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Filial Therapy: Culturally Sensitive Intervention for Children and their Parents

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Rationale

I have always thought that playing is a kind of sacrament of childhood. It is something transcending reality and imagination to create a separate

magic called make believe. The shearing of Barbie Doll hair: a ritual. The garbs of dress up: ceremonial. The family cat: a totem…a familiar. The imaginary friend: a shaman.

Play is a manifestation of children's inner thoughts and emotions. It is not meaningless or random. The child creates her own meaning in the mysterious and sacred ways of play. For the child, it is a symbolic expedition into her/his inner sanctum. Children embody themselves, their experiences and other meaningful people in their life during symbolic or dramatic play (Curry, 1988). According to Landreth (2002), the mental health community acknowledges the deeper symbolic meaning in play. In recognition of the therapeutic power of play for children in crisis, and the necessary nature of play for the overall well being of any child, play therapy has become an intervention of choice for young children. (see Ray, Bratton, Rhine, & Jones (2001) for review).

Play is a vital and necessary element of childhood. The child uses play to synthesize the world around them, giving form to emotions and thoughts that they do not yet have the cognitive ability to express in any other way. Children communicate through play: it is the innate language of childhood (Schuman, 2003).

Most attachment disruptions and other pervasive personality problems begin in childhood. Guerney (1969) reported that maladjustment in children could logically be traced to the relationship dynamic within the family. Research shows that play therapy helps children resolve issues arising from traumatic occurrences. Children use play to express and resolve terrifying events (Oggwa, 2004) Children will recreate the original event in trauma inspired play (Ogguwa, 2004). We know that play therapy as an intervention is effective. What we are learning, now, after years of empirical research is that Filial Therapy, a family focused play intervention that uses the relationship with the primary caregiver, is even more effective (Ray, Bratton, Rhine, & Jones, 2001).

No other relationship is more important in shaping a child's adjustment than that with the primary caregiver. Children often have intense and complicated emotions after experiencing significant life events such as domestic violence, abuse, homelessness, natural disasters, war, and acts of terror. Even positive events, or seemingly benign occurrences, have the potential to disturb a child's emotional well-being.

According to Landreth (2002), many parents do not have the communication skills required to meet their child's emotional needs.

"…Parents struggle with how to raise their child in the face of constant cognitive, emotional, physical, and social oscillations" (Clarice Evans Goodwin, 2003) Parents can, however, learn the basic techniques of child-centered imaginary play, understand play themes, limit setting, and empathic listening (Van Fleet, 2004).

Filial Therapy is a specialized hybrid of play therapy that utilizes the parent-child relationship to facilitate healing. The parents (or primary caregiver) are taught non-directive play techniques, interacting in a child-centered manner during dedicated play therapy sessions. The counselor guides and oversees the process, but the actual change agent is the family. Developed in the early 1960's by Dr.'s Bernard and Louise Guerney, this psycho-educational model has been empirically researched and developed over the last 40 years to emerge as an optimistic leader in treatment for children and families in crisis and a preventative measure against future relapse of undesirable behaviors. (Hutton; Ray, Bratton, Rhine, & Jones, 2001)

Literature Review

Introduced into to the psychological community as a treatment for children with social, emotional, and behavioral issues, Filial Therapy was not

readily embraced. (Cleveland and Landreth, 1997, p. 19/ source dissertation). In 1966 the National Institute of Mental Health studied the fledgling model with mothers of behaviorally and emotionally challenged children. The participants in the study showed clinically significant improvements. Unfortunately, the lingering specter of Freudian Psychoanalysis and the rise of behaviorism in the 1970's stymied widespread application of this promising new modality (Guerney, 2000, p.7 / source dissertation).

The 1980's brought a renewed interest in play therapy and the re-conceptualizing of therapy in the context of the family system. Filial Therapy was poised to gain momentum in the mental health profession (dissertation)

In the 1990's Dr. Gary Landreth of the University of North Texas began studying Filial Therapy prolifically and "[has] been setting precedents in both quantitative and qualitative filial therapy research" (dissertation) The Guerney's credit the prolific work of Landreth and his graduate students with "raise[ing] interest in filial therapy." (dissertation)

Filial Therapy research from 1990's to date has focused on establishing applications and efficacy with successful results. According to Van Fleet

(2004):

Filial Therapy has been used successfully as a preventative program to strengthen families as well as a therapeutic intervention for many child/family problems. : anxiety, depression, abuse / neglect, single parenting , adoption / foster care/ kinship care, attachment disruptions, high conflict divorce , family substance abuse , traumatic events, oppositionality, anger / aggression problems, chronic medical illness, step parenting , relationship problems, multi problem families.

More recently, multicultural and non-traditional applications are being studied. Bratton and Landreth (1995) studied the intervention with single parents. Chau and Landreth (1997) with Chinese parents, Jang (2000) Korean parents. In 1997 Harris and Landreth used filial therapy with incarcerated mothers followed in 1998 by Landreth and Lobaugh's study with incarcerated fathers. Glover and Landreth (2000) researched Filial Therapy with Native Americans Living on reservations. In 1999 Costas & Landreth studied non offending caregivers of sexually abused children. The efficacy of filial therapy has been validated in these studies. Significant results were reported in all the above referenced studies. Caregiver empathy and acceptance of their children increased, caregiver stress decreased. There was also a significant decrease in child problems as perceived and reported by the adult participant.

The review of literature presented here is a representative sampling of available research, as a comprehensive review is beyond the scope of this milieu. Rennie and Landreth (2000) provide an in depth review of the filial therapy research.

The Basics: The Four Skills of Filial Therapy

Structuring. During the special play sessions the parent may wish to make some sort of boundary delineating the area from the rest of the home. Entrance into and exit from the play area is acknowledged. The parent may say, "we are now in our special place. During the time we are here, you may play with almost anything you wish in almost any way you wish. If there is something you may not do, I will tell you."

Empathic Listening. Parents are taught to track and reflect the child's behavior in the play room. To some parents, the reflective syntax of empathic responding may seem awkward at first. Parents are taught to reflect action and emotion, being thoroughly in the here and now with the child.

Child -Centered Imaginary Play. As the authors mentioned in the introduction, the child's symbolic play can be likened to a shamanistic

journey. Child centered imaginary play is a vision quest and we mere watchers. The adult's task during the symbolic play of Filial Therapy is to watch and follow. Be non-directive!

Limit Setting. Ah, yes. The Rules. Kept to a minimum, the rules should insure personal safety (no fire starting, no shooting up the living room with a potato launcher, etc) and basic respect for property. Aggression should be allowed to play out, however, large scale destruction of the toys and play area is inappropriate.

The Process of Filial Therapy

Originally developed as a group therapy intervention, the process of filial therapy is highly adaptable to various situations. According to Van Fleet (2004) "applicability [is] rapidly growing …adaptations include …use with Head Start families, elementary teachers, high school students, and paraprofessionals."

The model presented here follows Van Fleet's 16 week course of therapy. Other models exist and can be adapted accordingly. Landreth developed his 10-week model based on frustrations common to any therapy: the interruptions of real life (family vacations, spring break, etc), client drop-

out, and reluctance to commit to long term therapy (Broaddus 2002).

(1) Preliminary intake to include: social, medical, developmental, and previous mental health history. The therapist collects whatever information is usually gathered by the agency. The therapist begins discussion about the basic principles of Filial Therapy, observes family interaction, parent /child behaviors, attitudes and skills.

(2) Detailed discussion with parents about the premise, structure and course of Filial Therapy. Although principle skills of Filial Therapy are quite simple, the therapist should establish that the adult participant (parent or other primary caregiver) understands what is expected.

(3) Parents observe therapist engaging the child in therapeutic play. There are many ways to effectively accomplish this. Uses of a two-way mirror room or a video monitor station are excellent options. For agencies that do not have such accommodations, the play space may be divided with something as simple as bean bags.

(4) Parents begin to learn the basic play session skills: structuring, empathic listening, non-directive child centered play, and limit-setting. Therapist will model appropriate behavior during mock play sessions with the parents. Therapist should encourage and support the parent with positive feedback, gentle suggestions for improvements, and praise. This in vivo feedback is critical for empowering the parent.

(5) Parents begin to conduct non-directive play sessions with the child under the direct supervision of the therapist. After the session there is an immediate discussion time. The

therapist may point out things the parent missed, while keeping the tone of the feedback positive.

(6) Family transitions to home based play therapy sessions in conjunction with office sessions to discuss issues that arise during the course of play. Parents continue to work on parenting skills. Taping sessions, journaling and taking part in group support meetings with other parents participating in Filial Therapy are all excellent activities for this phase of the process.

(7) Maintenance and support sessions periodically take place in the office which is directly supervised by the therapist.

(8) Discussion of generalizing the skills of Filial Therapy to other areas of parenting and life. Therapeutic gains usually reported after Filial Therapy are: parents' acceptance of their children, reduction in parent stress levels and overall parent satisfaction (Van Fleet 2004)

(9) Closing discussions: Periodic maintenance, follow up care, evaluation of progress to date and discharge.

Common Problems and Contraindications.

Most parents will be capable of understanding the basic skills of this intervention. According to Van Fleet (1999), inability to understand "rules out very few as the skills are quite simple." Filial Therapy has also been used with developmentally delayed parents.

Regardless of simplicity, some parents, for whatever reason, are not

capable of being emotionally present with their child for 10-15 minutes at a time. The therapist should defer to clinical judgment in most cases to determine if Filial Therapy would be a successful intervention. In certain cases, including physical abuse or neglect, Filial Therapy may or may not be an option. Filial Therapy is usually not recommended when the parent is the perpetrator of sexual abuse.

Filial Therapy is contraindicated when the parents are perpetrators of abuse. This includes a non-offending parent who is still *in the home with the abuser*. Costas and Landreth (1999) utilized Filial Therapy with sexually abused children and non-offending care givers with encouraging results. Filial play therapy is useful and effective in a variety of difficult family situations. In some instances, however, the needs of the child may be better served by individual therapy and traditional play therapy.

The overall decision should defer to comprehensive clinical judgment, rather than any specific diagnosis.

Summary

Filial therapy offers training to parents to provide play therapy to their own children. This is an innovative and creative use of resources. Not only does

it provide the child with needed intervention, it increases the parent's ability to communicate, accept and understand their child. Additionally, parent confidence in their ability to interact and help their child increases. Filial therapy uses the best of all possible worlds to a child.

Reference:

Ray, D., Bratton, S., Rhine, T., Jones, L. (2001). The effectiveness of play therapy: Responding to the critics. *International Journal of Play Therapy*, *10* (1), 85-108.

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