An Overview of Filial Therapy
Risë VanFleet, Ph.D., RPT

Filial Therapy was created by Drs. Bernard and Louise Guerney in the late 1950s and developed throughout the rest of their careers. It was astonishingly ahead of the times, representing one of the first systemic family interventions, and using a psychoeducational framework that remains unparalleled in mental health work today. It remains unique in that family members are involved as the primary change agents for other family members.

In Filial Therapy, the therapist teaches parents to conduct special nondirective play sessions with their own children. Those sessions are supervised live at first, and later shifted to the home setting. The therapist continues to monitor the home sessions until presenting problems are resolved or significant progress has been made.

Filial Therapy is deceptively simple - there is much that goes on within the therapy, as it was conceived and developed as a form of family therapy. Its popularity has grown among therapists and families as the mental health climate has changed, and 50 years of research have demonstrated its effectiveness, both in its original form and in adapted versions. Worldwide interest in Filial Therapy is growing rapidly as well. Its use of nondirective play sessions and its involvement of parents as partners in the therapeutic process crosses cultural lines easily, and many have found great value in its respect and empowerment of the family.

Filial Therapy was initially developed as a group family program, but it can easily be used with individual families. Because it is a process-oriented and relationship-oriented approach, it is applicable to a wide range of problems.

Filial Therapy typically is a time-limited approach with the flexibility to meet family needs. Individual families often complete the entire process within 15 to 20 one-hour sessions, and there are several group formats ranging from 10 to 24 weeks.

Filial Therapy is comprised of several phases, including the initial family assessment and family play observation (2 sessions), play session demonstrations by the therapist (1 session), a parent training period (3 sessions), direct supervision of parents' first play sessions with their children (4-6 sessions), transition to home play sessions monitored by the therapist coupled with skills generalization (4-6 sessions), and discharge. The number of sessions varies with each family.

Filial Therapy is an empirically supported therapy, with nearly 50 years of research. Three- and five-year follow up studies of the original model of Filial Therapy have shown that improvements in child behavior, parental empathy, parent skills, parent stress, and parent satisfaction have been maintained. Research on the CPRT short-term group parenting format derived from Filial Therapy has been consistently positive, and new research is showing that it has the biggest impact for the most dysregulated children and parents.
To learn more, visit www.play-therapy.com. Information about training and certification in Filial Therapy is listed there as well. A Facebook group called Filial Therapy Forum is available to anyone who is interested. Please contact the author at rise@risavanfleet.com for more information or send a friend request to Rise VanFleet on Facebook.

Select Resources on Filial Therapy:


There are many other chapters and articles available, and some references for alternative formats derived from Filial Therapy are included in the article series that follows. Several new group manuals and other resources are currently in progress or in press.

The article series that follows explores the unique features of Filial Therapy and the variety of adaptations that have been made based upon it. The series is provided here with the generous permission of the British Association of Play Therapists, which first published them in their *Play Therapy* magazine.

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Filial Therapy: What Every Play Therapist Should Know

Part One of a Series
Risë VanFleet, Ph.D., RPT-S

In the 54 years since Dr. Bernard Guerney walked onto the back porch of his home and suggested the idea of Filial Therapy to his wife, Dr. Louise Guerney, the method has been refined, researched, and disseminated throughout the world. Because the concept was far ahead of its time, it was met with initial criticism. Critics could not quite imagine that parents would be capable of making a difference in their children’s lives this way, especially because the prevailing view was that parents were the cause of all the child’s problems. The Guerneys and their colleagues answered those criticisms by doing research—research that clearly showed that parents were capable of learning to conduct the special play sessions and research that clearly showed that this method led to lasting improvements for children and their families.

It is perhaps only in the past 20 years that Filial Therapy has gained a strong foothold in the professional community, and just in the past decade that international interest in this effective form of family therapy has grown rapidly. As is often the case when a therapeutic method gains popularity, there grows with it misunderstanding and misapplication. People with insufficient training or partial understanding of the method try it, often without good results, and others claim it for their own while changing its essential nature. Others obtain training but little or no supervision, and once again, the strength of the method can be diluted, or its use is never expanded to its full potential.

In the history of psychology, this phenomenon can be observed many times, and I have seen it affecting the practice of Filial Therapy. I am excited that so many of my colleagues throughout the world have embraced Filial Therapy and found it to be as powerful as I always have, but I am also concerned that there are so many misunderstandings about what Filial Therapy really is and isn’t. Most often, people underestimate its strength and applicability, limiting its use to cooperative or motivated families. I learned Filial Therapy from both Bernie and Louise Guerney 30+ years ago, and I still marvel at the theoretical and practical brilliance of their conceptualisation of the method. The Guerneys played a role in the refinement of the method throughout their careers and even into their retirement and this evolution of the approach is also misunderstood by some. Because of the flexibility that was built into Filial Therapy from the beginning, I have found very little need to “tinker” with it, despite using it with a vast range of families and problems, including very severe ones. Since so many Play Therapists, Family Therapists, and other clinicians have seen the value of Filial Therapy, whilst there are others who have not, I thought a series of articles detailing its foundations, methods, and adaptations would be helpful at this time.

What Is Filial Therapy?

Filial Therapy is a form of family therapy. It is based on a psycho-educational model, not a medical model, of service delivery. It harnesses the power of Play Therapy. It empowers children, parents, and families. It changes children. It changes parents. It changes the family.

The term "filial therapy" derives from the Latin filios or filias, meaning sons or daughters. Loosely translated, it means parent-child. As Filial Therapy evolved, the Guerneys and others tried to find more user-friendly terms for it, but the name Filial Therapy has stuck. In 2003, Louise Guerney (personal communication) asked that the term be capitalised when referring specifically to the Guerney model of conducting Filial Therapy (FT), and that the...
lower case “filial therapy” or other terminology be used to refer to significant variations from the original approach. I am honoring that request in this article as I have in most of my recent writings.

FT refers to a theoretically integrative form of therapy in which therapists train and supervise parents or carers as they conduct special non-directive play sessions with their own children. The therapist provides feedback to the parents or carers to help them develop their competence and confidence, and the therapist considers parents to be full partners in the therapeutic process. The therapist also discusses children’s play themes with parents and helps parents understand their children’s motivations, feelings, intentions, and behaviors in context. As parents attain solid skills in conducting and understanding their play sessions, the therapist assists as they shift the play sessions to the home environment. The therapist continues to monitor the play sessions with weekly or bi-weekly meetings with the parents. As problems begin to resolve, the therapist helps the parents generalise what they have learned to everyday life and parenting situations. FT is considered a time-limited intervention, and it typically requires 17 to 20 one-hour sessions for moderately difficult problems.

FT was initially developed as group family therapy and is still conducted that way today when feasible. The length of family therapy-oriented groups has shrunk from 9 to 12 months in the very early days of FT to 16 to 24 weeks now. There are several group formats that are even shorter than this that I will review later in the series. FT easily can be used with individual families, and it can be applied for both prevention work as well as an intervention for seriously distressed children and families.

Theoretical Integration

The heart and soul of any form of therapy depends on the theories and assumptions behind it. To truly understand an intervention, one must understand its foundations. Even I have been remiss in covering this information too quickly or too superficially in my writings and trainings. Now seems a good time to revisit the theories and principles underlying the practice of FT.

When Bernie Guernsey began detailing his idea of having parents conduct non-directive play sessions with their own children under the supervision of a therapist, he pulled what he thought were the strongest aspects of several theories of human psychology (personal communication). FT represents a true synthesis of features of psychodynamic, humanistic, interpersonal, behavioral, developmental, cognitive, and family systems theories. The contributions of these theories for children and parents in FT are described briefly below and in greater detail in VanFleet (2009) and Ginsberg (2003), and Cavedo and B.G. Guernery (1999).

Psychodynamic. From psychodynamic theory, FT pulls a recognition of the importance of the unconscious and of defence mechanisms and highlights the role of self-understanding for growth. Catharsis offers release and healing, while Adlerian psychology emphasizes the need for goals, mastery, and social interest. It is assumed that children’s play during FT reveals their inner worlds, including their anxieties and their hopes. Their play is symbolic and meaningful. From the parents’ perspective, children’s play themes reflect matters of family dynamics. Children’s play within the safety of the FT sessions helps parents see dynamic issues, not only for the child, but for themselves and the entire family. The therapist helps the parents work through these insights so that families can reach goals that yield better adjustment for all family members and the family as a whole.

Humanistic. FT applies humanistic, and specifically, Rogerian, theory amply throughout its process. FT aims to enhance each family member’s self-concept through the use of acceptance, genuine respect, and empathy. Children receive positive regard from their parents during the non-directive, child-centred play sessions. Parents learn to provide genuine acceptance and empathy for the children’s feelings, thoughts, and motives. It is a key feature of FT that therapists provide this same type of safe and accepting environment for the parents, using empathy to convey understanding of parents’ feelings, thoughts, and desires. Deep empathy is essential for the effective engagement of parents in the process, and it helps parents make the sometimes difficult but necessary changes for a more satisfying family life. FT represents a chain of empathy, giving to parents the same acceptance the therapist provides for their children and each other.

Behavioural. FT employs principles and methods from behaviourism and learning theory, including the use of teaching methods that ensure success. There are behavioural components within the play sessions for children, where the structuring and limit-setting skills add security, boundaries, and clear consequences to eliminate unwanted child behaviours. Parents learn a balanced approach to parenting. Therapists use reinforcement, shaping,
and vicarious learning to help parents to master new skills and behaviours for use with their children. The parent training process heavily depends on behaviour and learning principles.

**Interpersonal.** FT is based on the premise that individual behaviour is largely influenced by interpersonal experiences. Sullivan's (1947) circumplex model of interpersonal theory suggests that people's actions are closely associated with other people's reactions. FT seeks to alter the rather automatic action-reaction pairs that are common in the parent-child relationship by bringing them to awareness and selecting different ways of acting or reacting to circumstances or each other. Furthermore, incorporation of interpersonal theory suggests that attention to the reciprocal nature of parent-child relationships during play sessions helps both parent and child take responsibility for changes, resulting in more satisfying family relationships overall.

**Cognitive.** Cognitive therapy is based on the idea that what we think affects how we feel and how we behave. In FT, non-directive play sessions help children change the way they think about themselves, others, and the world. They can move from viewing themselves as victims to having a sense of personal power and self-efficacy. Much of this occurs during the play sessions as the children work through various feelings and try on new roles in their imaginations. Therapists also help parents think differently about their children and themselves. When parents react to dynamic issues that arise during the parent-child play sessions, therapists help them sort out their thoughts and help them reframe their understanding of the situation. For example, many parents start therapy thinking that their children are deliberately trying to anger them, but they often leave FT without this attitude, having replaced it with a more compassionate understanding of how trauma or anxiety drives behaviour.

**Developmental/Attachment.** Children's feelings and behaviours are deeply influenced by their developmental levels and attachment experiences. Children's play during FT sessions often reflects developmental tasks relevant to them at the time, such as when a five-year-old endlessly pours water back and forth in a time warp tea party to suggest developmental mastery. Therapists help parents understand developmental features when they emerge in the play and help parents set realistic expectations or become more accepting as needed. Attachment issues also naturally occur, such as when a child from an enmeshed, insecure attachment situation does not invite her mother to play any roles with her. The therapist often must reassure the mother that this is a good thing, that healthy attachment involves episodes of child exploration and independence followed by a return to the secure base. In this way, even parental attachment dilemmas can be addressed and modified. FT empowers all family members in such a way that they can shift to healthier attachment styles and ways of relating. Even severe problems associated with trauma and attachment disruption can be addressed successfully by a properly trained and experienced Filial Therapist.

**Family Systems.** From a theoretical perspective, the client in FT is not the child, nor is it the parent. The client is the relationship that exists between each parent and child and among all the family members. Whenever possible, all members of the family are included in FT because change affecting an individual or dyad within the family affects everyone. Although the play sessions are held with one parent and one child at a time, the entire family is involved in the process. Therapists using FT must attend to changes at all levels within the family system, as well as to the impact of broader systems within which the family is embedded, such as extended family, neighbourhood, school, work, and culture. The essential family therapy features of FT have been outlined elsewhere (VanFleet & Topham, 2011).

**Psychoeducational Model.**

All of these theoretical contributions work together within FT primarily because it is based on a psycho-educational model that assumes that most problems arise for individuals and within families due to a lack of knowledge or skill. The family's repertoire of parenting or relationship tools is not sufficient to the stressor/s the family is facing. Psycho-educational interventions are designed to teach and supervise family members in applying the knowledge and skills that will help resolve their problems. This is a fundamentally different way of thinking about therapy than traditional approaches, and perhaps this is one reason that FT is sometimes misunderstood.

Early in its development, the Guernseys and their colleagues (Andronico, Fidler, Guerney, & Guerney, 1967) wrote about the didactic and dynamic aspects of FT. Louise Guerney (1997) discussed "the dual commitment to the forthright teaching of play sessions and simultaneous focus on the parents' feelings as players and on parents as
parents. ... In involving parents in this process, one is entering the potentially emotionally threatening world of the parent-child relationship—a world of feelings and attitudes and family dynamics that would require the same respect and understanding that parents were asked to provide for their children. It should be understood, however, that the task of working with the children is always given top priority and the parents' feelings and personal concerns never dominate. FT is not a circuitous route to providing client-centered personal or parental therapy to parents. The perspectives of parents are critical and require acceptance and understanding on the way to learning how to develop the competence to conduct an appropriate child-centered play session for the benefit of their children and their relationships with their children." (pp. 131-132)

Therapists who practice FT must be a clinician and an educator, developmental specialist and family therapist. A clear understanding of the theoretically integrative nature of the approach is essential for FT best practices.

In the second installment of this series on FT, the essential features of FT will be covered—those elements that distinguish FT from other interventions sometimes confused with it. Key variations and adaptations of FT will also be included, as well as their relative strengths and weaknesses. It is hoped that this review will help raise interest in FT and show how it can be implemented with many different types of problems and in a wide range of settings.

References


Violet Oaklander Gestalt Child Therapy Video
www.youtube.com

Gestalt child therapist Violet Oaklander has a knack for getting her clients to speak honestly and reveal their difficult feelings. In this video link, you can watch Dr. Oaklander in an interview about her approach. The full 3-part video shows an actual counselling session with a 13-year old boy who has difficulties. There are other video links via this Youtube link which we think will be of interest.

An interesting one to watch?

**Neil Morrissey – Care Home Kid**

The actor Neil Morrissey (of ‘Men Behaving Badly’ fame) was removed from his birth parents to a Children’s home in Stoke on Trent at the age of ten and comments “for many years I thought that I had been taken into care because of my behaviour. It was only recently that I saw my file and spoke to the social worker involved with my case and found that the truth was probably quite different”. Follow his story in this two part documentary which screens on 7th & 14th April on BBC2 at 9pm.
Filial Therapy: What Every Play Therapist Should Know

Part Two of a Series
Risë VanFleet, Ph.D., RPT-S

In Part 1 of this series, I explained my desire to supply accurate information about Filial Therapy (FT) for play therapists, as this effective and empirically supported method has garnered growing interest throughout the world.

I am frequently asked about various interventions or forms of therapy that bear a resemblance to Filial Therapy most often in the form of parent involvement and the use of play (such as Parent-Child Interaction Therapy, Theraplay, or others), if the two approaches are pretty much the same. My reply usually is no, although they do have these two characteristics in common.

At other times, I have heard statements about Filial Therapy that simply are not true. I consider these "growing pains" for a form of therapy that was created far ahead of its time in the 1960s. Also in Part 1, I described the contributions of various psychological and developmental theories that are woven into the fabric of FT. I have yet to learn of a form of therapy that more artfully integrates the relative strengths of so many theoretical orientations.

In this article, I want to explore the essential features of FT that make it unique. It is the combination of these qualities, drawn from the contributing theories, that defines FT as a distinct form of family therapy and play therapy. These features can certainly be found individually or in smaller combinations in other interventions, but it is the presence of all of them that defines FT as the Guernneys originally developed it. Other formats of FT sometimes omit one or two of these features but are still considered part of the family of FT because they include most of them and have altered their stated objectives or scope accordingly. In the third article of this series, I will review the various adaptations of FT, the types of problems and clients for which FT has been applied, and the growing body of research supporting it.

Essential Features of Filial Therapy

The Client is the Relationship, Not the Individual

Current systems of care often emphasise the identification of a single client, and that frequently is the child. Often, parents come to therapy, or are referred for help, because of the behaviour of a child. More often, the real root of the problem is something within the family dynamic—marital tension, illness or death in the family, poor parenting practices, or maltreatment. Rarely do problems arise solely from the child. Even problems that are centred within the child, such as ADHD with its biological underpinnings, influence the entire family and psychosocial problems once again reflect the functioning of the family system.

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For example, when six year old Sally was diagnosed with diabetes, her parents did everything possible to ensure good medical care. Sally resisted the insulin injections and the finger pricks for blood glucose testing that were necessary several times each day for good diabetic control. Sally also began sneaking low-lying candies and sweets into her room for later consumption. Her parents, worried, began constant supervision leading to major rebellion. They brought Sally to treatment because of her temper tantrums. Was Sally the source of the problem? Probably not—diabetes is a complicated and serious disease that causes changes for all family members and Sally's parents had shifted their parenting approach to ensure her health. All of them needed help finding equilibrium again.

In FT, therapists do not view the child as their...
Filial Therapy: What Every Play Therapist Should Know

primary client. Neither do they focus on the parent as the client. It is the relationship between parent and child that becomes the client. Therapy is applied to strengthen that relationship and to resolve weaknesses that threaten that relationship. From a pragmatic point of view, therapists sometimes must identify a single client for payment or reporting purposes, so a parent or child might be listed as "the client," but foremost in therapists' minds and guiding all decisions must be a focus on relationships.

Empathy Is Essential for Growth and Change

In FT, empathy plays a prominent role on several levels. Therapists who wish to practice FT must be highly skilled in providing empathy to adults and children alike. They provide genuineness and acceptance as shown through their empathic listening abilities. Filial therapists provide empathy at the parent level by truly trying to see things through parents' eyes without judgment. They empathically listen to the deepest levels of parent feelings and concerns, and they convey acceptance of these at the deepest levels possible. This does not mean that they accept or approve of parents' prior bad acts, but they accept the parents' underlying emotions, motivations, and hopes. A therapist would never condone a parent's use of spanking or hurting a child, but their focus is on the parent's frustration or rage that fuelled that behaviour. Deep understanding of parent feelings typically results in more engagement in the therapeutic process, enhancing the potential for positive parent change. Empathic listening with parents is not a simple restatement of their thoughts and feelings; rather, it is a commitment to understanding parent feelings at the deepest level possible. An example would be if a parent asserted, "Sometimes I just can't stand that kid. He's hateful!" A response such as "You're upset with him" would be considered empathic, but it fails to reflect the intensity of the parent's feelings. A deeper empathic response would be, "You're furious with him and feel at the end of your rope!" In FT, therapists use empathy and acceptance with parents throughout the process.

At the child level, filial therapists must first become proficient in non-directive play therapy (NDPT). They typically provide demonstrations of NDPT with the family's children while parents observe. Filial therapists also must be able to reflect children's feelings at the deepest level. They recognise that surface behaviours, such as aggression or oppositional behaviours, comprise more fundamental feelings and motivations beneath the surface, such as fear and anxiety respectively and they know how to respond empathically to all levels to convey true acceptance. Therapists also know what to expect in NDPT and how to recognise and interpret play themes within developmental and psychosocial contexts. In essence, they must practice what they preach.

Finally, the parent-child play sessions throughout the FT process remain non-directive in nature. Parents do not switch to more directive behaviours such as positive reinforcement at any point during the play sessions, as this represents a fundamental shift away from the empathy and acceptance considered critical for relationship-building and parent-child change. While therapists can help parents use skills such as positive reinforcement and parent messages in daily life, this is never brought into the play sessions.

The use of empathic listening in FT belies an essential belief that people—children and adults—will move in the direction of psycho-social health when an atmosphere of safety and acceptance is created for them. In many ways, empathy is the cornerstone of the FT model because it defines so much of the therapist-family and the parent-child relationships.

The Entire Family Is Involved Whenever Possible

FT was conceived as family therapy, although family psychology was first being articulated at approximately the same time. This means that all of the relationships within the family are of importance to filial therapists. Therapists encourage both parents to participate in the process and to observe each other's play sessions and feedback. They learn vicariously from this. It is common to hear one parent use some of the same phrases and reflections they heard the other parent use in a previous play session. Efforts are made to bring reluctant parents into FT, assuring them of the importance of their input and the value to their children. Because both parents or carers are learning the same balanced approach of empathy and limit setting, FT often brings parents with radically different parenting styles to a centre place. The disciplinarian learns also how to be understanding. The nurturing parent becomes firmer with limits. It is precisely because of this process that parents, from the earliest days of FT, have reported that their marriages seem to improve because they are more in tune with each other vis-à-vis parenting matters.

Therapists using FT also try to include all of the children in the process. For adolescents, this means the inclusion of "special times" instead of play
sessions as a means of providing undivided parental attention, understanding, structure, and enjoyment on a regular basis. For children between the ages of 2 and 12 (approximately), FT works best when they are all included in weekly or biweekly one-to-one play sessions with their parents. As noted earlier, the problems that bring families to therapy affect everyone in the family. ADHD challenges with one child can easily draw parental attention away from siblings who do not show problems. Divorce may result in one child acting out, while the quieter child is viewed as being "fine", when in actuality that child is quite depressed or anxious. True to its family systems roots, FT advocates that all children be included somehow. Ideally, this would be from the start of therapy, but because of limitations current models of service delivery sometimes require therapists to become creative in the inclusion of all the children.

It is quite common in FT for parents to be more challenged during the play sessions by the child they originally said did not need any assistance. In my experience, involving all the children pays dividends that strengthen the family as a whole. Parents seem to learn the skills much more quickly and solidly when they hold them with each of their children. Perhaps holding play sessions with different child personalities and issues strengthens parents' use of the skills, just as experience with more than one child enhances a therapist's competence and effectiveness. I have noticed that parents who have difficulty with one child during play sessions (for example, having to set lots of limits) take heart from their play sessions with their other children where it is more obvious to them (parents) that they are learning and doing well.

A Psycho-educational Training Model Is Used with Parents

FT uses a training model for parents that has been shown to lead to successful acquisition of the necessary skills. The model entails four elements: (1) explanation, (2) demonstration, (3) skills practice and (4) individualised feedback. Therapists explain the rationale and methods of each skill taught to parents. They demonstrate those skills at work through live demonstrations of non-directive play sessions with the family's children and/or use of videotaped demonstrations. By far, the live demonstrations seem to engage parents most quickly. Discussions afterwards help parents process their observations, questions, and doubts about the process and its relevance to their family.

Therapists train parents through the use of skills practice, including tried-and-true behavioural and learning methods. Initially this takes the form of mock play sessions in which the therapist role-plays a child while the parent uses the play session skills. The therapist can match the level of difficulty of the child they role-play to the parent's current ability, gradually increasing the challenge until the parent is fully trained. Therapists' use of in-the-moment encouragement applies the behavioural shaping principle to give parents immediate feedback on their efforts, reducing anxiety and assisting the learning process. This ingenious training method helps parents learn to use the skills rather quickly.

After each mock play session, the therapist provides more detailed feedback, the majority of which focuses on what the parent did well, adding just one or two things for the parent to try to improve the next time. This individualised feedback, done in such a supportive manner, helps parents learn rapidly and thoroughly by creating a supportive and collaborative climate. Parents are given ample opportunity to discuss their own feelings in order to clear out misconceptions, to eliminate obstacles to progress, and to give them "ownership" of their own learning. This same process is applied after parents start their play sessions with their own children, as noted in the next section.

Therapists Provide Live Supervision of Parents' Early Filial Play Sessions

A key feature of FT is to create the circumstances through which parents are successful. One of the problems of traditional parenting skills programmes is that parents briefly learn about a new skill, such as listening, and are then expected to use it at home. It is not uncommon for parents to return to the next session saying, "I tried it and it didn't work." It is tempting to think this response is due to lack of parent motivation, but I would suggest otherwise. It is more likely to be the result of a parent trying to implement a skill they have not mastered in a very complex environment--daily life. FT bypasses this difficulty by asking parents to refrain from using the skills in daily life until they have mastered them during the play sessions. Filial therapists then observe parents' first four to six play sessions directly, often by sitting unobtrusively in the corner of the playroom. This gives the therapist the three-dimensional vantage point to see the full sessions and the nuances that always attend. It also offers parents tacit support as they begin to apply their new learning with their children.

After the half-hour play session, the children are excused to a safe childcare location, and the therapist goes through the feedback process used
during the training phase. Parents are first invited to reflect on their own use of the skills: "What was easy for you?" "What was difficult?" Therapist empathy is followed by skills feedback, again providing mostly positive reinforcement about specific behaviours and offering just one or two suggestions for improvement: "Connie, when you kept describing what your daughter was feeding all of her dolls—the lettuce and the tomatoes and the carrots—you were doing such a nice job reflecting the content of her play! Next time, if you can bring out her feelings a bit more, that would be great, such as 'You think it's funny that they have to eat all those veggies.' ".

After four to six sessions of live supervision, parents have typically developed their competence and confidence to a point where they can begin their home sessions. The therapist provides indirect supervision of these, based upon parent reports and/or home videos.

*The Process Is Truly Collaborative*

In every way possible, filial therapists involve parents as partners in the therapeutic process. It is a misconception, however, that FT teaches parents to become therapists. The filial therapist remains responsible for the therapy throughout the process, while parents simply learn a set of play session skills that, when eventually generalised from the play sessions to daily living, have been shown to improve parenting practices significantly. (I will report on some exciting new research relevant to this in the final article in this series). It is the therapist's responsibility to monitor and manage the therapeutic process in its many complexities. With that said, filial therapists welcome and encourage parent input at every step of the way. What parents think, feel, and say matters—a lot. Whether they are reflecting on their own play sessions or trying to determine the possible meanings of their children's play, parents' views are elicited and discussed first, with the therapist adding his or her own ideas afterwards. Therapists consider and use parents' perceptions, realising that parents know the child's context much better than they and that parent contributions to understanding the child may have more weight because of this. The relationship between a therapist and a parent during FT is one that looks decidedly collegial: sharing of ideas, listening, collaboratively deciding on options, mutual respect and laughter. Metaphorically, it is the difference between sitting side by side (or around an open circle, for groups) discussing an issue of mutual concern or sitting across a desk or table doing the same. The climate of FT is definitively an open, side by side type of approach.

**Essential Features and Adaptations of FT**

FT is most truly FT when the essential features outlined here are in place. There are times, however, when families' needs, the organisation of the care system, or funding issues are such that the approach must be adapted, with some aspects altered. The key is to know what FT is really all about so that one is in a better position to determine whether a particular method retains sufficient features to be considered FT. In the third article of this series, I will discuss some of the most useful adaptations of FT in light of these essential features, including a review of accumulated and new research that has appeared in refereed journals or critically reviewed books and reports.
Filial Therapy: What Every Play Therapist Should Know
Part Three of a Series
Risë VanFleet, Ph.D., RPT-S

In Part 1 of this series, I discussed Filial Therapy (FT) as a form of family therapy and reviewed the comprehensive integration of a variety of psychological theories into this powerful, empirically-based approach to helping children and families. My aim was to clarify misunderstandings and misstatements about FT that have become more frequent as its popularity as an intervention has risen in the U.S., the U.K., and throughout the world. In Part 2, I discussed the essential features of FT, as originally conceptualized by its founders, Drs. Bernard and Louise Guerney, and practised by many for over 50 years. In Part 3, I close the series by discussing various formats for delivering FT to children and families, adaptations of the method that can be useful, a summary of the research findings, and a brief description of the applicability of FT to a wide range of problems.

As noted in Part 2, the original, full family therapy form of FT is flexible, and as such, has been used with many different presenting problems and in a variety of settings and circumstances. To be assured of the most effective and long-lasting family systems results, it is important to maintain as many of the essential features of FT as possible, and preferably all of them. Nevertheless, today’s economic climate coupled with changing philosophies of mental health service delivery result in situations where some of the essential features sometimes must be omitted if FT is to be offered at all. While working in community mental health in the U.S. (similar to CAMHS) and in private practice, I usually have been able to conduct FT according to the original Guerney model including all of the essentials, but there are times when creativity was needed or funding or time constraints meant that something “had to give.” The key when altering such a powerful family intervention as FT is to be thoughtful when doing so—to think through exactly what is gained and what is lost when one or more of the essential features cannot be included. It is hoped that Part 2 of this series provides information useful to that treatment planning process.

Several different formats of FT have arisen through the years and have demonstrated their value in meeting specific child and family goals. In the section below, I start with a description of the original model and follow that with several adaptations that have been developed, along with references and resources for them.

Original Guerney Filial Therapy Model

This section outlines FT methods that are closely aligned with the original Guerney approach, with few changes and the essential features/principles of FT intact.

Guerney Group Filial Therapy. The Guernseys began researching FT in its earliest days, and they used that research to improve the method. By the time I learned it in the early 1980s, it had been transformed into the robust, flexible model it remains today. The Guerney FT model has been used both for prevention as well as intervention with very serious problems, and it can be delivered in groups as well as with individual families. Groups have the advantage of social support, vicarious learning as parents watch each other’s sessions, and efficiency in terms of service delivery. The Guerney model also provides considerable time for parents to have individualised skill practice with therapist feedback, live supervision of four to six play sessions as parents master the process, and sufficient time to process the play themes and myriad family dynamics issues that the play sessions inevitably reveal. The primary disadvantage is the longer time period typically required for groups employing the original FT model. Today, Guerney FT groups typically run for two hours each, serve six to eight families at a time (depending on the total number of children involved),

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and span 18-24 sessions. Most of the research on the long-term gains of FT have been conducted on this model. Louise Guerney and Virginia Ryan will soon be publishing a manual, Group Filial Therapy, outlining this method which includes all of the essential features of FT in a 20 week programme (Guerney & Ryan, expected 2012). Groups conducted with this model are typically very effective in producing long-term change for children, parents, and families, and would be my preferred mode of FT when possible. The forthcoming Guerney & Ryan book will be an important addition to every FT therapist’s library.

Filial Therapy with Individual Families. My own books, manuals, DVDs, and training s are focused primarily on the implementation of FT with one family at a time (e.g., Van Fleet, 2005, 2006, 2011). This approach retains all of the essential features of FT, remains nearly identical to the original Guerney model as I learned it from both Bernie and Louise, and can be easily adapted to many different problems and situations, including independent practice, agency work, home-based intervention, schools, hospitals, and other settings. The approach includes 15-20 one-hour sessions with families experiencing mild to severe problems, with the ability to include all children within the family and to expand or contract the number of sessions depending on the family’s needs. It is designed specifically as a form of family therapy.

Ginsberg (1997) has also written about an individual family model of FT and how that works in conjunction with the Guernesys’ Relationship Enhancement® family of interventions. Van Fleet, Sywulak, & Sniscak (2010) devote several segments of their book to FT and other work with parents, and the Casebook of Filial Therapy (Van Fleet & Guerney, 2003) includes half of its chapters based on the original Guerney model and how FT is applied with trauma, attachment problems, medical illness, oppositional defiant disorder, adolescent parents, and many others.

The VanFleet-Sniscak FT Group Format for Foster and Adoptive Families (Van Fleet & Sniscak, expected 2012) uses an 18-week group FT model with parents of children with serious trauma and attachment problems. This programme for foster carers and adoptive parents is also applicable to other highly challenging child/family problems. It closely resembles the Guerney Group FT, with additional components that specifically address the trauma and attachment issues within the family system. It includes a foster-to-adopt transition model that involves the collaborative use of FT with foster carers during placement and with adoptive parents early in the adoption process. It retains all of the essential features of FT.

Other Filial Therapy Formats and Adaptations

It is expected that, as the number of fully trained FT practitioners grows, additional adaptations of the method will arise. At present, there are several formats that have been developed and studied. For these, one or more of the essential features of FT have been omitted, but the goals of these programmes vary to some extent from the full family therapy goals of the original Guerney model. Due to space limitations, only parent-child formats are described here, but it should be noted that there are several excellent FT adaptations made for teachers, paraprofessionals, and others (please contact me for more details).

Child-Parent Relationship Therapy (CPRT). Landreth and Bratton (2006) have established a strong foundation for their 10-week group programme based on FT. This format provides a viable alternative with a parent education programme flavour. In order to reduce the number of sessions, they have created an alternate route for training parents, reduced the amount of supervision of parents’ filial play sessions, and limited the play sessions to one parent and one child rather than all of the children, but their manualised approach has spawned considerable positive research and offers strong advantages over other parent education models. Their emphasis on the skills and importance of empathy and acceptance through the use of play is invaluable in the development of effective child-rearing skills for parents. Considerable research on this method with many different presenting issues has shown significant parent gains. The Casebook of Filial Therapy (Van Fleet & Guerney, 2003) contains numerous chapters highlighting the CPRT approach as well. Practitioners of the CPRT method continue to add steadily to the growing literature on FT effectiveness.

Wright-Walker Group FT for Head Start Families. Described in detail in the Casebook of Filial Therapy, this format uses two co-leaders for FT groups of approximately 10 parents. Because the families involved in their programme often have many needs, Catherine Wright and Jason Walker have provided transportation, meals, and toy-making opportunities to assist parents and encourage attendance. At the request of parents, the programme was expanded to a 13-week format, with the last session spaced a bit further from the others to assist with generalisation. One empowering adjustment they made was to enlist...
the assistance of one or two parents from prior FT groups to demonstrate the play sessions for the new group. In the Wright-Walker format, the two group leaders meet with the entire group for information-giving and discussion, and then break into two smaller groups, each with a single leader, for actual skill practice and parent-child play sessions directly observed by the leader. Individual feedback is provided to each parent within the smaller groups. At the final session, the group watches a pre- and post-video of each parent’s play sessions, and parent improvements are celebrated. In addition to the Casebook chapter, more information is available directly from Catherine Walker (contact me at Risevanfleetaol.com for ways of reaching her).

Pernet-Caplin FT Format for Disadvantaged Families. Karen Pernet and Wendy Caplin (Pernet & Caplin, in progress) developed their 12- week FT format for disadvantaged families at the Children’s Crisis Treatment Centre in Philadelphia. Sue McCann has also used their format as a major component for working with New Orleans families deeply affected by Hurricane Katrina. Developed independently, it has some similarities with the Wright-Walker format. Two leaders meet with the entire group for the didactic parts of FT, and then provide direct supervision to parents in smaller groups. To reduce the number of sessions overall while providing live observation and feedback to parents during their play sessions, Pernet & Caplin have decreased the supervised sessions from the usual thirty minutes to ten minutes each. Only when parents begin their home sessions do they increase them to thirty minutes. This keeps the play sessions manageable for families with multiple needs while providing direct parent skill development and support, and more informed discussion of the children’s developing play themes. A leader’s manual for the Pernet-Caplin format is nearing completion and is expected to be available in 2012 as well.

While other valuable formats of FT exist, and others are certain to be created, it is important that play therapists know how to evaluate them in terms of their allegiance to the Guerney FT model, as that continues to be the gold standard in FT. Consideration of the theories, principles, and essential features of FT outlined in this series is likely to provide a clearer picture of what is truly FT and what is not. The greater the number of theories and essential features that are included, the more congruent the approach is with the original family therapy conceptualisation and practice of FT.

Research Highlights

From its inception in the late 1950s, FT has been researched. Controlled studies reported in refereed journals of the original Guerney model as well as the CPRT format have clearly demonstrated its efficacy, and a number of (U.S.) government-sponsored wait-list-control programme evaluations, subjects-as-own-controls studies, and case studies have illustrated its empowering impact and have established FT (as described herein) as an empirically-supported therapy. Key summaries of the FT research can be found in VanFleet, Ryan, and Smith (2005), and Bratton, Ray, Rhine, and Jones (2005). [Please contact me at Risevanfleetaol.com for reprints, if needed.]. In general, the involvement of parents in play therapy, especially in FT, has been found to increase the effectiveness of therapy significantly. Children have consistently shown decreases in presenting problems as well as improved relationships with their parents. Parents have shown significant improvements in acceptance, parenting skills, and satisfaction, as well as decreases in parenting stress. Three- and five-year follow up studies of the Guerney FT model have shown that gains are maintained. An exciting preliminary study of 27 families (Topham, Wampler, Titus, & Rolling, 2011) has found that initial higher levels of parent distress and poorer child emotional regulation were predictive of greater reductions in behaviour problems after FT, and poorer initial parent emotional regulation was predictive of greater parental acceptance after FT. These results suggest that FT can be effective in changing the family relationships and dynamics in some of the most distressed families.

Applications of FT

FT has long been used with a wide range of presenting problems in children and families in the U.S., the U.K., and beyond. Because it is a systemic, process-oriented, and psycho educational approach, it can be applied successfully to most child and family problems. FT has been used with children, their siblings, and parents facing chronic medical illness to help deal with issues of illness or treatment anxiety, skewed family attention patterns and dynamics, medical compliance issues, and to build a cohesive family system despite the many stresses of illness. FT is valuable in situations of trauma, grief, and loss. For example, FT was used with families experiencing traumatic grief after 9/11. Parents learned to be accepting of their children’s play themes relating to their loss (through therapist empathy and skilful practice of how to respond), and the children frequently played out their perceptions, anger, and
sadness. Parents reported feeling empowered. They were able to do something to help their children through this devastating experience, and parents said that FT not only built their confidence in dealing with the family’s traumatic loss, but helped them work through their own grief at the same time with the supportive containment of the FT therapist. FT has been used with a variety of behavioural problems that often have their roots in emotional or familial distress, such as divorce reactions, oppositional defiant disorder, domestic violence situations, or the residuals from maltreatment or attachment disruption. This approach is useful in conjunction with other interventions for attention deficits, especially when parent-child relationships are strained by the behavioural issues that arise. Anxious and perfectionistic children benefit from the freedom of the nondirective play sessions, and their parents (who often have some anxiety of their own) find similar release in the playful interactions that are common. Adoptive children often enact themes relating to birth, development, and family life with their new parents, something difficult to achieve to the same degree of intimacy in play sessions with a therapist. Parents in recovery with addiction problems can begin to rebuild the bridges with their children through FT. Military families have used FT to renegotiate their roles and relationships when the absent member returns.

FT also has tremendous multicultural applicability. Children all over the world play, and they play within their culture as well as the more specific family culture or events. FT, by virtue of its nondirective play sessions, permits this expression in a culturally relevant way. By involving the parents as true partners in the sessions, therapists gain invaluable information about the context of family life and cultural backdrop that helps everyone understand possible meanings of the child’s play. Parents the world over want to build strong families, even though the precise organisation or practises of those families might differ. FT has been shown to strengthen families in fundamental ways. Perhaps because FT shows such respect for each person’s and each family’s uniqueness and engages parents so collaboratively in the entire process, international interest has been growing rapidly.

It is my hope that this series of articles has provided more detailed information about the true nature of FT and its power in transforming children and families. I welcome any questions or comments through my primary website, www.play-therapy.com, or email, Risevanfleet@aol.com.

References


