Child Abuse Review Vol. **29**: 159–166 (2020)
Published online in Wiley Online Library
(wileyonlinelibrary.com) DOI: 10.1002/car.2602

Filial Therapy as a Core Intervention with Children in Foster Care

Continuing Professional Development

Daire Gilmartin*
Five Rivers Fostering, Dublin, Ireland
School of Nursing and Human Sciences, Dublin City University, Dublin, Ireland

Rosaleen McElvaney
School of Nursing and Human Sciences, Dublin City University, Dublin, Ireland

Introduction

This article provides a summary of the central elements of Filial Therapy (FT), its empirical base and key ingredients that contribute to its suitability as an intervention of choice in the area of foster care. The target audience is professionals and carers working therapeutically with children in foster care.

Context

Children in foster care frequently enter care due to significant psycho-social difficulties including maltreatment, and as a result have a higher degree of mental health difficulties than the general population (Scozzaro and Janikowski, 2015). Children who have experienced maltreatment frequently experience difficulties in trusting adults and display emotional and behavioural difficulties that are challenging for foster families (Jee *et al.,* 2014; Tarren-Sweeney and Vetere, 2014). In the face of these oftentimes extreme and complex behaviours, foster carers are expected to be emotionally available, open-minded, child-centred and authoritative in their parenting approach (Ahmed *et al.,* 2015). Foster carers can and should play a significant role in positively influencing and helping the children in their care, however, this is not an easy task and foster carers require tailored therapeutic support that can support them in this process (Wilson, 2006). FT can assist foster carers in helping the child in care as well as their whole family while supporting the development of strong and lasting relationships.

With the emergence of other therapeutic approaches, for example, theraplay, parent–child interaction therapy and others, that resemble FT due to their use of play and the involvement of parents, some misunderstandings have arisen regarding what exactly FT is and how it should be used (VanFleet, 2011a). According to VanFleet (2011b), this has led to misapplication: FT being used by people with insufficient training or who only partly understand it, while others have claimed it as their own, diluted its power and altered its essential nature. This article seeks to emphasise the importance of the original individual FT framework as a core intervention to help with many child and family issues that present in foster families. It will briefly introduce the reader to the

'FT [Filial Therapy] can assist foster carers in helping the child in care as well as their whole family'

*Correspondence to: Daire Gilmartin, Dublin City University, School of Nursing and Human Sciences, Glasnevin, Dublin 9, Ireland. E-mail daire.gilmartin3@mail.dcu.ie

Accepted: 20 June 2019

background and process of FT while highlighting its empirical base. An individual discussion of six key learning points that make FT unique and how they contribute to making it a core intervention in foster care will then be discussed.

FT: Background and Process

FT was developed over 50 years ago by Bernard and Louise Guerney as a therapeutic intervention to help with a variety of child emotional and behavioural difficulties, parenting issues and parent–child relationship difficulties. Initially introduced as a group intervention, FT was later developed as an individual family therapy model (VanFleet, 2014) and more recently was adapted for shorter-term groups (Landreth and Bratton, 2005). It can be used as a core intervention or in combination with other therapeutic interventions.

'FT is a time-limited intervention that typically requires 17–20 one-hour sessions for moderately difficult problems'

FT is a time-limited intervention that typically requires 17–20 one-hour sessions for moderately difficult problems (VanFleet, 2014). Carers are trained in four core skills that are necessary to conduct non-directive play sessions. Structuring teaches carers how to begin and end sessions in order to help children with these transitions. Empathic listening helps carers to put their own feelings and thoughts to one side in order to fully attune to the child's feelings, behaviours and intentions, and to learn how to verbally communicate this empathy to the child. Child-centred imaginary play involves learning how to engage in imaginary play by always following the child's lead within safe limits. Finally, limit-setting helps carers learn to set firm limits while being non-punitive, thus offering children two opportunities to self-correct before applying the consequence of finishing the play session early (Topham and VanFleet, 2011).

Carers are then supervised in holding special non-directive play sessions with children who are generally aged three to 12 years. They receive tailored feedback from the therapist after every supervised play session held with each child. The feedback sessions contribute to skill development, a growing awareness of the child's thoughts and feelings while assisting carers in understanding what might hamper them in being fully available and attentive to the child. After a number of observed play sessions, the carer-child play sessions are moved to the home environment where sessions are no longer directly observed. Carers continue to meet with the therapist to discuss the home play sessions together with other family issues that arise, while also focusing on generalising the skills that they have learned to use in everyday family situations (see VanFleet, 2014, for full background and procedural details, and the website for information regarding FT training: www.play-therapy.com).

FT: Empirical Base

FT has accumulated a solid research base over the years that has consistently established it as an effective therapeutic intervention in addressing a range of child and family problems that present in a variety of cultural and ethnic contexts. These include: child and family trauma, bereavement, domestic

DOI: 10.1002/car

violence, conduct problems, attention deficit, pervasive developmental disorders, children with learning difficulties, chronically ill children and children of incarcerated parents (Cornett and Bratton, 2015; VanFleet and Topham, 2016). A comprehensive meta-analysis conducted by Bratton *et al*. (2005) of 93-controlled outcome studies of play therapy, 22 of which focused exclusively on FT, demonstrated a significantly greater effect size for FT over professional-directed play therapy interventions. Other studies have consistently demonstrated that FT is effective in: a variety of formats; maintaining benefits over time; decreasing parent stress and increasing parental acceptance; improving parent–child relationships; and in a wide variety of cultures and family constellations including foster care (Cornett and Bratton, 2015; VanFleet *et al.,* 2005).

Key Learning Points for Practice

The following core aspects of FT, when used together, make it a unique and powerful way of working with foster care families. It is the presence and combination of all of these features that differentiate the model from other parent–child interventions that use play, and some variations that were derived from the original FT model (VanFleet and Topham, 2016).

The Client is the Carer–Child Relationship

Children in foster care often present to therapeutic services with complex emotional and behavioural difficulties. As a result, they frequently receive diagnoses from treating professionals who do not adequately recognise their presenting issues as adaptive responses to significant adversity (Tarren-Sweeney and Vetere, 2014). Labels or diagnoses, although sometimes helpful, can lead to increased feelings of stigmatisation for children who already feel labelled due to being in care and suffering from mental health difficulties (Tatlow-Golden and McElvaney, 2015). As a result and due to their understandable distrust of adults, children in care frequently avoid therapeutic help that demands them building a relationship with another stranger (Jee *et al.,* 2014; Plaistow *et al.,* 2014). FT's focus on the carer–child relationship as the client takes the emphasis off the child in care as the problem and concentrates attention on building carer–child relationships.

Non-Directive Carer–Child Play is Key

‘FT recognises play as central to children's healthy development’

FT recognises play as central to children's healthy development and a truly helpful avenue in gaining a greater insight and understanding of children (VanFleet, 2014). FT's use of non-directive play sessions creates carer–child interactions that are similar to early healthy parent–child interactions that normally occur in infancy and promote the development of secure attachment (VanFleet and Sniscak, 2003). These interactions include: carers responding promptly, appropriately and predictably by verbal and non-verbal means; the encouragement of exploratory play; face-to-face communications; and reciprocal relations (Ryan and Wilson, 1995). The non-directive nature of its approach makes it particularly suitable for maltreated children who find it difficult to trust adults (Jee *et al.,* 2014). Non-directive play creates an

atmosphere of increased safety for maltreated children as they freely choose the direction of the sessions and the extent to which they involve their carers in the play. Facilitating a permissive and playful atmosphere encourages children to express difficult emotions and experiences through the safe medium of play (Ryan, 2007).

Entire Family Involvement Where Possible

All relationships within the foster family are of importance to the filial therapist who tries to involve every member of the family in the process (Topham and VanFleet, 2011). This is of great importance in foster families as research consistently shows that placements are at an increased risk of breakdown where the carers' biological children are living in the family home. This results from a number of factors, including: the loss of parental attention as a result of the child in foster care being in the family; difficulties in relationships with the child in care; the pressure to be responsible and a role model; and the resulting tensions within the household (Thompson and McPherson, 2011). FT can help ameliorate these difficulties by encouraging all children to take part in FT sessions with their parents, including adolescents who have 'special times' that are adapted to their developmental stage.

Where there are two foster carers in a family, they are both encouraged to take part in the FT process. Learning the same skills increases consistent parenting practices while improving couple relationships and overall family functioning (Wickstrom and Falke, 2013). Please see Box 1 for a composite case example of FT.

Central Focus on Empathy as Agent of Positive Change

'FT provides children with experiences of felt empathy'

FT provides children with experiences of felt empathy where carers who have experienced this in relationship with the filial therapist in turn practise these skills with the children in their care. Through this process, children can learn self-acceptance. They also learn the skills of empathy, essential to overall wellbeing, quality relationships, trust, collaboration, love and charity (Perry and Szalavitz, 2010).

After each play session, foster carers have time to fully debrief with the therapist and trouble shoot any difficulties arising, while learning about emerging play themes and how they relate to the child's internal world. This can be an evocative and intensely emotional experience for carers where personal issues are triggered and confronted with the help of the therapist. Collaborating with foster carers in a deeply empathic way allows natural human defensiveness to fall away, helping them expose and acknowledge their own vulnerability. This creates space to accept, understand and tolerate the underlying fragility and profound hurt of the children they care for.

Collaborative Partnership

Foster carers frequently report being sidelined by professionals and have a sense of being undermined in their roles (York and Jones, 2017). The filial therapist recognises the central role of carers and endeavours at all times to truly see things through the foster carers' eyes, while aiming to accept carers' underlying emotions and motivations (VanFleet, 2011b). Foster carers are seen

as the primary change agent. This minimises fears and rivalry that can emerge for carers when children develop attachments with therapists (Sweeney, 2003).

Box 1. A case example.

Brian, aged nine, had a history of physical abuse by his mother's partners and neglect by his mother which resulted in his placement in foster care at the age of seven. Brian was in his third foster placement in two years with new foster carers John and Cathy and their 12-year-old son Jack. Emotional and behavioural difficulties were emerging for both children.

Following the training phase, both children were involved in the supervised play sessions where on alternate weeks John and Cathy played with either Brian or Jack. Brian appeared delighted to play with his carers. His play sessions with John were full of battles and aggressive play, while he was quieter with Cathy but tested out the limits more. The therapist worked with John on his difficulties with maintaining empathic listening in the face of aggressive play and with Cathy on setting firm limits. The importance of how much Brian was enjoying the sessions and how he did not push the limits to the consequence stage at any point was emphasised.

Brian's play over time included themes of imaginary villain play where he fought with bad guys, overcoming them sometimes and other times being beaten down but getting back up. His carers were able to reflect: 'Wow, you're not letting them away with that, you're gonna make sure they can't hurt anyone again.'

Jack's play reflected his struggles with fostering as themes of competition were rife, with baby dolls being the subject of some quite aggressive play. These sessions were difficult for John and Cathy but with the therapist's help they became better able to empathically reflect Jack's difficult feelings and gain new insights about him.

Over time, John and Cathy recognised that underlying Brian's play themes were feelings of threat, fear, safety and protection. Jack's play reflected his natural feelings of resentment and jealousy towards Brian, as well as protectiveness towards his parents in the face of Brian's difficult behaviours. The carers gained a deep understanding of the children's worlds, noting how Brian's trust in them had grown and his behaviour had gradually improved, while Jack seemed happier and more settled. They were spending more individual time with Jack and recognised that they were much more consistent in how they approached managing both boys' behaviour. They also reported positive changes in their own relationship where they had adopted more empathic attitudes toward each other leading to a lot less stress.

Psycho-Educational Approach and Live Supervision

Many traditional parenting programmes and training for foster carers teach skills to parents that they are then expected to go home and use in daily life. Transferring generic parenting skills to everyday life in a complex home

'Carers are specifically asked not to use FT skills in daily life until they have had ample time to practise'

environment can prove to be difficult. Fostering is a challenging task and each individual child requires tailored parenting approaches (Van Andel *et al.,* 2014). In FT, carers are specifically asked not to use FT skills in daily life until they have had ample time to practise and achieve success in using these skills in the special play times. Filial therapists supportively observe carers conducting play sessions with their children in the initial stages and provide individualised feedback which maximises carer progress.

Test your Knowledge

1 Why is FT helpful for foster carers and the children in their care?

a It can help diagnose particular difficulties present within the child.
b It helps develop the carer–child relationship with a view to alleviating child and family difficulties.
c It helps carers learn about the internal world of the children in their care and attune to their needs in the context of a growing positive relationship.

2 A foster carer asks you how play can help their six-year-old foster child who has emotional and behavioural difficulties. Do you say?

a Play is helpful but it would be better to sit down with the child and talk about what is wrong with them, letting them know that they are not allowed to misbehave.
b Child-led play can help develop the relationship between the carer and child in a safe and non-threatening way.
c Play can help children process difficult experiences and express difficult emotions.

3 How does FT help families who foster?

a FT is a family therapy approach that involves all members of the family where possible. Each child/young person gets their own one-to-one time with their parent/carer.
b It can assist carers in developing their own consistent parenting approach and give time and space to the carers to process and resolve difficulties emerging within the whole family.
c It is a form of marriage counselling that can help carers resolve significant difficulties in their relationship.

4 A foster carer questions you about their use of empathy as they are worried that they are being 'too soft' and that the children will take advantage of this. What do you say?

a Its use creates safety and trust in the therapist–carer and the carer–child relationships which can only be helpful to the child.
b Sometimes children will take advantage when you are not strict enough and maybe you should be more authoritarian in your approach.
c The use of empathy together with the limit-setting skill help children learn that carers can be trusted and are safe and consistent adults who appropriately set limits in order to keep children safe.

DOI: 10.1002/car

5 How does FT help with family problems?

a The therapist will focus the intervention on the child difficulties described by the carers and tailor the therapy to the particular behaviours of the child.
b The carer–child relationship is the central agent of change in FT. Through the development of this relationship and the use of non-directive play, the carer's attunement, understanding and connection to the child are enhanced. At the same time, parenting skills are improved, satisfaction with parenting improves, child difficulties decrease and family problems decrease.
c As the therapy progresses, the parenting skills learned are generalised and practised in everyday parenting situations.

The answers can be found at the end of the article.

Reflection

Reflecting on what you have read here, consider one child in foster care and/or their foster carer(s) who you have met where FT could have been used as a core intervention in helping the child and family. Identify and write down the specific learning point(s) that would support a recommendation for FT for this child and foster carer(s), and how FT could benefit them. What specific action will you take in your work as a result of reading this article?

'What specific action will you take in your work as a result of reading this article?'

References

Ahmed K, Windsor L, Scott S. 2015. In their own words: Abused children's perceptions of care provided by their birth parents and foster carers. *Adoption and Fostering* **39**(1): 21–37. https://doi.org/10.1177/0308575914565068.

Bratton SC, Ray D, Rhine T, Jones L. 2005. The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice* **36**(4): 376–390. https://doi.org/10.1037/0735-7028.36.4.376.

Cornett N, Bratton SC. 2015. A golden intervention: 50 years of research on filial therapy. *International Journal of Play Therapy* **24**(3): 119–133. https://doi.org/10.1037/a0039088.

Jee SH, Conn A-M, Toth S, Szilagyi MA, Chin NP. 2014. Mental health treatment experiences and expectations in foster care: A qualitative investigation. *Journal of Public Child Welfare* **8**(5): 539–559. https://doi.org/10.1080/15548732.2014.931831.

Landreth GL, Bratton SC. 2005. *Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model*. Routledge: New York, NY.

Perry BD, Szalavitz M. 2010. *Born for love: Why empathy is essential--and endangered*. Harper Collins: New York, NY.

Plaistow J, Masson K, Koch D, Wilson J, Stark R, Jones P, Lennox B. 2014. Young people's views of UK mental health services. *Early Intervention in Psychiatry* **8**(1): 12–23. https://doi.org/10.1111/eip.12060.

Ryan V. 2007. Filial therapy: Helping children and new carers to form secure attachment relationships. *The British Journal of Social Work* **37**(4): 643–657. https://doi.org/10.1093/bjsw/bch331.

Ryan V, Wilson K. 1995. Non-directive play therapy as a means of recreating optimal infant socialization patterns. *Infant and Child Development* **4**(1): 29–38.

Scozzaro C, Janikowski T. 2015. Mental health diagnosis, medication, treatment and placement milieu of children in foster care. *Journal of Child and Family Studies* **24**(9): 2560–2567. https://doi.org/10.1007/s10826-014-0058-6.

Sweeney DS. 2003. Filial therapy in foster care. In *Casebook of Filial Therapy*, VanFleet R, Guerney L (eds). Play Therapy Press: Boiling Springs, PA; pp. 235–257.

Tarren-Sweeney M, Vetere A. 2014. *Mental health services for vulnerable children and young people: Supporting children who are, or have been, in foster care*. Routledge: London.
Tatlow-Golden M, McElvaney R. 2015. A bit more understanding: Young adults' views of mental health services in care in Ireland. *Children and Youth Services Review* **51**: 1–9.
Thompson H, McPherson S. 2011. The experience of living with a foster sibling, as described by the birth children of foster carers. *Adoption and Fostering* **35**(2): 49–60.
Topham GL, VanFleet R. 2011. Filial therapy: A structured and straightforward approach to including young children in family therapy. *Australian and New Zealand Journal of Family Therapy* **32**(2): 144–158. https://doi.org/10.1375/anft.32.2.144.
Van Andel HWH, Grietens H, Strijker J, van der Gaag RJ, Knorth EJ. 2014. Searching for effective interventions for foster children under stress: A meta-analysis. *Child & Family Social Work* **19**(2): 149–155. https://doi.org/10.1111/j.1365-2206.2012.00885.x.
VanFleet R. 2011a. Filial therapy: What every play therapist should know, part one of a series. *Play Therapy: Magazine of the British Association of Play Therapists* **65**: 16–19.
VanFleet R. 2011b. Filial therapy: What every play therapist should know, part two of a series. *Play Therapy: Magazine of the British Association of Play Therapy* **66**: 7–10.
VanFleet R. 2014. *Filial therapy: strengthening parent-child relationships through play*, 3rd edn. Professional Resource Press: Sarasota, FL.
VanFleet R, Sniscak CC. 2003. Filial therapy for attachment-disrupted and disordered children. In *Casebook of Filial Therapy*, VanFleet R, Guerney L (eds). Play Therapy Press: Boiling Springs, PA; pp. 279–308.
VanFleet R, Topham GL. 2016. Filial therapy. In *Handbook of play therapy*, O'Connor KJ, Schaefer CE, Braverman LD (eds). John Wiley & Sons, Inc.: Hoboken, NJ; pp. 135–164.
VanFleet R, Ryan SD, Smith SK. 2005. Filial therapy: A critical review. In *Empirically based play interventions for children*, Reddy LA, Files-Hall TM, Schaefer CE (eds). American Psychological Association: Washington, DC; pp. 241–264.
Wickstrom AC, Falke SI. 2013. Parental perceptions of an advanced filial therapy model. *Contemporary Family Therapy: An International Journal* **35**(1): 161–175. https://doi.org/10.1007/s10591-012-9228-0.
Wilson K. 2006. Can foster carers help children resolve their emotional and behavioural difficulties? *Clinical Child Psychology and Psychiatry* **11**(4): 495–511. https://doi.org/10.1177/1359104506067873.
York W, Jones J. 2017. Addressing the mental health needs of looked after children in foster care: The experiences of foster carers. *Journal of Psychiatric and Mental Health Nursing* **24**(2–3): 143–153. https://doi.org/10.1111/jpm.12362.

Answers: Test Your Knowledge

1b and c; 2 b and c; 3 a and b; 4 a and c; 5 b and c