MSU SCHOOL OF SOCIAL WORK MISSION: We are dedicated to educating students for competent, responsive, and ethical social work practice. Our teaching, research, and outreach seek to promote positive change and social justice for diverse communities, organizations, groups, families, and individuals.

MICHIGAN STATE UNIVERSITY
School of Social Work – Semester, Year
Time:
Location:
Section:
Office Hours:

Victoria Fitton, PhD, LMSW, ACSW
Address:
Address:
Email:
Phone:
Fax:

[needs a course number] FILIAL THERAPY: THE PARENT-CHILD RELATIONSHIP (SAMPLE SYLLABUS – 1 CREDIT COURSE)

PREREQUISITES:
To be determined.

COURSE DESCRIPTION:
Filial therapy is an alternative method for treating emotionally disturbed children when the parent is used as an ally in the therapeutic process to help repair the interpersonal relationships within the family. This approach is based on the therapeutic nature of play and the parent's ability to learn to assume the therapeutic role required of them for a short period of time under special conditions. This course consists of didactic and experiential training in Filial Therapy, an effective intervention that emphasizes the parent-child relationship and the inclusion of the parent/s in the treatment process. Included in this course is material on attachment theory since it undergirds the filial model. Autism spectrum disorders are also included because high levels of parental involvement are necessary for intervention.

METHODS OF INSTRUCTION:
Class format includes a combination of lecture, discussion, individual and group experiential exercises, video clips, and role-play. Students will have numerous opportunities to practice play therapy situations and experiment with a variety of play therapy media in each class session. This course is designed for ***maximum student involvement and participation*** to facilitate the integration of practice, theory, and research. Students are expected to attend class and come prepared by completing assigned readings prior to the respective class period.

COURSE OBJECTIVES:
1. Identify the unique ethical considerations with Filial Therapy. (Assignments 1, 2, and 3)

2. Actively engage children and their families with awareness of and sensitivity to culture utilizing Filial Therapy. (Assignments 1, 2, and 3)

3. Identify the theories and research underlying Filial Therapy. (Assignments 2 and 3)

4. Demonstrate understanding of the impact of attachment disruption on the interpersonal relationships within a family and the use of Filial Therapy in moderating these risk factors. (Assignments 1 and 3)

5. Demonstrate knowledge of the skills necessary to train and supervise parents as they conduct special play sessions with their own child using Filial Therapy. (Assignments 2 and 3)

CLASS NORMS:

Attendance and Participation Policy: Class begins promptly at **TIME** and ends at **TIME** with breaks timed to accommodate the class schedule. Lateness and absence significantly and negatively affect final grades. Students are responsible for all information presented in each class session. Attendance will be taken at each class session. And students are responsible for obtaining any class notes, handouts, or any other relevant material for any classes or time missed. Also, be advised that it has always been the **policy of the University** to permit students and faculty/academic staff to observe those holidays set aside by their chosen religious faith.

Late Papers: Assignments are due at the beginning of class on indicated dates. Completion of work on time is a professional obligation in counseling settings. Students are expected to adhere to this requirement for the purposes of this course. A 5-point deduction will be made for every day an assignment is late. Assignments more than two days late will not be accepted without prior agreement from instructor. For extenuating circumstances, call or email the instructor.

Class Atmosphere: Counselors must make every effort to understand, value, and respect the uniqueness, worth, and diversity of other people. Differences in values, opinions, and ideas are encouraged, yet refinement is necessary to ensure a respectful discourse with other students and the instructors. It is also imperative to maintain discretion and **CONFIDENTIALITY**.

Digital Devices: Laptops may be used in class only for educational purposes and in direct relation to the material under consideration. Other uses, including browsing unrelated websites or checking email, results in revocation of this permission for the entire class. Cell phones and other wireless devices must be turned to "vibrate" or "silent" during class.

Experiential Activities: Presentation of case material is encouraged with appropriate attention to disguising identifying information with respect for confidentiality. Self-reflective learning is supported, but individual concerns will not be the focus of the class. Please use judgment by address supervision or personal issues with a field instructor, therapist or instructor after class.

Persons with Disabilities: The instructor is committed to providing a safe and comfortable environment for students with disabilities. Students who feel they will need accommodations should contact the Resource Center for Persons with Disabilities to determine eligibility, if they have not done so already. Please approach the instructor as soon as possible with any need for accommodation. Resource Center for Persons with Disabilities (RCPD): Michigan State University, 120 Bessey Hall, East Lansing, Michigan 48824-1033; (517) 353-9642; (517) 355-1293 (TTY); www.rcpd.msu.edu. **INSERT PERTINENT INFORMATION HERE**.

Academic Honesty: Article 2.3.3 of the Academic Freedom Report states, "The student shares with the faculty the responsibility for maintaining the integrity of scholarship, grades, and professional standards." In addition, the School of Social Work adheres to the policies on academic honesty as specified in General Student Regulations 1.0, *Protection of Scholarship and Grades;* the all-University Policy on *Integrity of Scholarship and Grades*; and Ordinance 17.00, Examinations. (See *Spartan Life: Student Handbook and Resource Guide* and/or the MSU Web site: www.msu.edu). Therefore, unless authorized by your instructor, you are expected to complete all course assignments, including papers and exams, without assistance from any

source. You are expected to develop original work for this course, therefore, you may not submit course work you completed for another course to satisfy the requirements for this course. Students who violate these rules may receive a penalty grade, including but not limited to a failing grade on the assignment or in the course. Contact your instructor if you are unsure about the appropriateness of your course work. (See http://www.msu.edu/unit/ombud/honestylinks.html). **[INSERT PERTINENT INFORMATION HERE.]**

"**Plagiarism** - is using another person's ideas or creative work without giving credit to that person. It includes:

- paraphrasing information from a source without referencing the source
- copying and pasting Internet information, graphics or media into your work without citing the source
- using someone else's homework or buying papers or research you did not do and turning it in as if you had done the work yourself
- not putting quote marks around parts of sources you copy exactly.

All of these are plagiarism when a citation for each source you used is not included in your paper, speech, project, etc." (Columbia College, 2006).

Academic honesty means using your own words to communicate an idea, therefore, changing a few words of another's text and/or rearranging words from another source constitutes plagiarism. If you paraphrase material you must still cite and reference the source. (To paraphrase means to restate a text or passage in other words, often to clarify meaning. Paraphrasing is a restatement of an idea, not rearrangement of specific words.) If you copy material exactly, you must use quotation marks and then cite and reference the source.

REQUIRED TEXTS:

Hughes, D. A. (2006). *Building the bonds of attachment: Awakening love in deeply troubled children* (2nd ed). Lanham, MA: Jason Aronson.

Bratton, S. C., Landreth, G. L., Kellam, T. & Blackard, S. R. (2006). *Child parent relationship therapy (CPRT) treatment manual: A 10-session filial therapy model for training parents*. New York, NY: Routledge.

VanFleet, R. (2005). *Filial therapy: Strengthening parent-child relationships through play* (2nd ed.). Sarasota, FL: Professional Resource Press.

FILIAL THERAPY BIBLIOGRAPHY (includes attachment):

Ammen, S. A. (2000). A play-based teen parenting program to facilitate parent-child attachment. In H. G. Kaduson & C. E. Schaefer (Eds.), *Short-term play therapy for children* (pp. 345-369). New York, NY: The Guilford Press.

Bailey, B. A. (2000). *I love you rituals*. New York, NY: Harper Collins.

Bailey, C. E. (Ed.). (2005). *Children in therapy: Using the family as a resource*. New York, NY: W.W. Norton & Co.

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York, NY: W. W. Norton & Co.

Barnard, K. E., & Brazelton, T. B. (Eds.). (1990). *Touch: The foundation of experience.* Madison, CT: International Universities Press Inc.

Bialik, M. (2012). *Beyond the sling: A real-life guide to raising confident, loving children the attachment parenting way*. New York, NY: Simon & Schuster.

Blaustein, M. E. & Kinniburgh, K. M. (2010). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation and competency*. New York, NY: The Guilford Press.

Bratton, S. C., Landreth, G.L., Kellam, T., & Blackard, S. R. (2006). *Child parent relationship therapy (CRPT) treatment manual: 10-session filial therapy model for training parents*. New York, NY: Routledge.

Bratton, S., & Landreth, G. (1995). Filial therapy with single parents: Effects on parental acceptance, empathy, and stress. *International Journal of Play Therapy, 1*(4), 61-80.

Ferguson, S. B. (2002). *What parents need to know about children*. Carlsbad, CA: Create Press.

Forbes, H. T. (2009). *Dare to love: The art of merging science and love into parenting children with difficult behaviors*. Boulder, CO: Beyond Consequences Institute, LLC.

Forbes, H. T. (2008). *Beyond consequences, logic and control: A love based approach to helping children with severe behaviors* (Volume 2). Boulder, CO: Beyond Consequences Institute, LLC.

Forbes, H. T. & Post, B. B. (2006). *Beyond consequences, logic and control: A love based approach to helping children with severe behaviors*. Boulder, CO: Beyond Consequences Institute, LLC.

Gil, E. (1994). *Play in family therapy*. New York, NY: The Guilford Press.

Ginsberg, B. G. (1995). Parent-adolescent relationship program (PARD): Relationship enhancement therapy with adolescents and their families (fathers and sons). *Psychotherapy*, *1*(32), 108-112.

Glazer-Waldman, H. R., Zimmerman, J. E., Landreth, G. L., & Norton, D. (1992). Filial therapy: An intervention for parents of children with chronic illness. *International Journal of Play Therapy*, (1), 31-42.

Golding, K. S. & Hughes, D. A. (2012). *Creating loving attachments: Parenting with PACE to nurture confidence and security in the troubled child*. Philadelphia, PA: Jessica Kingsley Publishing.

Guerney, L. F. (1997). *Filial therapy.* Hoboken, NJ: John Wiley & Sons.

Guerney, L. (1997). Filial therapy. In K. O'Connor and L. M. Braverman (Eds.), *Play therapy theory and application: A comparative presentation* (pp. 131-159). New York, NY: John Wiley & Sons, Inc.

Guerney, L. F. & Ryan, V. M. (2013). *Group filial therapy: The complete guide to teaching parents to play therapeutically with their children*. Philadelphia, PA: Jessica Kingsley Publishing.

Hughes, D. A. (2009). *Attachment-focused parenting: Effective strategies to care for children*. New York, NY: W. W. Norton & Company.

Hughes, D. A. (2007). *Attachment-focused family therapy*. New York, NY: W. W. Norton & Company.

Hughes, D. A. (2011). *Attachment-focused family therapy workbook*. New York, NY: W. W. Norton & Co.

Jennings, S. (2011). *Healthy attachments and neuro-dramatic-play*. Philadelphia, PA: Jessica Kingsley Publishing.

Jernberg, A. M. (1993). Attachment formation. In C. E. Schaefer (Ed.)*, The therapeutic powers of play*. Northvale, NJ: Jason Aronson, Inc.

Killough-McGuire, D., & McGuire, D. (2000). *Linking parents to play therapy: A practical guide with applications, interventions, and case studies.* New York, NY: Brunner-Routledge.

Landreth, G. L. & Bratton, S. C. (2006). *Child parent relationship therapy (CPRT): A 10-session filial therapy model*. New York, NY: Routledge.

Morin, V. K. (1999). *Fun to grow on: Engaging play activities for kids with teachers, parents, and grandparents*. Chicago, IL: Magnolia Street Publishers.

Newton, R. P. (2008). *The attachment connection: Parenting a secure & confident child using the science of attachment theory*. Oakland, CA: New Harbinger Publications.

Perry, B. D. & Szalavitz, M. (2006). *The boy who was raised as a dog: What traumatized children can teach us about loss, love, and healing*. New York, NY: Basic Books.

Prouix, L. (2003). *Strengthening emotional ties through parent-child dyad art therapy: Interventions with infants and preschoolers*. Philadelphia, PA: Jessica Kingsley Publishing.

Ramirez, L. M. & Salcines, M. L. (2002). *Playtime for Molly.* McAllen, TX: Marlin Books. (Explains the concept of filial therapy to parents and professionals.)

Schore, A. (2003) *Affect regulation and the repair of the self*. New York, NY: W.W. Norton.

Siegel, D. J. (2012). *Pocket guide to interpersonal neurobiology: An integrative handbook of the mind*. New York, NY: W. W. Norton & Co.

Siegel, D.J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York, NY: The Guilford Press.

Siegel, D. J. & Bryson, T. P. (2011). *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind, survive everyday parenting struggles, and help your family thrive*. New York, NY: Random House.

Siegel, D. & Hartzell, M. (2003). *Parenting from the inside out*. New York: Tarcher/Putnam.

Solomon, M. F. & Siegel, D. J. (Eds.) (2003). *Healing trauma: Attachment, mind, body and brain*. New York, NY: W. W. Norton & Co.

Solter, A. J. 2013). *Attachment play: How to solve children's behavior problems with play, laughter and connection*. Goleta, CA: Shining Star Press.

Szalavitz, M. & Perry, B. D. (2010). *Born for love: Why empathy is essential and endangered*. New York, NY: Harper Collins.

VanFleet, R. (2005). *Filial therapy: Strengthening parent-child relationships through play* (2nd ed.). Sarasota, FL: Professional Resource Press.

VanFleet, R. (2000). *A parent's handbook of filial therapy: Building strong families with play.* Boiling Springs, PA: The Family Enhancement & Play Therapy Center.

VanFleet, R. & Guerney, L. (Eds.). (2003). *A casebook of filial therapy.* Boiling Springs, PA: The Family Enhancement & Play Therapy Center.

Vogelsong, E., Guerney, B. G., & Guerney, L. (1980). *Filial Therapy*. [Video Cassette Format]. Silver Spring, MD: IDEALS.

COURSE REQUIREMENTS AND EVALUATION:

Always keep in mind two things. 1) Adhere to the **ethical standards** of counselors as outlined by the National Association of Social Workers, Code of Ethics. 2) Obtain consultation from the instructor or, preferably, from your supervisor *immediately* if you become aware of any information that would cause you concern for anyone's **safety**.

The assignments for this course comprise a total of 100% of the final grade. Assignments involve an integration of class readings, class discussions, library and on-line research, and group and practice experiences. Assignments will be graded on the basis of application of course material, critical thinking, appropriate writing style, and clarity. Integration of course material refers to a demonstrated understanding of the content, *and* expression of an active intellectual consideration of its use. Graduate students must be able to think critically about the material, articulate relative strengths of various approaches, and integrate ideas from different sources or frameworks. Papers should be free of grammatical and organizational errors, and meet **APA style guidelines**. This means that papers must include an **APA style title page**, all research and text material must be **cited** using APA style, and a **reference page** must be included to match the citations. For APA style guidance use the *Publication Manual of the American Psychological Association* (6th edition) or check out Purdue OWL: APA Formatting and Style Guide: owl.english.purdue.edu/owl/resource/560/01/. APA style omissions or mistakes will be subject to point deductions regardless of the grading rubric. Papers with **more than 10 spelling and/or grammatical errors will be docked 5 points or returned for revision and considered a late paper**. Write clearly and concisely to address assigned topics. If you need help, consider the writing lab.

GRADING:

Percentage Points	*Numerical grade*	*Description*
100% - 95%	4.0	Excellent
94% - 90%	3.5	Very Good
89% - 85%	3.0	Above Average
84% - 80%	2.5	Some Deficiencies
79% - 75%	2.0	Significant Deficiencies
74% - 70%	1.5	Many Deficiencies
69% - 65%	1.0	Unacceptable
64% and Below	0.0	Failure
	I	Incomplete

Final grades will be issued in the standard university numerical format, based on points earned. An incomplete will be given only in extraordinary circumstances and at the discretion of the instructor. The incomplete must be negotiated *before* the end of the semester.

NOTE TO INSTRUCTORS ABOUT ASSIGNMENTS:

This is a 1-credit course. The instructor will have to balance time students spend in the class with assignments and homework. I typically use one large assignment per one credit of instruction and usually include homework for a course, especially when I teach graduate level courses, but I also include out-of-class instruction: watching videos, reading additional texts, interacting in a discussion forum, etc. You may choose to use the homework and one assignment or you may choose to use only the assignments or you may choose to use all three or you may choose to write your own homework and assignments. For a graduate course, a 1-credit course requires 15 hours of in-class instruction with the expectation of 1 hour per week (in a 15-week, semester long course) of outside additional study: reading, writing, researching, preparation, homework, etc. The way you structure your course should depend on time allotted to that course.

REQUIRED ASSIGNMENTS/HOMEWORK:

30 points Assignment #1 – The Child of Rage (RAD Case) Due Date:
(Objectives 1, 2, 4)

Watch the case study of a severely abused and neglected child with RAD called, ***Child of Rage*** (located on YouTube in the full documentary). Write a brief (3 page) reflection on the case presented. What are your emotional reactions to the story? Be specific and self-reflective. Digging into our own feelings is a powerful way to grow our own empathic experience and form a base that serves to validate our clients. What do you believe to be the underlying causes of reactive attachment disorder? What are the evidences of attachment disorder in this little girl? Why do you imagine that her attachment disruption triggered these kinds of responses? Do you believe that RAD can be moderated or cured? What kind of treatment would that entail? What are the ethical concerns of treating a child with RAD? Are there cultural considerations? Was this video helpful to you? Why or why not?

Child of Rage – The Documentary (HBO Full Documentary) found on YouTube at:
https://www.youtube.com/watch?v=g2-Re_Fl_L4

GRADING RUBRIC – Assignment #1 – The Child of Rage – 30 Points

Emotional reactions and reflections	5 points ____
Underlying causes of RAD	5 points ____
Evidence and symptoms of RAD	5 points ____
Why and what triggered her responses	5 points ____
Moderated or cured	2 points ____
What kind of treatment	2 points ____
Ethical concerns about treating RAD	2 points ____
Cultural considerations in treating RAD	2 points ____
Helpful? Why or why not?	2 points ____

Total Points _____/30

30 points Assignment #2 – Filial Therapy Reading & Critique Due Date:
(Objectives 1-3, 5) Read the VanFleet required text, *Filial Therapy: Strengthening Parent-Child Relationships Through Play*. Write a 3-4 page critique of the book.

1. State the title of the book and the author. What qualifications does the author have to write this book?
2. Write a brief synopsis of the book. What are the main points of the book? What general constructs of filial therapy does it address?
3. Discuss three things you learned from the book and how they impacted your thinking and clinical awareness.
4. Does the filial method match with your own way of thinking? Why or why not?
5. Discuss how the book could help/guide you in your engagement and therapeutic work with children and their families?
6. What are your own reactions and considered opinions about the book?
7. Are there any ethical and/or cultural problems with the book? Conversely, are there positive and helpful ethical and/or cultural teachings within the book?
8. How do the principles outlined in the book align with social work values and your religious faith and/or spirituality?
9. Will you use filial therapy in your future work with children and families? Why or why not?

GRADING RUBRIC – Assignment #2 – Filial Therapy Reading & Critique – 30 Points

Title of Book, Author, Credentials	3 points ____
Brief Synopsis; Main Points; General Constructs Addressed	6 points ____
Three Things Learned; Impacted Thinking/Clinical Awareness	6 points ____
Filial Method Match Your Thinking; Explanation	3 points ____
Help/Guide Therapeutic Work with Children and Families	3 points ____
Reactions and Considered Opinions	3 points ____
Positive/Negative Ethical and/or Cultural Considerations	3 points ____
Principles Align w/ Social Work and Your Faith/Spirituality	3 points ____

Total Points _____/30

40 points Assignment #3 – Filial Therapy Presentation Due Date:
(Objectives 1, 2, 3, 4, 5) Divide into groups of three or four and then select one child/family problem (e.g., asperger spectrum, anxiety, aggression, abuse, adoption, divorce, substance abuse, trauma, chronic illness, single parenting, teen parenting, and attachment/relationship problems) and present a 30-minute instruction on the use of Filial Therapy with that child/family problem. You may use a variety of formats such as demonstration, video clips, photos, case presentation and live enactment, role-plays, etc. to show your classmates how this particular intervention model may be used with a family system. Each member of your group must participate verbally in the group presentation and each member of the group will receive the same grade on this assignment. **Handouts are optional but a reference page (with a minimum of 5 references including 3 peer-reviewed articles) is required**. Your presentation must include the following:

- A **description of primary techniques** of the filial therapy model adapted to this

child/family problem with relevant clinical material presented.

- A **discussion of the impact of filial therapy** with this child/family problem and any adaptations to the model to suit the treatment of this child/family problem. Teach any applicable, adapted filial therapy techniques to the class. How would the training of the parent be impacted by the presenting problem?
- A **discussion of the evidence base** for the use of the filial therapy model with this population as reported in the literature. What **empirical evidence** exists for application of the model to particular problems, contexts, or systems? What is the quality of this evidence and what does it mean to practitioners?
- A discussion of the application of the filial therapy model across **age, economic status, race and ethnic or cultural groups, gender and/or sexual orientation, ability level, education, social power, developmental stage and life cycle, and religion**. Is the filial therapy model more or less applicable in these circumstances or would another intervention model be more effective? Are there particular strengths, limitations, or complications of filial therapy in these circumstances? How does filial therapy fit with the values of the social work profession and faith/spirituality?
- A **reference page** showing all sources you actually used to prepare your presentation.
- Lead a brief discussion with your classmates relative to the material you presented.
- A process discussion with the instructor following your presentation concerning your group experience and how you worked together.

GRADING RUBRIC – Assignment #3 – Filial Therapy Presentation – 40 Points

Description of Primary Techniques/Clinical Material	5 points ____
Discussion of Impact of Filial Therapy/Teach Technique/s	5 points ____
Discussion of Evidence Base with Population/Problem	7 points ____
Critical Review; Applicability; Strengths, Limitations, or Complications; Fit with Social Work Profession and Faith	10 points ____
Discussion Questions and Format	5 points ____
Process group experience with instructor	5 points ____
Reference Page	3 points ____

Total Points _____/40

TOPICAL OUTLINE

The following outline of instruction includes about 15 hours of content/instruction to account for the 1-credit class. It is laid out in 6 segments but can easily be arranged into any format necessary to an instructor. The detail included below will hopefully offer the instructor avenues of exploration to supplementary material and research.

TOPICAL OUTLINE AND REQUIRED READING:

Section 1 – Date and Time (3-4 hours of material):

1. Introductions – instructor and students (20-30 minutes)
2. Course Overview – Syllabus, Required Reading, Assignments, and Expectations (15 minutes)
3. Warm-Up Activities and Icebreakers (designed by the instructor; suggestions attached in Small Group Activities folder (30 minutes)
4. Attachment – Setting the Stage (Objectives 3 and 4)
   Johnson & Johnson Pediatric Institute. (2006). *Amazing talents of your newborn: A guide for parents and caregivers*. Calverton, NY: Author.
5. Attachment videos and research – choose a few to show students. Be sure to give historical context to what is being demonstrated. You will need some background information on Harlow's studies and how those primate studies influenced Bowlby's development of attachment theory. You will need some information about the development and use of the Strange Situation by Mary Ainsworth in the Baltimore Studies. And you will need to understand that the more recent attachment researchers (Cassidy, Powell, Hoffman, Cooper) use the Strange Situation to train mothers to understand the needs of their children and be more sensitive those needs. Much of this is easy to find on the Internet and is necessary for background for these videos. (Objectives 3 and 4) (20-30 minutes)
   - Harlow's Studies on Dependency in Monkeys (Located at YouTube.com: http://www.youtube.com/watch?v=OrNBEhzjg8I&feature=related)
   - Food or Security? Harlow's Study on Monkey's Attachment (Located at YouTube.com: http://www.youtube.com/watch?v=hsA5Sec6dAI&feature=fvwrel)
   - Still Face Experiment: Dr. Edward Tronick (Located at YouTube.com: http://www.youtube.com/watch?v=apzXGEbZht0&feature=related)
   - Check out other Still Face videos on YouTube
   - Strange Situation Experiment (Located at YouTube.com: http://www.youtube.com/watch?v=PnFKaaOSPmk)
   - Check out other Strange Situation videos on YouTube
   - Circle of Security – Bonding (Located at YouTube.com: http://www.youtube.com/watch?v=xH1CbC4No24)
   - Check out Circle of Security (great info) on their website: circleofsecurity.net
   - Check out Baby/Infant Massage in videos on YouTube
6. The Strange Situation:
   In this procedure the child is observed playing for 20 minutes while caregivers and strangers enter and leave the room, recreating the flow of the familiar and unfamiliar presence in most children's lives. The situation varies in stressfulness and the child's responses are observed. The child experiences the following situations:
   - Mother (or other familiar caregiver) and baby enter room.
   - Mother sits quietly on a chair, responding if the infant seeks attention.
   - A stranger enters, talks to the mother then gradually approaches infant with a toy. The mother leaves the room.

- The stranger leaves the infant playing unless he/she is inactive and then tries to interest the infant in toys. If the infant becomes distressed this episode is ended.
- Mother enters and waits to see how the infant greets her. The stranger leaves quietly and the mother waits until the baby settles, and then she leaves again.
- The infant is alone. This episode is curtailed if the infant appears to be distressed.
- The stranger comes back and repeats episode 3.
- The mother returns and the stranger goes. Reunion behavior is noted and then the situation is ended.

Two aspects of the child's behavior are observed:

- The amount of exploration (e.g. playing with new toys) the child engages in throughout, and
- The child's reactions to the departure and return of its caregiver.

7. Circle of Security™ (COS):
   Glen Cooper, Kent Hoffman, and Bert Powell have been working together since 1983, designing and implementing treatment protocols for individuals, couples, and families. Their work is based upon an interface of attachment theory, object relations theory, and family systems theory. The COS™ is a user-friendly, visually based approach (utilizing extensive use of both graphics and video clips) to helping parents better understand the needs of their children. It is based extensively upon attachment theory (from the work of John Bowlby and Mary Ainsworth) and current affective neuroscience. It is also a basic protocol that can be used in a variety of settings, from group sessions (20 weeks) to family therapy to home visitation. The common denominator is that all of the learning is informed around the following themes:
   - Teaching the basics of attachment theory via the Circle of Security™
   - Increasing parent skills in observing parent/child interactions
   - Increasing capacity of the caregiver to recognize and sensitively respond to children's needs
   - Supporting a process of reflective dialogue between clinician and parent to explore both strengths and areas of parent difficulties (i.e., being "Bigger, Stronger, Wiser, and Kind," supporting exploration, and supporting attachment)
   - Introducing parent to a user-friendly way to explore defensive process
8. Discussion about Videos (15-20 minutes)
   1. What did you observe?
   2. What stands out to you as protective features of secure attachment?
   3. What stands out to you as risk factors in attachment disruption?
   4. How do you see attachment systems at work?
9. Overview of Attachment Principles and Theory (Objectives 3 and 4) (30-45 minutes)
   - Definition of attachment and biological necessity of attachment
   - Components of attachment
   - Attachment and development
   - Core beliefs
   - Protective factors of attachment security
   - Risk factors in disrupted attachment
   - Treating attachment wounds in play therapy through filial therapy
10. Experiential Activities (Objectives 3 and 4) (30 minutes)
    - Instructor should plan interactive activities to support material presented.

11. Reading:
    Hughes – Chapter 1
    Landreth & Bratton – Chapters 1-3
    VanFleet – Pages 1-52
12. Assignments due this week:
13. Assignments due next week:

Section 2 – Date and Time (4-5 hours of material):

1. Assessment and diagnosis of a child with a Reactive Attachment Disorder (This connects to the Homework Assignment – Child of Rage) (Objectives 1, 2, 4, 5) (15-20 minutes)
    - Use DSM-IV-TR
    - Deficit in basic trust is unmistakable
    - Common Symptoms of Attachment Disorders
    - *American Academy of Child and Adolescent Psychiatry*: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Reactive Attachment Disorder of Infancy and Early Childhood (for more information). Located at: http://www.center4familydevelop.com/parameters.htm
2. Reactive Attachment Disorder Defined:
   Reactive attachment disorder is a rare but serious condition in which infants and young children don't establish healthy bonds with parents or caregivers. A child with reactive attachment disorder is typically neglected, abused, or moved multiple times from one caregiver to another. Because the child's basic needs for comfort, affection and nurturing aren't met, he or she never establishes loving and caring attachments with others. This may permanently alter the child's growing brain and hurt their ability to establish future relationships. Reactive attachment disorder is a lifelong condition.
    - Make sure you consider the work of Bruce Perry:
      Perry, B. D. & Szalavitz, M. (2006). *The boy who was raised as a dog: What traumatized children can teach us about loss, love, and healing*. New York, NY: Basic Books.
      Szalavitz, M. & Perry, B. D. (2010). *Born for love: Why empathy is essential and endangered*. New York, NY: Harper Collins.
    - Make sure you consider the work of Daniel Siegel
      Siegel, D. J. & Hartzell, M. (2003). *Parenting from the inside out*. New York: Tarcher/Putnam.
      Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York, NY: The Guilford Press.
      Siegel, D. J. (2012). *Pocket guide to interpersonal neurobiology: An integrative handbook of the mind*. New York, NY: W. W. Norton & Co.
      Siegel, D. J. & Bryson, T. P. (2011). *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind, survive everyday parenting struggles, and help your family thrive*. New York, NY: Random House.
    - Make sure you consider the work of Bonnie Badenoch
      Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology*. New York, NY: W. W. Norton & Co.

3. Signs and Symptoms of Reactive Attachment Disorder (Common Symptoms of Attachment Disorder)
   (Objectives 3 and 4) (15-20 minutes)
   Reactive attachment disorder begins before age five. Signs and symptoms of the disorder may begin when the child is still an infant. Signs and symptoms in babies may include:
   - Withdrawn, sad and listless appearance
   - Failure to smile
   - Lack of the normal tendency to follow others in the room with the eyes
   - Failure to reach out when picked up
   - No interest in playing peek-a-boo or other interactive games
   - No interest in playing with toys
   - Engaging in self-soothing behavior, such as rocking or self-stroking
   - Calm when left alone

   Signs and symptoms in toddlers, older children and adolescents may include:
   - Withdrawing from others
   - Avoiding or dismissing comforting comments or gestures
   - Acting aggressively toward peers
   - Watching others closely but not engaging in social interaction
   - Failing to ask for support or assistance
   - Obvious and consistent awkwardness or discomfort
   - Masking feelings of anger or distress
   - Alcohol or drug abuse in adolescents
4. As children with reactive attachment disorder grow older, they may develop either inhibited or disinhibited behavior patterns. While some children have signs and symptoms of just one type of behavior, many exhibit both types.
   - **Inhibited behavior.** Children with inhibited behavior shun relationships and attachments to virtually everyone. This may happen when a baby never has the chance to develop an attachment to any caregiver.
   - **Disinhibited behavior.** Children with disinhibited behavior seek attention from virtually everyone, including strangers. This may happen when a baby has multiple caregivers or frequent changes in caregivers. Children with this type of reactive attachment disorder may frequently ask for help doing tasks, have inappropriately childish behavior or appear anxious.

   While treatment can help children and adults cope with reactive attachment disorder, the changes that occur during early childhood are permanent and the disorder is a lifelong challenge.
5. Causes of Reactive Attachment Disorder: (Objectives 3 and 4) (10-15 minutes)
   - To feel safe and develop trust, infants and young children need a stable, caring environment. Their basic emotional and physical needs must be consistently met. For instance, when a baby cries, his or her need for a meal or a diaper must be met with a shared emotional exchange that may include eye contact, smiling and caressing.
   - A child whose needs are ignored or met with emotionally or physically abusive responses from caregivers comes to expect rejection or hostility. The child then becomes distrustful and learns to avoid social contact. Emotional interactions

between babies and caregivers may affect development in the brain, leading to attachment problems and affecting personality and relationships throughout life.
- Most children are naturally resilient, and even those who've been neglected, lived in orphanages or had multiple caregivers can develop healthy relationships and strong bonds. It's not clear why some babies and children to develop reactive attachment disorder and others don't.

6. Treatment techniques that can be used to strengthen (and/or build) the attachment between a child and significant adults in her/his life (Objectives 3 and 4) (30-45 minutes)
    - Include here attachment reparation therapy for the child
    - Include here attachment reparation therapy for the parent/s
    - Adult Attachment Interview, available on the internet
    - Evergreen Psychotherapy Center: Attachment Treatment and Training Institute (two week removal intervention). Located at: http://www.attachmentexperts.com/
    - Therapeutic Homes
    - Filial Therapy
    - Theraplay®
7. Discussion Questions: (10-15 minutes)
    - What are some of the positive and protective factors of a secure attachment?
    - What are some of the risk factors for insecure or disrupted attachment?
    - How does insecure and/or disrupted attachment show up in child behavior?
    - If a child is a "behavior problem," what do you consider the source or purpose of that negative behavior? Is the "fault" the child, the parent/s, the community, genetic…?
8. Articles on Attachment Disorders (Located Through University Library System)

    Boekamp, J. R. (2008). Reactive attachment disorder in young children: Current perspectives on diagnosis and treatment. *Brown University Child and Adolescent Behavior Letter, 24*(8), 1, 6, 7.

    Cornell, T. & Hamrin, V. (2008). Clinical interventions for children with attachment problems. *Journal of Child and Adolescent Psychiatric Nursing*, 21(1), 35-47.

    Lake, P. M. (2005). Recognizing reactive attachment disorder: Early intervention is essential to prevent lifelong consequences. *Behavioral Health Management, 25*(5), 41-44. *Expanded Academic ASAP*. Retrieved October 8, 2010.

    Zeanah, C. H., Smyke, A. T., Koga, S. F., & Carlson, E. (2005). Attachment in institutionalized and community children in Romania. *Child Development, 76*(5), 1015-1028.
9. Reading:

    Hughes – Chapter 2

    Landreth & Bratton – Chapters 4-6
10. Assignments due this week:
11. Assignments due next week:

Section 3 – (4 hours of material):

12. Assessment and Diagnosis of children with Autism Spectrum Disorders (ASD) (Objectives 1-3) (30-45 minutes)

- Use DSM-IV-TR
- Include case examples

13. Autism Definition:
    Autism is a complex developmental disability that causes problems with social interaction and communication. Symptoms usually start before age three and can cause delays or problems in many different skills that develop from infancy to adulthood.
14. Autism Spectrum Disorders Defined:
    Autism Spectrum Disorders, also known as ***Pervasive Developmental Disorders*** (PDDs), cause severe and pervasive impairment in thinking, feeling, language, and the ability to relate to others. These disorders are usually first diagnosed in early childhood and range from a severe form, called autistic disorder, through pervasive development disorder not otherwise specified (PDD-NOS), to a much milder form, Asperger syndrome. They also include two rare disorders, Rett syndrome and childhood disintegrative disorder. Currently, the autism spectrum disorder category includes:
    - Autistic disorder (also called "classic" autism)
    - Pervasive Developmental Disorder Not Otherwise Specified (or atypical autism)
    - Asperger syndrome
    - In some cases, health care providers use a broader term, **pervasive developmental disorder**, to describe autism. This category includes the autism spectrum disorders above, plus Childhood Disintegrative Disorder and Rett syndrome.
        - ***Childhood Disintegrative Disorder***, also known as Heller's syndrome, is a condition in which children develop normally until ages 2 to 4, but then demonstrate a severe loss of social, communication and other skills. Childhood disintegrative disorder is very much like autism. Both are among the group of disorders known as pervasive developmental disorders, or autism spectrum disorders. And both involve normal development followed by significant loss of language, social, play and motor skills. However, childhood disintegrative disorder typically occurs later than autism and involves a more dramatic loss of skills. In addition, childhood disintegrative disorder is far less common than autism. Treatment for childhood disintegrative disorder involves a combination of medications, behavior therapy and other approaches.
        - ***Rett Syndrome*** is a neurological and developmental disorder that mostly occurs in females. Infants with Rett syndrome seem to grow and develop normally at first, but then stop developing and even lose skills and abilities.
    - For the purposes of this class, we will use "autism spectrum disorder" and "autism" to mean the same thing.
15. Symptoms of Autism involve problems in the following areas:
    - Communication - both verbal (spoken) and non-verbal (unspoken, such as pointing, eye contact, and smiling)
    - Social - such as sharing emotions, understanding how others think and feel, and holding a conversation
    - Routines or repetitive behaviors (also called stereotyped behaviors) - such as repeating words or actions, obsessively following routines or schedules, and playing in repetitive ways
    - The symptoms of autism can usually be observed by 18 months of age
16. Red Flags for Autism - Behaviors that may be signs or symptoms of autism.

- The child does not respond to his/her name.
- The child's language skills are slow to develop or speech is delayed.
- The child doesn't follow directions.
- At times, the child seems to be deaf.
- The child seems to hear sometimes, but not other times.
- The child doesn't point or wave "bye-bye."
- The child used to say a few words or babble, but now he/she doesn't.
- The child throws intense or violent tantrums.
- The child has odd movement patterns.
- The child is overly active, uncooperative, or resistant.
- The child doesn't know how to play with toys.
- The child doesn't smile when smiled at.
- The child has poor eye contact.
- The child gets "stuck" doing the same things over and over and can't move on to other things.
- The child seems to prefer to play alone.
- The child gets things for him/herself only.
- The child is very independent for his/her age.
- The child does things "early" compared to other children.
- The child seems to be in his/her "own world."
- The child seems to tune people out.
- The child is not interested in other children.
- The child walks on his/her toes.
- The child shows unusual attachments to toys, objects, or schedules (i.e., always holding a string or having to put socks on before pants).
- Child spends a lot of time lining things up or putting things in a certain order.
- The child cannot explain what he/she wants.

17. Treatments for Autism: (Objectives 1-3) (30-45 minutes)

    There is no cure for autism, nor is there one single treatment for autism spectrum disorders, but there are ways to help minimize the symptoms of autism and to maximize learning. The parents should make decisions about the best treatment, or combination of treatments, with the assistance of a trusted expert diagnostic team.

    - Behavioral therapy and other therapeutic options:
        - Behavior management therapy helps to reinforce wanted behaviors, and reduce unwanted behaviors. It is often based on Applied Behavior Analysis (ABA).
        - Speech-language therapists can help people with autism improve their ability to communicate and interact with others.
        - Occupational therapists can help people find ways to adjust tasks to match their needs and abilities. (This is worth exploring with an occupational therapist or websites for further information about techniques and tools.)
        - Physical therapists design activities and exercise to build motor control and improve posture and balance.
    - Educational and/or school-based options:
        - Public schools are required to provide free, appropriate public education from age 3 through high school or age 21, whichever comes first.

- Typically, a team of people, including the parents, teachers, caregivers, school psychologists, and other child development specialists work together to design an Individualized Education Plan (IEP) to help guide the child's school experiences.

- Medication options:
  - Currently there are no medications that can cure autism spectrum disorders or all of the symptoms. The U.S. Food and Drug Administration has not approved any medications specifically for the treatment of autism, but in many cases medication can treat some of the symptoms associated with autism.
  - Selective serotonin reuptake inhibitors (SSRIs), tricyclics, psychoactive/anti-psychotics, stimulants, and anti-anxiety drugs are among the medications that a health care provider might use to treat symptoms of autism spectrum disorders.

18. Autism and Vaccines:
    There is no conclusive scientific evidence that any part of a vaccine or combination of vaccines causes autism, even though researchers have done many studies to answer this important question. There is also no proof that any material used to make or preserve the vaccine plays a role in causing autism.
19. Autism is more common in certain groups of people:
    - Boys
    - Siblings of those with autism
    - People with certain other developmental disorders, such as Fragile X syndrome
20. Asperger Syndrome Defined: (Objectives 1-3)
    Asperger Syndrome is an autism spectrum disorder. People with Asperger Syndrome have autism-like problems in areas of social interaction and communication, but have normal intelligence and verbal skills. Asperger syndrome is usually thought to be the mildest of the autism spectrum disorders.
21. Common Symptoms of Asperger Syndrome: (Objectives 1-3) (15 minutes)
    One of the most distinct symptoms of Asperger syndrome is having an obsessive interest in a single object or topic—so much so that the person ignores other objects, topics, or thoughts. Unlike some children with autism spectrum disorders, children with Asperger syndrome tend to have good vocabularies and grammar skills. But they usually have other language problems, such as being very literal and having trouble understanding non-verbal communications, such as body language.
    Other symptoms of Asperger syndrome may include:
    - Obsessive or repetitive routines and rituals
    - Motor-skill problems, such as clumsy or uncoordinated movements and delays in motor skills
    - Social-skill problems, especially related to communicating with others
    - Sensitivity to sensory information, such as light, sound, texture, and taste
22. Treatment for Asperger syndrome: (Objectives 1-3) (30 minutes)
    There is no cure for Asperger syndrome, but people with Asperger syndrome can live full and happy lives, especially with early treatment intervention. Treatment for Asperger syndrome can include educational and social skills training. It may also include behavioral therapy and medication for related conditions.
    Asperger Documentary on YouTube found at: (10 minutes)
    http://www.youtube.com/watch#!v=WAfWfsop1e0&feature=related
23. Articles on Autism Spectrum Disorders (Objectives 1-3)

Duncan, A. W. & Klinger, L. G. (2010). Autism spectrum disorders: Building social skills in group, school, and community settings. *Social Work with Groups, 33*, 175-193. DOI: 10.1080/01609510903366244.

National Institute of Child Health and Human Development. (2005). *Autism overview: What we know*. Washington, DC: NICHD. (Located in the Autism Folder)

National Institute of Child Health and Human Development. (2005). *Autism and genes*. Washington, DC: NICHD. (Located in the Autism Folder)

National Institute of Mental Health. (2008). *Autism Spectrum Disorders*. Washington, DC: NIMH.

Oosterling, I. J., Wensing, M., Swinkels, S. H., Jan van der Gaag, R., Visser, J. C., Woudenberg, T., Minderaa, R., Steenhuis. M-P., & Buitelaar, J. K. (2010). Advancing early detection of autism spectrum disorder by applying an integrated two-stage screening approach. *Journal of Child Psychology and Psychiatry 51*(3), 250-258. Doi:10.1111/j.1469-7610.2009.02150.x

Pasco, G. (2010). Identification and diagnosis of autism spectrum disorders: An update. *Pediatric Health, 4*(1), 107-114.

See also: National Institute of Child Health and Human Development website at: http://www.nichd.nih.gov/health/topics/asd.cfm

24. Experiential Activities – Video – *Natures Newborn*. (These VHS cassettes are available at Amazon for just a few dollars.) (Objectives 3-5) (30 minutes)
    Brainstorm ideas and then practice engagement, assessment, and treatment techniques that can be used with children diagnosed with an Autism Spectrum Disorder.
25. Review Child Centered Play Therapy
    (Objectives 3-5) (30 minutes)
    - Definition
    - History
    - Theory
    - Rationale
    - Play Materials
26. Introduce "Play Therapy in a Bag" – Materials lists available in Play Therapy in a Bag Folder (Objectives 2, 3, 4, and 5) (45 minutes)
    - Discuss contents and rationale
    - Categories of materials and potential uses
    - Set up a play area using the Play Therapy in a Bag
    - Practice and review child centered play therapy sessions

Moor, J. (2008). *Playing, laughing and learning with children on the autism spectrum: A practical resource of play ideas for parents and carers*. London, Great Britain: Jessica Kingsley Publishers, Ltd.

27. Reading:
    Hughes – Chapters 3-5
    VanFleet – Pages 53-65
28. Assignments due this week:
29. Assignments due next week:

Section 4 – Date and Time (5 hours of material):

1. Filial Therapy – History and Overview (Objectives 1-5) (60 minutes)
2. Filial Therapy History
   - Developed by Bernard and Louise Guerney in the early 1960's
   - Has also been known as:
     - Child Relationship Enhancement Family Therapy (CREFT)
     - Filial Play Therapy (FPT)
     - Filial Family Therapy (FFT)
   - Further refined by Garry Landreth in 1980's into a more time-limited structure
   - *Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model* (Landreth & Bratton, 2006) (discussed below)
3. Filial (parent-child) Play Therapy Defined
   - Highly effective intervention integrating play and family therapies to address child and family problems
   - Trains and supervises parents to conduct special child-centered play sessions with their children
   - How to incorporate family issues in a mutual problem-solving process that benefits children and parents alike
   - A developmentally attuned way of communicating and understanding
   - Used successfully with a wide range of child/family problems including:
     - Anxiety
     - Aggression
     - Abuse
     - Adoption
     - Divorce
     - Substance abuse
     - Trauma
     - Chronic illness
     - Single parenting
     - Teen parenting
     - Relationship problems
4. Filial play therapy creates a safe atmosphere where children can:
   - Express their feelings and fears through the natural activity of play
   - Understand their own feelings better
   - Become able to express their feelings more appropriately
   - Be more able to tell parents what they need, what is worrying them
   - Try new things and experience new things
   - Become more confident and skilled in solving problems as well as asking for help when they need it
   - Learn about social rules and restrictions
   - Reduce their problem behaviours
   - Develop family attachments
   - Feel more secure and trust their parents more
   - Develop effective social skills and bonds

- Have a more healthy self esteem and increase their self-confidence

5. Filial therapy can help parents to:
   - Understand their child's worries and other feelings more fully
   - Enjoy playing with their children and giving them positive attention
   - Increase their listening skills and develop open communication with their children
   - Develop self-confidence as parents
   - Become more able to trust their children
   - Deal in new ways with frustrations in family life
   - Form closer and happier relationships with their children
6. Research has shown that play therapy is more effective when parents are involved, so this approach involves training parents how to effectively play with their children.
7. Cultural Considerations
   - Changing demographics in the United States
   - Marginalization of ethnic/racial minority groups
   - Poverty as an intervening factor
     - "Regardless of race or ethnicity, poor children are much more likely than non-poor children to suffer developmental delay and damage, to drop out of school, and to give birth during their teen years" (Payne, 2001, pp. 11)
   - Need for Filial Therapy: Importance of positive relationships in early childhood and its link to socio-emotional and academic success
8. Be A Reflective Practitioner
   - Be aware of your own prejudices and stereotypes
   - Reflect on your experience
   - Be open to the journey
9. Self-Reflection Activity: (Objectives 1-5) (20-30 minutes)
   Answer these questions independently and then share with a partner.
   - What are the major themes in your life?
   - How do you think the themes of your own life story so far influences your work with others and children specifically?
   - Reflect on ethnic considerations and the values of your family of origin and their impact on you as a person and counselor.
   - How much of your life do you believe is controlled by your past?
   - What will you specifically do in your therapy practice to promote cultural sensitivity in yourself (e.g., read, attend trainings) and in your observable counseling setting (e.g., select culturally sensitive toys, choose multicultural art)?
   - How does your religion/spirituality perspective integrate with filial therapy? And how will that be impacted with families from other religion/spirituality perspectives?
   - What are some of the ethical considerations in this process?
10. Filial Play Therapy Articles (Located in the University Library System)

Edwards, N. A., Ladner, J., & White, J. (2007). Perceived effectiveness of filial therapy for a Jamaican mother: A qualitative case study. *International Journal of Play Therapy ,16*(1), 36-53. DOI: 10.1037/1555-6824.16.1.36.

Garza, Y. & Watts, R. E. (2010). Filial therapy and Hispanic values: Common ground for culturally sensitive counseling. *American Counseling Association, 88*, 108-113.

Garza, Y., Kinsworthy, S., & Watts, R. E. (2009). Child-parent relationship training as

experienced by Hispanic parents: A phenomenological study. *International Journal of Play Therapy, 18*(4), 217-228. DOI: 10.1037/a0017055.

Ginsberg, B. G. (1995). Parent-adolescent relationship program (PARD): Relationship enhancement therapy with adolescents and their families (fathers and sons). *Psychotherapy, 32*(1), 108-112.

Grskovic, J. A. & Goetze, H. (2008). Short-term filial therapy with German mothers: Findings from a controlled study. *International Journal of Play Therapy, 17*(1), 39-51. DOI: 10.1037/1555-6824.17.1.39.

Reynolds, C. A. & Schwartz, R. C. (2003). Filial therapy. *Annals*, Fall, 22-26.

Solis, C. M., Meyers, J., & Varjas, K. M. (2004). A qualitative case study of the process and impact of filial therapy with an African American parent. *International Journal of Play Therapy, 13*(2), 99-18.

Packman, J. & Solt, M. D. (2004). Filial therapy modifications for preadolescents. *International Journal of Play Therapy, 13*(1), 57-77.

Ryan, V. (2007). Filial therapy: Helping children and new carers to form secure attachment relationships. *British Journal of Social Work, 37*, 643-657. Doi:10.1093/bjsw/bch331.

11. Show a Filial Therapy video (Objectives 1-5) (100 minutes)

    VanFleet, R. (2008). *Filial Play Therapy* [DVD Format]. Washington, DC: American Psychological Association. ($99.95 from APA) 100 minutes.

    VanFleet, R. (2006). *Introduction to Filial Therapy* [DVD Format]. Play Therapy Press. ($75.00 from the Family Enhancement and Play Therapy Center [3-DVD set]) 4 hours. Dr. VanFleet provides an overview of the entire process of Filial Play Therapy.

    Vogelsong, E., Guerney, B. G., & Guerney, L. (1980). *Filial Therapy*. [Video Cassette Format]. Silver Spring, MD: IDEALS.

12. Discussion Questions: (Objectives 1-5) (15-20 minutes)
    - What do you believe to be the major source of problems in children?
    - What is the role of development, of family, of the past in child problems?
    - Where do you look for solutions in work with children? Why?
    - Do you think filial therapy is a viable tool for working with children and families?
    - What do you wish your parent/s (caregiver/s) did more of for you when you were a little child?
    - What do you think children hope for, wish for, long for?
13. Experiential Activity: (Objectives 1-5) (20-30 minutes)

    In pairs, practice (through role-play) explaining to a parent the rationale for filial therapy and the process of how to conduct special play sessions with their child/ren. Use the Play Therapy in a Bag to demonstrate a special play kit for the "parent," its potential uses for the presenting problem/s of the child and family system, and how to adapt the "bag" to meet the special needs in their family (e.g., medical). The second student to play the counselor might then practice explaining and demonstrating child-centered play therapy to the parent and why these principles are so important to the process. In other words, what the parent and child will get out of these kinds of interactions. Make this specific (e.g., "Experience has shown us that parents and their children feel more emotionally connected through playing together in this special way.")

Ramirez, L. M. & Salcines, M. L. (2002). *Playtime for Molly.* McAllen, TX: Marlin

Books. (Explains the concept of filial therapy to parents and professionals.)

14. Reading:
    Hughes – Chapters 6 and 7
15. Assignments due this week:
16. Assignments due next week:

Section 5 – (3 hours of material):

1. Child Parent Relationship Therapy (Objectives 1-5) (20-30 minutes)
2. Child Parent Relationship Therapy – Defined
   - Strengths-based, child-centered approach to parent training for children 3-10 years old
   - Teaches parents to become therapeutic agents in their children's lives
   - Uses a format of didactic teaching and group process
   - Provides supervision to parents
   - Flexible to meet the unique needs of participants
3. Child Parent Relationship Therapy – Outline
   - Group Format
     - 6-8 participants
     - Role-play, Modeling, and Video/Live Supervision
   - Group meets weekly for 2 hours
   - Screening and selection of parents and children
   - Parents choose "child of focus" for the 10 sessions and conducts weekly 30-minute home play sessions
4. CPRT: Sessions 1-3 (Bratton, Landreth, Kellam, & Blackard, 2006)
   - Concentrate on teaching parents *basic* Child-Centered play therapy skills and basic protocol for play sessions
   - The 4 messages:
     - "I am here"
     - "I hear/see you"
     - "I understand"
     - "I care"
   - Objectives for the play session (e.g., allowing the child to lead, being verbally active)
   - Toy selection
   - Introduction to limit setting: ACT Method
     - Acknowledge the feeling
     - Communicate the limit
     - Target alternatives
5. CPRT: Sessions 4-10
   - Supervision of videotaped play sessions
   - Concentrate on teaching parents *advanced* Child-Centered play therapy skills
     - Choice-giving
     - Returning responsibility
     - Encouragement versus praise
     - Generalizing skills

6. Competencies and Skills for the Filial Therapist (Objective 5) (10-15 minutes) (Taken from the Play Therapy United Kingdom Certificate in Filial Play Coaching/Mentoring located on the world wide web at: http://www.playtherapy.org.uk/TrainingCourses/TrainCrseFilialPlay1.htm
   - Carry out assessment of parents and children being considered for filial play
   - Recognize when either parent or child is not currently suitable for filial play and refer on appropriately
   - Monitor parents' filial play sessions using an appropriate model, providing advice, guidance and support
   - Advise and instruct parents upon how to make notes on home play sessions, using a log, so that they are suitable for use during the coaching sessions
   - Plan, equip and manage the equipment, materials and toys in a suitable room for the training and coaching of parents
   - Advise and instruct parents on how to acquire and use appropriate equipment, materials and toys during their home play sessions according to their circumstances
   - Teach parents the importance of play, the main types of play and their purpose so that they can achieve a suitable balance with their children
   - Ensure that parents understand the objectives of filial play
   - Ensure that parents know how to structure a filial play session
   - Ensure that parents know how to accept the behavior of the child during a filial play session
   - Ensure that parents know how to focus on the child during a filial play session
   - Ensure that parents know how to let the child lead throughout a filial play session
   - Ensure that parents know how to reflect upon the child's non verbal behavior during a filial play session
   - Ensure that parents know how to reflect upon the child's verbalizations during a filial play session
   - Ensure that parents know how to reflect upon the child's expressed emotions during a filial play session
   - Ensure that parents know how to use encouragement and praise during a filial play session
   - Ensure that parents set, manage and maintain appropriate boundaries during a filial play session
   - Ensure that parents know and put into practice the principles of non-directive play
   - Ensure that parents recognize and deal appropriately with any sibling issues that arise as a result of filial play
   - Demonstrate use and applicability of the main non-directive play media: art media, music, movement, sandtray (or substitute), storytelling, puppets clearly indicating which are appropriate for use at home and those that may be used in the therapist's playroom
   - Carry out regular progress reviews as appropriate to each family's circumstances
   - Carry out appropriate procedures at the end of the formal training of the parent/caregivers program
   - Integrate the use of filial play with play therapy if this is being used concurrently or after play therapy has finished

- Consult with the parents, children and others involved on appropriate follow up and continuing support services
- Brief other involved organizations and colleagues upon the purpose and methods of filial therapy Maintain suitable records of progress and carry out quality management of filial play work
- Apply an ethical framework, confidentiality and the requisite child protection procedures to all filial play work

7. Review Items Useful for a *Play Therapy in a Bag* Kit (Objectives 1-5) (20-30 minutes)
   Lists available in the *Play Therapy in a Bag* Folder
   Brainstorm ways to make this more affordable to parents.
   Brainstorm additional or alternative miniatures, toys and objects for Filial Play Kits.
8. Filial Therapy Basic Parent Skills: (Objective 5) (20-30 minutes)
   - *Structuring*. During parent-child special play time, parents may set boundaries delineating the special play space from the rest of the home. They may also acknowledge the entrance into and exit from the special play time. Teach the parent to say something to the child like, "We are now in our special place. During the time we are here, you may play with almost anything you wish in almost any way you wish. If there is something you may not do, I will tell you."
   - *Empathic Listening*. Parents are taught to track and reflect the child's behavior in the play space. This can be awkward for some parents at first. They are taught to reflect both action/behavior and affect/emotion. They are taught to be fully present, in the here and now with their child.
     - Tracking: Verbally state what the child is doing and saying, using names of items after the child has named them.
     - Reflection of Feelings: Using verbal and visual cues, you respond to the feelings.
   - *Child-Centered Imaginary Play*. A child's symbolic play is a journey, a process for them. Parents are taught to watch and listen and follow this symbolic journey. They are taught to be non-directive and rely on the basic tenet of encouragement.
     - Encouragement: Conveying belief in the child's ability to solve his or her own problem/s.
   - *Limit Setting*. Keep to a minimum. These limits are about personal safety and basic respect for others and their property. Aggression is necessary for the child, with limits.
     1. **A**cknowledge the child's feelings or desire to do something unacceptable.
     2. **C**ommunicate and firmly set the limit on the behavior.
     3. **T**arget and verbally provide an acceptable alternative.
9. Experiential Activity: (Objectives 1-5) (20-30 minutes)
   In pairs, practice (through role-play) training a parent to conduct special play sessions with their child/ren. The first student to play the therapist might start with teaching the other "parent" student how to track their child's play. Use the Play Therapy in a Bag to demonstrate these skills. The second student to play the counselor might then practice teaching a parent how to reflect their child's feelings.
10. Applications of Filial Therapy including contraindications: (Objectives 1-5)
    (20-30 minutes)
    - Most parents are capable of understanding the basic skills of this intervention.

- Parents need a basic ability to understand the conceptual framework and be able to follow the procedures of filial therapy.
- Filial Therapy has also been used with developmentally delayed parents.
- Some parents are simply not capable of being emotionally present with their child for 10-15 minutes at a time.
- The counselor must use clinical judgment to determine if filial therapy is a viable intervention for a particular set of parents/caregivers and child/ren.
- In some cases filial therapy may or may not be an option.
- Filial therapy is not recommended when the parent is the perpetrator of sexual abuse.
- Filial Therapy is contraindicated when the parents are perpetrators of abuse. This includes a non-offending parent who is still in the home with the abuser.
- Filial play therapy is useful and effective in a variety of difficult family situations.
- Obviously, in some instances, however, the needs of the child may be better served by individual therapy and traditional play therapy.
- The overall decision should defer to comprehensive clinical judgment, rather than any specific diagnosis.

11. Applications of Filial Therapy to special populations. (Objectives 1-5)
(20-30 minutes)

Bratton, S. & Landreth, G. L. (1995). Filial therapy with single parents: Effects on parental acceptance, empathy, and stress. *International Journal of Play Therapy, 1*(4), 61-80.

Glazer-Waldman, H. R., Zimmerman, J. E., Landreth, G. L., & Norton, D. (1992). Filial therapy: An intervention for parents of children with chronic illness. *International Journal of Play Therapy,* 1, 31-42.

Green, E. J. & Connolly, M. E. (2009). Jungian family sandplay with bereaved children: Implications for play therapists. *International Journal of Play Therapy, 18*(2), 84-98. DOI: 10.1037/a0014435.

Kolos, A. C., Green, E. J., & Crenshaw, D. A. (2009). Conducting filial therapy with homeless parents. *American Journal of Orthopsychiatry, 79*(3), 366-374.

Robinson, J., Landreth, G., & Packman, J. (2007). Fifth-grade students as emotional helpers with kindergartners: Using play therapy procedures and skills. *International Journal of Play Therapy, 16*(1), 20-35. DOI: 10.1037/1555-6824.16.1.20.

Ryan, S. D. & Madsen, M. D. (2007). Filial family play therapy with an adoptive family: A response to preadoptive child maltreatment. *International Journal of Play Therapy, 16*(2), 112-132. DOI: 10.1037/1555-6824.16.2.112

Smith, D. M. & Landreth, G. L. (2004). Filial therapy with teachers of deaf and hard of hearing preschool children. *International Journal of Play Therapy, 13*(1), 13-33.

Smith, D. M. & Landreth, G. L. (2002). Intensive filial therapy with child witnesses of domestic violence: A comparison with individual and sibling group play therapy. *International Journal of Play Therapy, 12*(1), 67- 88.

Tew, K., Landreth, G. L., Joiner, K. D., & Solt, M. D. (2002). Filial therapy with parents of chronically ill children. *International Journal of Play Therapy, 11*(1), 79-100.

Timmer, S. G., Urquiza, A. J., Herschell, A. D., McGrath, J. M., et al. (2006). Parent-child interaction therapy: Application of an empirically supported treatment to maltreated children in foster care. *Child Welfare, 85*(6), 919-939.

Wickstrom, A. (2010). Influencing gender relations through child parent relationship therapy. *International Journal of Play Therapy, 19*(2), 79–94. DOI: 10.1037/a0017339.

12. Show a parenting video using these techniques: *Choices, Cookies & Kids* (Objectives 1-5) (30 minutes)
    Landreth, G. (1997). *Choices, cookies & kids: A creative approach to discipline* [Video Format]. Center for Play Therapy, University of North Texas. (Available from the SelfEsteemShop.com for $50)
    Other Possible Choices:
    Love and Logic
    Nurtured Heart
    1-2-3 Magic
13. Discussion Questions: (Objectives 1-5) (15 minutes)
    - What do you think are the most difficult issues for parents as they discipline their children? What makes limit setting and discipline so hard?
    - What do you believe would be the most helpful for parents to learn or understand about limit setting and discipline?
    - How were you disciplined as a child? And how will that impact your work with children and families?
14. Give Students Time to Work in Small Groups for Assignment #3 (30-45 minutes)
15. Reading:
    Hughes – Chapters 8-10
16. Assignments due this week:
17. Assignments due next week:

Section 6 – Date and Time (3 hours of presentations):

1. Filial Therapy Small Group Presentations (Assignment #3). (Objectives 1-5) (30 minutes for each presentation group x four groups + discussion + evaluation + setup = ~180 minutes)