

THE EFFECTIVENESS OF FILIAL PLAY THERAPY ON CHILDREN AND CARE-  
TAKERS

by

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ABSTRACT

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The Effectiveness of Filial Play Therapy on Children and Caretakers.				
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Originally created for children with emotional problems, filial therapy can also be understood as Child Relationship Enhancement Family Therapy (CREFT), and is known as a proven technique to enhance family relationships (Van Fleet, 1994). Van Fleet views filial therapy as a strengthening device to avert or surmount parent-child tribulations. This therapy creates an understanding in the parent-child relationship, and builds a stronger familial union.

The purpose of this literature review is to analyze the effectiveness of filial play therapy for children and caretakers through a critical analysis. Numerous studies were examined in order to successfully demonstrate the value of filial play therapy and the outcome it derives.

By utilizing filial therapy thirty minutes per week, children are able to recognize themselves as significant in the caretaker life (Ramirez & Salcines, 2001). Approval of the child's emotions, whether they are vicious or tender, has a soothing effect on the child and the way they feel about themselves. By accepting these behaviors, overtime the child learns to understand their emotions and will ultimately prosper into a conscientious adult having worked through untouched emotions (Ramirez & Salcines, 2001).

An empirically sustaining method of healing, filial therapy can overcome deficits in communication between caretakers and children. Filial therapy is preferred due to improved relationships and can avert potential child tribulations (Schuman, 2002).

Filial therapy can be utilized for serious family tribulations, or to reinforce familial connections by enhancing caretaker and child relations. It is a flexible alternative to family therapy that can satisfy many different familial needs, and serves as a pleasing approach for the whole family (Van Fleet, 1994).

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## DEDICATION

Of all the wonderful people who have entered my life, I would like to recognize a woman who sadly exited mine too soon. A person, who touched many people around her, graced people with unconditional love, wore strength on her sleeve and left memories on those she encountered to last a lifetime. I dedicate this paper to my grandma, the late Betty Marie Hach. Thank you for all the memories you have left in my heart, your love and affection, strong morals and for always instilling in me that I could be anything I set my heart to. Although you are not physically with me anymore, your love is instilled in my heart; reminding me as you once did to "Take each day one step at a time."

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## CHAPTER ONE

### Introduction

With our fast paced society and increasing number of single parent families, parents are losing touch with their children. In the past, most two parent families were able to depend on one income. As the American society strives for the American dream, economic strain is challenging even two parent families. Both parents are forced into the workforce, and young children are placed in daycare. After a long day of work, parents may spend only a few hours with their child, focusing on dinner, bathing, and a little play time. Out of a fifteen hour day, some parents may only spend four or five hours with their children depending on the child's age (Landreth, 2002). An increase amount of stress is being put upon these families; ultimately leaving children's emotional needs unfulfilled (Landreth, 2002).

It's important that parents, educators, and therapists learn to communicate with children, shaping their understanding of the world. A lack of communication with children is not typically on purpose; usually it's because parents carry over what was said to them as they were being raised (Ginnot & Goddard, 2003). Parents may not use open ended questioning, prompting a conversation or reflect upon their feelings accurately. A deficient understanding often reflects negative communication between a parent and child. Parents need preparation in communicating efficiently with their children (Ginnot & Goddard, 2003).

Play therapy is a form of therapy that enables adults to avoid or solve psychosocial difficulties of children and help them develop appropriately (Kottman, 2001). Kottman describes play therapy as a way to communicate with children in a

manner that they may have never experienced before as the therapist is able to utilize and comprehend the child's language. This has potential to create an understanding and positive connection between the therapist and child.

Axline (1969) describes play therapy as a way to "play out" emotions just as adults "talks out" their dilemmas. As the child works out his/her emotions in play therapy, they are discarding and facing dilemmas that are affecting them, ultimately teaching the child to value him or herself, and feel emotionally calm (Axline, 1969). It is not how the play therapist perceives the child's session, as much as it is the way the child feels inside after working through issues (Axline, 1967). An inner feeling of value and understanding of one-self is one of the most crucial outcomes in play therapy for a child (Axline, 1967).

Originally created for children with emotional problems, filial therapy can also be understood as Child Relationship Enhancement Family Therapy (CREFT), and is known as a proven technique to enhance family relationships (Van Fleet, 1994). Van Fleet views filial therapy as a strengthening device to avert or surmount parent-child tribulations. This therapy creates an understanding between the parent-child relationship, and a builds a stronger familial union.

Landreth (2002) suggested that parents need to take time from their demanding schedules and learn to understand and facilitate healthy parent-child relationships. Protecting the mental health of all children should be a priority of play therapists; Landreth viewed filial play therapy as a way to train adults in this respect. It should not be assumed that families instinctively know how to parent; teaching effective parenting techniques to enhance mental health in children could ultimately lead to healthy parent-

child relationships. Successful ways should be taught to parents that create meaningful exchanges between the parent and child.

Parents need to be accepting and willing to create change with their children when adapting therapy (Axline, 1967). If parents are hesitant, it can hold up the process of therapy, creating a more detrimental effect on a child. Axline (1967), accentuates the importance of parents receiving therapy themselves if needed, which creates a more accelerated therapeutic process overall.

In order for children to be capable of change, they need to feel that whatever they do, their parents will be supportive (Gordan, 2000). Dr. Thomas Gordan, a leader in parent effectiveness training discusses the importance of acceptance. Gordan (2000) believes that most parents feel that they need to inform their children of what is not acceptable, in hopes to keep them from making mistakes. This is portraying condemnation of children, and does not exude approval, but can cause children to shut down. In order to correspond effectively and implement the power to grow, a parent must show acceptance of their child, using an understanding communication style (Gordan, 2000).

Talking through problems with a young child can create an awkward silence between the therapist and child, since a child's cognitive level is still developing (Straus, 1999). A child's brain is rapidly growing; being able to think through why s/he is acting out is beyond their reasoning. Looking at this concept through Piaget's theory, children are in the concrete operational stage typically until the age of seven (Piaget, cited in Straus, 1999). Before the concrete operational stage, children under the age of seven are not developmentally ready for talk-therapy. Implementing filial play therapy is an

alternative to talk-therapy, utilizing toys into therapy to open up the lines of communication. Children are able to “act out” scenes of their lives without even understanding that they are displaying or modeling their everyday life.

Filial play therapy motives are to improve the quality of the parent-child relationship, decrease the amount of problem behaviors, and to teach parents everyday skills that will augment effective communication with their children (Guernsey, cited in Kottman, 2001). Parents act as the therapist in filial play therapy, which ultimately leads to a stronger outcome since meaningful relationships are typically established, plus in most cases the parent has authority over their child (Glazer & Kottman, 1994). Van Fleet (cited in Kottman, 2001) developed a specific set of skills that are taught to parents in filial play therapy. These skills include permanence and guidance in a child’s life, sympathetic listening skills, client focused imagery play, and learning to set limits.

Utilizing filial play therapy focuses on the rapport between the parent and child, and helping the child prosper and grow (Landreth, 2002). Filial therapy incorporates not only play therapy for children, but parenting skills for the parents encompassing a technique that has proven effective when looking for family therapy solutions (Van Fleet, 1994). Landreth gave many outcomes of a stronger relationship that is established through filial play therapy. More specifically, the parent is able to better support their children, develop self-understanding of themselves and of their children, gain approval, have empathy for their child’s emotions and thinking, and even teach their children skills such as accountability and dependence (Landreth, 2002).

In order for therapy to be effective in families, parents must have an understanding and appreciation for their child as a significant person who is caring and

brings happiness to them (Moustakas, 1959). In any therapy setting a need for respect and intentions of change are an ethical concern, in order to promote healing and trust. Change comes from within, and without a person's own self-understanding are they able to help someone else, especially one's own child.

### *Statement of the Problem*

The purpose of this literature review is to analyze the effectiveness of filial play therapy for children and care-takers through a critical analysis of the literature.

### *Research Questions*

In order to analyze the effectiveness of filial play therapy for children, there are some questions to be explored in the research. The following questions were taken into consideration while investigating the topic:

1. In what way has the effectiveness of filial play therapy been measured?
2. How effective is filial play therapy for children and their caretakers?
3. Who should conduct and participate in filial play therapy?

### *Definition of Terms*

Crucial words that will be used throughout this paper have been defined and are listed below:

*Child-Centered Play Therapy*: Garry Landreth (2002) described child centered play therapy as:

The child-centered philosophy considers play essential to children's healthy development. Play gives concrete form and expression to children's inner worlds. Emotionally significant experiences are given meaningful expression through play. A major function of play is the changing of what may be unmanageable in reality to

manageable situations through symbolic representation, which provides children with opportunities for learning to cope by engaging in self-directed exploration. The therapist uses play with children because play is children's symbolic language of self-expression. (p. 12)

*Filial Play Therapy:* According to Bratton, Ray, Rhine, and Jones, (cited in the Association for Play Therapy, 1982) filial play therapy is described as:

“A therapeutic intervention that can help children by teaching parents (and other paraprofessionals such as teachers) basic play therapy principles and methods. Parents learn to become a constructive force for change in their children's behaviors and attitudes by utilizing basic play therapy skills in once-a-week 30-minute play sessions with their children. Throughout the process, parents receive on-going training and direct supervision from a play therapist” (n.p.).

*Play Therapy:* The Association for Play Therapy (1982) described play therapy as:

“The systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (n.p.).

#### *Assumptions and Limitations*

After thoroughly researching the literature, some limitations were found while conducting a critical analysis of filial play therapy for the research study.

Guerney and Welsh (cited in Kottman & Schaefer, 1993) address the concern that filial therapy may not be utilized as hoped due to caretakers not as accessible to children in an emotional or concrete way. Another criticism of why filial therapy does not always

prove successful is due to inefficient ability for therapists to work with adults. It has been suggested that child therapists work directly with the children, and the caretakers receive mental health separately (Kottman & Shaefer, 1993). Filial therapy can prove an effective source of therapy for a parent and child, under the assumption that proper effort is obtained by the parent and therapist. When used effectively, filial therapy is a great form of teaching appropriate parent-child communication techniques.

## CHAPTER TWO

### Literature Review

#### *Introduction*

This chapter will thoroughly discuss filial play therapy. More specifically this section will look at current scholarly research and the effects of adapting filial play therapy to promote the effectiveness of utilizing filial play therapy.

#### *Background: The Development of Filial Play Therapy*

The first training outline was established by Bernard Guerney and his wife Louise in 1964. Filial therapy was created as a therapeutic tool for parents to utilize with their children (Guerney & Guerney, 1989). Guerney (1969) believed in training parents through weekly appointments incorporating supervised play between parent and child by a therapist. This adaptation of filial therapy included direct instruction through observation and a positive learning environment for the clients (Guerney, 1969; Guerney & Guerney, 1989). As parents learned to interact with their children, the therapist observed and guided the parents through appropriate play techniques.

Therapy of this kind works best with children between the age of two and ten (Bratton, Ray & Moffit, 1998). Since toys are used to facilitate play sessions, children past the age of ten may not respond as well as younger children. Possibly the use of games or art could be substituted at older ages, but is not highly recommended. In order to achieve the best possible parent-child connection, sessions are kept to one parent and one child at a time (Van Fleet, 1994).

Guerney (1969) suggested training parents to use filial play therapy in sessions that include six or eight parents, facilitating appropriate practice. Parents are taught to

use the play therapy techniques with their children at home. Sessions are suggested to last up to 30 minutes once per week, and have the opportunity for extending play through 45 minutes as the play sessions increase. Guerney (1969) suggested continuing to meet with the parent groups weekly in order to adequately discuss how their sessions were prospering and reflect on themselves and their children. During parent instruction and discussion, the filial play therapist implements the client-centered approach, which is in line with filial play therapy techniques.

In training and follow-up sessions, Guerney (1969) used role play situations and facilitative skills as part of implementing filial play therapy. Mothers and fathers participated in weekly groups. Guerney wanted them to be divided in an equal way and not include both parents of one child, just one parent per family. The effect of the training sessions was for the parents to discuss and explore possible feelings through filial therapy. Parents were not taught to conduct therapy in a strict way, but rather where feelings and emotions were involved. Guerney (1969) suggested four goals in the training sessions with parents:

1. As long as the child is not harming the materials, themselves or others, caretakers should promote acceptance and support of the child's play choices by not controlling what they can and cannot do or play with.
2. To show empathy, and comprehend what the child is expressing through play.
3. Demonstrate an understanding of the child's choices, so the child knows she/he is accepted fully by the parent no matter what.
4. Teach children to take ownership of their choices. The child must know that if they disobey the limits in the play session, a consequence will occur.

In order to meet the goals indicated above by Guerney (1969), parents practiced techniques learned by watching the therapist work with children. Other approaches included working at the center where the training was taking place in a session with their own child, or another parent's child. The practice sessions were preceded by a group conversation, where parents were able to reflect upon their practice sessions.

After the first few initial supervised play sessions where a child will typically explore the toys, the child will usually embrace themes by the third or fourth session (Van Fleet, 1994). By this time, an accepting and loving tone is set, allowing the child to open up and convey themselves. Some typical themes suggested by Van Fleet are usually real life situations, dominance, caring for others, hostility, and power are common. These themes tend to be short-term, and children typically work through their emotions as they learn beneficial alternative conduct (Van Fleet, 1994).

As themes play out, parents may question themselves or their child. Van Fleet (1994) categorizes some common concerns parents may have:

**Child Concerns:** Caretakers may question if their child is normal. If a child shows strong dominance during the session, a parent may view their child as bossy. The role of the therapist is to reassure that these are typical behaviors that will eventually be worked through. Parents must learn to not over analyze their child's play, but to reflect on why the behavior is occurring (Van Fleet, 1994).

**Parent Concerns:** It is important that parents do not assume their child's behavior implies a lack of parenting. The therapist must assure and use concerns as a teachable moment to continue to not threaten a parent's involvement. An example given about a child holding a doll, then throwing it across the room may

mean that the child views the parent as mean. It's the therapist's job to use caution to not offend the parent, but explain and further discuss concerns the parent may have (Van Fleet, 1994).

After proper training, parents were then able to start utilizing the filial therapy techniques at home (Guerney, 1969). Certain toys are encouraged for conducting play therapy in the home. Guerney suggested incorporating dolls, a toy house, paper and markers, or even a fake weapon. Other items that could be used are a sand tray, puppets, fake telephones, a kitchen set with dishes and food, painting materials, etc. Van Fleet (1994) recommends utilizing toys that ensure an opportunity to express oneself, and not direct play. In selecting toys, it is best to include ones that; promote expression of mad emotions like, a fake knife, or a bop bag. It is also recommended to include toys that allow a child to care for others, such as a bottle or baby doll. Along with these, an opportunity to act out family situations, such as a doll house or puppets is also beneficial. Toys that allow a child to relate to others are valuable; such as a medical kit, or career hats. Play-doe and art supplies will support the expressive side of play (Van Fleet, 1994). These toys allow a wide range of emotions that children are able to work through when utilizing filial therapy.

The location for the sessions in the home are suggested by Van Fleet to be a big enough area to occupy two people and some toys, an area that does not include anything breakable, and a place where water and messy activities are allowed (Van Fleet, 1994). The space does not need to be set up at all times, packing away the materials until needed is acknowledged. Some examples of locations are; a garage, basement, or part of a kitchen.

When conducting filial therapy in one's home, it's advised that little interruptions occur (Van Fleet, 1994). Posting a 'do not disturb' sign outside the door of the created playroom can be helpful to ward off interruptions (Ramirez, & Salcines, 2001). Van Fleet stresses the importance of creating quality time for the child, where interruptions don't alter the energy during the sessions. It is advised that ensuring non-interruptions may entail talking with neighbors or other family members to work around the play session. In a children's book entitled, "Playtime for Molly," Ramirez and Salcines (2001) advise parents to utilize a calendar. Parents should locate the calendar in a busy room like the kitchen, at eye level with play sessions written down. Letting the child write their playtime on the calendar, and the visual it displays exemplifies significance and quality time with a parent.

Who should use filial therapy? Garry Landreth (2002) described many different scenarios that would fit into the realm of filial therapy. In general, Landreth noted that most any child would benefit from this type of therapy. Some parents consumed filial therapy to improve their relationship with their children, or to better handle emotional or alteration problems (Landreth, 2002). In the past, people have used this type of therapy for children who were emotionally disturbed, but as Landreth pointed out, almost any family who wants to better understand their child would qualify. Other populations that Landreth has served in training are grandparents, expectant parents, nannies, soon to be incarcerated parents, mothers who have been victims of domestic violence, etc. (Landreth, 2002).

Van Fleet (1994) cautions three situations where the use of filial therapy would not be recommended; first, caretakers who are not competent of understanding the skills,

second, those that are in need of their own mental help, and are incapable of their child's needs, and lastly, children that have been abused by the person utilizing filial therapy.

Kraft (1973) questioned why most parents seek assistance when difficulty arises with their child, rather than seeking play therapy to enhance the parent-child relationship. Financial stability, services available in a parent's community, and a belief in therapy should not be the determining factors in whether or not a parent implements filial therapy. Kraft believes that although a trained professional can do an exemplary job conducting play therapy with a child, after the sessions cease, so will the reformed behaviors. Parents can be trained to implement play therapy, and the techniques can be consistent and long term. In addition, Kraft believes that the parent along with the child will see improved results.

How long should a parent use filial play therapy? Van Fleet (1994) recommends parents to be aware of certain factors, which signal closure in the filial therapy process. If parents are unwilling to effectively use the filial therapy process, discharge is recommended. At that time, another solution would be recommended, like the therapist conducting play therapy with the child. Another reason for release is when conflicts between the parent and child have been worked through. Children who appear uninterested may also deem closure, as long as the reason for their behavior is not because of scheduling or interruption conflicts. Lastly, filial play therapy could end if substantial growth has been established and the parent's application levels are strong enough to go without therapy (Van Fleet, 1994).

In the last phase of therapy, there is a conversation between the therapist and

caretaker regarding the progress made during therapy, and conflicts left to resolve over time (Van Fleet, 1994). There must be a mutual agreement in order to carry out the discharge process. In agreement, the therapist will monitor a therapy session. If demonstration of effective techniques, and proof that resolution of conflicts is occurring, that the process will continue. If not, the therapist continues meeting regularly with the parent. Typically a questionnaire is administered, to analyze the effectiveness of the filial process (Van Fleet, 1994). The last phase of discharge includes a discussion with parents on carrying out their own play sessions un-monitored. This could be a “special time” for the parent and child, not necessarily play therapy but a time between the two.

Another meeting may be arranged for the future, based on the desires of the family, a time to check in on the progress of play therapy, and if any assistance is needed. Telephone contact may be administered months later by the therapist, as well as leaving the door open for future assistance.

#### *Measuring the Efficiency of Filial Play Therapy*

Garry Landreth, a certified play therapist and a significantly large contributor to the play therapy field, commented on the parental change that occurs throughout filial play therapy training in an interview published by Watts, and Broaddus, (2004).

Landreth described the training with parents as giving them back ownership in their parental relationships. He emphasized that parents begin to understand the meaning behind their child’s behavior and are able to adapt and sympathize with their mood. An awareness occurs that may have not been there before, and parents can understand why their child is acting a certain way. Instead of changing the behavior by punishing the child through shouting or spanking, rather the parent learns a new approach of re-

directing and calmly setting limits appropriately as a therapist would do during a play therapy session (Watts & Broaddus, 2004).

As parents conduct filial play therapy sessions with their children, they are acquiring wisdom to not assume or punish before fully understanding their child's motives or actions (Guernsey, 1969). In most households, parents are the disciplinarians, children may learn to fear or conceal things from parents. One aspect of play therapy in general is to give back a child's world as they construe it, so they have a sense of understanding or approval.

Through filial play therapy, the parent learns how to accept their child for whom they are and not critique them (Landreth, 2002). One example is for the parent to not label any toys that their child is playing with, even if the fork and plate the child is playing with in the sand seem obvious to the parent, to the child they may be a truck and a person in the snow. As a result of being accepted and not judged, children will often open the door to other aspects of themselves (Landreth, 2002). As the play sessions are conducted over time, Landreth (2002) described the child as perceiving their parent as an encourager. A sense of responsibility and self acceptance should emerge from the child.

Landreth (2002) included objectives of filial play therapy; these give more insight into what the child will gain from therapy:

(a) allow the child, through the medium of play, to communicate her thoughts, needs, and feelings to her parents; (b) facilitate the child's development of positive self-esteem and confidence; (c) help the child develop an internal locus of control, become more self-directing and self responsible, and develop effective problem-solving skills; (d) help the

child change any negative perceptions of his parent and to see his parent as an ally; and (e) reduce or eliminate problematic, self defeating behaviors. (p. 372)

Landreth (2002) explained a parent's outcome from filial play therapy as hopeful towards the future of their children. Parents characteristically use the skills learned in their daily lives with their children, such as implementing compassion and support, rather than solving the problem for them.

Van Fleet (1994) offers two possible tribulations when implementing play sessions into the home; conflicts in implementing home sessions, and restorative concerns. In conflicts executing home sessions, a decrease in the parent's therapy skills may occur, interruptions while conducting a session, or obstacles in setting up sessions. The filial therapist should attend to the hindrance parent's face in scheduling and interruptions to promote the effectiveness of filial play therapy, effectively working towards a solution (Van Fleet, 1994). In order to determine dilapidated skills, a therapist may need to examine a session between the parent and child to properly assess skills. If a decline in therapeutic skills is noticed, the therapist should re-apply the core skills learned in parent training (Van Fleet, 1994).

When addressing restorative concerns, some new behaviors may appear when the play therapy changes from in the office, to at home. One concern Van Fleet (1994) notes as common is when children test their boundaries in their home play room. Children are taught what their limits are at the clinic after the first session or two, but may revert back and re-test these limits after in-home filial therapy begins. Van Fleet recommends encouraging parents to utilize the skills they learned in their training, which will decrease the behavior if done properly. Another worry parents report is monotonous play.

Although a parent may feel they are not prospering effectively, Van Fleet disagrees. Repetitive play represents a child playing out a considerable event or concern. They could be assimilating a new ability, understanding something new, and integrate it into their perspective, or deal with an intricate quandary (Van Fleet, 1994). In order for the therapist to know if this is happening, is to assess the child's extent of significance in a play session. If the child's interest is significant, the parents are reminded of the child-centered focus in filial play therapy. What the parent views as dull, may be very imperative in their child's world. Parents are encouraged to keep patience. Van Fleet adds that if it's not meaningful play that the child is engaging then it may be that they have already worked through their most enduring issues. It is then recommended that the parents discharge from the filial play therapy, and utilize what Van Fleet (1994) calls, "special times."

### *General Findings*

Filial play therapy's effectiveness can be measured through qualitative case studies. Many studies have been conducted on not only parents, but grandparents, incarcerated parents, single parents, etc. The following studies represent the value of filial play therapy.

Dee, Bratton, and Brandt (2000) conducted a study on single parents attending a community college. Training was for two hours incorporating education about filial play therapy over a 10 week period. The single parents had the opportunity to include 30 minute practice sessions with their children. These sessions were taped and later analyzed by group members and the therapist. Support and tips for development were given (Dee et al., 2000).

Kathy, a single parent, and her son Robert, were two of the participants in the study. Robert was conflicted by destructive behavior, and constant problems at home and school. Recently he was put into a gifted education class, as Robert was showing special talents. Kathy was battling with many academic, parenting and income troubles, and desired relief from her anxiety (Dee et al., 2000).

The first few sessions Kathy and Robert entered almost a half an hour late indicating tension between them. Other group members disturbed by their interactions were not sure how to act around them. It was perceived that Kathy's mothering skills were rigid and controlling, which Robert naturally resisted (Dee et al., 2000).

Dee et al., (2000) reported a small change that emerged in Kathy almost half way through the training sessions. Kathy, who was typically focused on cynicism shared a few encouraging and optimistic comments towards the play sessions. Through much discussion and role playing, Kathy started letting go of the control and let Robert direct the play sessions. Working with Kathy to accept Robert and his choices was the main theme in their play sessions. Rather than demanding Robert to stop playing with a certain toy, Kathy was trained to reflect on how Robert chose the toy (Dee et al., 2000).

Half way through the play sessions, Kathy was able to break through her barrier of control and portray acceptance of Robert, which the group had not yet seen (Dee et al., 2000). For the first time Kathy used reflection to mirror how Robert was feeling when he used hostility in their session with a toy. In response to Kathy's reflection, Robert moved away from the aggressive play and utilized the paint station where he eventually included Kathy in painting with him. Later, reviewing the tape of that session struck Kathy

emotionally as she was able to see the change in Robert's behavior, one that she had never seen before (Dee et al., 2000).

Although the change in behavior was an improvement, the researchers recommended that more assistance was still needed in Kathy's training (Dee et al., 2000). She continued to show improvements in her parenting in and out of the sessions, portraying a calmer manner and approval of Robert. As a result of the filial play therapy, the researchers concluded Robert as working more effectively at school and gaining a stronger relationship with his mother (Dee et al., 2000).

Through the use of filial play therapy on single parents in a community college, constructive results were shown. As revealed in the case study, parenting is a challenge, but single parenting can weigh more heavily on parents, causing miscommunication and struggles between the parent and child. In 2003, there were an estimated 8,294,092 female single parents in the U.S alone, according to the United States Census Bureau (2003). Through training, supervision and constructive feedback, single parents can learn to better function as a person and a parent.

Filial play therapy proved successful to reinstate a father-daughter relationship in one case study. A father, Lee was ordered by court to not only seek individual counseling, but to implement supervised time with his daughter, Sarah learning filial therapy techniques (Glazer & Kottman, 1994). It should also be noted that Lee was suspected by Sarah's mother of sexual abuse. Both father and daughter denied the allegations, and not evidence was obtained. Because of the nature of the allegations, and the need for consistent concrete examples, a one-on-one filial play therapy training session was administered.

The court ruled in favor of filial therapy, to re-establish a relationship between the father and daughter (Glazer & Kottman, 1994). Supervised play sessions were administered by the therapist, under the sexual allegation circumstances.

Throughout the therapeutic intervention, Lee and Sarah attended the clinic ten times. Lee met with the therapist for an hour, learning play therapy skills, an assessment of his performance from the prior week, engaging in role-play, and practicing responses (Glazer & Kottman, 1994). Thirty-minutes was spent in the play room where the therapist supervised Lee and Sarah, which started after Lee's third training hour.

In the first few training times, before Lee was able to administer play therapy, he learned tracking techniques, child-centered approach, valuable techniques to mirror emotions, and suitable ways to set restrictions in the play room (Glazer & Kottman, 1994). In addition, Lee was taught the value of meeting Sarah at eye level, this portrayed acceptance to Sarah. Glazer and Kottman reported an expansion in Sarah and Lee's connection after eight sessions, with an increase in appropriate response.

Throughout the case study, three themes were identified in the play room by Sarah (Glazer & Kottman, 1994). Sarah displayed fear of desertion by Lee, as she often had a difficult time finishing play time, and would often help clean up to prolong her time with Lee. In play time, Sarah portrayed control by acting as a teacher, and demanding Lee to be the student. Sarah showed independence at times, by excluding her father in activities. Sarah would also act as an adult figure, dressing up and directing their activities. Lastly, Sarah often pushed limits. This was portrayed by testing how far Lee would let her go with water, or paint (Glazer & Kottman, 1994). Lee had difficulty setting limits, either he would adapt them pre-maturely, or let them carry on too long.

From the use of filial play therapy, between Lee and Sarah, it was evident that; they engaged in meaningful dialogue, especially Lee, and appropriate affection was portrayed (Glazer & Kottman, 1994). It was also clear that Lee had the ability to give Sarah control of their time together, while enjoying her orders. At first Lee was un-sure of himself during the sessions, but over time he was more confident, feeling happiness afterwards. Lee proved capable of exceeding self-esteem reflections toward Sarah. In return, Sarah showed more assurance in her rapport with her father, through appropriate touch, and lessened her phobia of being forsaken. Sarah was more aware of Lee's love for her, and their father-daughter union (Glazer & Kottman, 1994).

Following Lee's mandated filial therapy and individual counseling interventions, the court awarded Lee un-supervised visitations with Sarah. They continued visiting the clinic weekly for their filial play therapy times for the next six months. Lee also started the use of filial therapy with his step daughter.

The use of filial play therapy proved successful in this case, creating a stronger relationship between the parent and child. It was an effectual tool for rapport enhancement, and life-long parental techniques (Glazer & Kottman, 1994).

A study conducted at Pennsylvania State University by Dr. Louise Guerney and Ann Welsh, it was determined that a family in need would utilize filial therapy (Kottman & Schaefer, 1993). The Austin family was serviced alone, since no other families meet the category of needs for filial therapy at that time. The family received services for four and a half months, incorporating filial therapy techniques. In contrast to a typical filial therapy intervention, the family utilized therapy at the Individual and Family

Consultation Center located at the University due to inefficient space at their home (Kottman & Schaefer, 1993).

The Austin family was suggested to the center because of their four-and-a-half son Billy, who exemplified many troublesome actions at home and in the classroom (Kottman & Schaefer, 1993). Billy was portraying anger, a lack of skill in the classroom, and loud disturbances in the classroom. Conflicts between the parents and their two other children; their nine-year-old daughter Beth, and three year-old-daughter Joy were affecting the Austin family. Beth in particular was demonstrating the need to be grown up. Home life included a lack of consistency, economic problems, and a previous history of physical abuse inflicted on the mother as a child.

Mrs. Austin was hesitant to participate in filial therapy, but wanted some form of play therapy utilized for her children (Kottman & Schaefer, 1993). After two futile attempts to participate in services, the Austin family decided to seek services as they had reached their level of irritation.

Training was implemented over four sessions (Kottman & Schaefer, 1993). A play therapy session between the therapist and Beth was shown to the parents, followed by instruction, and a supervised session of their own. Through observation the Austin's were able to view Beth as a child, not mature as she revealed at home. Mrs. Austin sought out assistance setting limits at home, and Mr. Austin gained knowledge on the practical portion of filial therapy. Both parents gradually attained the appropriate filial therapy skills through their instruction, and supplementary participation in a parenting group. Some hesitation was experienced by the Austin's, as they struggled with control. They had an intricate time communicating to Beth that she needed to attend play

sessions. Eventually Beth conformed to attending sessions, and was pleasant during play time (Kottman & Schaefer, 1993).

After proper instruction, the Austin's were prepared for supervised play sessions (Kottman & Schaefer, 1993). Mr. Austin facilitated with Billy and Mrs. Austin with Joy for the first session. Both parents were unsure of themselves, during the first few minutes of their sessions, but proceeded nicely, reflecting appropriately. Each week the parents rotated their children, gaining appropriate skills.

Progression was exemplified after the first week (Kottman & Schaefer, 1993). A decrease in negative behaviors was reported by the Austin's. A peak of aggression was shown between Beth and Billy as they utilized play time over the next couple of weeks. Eventually, there was a decrease in these behaviors and a more euphoric atmosphere was created. Beth continued demonstrating controlling behaviors, but showed an effort towards including her parents' opinions. Billy exemplified supremacy into his play time, over time he explored more self-gratification play, integrating what he'd accomplished at school.

Through the filial training, Mrs. Austin was able to reflect appropriately her children's feelings, often on her second attempt (Kottman & Schaefer, 1993). She also mastered the ability to utilize boundary setting. Mr. Austin demonstrated effective reflections, communicating acceptance to his children, he also controlled his emotions when Beth acted out and pretended to shoot him.

After extensive supervised training, the parents were able to facilitate weekly play sessions at their new home they had bought. Some adaptation was needed, like unplugging the phone during sessions. Occasionally the parents would hold sessions at the

center, sustaining their success as facilitators of filial therapy (Kottman & Schaefer, 1993).

A year after the first training session, the Austin family was contacted. Mr. and Mrs. Austin were satisfied with the effectiveness of the therapy, and agreed on their children's progress in school and home climate (Kottman & Schaefer, 1993). Filial therapy was an effective form of a family intervention for this once troubled family. Victorious results were reported, and a happier life was established from this intervention.

Landreth and Lobaugh (1998) conducted a qualitative and quantitative study on the efficiency of filial therapy with imprisoned fathers. Landreth and Lobaugh addressed the need for a program used with fathers in prison, there are a plethora of programs for women, but are absent for men. There are an estimated 70% of imprisoned mothers with reliant children who are minors, but a lack of information for fathers (Landreth & Lobaugh, 1998). This could imply that imprisoned fathers are ignored inhabitants.

The study was promoted at a male prison through flyers endorsing a parent instruction course (Landreth & Lobaugh, 1998). Participants were chosen based on; (1) currently serving a sentence for at least six months; (2) a child not receiving therapy and is amid 3 years and seven years of age; (3) father must have English language comprehension; (4) father must not be receiving therapy; (5) no current parent instruction courses being taken; (6) be present at the full 10 weeks of training; (7) comply with the pre-and posttest instruments; (8) conduct weekly half an hour play sessions with their children; and (8) endorse a consent form. In addition, the child's other parent or guardian needed to approve and sign the consent form (Landreth & Lobaugh, 1998).

After going to the pre-session, two groups were capriciously elected for one of two groups; an experimental and a control group for filial therapy instruction courses (Landreth & Lobaugh, 1998). Of the thirty-two men selected, sixteen were put in the experimental group, and sixteen in the control group. Each group was randomly chosen, and each group had an average age of thirty, blend of race, and educational milieu. As for the children, Landreth and Lobaugh (1998) also indiscriminately selected fairly equal clusters consisting of ten girls and six boys in the experimental group with an average age of 5.94, and nine girls and seven boys with a 6.52 average age for the control group.

Four instruments were utilized in pre-and posttests according to Landreth and Lobaugh (1998). The Porter Parental Acceptance Scale (PPAS) calculated parental approval. The Parenting Stress Index (PSI) calculated the stress level in the familial relationship. The Filial Problem Checklist (FPC) was utilized to evaluate outcomes acquired in this study with other filial therapy studies. Lastly, the Joseph Preschool and Primary Self Concept Scale (JSCS) deciphered a child's identity perception through images.

In the experimental group, the sixteen parents were divided to better fit filial therapy suggested guidelines (Landreth & Lobaugh, 1998). The groups met once a week for an hour and a half, over a ten week period. Landreth and Lobaugh each facilitated the groups, following the suggested filial therapy guidelines, incorporating child-centered techniques. The fathers were instructed on how to be insightful to their children, comprehending needs, feelings, and how to react in a sympathetic manner. The participants practiced these skills in weekly play sessions, and then shared reflections

with the group. Throughout the ten weeks, group support was a strong subject in weekly meetings.

Because of supervision requirements, the play sessions took place in a small room, with the door left open. No video recordings were permitted in regard to fortification of civil rights, so an oral depiction of the session was described by each father to the group. In the play room, many toys were supplied for the children to engage in, including puppets, play guns, and games. As a group the fathers would promote and learn from each others experiences through group discussions.

In the control group, no weekly meetings to enhance play therapy skills were offered. The pre- and posttests were administered equally as the experimental group. The fathers were advised to interact with their children during weekly visits in an open play room, and were instructed to carry on as normal. Landreth and Lobaugh (1998) utilized the control group in anticipation that it would establish the effectiveness of filial therapy training.

Results of Landreth and Lobaugh's study indicated powerful outcomes of utilizing filial therapy with imprisoned fathers. When comparing the pre and posttests to the experimental and control group; there was an elevated level of child approval and decreased amount of familial stress, and a lowered level of problem behaviors demonstrated by the children in the experimental group. One reason that the experimental group was so effective was in part the child centered techniques used during the play sessions. One father from the experimental group commented on how the sessions positively changed the relationship with their child, spending valuable time together for the first time. Another mentioned how they never learned what a father was

like, being raised by a single mother, and how they feel more adequate to play a fatherly role in their child's life after the training.

Due to the lack of participation in the control group, not all children finished the JSCS posttest, which limits the value of the study (Landreth & Lobaugh, 1998). As a result, the experimental and control child JSCS scores were not able to be contrasted. Another limitation was the educational levels incorporated into the study. Landreth and Lobaugh indicated abnormally higher education levels than usual, but preface that educational level is not momentous when learning filial therapy techniques. No follow up study was performed, which could portray if the results are lasting or not. In defense, Landreth and Lobaugh shield the lack of extended outcomes due to the lofty turnover rates of prisoners.

The outcome of this study designates filial therapy as a valuable tool when working with imprisoned fathers. Filial therapy offers successful skills to better comprehend a child, and exemplify healthy parent-child relationships. Although a child may not have daily contact with an incarcerated parent, when time is spent together it can ensure an affirmative and influential effect (Landreth & Lobaugh, 1998).

## Chapter Three

### Summary, Critical Analysis and Recommendations

#### *Summary*

Filial play therapy is a parent based therapy approach that helps parents establish a more meaningful and clear connection with their child. The spotlight is on parents establishing a rapport with their children so that the child plays out conflicts in their lives, resulting in a more vigorous mental health (Watts & Broaddus, 2004).

In addition to establishing parent-child rapport, limit setting is also utilized in filial play therapy. By setting limits, a child learns to restrain impulses and be accountable, which is crucial in communicating thoughts efficiently (Kellam, 2001).

Play is the language of children, an un-tapped resource that many therapists don't utilize. It's an innate occurrence with children, and serves as the foremost medium for change to occur (Russ, 2004). As children immerse themselves in pretend play, they lose track of the world around them, making it a soothing method of counseling where children are apt to play out disturbances in their lives.

Filial play therapy is unique compared to other familial training options (Bratton, 1998). Other forms of familial instruction focus on behavioral techniques, changing the way a child acts. Filial play therapy focuses on the connection between the caretaker and child. The caretaker serves as the tool that enhances positive behaviors, through reflection of feelings, understanding, and approval (Bratton, 1998).

By utilizing filial therapy thirty minutes per week, children are able to recognize themselves as significant in the caretaker's life (Ramirez & Salcines, 2001). Approval of the child's emotions, whether they are vicious or tender, has a soothing effect on the child

and the way they feel about themselves. By accepting these behaviors, overtime the child learns to understand their emotions and will ultimately prosper into a conscientious adult having worked through untouched emotions (Ramirez & Salcines, 2001).

An empirically sustaining method of healing, filial therapy can overcome deficits in communication between caretakers and children. Filial therapy is preferred due to improved relationships and can avert potential child tribulations (Schuman, 2002).

Filial therapy can be utilized for series family tribulations, or to reinforce familial connections by enhancing caretaker and child relations. It is a flexible alternative to family therapy that can gratify many different familial needs, and serves as a pleasing approach for the whole family (Van Fleet, 1994).

There have been numerous studies conducted to establish the efficacy of filial play therapy. A study by Dee, Bratton and Brandt (2000) focusing on single parents attending community colleges conclude that filial therapy is beneficial in a precautionary, instructive, and clinical repercussions. Along with training at a community college, the authors expanded training options to schools, neighborhood centers, places of worship, penitentiaries, hospitals, and treatment facilities. The need for parental assistance is crucial, especially for single parents. Unfortunately there is a lack of filial therapy therapists available, creating a shortage of trainers (Dee et al., 2000).

A study conducted with incarcerated fathers indicated positive results of implementing filial play therapy. Landreth and Lobaugh (1998) proved skill building between parent and child communications, an elevated rate of child approval, a decline in parental anxiety, and a reduction in behavior problems by the children in the study. In addition, the children in the study had improved concepts of self, accomplishing a goal of

filial therapy. Landreth and Lobaugh (1998) established the effectiveness in utilizing filial therapy with imprisoned fathers, as it creates positive precautionary, academic and mental health inference.

In addition to Landreth and Lobaugh (1998), Glazer and Kottman (1994) conducted a study on a father and daughter. The father, Lee was court mandated to have supervised play therapy sessions with his daughter, Sarah. Ten sessions were administered, including individualized therapy for Lee, and filial therapy with Sarah. As a result of the study, Lee was allowed un-supervised visitations with Sarah, and their father-daughter relationship was enhanced. Sarah demonstrated rapport, and Lee was equipped with life-long parenting skills, as well as appropriate affection for his daughter (Glazer & Kottman, 1994). The outcome of utilizing filial therapy in this study supports its successful use.

Lastly, a study performed by Kottman and Shaefer (1993), exemplifies a successful outcome of the Austin Family and the implementation of filial therapy. The Austin's had three children whom were portraying aggressive and un-satisfactory behaviors. Filial therapy was implemented by both parents, and encouraging results were revealed as a result of employing filial therapy. Their children demonstrated more self-gratification, and inclusion of parents in their play. The Austin's verified effective boundary setting and acceptance of their children's behavior. A follow up interview was implemented a year after their training, the results were in favor of filial therapy. The family reported a happier home environment as a result of filial therapy (Kottman & Shaefer, 1993).

In summary, due to communication barriers between caretaker and child, an effective familial therapy is needed. As opposed to talk therapy, filial therapy has proven its effectiveness in creating child acceptance and understanding between the caretaker and child.

### *Analysis of the Literature*

Though various amounts of literature exist on the value of filial therapy, most are narrative case studies, and not empirically based. Case studies often contain small samples, which make it impractical to generalize the results to all inhabitants. In the Kottman and Shaefer (1993) and Glazer and Kottman (1994) study, only one family was analyzed, lessening the results of the study.

Narrative case studies leave room for subjectivity, weakening the impact of the results, as well as the field of play therapy. Play therapy is open to interpretation, and metaphorical in nature. Some may interpret different types of play with different meanings. Russ (2004) cautions therapists, forewarning that interpretations should be carefully considered by the therapist.

Another limitation is the lack of diverse populations studied. The majority of subjects utilized were Caucasian. Apprehension of how universal the effectiveness of filial play therapy is with minority populations is questioned. In the Landreth and Lobaugh (1998) study, both experimental and control groups were represented by around 52% Caucasian, 30% Hispanic, and 18% African American populations (Landreth & Lobaugh, 1998). This study indicates some diversity in its selection of participants. Of the other case studies utilized for this literature review no mention of ethnicity was included other than the Landreth and Lobaugh (1998) study.

In an interview with Landreth (cited in Watts & Broaddus, 2004) a discussion of projects focusing on Chinese and Native American cultures were noted. Landreth measured to see if new Chinese immigrants to the United States and a Native American tribe in Montana would compare to previous Caucasian results. The outcome indicated comparable results toward child acceptance and empathetic responses across cultures (Watts & Broaddus, 2004).

A change in the child's environment or cognitive functioning may alter results of a study. Outside factors are uncontrolled, and make the validity of the data weak. There were no measurements utilized in the case studies to analyze if it was due to child maturation or the home milieu that caused an alteration in behavior.

A final inadequacy in the effectiveness of filial therapy is the skill level of the therapist administering the training. Through researching the topic, little information was given on the qualification of the filial therapist. In the Landreth and Lobaugh (1998) study of incarcerated fathers the facilitators were listed as the authors, but failed to address what their qualifications were. Most scholars in the counseling field recognize Garry Landreth as a pioneer in the play therapy world, but as for Lobaugh, his name is lacking credibility. Very few narratives listed who the conducting filial therapists were and their academic credentials, leaving the validity of credibility stagnate.

### *Recommendations*

A need for future research of filial therapy is desired. In particular, more research on who should be administering filial therapy, a therapist or trained caretaker? The effectiveness of a caretaker is questioned as a facilitator in play therapy. Caretakers also administer punishments, where a therapist only sets reasonable boundaries, and acts as a

neutral party. A child only sees the therapist in that specific role, whereas the caretaker has many roles. A study to determine which facilitator has more therapeutic outcomes would be beneficial for future research.

Another variable that is difficult to determine is the placement of where the play sessions are held in the home, and if the subjects would greater benefit from using a clinic setting where little distractions would occur. Van Fleet (1994) stresses the importance of un-interrupted play sessions, and how this is most likely to occur in the home rather than clinic setting. Interruptions can impose on the energy of the session, and decrease the therapeutic value of play. No mention of the effects interruptions had on families in the case studies reviewed, and if progress was stalled due to interruptions. Further research measuring the location and efficacy of where filial therapy is best administered, between homes or a clinic setting is recommended.

Another recommendation is the long term effectiveness of filial therapy. Van Fleet (1994) recommends that the therapist checks in with the clients to ensure quality play therapy is being implemented by the caretakers. In Landreth and Lobaugh's (1998) study of incarcerated fathers, no follow up was administered after their study, due to a high turnover rate in prison. A study that examines the rate of occurrence of therapist contact would be valuable in ensuring long term effectiveness.

More resources on filial therapy are needed, as it was difficult to find reliable sources. Many were outdated, addressing the need for more current research. Specific books dedicated to filial therapy would be helpful in educating others of the effectiveness of filial therapy. Most sources include many other play therapy resources as well as filial therapy.

In conclusion, further research of filial therapy is needed. In analyzing the limitations of this literature review, the value of filial therapy appears prominent as a successful therapeutic agent, with room for further expansion. Current research consists of mostly case study narratives; further quantitative research would be beneficial.

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