevention, this is effective on a variety of emotional and behavioral problems specially on children with oppositional defiant disorder and their parents. Filial play Therapy is a new treatment that can help reducing the problems of defiant children and their parents by creating a kind atmosphere and make the parents less sensitive towards their children's behavior because they only see their problematic behaviors and that causes problems in their relationships and minds.

But filial play therapy is an approach structured and based on therapeutic theory that establishes the normal learning and communication processes of children (5). Play therapy is a technique in which children's nature is defined in an explanatory way by it. Filial therapy is a special type of play therapy that is applicable for children between the ages of 3 and 11-12. Filial therapy is closely related to forms of child-centered play therapy that engage parents and care givers (6). This approach is considered a good way to communicate with the child because of the focus on him. This method is taken from the theoretical foundations of DanCai (2013)(4) which is an indirect treatment without guidance. This intervention is a short-term method and is a combination of play therapy and family therapy.

According to researchers, children with oppositional defiant disorder are constantly exposed to serious risks like emotional problems, academic failure, learning disabilities, difficulty in adaptation and social skills, and behavioral and social disorders. On the other hand, this disorder affects the development process of mental talents and socio-emotional skills of diagnosed children, which can lead to poor academic results along with low self-esteem, delinquency, depression and personality disorder and alcohol addiction (7).

Since there is no research in Iran about the effect of filial therapy on reducing oppositional

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defiant disorder symptoms in children, this research that is done on preschool children in Falavarjan is new in its kind. Since children while playing, can express their emotions and show what's on their mind in the form of play activities, this can provide beneficial results for reducing behavioral problems. By using play therapy on children, their concentration and attention skills are significantly stimulated and it can lead to the development of executive functions such as memory. Doing this type of research can also offer results and finding which prove that this can be used as an effective psychotherapy method in the medical method in specialized counseling psychology centers, schools, hospitals, etc. to help people.

The aim of this study is to determine the effectiveness of filial therapy (play therapy based on child-parent relationship) on oppositional defiant disorder in preschool children.

Oppositional Defiant Disorder (ODD)

Based on the description of the fourth edition of the Diagnostic and Statistical Manual of Mental disorders (DSM-IV) oppositional defiant disorder's symptoms are negativity, stubbornness, disobedience, hostility and defiance against authority figures, four of these behaviors (or more) must be seen in the past six months: frequently temper tantrums, excessive arguments with adults, spitefulness, frequents outbursts of anger and resentment, sensitivity, deliberately annoying and upsetting others(8).

Theoretical background and history

In terms of the history, the diagnosis of oppositional defiant disorder was brought up in 1996 by a group of psychiatrists for the first time in (DSM-III -1980) and exists in subsequent revisions. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association 1980) has listed the criteria for oppositional defiant disobedience:

stubbornness, actively defying or refusing to comply with requests from authority figures or rules, deliberately annoying others, blaming others for their mistakes, sensitivity, being angry, resentful, spiteful or vindictive, excessive use of profanity and swear (9).

These behaviors should be more than what is expected from children at that age of development. Also this disorder must cause considerable damage in social, academic, or occupational performance of the child. These behaviors should not exclusively happen during a temperament or psychiatric disorder.

Also the criteria should not be consistent with the symptoms of conduct disorder or antisocial personality disorder (10).

According to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the criteria for oppositional defiant disorder is:

A) A continuous and frequent pattern of anger, rage, sensitivity, being argumentative, disobedience, stubbornness, defiance, resentment and deliberately upsetting others lasting at least 6 months and at least 4 out of 8 symptoms (when the child is interacting with someone other than his sibling).

B) These behaviors are not observed exclusively during a period of psychotic, substance use, major depression or bipolar disorder. Also, the criteria are not met for disruptive mood dysregulation disorder (11).

Diagnostic features:

The main feature of oppositional defiant disorder is a repetitive and persistent pattern of anger, irritability, resentment, stubbornness, or vindictive behavior (Criterion A). Diagnosed children sometimes show angry or irritable behavior and its features also. Symptoms of oppositional defiant disorder may be limited to a predominantly home situation. These people do not have enough signs to meet the detection threshold, even if the symptoms only appear at home.

Their social functioning may be significantly impaired. Still, these symptoms appear in more severe cases in several situations. Given that the extent of the symptoms is an indicator of

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the severity of the disorder, it is important to evaluate a person's behavior in various situations and relationships. Since this behavior is common among siblings, it should be observed during interactions with other people. Because the symptoms of this disorder are usually more obvious in interactions with adults or peers who the child knows them well. It may not be obvious during a clinical examination, the symptoms of oppositional defiant disorder may appear to some extent in people without the disorder. There are several important considerations in determining whether or not these behaviors are a sign of oppositional defiant disorder. First; the diagnostic threshold of four or more symptoms during the last six months must be met. Second; the persistence and frequency of symptoms should be beyond the norms of age, gender or culture of the individual. For example, preschool children usually throw temper tantrums every week. Outbursts of anger for preschool children are considered symptoms of oppositional defiant disorder only if it has occurred on most days in the past 6 months and is associated with at least three other symptoms of the disorder, with these outbursts of anger contributing to significant damage. Symptoms of this disorder are often part of a problematic pattern in interacting with others. In addition, individuals diagnosed with this disorder usually do not consider themselves angry, stubborn, or rebellious. On the contrary, they often justify their behavior as a response to unusual requests or circumstances, thus separating the relative role of the diagnosed individual in the problematic interactions they experience is difficult. Whether the clinical psychologist can or cannot distinguish the relative role of potential causal factors, this should not affect the diagnosis. If the child is living in certain adverse conditions (for example, in the environment of orphanages or shelters) where the possibility of neglect or misconduct, clinical attention to the role of environmental factors will also be helpful (6).

Formation and process

The first signs of oppositional defiant disorder usually appear during the preschool years and rarely after early adolescence. This disorder often precedes the onset of conduct disorder, especially childhood-onset conduct disorder. However, in many children and adolescents with oppositional defiant disorder, conduct disorder does not appear later in their lives. Also, oppositional defiant disorder is a risk factor for anxiety disorders and major depressive disorder, even in the absence of conduct disorder. Symptoms of disobedience, quarrelsome and resentment carry the greatest risk for conduct disorder. While the symptoms of irritable and angry temperament are actually the highest risk for emotional disorders. The effects of this disorder are apparently evident during the transformation. Children and adolescents with oppositional defiant disorder, like adults, are at increased risk for a number of adjustment disorders including antisocial behavior. Oppositional defiant disorder increases during preschool and adolescence. Therefore, before deciding whether these behaviors are signs of oppositional defiant disorder or not, it is important to evaluate the severity of these behaviors during these developmental periods compared to their normal levels (12).

Risk factors and prognosis

1. Natural factors: Natural factors related to emotional regulation problems (for example, high levels of emotional responsiveness, low tolerance for failure)

2. Environmental factors: Violent, contradictory or neglectful parenting methods are common in families of children and adolescents with oppositional defiant disorder, and these parenting methods play an important role in many scientific theories related to this disorder.

3. Genetic and physiological factors: A number of neurobiological indicators (for example,

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lower heart rate, skin reactivity, decreased basal cortisol reactivity, continuous abnormalities) are associated with oppositional defiant disorder. However, most studies have not distinguished children with oppositional defiant disorder from conduct disorder. Therefore, it is not clear what the specific indicators of oppositional defiant disorder are (6). Beyk et al. (2014) in their study showed that among a group of children with oppositional defiant disorder, 92.4% of them meet at least the criteria of one other disorder based on (DSM-IV) which include mood disorders (45.8%), Anxiety (62.3%), Impulse control (68.2%) and substance abuse (47.2). They also expressed that among a large number of concomitant mental disorders, oppositional defiant disorder is the first disorder in terms of time. Also, this disorder can be the strongest predictor of depression in adulthood (13).

Differential Diagnosis of conduct Disorder: Conduct disorder and oppositional defiant disorder and are both associated with behavioral problems that put a person in conflict with adults and other authority figures (such as teachers, caregivers). The severity of these behaviors are usually less in oppositional defiant disorder than conduct disorder, and does not involve aggression against individuals or animals, destruction of property or the pattern of theft or fraud. In addition, oppositional defiant disorder includes problems with emotional disorder (angry and irritable mood) that have been proposed in the definition of conduct disorder.

Necessity of intervention for oppositional defiant children:

Given the importance of the issue and the problems that exist in relation to oppositional defiant disorder and its relationship with the mental health of parents, and given that oppositional defiant disorder causes many problems for the child, family and society, so it is necessary to deal with this problem. Therefore, it is necessary to take action to reduce or eliminate this problem.

Treatment Interventions and Prevention Programs for Oppositional Defiant Disorder:

Different intervention methods have been proposed for children with symptoms of oppositional defiant disorder. One of the factors that led to the development of these therapies is the persistent nature of the disorder. Findings have shown that early destructive behaviors stay persistent during the developmental stages, which is a powerful predictor of delinquency and subsequent criminal behaviors. These two factors require therapies which are both useful and durable (14).

Some of these methods focus on the child himself and some of them focus on the family and peers. In general, methods used to treat children with oppositional defiant disorder should be tailored to the specific needs of the child and family and cover all aspects of the child's environment and functioning.

Medical treatments

In some cases, medical treatment can be used as adjunctive therapy. Haloperidol is effective in reducing aggressive behaviors and aggression. However, risperidone and olanzapine have now replaced haloperidol due to less side effects. Specific serotonin reuptake inhibitors such as fluoxetine, sertraline, and paroxetine are effective in reducing impulsivity, irritability, and mood instability (15).

Some studies have shown that medications used to treat Attention Deficit Hyperactivity Disorder, such as Methylphenidate (Ritalin), Atomoxetine (Strattera), and Amphetamine/ Dextroamphetamine (Adderall), are also used to treat oppositional defiant disorder. Based on these studies, these drugs reduce the symptoms of both Attention Deficit Hyperactivity

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Disorder and Oppositional Defiant Disorder (16).

Non-medical treatments:

Psychotherapy: In this method, by using cognitive-behavioral processes, they improve problem solving skills, communication skills and emotional control, and among the therapies that seem to have a good potential to empower the population under pressure and vulnerability such as families who have a disobedient child and due to the importance of family organization as a system affecting all individual and social dimensions of a person and according to the statistics of antisocial behaviors, depression, and incompatibility and family problems that struggle with having such children and that this population is facing a real and chronic problem, which is child's problematic behaviors, it is essential for the effectiveness of interventions such as compassion therapy that, regardless of external stressors, can improve mental health through internal changes, to be used to improve the situation of these children and families.

Family therapy: often focuses on making changes in the family system, such as improving communication skills and family interactions.

Therapy through peers: This method often focuses on improving social and interpersonal skills.

Educating parents: This method has studied the effect of parent education and parent-child interaction. In this treatment, mainly goals such as improving the quality of parent-child relationships, reducing behavioral problems and increasing social behaviors, increasing parenting skills including positive discipline and reducing parental stress is followed (17).

Play

Playing is a natural, amazing and mysterious activity. Playing is a way for expressing emotions, establishing relationships, describing experiences, revealing desires, and self-fulfillment, and because children often have less verbal and cognitive abilities to express their emotions, playing is a natural and exact way of communication for them to cope with the world (17).

Chance said; "playing is like love, everyone knows what it is but no one can define it." Whether or not an activity is considered playing may depend on the mental virtues of the people who perform it (18) He defined playing as: an inherent and natural activity and is often done for one's own sake rather than as a means to an end, that is, voluntarily and spontaneously, in a pleasurable state.

Child-Parent Relationship Therapy (CPRT)

Child-parent based play therapy can be a good way to communicate with the child because it focuses on the child. This method is taken from Rogers' theoretical foundations. Carl Rogers' method of therapy led to the analysis of therapeutic communication theory and the creation of nondirective (unguided) therapy (10). Educating parents about parent-child based play therapy was first done by Ahmadvand (2002) using Axline's bases and principles of child-centered play therapy. He realized the importance of parents' role in raising and interacting with their children. He invites parents to sit and watch what happens in the playroom. Gurney's next step was to ask parents to play a greater role in the playroom and to play with the child in his presence (19).

In 1980, Landreth and Bratton introduced their short-term model, which was a 10 session model. The parent-child play therapy educational model is a 10 session model to educate parents or child's caregiver. This model strengthens the relationship between the child and the parent (10). For 30 minutes each week the child is the focus of the parents' attention. In this educational model, the child experiences the feeling of being empowered, important and accepted and feels better about himself. Many parents share the same time and space with their children but are unfamiliar

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with their child's feelings and needs. Being a parent goes far beyond biological events. Children need enough time to engage emotionally with their parents, and parents need to know how to interact with their children in effective ways in order to connect with them. Due to the fact that many parents deprive the child of independence and autonomy by their inappropriate and untimely interference in the child's playing, and are not familiar with the correct methods of play and its positive effect on the child's development, teaching play therapy based on child-parent relationship leads to improvement of the relationship between the parent and the child.

Child-centered approach

The evolution of personality in a person-centered approach: Carl Rogers explored relationship therapy, expanded its concepts, and later created the term nondirective play therapy, known as child-centered play therapy and now person-centered therapy. According to the principles of person-centered theory, child-centered play therapy can be considered as the child's inner journey to search for himself and self-exploration. Here it is assumed that each child is an innate pulling unit to move towards development, and the play therapist facilitates the child's movement by releasing this pulling and removing the obstacles in front of it. Play, as a mediator of expression, allows the child to express his inner events externally and to be able to add to his conscious and encrypted experiences by becoming aware of what has been distorted so far. These conscious experiences are gradually organized in the form of "self-construction" and lead to a harmonized and unified self-concept. So, to summarize, the play therapy experience becomes a phenomenal field in which the child makes his or her own discovery. In his theory of personality evolution, Rogers identifies the three basic structures of the person (organism) in the phenomenal field (or self). The person is the place of all perceptions and experiences, including thoughts, feelings, and behaviors, as well as physical perceptions. For Rogers, evolution means being in the constant and variable flow of experiences that take place on a person-centered basis. In this context, the child encodes conscious experiences as good or bad. The phenomenal field consists of a set of conscious and unconscious experiences that is considered an internal reference and determines the individual's feedback to life. Whatever the child perceives becomes real in the phenomenal field, and is determined by this fact in terms of individual and actual perspective. (Self) is the result of the organism's experiences and is achieved in the usual interaction with the flow of changes in the phenomenal field. Thus, we can speak of a dynamic process within each individual that leads to progress, independence, development, and equipping and strengthening (the self). In childhood, the experiences gained from the reaction and evaluation of parents and others have profound effects on the concept. The child's behavior is an attempt to satisfy the personal needs experienced in the phenomenal field and is affected by all the conscious and unconscious experiences inside and outside the child. In person-centered theory, it is assumed that in every child there is a latent desire to move towards adaptation, mental health, optimal development, independence and self-reliance, and finally what is called self-realization (17).

Play therapy based on filial therapy

Play therapy based on filial therapy is a structured approach based on treatment theory that establishes the normal learning and communication process of children. Play therapy is a technique by which the nature of children is expressed. Filial therapy is a special type of play therapy that is applicable for children between the ages of 3 and 11-12. Filial therapy is closely related to forms of child-centered play therapy that involve caregivers and parents (18). This approach can be a good

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way to communicate with the child because of the focus on the child. This method is taken from the theoretical foundations of Bisch (2016)(14). Which in this method is an indirect treatment without guidance. This intervention is a short-term method and is a combination of play therapy and family therapy. The therapist educates the family and supervises their activities, and parents hold child-centered play therapy sessions with their children. Parents start sessions with the child, play sessions are initially designed for one child and one parent, and gradually involve the whole family. The therapist observes the initial sessions and gives appropriate feedback to the parents. As soon as parents feel more relaxed and confident during the intervention, they can continue the sessions independently. The play therapy environment is altered in a way that although it is nondirective and the parents treat the children warmly and lightly, they also place restrictions on the child. For example, they define an environment for the child to play games in that place so that he can become independent and organize his environment.

Principles filial therapy is based on the principles of child-centered play therapy, which has been around for more than 60 years since Hebrani et al (2007) introduced and described the eight basic principles of child-centered play therapy; However, the following principles are still widely accepted by child-centered play therapists and have formed the main lines of this approach.

1- The therapist is obliged to establish a warm and sincere relationship with the child, based on which a good therapeutic relationship is established in the shortest possible time.

2- the therapist must accept the child as he or she is.

3- The therapist should establish a relaxed atmosphere and a feeling of permission in the relationship so that the child feels free to express his or her feelings completely.

4- The therapist should be alert to recognize the emotions expressed by the child and reflect them to the child in a way that he or she gains insight into his or her behavior.

5- The therapist must believe deeply in the principle that if the child is given the opportunity, he will be able to solve his problems.

6- The therapist should not try to direct the actions or conversations of the child in any way. The child leads the way and the therapist follows.

7- The therapist should not hurry the therapy along. It is a gradual process and must be recognized as such by the therapist.

8-The therapist should only establish limitations that believes are necessary to anchor the therapy to the world of reality and to make the child's aware of his or her responsibilities in relationships.

In general, in filial therapy the key role of the therapist as the creator of favorable conditions and necessities for the child in this journey is emphasized. The therapist should create a safe, receptive, and supportive environment in which the child feels comfortable, avoid worrying about even the simplest behaviors of the child, and strives deeply to know each child's internal reference framework. With the help of therapist's nondirective feedback, the child's needs and feelings will determine the path of formation of topics and themes in the game, and the therapist, using reflection, enables the child to have a higher level of insight and awareness of his needs, feelings and thoughts.

Methods and material

In this research, the statistical population of the research are all children with oppositional defiant disorder in Falavarjan city in 2018 who were referred to counseling centers in this city. Thirty of these children were selected by convenience sampling from the counseling centers of Falavarjan city and randomly assigned to 2 experimental and control groups (15 people in each group). The entry and exit criteria of the research are:

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- Entry criteria
- Exit criteria

The method of this study consisted of two stages. In the first stage, the library research method was used to collect information and research background, and in the second stage, by obtaining permission from the qualified centers, referring to those centers and coordinating with the tutor and parents of children using the quasi-experimental method to perform the treatment method. Then, pretest and posttest questionnaires were collected and finally the data were analyzed. The number of training sessions for the experimental group was ten one and a half hour group training sessions held once a week by the researcher under the supervision of the tutor. At the beginning of the first session, participants completed the questionnaires. During the training and treatment sessions, all subjects in the experimental group were present and none of them were excluded from the program. Data were analyzed using one-way analysis of covariance and SPSS22 software.

Result

In the present study, the level of education of mothers was divided into groups.The results showed that in the experimental group, 6 (40%) had a high school diploma or lower, 7 (46.70%) had a post-diploma, 2 (13.30% had a bachelor's degree or higher. In the control group, 3 (33.33%) had a high school diploma or lower, 6 (40.00%) had a post-diploma, 4 (26.70%) had a bachelor's degree or higher.

Demographic information related to the age of the subjects's mothers is examined in Table 2-4.

The table above shows the majority in the experimental group are 36 to 40 years old, so 53.30% of mothers in the study have are this age. The table above also shows that the majority in the control group are 36 to 40 years old, so 53.33% of the mothers of the subjects in the study are in this age group.

Also, the majority in the experimental group are 8 to 10 years old, so 46.66% of the participants in the study are this age. The table above also shows that the majority in the control group are 6 to 8 years old, so 53.33% of the participants in the study are in this age group.

The table above shows the oppositional defiant disorder scores in the pretest and posttest.

Inferential findings

Findings related to the research hypothesis

Research Hypothesis: Filial therapy (play therapy based on child-parent relationship) has an effect on oppositional defiant disorder in preschool children of the city.

Assumptions of research hypothesis

In applying the statistical method, first by using statistical tests such as Kolmogorov-Smirnov, the normality of the data was tested and then Levene test for equality of variances was used and also the equality of regression slopes was tested to determine the type of statistical test (parametric, Non-parametric), the results of which are presented below:

According to Table 2. Since the significance obtained for the research variable is more than 0.05, the data of this research are normal and parametric tests can be used to analyze them.

According to Table 3. as you can see, the assumption of equality of variances for all variables is valid (P>0.05).

As you can see in Table 4, the F statistic is not significant for group interaction and pretest at the 0.05 level. These results mean that no significant difference is observed between the coefficients, thus the assumption of the equality of the coefficients is confirmed.

It should be concluded here that according to the assumptions of analysis of covariance, this test can be used to analyze the data. The next table will show the results of this analysis.

Table 5 shows that the hypothesis of the present study has been confirmed and the adjusted mean scores show that the effect of the interventions on reducing the oppositional defiance of the experimental group members i

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Table 1: Mean and standard deviation of scores of research variables in the two groups before and after the interventions

Variables	Group		Mean	Standard deviation	Minimum	Maximum
Oppositional defiant disorder	Experimental	Pretest	14.00	2.23	10.00	18.00
		Posttest	10.20	1.42	7.00	14.00
	Control	Pretest	15.86	1.48	12.00	20.00
		Posttest	14.73	2.71	12.00	18.00

Table 2: Kolomogorov-Smirnov's one-sample test for oppositional defiance in posttests

Statistical index	Z	P	Two-tailed significance level
Oppositional defiance	1.01	0.22	0.05

Table 3: Levene test for equality of variance of oppositional defiance in research in posttest

Statistical index	F	df1	df2	P	Two-tailed significance level
Oppositional defiance	0.10	1	28	0.74	0.05

confirmed. In other words, after adjusting the pretest scores, there is a significant effect of the factor between the subjects in the experimental group ($P < 0.05$, $F_{(1\&29)} = 18.38$).

Discussion

Interpretation of research findings

Research Hypothesis: Filial therapy is effective on oppositional defiance of preschool children in Falavarjan.

The findings obtained in Table 5 show that the hypothesis of the present study has been confirmed and the adjusted mean scores show that the effect of the interventions on reducing the confrontational disobedience of the experimental group members is confirmed. In other words, after adjusting the pretest scores, there is a significant effect of the factor between the subjects in the experimental group ($P < 0.05$, $F_{(1\&29)} = 18.38$).

The results above are consistent with the findings of Heath et al (2021)(3), Behzadi Seifabad, Meshkati, Nezakat Al-Hosseini and Jafari (2015)(8) , Hicks et al. (2016)(18), Bahramkhani et al. (2012) (7), Bisch et al (2016)(14), Hooshvar et al. (2009)(19), Akbarzadeh et al ,(2014), Haack et al (2013)(16), Akbar Ebrahimi et al (2009)(20).

By improving communication skills and sharing new experiences and receiving empathetic understanding from parents and therapists, the child gradually overcomes his inner and outer fears and finds the confidence to live and face his problems, as if he is resilient towards facing new and challenging events. Now, as the child expresses his or her inner and outer fears during play therapy, as well as being empathetically accepted by the parent and therapist, the child becomes more self-sufficient and empowered in the face of life's problems, and his or her oppositional defiance is greatly reduced. Another noteworthy point is that since parents impose restrictions on the child (not verbally, but by adapting the child's

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Table 4: Results of analysis of variance for equality of regression line slope

	Total sum of squares	Degrees of freedom	Average of squares	F statistic	Significance level
Group interaction and oppositional defiance pretest	54.23	2	27.11	1.95	0.18

Table 5: Results of one-way analysis of covariance for oppositional disobedience

Diffraction source	Total sum of squares	Degrees of freedom	Average of squares	F	Significance level	ETA coefficient
Pretest	11.72	1	11.72	1.61	0.21	0.05
Group	133.70	1	133.70	18.38	0.001	0.40
Error	196.40	27	7.24			
Total	16986.00	30				

environment) in filial therapy, they teach the child that he should not consider everything his own and should plan for the environment he is given, and organize his decisions and divert his attention from the whole environment, thus reducing his problem of oppositional defiance.

Conclusion

Explaining the findings of this study and the results of similar studies, we can say that play therapy in the form of filial therapy gives children the opportunity to freely explore their surroundings and communicate with family members in an environment free from threats and fear and develop their communication skills.

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