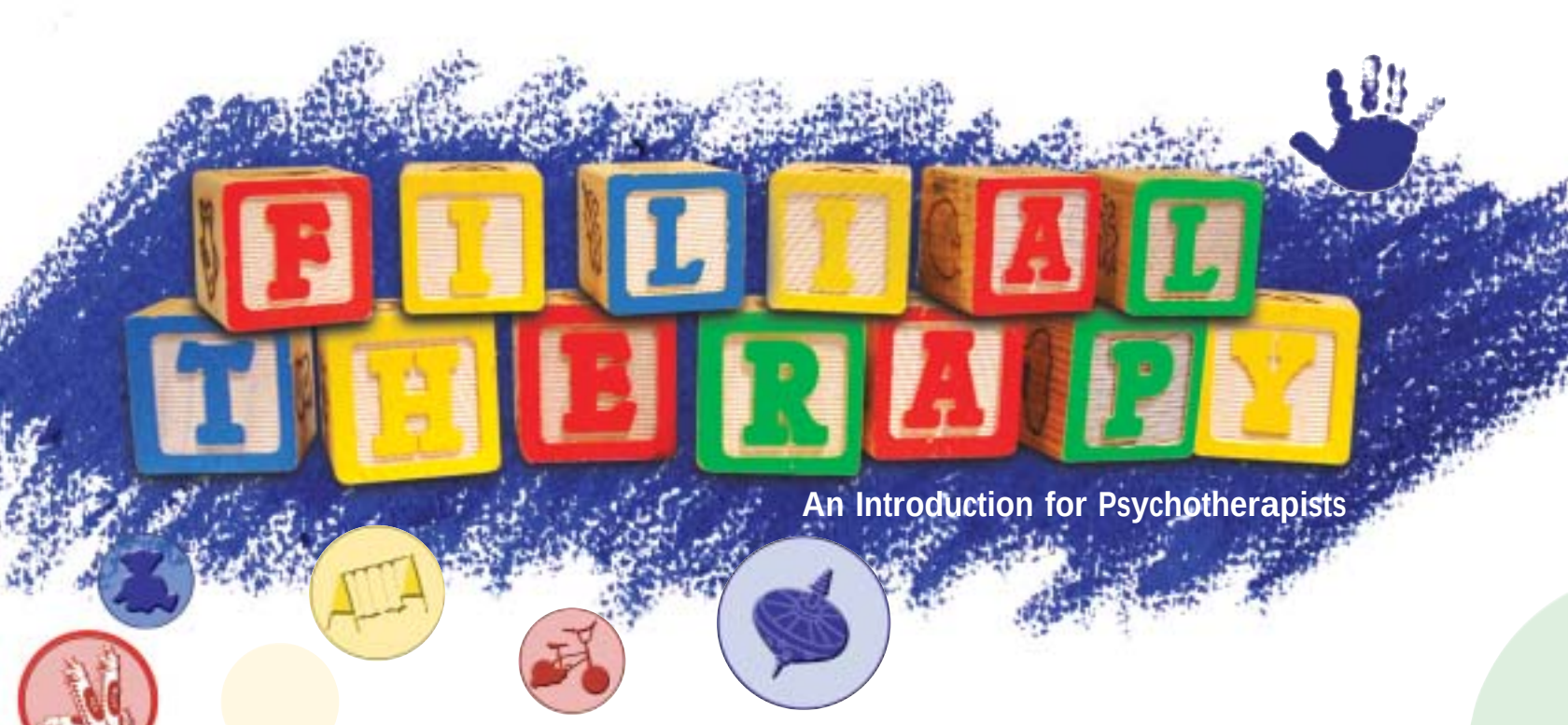

An Introduction for Psychotherapists

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KEY WORDS: filial therapy, play therapy, child-parent relationships

Abstract

Filial therapy is an innovative psychotherapeutic approach to helping children ages 3-10 by teaching parents pertinent play therapy techniques. Recent research on filial therapy has shown that this approach leads to increased parental awareness of children's needs, a reduction in parental stress, and better child-parent relationships. This article describes the history, techniques, and positive outcomes of filial therapy.

In the early 1960s, Bernard and Louise Guerney recognized the burgeoning demand for and unavailability of mental health services for children and their families. They developed an innovative treatment methodology based on training parents in basic child-centered play therapy skills (VanFleet, 1994). The objective of this approach is to help parents become the therapeutic change agents in their children's lives by using the naturally existing bond between parent and child. Thus, this approach is termed filial therapy (Guerney, 1964).

The child-centered play therapy model taught to parents was developed by Virginia Axline (1947), a student of the client-centered theory espoused by Carl Rogers (1951). Axline translated Rogers' theory and therapeutic methods into a play therapy model that allowed children to benefit from a non-directive approach to play (Guerney, 1997). In her model, the therapist is guided to use empathy, acceptance, and unconditional positive regard, and to allow the child to lead the way. The therapist should avoid the use of criticism, judgment, interpretation, or questions. Thus, the therapist is expected to enter into the child's world. Axline also included limit-setting in her basic principles; the therapist sets limits in order to protect the child, the therapist, and the physical materials. She also believed that children have the capacity to heal themselves when placed in an appropriately supportive atmosphere.

Louise Guerney (1997) asserted that most problems experienced by children are not the result of parental pathology, but rather are the product of the parents' failure to learn how to understand their children, appreciate their perspectives, and use reasonable non-violent control when teaching their children. Because parental problems were defined as learning problems, the Guerneys believed that teaching parents child-centered play therapy skills would ultimately help parents overcome these problems and strengthen the parent-child relationship.

Typically, filial therapy takes place in a support group format that meets for two hours each week over a 10-12 week period. During this time, six to eight parents learn basic child-centered play therapy principles to use with their children in special half-hour weekly play sessions. The combination of didactic instruction and supervision in a supportive atmosphere provides a dynamic process that sets filial therapy apart from other parent training and psychotherapy programs that are exclusively educational in nature (Andronico, Fidler, Guerney, & Guerney, 1967). As in child-centered play therapy, filial therapy is structured to enhance and strengthen the relationship. However, in filial therapy the focus is the relationship between parent and child, rather than the relationship between therapist and child. Through viewing play sessions (videotaped or live), receiving supportive feedback from the therapist and the group, doing role plays, and participating in a variety of didactic experiences, parents learn to convey acceptance, empathy, and encouragement to their children, as well as to master the skills of effective limit-setting. This new creative dynamic of empathic responding by parents becomes the creative process through which change occurs both *within* the parent and child and *between* the parent and child.

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Filial therapy training fulfills the dual function of intervention and prevention of problems. In addition, it offers significant possibilities for enhancing and strengthening the parent-child relationship in families at risk. Because parents are provided with both training and support, they can learn to move toward healthier parent-child interactions. If the parent can be taught to execute the essentials of the role usually taken by a play therapist, the parent can conceivably be more effective with his or her

child (Guerney, 1964). This rationale rests on the assumptions that the parent has more emotional significance to the child than does the counselor, and any of the child's anxieties learned or influenced by parental attitudes can be more effectively extinguished under similar conditions. In addition, parent-child misperceptions can be corrected when the parent clearly identifies behavior for the child that is appropriate to time, place, and circumstance (Guerney, 1983a).

The goals of filial therapy (Guerney, 1964) are:

- To reduce the problem behaviors in children.
- To help parents acquire the skills of a play therapist for application in play sessions and ultimately for use in everyday life.
- To improve the parent-child relationship. Children and parents will experience more positive feelings toward one another after experiencing the play therapy sessions.

Filial therapy typically has four stages that are taught during the 10-12 parent sessions. Stage One involves general training, and lasts for two or three meetings. During this stage, the rationale for the method and the particular behaviors of the adult are fully explained. The therapist demonstrates how play therapy is done with the families' own children while the parents observe the interaction. Stage Two requires that the parents practice doing one or two play sessions without the children present. During Stage Three, parents conduct actual play sessions with their children, followed by feedback from the therapists and the other parents in the group. Feedback includes a discussion of parents' feelings about the process, as well as instruction in areas in which the parents need additional assistance. Parents are also encouraged to share information about the child's behavior outside of play sessions. The number of sessions (from six to eight) is determined by the children's progress through the expected stages of child-centered play therapy (Guerney, 1983b). Stage Four involves the transfer and generalization of skills learned during the play sessions to everyday life. Stage Four is usually completed over the course of two sessions. If time permits, an additional stage may be added. For example, a fifth stage may involve a formal evaluation of progress, discussion about how to maintain positive changes, and guidance for any areas that still need improvement.

There are two main criteria for a therapist to consider when making the decision to employ the filial therapy approach (Guerney & Welsh, 1993). The first part of the process involves deciding if the child can benefit from filial therapy. Any child who can benefit from child-centered play therapy would be a candidate. The second part of the decision involves both the physical and psychological availability of the parent. Regular attendance is of critical importance. If parents are unable to attend on a regular basis, an alternative approach should be sought. In terms of psychological availability, parents who are psychotic, mentally handicapped, suicidal, homicidal, or substance abusers should be ruled out (Guerney, 1976).

A considerable number of empirical studies (Guerney, 1975; Oxman, 1971; Guerney, & Stover, 1971; Glass, 1986; Sensue, 1981; Sywulak, 1978) have shown that filial therapy can increase parental empathy and acceptance, as well as reduce parental stress. Research with parents and children of diverse cultures has recently been initiated to determine the effects of filial therapy across cultures. For example, Chau and Landreth (1997) studied the effects of filial therapy with Chinese parents and found a significant increase in the level of empathy in interactions with their children, a significant increase in parental attitudes of acceptance toward their children, and a significant reduction in the level of stress related to parenting. Glover (1996) studied the effects of filial therapy on Native American parents and found that parents significantly increased their level of empathy in their interactions with their children. Although parental acceptance, parental stress, and children's self-concept did not improve significantly in this particular study, positive trends in these areas were indicated.

Filial therapy has also been adapted to work successfully with learning-disabled children (Gilmore, 1971; Guerney, 1979; Kale, 1998), chronically ill children (Glazer-Waldman, Zimmer-

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man, & Landreth, 1992; Tew, 1997; Van Fleet, 1992), children with spectrum-pervasive developmental disorders (Beckloff, 1998), children in Head Start families (Johnson, Bruhn, Winek, Krepps, & Wiley, 1999), adoptive children and foster parents, (Ginsberg, 1976; Van Fleet, 1994a), children of single parents (Bratton & Landreth, 1995), children of divorced parents (Bratton, 1998), children of incarcerated mothers (Harris & Landreth, 1997), and children of incarcerated fathers (Landreth & Lobaugh, 1998).

In recent years, the 10-week filial therapy group format has been modified in length, format, and intent. Van Fleet (1994b) advocated individual parent sessions over a shorter period of time. Harris and Landreth (1997) have used a condensed five-week filial therapy model (10 sessions, twice a week) with positive results. Landreth (1991) suggested that the original intent of filial therapy should be modified to include the parents of all children, not just children with adjustment problems. He found that many parents attended his filial sessions because they wanted to be better parents, and he promoted filial therapy as an educational tool to strengthen parent-child relationships and enhance parenting skills.

Dr. Reynolds, in collaboration with an elementary counselor, developed a filial program as a part of a family literacy grant focusing on helping mothers without high school diplomas interact with their preschool-aged children. These mothers were taught filial therapy as part of earning their general equivalency diplomas. They reported better relationships with their children and less stress about parenting as a result of the filial training (Reynolds, in press).

In the 30 years since its development, filial therapy has demonstrated both clinical success and strong empirical evidence for its efficacy. It is an option worthy of consideration for those psychotherapists who are looking for a powerful means of changing both parent and child behaviors as well as parent-child relationships.

For more information on using filial therapy in psychotherapy, please refer to the following source:

VanFleet, R., & Guerney, L. (2003). *Casebook of filial play therapy.* Boiling Springs, PA: Play Therapy Press. This book addresses the value and variations of filial play therapy. Part I covers filial play therapy for specific problems, Part II addresses filial play therapy issues related to different family circumstances, and Part III summarizes filial play therapy techniques in different cultures.

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