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Andrea White
The Benefits of Child-Centered Play
Therapy and Filial Therapy for
Preschool-Aged Children with
Reactive Attachment Disorder and
Their Families

ABSTRACT

The purpose of this study was to investigate, from a theoretical perspective, the best treatment approach for preschool-aged children with Reactive Attachment Disorder. The challenges and needs of these children can be extensive, and the search for effective treatment is ongoing. Two specific questions of focus were: How are the theories behind Non-Directive Play Therapy/Child-Centered Play Therapy and Filial Therapy useful in conceptualizing the experience of therapy for a child with attachment disorder? And, how could these treatments be used to benefit children with attachment disorders and their families?

The research for this paper involved a literature review of peer-reviewed articles on Reactive Attachment Disorder (RAD) and treatment, original sources describing Attachment Theory, Non-Directive Play Therapy and Filial Therapy, and the DSM-IV-TR and ICD-10.

Both types of therapy were found to be helpful for children with RAD because they create a therapeutic relationship that encourages secure attachment, allow children to process trauma as needed, and provide conditions which help children build affect-regulation, improve self-concept and regain healthy development. Filial Therapy showed an additional benefit in training parents to provide ideal caregiving conditions. A comprehensive assessment and treatment program, utilizing aspects of both treatment types was suggested for children with Reactive Attachment Disorder and their families; it includes the potential for use in clinical settings, child welfare investigations and with foster and adoptive families.

THE BENEFITS OF CHILD-CENTERED PLAY THERAPY AND
FILIAL THERAPY FOR PRESCHOOL-AGED CHILDREN
WITH REACTIVE ATTACHMENT DISORDER
AND THEIR FAMILIES

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2014

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Chapter I

Introduction

This paper will look at the challenges faced by preschool-aged children with Reactive Attachment Disorder (RAD) and their families, and investigate types of therapy that may be most beneficial to this population. Attachment is crucial to multiple areas of child development. In infancy a positive secure attachment provides security, safety and comfort within the parental bond. For children between the ages of three and six, the importance of this infant attachment becomes increasingly observable in multiple developmental areas. Psychological, social, emotional and intellectual competency can be seen in the behavior of securely attached children entering preschool or daycare during these ages. However, children who develop insecure attachments often have less success in their development, with the most extreme difficulties being related to disordered attachment.

Reactive Attachment Disorder is, by definition, the result of abuse, physical or emotional neglect, or lack of a consistent caregiver, such as experienced in under-staffed orphanages or multiple changes in foster placements. Symptom description shows a lack of age-appropriate social interaction with others, most significantly with regard to parents or other primary caregivers. Social inhibition may be observed in contradictory patterns of approach, avoidance, appearing to freeze in fear and resisting comfort even when distressed. Disinhibited sociability may be demonstrated through charming or friendly behavior toward many adults without concern for safety (i.e. leaving with a stranger) and lack of a deep, emotional connection with a parent or primary caregiver. This history of fearful or unavailable caregivers as well as multiple

related behavioral symptoms must be present before the age of five to be considered for the diagnosis.

Children with attachment disorders have multiple needs and challenges. Direct manifestations related to a lack of positive attachment experiences include: difficulty in regulating affect and behavior, problems with social relationships and developmental losses in self-awareness and self-concept. In addition, children who have experienced abuse and neglect often suffer traumatic symptoms, and grieve the loss of the biological parents from whom they have been removed. Children who have been moved through multiple foster placements typically have histories involving abuse, neglect and loss as well. These children often have co-existing attachment and trauma symptoms and/or disorders. Children raised in large, understaffed orphanages have additional conditions and syndromes related to the severe deprivation (ie. insufficient food and medical care, complete lack of stimulation and touch) present in such places. While not directly related to attachment issues, co-occurring diagnoses of attentional problems, aggression, stereotypies and language delays are often found among these institutional-care populations. Further, parents who adopt children with RAD often find it hard to cope with their child's behavior, misunderstand the child's psychological experiences and needs, and feel rejected by them. The need for effective treatment for this population is clear. Whether working within the foster care system, carrying out home visits, or in a clinical setting, social workers will no doubt have these children among their client populations. The field of social work is dedicated to the care of such disadvantaged populations as children with RAD and their families.

The literature describes two general categories of successful intervention for children with attachment disorder. First, removal from the abusive, neglectful and/or attachment-

deprived caregiving environment to a place where a reliable, empathic, attentive, primary caregiver is consistently available can result in considerable improvements in attachment security and healthy development (Morrison & Elwood, 2000). This is especially true for children removed to the optimal caregiving environment by the age of two; children may need more professional help if they remain in very poor caregiving situations much beyond that age (Morrison & Elwood, 2000). Second, therapy for this population may have an impact in ameliorating barriers to healthy attachment in early childhood development. However, as noted by Boekamp (2008), our understanding of what constitutes effective treatment at this point is still evolving. For instance, in the 1980's and 1990's many therapists circulated a general clinical belief that these children were impossible to treat, based on clinical experiences in which types of child therapy typically used with other populations were largely unsuccessful (Boekamp, 2008; Chaffin et al., 2006; O'Connor & Zeanah, 2003). As a result, more extreme forms of "attachment therapies" were developed and their use rationalized, despite any clear evidence for their success. "Rage reduction," "holding therapy" and "re-birthing" are three such therapies that became controversial due to their use of physical restraint (ie. being tightly wrapped in a blanket or held down forcefully by the therapist or parent), and provocation to anger or crying (via poking, yelling at and/or demeaning the child). There is now a general consensus that these treatments should be avoided due to deaths of children and risk of psychological traumatization (Boekamp, 2008; Heller et al., 2006; VanFleet, 2006; Zilberstein, 2006).

Thus, the search for successful treatments for children with Reactive Attachment Disorder continues. Behavioral therapies appear to show success in temporarily retraining outward behaviors related to RAD, but their use in providing for deep psychological and emotional needs related to attachment is questionable (Guerney, 2000; Yi, 2000). Research on

newer treatments often has limited empirical reliability due to the use of small client samples or case studies, and the lack of a control group. Reasons for this problem include the relative infrequency of the RAD diagnosis and difficulty defining a control group. Furthermore, it appears that each new type of treatment seeks to define what exactly needs to be helped, and develop a theory as to the mechanisms to do so.

As a result of these multiple issues, this paper will review current literature and research from a theoretical point of view to help clarify the phenomenon of treatment of Reactive Attachment Disorder in preschoolers (ages 3-6). This age group was selected for three reasons: First, Reactive Attachment Disorder must be diagnosed by the age of five (DSM-IV-TR, APA, 2000). Second, children adopted from attachment-critical backgrounds up to age two often resolve their attachment and developmental needs based on access to appropriate caregiving without need for treatment (Morrison & Elwood, 2000). Third, preschool age children are young enough to have significant recovery of attachment, trauma and other psychological issues when provided with proper therapy.

Once the theoretical underpinnings of the prevailing treatment approaches have been discussed, two treatment theories will be examined as well as comparisons of both with regard to strengths, weaknesses and limitations of each in terms of clinical work with these children and their families. A case example will be presented and applied to illustrate the theoretical context for each. Literature and research behind these two treatment theories, as useful to conceptualizing practice with children disadvantaged by RAD will be explored. The goals of this investigation are to seek more clarity in understanding the treatment needs of a preschool age child with RAD, and to discuss specific beneficial clinical practices in this regard.

Chapter II will present the conceptualization and methodology used in this theoretical research project. Chapter III will describe Non-Directive Play Therapy, in history, theory, practice, and current developments. Several case studies indicating the use of non-directive play and similar types of therapies with children with attachment disorders will be investigated for the purpose of defining the specific needs and crucial therapeutic experiences required for treatment success with these children in individual therapy. Chapter IV will investigate Filial Therapy, in history, theory, practice and current developments. The benefits of this therapy for children with attachment disorder and their families is based on the direct interaction of parents and children in the therapy together, as well as the resulting improvements in parent-child relationships that result in strong attachments. Chapter V will discuss the use of Non-Directive Play Therapy and Filial Therapy or both for children with attachment disorder and their families. A deeper consideration of the experience of a child with RAD during Non-Directive Play Therapy, the experiences of dynamic change in parents in Filial Therapy, the appropriateness of each type of therapy for the needs of individual children and families, and a suggested comprehensive plan of assessment and treatment based on these two therapy's theories will be presented.

Chapter II

Conceptualization and Methodology

The research question for this paper was the following: When to use which therapy: understanding theoretical context in determining the best approach for preschool age children with attachment disorder and their families. Given the scope of this paper two theories and their practice as treatments will be chosen for further evaluation. Thus, two related questions will be: How are the theories behind Non-Directive Play Therapy and Filial Therapy useful in conceptualizing the experience of therapy for a child with attachment disorder? And, how could these treatments be used to benefit children with attachment disorders and their families?

The research method for this theoretical thesis was primarily based on a literature review of peer-reviewed articles searched through EBSCO spanning the years from 1964 to 2011. The purpose for this search was to seek any peer-reviewed literature and research available regarding definitions of attachment disorder, issues related to the needs of these populations and the various treatments that have been tried. In addition, a detailed exploration of the original, seminal volumes on Attachment Theory and Non-Directive Play Therapy was completed to explicate theories crucial to the research questions. These works included: John Bowlby's trilogy *Attachment and Loss* (1969-1980) and two works by Virginia Axline: *Play Therapy: The Inner Dynamics of Childhood* (1947, 1969) and *Dibs: In Search of Self* (1964). Further, complete descriptions of diagnostic categories for attachment disorders were taken from both the DSM-IV-TR (APA, 2000), and the ICD-10 (WHO, 2007). These are the sources used by practitioners with the definitions of RAD based on clear empirical data. Also, all peer-reviewed

studies investigating RAD and related treatments have used the definitions from these sources when creating their treatment samples.

Two theories of practice relevant to the treatment of children with RAD will be presented in this paper: Non-Directive Play Therapy and Filial Therapy. Non-Directive Play Therapy (NDPT) has been found to create, within the child client and therapist relationship, conditions similar to those between parents and children who have secure attachments. The theory behind NDPT is that each child has within him/herself the ability to heal old traumas and find a path back to age-appropriate development. Within the complete acceptance of the therapist, the child is entirely in charge of expressing his/her problems and needs through any kind of behavior and play desired. In Filial Therapy, the child's parent is taught to engage in and develop attitudes similar to those in NDPT. The difference is the use of the parent as the therapeutic agent, so that an empathic, attuned and secure attachment can be developed between the parent and the child with RAD, rather than between child and therapist as in individual NDPT treatment.

These two theories were selected for several reasons. First, they are the clear antithesis of the original "attachment therapies." That is, the child-centered, empathic, total acceptance of the child, versus the coercive, restraining, provocative attempt to force change. Second, NDPT has the longest history of use, and the most far-reaching effect on the practice of child therapy. Today, most child therapy is based on some form of play therapy and a supportive relationship with the therapist. Third, Filial Therapy has been found to have empirically tested success for children with many types of psychological disorders. Fourth, both of these therapies have been shown to create conditions needed for a secure attachment relationship, which would indicate their usefulness for attachment disorders. Finally, while newer treatments are now being

developed there is not enough research on any one of these methods to allow for an extensive evaluation of their possible benefits for children with RAD.

Critical points needed to discuss the phenomenon of Reactive Attachment Disorder in preschoolers will include a description of Attachment Theory, an explanation of optimal, sufficient and disordered attachment types, the official definitions of the disorder, and a case study to demonstrate the phenomenon. In addition, a brief history of how children with this constellation of problems were first discovered and described, a review of current disputes with regard to the official RAD diagnoses and a discussion of “attachment therapies” and other newer treatments that are being developed will be included.

The choice of the two theories should not be taken as evidence that they are the two best treatments for Reactive Attachment Disorder. Rather, they were selected because they represent two key theoretical approaches in this area of treatment. This paper is exploratory in regard to the match of Attachment, Non-Directive Play and Filial theories. The scope of this paper only allows for two theories, and requires that each have enough description to be useful in evaluating, interpreting and discussing the phenomenon.

Strengths of this research plan included the opportunity to summarize the current state of thinking about attachment disorders and their treatment. In addition, a synthesis of how two treatment theories could be applied to RAD can be developed. Limitations are related to the moderate scope of the paper and the available literature that is often clinical rather than empirical, or has modest empirical validity due to small sample sizes.

The next chapter will describe the phenomenon of Reactive Attachment Disorder in young children in detail, with sections based on the critical points mentioned earlier.

Chapter III

Phenomenon – Preschool-Aged Children (Ages 3-6) with Attachment Disorders

The purpose of this paper is to seek and discuss treatment theories that may apply to young children with attachment disorders. As a first step towards this investigation, this chapter will provide a foundation for understanding the phenomenon of early childhood attachment, ranging from ideal to disordered. It will begin with an explanation of Attachment Theory on which the understanding of both normative and disordered attachment is based. Next, the mild to moderate difficulties incurred by preschoolers with Insecure attachment patterns will be described, to set the stage for a later comparison with the severe problems of disordered attachment. The original discovery of attachment disorders in populations of institutionalized, severely abused or neglected children and foster children will then provide history for the following section explicating the current diagnoses of Reactive and Disinhibited Attachment Disorders as defined in the DSM-IV-TR (APA, 2000) and ICD-10 (WHO, 2007) manuals. Several researchers have argued that these currently-used definitions may be inaccurate or insufficient. Due to the importance of providing correct diagnoses for optimal treatment some further material regarding these diagnostic issues will be presented. A description of preschool age children with attachment disorders will be given, followed by a case study illustrating a five-year-old child with this disorder. Finally, some types of treatment that have been used to treat attachment difficulties and new treatments that have just begun to be studied will be presented. The chapter will conclude with an introduction to the two types of child therapy that have been selected for

extensive investigation in this paper. This author will argue the potential usefulness of each for preschoolers with attachment difficulties.

Attachment Theory

According to original attachment theory, infants have an adaptive and biological drive to maintain proximity to their caregiver and to resist separations, particularly in the face of threat. The attachment system develops through the ongoing interaction between the child's developing cognitive capacities and their caregivers' responses within the environmental context and is then thought to organize emotion and behaviour throughout life (Bowlby, 1988). (Meredith, 2009, p. 285).

According to Bowlby, there are four major functions of attachment: providing a sense of security; regulation of affect and arousal; promoting the expression of feelings and communication; and serving as a secure base for exploration. In the first case, the attachment system allows the child to signal his/her distress, the caregiver to respond in a soothing manner and the child's distress to decrease. The child is soothed and feels secure and safe. In the second instance, the child experiences distress related to physiological symptoms of arousal and by using an attachment behavior draws the parent to him/her. The parent then provides touch and/or soothing talk, and the child's arousal level is reduced (Bowlby, 1969). If the caregiver is attuned to the child's affect, and thus responds effectively to the child's need for soothing or stimulation this will eventually allow the child to regulate his/her own affects (Allen, 2006).

The third function of attachment is to help the child develop the capacity for expression of feeling and communication. Through synchronous interactions with a well-attuned caregiver,

the child's abilities to communicate needs and feelings are enhanced. When attunement is briefly missed and then repaired, the child learns that periodic disconnections are natural and can be healed and overcome (Davies, 2004). Beyond the first year of life, children utilize the attachment relationship as a secure base for exploration. The child is able to venture into the world to investigate items and interact with new people, increasing chances for cognitive and social development. When needed, the child can return to the caregiver for comfort or safety.

Early research grounded in Attachment Theory. Mary Ainsworth and Mary Main were two early researchers who applied Bowlby's Attachment Theory in an empirical way. Beginning in the mid-1960s, Mary Ainsworth tested the attachment between the child and primary caregiver via an experimental procedure she created called the "Strange Situation." In a room unknown by the child, infants of 12 to 18 months of age and their mothers were tested through a series of departures and returns. The most significant determinant of attachment was the child's response to the mother's return. The child's reactions were considered to result from their attachment history with their caregivers; with the parent's behavior towards the child, and the child's strategies for dealing with it, developing over time (Ainsworth, Blehar, Waters & Wall, 1978).

Attachment Categories. Ainsworth identified three patterns of attachment from her research: secure, insecure-avoidant and insecure-ambivalent/resistant. Securely attached infants showed an expected response of mild upset at the mother's departure, strong attachment-seeking behavior upon her return, and successful comforting and soothing, leading to the child's return to play (Ainsworth, Blehar, Waters & Wall, 1978). Infants classified as insecure were believed to be demonstrating learned behavior patterns through which they coped with anxiety produced by

the mother rejecting the child's attachment-seeking, ignoring the child, or showing poorly-timed or mis-attuned responses to the child's needs.

Infants with insecure-avoidant attachment showed very little attachment-seeking behavior. They ignored their mothers, focused on the toys, showed blank or restricted affect and actively avoided their mothers. These infants showed no response to their mothers' presence, departure or return. This was a defensive behavior toward mothers who ignored or rejected their infants' bids for attention (Ainsworth, Blehar, Waters & Wall, 1978). These mothers' held negative attributions towards their infants' expressions of distress. "Distress is split off from consciousness, and the defense mechanism of isolation of affect emerges" (Davies, 2004, p.14). Rather than be rejected outright, these infants developed an appearance of self-sufficiency that allowed them to at least remain within physical proximity of their caregivers. They had developed the best option for maximizing a felt sense of security, given their mothers' behavior.

Insecure-ambivalent/resistant attachment was characterized by observable anxiety in the infant throughout the Strange Situation procedure. These infants seemed preoccupied with their mothers' location prior to her departure, were very upset when she left and though they sought physical contact upon her return, they also resisted it and were nearly inconsolable. It was found that the behavior of these infants was a reaction to the mothers' pattern of inconsistent and mis-attuned availability to provide for their children's attachment needs. These children were attempting to draw the most possible attention from their mothers, but had no confidence that they would be truly comforted. They had learned that their mothers would not pick them up often enough or hold them long enough for them to feel secure (Ainsworth, Blehar, Waters & Wall, 1978).

A fourth classification was defined by Mary Main and colleagues (Main & Solomon, 1990). These researchers described infants having no clear or consistent pattern of behaviors to cope with attachment anxiety. In the Strange Situation these children exhibited simultaneous, contradictory approach/avoidance behaviors when re-uniting with their mothers. They would approach the mother for comfort and then freeze and “look dazed.” Other researchers have suggested that this “dazed” look may be akin to or a precursor for the dissociative behavior observed in adults with a trauma history (Hesse & Main, 1999). Further contradictory behaviors included walking toward their mother without making eye-contact or backing toward her; going to a stranger for comfort rather than the primary caregiver; or engaging in self-stimulating behavior.

Mary Main and colleagues (Main & Solomon, 1990) classified these children as having insecure-disorganized/disoriented attachment. They found that these children’s attachment behavior was a response to mothers who manifested unpredictable behaviors toward their infants, either due to their own unresolved trauma or abusive behavior. These infants, while in need of soothing and protection, were frightened by their mother’s behavior. Van Ijzendoorn and colleagues have described the attachment experience of Disorganized/Disoriented infants as “fright without solution” (Van Ijzendoorn, Schuengel & Bakermans-Kranenberg, 1999). Mothers, who lived with trauma symptoms as if they were in the present, showed fearful facial expressions that frightened their infants. Infants subjected to abuse by their mothers were also caught in the situation where the source of security is a source of fear. In addition, it has been found that the unpredictable parental behaviors produced by Bipolar Disorder, or drug or alcohol abuse also lead to infants’ likelihood of developing disorganized/disoriented attachments (Davies, 2004).

Internal working models. Bowlby (1973) described “internal working models” (IWMs) as expectations for care developed by children over time in interactions with their primary caregivers. Secure working models are created by the expression of empathy, verbal recognition of the child’s distress, the provision of support and respect for the child’s developing abilities. Based on this experience, securely attached infants come to expect that “...people will respond to me with interest, concern, and empathy. My actions are effective in communicating my needs and maintaining my attachments” (Davies, 2004, p. 22).

Within the formation of children’s working models, several areas of development are affected. Children with secure working models develop a positive sense of self within relationships. Infants who have successfully been soothed by caregivers will come to the conclusion that arousal and affective distress can be resolved, and will develop the ability to self-soothe and self-regulate, as well as being able to draw on social connections to assist with this need. As a result, they have a better ability to cope with stress (Bowlby, 1973).

Those with a history of insecure attachments will have significant difficulties in these areas, due to the defenses they have developed to cope with their caregiver’s poor treatment. They develop disturbances with self-esteem and how they view themselves. Infants who have experienced high levels of arousal and intense affect with no comforting, come to expect that they will continue to be out of control and unable to calm themselves. This view of self leads infants to adopt poor and unsuccessful coping strategies such as affective numbing or hyper-reactivity. Common signs of these issues include aggression and tantrums in toddler and preschool years (Sroufe, 1989).

Specifically, children with disorganized/disoriented attachment have trouble with affect regulation, due to traumatogenic behavior of their caregiver. There is now some evidence to

suggest that trauma impacts brain development in a manner that results in emotional deregulation. According to Schore (2003, p. 113): “early trauma alters the development of the right brain, the hemisphere that is dominant for the unconscious processing of socio-emotional information, the regulation of bodily states, the capacity to cope with emotional stress, and the corporeal and emotional self.”

A History of Insecure Attachment in 3 to 6-Year-Olds

Preschoolers who developed an insecure attachment style during infancy through toddlerhood show several differences from those with secure attachment. Areas most often researched include the following: affect regulation, self-regulation, generalization of attachment, social relationships and sense of self (Davies, 2004; Sroufe, 1989).

Preschool children with insecure attachment have been found to vary from securely attached children in their ability to regulate themselves. They demonstrate an under- or over-control of impulses, lower frustration tolerance and higher levels of anxiety than their securely attached peers. Children with an avoidant attachment style demonstrate more defensive restriction of affect. They have learned that minimizing emotional reactions gives them a better chance of maintaining proximity and thus safety. Children with an ambivalent attachment style will present more negative affect, moodiness and depression. This is a reaction to the stress of uncertainty whether the parent will be available or not when needed (Sroufe, 1989).

Children who have developed secure attachment to a primary caregiver during infancy derive the benefits of attachment generalization when they reach preschool ages. They use an age-appropriate range of attachment seeking-behaviors including crying, fussing, shadowing, monitoring, clinging, smiling, and talking, particularly when feeling ill, anxious or distressed. These preschoolers feel generally safe and cared for, and expect to be able to communicate with

adults and have their needs met. As a result, they will seek out any caregiving adult for help when the primary caregiver is not available (Davies, 2004).

This is not true for insecurely attached preschoolers who expect instead that their needs for help and safety will be ignored, misunderstood, rejected or responded to inconsistently. Typical preschool behaviors that show generalization of insecure attachment patterns include social withdrawal, less comfort-seeking from adults and precocious self-reliance. These children may also act oppositional or provoke negative reactions from adult caregivers to ensure these adults will pay attention to them. Children with an ambivalent attachment style are likely to spend much more time anxiously monitoring the availability of caregivers, to the detriment of developing social skills and relationships with peers. Without the expectation of a reliable safe-base, they do not feel comfortable venturing into the world to experience social interaction (Sroufe, 1989).

Children with insecure attachment also have trouble making friends in preschool. They misperceive other children's neutral behavior as threatening or hurtful, and have difficulty understanding peer's intentions and emotions. Children with avoidant attachment tend to feel or create emotional distance between themselves and peers. Finally, preschool children with a history of insecure attachment suffer in areas related to their sense of self. They may feel incompetent based on a perceived inability to elicit caregiving. They often have a view of themselves as not valuable and not loveable. This view leads to depression and angry, mistrustful behavior towards caregivers. In another pattern, an insecurely attached child who misbehaves in order to guarantee receiving some attention will then be rejected by peers. This rejection can damage their self-esteem (Sroufe, 1989).

Historical Discovery/Delineation of Attachment Disorders

The origin of the classification for RAD can be traced back to observational studies of very young children placed in hospitals in the 1940's and 1950's. Rene Spitz (1949) compared two groups of infants living in two institutions. Most variables of the babies' lives were alike; each was placed in care shortly after birth and each institution provided similar conditions with regard to "adequate" food, cleanliness, housing and medical care. The independent variable, according to Spitz, was "mother-child interaction"; infants placed in the "nursery" were raised by their mothers. In the infant hospital, each nurse was charged with the care of 8-12 babies. Beginning at 3 months old, these infants received no emotional or social interaction. The results were dramatic. As measurement of his observations, Spitz (1949) rated six areas of development: "perception, bodily functions, social relations, memory and imitation, manipulative ability, and intelligence" (p. 147). Nearly all of the hospitalized infants showed first arrest and then decline in all categories (p. 149). By the end of the two-year observation, all the "nursery" children had developed into "normal healthy toddlers" (Spitz, 1949, p.149). However, none of the emotionally deprived infants learned to walk, talk, or feed themselves, and thirty-seven percent died (p.149). Spitz filmed infants for observation (Psychoanalytic Research Project, 1952); behaviors seen most commonly in these infants were staring at strange shapes they made with their fingers, and vigorous self-rocking. Notably, the babies did not cry (expected attachment behavior), they showed no facial expressions whatsoever and their eyes were wide, vacant and unfocused. Spitz reported the babies' conditions as "marasmus" or severe malnutrition, developmental failures, and "hospitalism" based on the environment. Spitz concluded that his study showed the effects on infants of being deprived of their mothers (1949, 1952). However, his studies were based purely on his observations, and his evaluations of those

observations, and thus, lacked empirical measurements. A further problem with this conclusion was that the children were not only removed from their mothers but subjected to total emotional and social neglect. Importantly though, he was the first to demonstrate that food, hygiene and medical care are not enough for infants' healthy development; in fact, he showed that infants' needs for social and emotional contact can sometimes mean the difference between life and death.

The next generation of studies on institutional care and resulting problematic issues was undertaken in London nurseries in the 1970s'. Research carried out by Tizard and Rees (1975) and Tizard and Hodges (1978) was fairly rigorous; they measured children's behaviors and caregivers' reports with rating scales that had high levels of inter-rater reliability, and they used well-selected control groups. The data collected in these studies showed patterns of behaviors that were fairly consistent when tested at both 2 and 4 ½ years of age. The researchers compared four groups of children: those placed in nurseries and large group homes who remained there at the time of study, a group of children previously raised in those institutions but had since been adopted, institutionalized children who had returned to their parents, and children raised by their own working class parents since birth. Results indicated groups of behaviors related to emotional neglect, which could be made sense of based on attachment theory. In particular, the children always institutionalized and institutionalized but returned to their parents showed significantly higher ratings in attention-seeking, crying, following and clinging (normative attachment behaviors). More significant, high measures of overt friendliness towards multiple caregivers and strangers, and shallow relationships with even "favorite" caregivers were also found (Tizard & Rees, 1975). These types of behaviors eventually came to be associated with the diagnoses of attachment disorders (Smyke, Dumitrescu & Zeanah, 2002).

Research literature with regard to disordered attachment in the general public is practically non-existent (Boekamp, 2008; Heller et al, 2006). Individual cases of RAD are not numerous enough in the general population to make up a significant sample population, and defining a useful control group is difficult. However, case studies show that some children maltreated by their parents and/or subjected to multiple foster placements develop disordered attachment symptoms very similar to those found in the institutional research (Boekamp, 2008; Heller et al, 2006).

Diagnoses of Disordered Attachment

Both the APA's DSM-IV-TR (2000) and the World Health Organization's ICD-10 (2007) have listings for attachment disorders. Unlike insecure or disorganized attachment which may have mild to moderate effects on a child's functioning, only the most serious levels of attachment problems will meet the criteria for attachment disorders. The next section will describe the official attachment disorders and criteria from these two sources. Similarities and differences between the types of disorders and criteria will be presented.

Reactive Attachment Disorder per DSM-IV-TR. Reactive Attachment Disorder (RAD) as described in the DSM-IV-TR (APA, 2000) is a disturbance of developmentally appropriate social relatedness occurring before the age of 5 and resulting from "pathogenic care." In DSM, pathogenic care refers to one or more of the following: emotional neglect that fails to provide needed comfort, stimulation and affection; physical neglect (not providing for physical/medical needs); physical abuse; or frequent changes of primary caregiver that prevent stable attachment (p. 130).

The DSM-IV-TR differentiates between two types of RAD: Inhibited and Disinhibited. Children with RAD, Inhibited type, do not initiate or respond in a socially developmentally

appropriate manner. They are excessively inhibited and hypervigilant. Such children exhibit ambivalent social behavior towards caregivers; they may respond with a mix of approach and avoidance behaviors, and display “frozen watchfulness” (DSM-IV-TR, APA, 2000) similar to the dazed or dissociative appearance of the children with disorganized/disoriented attachment described by Mary Main (Main & Solomon, 1990). Lenore Terr (and Rene Spitz) has described these as “withdrawn” children (Terr, 1990, p.85). Most significantly in term of attachment relationships, children with inhibited type RAD prevent themselves from seeking comfort and will resist it when offered, even when they feel threatened or distressed (Boekamp, 2008).

Children with RAD, Disinhibited type are characterized by indiscriminant sociability and non-selective attachment (DSM-IV-TR, APA, 2000). Terr (1990) describes similar children as “hail fellow well met” (p.85-86, 269). These children are friendly and sociable, but have adapted to a life where attachment to a single, consistent caregiver was impossible by denying this need. As a result they present as likable and express outward affection, without specifically attaching to anyone. Each new person who may be able to provide something the child wants, will temporarily be her focus of positive attention, only to be cast aside should that person decline her wishes. The child then easily moves on to the next potential provider.

Terr’s (1990) experience of a little girl in a hospital demonstrated the shallowness with which the child attached, and child’s constant interest in her own immediate needs and wishes. When visiting her the first week, the child was very responsive and affectionate. However, a week later, the child had forgotten her name. Boekamp (2008, p. 6) described disinhibited RAD behaviors as: “a pervasive pattern of inappropriate interactions with unfamiliar adults, including indiscriminant approach, lack of wariness, seeking out physical contact, and, in some cases, comfort in leaving with them.”

Attachment Disorders in ICD-10. ICD-10 lists two separate attachment disorders: Reactive Attachment Disorder of Childhood and Disinhibited Attachment Disorder of Childhood (WHO, 2007). Behavioral symptoms for these ICD-10 diagnoses are similar to those of the DSM-IV-TR RAD, with Inhibited Type appearing most related to ICD-10's Reactive Attachment Disorder and the Disinhibited Type mostly akin to ICD-10's Disinhibited Attachment Disorder. However, ICD-10 clearly delineates the origins of each separate disorder as related to the child's early history and projects a different prognosis for recovery. The ICD-10 also describes each population in more detail, and includes additional syndromes that relate only to the disinhibited group. The DSM-IV-TR appears to take children with RAD as a single population, does not connect behavioral type with history or prognosis, and excludes these other syndromes.

Like DSM-IV-TR's RAD Inhibited type, the ICD-10 definition of Reactive Attachment Disorder describes an abnormality in social relationships, and lists similar symptoms of fearfulness, hypervigilance and "frozen watchfulness;" lack of responsiveness to comforting; and poor social interaction with peers. To this ICD-10 adds: "misery;" aggression towards self and others; and sometimes "growth failure" (WHO, 2007). The ICD-10 also states that this disorder reacts to changes in quality or availability of consistent, healthy attachments (WHO, 2007). That is, children who fit the criteria for ICD-10's Reactive Attachment Disorder have a chance for considerable recovery of symptoms leading to more developmentally-appropriate social functioning, if placed in an environment that provides emotionally-sensitive and attentive care and the opportunity to make a secure attachment to one consistent caregiver. The DSM-IV-TR diagnosis for both types of RAD states: "Considerable improvement or remission may occur if an appropriately supportive environment is provided" (APA, 2000, p. 129).

The ICD-10 symptomology for Disinhibited Attachment Disorder matches with DSM-IV-TR's RAD Disinhibited Type in terms of an abnormal pattern of diffuse, non-selective attachment behavior and indiscriminate sociability. However ICD-10 gives a more detailed picture of children clinging to potential attachment figures at the age of 2, developing attention-seeking, indiscriminately friendly behavior at the age of 4, having poorly modulated peer interactions, and the possibility of related emotional or behavioral problems. ICD-10 also includes "affectionless psychopathy" and "institutional syndrome" within this category and states that symptoms of Disinhibited Attachment tend to persist, despite significant improvements in availability of attachment figures (WHO, 1992).

DSM-IV-TR gives a definition of "affectionless psychopath" as children raised in institutions, showing antisocial and aggressive behavior and an inability to form lasting relationships with adults. DSM also states that disinhibited children may continue to show indiscriminate sociability even after developing selective attachments (APA, 2000, p. 129). This would seem to overlap with ICD-10's connection between a history of institutionalization, behavioral and emotional problems, and poor prognosis for disinhibited attachment. However, DSM-IV-TR again taking both types of RAD as one group, states: "No direct link between Reactive Attachment Disorder and 'affectionless psychopathy' has been established" and does not mention an institutional syndrome (APA, 2000, p. 130).

DSM-IV-TR's description of causation for RAD has been described above. While ICD-10 includes all of the same early childhood experiences as origins of disordered attachment, it divides them between the two separate disorders. Reactive Attachment is specified as "the result of severe parental neglect, abuse or serious mishandling." The cause of disinhibited attachment is described as being raised in an institution since infancy or experiencing the "persistent failure

of opportunity to develop selective attachments as a consequence of extremely frequent changes in caregivers” such as when a child has had multiple foster placements (WHO, 1992).

Diagnostic Issues

The validity of the definitions of Reactive Attachment Disorder in DSM-IV-TR and ICD-10 has been demonstrated empirically (O’Connor & Zeanah, 2003). However, the literature indicates that the process of diagnosis contains many complications (Muladdes, Bilge, Alyanak & Kora, 2000; Sheperis et al., 2003; Zilberstein, 2006). A considerable amount of research published after the release of DSM-IV-TR presents diagnostic issues worthy of consideration (Minnis, Marwick, Arthur, J. & McLaughlin, A., 2006; Smyke, Dumitrescu, & Zeanah, 2002). Two categories of diagnostic issues commonly discussed in the current literature will be reviewed in this section. They are: 1. the frequent comorbidity between the diagnosis of RAD and other psychiatric illnesses and co-occurring mental and behavioral problems related to institutionalization or severe deprivation in infancy and early childhood; and, 2. the prevalence of mixed type cases showing symptoms of both Inhibited and Disinhibited Types of RAD, especially symptoms of indiscriminant social behavior.

Comorbid diagnoses and other co-occurring problems. As described in the previous section, the DSM-IV-TR and ICD-10 link a history of abusive/neglectful caregiving or lack of availability of attachment figures with current observable behaviors in their definitions of attachment disorders. Several authors have commented on the difficulty of using the RAD diagnosis correctly, due to overlapping symptoms with other diagnoses (Muladdes, Bilge, Alyanak & Kora, 2000; Sheperis et al., 2003). For example, disinhibited behavior (ie. walking off and not checking back with caregivers) can be confused with the attentional/hyperactive problems present in Attention Deficit Hyperactivity Disorder; lack of ability to interact with and

respond to caregivers can be misconstrued as intentional disobedience, leading to diagnoses of Oppositional Defiant Disorder or even Conduct Disorder; and children with the withdrawn pattern such that they avoid or ignore caregivers may be accidentally diagnosed with a Pervasive Developmental Disorder (Sheperis et al., 2003).

Another issue in terms of comorbidity is the need to separate symptoms of disturbed attachment from other problematic behaviors, when both may appear in response to a history of extremely neglectful environments. In their studies of children in a large, underfunded, understaffed orphanage in Romania, Zeanah, Smyke and Dumitrescu (2002; a further description of this study appears in the next section) showed clear empirical evidence that aggression, while common in these institutionalized children, was not significantly related to attachment disturbances. Stereotypies and language delays were also found in a majority of these children who spent the majority of their time in large rooms of 30-35 children with 1 or 2 caregivers (Smyke, Dumitrescu, & Zeanah, 2002). However, this research presented empirical evidence that these problems were related to the extreme neglect present in these settings, and not their assessments of disordered attachment based on current behaviors. Helen Minnis, while working as a doctor in a Guatemalan orphanage in 1991/2, observed a similar pattern. The majority of the children showed socially indiscriminant and disinhibited behaviors, and a small minority was also aggressive (Minnis, Marwick, Arthur & McLaughlin, 2006). Thus, children reared in extreme institutional environments may present with symptoms related to ODD or Conduct Disorder (aggression) or PDD (stereotypies, language delays) in addition to signs of disordered attachment.

In conclusion, children with Reactive Attachment Disorder via the construct validity of DSM-IV-TR /ICD-10 may also have symptoms that fit the classifications for other disorders, or

behavior patterns linked specifically with an extreme caregiving environment. Research to date has proven behaviors such as aggression, stereotypies and language delays to be “distinct yet comorbid” with attachment disturbances (Minnis, Marwick, Arthur, J. & McLaughlin, A., 2006, p. 337). Sheperis et al. (2003) state some key factors in differentiating attachment disorders from these other diagnoses, including: noting cognitive levels compared to other developmental disorders; focusing on behavioral symptoms that are not the same as in oppositional or conduct disorders; and relating maltreatment or lack of caregiving opportunity history to current behaviors. Minde (2003) has also warned that clinicians may expect children with histories of pathogenic caregiving to have “...attachment problems as a mediating variable for oppositional or other externalizing symptoms when in reality they are comorbid symptoms of a neglectful upbringing” (p. 292). Clearly, assessment of these children requires a solid understanding of potentially comorbid diagnoses, and close attention to clearly differentiate valid symptoms of attachment disorders from other problems that occur in depriving institutions (Zilberstein, 2006).

Mixed types and pervasive indiscriminant sociability. Empirically-sound research has demonstrated that most children with RAD appear to have symptoms of both Inhibited and Disinhibited types. Researchers such as Zeanah et al. (2004) and Smyke, Dumitrescu, and Zeanah (2002) have stated that these children often have mixed types of RAD. Two types of populations have been studied: children maltreated in their homes and removed to foster care, and institutionalized children. Zeanah et al. (2004) reported a 40% rate of toddlers entering foster care for whom RAD was an appropriate diagnosis, with a clinically significant number of these children showing a pattern of both types of RAD. Likewise Zeanah and Smyke (2008) found 35% of children entering foster care showed significant enough levels of disordered attachment behaviors to qualify for RAD diagnosis.

The majority of research on attachment disturbances has been based on populations raised within Romanian orphanages during the 1990's. Under the Romanian Ceausescu regime, abortion was prohibited by law and poverty was rampant. As a result of this policy, thousands of children were placed in large, underfunded, understaffed orphanages. When Ceausescu was removed from government, researchers discovered these children, and found that they experienced severe physical and social/emotional deprivation (Smyke, Dumitrescu, & Zeanah, 2002). Conditions for rigorous empirical research were met with large available sample sizes and a population in which all children were placed in the institution prior to six months of age and none were adopted before or during the initial studies (Rutter & ERA Study Team, 1998; Smyke et al. 2002; Zeanah, Smyke, & Dumitrescu, 2002).

The primary symptoms of RAD found in institutionalized children are indiscriminant or disinhibited sociability, as described in DSM-IV-TR: not checking with primary caregivers before wandering away, seeking social connection with any available caregiver, and being willing to leave with a stranger (APA, 2000, p. 130). This has been demonstrated in adoption studies (Rutter & ERA Study Team, 1998; Zeanah & Smyke, 2008) and studies comparing standard care to a pilot program within the orphanage (Smyke, et al., 2002; Zeanah et al. 2002). Conversely, a pattern of behaviors signifying cases of purely inhibited attachment were not found in either adoptive (Zeanah & Smyke, 2008) or within institution (Smyke et al., 2002) studies. The majority of children in severely neglectful orphanages appear to show a primarily disinhibited attachment disorder, with some inhibited behaviors part of the clinical picture in a smaller number of children (Smyke et al., 2002).

In one oft-cited study, Smyke, Dumitrescu, and Zeanah (2002) compared three samples of children: two within a Romanian orphanage and one never-institutionalized group. The

researchers described the standard care setting as groups of 30 – 35 children spending many hours of the day in a large playroom or outside playground. There were a total of 20 caregivers that worked rotating schedules; the ratio during any one shift was 2 or 3 caregivers to 30 – 35 children. Children were placed in these large groups as toddlers. Very young children who could not yet walk were kept in glassed-in enclosures 24 hours a day in groups of 5 or 6. This standard group was compared to children in the institution’s pilot unit, which attempted to improve attachment conditions for children. Although the caregivers were still in rotating shifts, a total of 4 caregivers were consistently assigned to each specific group of children, with ratio 1:10 or 1:12 on each shift. These children spent all their time in the same group of 10-12 other children, and each of these smaller groups had their own room. The never-institutionalized sample consisted of children who had always been at home with their parents, those who were in day care, and those who were in “weekly nursery” in which they remained in care from Monday morning through Friday afternoon and spent the weekend with their parents. All of these never-institutionalized groups did not show differences in any of the study variables, so they were combined into one group.

This study (Smyke et al., 2002) showed what the writers called a “continuum of caretaking casualty;” that is, children in the standard group always had the most severe attachment symptoms, the pilot unit children showed moderate symptoms and the never institutionalized scored very low on ratings of attachment disturbance (p. 976). These differences were empirically significant.

Smyke, et al. (2002) also found empirical evidence for three variations that could be described as a mixed type of RAD. They described clusters of behavior shown by each child that proved to be internally valid. These are of particular interest because they contain significant

symptoms of disordered attachment, but are not organized by the definition of inhibited and disinhibited types. The clusters described were as follows: cluster 1: no disturbed attachment behaviors present; cluster 2: “unattached, inhibited/withdrawn,” somewhat socially responsive, some ability to regulate own emotions, and moderately high levels of indiscriminant behaviors; cluster 3: “attached, highly indiscriminant” based on having a preferred caregiver, but not seeking comfort when distressed, and showing high levels of indiscriminant behavior; and cluster 4: “unattached, inhibited, withdrawn and indiscriminant,” having no identified attachment figure, moderately high levels of both inhibited/withdrawn symptoms and indiscriminant behavior, with no social responsiveness or ability to regulate emotions present. Further, the clusters were significantly related to their “continuum of caretaking casualty” with standard group showing the highest number of children in the most disturbed behavior cluster, the non-institutionalized group showing no symptoms of attachment disorder (100% of them were in cluster 1) and the children in the pilot unit falling primarily in the less severe but diagnosis significant clusters.

In conclusion, mixed symptoms from both inhibited and disinhibited types currently differentiated in DSM-IV-TR RAD diagnoses have been found in institutionalized populations of children, with indiscriminant sociability particularly prevalent. These studies have repeatedly found very few if any cases of true DSM-described inhibited attachment type, without indiscriminant behaviors. However, institutionalized children are just one subset of cases of RAD, and the predominance of mixed types, prevalent indiscriminant sociability and non-existence of children with purely withdrawn/inhibited type RAD, may not apply to non-institutionalized children with RAD (Hardy, 2007; Smyke et al., 2002). Research on children living at home and developing RAD in response to pathogenic caregiving is rare because RAD

appears infrequently in the general population (outside institutions) (Boekamp, 2008), and thus it is typically not feasible to find sample sizes sufficient for empirical measurement. Instead, literature describing these children is typically in the form of case studies, and they are rarely written in peer-reviewed journals (Heller et al., 2006).

Case Studies of Child Maltreatment and Disordered Attachment

Two peer reviewed case studies have been published that describe young children subjected to physical and emotional neglect and domestic violence in their homes, removed from their parents, and diagnosed with Reactive Attachment Disorder (Boekamp, 2008; Heller, et al., 2006). John Boekamp (2008) describes Joseph who was removed from his parents and placed in a group home at the age of three (Boekamp, 2008). There he showed a mixed pattern of symptoms for RAD Inhibited type (DSM-IV-TR), as well as some additional ones listed under ICD-10's Disinhibited Attachment Disorder. In his study, Boekamp (2008) states that Joseph "appeared minimally interested" in social interactions and "uninterested or non-compliant with basic daily routines or familiar activities" (p.1). It seems possible that this "lack of interest" may in fact be an indication of inhibited behavior showing social-emotional withdrawal as described as Inhibited Type RAD. In addition, Boekamp (2008) observed that whenever this child entered a room, he approached each adult briefly, with his back turned and minimal eye-contact (Boekamp, 2008, p. 1). This reaction towards caregivers demonstrates the contradictory approach/avoidant behavior pattern also seen in RAD Inhibited Type. Joseph also showed symptoms attributed to ICD-10's Disinhibited Attachment Disorder: aggression towards others (hitting and kicking) and towards himself (banging his head, pulling his hair) when frustrated (Boekamp, 2008, p. 1). When Joseph was finally removed to a foster family at the age of four, some of his symptoms subsided, particularly those related to Inhibited Type: after a month there

he initiated social contact with other children and adults, and carried on reciprocal interactions at an age-appropriate level (Boekamp, 2008, p. 6). Even more importantly, he began to seek comfort from a nearby adult when he was distressed. These improvements are in line with the expectations of both DSM-IV-TR's RAD (APA, 2000) and ICD-10's RAD (WHO, 1992). Both state that when children with RAD inhibited social behaviors are moved to a setting where they can find an available caregiver, they may become more sociable and come to trust that an adult will provide comfort when needed. Boekamp (2008) does not mention whether Joseph's aggressive behaviors were improved. He does point out that this child continued to seek contact and comfort from any adult, thus showing a persistent indiscriminant pattern symptomatic of the disinhibited type of RAD (Boekamp, 2008, p. 6).

Heller et al. (2006) presented a case-study of Claire and Bobby, 18 month old fraternal twins removed from their parents' home due to severe neglect. The apartment where the family lived was overcrowded, filled with garbage and feces, and the parents were not watching the children well enough for safety. After being placed in foster care, the children were moved 11 times by the age of 27 months (Heller et al., 2006). During that time Claire and Bobby had parental visitation on and off, and spent time in kinship care, foster care, home, day care and in a respite nursery. In addition, during one of their stays in a foster home they were found to have burns on their hands. Finally, at the age of 30 months they were adopted by an aunt and uncle and remained with them at follow ups of 3 and 8 years of age (Heller et al., 2006). Clearly, in terms of etiology these children had both "pathogenic caregiving" and so many placements that there was no opportunity to develop attachment to a caregiver.

This case study tested Claire and Bobby at 18 months, 3 years and 8 years of age (Heller et al., 2006). Data was gathered from team observations of the twins both at home and in a

clinic, and through a combination of structured and unstructured interviews, with both foster and biological parents. At 18 months the twins showed symptoms of developmental delay, disorganized attachment towards their biological parents, and attachment disorders. They displayed flat affect and blank facial expressions and neither child attempted to communicate with anyone or vocalize at all; the researcher's felt these were signs of developmental delay (Heller et al., 2006). Both children showed disorganized attachment via "exhibited heightened distress and...approach mixed with avoidance" in response to their parents' arrival (Heller et al., 2006, p. 68). Claire showed additional features of fearful facial expressions, stereotypies and "prolonged freezing." During periods of freezing, she was not responsive to sight, sound or touch. Signs of attachment disorder were that neither twin preferred either the biological or foster parents, Claire was described as "socially withdrawn" and Bobby as socially indiscriminant (Heller et al., 2006, p. 68). The example given is that Bobby immediately approached the researchers to be held, and cried inconsolably when they left, despite never having seen them before.

In parent interviews, it was learned that the twins' mother had witnessed severe violence in her own family, appeared to dissociate during the part of the interview when this was discussed, and denied that it had any effect on her life (Heller et al., 2006, p. 69). The twins' father had been abandoned by his mother at age 2, abused by his stepmother, and treated in a cold, critical manner by his father. He had diagnosed depression and developmental learning disorder, and appeared anxious around both the clinicians and his own children. Both parents believed that their children were too young to be effected by hearing their fights with each other, and that they could be left alone to play in the playpen all day. Neither parent could describe anything special about either of the twins, indicating relationships emotionally distant from their

children (Heller et al., 2006). In parent/children observations, their mother rarely spoke to them, and father attempted to engage but was too “rigid and repetitive” to succeed. Claire was self-directed, focused on the toys, avoided eye-contact and ignored her parents’ attempts to interact with her. Bobby showed a pattern of expressionlessness and irritation, approach and avoidance. Mother’s response to this was to cradle him like an infant or tickle him. Bobby’s response to his father’s verbal style was to stare into space. Neither of the twins sought help when frustrated, or comfort when distressed.

Claire and Bobby were permanently adopted by a great-uncle and great-aunt at age 30 months, and a follow up observation was done at 36 months (Heller et al., 2006). At this time, the children seemed to have developed an attachment to the great-aunt, seeking comfort specifically from her when distressed; this shows resolution of two symptoms of disordered attachment: showing a preference for one caregiver, and seeking comfort when distressed. The writers (Heller et al., 2006) indicate that some aggression had begun to be present before the adoption, and had stopped by this follow up. Another significant improvement was that Claire’s freezing behaviors, and both twins’ approach/avoidance behaviors had stopped altogether. However, some new concerning behaviors had begun: Claire was alternatively punishing or comforting in her behavior towards the great-aunt, and Bobby had begun to engage in physically dangerous behavior (ie. jumping from a high structure in the playground) and then laughing. Heller et al. (2006) suggest that Claire is expecting her new attachment figure (great-aunt) to have the same fearful or hurtful behavior, and the same inability to provide care, as her biological mother did. Thus Claire’s reaction is to punish her great-aunt for the hurt and fear she experienced with her mother, and to simultaneously seek to take the parental role away from her out of mistrust that the great-aunt can manage it (p. 72). As for Bobby’s self-endangering

behavior, Heller et al. (2006) state that while this symptom has not been empirically proven or written about in peer-reviewed literature, it has been mentioned in clinical writings. The purported symptoms of RAD described in non-scientific literature will be presented later in this chapter.

These two case studies seem to illustrate the expectations within ICD-10's definitions of attachment disorders assigning etiologies to each set of symptoms. ICD-10 specifies that Reactive Attachment Disorder (with very similar symptoms to DSM-IV-TR's inhibited type), follows experiences of maltreatment in the child's home, while Disinhibited Attachment Disorder (like DSM-IV-TR's RAD disinhibited type) is the result of the lack of availability of a consistent caregiver, as occurs in institutionalization or multiple placement changes like in the foster care system (WHO, 2007). In each study, the children experienced abuse/neglect at home, and either institutionalization (Joseph in the group home) or multiple foster care placements (Claire and Bobby: 11 moves between foster and kinship care). With both indices of RAD etiologies present, the resulting mixed picture of symptoms is the logical outcome. It is also important to note some similar effects of being placed with a consistent caregiver were found; increased social interaction, reduced aggression, reduced withdrawal, and most importantly, seeking comfort in times of distress.

The fact that no pure cases of RAD, inhibited-type have been presented in peer-reviewed literature may be due to the very minimal study of RAD outside of institutions (Boekamp, 2008; Minde, 2003; O'Connor & Zeanah, 2003). In order to illustrate a case of inhibited-type RAD in a preschool age child experiencing pathogenic caregiving at home, a full case of this type will be presented here.

Case Example of Inhibited Attachment Disorder in a Five-Year-Old Child

In her novel *Dibs, In Search of Self* (1964), Virginia M. Axline describes her treatment and research on the case of a five-year-old child who she gives the pseudonym of Dibs. Throughout this paper, the case of Dibs will be used to exemplify a child with Reactive Attachment Disorder. Dibs' constellation of symptoms and their origin in pathogenic care will be detailed below. Dibs' successful treatment in Non-Directive Play Therapy with Axline will be included in chapter IV. This author's consideration of how Filial Therapy may have assisted Dibs and his family will be included in chapter V.

Although at the time of the book's writing in 1964, the author did not identify Dibs' emotional disturbance as Reactive Attachment Disorder (The disorder was not formalized in the DSM until 1980, O'Connor & Zeanah, 2003; or in the ICD until 1990, WHO, 1975, 1990) her description of Dibs' behavioral symptoms show a clear case of the DSM-IV-TR RAD, Inhibited type. In addition, enough information can be extracted about Dibs' treatment by and relationships with his parents to safely infer the causal "pathogenic care" as defined in the DSM-IV-TR. Specifically, his parental relationships qualify under the category: "C. (1) persistent disregard of the child's basic emotional needs for comfort and affection" (APA, 2000, p.130).

Behavioral symptoms of RAD, Inhibited type. At age five, Dibs demonstrated a behavior pattern consistent with Reactive Attachment Disorder. One example was his daily resistance to leaving school to go home. At the first announcement he would hide in a corner, "crouched there, head down, arms folded tightly across his chest" (Axline, 1964, p. 1). When the teacher calmly approached and tried to gently coax Dibs to put on his coat he became physically and verbally violent; trying to punch, scratch or bite the teacher, and screaming "No go home!" (p. 1). When the teacher acknowledged that he did not want to go home, but stated that he had

to, Dibs' appearance changed completely. He went limp, stopped fighting, let the teacher put on his coat, and left with a blank look on his face. If Dibs was still crying, fighting and screaming when the car arrived, his mother would send in the chauffer to remove Dibs from the classroom. At these times the same behavior pattern was seen clearly, as Dibs either continued to scream and punch the driver or went limp and silent in the man's arms. This behavior showed Dibs' working models of disordered attachment. His five-year-old tantrums showed refusal to approach the caregiver, his source of fear and distress. When forced to approach, his shift to limp and silent, like the "frozen watchfulness" found in children with RAD, inhibited type, signified disassociation, the only available way to avoid that distressful experience of returning to a caregiver who aroused fear and emotional pain, rather than soothing and a sense of safety.

Dibs' RAD symptomatic behavior in the classroom included: avoidance of others, lack of social interaction, hypervigilance, frozen watchfulness and resistance to comfort. He would move away from the teachers by climbing off his chair and crawling around the periphery of the room, sitting underneath tables or behind the piano. He also maintained his attention to books and toys for the most part, and did not speak. He was excessively alert to the movements of others and moved away quickly if they came near him. He would sit or lie in one position, frozen and dazed-looking for long periods of time. He responded to any kind overtures from teachers with an all-out tantrum, throwing himself on the floor, kicking and screaming until everyone went away. All of these behaviors served the purpose of disengaging his attachment; preventing him from seeking or showing any signs of his emotional needs. Further, it allowed him to feel safe, by preventing a fearful interaction from occurring.

However, Dibs also made attempts to gain limited proximity to teachers (potential caregivers). He would sit under a table, but the nearest one to the story-circle or take his nap

near the nap area, albeit hidden behind the piano. If a teacher read a book or showed an object and explained about it, but without seeking interaction, he would sometimes look on, or sit with his back to her, but appear to listen intently. Thus, Dibs demonstrated internal working models indicating he was used to proximity with a caregiver at home, but needed to hide any need of attachment in order to feel safe.

Dibs showed a younger child's focus on the need for protection and caregiving, as he seemed quite fearful and helpless when his mother brought him to school. However, like in RAD, he would prevent himself from seeking comfort, even in this state of distress. "Left just inside the door, Dibs would stand there, whimpering, waiting until someone came to him and led him into the classroom" (Axline, 1964, p. 2). Unlike the other 5-year-olds who took off their own coats and moved into some activity, Dibs would wait for a teacher to take off his coat, before going to hide under a table.

In addition to these attachment-related behaviors, Dibs showed other symptoms of Reactive Attachment Disorder as described in the ICD-10. These included poor peer interactions and aggression; when he was unable to avoid his classmates, he reacted to their approaches by trying to hit, scratch or bite them. His inhibited behavior pattern that provided him some protection at home, led him to try to scare everyone away at school.

A history of pathogenic caregiving. Because Dibs' parents initially refused to come in for any interviews, the therapist was left to surmise their caregiving relationships with Dibs from his acting out parental themes in play therapy. However, when his mother did eventually request to speak to the therapist, her guilt and fear about Dibs caused her to give the therapist a considerable idea of Dibs' early care. While no physical or sexual abuse was reported, the therapist stated that the verbal, psychological and emotional behavior of the parents towards Dibs

could certainly be harmful enough to cause severe emotional/psychological disturbance. Dibs' symptoms of Reactive Attachment Disorder very likely resulted from pathogenic care.

Dibs' mother described to Axline (Dibs' therapist and author of the book) her attitudes toward and relationship with Dibs. She confessed that she felt he had ruined their lives. She had been a surgeon with a promising career and felt that becoming pregnant had ended her opportunities. She stated that her husband had always blamed her for becoming pregnant, after which he became silent, hostile, and often spent time alone in his study. This mother's attitudes towards Dibs were very negative even from birth. She told Axline:

“And when he was born he was so different. So big and ugly. Such a big, shapeless chunk of a thing! Not responsive at all. In fact, he rejected me from the moment he was born. He would stiffen and cry every time I picked him up!” (Axline, 1964, p. 64)

She then went on to explain that both she and her husband were from very intelligent, accomplished families and they were ashamed of Dibs, because they felt he was “So peculiar. So remote. So untouchable. Not talking. Not playing. Slow to walk. Striking out at people like a little wild animal” (Axline, 1964, p. 65). Dibs parents decided that he must be “mentally defective” in some way and began taking him to neurologists and specialists. None of these doctors could find anything medically or cognitively wrong with Dibs. Then a psychiatrist told them that Dibs “...was not mentally defective or psychotic or brain-damaged, but the most rejected and emotionally deprived child he had ever seen” and told the parents they needed therapy (Axline, 1964, p. 66). Dibs' mother and father were so offended that they hid Dibs away, often locking him in his playroom.

Dibs' mother then describes her relationship with him as purely based on her shame of him as mentally deficient. She was obsessed with her need to prove that she was not a failure as a mother, by demonstrating that she could "fix" Dibs. For example, she explained that she taught him to read before age three by showing him letters and insisting he put them in order, then leaving the playroom until he did so. However, there was no affection or social connection between the two of them. She stated:

"I had been teaching him and testing him and trying to force him to behave in a normal fashion ever since he was two years old – all of it without any real contact between the two of us. Always going through *things.*" (emphasis in original; Axline, 1964, p. 136)

Dibs' mother was so worried about her son's intellectual competence, that the child's needs for social interaction, empathy and comfort were ignored. This utter rejection of Dibs' as a human being in his own right would have caused pain and distress. Leaving him alone, locked in his room, would have led to his feeling abandoned and unsafe. None of the conditions for attachment were met, except the temporary proximity he gained when she stayed with him to teach him things. Despite there not yet being an officially defined Reactive Attachment Disorder, the author shows an understanding of Dibs' care as pathogenic due to lack of emotional attachment when she states:

When a child is forced to prove himself as capable, results are often disastrous. A child needs love, acceptance, and understanding. He is devastated when confronted with rejection, doubts and never-ending testing... The pressure he had endured was enough to drive any child into a

protective withdrawal... This kind of exploitation of the child's ability, to the exclusion of a balanced emotional life, could destroy him. (Axline, 1964, p. 138)

One can understand Dibs' behaviors better in light of this parental relationship. His withholding speech, averting his gaze, avoiding physical contact with his parents, and focusing on things rather than people and intellectual abilities over feelings, can now be seen as a series of adaptive techniques. He could maintain proximity for some tiny sense of security, throw temper tantrums to protest his rejection, or whimper to seek the slightest assistance, but these were the closest he could come to signaling emotional needs or asking for help.

This ability to shut down attachment-seeking behavior is adaptive for children whose parents reject them, or who are unable to provide for their emotional attachment needs. It minimizes the child's pain and fear of seeking love and comfort, and receiving none, while concurrently maximizing proximity needed to have some little sense of a chance of protection. Unfortunately, when Dibs' behavior that was adaptive at home pervaded his working models of attachment, his opportunities for social interaction and exploration at school were severely limited. Indeed, he was left feeling isolated, fearful, insecure, and unable to engage with other children, to seek help from caregivers or to even feel he deserved to have his own thoughts and emotions. This is the picture of a preschool age child with Inhibited Reactive Attachment Disorder.

Treatment for Disorders of Attachment

Some literature has reflected a common belief within the clinical community that there is no successful treatment for Reactive Attachment Disorder, because traditional types of child

therapy do not work with this population (Boekamp, 2008; Chaffin et al., 2006; O'Connor and Zeanah, 2003). The following section will briefly describe treatments developed for use with children with attachment disorder. Of note, according to Zilberstein (2006), all current treatments for RAD claim to be based upon Attachment Theory, but interpretations vary widely, leading to very different techniques. In this section, peer-reviewed, empirically tested research will be provided wherever possible.

“Attachment therapies.” In her extensive review of the literature on diagnosis and treatment of attachment disorders, Zilberstein (2006) states that the “Attachment Therapy Movement” conceptualizes attachment disorders differently than DSM/ICD or studies on institutionalized children. She explains that “holding therapists” and other “attachment therapists” cite Bowlby’s (1979) Attachment Theory and Ainsworth’s research results (from the original Strange Situation research described earlier in this paper) that secure attachment is the optimal state for development. She further indicates that holding therapists “...extrapolate blanket consequences that do not appear elsewhere in the literature” (Zilberstein, 2006, p. 59). Zilberstein’s review (2006) found that holding therapists believe that children who do not have the opportunity for secure attachment are left without a conscience and identify themselves as bad and hopeless, and that this leads to a very long list of “attachment problems.” Having investigated several websites that post these lists of behaviors, she concludes that “holding therapy”’s description of attachment disorder includes many symptoms found in the DSM belonging to other disorders including Posttraumatic Stress Disorder, Oppositional Defiant Disorder, Attention-Deficit/Hyperactivity Disorder and mood disorders (Zilberstein, 2006, p. 59). Zilberstein (2006) remarks that “holding” therapists seem specifically focused on aggression and noncompliance in their clients. John Boekamp (2006), and Heller et al. (2008)

have also reported that “attachment therapies” endorse an extensive list of “attachment symptoms” that encompass other disorders, and pay special attention to oppositional, aggressive, coercive and dishonest behaviors.

In “attachment therapy” or “holding therapy” various aversive techniques are used to “return the child to the natural state” (before the disordered attachment began), and attempt to force them to attach to a new primary caregiver (Heller et al., 2006; Regas, 2011). John Boekamp (2008) has noted that all of these so called “attachment therapies” use physical restraint, forced eye-contact and coercion to induce the child to submit to the caregiver; it is assumed that the child will resist and this must not deter the therapist (Boekamp, 2008). He explains that “Rage Reduction” holds that these children are angry about the experiences that led them to disordered attachment and must be forced to release this feeling and accept the new caregiver (Boekamp, 2008). One such “attachment therapist” Neil Fineberg (ACTonline, 2010), lays the child across his lap, restrains one arm behind his back and has the caregiver or an assistant tightly hold the other arm. The child is then poked, tickled, yelled at, insulted, and threatened until “rage is provoked” (Boekamp, 2008). Thereafter, Fineberg orders the child to kick and scream angry phrases chosen by the therapist (ie. “I hate my mommy!” “I want to kill you!”). The child is not released from the hold until the directed behaviors are engaged in to the therapist’s satisfaction. Martha Welch (ACTonline, 2010) is another “attachment therapist” who developed “Holding Time.” This technique is similar to “Rage Reduction,” except Ms. Welch lies on top of the child on the floor using her full weight and forces from the child apologies to the new caregiver for misbehaving and promises to love and respect them. This therapist also instructs and supervises parents into performing this “treatment” on their children with attachment disorder (ACTonline, 2010). Zilberstein (2006) describes the “holding therapy”

process as “coercive holding, intrusive interventions aimed at breaking down a child’s defenses, demands for compliance with authority through shaming and punitive interventions, and provision of comfort and support upon acquiescence” (p. 59).

Reviews of “attachment therapies” state two outcomes of these techniques: the child is forced to give up behavior undesired by the new caregiver, and the caregiver is relieved that their child will now be accepted in society (Regas, 2011). Notably, even these “successes” are reported “as often as not” (Regas, 2011). When no improvement is seen, “attachment therapists” apologize to parents that some children are simply untreatable or require residential treatment. The child is then removed to an “attachment treatment center” and the parent released from guilt and reprieved of the child’s disturbing behaviors (Regas, 2011). Thus, “attachment therapies” pinpoint unacceptable behaviors as signs of attachment problems and coerce children to behave differently (Regas, 2011; Zilberstein, 2006). In her literature review, Zilberstein (2006) noted that only one outcome study on “holding therapy” had been carried out, and that the measurements tested were on reduction of aggression not increases in attachment.

In addition, “attachment therapies” have been decried by the professional and research communities, and described as traumatic, unethical, psychologically and physically damaging, and without clinical merit (Boekamp, 2008; Heller et al., 2006; VanFleet, 2006; Zilberstein, 2006). Further, six legal cases have reported children who died during these “therapies” (Boris, 2003; Mercer, Sarner, & Rosa, 2003; Zeanah & O’Connor, 2003). Unfortunately, many parents desperate for help after adopting a child with significant behavioral problems and “lack of love” for them, have been misled into the thinking that their child is “untreatable” except through these “attachment therapies” (Regas, 2011; VanFleet, 2006; Zilberstein, 2006). Zilberstein further comments: “As a result of this high-profile, ominous, and largely unwarranted conceptualization

of attachment problems, RAD has acquired a dire reputation in clinical circles and among adoptive parents for being an intractable, dangerous and severe disorder” (Zilberstein, 2006, p. 59).

Theraplay. Stubenbort, Cohen and Trybalski (2010) state that the theory of Theraplay is that children begin to feel secure in an attachment relationship when the caregiver helps create emotional and physical attunement and increased communication with the child. The authors state that this therapy consists of many directive reciprocal play activities between caregiver and child. During brief play episodes the adult uses such behaviors as gentle touch, soft speech, smiling, making eye-contact, giving appreciative comments about the child, and otherwise giving positive reinforcement to the child for engaging with the adult. In particular, physical touch and close social engagement are emphasized, but not forced.

Stubenbort, Cohen and Trybalski (2010) carried out a study integrating Theraplay into a therapeutic preschool for maltreated children between the ages of 3-6 years. They describe four goal categories of Theraplay, and give the following examples of an activity for each goal. “Nurturing” activities are a way for therapists (or caregivers) to demonstrate that a child’s physical and emotional needs matter and will be cared for. “Lotion” is one such activity: the therapist asks the child to identify “hurts” on their body, and then gently applies lotion to these spots. “Engaging” activities move into a child’s physical space to promote self-awareness and self-esteem, which may be as simple as the child and adult looking into a mirror together. A “structured” interaction is one in which the therapist creates boundaries for the child. A combination “engaging/structured” activity might be the adult tracing the child’s body on a large piece of paper. This activity is “structured” to require a proximity experience and “engaging” because it involves the adult entering the child’s body space. “Challenge” behaviors encourage

the child to step a little out of their comfort zone in terms of social/physical interaction.

“Challenge” behaviors are introduced carefully and gradually, and the adult responds sensitively if the child begins to exhibit distress. Stubenbort, Cohen and Trybalski (2010) point out that “rowboat” is a particularly challenging activity as it necessitates two children to make eye-contact, hold hands and rock back and forth together.

Stubenbort, Cohen and Trybalski (2010), used pre- and post-treatment assessments of the children’s global developmental status and social-personal range. At the beginning of the study, the children averaged 11.2 months behind in age-appropriate development, and a nearly 16 month delay in the social-personal domain. At the end of the preschool year, general developmental scores improved an average of 6 months closer to age-appropriate expectations. Considering that social-personal scores had been lower than the general ones at the beginning of the year, and they rose with the global scores, the improvement seems significant. Granted, not all children with attachment disorders have experienced maltreatment in the home, and not all maltreated children develop attachment disorders, but this study does suggest that some maltreated children with disordered attachment may be helped to reduce social withdrawal/increase sociability in treatment with Theraplay.

In her book review of *Theraplay: Innovations in Attachment-Enhancing Play Therapy*, Dr. Florence E Eddins-Folensbee (2001) refers to other Theraplay activities for child and caregiver including bundling in a blanket, flying-pillow ride, and cradled like a baby. She expresses concern that these activities may be more infantilizing than encouraging of attachment and social development, at least for children over the age of 3 years old. Dr. Eddins-Folensbee (2001) also questions whether these techniques are too simplistic to be effective for children with diagnosable attachment disorders. She further states that the book implies but does not present

research indicating the effectiveness of Theraplay, and that such information may be of a clinical anecdotal nature. In conclusion, it seems that Theraplay needs further testing as to its benefit for children with attachment disorders, and may be most applicable to young children age 3 and under.

Intersubjectivity in attachment treatment. Some newer treatment approaches employ combinations of Attachment Theory and intersubjectivity in therapy with a child and caregiver (Becker-Weidman & Hughes, 2008; Shi, 2003). Lin Shi's (2003) Constructive Parent-Child Play Therapy, and Dyadic Developmental Psychotherapy created by Arthur Becker-Weidman and Daniel Hughes (2008), are two types of therapies which emphasize the use of Attachment Theory and intersubjectivity. Shi (2003) describes this intersubjectivity as a process in which the therapist creates a supportive relationship with both the caregiver and child in session; the parent is able to both experience secure attachment with the therapist, and learn how to provide this for their child through the therapist's modeling. Becker-Weidman and Hughes (2008) define intersubjectivity as "...the shared, reciprocal experience between the parent and child whereby the experience of each is having an impact on the experience of the other" (p. 329).

In Constructive Parent-Child Play Therapy, Lin Shi (2003) stresses the concept of Attachment Theory's Secure Base as needed for clinical work with families affected by attachment disorder. This clinician/author explains that she temporarily places herself in the role of a secure attachment figure for the parent, so that the parent may feel comfortable in trying out new ways of interacting with the child. Shi states that the parent's changes in behavior allow the child to have new emotional and relational experiences with the parent. Shi's (2003) Constructive Parent-Child Therapy progresses in three stages: "joining and assessment, modeling constructive play, and facilitating parent-child constructive play" (p. 19). In the first stage, Shi

meets with both the parent and child, allowing the child to play freely with toys, and the parent to discuss concerns about the child. Shi states that part of the assessment is to determine the parent's attachment style from childhood. The therapist responds sensitively, with warmth and interest in the child, modeling how to encourage the child to engage in play in his/her own manner, and helping the parent to better understand his/her child. After a few sessions, Shi begins to teach the parent how to allow the child to direct his/her own play and to coach the parent in using positive responses when the child seeks attention or interaction. Shi then encourages and supports the caregiver to practice these behaviors with the child, within the session. The final goals of this treatment are: to create a secure attachment relationship between the parent and child, to have the parent recognize the needs of the child, and to change the child's working models of attachment based on the new relationship with the caregiver (Shi, 2003).

Arthur Becker-Weidman and Daniel Hughes (2008) developed Dyadic Developmental Psychotherapy (DDP) specifically for the treatment of attachment disorders. They state that DDP is successful due to "...the maintenance of a contingent, collaborative, sensitive, reflective and affectively attuned relationship between therapist and child, between caregiver and child, and between therapist and caregiver" (Becker-Weidman & Hughes, 2008, p.329). DDP is a multifaceted treatment involving a verbal and nonverbal "story-telling style" of trauma processing between therapist, caregiver and child. Art materials, stuffed animals, puppets, children's books and psychodrama are made available to the child during therapy. Legal documents regarding child protection investigations, court proceedings and adoption paperwork are also used to help the child make sense of past and current life events. The authors state that the intersubjective relationship that is developed and continually maintained is crucial in supporting the child during trauma processing. The therapist determines the pace of the therapy,

encouraging a therapeutic level of affect by being playful, accepting, curious and empathic while directing an open dialogue about the child's past. The primary caregiver is directly involved in the therapy also, and has the role of hearing the child's story, and interacting with the child in a playful, loving, accepting, curious and empathic manner. The caregiver also takes the role of comforting and supporting the child through touch and hugs when these are received by the child willingly. Becker-Weidman and Hughes (2008) have demonstrated that their combination of an attuned, intersubjective therapy relationship, improved connections between child and primary caregiver, and trauma processing, decreased symptoms of attachment disorder as well as other emotional problems related to trauma.

Conclusion

This chapter has described a range of attachment types in children, from secure to disordered. Research and literature on the etiology, symptoms, diagnosis and treatment of Reactive Attachment Disorder has been reviewed. Various problems with the current official descriptions of RAD in DSM-IV-TR and ICD-10 have been presented. However, for the purposes of the next two chapters, the manualized diagnoses will be used, just as they must be in the current practice of child therapy. Due to the scope of this paper, only a brief description of treatments tried with RAD has been presented thus far. The next two chapters will provide extensive information on two types of therapy that may hold promise for treating children suffering from disordered attachment and their families. In chapter IV, Non-Directive Play Therapy, also referred to as Client-Centered Play Therapy will be described. This type of therapy is one of the most popular among child therapists, and has been found to provide conditions needed for secure attachment within the therapy relationship, while allowing the child to self-direct the treatment course. In chapter V, Filial therapy will be explicated. Filial therapy

makes sense for treating RAD because it builds the therapeutic rapport relationship between the child and caregiver, assisting in the development of attachment to that caregiver.

Chapter IV

Non-Directive Play Therapy/Child-Centered Play Therapy

This chapter will engage in an extensive investigation into the history, theory and practice of Non-Directive Play Therapy (NDPT) and how it may be used for children with attachment disorders. It will be prefaced by a brief explication of the importance of play in the lives of children and in therapy. The origins of NDPT will then be presented, followed by a detailed description of the theory and practice of its original form as described by its creator, Virginia Axline (1947). Next, an update on how child therapists currently practice NDPT (or Child-Centered Play Therapy, CCPT, as it is now called in North America) will be given; this section will include two important areas that have evolved since Axline's time: the therapy relationship and parental involvement. Some empirical research on treatment outcomes with play therapy will then be provided. A review of recent studies showing the use of NDPT in treatment of young children with attachment disorders will then be reported. This will be followed by a return to the case of Dibs, presented in the last chapter, and his successful treatment in Non-Directive Play Therapy with Virginia Axline (1964). The chapter will conclude with a discussion of the needs and benefits of children with attachment disorders who participate in NDPT/CCPT.

The Importance of Play for Children

Piaget (1962) stated that children develop cognitively and emotionally through play. Children in Piaget's Preoperational Stage (ages 2-7) are rapidly developing more meaning and understanding but are unable to express it verbally. At this point they use play to express their

growing knowledge (Piaget, 1962). Preschool age children use creative play to try on adult social roles, to master stress, to express fantasies and wishes, and to dramatize negative or forbidden impulses and affects (Davies, 2004).

Play therapy has long been seen as the best medium for working therapeutically with children (Axline, 1947; Freud, 1965; Klein, 1932 cited in Ray, 2004; Landreth, 2002; Ray, 2006). In play therapy, children use toys as their words, and play as their language (Landreth, 2002). As Dee Ray (2006) points out: “Children more comfortably, safely, and meaningfully express their inner world through concrete, symbolic representation in play” (p. 90). Axline (1947, 1969) noted that children use play to express their thoughts and feelings, and process their concerns in therapy in the same way that adults engage in talk therapy.

Origins of Non-Directive Play Therapy

Virginia Axline (1911–1988) was a member of the faculty of Teachers' College, Columbia University (New York, New York), taught at Ohio State University (Columbus), and maintained an independent practice in child therapy in Columbus, Ohio (Singer & Singer, 1996). Her first book, *Play Therapy: The Inner Dynamics of Childhood* (Axline, 1947) established her as the founder of NDPT (François, Powell & Dautenhahn, 2009). Axline, a student and then colleague of Carl Rogers (Sweeney & Landreth, 2009), combined play therapy with Rogers' Non-Directive Counseling (for adults) to create Non-Directive Play Therapy (NDPT) for children. In this book, Axline states clearly that the principles of Non-Directive Play Therapy are based on Carl Rogers' Non-Directive Counseling, as explained in detail in his book *Counseling and Psychotherapy* (1942 cited in Axline, 1969). Therefore, a brief description of Roger's clinical theory of Non-Directive Counseling will now be presented.

Non-Directive Counseling. Carl Rogers' (1942 cited in Axline, 1969) Non-Directive Counseling is more than a therapy technique, but rather a philosophy that people have the ability to be self-directive in finding their own path towards mental health. This type of therapy is an experience between two people focusing together on the person needing help. The final goal is for the person to resolve what conflicts lay between his inner view of himself and his actual behavior in the world, and thereby, achieve a full integration of and satisfaction with his self-concept and consciously self-directed behavior.

Non-directive is more descriptive of the therapist's attitude than of the therapy itself. As far as the client's experience, a more accurate term would be self-directive, because the primary purpose is the active involvement of the self in a growth experience. The therapy relationship is based on an attitude within the therapist's personality that allows for complete acceptance of the person: to be who he is and his right to direct the therapy hour as he sees fit. The person seeking help selects the items he chooses to address, takes responsibility for those choices, and does his own interpreting. The therapist provides an atmosphere of mutual respect, and allows the person to follow his own internal pull towards maturity. The therapist leaves the pace and direction of the therapy at all times to the client. This is because the therapist understands that each individual enacts their behavior through their own will, in their own timing, and not by the instructions of another (Rogers, 1942 cited in Axline, 1969).

Non-Directive Play Theory

The following is a description taken from the seminal work by Virginia Axline: *Play Therapy: The Inner Dynamics of Childhood* (1947, 1969). For the sake of simplicity and readability, the therapist will be referred to in the feminine and the client as masculine throughout this section.

According to Axline (1969), Non-Directive Play Therapy (NDPT) is based on a theory of personality structure in which:

There seems to be a powerful force within each individual which strives continuously for complete self-realization. This force may be characterized as a drive toward maturity, independence, and self-direction. It goes on relentlessly to achieve consummation, but it needs good “growing ground” to develop a well-balanced structure. (p. 10)

In Non-Directive Play Theory, it is believed that the child client will show constant change towards the direction of improved mental health, increased self-esteem, and maturity. When given the complete acceptance of the therapist, he achieves complete acceptance of himself and discovers “his right to be an individual entitled to dignity” (Axline, 1969, p. 10). He then finds the power of self-direction and takes responsibility for his own decisions and actions. At this point, he begins to give up immature and dysfunctional behaviors that are no longer of use to him (p. 11).

Non-Directive Play Therapy in Practice

Axline’s central principles of Non-Directive Play Therapy are listed in her own words, in the box below (Axline, 1969, p. 73):

Eight basic principles of Non-Directive Play Therapy (Axline, 1969, p. 73):

1. The therapist must develop a warm, friendly relationship with the child, in which rapport is established as soon as possible.
2. The therapist accepts the child exactly as he/she is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his/her feelings completely.
4. The therapist is alert to recognize the *feelings* the child is expressing and reflects those feelings back to him/her in such a manner that he gains insight into his/her behavior.
5. The therapist maintains a deep respect for the child's ability to solve his/her own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.

The importance and challenge of “structuring.” According to Axline (1969), “structuring” consists of the way a Non-Directive Play Therapist both: develops rapport with the child, and demonstrates to him what he can expect in the therapy playroom (p. 74). The therapist must carefully discipline herself to follow the above-listed principles so that, from the child's first visit to the playroom, he experiences support and freedom for self-expression within the therapy relationship via the total acceptance of himself, and the complete permission to make his own choices. She does not explain or describe the principles to the child, but demonstrates them in her words and actions. The child discovers the possibilities within the therapy relationship and the playroom to be himself, to express himself, to experience himself and thus learn about

his own feelings, thoughts and actions. At all times these experiences are shared with a consistently empathic and caring therapist. It is in this manner that the key aspect of NDPT, the relationship between therapist and child, is built. Within this structure the child can fully engage in self-expression, hear his own feelings reflected back to him, and gain insight into himself.

The role and personality of the Non-Directive Play therapist. Despite her non-directive attitude, the therapist is not passive (Axline, 1969). She develops a warm and friendly relationship with the child while building a clear understanding of him through the feelings and ideas he expresses in each passing moment. She comments on her observations of the child's play without indicating any rules or limits to his behavior. She must leave him the open space to make his own choices, in order to allow him full room within the session to actively engage in self-expression. At the same time, the therapist must consistently express total acceptance of the child as he is in that moment, and show the utmost respect for his abilities, desires and self-determination. The therapist endeavors to give the child a feeling of safety within an experience of close connection, while supporting extensive growth in his self-understanding, self-acceptance and self-respect. As the therapist carefully reflects back the emotions and attitudes expressed, indicating full acceptance of them, the child is able to face his deepest feelings and ideas, evaluate them cognitively and then discard or accept them (Axline, 1969).

According to Axline (1969), the therapist must have certain personal qualities and a belief system that aligns itself easily with Non-Directive Play Therapy. The therapist cannot simply use NDPT as a technique, but must truly exemplify the principles and the full theoretical approach through her behavior within the therapy relationship. Specifically, the therapist must be alert, sensitive, open, honest and kind. At appropriate times the therapist should use a sense of humor and interact playfully with the child, so that he becomes more comfortable with her.

Finally, the ability to accept another completely and never pass judgment must be part of her personality.

The child's process in Non-Directive Play Therapy. According to Virginia Axline (1969), the most crucial part of a child client's experience of NDPT is when he: "...plays freely and without direction, he is expressing his personality...experiencing a period of independent thought and action...releasing his feelings and attitudes that have been pushing to get out into the open" (p. 22). The ideal conditions in the NDPT room give him the sense, possibly for the first time in his life, that he is the most important person, and no adult is going to tell him what to do, when to do it, or pry into his privacy through psychological interpretation. Everything centers on him, as he is in that moment, and he is a perfectly acceptable person, despite his flaws. He finds that he can do no wrong, that the therapist understands him fully and appreciates his deepest feelings and his true self. These conditions within the therapy relationship allow the child to play out all his feelings, derive insight, and become brave enough to withstand his most painful emotions. Having worked through this process, the child is then able to understand and value himself for who he is, mature psychologically and successfully live as his own person.

More Recent Developments in Non-Directive Play Therapy/Child-Centered Play Therapy

The use of Axline's Non-Directive Play Therapy principals. Reviewers in Axline's time commented that her work would be valuable to child psychologists, psychiatrists, and other clinicians who provide therapy to children (Long, 1948; Sears, 1948). Current clinicians continue to revere her work (Davids, 1969; Singer & Singer, 1996). Singer & Singer (1996) wrote that Axline's two books *Play Therapy* (1947, 1969) and *Dibs: In Search of Self* (1964) "...opened our eyes to see the constructive possibilities in deeply troubled children and to find ways to help them toward more effective living through the medium of play" (p. 765). In

addition, writers in this field have hailed Axline's methods as straightforward and easier to translate into practice than more complicated psychoanalytic theories (Sears, 1948). The original ideals and practices of Axline's NDPT continue to be used by play therapists (Singer & Singer, 1996).

Non-Directive Play Therapy (NDPT) or Child-Centered Play Therapy (CCPT), as it is now called in North America (Bratton, Ray, Edwards & Landreth, 2009), has been found to be the most commonly used form of play therapy (Bratton, Ray, Rhine & Jones, 2005). The theory and principles for practice of NDPT/CCPT are considered a good basis for understanding and working therapeutically with children (Landreth, 2002; Ray, 2006). NDPT is also seen as a helpful way to train beginning child therapists and expand the development of more seasoned clinicians (Kranz & Lund, 1993; Ray, 2004; Jackson, 2010).

Current practice of Non-Directive Play Therapy/Child-Centered Play Therapy. Dee Ray is Assistant Professor and Director of the Child and Family Resource Clinic in the Counseling Program at the University of North Texas. In her article "Supervision of Basic and Advanced Skills in Play Therapy" (2004) she presents a detailed method for training child therapists. The trainable skills listed by Ray are well aligned with Axline's original description of NDPT and serve to operationalize the practice of her eight principles in play therapy. For example, Ray lists the following non-verbal skills: "leaning forward/open stance," "appearing interested," "seeming comfortable/relaxed," and two types of tone "expression congruent with child's affect" and "expression congruent with therapist's responses" (Ray, 2004, p. 31).

Both Ray's (2004) training and the description of the current practice of CCPT by Bratton, Ray, Edwards and Landreth (2009) outline the proper use of language and pace with children, as well as eight therapeutic verbal skills necessary to CCPT. These supervisors and

CCPT practitioners state that comments made to the child should be brief and fit the child's developmental level, and that the therapist should pace responses to match the child's level of activity (Bratton et al., 2009; Ray, 2004). They describe the "verbal skill of tracking behavior" (Ray, 2004) or "reflecting nonverbal behavior" (Bratton et al., 2009) as responding to the child's behavior by stating out loud that which is observed, for the purpose of allowing the child to know the therapist is interested and accepting. This skill also helps the therapist to develop an understanding of the child by getting in touch with his or her self-expression through the toys (Landreth, 2002). "Reflecting content" is a skill in which the therapist repeats back a brief summary of a story or group of ideas a child has expressed verbally (Bratton et al., 2009; Ray, 2004). Landreth (2002) states that this skill validates the child's self-perception which leads to increased self-understanding. Ray (2004) and Bratton et al (2009) identify "reflection of feeling" as an important therapy skill in which the therapist comments on feelings observed in the child's play in order to help the child develop awareness and acceptance of personal feelings. The child feels that the therapist is close by and understands his or her needs and feelings in each moment (Bratton et al, 2009). Ray (2004) states that "facilitating decision-making/returning responsibility...helps children experience a sense of their own capability and take responsibility for it" (p.33). Landreth (2002) states the best way to think of this skill: never do for a child what the child can do for himself or herself. When a child asks for instructions or help that he or she does not need, a CCPT therapist will state the child can make that decision or find a solution himself or herself (Bratton et al, 2009). CCPT therapists also want to help build creativity and spontaneity in each child, by giving permissive responses and noting a child's unique ideas (Bratton et al, 2009; Ray, 2004). Another important CCPT skill is build self-esteem and to provide encouragement. The therapist verbally acknowledges the child's efforts and successes in

the session (Bratton et al, 2009; Ray, 2004). Any time a child interacts relationally with the therapist, a CCPT practitioner will respond with statement that includes both the child and therapist. For example stating “you wanted to show me that” when the child indicates this, or “you enjoy our special time in the playroom” when the child comments “I like it here” (Bratton et al, 2009, p. 274). With regard to limit-setting Ray writes: “In an attempt to provide for a therapeutic environment that allows for self-direction and self-responsibility, minimal limits are encouraged...limits are set when children attempt to damage themselves, another person, and certain expensive or irreplaceable toys” (Ray, 2004, p. 36). Bratton et al (2009) place limits based on safety in each of these areas: safety of the child, the therapist and certain breakable toys. Both writers espouse Landreth’s (2002) A-C-T limit-setting model. In response to an unsafe behavior, the CCPT therapist follows three steps: A-acknowledging the feeling, C-communicating the limit and T-targeting an alternative. In this manner, the therapist recognizes what the child wants and shows empathy for his or her feelings, sets the limit in simple, clear terms and offers an alternative behavior to allow the child to express the feelings in a safe way (Bratton et al, 2009; Ray, 2004). Ray (2004) includes an additional verbal therapeutic skill in her training list that is not included by Bratton et al (2009). She states that while some play therapists use interpretations to “enlarge the meaning,” CCPT therapists do not interpret; they comment on repeating patterns in play to draw together a theme in the child’s therapy (Ray, 2004, p. 34). She also notes that this skill is advanced and risky as it can damage the therapy relationship if not done carefully or timed well.

The therapy relationship. Bratton et al. (2009) wrote that the therapy alliance is most important in producing therapeutic change in CCPT. They described a process of building this relationship from the first time the therapist greets the child in the waiting room, already showing

direct attention to the child's experience. This reflects Axline's definition of structuring in NDPT; building up a close therapy relationship as soon as possible. They refer to the child's relationship with the CCPT therapist as possibly affecting all relationships the child may have in past, present and future (Bratton et al., 2009).

At the time of Axline's early work and writing (Axline, 1947), Bowlby's Attachment Theory and the first research on attachment had not yet been published. In recent years, researchers using NDPT/CCPT as treatment have identified attachment themes with regard to the therapy relationship (O'Sullivan & Ryan, 2009; Ryan, 2004). Ryan (2004) stated that relationships between therapists and children who receive NDPT exhibit features of sensitive attachment relationships. O'Sullivan and Ryan (2009) observed that "...characteristics of Non-Directive Play Therapy closely mirror the spontaneous play and social interactions of children with highly attuned caregivers in everyday life" (p.216).

Parental involvement. Axline's formulation of NDPT was between a child and a therapist in a play therapy room. Parents were not included in the treatment, but were granted separate meetings with the therapist to discuss their child if they wished to do so.

Current practitioners/researchers of NDPT/CCPT maintain the one-to-one session between therapist and child, but stress the importance of parental involvement (Bratton et al., 2009; Ray, 2006; Ryan, 2004). Ryan (2004) asks that parents always bring their children to therapy and wait in the waiting room, so that the children will feel more secure. Ryan regularly offers the parents their own meetings to discuss the child. Bratton et al. (2009) schedule a meeting with the parents before the child's first CCPT session to discuss the parents' concerns, to give them an overview of how CCPT works and to plan for any particular situations that may affect the therapy process (such as a child's discomfort in separating from the parents). During

this first meeting the importance of confidentiality, regular attendance and a definite last session are also reviewed. According to Bratton et al. (2009) the therapist treats the parents with the same nonjudgemental, accepting and warm manner as the child. Axline (1964) also used a non-directive, respectful and sensitive approach when meeting with parents. A CCPT therapist schedules regular parent meetings at least once per month to continue to build a relationship with the parents, to determine any new needs the child may develop, and to inquire about recent changes at home or school. These follow up meetings also provide an opportunity to share themes in the child's play that may also be seen at home, and to assist parents in learning how to deal with these issues at home (Bratton et al, 2009). Further, Bratton et al. (2009) may begin to train the parents in using some CCPT skills and often plan to turn the play sessions over to the parents when office sessions are terminated.

Research

Play therapy. Bratton et al. (2009) have pointed out that psychotherapy research necessarily has small study samples, and that this is also true with play therapy. Larger sample sizes would be needed to demonstrate statistical significance and generalizability. However, attempting psychotherapy research with larger samples is not feasible. Hence the common use of meta-analyses to demonstrate the effectiveness of types of therapeutic treatment (Bratton et al., 2009).

This writer found two meta-analyses of play therapy with children published since 2001. Michael LeBlanc and Martin Ritchie (2001) compiled a list of 42 empirically rigorous studies published between 1945 and 2001, comparing the therapeutic effect of play versus non-play types of child therapy. The standards they set for empirically-based research included a control group that did not receive any treatment, and results presented in statistics that could yield effect

sizes for the therapy studied. The factors most related to therapeutic change were the inclusion of parents in the treatment, and an optimal number of between 30 and 35 sessions. LeBlanc and Ritchie (2001) found an overall effect size of 0.66 standard deviations, and stated that this result was not significantly different than prior meta-analyses of non-play psychotherapy. Hence, the authors concluded that play and non-play therapies were equally effective in treating children with emotional and behavioral disturbances. They did not specify the differences between directive and non-directive therapy.

A second meta-analysis on the effectiveness of play therapy was published by Bratton, Ray, Rhine, and Jones in 2005. Their analysis of 93 studies published between 1953 and 2000 with empirical controls yielded a positive effect (.80 standard deviations). They replicated LeBlanc and Ritchie's (2001) finding that parental involvement yielded the most effect in the success of play-therapy treatment with children. Additionally, Bratton et al (2005) noted that humanistic treatments showed more positive results than non-humanistic, (with effect sizes .92 for the former and .71 for the latter). In general, humanistic referred to therapies providing unconditional positive regard and viewing the client as central to their own process. Non-humanistic treatments included those focused on therapist interpretation and cognitive/behavioral work. Thus, this meta-analysis points toward the use of humanistic therapies including NDPT/CCPT as creating more therapeutic success than non-humanistic.

Non-Directive Play Therapy/Child-Centered Play Therapy for attachment disorder.

Some recent literature describes the use of play therapy as treatment for preschool or early school age children with disordered attachment and presents outcome data (Corbin, 2007; Hough, 2008; Kim, 2010; Ryan, 2004; Yi, 2000).

Petrina Hough (2008) completed an evaluative multiple-case study using Non Directive Play Therapy as part of a treatment approach for children with Reactive Attachment Disorder. Hough (2008) obtained a sample of four foster or adopted children diagnosed with RAD, and their current, stable caregivers who agreed to participate fully in the program. The treatment consisted of three parts: a group play therapy session for the children, a concurrent psychoeducation and support meeting for the caregivers, and a caregiver-child interaction period. Each of these meetings occurred weekly for 12 weeks. Hough described the children's play group therapy as non-directive and directive social experiences with peers and a safe and supportive therapy space for dealing with individual issues. The caregiver's group provided clinical information about issues of disturbed attachment, a chance to process feelings and experiences of parenting their children, support in connecting with their child, and help in choosing and setting appropriate limits of behavior. During caregiver-child interaction times, attachment-based activities including safe touch, eye-contact and positive affect were shared with each pair in the group. In addition, the caregivers were asked to engage their children in one-on-one attachment-based play for 15 minutes at home every day.

Hough (2008) reported that the children seen in her program had complicated trauma and relationship histories with multiple previous caregivers resulting in overlapping diagnoses and a variety of attachment symptoms. Although there were similarities between the children, each case had unique symptoms and interactive patterns that would affect how well they could participate in and benefit from treatment. Therefore she argued that evaluative case study was the most effective way to investigate the results of treatment for these children. Hough collected qualitative and quantitative data on each child before, during and after 12 weeks of treatment. The purpose was to create a detailed picture of each child's attachment-related behavior /

interactive patterns with caregiver prior to treatment, in order compare the child's behavior after treatment. The measurement of treatment outcome was based on a decrease in RAD and trauma symptoms, and an increase in positive attachment behaviors. The treatment was reported as successful if the child made progress from their pre-treatment baseline over the course of treatment. Hough (2008) stated that due to the complexity of problems experienced by each child, "a reasonable expectation" for success in 12 weeks of intensive treatment, could be that "improvement is seen in one or two behavioral areas" (p. 81).

Hough (2008) gathered demographics and information about presenting problems from state documentation (all the children had been removed from their biological parents and were in the foster care system) and from taped interviews with the current foster or adoptive caregivers. The children were between the ages of five and eight, two were males and two females, three of them were living in safe, stable foster placements and the fourth had been adopted. The children had experienced between two and seven placements prior to the current permanent one and all had histories of physical and/or sexual abuse and neglect (including lack of food). In addition to RAD, all four children were diagnosed with Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder, two with Dysthymia and one with Oppositional Defiant Disorder. All four children also had delays in speech and language development, problems with both achievement and adjustment at school, and difficulty managing stress and coping with change. Presenting behavioral problems related to abuse/neglect included the following: food hoarding or gorging, difficulty falling or staying asleep, nightmares, bedwetting, dissociative episodes, head-banging, and aggression towards other children in their home and at school. The following symptoms specific to RAD diagnoses were also seen: clinging to caregiver, vigilance about caregiver, distress at separation from caregiver (crying, visible anxiety/anger), inhibited

symptoms (withdrawal, silence, lack of eye contact or “frozen watchfulness”), and disinhibited behaviors (inappropriate touching/hugging strangers in public, lack of awareness of others personal space or charming, pleasing behavior).

Caregivers in Hough’s (2008) study completed three standardized measurement instruments pre and post treatment and rated their child’s behavior each week in session. All the children in Hough’s study showed very high levels of symptoms of Post Traumatic Stress Disorder before treatment. Two children showed improvement in trauma related behaviors after treatment and one still had high levels. All children rated in the clinical range on internalizing, externalizing and overall severity of behavior before treatment. While three children showed decreased anxiety and mood disturbance (two of whom moved into the average range), all remained in the clinically significant or at-risk range in the externalizing problems at the end of the 12 weeks. Hough reported that these quantitative results matched well with and thus supported the qualitative data collected.

Each child’s play behavior was videotaped in individual non directive play therapy sessions pre and post treatment. Hough coded the videotapes using the Children’s Play Therapy Instrument (CPTI). The CPTI is a qualitative instrument based on a series of rating scales detailing children’s behavior in non directive play therapy; it has been shown to pick up on aspects of children’s play that result in positive therapy outcomes (Chazen, 2000 cited in Hough, 2008). Play behavior was observed to be more integrated, developmentally appropriate, showed less anxiety; play themes switched from uncertain social themes to families spending happy time together and appropriate nurturing. In addition, therapists produced a summary play therapy report for each child based on participation in the group play therapy sessions. In non-directive therapy, the children played out themes of safety, secrets, disasters, good vs. evil, nurturing and

hope. Therapists reported that three of the children were able to use the group to process past trauma as well as current issues through play. Affective changes over the course of treatment showed a progression from anxiety to anger to sadness and to resolution for some who were calm and smiling in latter sessions. In the group activities the initial social style of seeking adults and rejecting peers advanced to parallel play and finally appropriate assertiveness and an increased ability to interact well with peers. Overall, the therapists reported that the children's play had become more organized, focused and purposeful.

Hough (2008) utilized two methods to measure attachment relationships between child and caregiver: caregiver interviews pre and post treatment, and therapist's observations of the weekly caregiver-child interaction sessions. Caregivers reported a decrease in inhibited symptoms including apparent anxiety, hypervigilance and "frozen watchfulness" at home. While two children made some improvement in public disinhibited behavior, observing personal boundaries continued to be problematic for them. One child showed no change in disinhibited symptoms, but did seek caregiver more often for attention, play and hugs and kisses before bed. Three children showed increased eye-contact with caregivers, and two showed more affection towards them. Three caregivers reported that their children increased verbal expression of genuine emotions, rather than relying on aggression, remaining silent or feigning happiness to please the caregiver. One child significantly increased his ability to cope with changes in routine and other stresses, appeared happier, and increased self-esteem. Another showed a decrease in aggression towards siblings and reductions in food hoarding/gorging and head banging. In line with the improved ratings on the PTSD scale, caregivers of two children reported a significant decrease in dissociative episodes and nightmares. During the weekly interaction sections, the child and caregiver were observed by a trained play therapist from behind a one-way glass mirror

as they played together for 30 minutes. Therapists observed that three children “responded well” one-to-one play time with caregivers. Further details on improved play themes and behaviors were included in the summary play therapy reports described above. Caregivers also reported that their children showed increased interest in their play sessions at home, and often sought them out for play at other times.

Hough’s conclusion was that three of her four cases were successful in that the children benefitted from the treatment program. These children were observed to work through traumas and process attachment-related themes during play therapy. As sessions progressed, the children’s play evolved, and caregivers reported parallel changes in clinical and social behavior at home. In addition, disordered attachment behaviors decreased and attachment relationships with caregivers improved. In the fourth case, Hough reported several issues that hindered the child’s ability to participate well in the treatment program. This child experienced stress caused by the biological parents (perpetrators of abuse/neglect in past) seeking visitation/custody, tension between parents and the current caregiver, and the caregiver’s ambivalence about the adoption which continued throughout the treatment period. Hough stated that several of the caregivers in her study reported their children often showed spikes in regression, and increased separation anxiety, nightmares and aggressive behavior following visits with biological parents who had previously abused or neglected their children. These problems ended when visitation was discontinued, and their children’s ability to participate in and benefit from treatment increased. She therefore concluded that the fourth child’s success was significantly affected by the ongoing problems at home. Hough also stated that her program used a “strength-based approach” and modeled a strong belief that maltreated children can develop positive functioning. Therapists running the treatment program reported that the fourth child’s caregiver did not seem

to connect with these principles, and her motivation and faith in the treatment seemed tenuous. The play therapy summary report on this child showed themes of fighting, dominance and destruction that persisted throughout the treatment period. Despite these problems, Hough's fourth case did show some responses to the treatment program; his caregiver reported that he was "calmer and more manageable at home" and that he made increased eye-contact with her.

Several other cases involving play therapy in the treatment of children with attachment problems have shown similarities with Hough's findings (Corbin, 2007; Kim, 2010; Ryan, 2004; Wenger, 2007; Yi, 2000). Virginia Ryan (2004) described a case in which she provided two individual NDPT sessions per week for a brief period to an eight year old boy with disinhibited RAD. Like the children in Hough's study (2008), Ryan's (2004) case included a history of abuse and neglect and multiple foster placements, and presenting problems including RAD, developmental delays and aggressive behavior. The child in Ryan's case had visitation from his previously abusive mother, as seen in the unsuccessful case in Hough's study. Ryan's child client also had severe epilepsy and a tendency to run away from both his biological mother's and foster placement homes. Ryan (2004) stated that his current placement was temporary and the caregiver there had too many children to provide him with the individual attention he needed. In addition, Ryan tried to involve the current caregiver in his treatment, but she was unable even to bring him to therapy and often missed progress meetings held by phone. The child's case worker provided transportation, but often could not remain in the waiting room during the session. Further, Ryan's client's school had recently closed, ending whatever support or structure he may have had there. Play themes in NDPT in Ryan's case included lack of safety, attachment issues (placing large animals with small ones) and abuse trauma. Affect apparent in sessions was mostly distress. Ryan also described her child client's "direct behavioral enactments of previous

and current difficult experiences” that seemed to predominate the sessions over the symbolic play in NDPT (p.80). For example, the child attempted to take toys home with him and run away from her as she was walking him out of the office; requiring limit setting. He also demonstrated affection and behavior meant to please Ryan in order to be allowed to take toys. This child’s behavior, play style and themes did not change over the treatment period until termination, at which time he became emotionally detached and more controlling in sessions. Ryan stated that this child did not make progress in NDPT, in large part due to the lack of a stable home placement, visitation with his previously abusive biological mother and the unavailability of a caregiver invested in his treatment. She also cited the need for a longer period of treatment.

Jung Mi Yi (2000) also used NDPT with a child with attachment problems. This four year old boy had witnessed domestic violence between his biological parents, and had been physically abused and neglected for food and a safe environment from birth until he moved in with his foster family at the age of two. His foster parents reported that on arrival he had been malnourished, fearful, nonverbal and isolative. Within one month he gained appropriate weight, acquired age-appropriate verbal skills and developed an intense separation anxiety that resulted in tantrums and long periods of crying if he was separated from them. Six months after his move to the foster home, his biological mother began visitation. The foster parents stated that the child and his biological mother did not appear to interact in any way, and during the visits he sat and stared at her, looked confused and verbally resisted leaving with her. The foster parents also observed a pattern of behavioral problems before and after each visit that included expressing anger and frustration towards them that he had to go, and fearfulness that he would not be allowed to return. The child and his foster parents participated in behavioral therapy for four

months and reported some improvement at first but when aggression was reported at preschool, separation anxiety returned and disinhibited behaviors persisted, they came to the clinic where Yi (2000) worked. The child in Yi's (2000) case presented with the following problems at the start of treatment: aggression, difficulty making friends, inattention and hyperactivity at preschool; crying to foster parents that they did not love him; and disinhibited behaviors in which he would approach unknown adults in public, touch or stroke them in a nonsexual manner, state that he loved them and cry if they did not reciprocate.

Yi (2000) held 33 individual play therapy sessions with the child over a period of 11 months. Yi's (2000) child client processed numerous feelings and concerns related to his disrupted attachment: grieving over the loss of his biological mother; anger and frustration that foster parents had taken him away from her; and fearfulness that his foster parents would give him up too. The child's play themes showed a progressive pattern from aggression, destruction and helplessness, to the possibility of rescue, to safety and nurturing in social relationships. He also played out concepts of good and bad people saying they love and hate each other, and whether different people can be together. Yi stated that these showed his confusion about the various attachment figures in his life, and himself, as to who was good or bad, who felt love or hate for the others and who could live together. About one-third of the way through the treatment period, Yi described a session in which this child client engaged in symbolic, regressive play regarding his grief, trauma and terror of the lost attachment relationship. The child lay down inside a box of blocks and told Yi that he was a baby and the inspectors were coming to take him away. Yi (2000) suspected that the child was having a trauma reaction when he told her there were "screams in his head" (p. 54). He then quickly broke up his crib of blocks, ran to her with a look of terror and begged her repeatedly to tell him she loved him. The child

then spent several months working through ideas and feelings related to his foster parents' plans to adopt him. During the two-month termination period, Yi described her child client as playing calmly and happily with expressed themes of cooperation and caring between family members. He also expressed feeling powerful and strong. She stated that he appeared to have released his anger, grief and fear, become more confident in himself and developed a feeling that he belonged in his foster family.

Yi's (2000) child case also demonstrated attachment concerns in direct interactions within their therapy relationship. His disinhibited style was clear from their first meeting when he clung to her leg during the intake, then took her hand eagerly and went alone with her to playroom without hesitation. He also strongly resisted leaving the playroom for the first few sessions. Yi's child client initiated games of hide-and-seek, allowing him to play out being lost and having a caring adult find him. Several times he demanded that she say she loved him. He wanted to know if she missed him during vacation and what she would do if he fell on the stairs. Yi (2000) stated she used primarily NDPT with some directive cues. She reported that he typically smiled at her when she made reflections that acknowledged his ideas through displacement in the toys. However, when she asked direct questions he told her to be quiet, remained silent and/or moved away from her. Yi used limit-setting only twice when the child was throwing toys and when he pulled her hair with a puppet. The therapist said it is a safe room and hurting others is not acceptable, and that it is ok to show angry feelings but it has to be done in another way, such as punching a pillow or pounding clay. Yi stated she felt that he was testing to see if she would abandon him and it was good for him to hear that she accepted his feelings and learn different ways to release his anger. This method appears to have been successful because he did not engage in any other dangerous behavior, and he did use appropriate

displacement thereafter. During the last seven sessions, Yi brought up the subject of termination and her client talked about it a little. At termination, Yi's child client showed improvement in attachment behaviors as he did not ask if she loved him and asked permission for a hug. He engaged in making cards to say goodbye and left in a happy mood.

Yi's (2000) held monthly meetings with the foster parents to offer support, ask about issues taking place at home, and share some general play themes the child was expressing in therapy. Yi reported that the foster parents were very committed, they maintained structure and consistency and appeared empathic, they worked well on all the suggestions given by the therapist; also worked on teaching him to ask permission to hug people before doing so. Yi noted that when the foster parents reported the child had had contact with his biological family, anger and anxiety were evident in play therapy as well as his behavior at home. Behavioral plans to reduce aggression at home were increasingly successful as the NDPT progressed. Foster parents reported that his aggressive and pro-social behavior with peers improved significantly after his trauma release session (described above). The foster parents decided to adopt the child about half-way through the treatment period; Yi supported them in discussing the child's related thoughts and concerns as they played out in therapy. Towards the end of treatment the foster parents reported several successes: the child's separation anxiety was resolved, his aggressive behavior at home had stopped, and he was responding well to their limit-setting. He had also learned to ask if he could hug someone before doing so, and his disinhibited behavior in public had decreased. During the last month of treatment the adoption was finalized and the foster parents threw an adoption party with their extended family, after which they stated that their child seemed "at peace now" (p. 75). Eight months after termination the adoptive mother reported the child was "doing very well" (p. 77).

James R. Corbin (2007) treated a seven-year-old boy with RAD, Disinhibited type by utilizing a method he called “co-constructed play therapy” (p. 548). Corbin (2007) provided individual therapy to this child for three months while his foster parents were finalizing his adoption. There was no contact between the child and his biological parents during this time. Corbin (2007) gathered data regarding this case through a written report about the biological parents, a clinical evaluation by a child psychologist, and meetings with the foster parents. According to the report, the biological parents did not recall any of the child’s early developmental milestones; they stated that he had speech problems and was “impulsive, excitable, cried easily and was childish” Corbin, 2007, p. 547). The development of his fine and gross motor skills was delayed. This child experienced neglect from his biological parents, and witnessed physical and sexual abuse between them. They did not provide for their children’s physical or safety needs and often left them alone. The children were taken from the biological parents’ home when Corbin’s child client was three-years-old, after abuse was substantiated against his sister. Corbin’s client and his sister had been in 3 foster placements within the four years prior to the move to his current foster family. The child psychologist diagnosed the child with disinhibited type RAD and inattentive type ADHD. Corbin stated that this child showed indiscriminant and intense relationships with adults that he had only known a brief time. He also reported that the child was tried on a selective serotonin reuptake inhibitor (SSRI) for ADHD and showed considerable improvement.

In “co-constructed play therapy” Corbin (2007) is primarily non-directive, but encourages the child to include the therapist by giving him roles in the child’s symbolic play. In this case, Corbin (2007) reported that the child connected with him and the therapy room quickly, in line with the child’s attachment style. Corbin described play themes of

“abandonment and vulnerability” and observed the child repeatedly playing out his concerns about placement moves by playing with two playhouses at once, with people constantly moving back and forth between them (p. 548). In addition, a great number of emergency vehicles were used in this play, which Corbin felt represented feelings of “urgency, stress and danger” (p. 548). He stated that the child assigned him numerous roles and together they played out many of the child’s disturbing experiences from his past. At the end of treatment, the adoptive parents reported improvements in the child’s social interaction style and ability to form attachments with them, although some anxiety remained.

Eun Young Kim (2010) carried out a case study on a three-year-old girl with RAD, Disinhibited type, who was seen for play therapy twice per week for eight months. Kim (2010) collected data for the study through interviews with the child’s parents and day-care school staff, classroom observations, a semi-structured assessment tool, and a “moment-to-moment content analysis of sessions” (p. 156). Interviews described a pattern of contradictory, ambivalent and indiscriminant behaviors when mother dropped off and picked up at school; sometimes the child would resist separation, other times she would walk away from her mother as if she did not know her, sometimes she would appear content to leave with her mother, other times she would insist on staying at school, and on other occasions the child would try to leave with unknown people visiting the school. The child’s social behavior was also typified by attachment-related behaviors alternating between “over-compliance” with teachers and aggression towards peers and teachers. Self-harm caused by intentionally shutting her hand in the door was also noted. Kim (2010) reported that the teachers and parents also “complained about” the child’s not following directions, not sitting down and not staying focused (p. 158). Kim did not describe the severity of these behaviors, but did not diagnose this child with an Attention Deficit Disorder.

Kim stated that his child qualified for a diagnosis of RAD Disinhibited Type, and that the particular focus of the study was on symptoms of disorganized attachment including contradictory behaviors at separation and reunion with parent, aggression and disruptive behavior. Kim utilized the Self-Other Descriptions, a semi-structured assessment tool created by Blatt et al (1992 cited in Kim, 2010) to measure the child's perception of herself as separate and different from others and found her sense of these boundaries to be considerably blurred; the child's descriptions of each parent also included statements about herself, and her answers about herself included comments about them. Kim (2010) pointed out that this confusion is common in children with disorganized attachment and also results in ambivalence about oneself and others. This child showed her ambivalence with attributions to others and self as alternately good and bad in the assessment.

Kim's child client had lived within a pathogenic attachment context throughout her three years of life. The child's parents separated shortly after her birth, and the child remained with her mother. The child's mother worked a job that involved frequent moves to different countries, resulting each time in a change of caregiver for the child. When the child was two years old the mother moved back in with the father. The parents told Kim that the child had difficulty bonding with each of them. They also admitted to using physical punishment as discipline. In terms of including caregivers in the child's treatment, Kim (2010) stated that "the therapist provided educational meetings and consultations" about parenting/caregiving skills to parents and teachers during the child's treatment (p. 157). There is no information written in Kim's (2010) article about how the caregivers responded to these interventions.

Kim (2010) used a combination of non-directive symbolic play, with directive displacement and containment interventions. Kim (2010) created an analysis of the first and last

sessions to compare the child's cognitive, affective and behavioral styles, split into momentary interactions with the therapist. Kim reported that her analyses showed a pattern in which the child would involve the therapist in her play and treat her in a simultaneously nurturing and controlling way. The child paid anxious attention to the therapist's reactions and behaviors, and often reacted to a single action swiftly and directly towards the therapist with violence; this attack was usually followed by a period of running and jumping in a far corner on the room. Kim described the child as appearing in a dissociative state at these times; she was unresponsive and seemed completely disconnected from the room and therapist. After using NDPT to create a relationship, the therapist directed the child repeatedly towards animal/human figures to create displacement. She taught the client to direct her aggression towards these figures. The child then seriously abused these animals/humans (e.g. tried to cut their eyes out with scissors) until the therapist set a limit to not damage them. Kim stated this limit was set because these toys represented people/caregivers.

Kim (2010) reported in-treatment outcomes that included a decrease in the child's aggressive/dissociative episodes over the treatment period, and an increase in the child client's awareness of and ability to talk about her feelings during therapy. Additionally, Kim noted that a single play theme was repeated by this child throughout therapy; "a nurturing but aggressive caregiver interacting with a helpless child" (p. 164). There was no change in this play pattern even at termination. The school reported a significant decrease in aggressive behavior, but stated that disruptive and inattentive behavior remained. Kim (2010) did not report any changes in other attachment-related symptoms such as separation/reunion, indiscriminant and disinhibited behaviors or feedback from parents on their relationships with the child.

Dibs: A Case of Successful NDPT for a Child with Inhibited-Type RAD

Virginia M. Axline wrote *Dibs, In Search of Self* (1964) in order to share the story of this five-year-old boy's process in Non-Directive Play Therapy, leading to his eventual recovery. A description of Dibs' presenting symptoms and history of pathogenic caregiving qualifying him for a diagnosis of RAD, Inhibited Type were detailed in Chapter III. Axline (1964) engaged Dibs in weekly one-hour sessions of individual NDPT for four months. She treated Dibs in her play therapy room as part of an ongoing study of the practice of NDPT. Sessions were observed through a one-way mirror, action and dialogue recorded minute by minute, and the therapist took notes during sessions. All of this data was written into the book. Axline (1964) engaged Dibs in NDPT according to her theory and practice principles described earlier in this chapter (Axline, 1947). In reading the detailed session descriptions, many of her interactions and responses to Dibs can be understood via the operational techniques regarding the language, pace, verbal and non-verbal skills reviewed earlier in this chapter (Bratton, Ray, Edwards & Landreth, 2009; Ray, 2004).

Therapy relationship. Axline (1964) began to structure her relationship with Dibs from their first meeting, demonstrating to him the principles of NDPT through her words and actions. She led him into the playroom, informed him that they had one hour together there and told him that he could choose whatever he would like from the toys and materials. Then she remained silent and waited for him to take the lead. As soon as he had circled the room, naming each item, he stopped, and she commented that he had named the many objects in the room. He replied quietly "That's right," and then stood silent and still (Axline, 1964, p. 25). After giving him another minute, Axline asked Dibs if he would like to take off his coat. At that moment, Dibs demonstrated helplessness and a lack of self-concept; he stated "You take off your coat, Dibs,"

but remained still and whined (p. 25). Axline tried to encourage him to do it on his own, but after awhile she offered to help, asking him to come over to her in order that he at least have to take a few steps independently to receive assistance. In the book, Axline noted Dibs' tendency to refer to himself in the second and third person only; his sense of self was so impoverished that he had no "I." At the end of the session, Dibs became very upset when it was time to leave. He sobbed and screamed that he would not go home, that he would stay forever in the playroom. Axline spoke calmly, clearly and firmly; she explained that he could come back each week, but when their hour was up he would have to go home. As regards this limit-setting, Axline (1964) wrote "A child gets his feelings of security from predictable and consistent and realistic limitations" (p.40). She then empathized with Dibs' feelings by naming them for him, and tried to help him learn the difference between emotion and action by saying "You are unhappy, now. I understand how you feel, Dibs. But there are some things that we have to do sometimes, even though we don't want to" (p. 30). Thus began Dibs' treatment in NDPT.

As therapy progressed, Axline (1964) was able to build a supportive relationship with Dibs. During the third session, after a series of comments by Axline about his play, Dibs commented "Quite often you are right." Axline responded "Well, that's encouraging" and Dibs laughed (p. 45). He was beginning to feel that she understood him and was taking delight in it. After two months Dibs described to Axline his experience of the therapy relationship: "'You do not call me stupid,' he said. 'I say help, you help. I say I don't know, you know. I say I can't, you can'" (Axline, 1964, p.117). It was within this NDPT relationship that Dibs was able to build affect regulation, process trauma, develop a strong sense of himself and gain developmentally appropriate behavior.

Affect regulation. Dibs' ability to express and regulate his affect was greatly impaired at the start of therapy. In early sessions he frequently appeared sad, anxious and restricted and became very upset when it was time to go home. Axline wrote that he directed his attention to objects in order to avoid distressing emotions. In the session descriptions Dibs also appears to use regressive play, such as drinking from a baby bottle and pretending to be a baby, in order to comfort himself.

As the therapy relationship developed, Dibs gained stability in managing affect through support and comfort from the therapist. For example, when Dibs appeared overwhelmed by sadness and insecurity about having to leave, Axline responded consistently with calm, empathic and organizing statements (see above section). Over time, Dibs internalized this experience of soothing when upset, and was able to use Axline's verbal phrases to ensure himself that it was okay for this session to end because he would come back the next week. Axline (1964) emphasized the importance of Dibs' ability to develop an inner sense of security. Dibs' growing ability to cope with affect also increased his capacity to feel and express a full range of emotions. From restricted play tinged with sadness, anxiety and restrained anger, Dibs progressed to fuller expressions of anger and hurt and increasingly showed pleasure, happiness, humor and relaxation in his play. Near the end of treatment Dibs was consistently happy and calm when arriving to, during, and departing from sessions. This building stability also enabled him to process trauma in his play (as described below), and return to a state of calm afterwards.

Trauma play. Over the course of therapy, Dibs played out issues related to the emotional and verbal abuse and neglect that he received from each of his parents. His fear and anger about being locked in his room were often seen in his repeatedly locking and unlocking the doors on a playhouse. His anger towards his father for his harsh judgments and cold behavior

was demonstrated through aggression enacted on toy soldiers, knocking them over with his fist, burying them in deep holes in the sand box and on one occasion stating “He will never never never get out of that grave,” and then “That one was Papa” (Axline, 1964, p. 82). Dibs did not show play regarding his relationship with his mother until more than two months into therapy. Then, in two sessions, he enacted scenes expressing anxiety, perfectionism, intellectual pressure and shame. Axline (1964) stated that Dibs’ voice matched the restrained, tense inflection and expression of his mother’s voice in these trauma reenactments. For example, he played out a very fussy tea party complete with his mother’s rigid instructions and deprecating language. Then, Dibs accidentally spilled the pretend tea, showed a fearful affect, yelled that the party was over and he was stupid, knocked all the cups on the floor and kicked over a chair. When Axline said to him “It was an accident,” he yelled back “Stupid people make accidents!” (p. 106). Dibs parents, by reacting to his emotional needs with rejection and constantly teaching and testing him intellectually, had wounded him where they should have provided attuned care. In NDPT with Axline, he was given the corrective experience of her attentive, empathic responses.

After three months of treatment, Dibs demonstrated that he felt very secure within their relationship, and with Axline’s support he was increasingly able to release his vengeful and painful feelings stemming from his deepest trauma. Before he played out some of his most difficult memories and emotions, he verified out loud to her and himself: “In here I am safe, ... You won’t let anything hurt me.” (p. 123). This was followed by an intense period of play in which he pretended to lock his parents in the house while it was on fire. Axline (1964) wrote that Dibs seemed to feel that she was experiencing the trauma scenes along with him as he played them out; she witnessing his suffering with respect and understanding. Shortly thereafter, he ran to her and collapsed in tears, crying out: “I weep because I feel again the hurt of doors

closed and locked against me!” (p. 126). Dibs had often been locked in his room, as well as denied the emotional connections he needed for attachment, and was now able to release these feelings and process his trauma. Axline (1964) writes eloquently about this turning point in Dibs’ therapy:

It had been a rough hour for Dibs. His feelings had torn through him without mercy. The locked doors in Dibs’ young life had brought him intense suffering. Not only the locked doors of his room at home, but all the doors of acceptance that had been closed and locked against him, depriving him of the love, respect, and understanding he needed so desperately (p.126).

Axline then describes how Dibs appeared healed and released from his trauma at the end of that session: “He was relaxed and happy now. When he left the playroom he seemed to leave behind him the sorrowful feelings he had uprooted there” (p 127). Dibs had processed trauma and demonstrated a solid capacity to regulate his affect within the safety of the therapy relationship.

Development of self. Dibs sense of self was also built up during his experiences in NDPT. Axline encouraged his self-value and belief in his own abilities by acknowledging his successes in play with responses such as “You really did. And by yourself, too” (Axline, 1964, p. 33). Over the treatment period, Dibs showed increasing confidence in choosing his own activities, making his own decisions, and solving problems. He also displayed pride in his accomplishments. He demonstrated an understanding and acceptance his own feelings when he stated “There are sad times and happy times.” (p. 97). In addition, he gradually began to refer to himself in the first person, indicating a growing sense of self and self-esteem. Initially hesitant

and stuttering the word “I,” he progressed to statements such as “I am Dibs. I like me.” (p. 131) and included confidence in Axline’s positive regard for him saying “I like Dibs. You like Dibs. We both like Dibs.” (p. 120). Towards the end of therapy Dibs frequently made comments that demonstrated feelings of strength and capability, announcing “I can be as big as all the world in here. I can do anything I want to do. I am big and powerful” (Axline, 1964, p. 131).

Developmentally-appropriate behavior. Dibs also returned to a developmentally-appropriate level of behavior. In the early stages of therapy, Axline offered assistance when Dibs displayed helplessness about tasks most children his age can easily do (e.g. taking off his coat, see above). However, in keeping with NDPT principles she never provided help unless it was clearly needed. Axline (1964) stated that these interactions with Dibs demonstrated her confidence in his capacity to increase his level of achievement. In session descriptions, Dibs showed rapid increases in age-appropriate tasks, and the end of his helpless behaviors. Dibs also gradually decreased his reliance on regressive play to manage difficult emotions, and furthermore, demonstrated an understanding his own self-determination in stating “When I want to be a baby, I can be. When I want to be grown-up, I can be. When I want to talk, I talk. When I want to be still, I be still. Isn’t that so?” (p. 131). In the later stages of therapy, he intentionally chose mature behavior more and more often.

Parental involvement. Initially Dibs was referred for treatment by his school. When his mother first met with Axline, she made it clear that neither she nor her husband wanted to be involved in Dibs’ treatment. She stated that they could not come for any other interviews, and she would not stay in the waiting room during his sessions. Following her non-directive stance, Axline accepted these conditions and offered that the mother could call anytime if she wanted to

have a meeting. It took Dibs' parents a month to agree that he would have treatment, but they did bring him consistently and promptly for all his appointments.

After one month of treatment, Dibs' mother did request an appointment and expressed a great deal of concern that he was "worse." Axline's impression was that Dibs was showing his feelings more and asserting himself when feeling insulted or rejected by his parents. Mother also talked a great deal about her feelings of shame and guilt in regards to Dibs, and indicated her negative reactions to him and poor relationship with him (see chapter III for details). However, Dibs' mother did show some insight as she correctly interpreted Dibs' negative behavior in one incident not as a tantrum but as "...his protest at the insult he must have felt in his father's remark" (Axline, 1964, p. 68). She also stated she could see some behavioral improvements as Dibs' "awful temper tantrums" and thumb-sucking had stopped.

Three months into his sessions with Axline, Dibs began showing great improvements at home. At the end of one meeting he ran to his mother and spontaneously hugged and declared his love for her. Dibs' mother again called to meet with Axline and stated she was thrilled with her son's progress; she said he was calmer and happier, made positive eye-contact, almost always answered when spoken to, and showed affection towards her. She declared "I think he is beginning to feel that he belongs to the family now...I think am I beginning to feel that he is one of us" (p. 135). Further, she expressed pride and acceptance towards Dibs.

During termination sessions Dibs showed calm, outgoing and happy behavior. He easily found ways to review his experiences in the playroom and bring conclusion to his relationship with Axline. He also stated that he had enjoyed talking and playing with his father during their vacation. Dibs was able to tell Axline directly that his parents used to be mean to him and lock him in his room, but they did not do it anymore. He said he used to be afraid of his father, but

now he felt strong and brave. After the final appointment mother reported to Axline that Dibs was very well behaved, happy, relaxed and related well within the family. Axline commented “They left together – a little boy who had had the opportunity to state himself through his play and who had emerged a happy, capable child, and a mother who had grown in understanding and appreciation for her very gifted child” (p. 176). Teachers at Dibs’ school stated that he had gradually increased his proximity and social interaction with his classmates and teachers and now exchanged greetings, smiled, participated in classroom activities and no longer showed aggression or had temper tantrums.

Non-Directive Play Therapy was considered successful in the case of Dibs. He was able to develop affect regulation, process attachment trauma, achieve total acceptance and appreciation of himself, take responsibility and confidence in the choice of own actions and gain age-appropriate skills. In addition, relationships with his parents were healed and built, and Dibs’ social interaction and classroom participation were developmentally-appropriate at the end of treatment.

Non-Directive Play Therapy for Preschool-age Children with Attachment Disorders

Rubin and Babbie (2010) have pointed out that the purpose of a single-case study is to give a detailed description of one person’s situation and response to treatment. As individual studies are engaged by multiple therapists/researchers, patterns of information can begin to be found. In reviewing the literature, several themes emerge regarding the applicability of NDPT/CCPT to the therapeutic needs of children with RAD.

Aspects of Non-Directive Play Therapy appropriate for treatment of RAD. Several writers have commented that therapy for children with RAD should be based on a healthy attachment relationship between the therapist and child (Corbin, 2007; Hardy, 2007; Shi, 2003;

Wegner, 2007). Hardy (2007) stated that this makes sense from the perspective of attachment theory. Wegner (2007) described the interactions between the therapist and the child with RAD as active, playful and nurturing, like in a secure attachment relationship. According to Corbin (2007), “Individual therapy with the child with RAD should mirror the stability, consistency, attunement, and reliability of an appropriate caregiving environment” p. 545). As mentioned earlier in this chapter, current practitioners believe that the therapy relationship in NDPT/CCPT resembles a secure attachment relationship (O’Sullivan & Ryan, 2009; Ryan, 2004). In this regard, several aspects common to NDPT/CCPT and the needs of children with RAD have been cited. These include: sensitivity, attunement and attentiveness (Axline, 1947 in NDPT; Becker-Weidman & Hughes, 2008, and Shi, 2003, in treatment for RAD), consistency (Axline, 1964 in NDPT; Hardy, 2007 for those with insecure attachment), reflective interaction (statements that reflect feeling) (Axline, 1964, and Bratton, Ray, Edwards & Landreth (2009) in NDPT/CCPT; Becker-Weidman & Hughes, 2008 for children with RAD; Hardy, 2007, in treatment for insecure attachment) and acceptance of child’s feelings, meanings and experiences (Axline, 1947 in NDPT; Becker-Weidman & Hughes, 2008, and Corbin, 2007, in treatment for RAD).

Further principles of NDPT have also been discussed as important for treatment of children with RAD. Axline’s NDPT (1947) was based on a conviction that troubled children will show change towards mental health, self-development and age-appropriate behavior given the appropriate conditions in therapy. Hough (2008) espoused a similar belief that maltreated children can develop positive functioning, and felt that this had an important, positive effect on the successful outcomes in her treatment study. Several authors have also talked about the appropriate use of limit-setting in NDPT with children with RAD, and its value for treatment in their case studies (Axline, 1964; Bratton et al., 2009; Hough, 2008; Wegner, 2007; Yi, 2000).

Axline (1964) showed in her case of Dibs that setting limits in a calm, predictable manner helps the child to develop an inner security and stability. Bratton et al. (2009) described the proper method of limit-setting to include acknowledging the child's feelings, clearly and consistently stating the limit, and offering an alternative behavior. Yi (2000) used this same method with the attachment disordered child in her study and felt that it showed acceptance for all the child's feelings and taught safe expressions of those feelings. Hough (2008) stated that showing empathy to the child with RAD while setting limits was crucial to success in therapy as well as helping the child to develop the ability to accept limits from parents at home. A final related aspect of NDPT/CCPT is that the child must be given time to complete his or her own process in therapy; it cannot be rushed (Axline, 1947). Hardy (2007) stated that, based on attachment theory, children with severe attachment problems could be expected to require a long-term course of treatment. Of the studies covered in this review, the child who Ryan (2004) treated for an unspecified "brief" period, did not make progress. Corbin's (2007) child client made progress in three months, but some anxiety remained. Axline's (1964) Dibs excelled in four months. Hough's (2008) study showed measurable improvement in three months, and she felt that her clients would have been well-served if the treatment continued for a full year. She stated that children with RAD and complex other issues as seen in her study needed a long, intensive form of treatment. In Yi's (2000) case, treatment was able to be continued until the child and parents felt it was no longer needed; the therapy lasted eleven months and had an excellent outcome. Thus, several aspects of NDPT/CCPT make it well-suited to the treatment of children with RAD.

Important therapeutic experiences for children with RAD in Non-Directive Play Therapy/Child-Centered Play Therapy. In addition, the use of NDPT/CCPT appears to provide the opportunity for children with RAD to engage in certain vital therapeutic experiences

that can lead to improved outcomes. These include: the development of affect regulation (Becker-Weidman and Hughes, 2008; Hardy, 2007; Wegner, 2007), the processing of attachment and trauma issues through play (Axline, 1964; Corbin, 2007; Hough, 2008; Wegner, 2007; Yi, 2000), and the growth of the self (Axline, 1964; Becker-Weidman & Hughes, 2008; Bratton et al., 2009; Hardy, 2007; Hough, 2008; Yi, 2000). Each of these areas of engagement can be observed through the child's appearance and behavior during NDPT/CCPT sessions (Bratton et al, 2009). In the case studies reviewed in this chapter, development of affect regulation was observed via the changes in affect showed by the child clients. In general, the children with successful outcomes showed a progression from anger, fear and anxiety, through hurt and sadness, to resolution, calm and expressions of happiness and joy (Axline, 1964; Hough, 2008; Yi, 2000). Researchers also reported that children who did not show improvements consistently appeared anxious, distressed and angry throughout the treatment period (Hough, 2008; Ryan, 2004; Kim, 2010).

A second crucial experience for children with RAD in therapy is that of processing issues related to attachment and trauma through symbolic play (Axline, 1964; Corbin, 2007; Hardy, 2007; Hough, 2008; Yi, 2000). Wegner (2007) emphasized that a child will begin to play out psychological issues once trust has been gained within the therapy relationship. In the cases under review, therapists observed play themes and their evolution throughout therapy as a child processed psychological issues and this led to resolution of those issues coinciding with improvements in functioning and reduction of attachment and trauma symptoms (Axline, 1964; Hough, 2008; Yi, 2000). Play themes most commonly seen in the studies in this chapter included: lack of safety and danger (Axline, 1964; Corbin, 2007; Hough, 2008; Ryan, 2004; Yi, 2000), disasters (Corbin, 2007; Hough, 2008; Yi, 2000), abandonment (Corbin, 2007; Yi, 2000),

good vs. bad (Hough, 2008; Yi, 2000), aggression and destruction (Axline, 1964; Hough, 2008; Kim, 2010; Ryan, 2004; Yi, 2000), and helplessness and vulnerability (Axline, 1964; Corbin, 2007; Kim, 2010; Yi, 2000). Several children acted out play scenes related directly to attachment concerns such as: mother and child cannot find each other (Yi, 2000), child moves back and forth between two houses (Corbin, 2007), and parent alternately nurtures and acts controlling or demeaning towards the child (Axline, 1964; Kim, 2010). As with affect, changes in play themes over the course of treatment indicated progress; the themes listed above were gradually replaced with healthier ones including rescue, cooperation, positive nurturing and parents and children together (Axline, 1964; Hough, 2008; Yi, 2000). Cases which were viewed by the writers to be unsuccessful did not show changes in play themes, but rather continued to play out anger, aggression, fear, danger and helplessness (Hough, 2008; Ryan, 2004; Kim, 2010). Child clients also reenacted specific trauma scenes in symbolic play (Axline, 1964; Corbin, 2007; Hough, 2008; Yi, 2000). Sessions including this trauma releasing play typically included some regressive play or self-soothing behavior, intense affective expressions, experiences of reliving the traumatic event, seeking contact, safety and comfort from the therapist, and an apparent calm and peace by the end of the session (Axline, 1964; Yi, 2000). Children who engaged in this trauma play appeared calmer and happier and showed less aggression in later sessions and at home according to parent report (Axline, 1964; Hough, 2008; Yi, 2000).

Thirdly, for children with RAD, “the therapeutic setting should provide a protective sphere not only to explore painful events but also to retrieve and integrate experiences that promote self-worth” (Corbin, 2007, p. 512). Aspects of self development observed in children with RAD in NDPT/CCPT included the following: self-esteem (Axline, 1964; Hough, 2008; Yi, 2000), self-efficacy (e.g. choosing healthier, more mature behaviors and better coping strategies;

Axline, 1964; Wegner, 2007), self-concept (e.g. feeling big and powerful; Axline, 1964; Yi, 2000), self-knowledge and self-acceptance (e.g. comes to understand and accept own feelings, Axline, 1964; Wegner, 2007; Yi, 2000).

Outcomes of play therapy for children with RAD. Some of the case studies reviewed in this chapter reported some positive outcomes with regard to changes in RAD symptoms and other presenting problems. A considerable reduction was seen in inhibited RAD symptoms including separation anxiety, withdrawal and silence (Axline, 1964; Hough, 2008; Yi, 2000). This coincided with an increase in appropriate attachment behaviors towards caregivers such as improved eye-contact, appropriate physical contact, genuine expressions of affection and seeking proximity and playful interaction (Axline, 1965; Hough, 2008). Changes in disinhibited RAD symptoms were more modest; two of the children in Hough's (2008) study reduced their inappropriate contact with strangers significantly, but still had difficulty respecting physical boundaries with family and friends. Yi's (2000) child client succeeded well in both these areas. In addition, one child in Hough's (2008) study began to express his true emotions, giving up his disinhibited "pleasing" behavior. Improvements were also reported in other areas of presenting problems. Several studies reported improvements in social interaction with classmates and siblings (Axline, 1964; Corbin, 2007; Hough, 2008; Kim, 2010; Yi, 2000). The children in Hough's (2008) and Yi's (2000) studies were better able to accept their parents' limit-setting. Hough's (2008) child clients improved with regard to food hoarding and sleep difficulties. Two studies reported reductions in PTSD symptoms (Hough, 2008; Kim, 2010). In four cases, the children increased their ability to verbalize their feelings and this led to decreases in head-banging, screaming/crying, aggression, and/or withdrawn silence (Axline, 1964; Hough, 2008 – 2 children; Kim, 2010). In addition, the two studies that reported follow up information stated

that positive functioning had been maintained at eight months (Yi, 2000) and three years (Axline, 1964) after termination. These results suggest that NDPT/CCPT has the potential to create some positive outcomes for children with RAD.

Important attachment conditions that support RAD therapy outcomes. The case studies on children with RAD reviewed in this paper emphasized the importance of a stable and reliable attachment figure in the child's life (Boekamp, 2008; Heller et al, 2006). Several writers have indicated that a permanent caregiving placement (Corbin, 2007; Hardy, 2007; Hough, 2008; Ryan, 2004; Yi, 2000) and disconnection from abusive/neglectful parent(s) (Hough, 2008; Ryan, 2004; Yi, 2000) support the success of therapy for a child with RAD. RAD treatment and outcome studies presented in this chapter cited the positive effect of permanent placements (Hough, 2008; Yi, 2000) and the detrimental effect of the lack thereof (Hough, 2008; Ryan, 2004). Most notable are Hough's (2008) findings showing positive outcomes for three children who had consistent caregivers and permanent homes versus the lack of significant benefits of treatment for the child with the uncertain placement. Yi's (2000) description of greatly improved attachment behaviors and calm, happy affect after the adoption was completed are also compelling. These two studies also discussed the problems caused for children with RAD by visitation with previously abusive/neglectful parents. Foster and adoptive parents reported an increase in attachment symptoms, anxiety, aggression, nightmares and other behavior problems both before and after such visits (Hough, 2008; Yi, 2000). In Yi's (2000) case these feelings and concerns also appeared as play themes during NDPT. In two studies, the child's knowledge that visitation had even been requested was cited as reducing the child's ability to benefit from therapy (Hough, 2008; Ryan, 2004). In Hough's (2008) and Yi's (2000) studies, the permanent

cessation of visitation from previously abusive/neglectful parents led to a decrease in symptoms and an improvement in therapy participation.

Parental involvement. The involvement of the current foster or adoptive parent(s) in treatment for a child with RAD is viewed as crucial for the child's success in therapy (Becker-Weidman & Hughes, 2008; Hough, 2008; Ryan, 2004; Shi, 2003; Yi, 2000). Several authors have noted the importance of helping parents understand the feelings and motivations behind their children's behaviors in order to encourage attuned, sensitive care and reduce frustration in parenting (Boekamp, 2008; Hardy, 2007; Hough, 2008). In the studies under review in this chapter, parents were offered education about RAD symptoms (Hough, 2008; Kim, 2010), personal support and the opportunity to discuss their child's progress over the course of treatment (Axline, 1964; Hough, 2008; Ryan, 2004; Yi, 2000). In addition, parents were taught to set limits at home in the same manner that NDPT/CCPT therapists do in sessions; the most important aspect for children with RAD, according to these researchers, was to acknowledge the feelings behind their children's behavior out loud to them when requesting changes in behavior (Hough, 2008; Yi, 2000). Most of the children showed an improved ability to accept behavioral limits (Hough, 2008; Yi, 2000). Hough (2008) further required parents to participate in parent-child interaction sessions as part of the weekly treatment, and to engage their child in a one-to-one play period each day. Therapists and parents both reported the children responding well and initiating individual play time with parents. Hough (2008) felt that these direct interventions to connect parent and child had been an important part of treatment in terms of outcomes related to improved attachment relationships.

Research Considerations

Several issues should be mentioned with regard to the validity of the research review in this chapter. Single and multiple case studies have an inherent lack of external validity (Rubin and Babbie, 2010). Despite having reviewed six studies (one of which contained four clients, Hough, 2008) a sample size of ten cannot be expected to describe all children with RAD. Further, the children with RAD represented in these cases had complicated attachment histories including differing types of abuse, neglect and experiences in foster care; they also showed various sets of RAD symptoms, overlapping psychological diagnoses, speech and language delays and other behavioral problems. Therefore, no one child can be seen to represent a “typical” case of RAD. As a result, treatment response may vary based on any or all of these factors, or other issues not seen in these studies.

Another important point is that, as discussed in the last chapter, there is another known population of children with RAD; those raised in institutions. All of the children in this review began their lives in parental homes and experienced abuse and/or neglect at the hands of their biological parents. Many of these children had also moved through several foster placements before arriving at their current one. The research presented in Chapter III described children that had spent their entire lives in one placement; an orphanage without sufficient available caregivers to provide for their attachment needs. Heller et al. (2006) stated that there was no research following institutionally-raised children with RAD through treatment. No case studies could be found on such children at the time of this review. The similarities and differences between the home-raised children presented in this chapter and the institutionalized ones described in Chapter III cannot be surmised in terms of how they may respond to treatment.

Therefore, this review cannot make any conclusions about how institutionalized children might respond to play therapy treatment.

However, some tentative conclusions can be drawn from the studies presented in this review. It appears that some RAD-diagnosed children raised in homes may benefit from NDPT/CCPT, provided that the necessary current attachment conditions of a consistently available caregiver, a permanent home placement, discontinued visitation with previously abusive/neglectful parents and parental involvement in treatment, are met. These children, despite extreme histories and complicated constellations of attachment symptoms, overlapping diagnoses and other presenting problems, can develop affect regulation, process attachment and trauma issues, and improve aspects of the self in NDPT/CCPT. Outcomes may include reductions in attachment and trauma symptoms, improved relationships with caregivers and the resolution of other behavioral and social problems.

Conclusion

This chapter has detailed the development and current practice of NDPT/CCPT. Research has been presented with regard to the applicability of this form of treatment to children with RAD. Of note, literature reviewed in this chapter has pointed to the importance of parental inclusion in NDPT/CCPT treatment for children with RAD.

Chapter V will investigate Filial Therapy. Filial therapists teach the principles and techniques of NDPT/CCPT to parents for use with their own children. As will be shown, considerable empirical research has demonstrated the positive effects of Filial Therapy with a large variety of populations. In addition, practitioners have successfully employed Filial Therapy to build secure attachment relationships between young children with RAD and their permanent caregivers.

Chapter V

Filial Therapy

This chapter will delve into the history, theory and practice of Filial Therapy and discuss how it may benefit children with attachment disorders and their families. It will begin with a description of the theory and practice of Filial Therapy as originated by Bernard Guerney (1964). Next, the evolution of this treatment and development of modern variations of widely-applicable, culturally sensitive, evidence-based practice will be examined. A section discussing the decision to offer Filial Therapy as treatment will then be presented. This will be followed by a review of the empirical research. The case of Dibs (Axline, 1964) will then be revisited with an eye towards how Filial Therapy might have helped his family. The chapter will conclude with a discussion of the possible therapeutic usefulness of Filial Therapy for children with attachment disorders and their families.

The History of Filial Therapy

Filial Therapy (FT) was created by Bernard Guerney in the 1960s (Guerney, 1964). Guerney earned his doctorate in Clinical Psychology from Pennsylvania State University in 1956 (Guerney, 1956), where he also founded and directed its Individual and Family Consultation Center for 25 years (nire.org). In his first published article on the subject “Filial Therapy: Description and rationale,” Guerney (1964) stressed that the need for mental health services greatly exceeded the availability of therapists at the time. Therefore, he stated that new, more effective and efficient methods of treatment should be sought. Guerney felt that it was important to provide treatment during early childhood before problems become ingrained, and that new

therapeutic models should make the best possible use of each therapist's time. Filial Therapy fit both of these goals by training parents to be "therapeutic agents" for their young children, and by training small groups of parents at a time, allowing more people to be helped than when a therapist provided individual therapy to each child. Guerney also noted that such a method could be used in a preventative way to enhance children's mental health and set them on a path towards self-actualization in adulthood.

At the time his first article was published, Guerney's (1964) concept of training parents as "therapeutic agents" for their own children was seen as controversial by others in the field of child psychology (Guerney, 2000, Ryan, 2007). At that time it was thought that children's problems were caused by their parents' mental illness. No one thought parents were capable of helping their own children (Guerney, 2000; Ryan, 2007). However, Guerney (1964) gave several reasons why he believed that therapy training for parents was appropriate. First, he noted that the parent-child relationship already had an effect on the child's mental health in daily life, for good or ill. Second, based on his experiences with parents of emotionally disturbed children, he stated that in fact most of these parents were not mentally ill, but that the child's problem typically had its origin within the parent-child relationship. Third, he described the existing, emotionally and psychologically important relationship of a child with his or her parent as a more desirable starting point for treatment than the therapist having to begin a new relationship with the child in individual therapy. For all of these reasons, Guerney felt that having the treatment come from and within the parent-child relationship held the possibility for even stronger results than from an individual therapist.

Guerney carried out research to demonstrate the effectiveness of his new treatment method. In the 1964 article, his early qualitative results with parents of emotionally disturbed

children who had been in Filial Therapy for 8 – 10 months indicated parents were highly motivated, enacted the appropriate therapy skills well, and reported improvements in their child's behavior at home. In addition, Guerney's (1964) team observed play therapy behavior typical of children in individual child-centered play therapy with therapists', in particular an early increase in verbal and symbolic aggression and playing out family dynamics. In 1967, Stover and Guerney carried out an empirical study and reported data showing that even critical and hostile mothers could be trained in the skills and attitudes of client-centered therapy, and that the children's play behavior in sessions would reflect that typically seen in the early stages of child-centered therapy in a clinician's office. Further, parents reported improvements in their children's behavior at home. Stover and Guerney's (1967) empirical study backed up the qualitative reports from Guerney's prior work (1964). Through this early research, Guerney showed that seriously emotionally disturbed children could be helped by their own resistant, judgmental and negative parents if those parents were given the right training and supervision and their own opportunity to work through their feelings about parenting and beliefs about how children are supposed to act (Guerney, 1964; Stover & Guerney, 1967).

The Theory behind Filial Therapy

The name Filial Therapy was chosen based on the meaning of filial as "of or pertaining to a son or a daughter in relation to the parent" (Guerney, 2000, p. 4). The treatment theory used with the child is that of Rogerian client-centered therapy and the techniques are very similar to Axline's Non-Directive Play Therapy or modern Child-Centered Play Therapy (Garza, Watts & Kinsworthy, 2007; Guerney, 1964, 2000; Landreth, 2002; Ray, 2006). The difference is that parents are taught these attitudes and methods for use with their own children.

Guerney (2000) stated that children's problems are typically not caused by their parents' mental illness. Rather, parents lack skill in parenting, do not have enough knowledge about child development, and/or do not understand their child's feelings or behavior. Their mistaken beliefs about child-rearing and misperceptions about their child's motivations lead to a lack of empathy and unhelpful or harmful treatment of the child. The use of Non-Directive Play Therapy techniques and attitudes by the parent has two benefits. First, when parents play in a therapeutic manner with their child, they develop an understanding of their child's behavior, and empathy for the child's feelings. Second, the child is able to communicate feelings and concerns through the language of play, and within the safe therapeutic relationship, that he or she likely would not in daily life (Guerney, 1964, 2000). With rigorous training, support and supervision, filial therapists can teach parents to become a therapeutic change agent for their child with emotional or behavioral problems (Guerney, 1964, 2000).

Guerney (1964) presumed that maladjustment of young children most typically results from problematic relationships within the family. He stated that the effectiveness of Child-Centered or Non-Directive Play Therapy results from the therapist showing respect and concern, leading to improved self-esteem in the child; demonstrating permissiveness and understanding, engendering a relaxing of the child's anxieties; and in general correcting the child's distorted interpersonal expectations and reactions learned in family relationships. The use of these same techniques by parents in Filial Therapy was meant to heal the troubled parent-child relationship and enhance the child's mental health in the same manner.

In addition, Guerney (1964) expected that the use of his Filial Therapy would decrease resistance and increase motivation of parents with regard to their child's treatment. He reported typical concerns of parents bringing children to therapy, primarily feelings of guilt that they have

caused their child's problems, a lack of understanding of the therapy process and a sense of competition with the therapist for their child's love. In filial training, Guerney gave parents the message that they were essential to and capable of supporting their child's recovery, and taught them the techniques to directly carry out the treatment themselves. This message engendered much-needed hope and conveyed a sense of agency (Guerney, 2000).

Finally, Guerney (1964) theorized that the very act of parents trying out a new role as non-directive therapists to their children could have a therapeutic effect on troubled parent-child relationships. In attempting this new role, parents chose to devote their undivided, respectful and caring attention to their children during specified therapy sessions. Despite this new behavior only occurring for a brief period of time each week, it seemed likely that children and parents would experience themselves and each other differently, resulting in a break from past detrimental parent-child interactive styles. Thus, parents and children would develop more positive, realistic, and comfortable connections with each other, eventually leading to a healing of the parent-child relationship.

The Practice of Filial Therapy

Guerney (1964) used Filial Therapy to teach parents how to carry out sessions of Non-Directive Play Therapy at home with their young children. He met with groups of six to eight parents, half fathers and half mothers, for instruction, modeling and discussion. Parents were taught to follow the traditional methods and attitudes of Non-Directive Play Therapy/Child-Centered Play Therapy (see Chapter IV) including verbal structuring, empathic listening/reflecting while the child plays freely, taking part in child-led imaginary play, and limit-setting for safety (Guerney, 2000). Guerney also gave play sessions himself to demonstrate the techniques, while the parents observed his sessions behind a one-way mirror. He further

engaged parents in role-plays to help them practice the skills before having them conduct sessions with children.

Guernsey (1964) openly encouraged parents to discuss any thoughts and feelings that arose in response to the non-directive play style they were learning, as well as the technical aspects of the therapy skills and role they were developing. He observed that parents tended to react most strongly to the attitudes and ideals presented in Filial training when they contrasted with their own beliefs about their child's behaviors and needs. He used the parents' comments and questions, and a client-centered style, to engage them in group therapy and provide corrective feedback within the group. Guernsey (2000) noted that parents often uncovered their own psychological issues during these discussions. Instead of viewing these as personal flaws, such issues were worked through as obstacles to goals parents had for themselves and their children (Guernsey, 2000). Guernsey demonstrated acceptance of the parents as persons, treated them with respect and helped them explore their own feelings in relation to which skills were difficult to learn, and which therapy attitudes were challenging to adopt. In this way, parents' personal problems, as well as problematic interactive styles with their children, could be resolved when framed as difficulties in learning the Filial Therapy techniques.

Stages of Filial Therapy practice. *Stage One.* In Guernsey's (1964) Filial Therapy, Stage One consisted of two parts. First, the therapist gave an explanation in clear language of the purpose and benefits of parent-child Non-Directive Play Therapy/Child-Centered Play Therapy sessions along with a detailed description of the techniques to be used. Guernsey presented the parents with four goals for the sessions as follows. First, the activities engaged in during therapy were to be completely determined by the child, with small limits set to prevent destruction of non-play items in the home and for the physical safety of both parent and child.

Second, the parents were to endeavor to develop an empathic understanding of their child's needs and feelings through their work in therapy sessions. Third, parents were to demonstrate complete acceptance of their child by making verbal statements indicating understanding of the child's needs and feelings. Fourth, the child was to develop a sense of responsibility for his or her behavior by experiencing the positive results or negative natural consequences resulting from that behavior. The parents were to teach this through clear, calm, consistent setting of the limits regarding certain destructive or physically dangerous acts. The consequence for breaking these limits was the termination of that day's session. The specific techniques of Non-Directive Play Therapy (NDPT) or Child-Centered Play Therapy (CCPT; see Chapter IV) were taught to parents with the important caveat that they must make a sincere effort to develop and express empathy and acceptance towards their child; it was made clear that methodical use of the techniques without true personal feeling would be worthless.

In the second part of Stage One, Guerney (1964) had the parents practice therapy techniques and their new role with their own or another parent's child in the office. These sessions were observed by the therapist and other parents from behind a one-way glass. Initially, discussion and training were mostly focused on learning the skills and understanding the parent's new role as a therapist. Guerney took care to clarify the differences between their roles as parents versus the new part they would play in their child's therapy. He did not ask parents to try to use therapy skills during their daily life. He felt that this generalization would occur naturally as the therapy progressed and an improved relationship developed between parent and child.

Stage Two. After six to eight sessions and when he and the parents felt that they were ready, Guerney had them begin NDPT/CCPT sessions at home with their own children. Guerney asked parents to begin with a single 30 minute session per week, which was gradually increased

to 45 minutes up to two or three times per week. A standard set of play therapy items including family dolls, a basic doll house, simple art materials, a punching bag toy, a rubber knife and a tea set, were provided at a nominal cost to parents. Parents were told that play sessions should be scheduled in advance, held in a room of the house where a variety of play was permissible and plans made to prevent interruptions during sessions. Guerney had parents take notes after each session based on a specific outline and audiotaping of sessions was encouraged. Notes and tapes were used as material for discussion. Throughout stage two, parents continued to attend group sessions to discuss their experiences, success of the therapy, their own feelings and perceptions of their child's feelings.

Final Stage. When parents stated they felt that the therapy had been successful and was no longer needed, Guerney allowed them to discontinue attendance of group sessions.

Termination included an in-depth discussion with the group and therapist.

The Evolution of Filial Therapy

Modern Filial Therapy theory. Modern filial therapists follow many of the same principles Guerney first outlined in 1964. Four principles of modern Filial Therapy (FT) shared by top filial therapists include: the parent-child relationship is the point of therapeutic attention (as opposed to the problems of either parent or child), parents are mutual helpers in the therapy process, parents are capable of learning new skills to improve interactions with their child, and parents play an important and valuable role in the life of a child that should always be respected (Guerney, 2000; Landreth, 2002; Ray, 2006; VanFleet, 2006). Like Guerney, current filial therapists interact with parents in a client-centered style, mirroring the attitudes taught to parents in FT (Kinsworthy & Garza, 2010; Landreth, 2002; Ray, 2006; VanFleet, 2006). Many parents who seek help for their children are focused on child behaviors that are problematic for the

parent (Garza, Watts & Kinsworthy, 2007; Kinsworthy & Garza, 2010; Landreth, 2002; Ray, 2006). Therefore, attempting to learn CCPT skills and principles, in which parents must allow their children to choose all their own activities and are required to demonstrate full acceptance of most of their children's behavior can be emotionally and psychologically challenging (Bratton, Ray & Moffit, 1998; Garza et al., 2007; Johnson, Bruhn, Winek, Krepps & Wiley, 1999; Ryan, 2007; VanFleet, 2006). Clinicians involved in FT respond to these concerns with empathy; they express acceptance of the parents' feelings and offer support, while simultaneously encouraging parents to change by refocusing them on the emotional and developmental needs of their children (Bratton et al., 1998; Garza et al., 2007; Johnson et al., 1999; Landreth, 2002; Ryan, 2007; VanFleet, 2006). Some filial therapists report that simply empathizing with parents' feelings can lead almost immediately to the parents' ability to empathize with their children (Bratton et al., 1998; Johnson et al., 1999). On the other hand, Hutton (2004) noted that filial therapists must guard against directly addressing parents' personal psychological issues, in the interest of maintaining the parents' role as partner to the therapy, and preserving the therapy's focus on the outcome for the child. Instead, filial therapists help parents recognize that the play sessions are not an attempt to change the child's behavior in any way; parents are directed to focus on creating an environment in the play session that encourages their children to fully express themselves and thereby work through any psychological issues through play (Landreth, 2002).

Modern filial therapists have shared new insights into the FT process. According to Landreth (2002), the goal is to change the child's experience of the parent. Training in filial therapy requires the parent to change their interactive style in order to demonstrate empathy to their child. This results in the child viewing the parent in a new way. The parent's ability to show understanding and positive interest towards the child leads to therapeutic changes within

the parent, the child and the parent-child relationship (Landreth, 2002). An important turning point occurs when parents begin to understand their children's emotions, realize that these emotions drive behavior, and accept that emotional development improves behavior. Thus, parents learn to see the value of Child-Centered Play Therapy to provide for the emotional development of their children, to help children gain self-control and responsibility, and to build an improved relationship between parents and their children (Garza & Kinsworthy, 2010; Landreth, 2002).

Child Parent Relationship Therapy theory. Child Parent Relationship Therapy (CPRT) is the newest Filial Therapy format most commonly used in recent research (Hutton, 2004; Kinsworthy & Garza, 2010; Landreth & Bratton, 2006). It is a focused, short-term parent group filial training model that lasts ten weeks (Landreth & Bratton, 2006). CPRT teaches the same CCPT principles and skills as Guerney's (1964) and Landreth's (2002) FT. Kinsworthy and Garza (2010) describe the thinking behind CPRT as: the focus is on the parent-child relationship, that by teaching the parent to observe and reflect the child's feelings, the parent will develop empathy, the child will experience acceptance and understanding, and the bond between them will be healed.

Modern practice of Filial Therapy. Guerney's original Filial Therapy (FT) groups in the 1960's ran for about a year (this was typical for most types of therapy at the time). In the 1970's they were shortened to five to six months with the same success rate (Guerney, 2000). In the late 1980's, Landreth began a 10-session group version (Landreth, 2002). Hutton (2004) states that Landreth follows all the important aspects of FT in his 10-week program, and that most modern filial therapists/researchers have used the 10-week group model. In 2006, Gary Landreth and Sue Bratton published a detailed description of the latest 10-session group format

called Child-Parent Relationship Training (CPRT), and Bratton, Landreth, Kellam, and Blackard (2006) operationalized CPRT in a handbook for group therapists. Guerney (2000) refers to Landreth and Bratton (and their students) as the next generation of FT practitioners/researchers. VanFleet has developed another version of FT for use with individual families (VanFleet, 2006).

A modern FT group program has two phases: a psychoeducational phase and a practice and supervision phase (Landreth, 2002; Ray, 2006). During the first phase, the filial therapist teaches parents basic Child-Centered Play Therapy skills (see Chapter IV). After several sessions, and at the discretion of the therapist, parents begin videotaped sessions with their child at home. Each week a different parent presents their tape for group discussion. Filial therapists focus on the positive when reviewing tapes with the group. They draw special attention to points in the session when the parent successfully demonstrated a CCPT skill, and the child's positive or therapeutic reaction to it (Landreth, 2002). When discussing videotaped sessions, filial therapists focus on the parent's and child's feelings during the session, ask what the parent is most proud of, indicate the child's positive reactions to the parent, and inquire as to what the parent would like to change about the session (Ray, 2006). Ray (2006) notes that the advanced CCPT skill of "enlarging the meaning" or drawing conclusions by identifying themes in the child's play (see Chapter IV) is not used in group FT, as this reduces the parent's concentration on creating positive interactions with their child.

Landreth (2002) schedules his FT as a single two-hour group meeting once a week for ten weeks. He states that he shortened the prior models because he found that parents could not commit to long-term treatment, that they could learn to successfully use the skills in sessions and that their children began to show behavioral changes within the ten week period. He trains parents in groups of six to seven, allowing the time he wants to devote to each parent. Landreth

(2002) uses many of the same methods as Guerney (1964) including: didactic learning, role-playing and demonstration play sessions of the therapist with the parents' children. Landreth (2002) trains parents in reflective listening, communicating understanding and setting limits in a therapeutic way; these are all aspects of CCPT (as described in Chapter IV) and match well with Guerney's (1964) FT training style. Landreth (2002) has parents begin in-home play sessions with their own children during the fourth week of the training. He advises them to set up a private place and uninterrupted time for the session. Landreth's (2002) suggested play therapy kit: Play-Doh, basic art supplies, rubber knife, rubber-tipped dart gun, doll family, toy soldiers, nursing bottle, lone-ranger-type mask, Tinkertoys, doctor kit, play money, ring toss, cardboard box for basic doll house, inflatable punching doll; is similar to that used by Guerney, but expanded, including more items seen in Axline's (1964) play room. Like Guerney, Landreth (2002) emphasizes the importance of supervision to his FT model. Parents engage in therapy with their children while observed by the group and therapist before starting sessions at home and parents are asked to videotape home sessions to be reviewed in the next meeting. Like Guerney (1964, 2000), Landreth (2002) tells parents they only have to use their new skills for one half-hour per week and does not ask them to try to adopt CCPT attitudes in daily life; he too finds that parents generalize the positive experiences of improved interactions with their children on their own as the training and therapy progresses.

After FT programs, many parents report that developing techniques to better relate to their children and learning new methods of limit-setting were the most helpful aspects of the training (Bratton, Ray & Moffit, 1998; Kinsworthy & Garza, 2010; Landreth, 2002). Many of these parents state wistfully that they never had the experience of full acceptance as children, and are proud in their new skills to provide empathy to their children (Garza, Watts & Kinsworthy,

2007; Kinsworthy & Garza, 2010; Landreth & Lobaugh, 1998). Once parents learn to use the limit-setting techniques of CCPT in FT play sessions, in particular giving choices and using firm, calm, consistent consequences, they tend to generalize this style of discipline to their daily interactions with their children (Landreth, 2002), replacing previous methods that may have been controlling (Guerney, 2000), physically and/or verbally abusive (Kinsworthy & Garza, 2010) and moving from a parenting stance of authoritarian to egalitarian (Bratton et al., 1998).

Child Parent Relationship Therapy. The Landreth and Bratton (2006) Child-Parent Relationship Therapy (CPRT) model consists of ten, weekly, two-hour long parent sessions of group process and didactic CCPT skills training. There are six to eight parents in a group. CPRT group leaders typically have background training in Child-Centered Play Therapy (Garza, Watts & Kinsworthy, 2007). CPRT group process is a focused discussion of parents' feelings, insights and experiences regarding parenting and their families. Processing periods are kept relatively short. Based on remarks from the parents, CPRT group leaders point out related subjects, indicate natural and common worries, and facilitate unity within the group (Landreth & Bratton, 2006). Didactic filial training is presented through straightforward instructions, achievement-focused home-work assignments, memorable "rules-of-thumb," consistent wording of CCPT skills, and captivating stories and metaphors (Garza et al., 2007; Landreth & Bratton, 2006).

Bratton, Landreth, Kellam, and Blackard (2006) have written *The Child-Parent Relationship Treatment Manual* which provides CPRT group leaders with specific content for each weekly session. A brief description of the 10 session plans follows. Session one opens with a group conversation about parenting, followed by an explanation of the goals of CPRT, and a lesson about the usefulness of play in understanding the life experience of a child. In

session two, parents are taught the basic principles of CCPT, are given a list of play therapy toys and asked to create a similar kit for use at home. Parents are also helped to plan a suitable time and place for home sessions. The third session involves training and activities to prepare parents to carry out their first home session with their child. Group leaders provide a list of basic techniques to use and common errors to avoid, and instruct parents on skills to encourage child-directed play sessions. Next, CCPT skills are modeled by group leaders and role-played by parents. After this third session, parents begin videotaping weekly half-hour long CCPT sessions at home with their child. During sessions four and five, parents give a description of their home sessions and two videotapes are watched by the group. The group leader and members engage in supervision detailing the parent's successful use of CCPT skills; the behavior of the child is not discussed. Sessions six through nine continue the processes of four and five. Additionally, parents are trained in three more advanced CCPT skills: giving choices, setting limits and enhancing the child's self-esteem. Session 10 is the termination meeting to facilitate closure of the group process. Group leaders identify strengths for each parent, share observations of how parents have developed over the course of the group, and promote a celebration of achievements. At termination, parents are encouraged to continue the home play sessions on their own (Bratton, Landreth, Kellam, & Blackard, 2006).

Filial Therapy with individual families. VanFleet (2006) described the following step process of individual family FT: 1. Therapist explains the purpose and method of FT to parents, answers questions and unites with them in a collaborative manner. 2. Therapist carries out demonstration play sessions one-on-one with each child in the family while parents watch and note their observations; therapist engages in a full discussion and answers questions afterwards. 3. Therapist trains the parents in the four CCPT skills of verbal structuring, empathic responding,

child-centered imaginary play, and limit-setting for safety. After the training, the therapist plays the child's role in simulated CCPT sessions with the parents, and coaches them in skill development. This is followed by a thorough conversation involving the parents' experiences during the session, a strength-based review of parents' improving use of the skills, and parents' expectations about engaging in CCPT sessions with their own children. 4. Parents begin to hold CCPT sessions with their children in the therapist's office and under direct supervision. Play sessions include one parent and one child at a time; parent-child pairs take turns until all family members have participated. The therapist then provides constructive feedback on parent skill development, helps them understand "...meanings of the child's play themes within the context of the family and community life" (VanFleet, 2006, p. 149) and comments on family dynamics that arise during the process. 5. Once parents are proficient and confident in their training, they begin independent sessions with their children at home. Parents are asked to hold one 30 minute session with each child per week. Continued parent and therapist meetings provide opportunities to discuss play session progress, create solutions for new family challenges, and collaborate on extending the principles and skills of CCPT to family relationships in general (VanFleet, 2006).

VanFleet (2006) uses several time-lines based on the severity of treatment issues presented by a family. For family situations with mild concerns, preventative FT can develop a healthy family environment and strengthen family relationships. A prevention schedule could include: two sessions of skills training (step 3 above), five sessions with directly-supervised play sessions (step 4 above) and five weeks during which parents do play sessions at home and have meetings with the therapist (step 5 above) for a total of fifteen sessions. When families present with more serious issues, additional support may be offered by extending the training period and/or the number of directly-supervised play sessions (VanFleet, 2006). In particular, parents

of children who display traumatic themes, severe behavior problems and attachment-disordered symptoms may face more challenges in providing therapy for their children. VanFleet (2006) provides extended training specifically focused on how to use CCPT responses with these conditions.

The Decision to Offer Filial Therapy

Several factors may be considered in the choice to provide FT. Practitioners/researchers on FT have suggested guidelines with regard to parent and child factors indicating appropriateness for this type of intervention (Guerney, 2000; Landreth, 2002; Ray, 2006). In addition, the specific benefits of group versus individual practice types, and length of filial training programs can be specially adapted to parents seeking help for their children (Ryan, 2007).

Guidelines regarding clients' appropriateness for Filial Therapy. Guerney's original Filial Therapy was successful with parents who did not have depression or another major mental illness and were not sexually abusive (Guerney, 2000). Landreth (2002) describes parents for whom FT will be problematic. He states that parents with severe retardation would be unable to learn filial skills, parents with extreme anger towards their children would be unable to demonstrate empathy and acceptance in play sessions, and parents who are not in touch with reality would find FT too challenging. Both Ray (2006) and Landreth (2002) suggest that some parents, very angry parents for example, may be more suitable to have their own individual therapy prior to engaging in a FT process. Beyond these limitations, most parents can learn to use FT successfully with their children (Landreth, 2002). With regard to children, Guerney's original Filial Therapy was successful with severely emotionally and behaviorally disturbed children (without organic illnesses) under the age of 10 (Guerney, 1964; Guerney & Stover,

1967). Ray (2006) wrote that young children will probably be most helped by their parents. Johnson, Bruhn, Winek, Krepps and Wiley (1999) reported on the successful use of FT for parents with children in Head Start programs (ages 3-5).

Group Filial Therapy/CPRT versus individual family Filial Therapy. The group format of Filial Therapy and CPRT provides a setting in which members feel acceptance, encouragement, understanding, and safety in a group of peers (Garza, Watts & Kinsworthy, 2007; Kinsworthy & Garza, 2010; Sangganjanavanich, Cook & Rangel-Gomez, 2010). In addition, training as a group helps parents face their feelings about parenting; group discussion provides corrective feedback of differing opinions about discipline and appropriate child behavior (Guerney, 2000) and parents support each other when learning the skills feels personally, emotionally or psychologically difficult (Bratton, Ray & Moffit, 1998; Garza et al., 2007; Kinsworthy & Garza, 2010).

The short term group format, usually 10 sessions in 10 weeks is well-suited to a wide variety of mildly challenging family and child issues (Landreth, 2002; Ryan, 2007). Parents with high levels of stress show less empathy and more negative reactions to their children; FT is appropriate for parents experiencing high levels of stress related to parenting (Guerney, 1964; Johnson et al., 1999; Kinsworthy & Garza, 2010; Landreth & Lobaugh, 1998). Research has shown that FT decreases parental stress and allows parents to reconnect with their children (Kinsworthy & Garza, 2010; Landreth & Lobaugh, 1998). Filial Therapy is ideal for healing problematic or unhelpful parent-child relationships (Guerney, 2000; Ray, 2006). For example, when parents request help for their children, but actually want to stop undesirable or hard to manage child behaviors (not clinical symptoms), this signifies that the parent is not connecting empathically with the child (Landreth, 2002). The type of parent-child relationship resulting

from this dynamic is one that can be well-served by short-term group FT (Kinsworthy & Garza, 2010; Landreth, 2002; Landreth & Lobaugh, 1998). In addition, parents concerned about a child's relational behavior at school or with family members can usually resolve these issues through FT because this intervention promotes healthy interpersonal relating (Ray, 2006).

Guernsey's six month group Filial Therapy model has been practiced and researched with more difficult issues, demonstrating success with critical, hostile, resistant, negative, and judgmental parents and children with serious emotional and behavioral disturbances (Guernsey, 1964; Stover & Guernsey, 1967).

VanFleet's (2006) individual family Filial Therapy model includes several aspects that provide intensive support and treatment for families at risk and children with more serious clinical issues. Direct, individual supervision allows the therapist to observe and intervene in parental relational issues and unhealthy parent-child interactive patterns (Johnson, Bruhn, Winek, Krepps & Wiley, 1999) as well as problematic family dynamics (VanFleet, 2006). In addition to training in standard FT skills, VanFleet (2006) discusses children's play themes and meanings to help parents build a deeper understanding of their children's psychological issues and needs. Also, VanFleet (2006) trains both parents in the family so that each child has play sessions with a parent and the whole family can participate. This aspect of individual FT reduces sibling rivalry, and is especially useful in adoptive families, promoting family cohesion and providing the adopted child with a solid sense of belonging in the family (VanFleet, 2006).

Populations benefitting from Filial Therapy / CPRT. Filial Therapy and CPRT have been described as successful treatment for many populations in the last two decades. These populations include (but are not limited to): incarcerated fathers (Landreth & Lobaugh, 1998), Korean parents (Jang, 2000), Native American parents living on a reservation (Glover &

Landreth, 2000), custodial grandparents (Bratton, Ray & Moffit, 1998), parents residing in a domestic violence shelter (Kinsworthy & Garza, 2010), parents of children enrolled in the Head Start program (Johnson, Bruhn, Winek, Krepps & Wiley, 1999), single parents attending community colleges (Ray, Bratton & Brandt, 2000), homeless parents (Kolos, Green, & Crenshaw, 2009), adoptive families (VanFleet, 2006), foster children (Ryan, 2007; VanFleet, 2006), children in residential care (Ryan, 2007), and children with attachment disorders (Ryan, 2007; VanFleet, 2006). Empirical research showing the positive results of group Filial Therapy/CPRT programs as interventions with some of these populations will be described next.

Review of the Empirical Research

Meta-analyses. Filial Therapy (FT) is now considered to be evidenced-based therapy for children and caregivers with a variety of presenting issues (Bratton, Ray, Rhine & Jones, 2005; Landreth, 2002). As discussed in Chapter IV, this writer found two meta-analyses on play therapy published since 2001 that reviewed empirical studies dated from 1945 – 2001. Both meta-analyses concluded that parental involvement in play therapy led to the highest levels of therapeutic effectiveness (Bratton et al., 2005; LeBlanc & Ritchie, 2001). Further, Bratton, Ray, Rhine and Jones (2005) presented measures specific to FT that showed the highest therapy success rates in the meta-analysis.

Quantitative research. Quantitative researchers have tested FT as a method of intervention with parent-child pairs with the general goal of improving the parent-child relationship (Glover & Landreth, 2000; Jang, 2000; Landreth & Lobaugh, 1998). The studies described in this section measured parental acceptance, parental stress, and child behavior problems, via parent self-report scales used in a pre-test/post-test design. These researchers used control groups of parents matched on demographics including age, education level, income,

socioeconomic status and ethnic origin. In each study, the children involved in the FT with their parents were between the ages of 4 and 9 years old and approximately half of them were male and half female. All the participants in control and experimental groups came for intake at the same time and were then notified whether they would be in the first or second series of FT groups; the group to receive training first became the experimental group, and the control group was provided training during the second series. In this manner, no-treatment control groups were created without any participants losing services. The results of these empirical studies will now be described.

Landreth and Lobaugh (1998), noting the difficulty and importance of maintaining parent-child relationships for children and parents separated due to imprisonment, provided FT to incarcerated fathers using the 10-week FT model developed by Landreth (2002). The researchers asked the control group fathers to visit with their families in their usual manner (typically once per week), in order to differentiate between the effect of basic parent-child contact and the results of FT. Landreth and Lobaugh (1998) described some program restrictions due to prison rules including that the practice play sessions could not be videotaped for feedback, participants had to be observed by guards and the play room was very small. However, the results of the training were overwhelmingly positive; statistically significant improvements were noted on all measurement tests (Landreth & Lobaugh, 1998). Fathers indicated increases of child acceptance on all four categories: acceptance of child's feelings and right to express them, unconditional love, acceptance of child's uniqueness and recognition of child's needs for autonomy and independence. All categories on the parent stress self-report showed improvement: a significant decrease in stress regarding self-perception as a parent, and significant increases in parent attachment and sense of parental competence. Fathers also

reported fewer parent-child interactive problems after the FT program was completed. In addition, Landreth and Lobaugh (1998) included pre- and post-tests of children's self-concept. The statistically significant results demonstrated that all of the children improved in four measured areas: significance, confidence, virtue and power (Landreth & Lobaugh, 1998). These researchers also reported that fathers in the experimental group began to make more contact with their children in the form of phone calls and letters, demonstrating to their children that they cared about them and planned to continue this increased contact after the play sessions ended. Landreth and Lobaugh (1998) concluded that these fathers were able to significantly improve their child's self-esteem under adverse conditions and with minimal time per week. Further, the fathers had developed a real appreciation of the importance of the relationship for themselves and their children. The authors stated that their study demonstrated the power of 10-week filial training in improving parent-child relationships despite the difficult separation experienced by children of incarcerated parents (Landreth & Lobaugh, 1998).

Glover and Landreth (2000) researched the use of FT with Native Americans living on the Flathead Reservation in Montana. The authors reported that Native Americans had the highest rate of mental health problems, primarily alcoholism, depression and suicide, than any other ethnic group living in the United States at that time. They noted that rates of family disruption were high due to conflicting pressures between traditional and Western cultures. These researchers felt that FT was a culturally-appropriate method to use with this population given that the principles of acceptance, empathy, giving choices and encouraging self-direction were well-aligned with Native American cultural parenting values. In addition, the researchers noted that Native American culture involves many members of the community in child-rearing. Therefore, the authors felt that the support group atmosphere of FT would feel socially

comfortable for Native Americans as a way to share parenting and learning experiences (Glover & Landreth, 2000).

Like Landreth and Lobaugh (1998), Glover and Landreth (2000) used Landreth's 10-week Filial Therapy model (Landreth, 2002) and the same parent-rating scales measuring parental acceptance, and parent stress, as well as the same child self-concept test. In addition, Glover and Landreth (2000) observed each parent-child pair before and after the training in brief play sessions. These sessions were then coded on two scales measuring parents' use of Child-Centered Play Therapy principles and skills to demonstrate empathy in play sessions, and children engaging in play behaviors expected in successful CCPT sessions. Glover and Landreth (2000) found mixed results on these measures. The parental acceptance scores increased, particularly on the acceptance of child's feelings and right to express them category, but not with statistical significance. Rating-scale scores of parental stress decreased minimally in both the experimental and no-treatment control groups. The children's self-concept test showed increased scores that were not statistically significant. On the other hand, results of the observed play sessions showed significant improvement on all three parent categories: paying full attention to the child, allowing child to lead rather than parent controlling behavior and parent responses show genuine acceptance of child's behavior and expression of feelings. Statistically significant increases in successful CCPT child-behavior were also found on two categories: self-directedness and parent-child connectedness initiated by the child, with an increase in sustained play, though it was not statistically significant (Glover & Landreth, 2000).

In reviewing their results, Glover and Landreth (2000) reported low attendance rates in the parent-group filial trainings; 50% of the participating parents attended five sessions and 75% came to the other five sessions. Although the researchers provided individual make-up sessions

for parents, they felt that many parents missed some of the benefit of the group support and feedback. The authors noted that poor attendance may have reduced the effect of the training to increase acceptance and reduce stress, resulting in less than significant score changes on the self-rating scales. However, due to the results shown in the videotaped play sessions, Glover and Landreth (2000) concluded that significant improvements in parental empathy and connection with their children in play, and increases in children's self-direction and involving parents in their play, suggested that parents successfully learned and demonstrated CCPT skills, and that FT was a successful intervention to improve parent-child connectedness in this Native American population.

Mikyung Jang (2000) carried out a study to determine the effectiveness of FT as a form of prevention and intervention of child-parent relationship problems in Korea. According to Jang, Korean parenting has traditionally focused on cognitive development, insisting upon high levels of educational achievement. Jang wrote that Korean parents do not know how to develop empathic relationships with their children, and that as a result, the prevalence of anxiety and emotional adjustment problems is increasing in Korea (Jang, 2000). The author stated that the educational aspect of FT reduced Korean parent's resistance against the therapy aspects of the treatment, because in Korean culture, psychotherapy is shameful but education is respectable. Jang recruited her participants through fliers sent home with kindergarten students, offering a "parent-child enhancement program for mothers" (quotation marks in original, Jang, 2000, p. 40). Jang used the same pre- and post-test parent-rating scales of parental acceptance, parental stress, and child-behavior interactive problems described earlier in this section. She also included pre- and post-training videotaped brief play sessions coded on the same scales of parental empathy and child play therapy behavior used by Glover and Landreth (2000).

Jang (2000) used an adapted form of Landreth's (2002) 10-week FT program; in response to the participating mothers' indications that they did not have time for ten weeks of meetings, and in an attempt to ensure mothers would complete the training, Jang revised the program to eight sessions scheduled in four weeks, that is, two 2-hour sessions of group filial parent training per week and one 30 minute play session at home with their child per week, beginning after the third training meeting. In addition, she scheduled one or two mothers each week to hold a play session with their child at the kindergarten, which was observed by the filial training group to provide feedback and support. After the program was complete, the therapist called each of the mothers for an open-ended interview to discuss any changes they had noticed in family relationships (Jang, 2000).

Jang's (2000) quantitative results showed non-statistically significant increases on the parent acceptance scale and non-statistically significant decreases on the parent stress scale. However, the results on observed and coded play sessions demonstrated statistically significant improvements in parental use of CCPT skills to show empathy and child play-therapy behavior. Jang (2000) also found statistically significant changes on the parent-report of child interactive behavior problems; mothers reported fewer problems and noted that their children showed more confidence, self-control and self-expression.

Jang (2000) described two possible causes for the less than robust results on the parental stress inventory. First, parents expressed feeling stressed during the training process, stating that the skills were harder to learn than they expected. The author suggested that the condensed training schedule (8 sessions in 4 weeks) did not allow enough time parents to practice and internalize the new parenting skills. Second, Jang (2000) stated that these Korean mothers likely downplayed their parental stress in pre-test to impress the trainer and may have been more

comfortable after sharing their feelings with other parents during the training, leading to a more honest report of their stress in the post-test.

The qualitative results of Jang's (2000) study were three themes from the phone interviews. Participating mothers were asked to comment on changes in family relationships other than that between the mother and child who had participated in FT. Mothers reported increased sensitivity to their other children, increased communication in the parent/couple relationship and an improved relationship between themselves and their fathers-in-law, who often live in same household in Korea. In addition, the group participants decided to meet on their own as a group once a month for continued support. Overall, Jang (2000) concluded that the training had a positive effect on Korean parent-child relationships as well as other family relationships, and helped reduce child problem behaviors and increase children's confidence, self-control and self-expression. Where parent-report scale scores did not show significant improvement, behaviors observed in play sessions did. Parents did not always feel they were doing better, but changes in the child, the parent-child relationship and other family relationships indicated parents had learned and were using skills effectively (Jang, 2000).

Qualitative research. Authors of qualitative studies have investigated the experiences of parents participating in Filial Therapy/CPRT (Kinsworthy & Garza, 2010; Sangganjanavanich, Cook & Rangel-Gomez, 2010). Kinsworthy and Garza (2010) engaged a group of parents living in a domestic violence shelter in Texas, in a program using the Landreth and Bratton Child-Parent Relationship Therapy (CPRT) model (Landreth & Bratton, 2006). The authors stated that they followed the ten session plans provided in The CPRT Treatment Manual by Bratton, Landreth, Kellam, and Blackard (2006). The participants included a total of fourteen mothers and two fathers who had been victims of domestic violence; the children chosen for

parent-child play sessions lived with their parents in the shelter and had likely witnessed the violence between their parents. Ten of the parents self-identified as Hispanic and six as White. The researchers provided two CPRT groups, one held in Spanish and one in English. The authors noted that each group was run by one group leader and one facilitator, all of whom had specific training in CPRT; the group leader and facilitator for the Spanish-speaking group were both fluent and bilingual in Spanish and English (Kinsworthy & Garza, 2010).

Kinsworthy and Garza (2010) described their research as a phenomenological inquiry into the perceptions of parents participating in CPRT. After the CPRT program ended, the researchers conducted a semi-structured, open-ended whole-group interview in which they asked parents to describe their day-to-day experiences of their ten weeks in the program. The researchers used a non-directive question style and asked follow-up questions for clarification and expansion of ideas. The interview was audiotaped and coded, and themes collected as data. At the end of the researchers' analysis, CPRT participants were asked to read the results and verify correct representation of their experiences.

Kinsworthy and Garza (2010) reported parent interview responses in two basic areas: the structure of the program and the relevance of the treatment to their own experiences of parenting. In terms of structure, parents reported that there had been sufficient time for skill training, that they enjoyed the support group format, and that they felt comfortable receiving training in a familiar location, and appreciated that child care was provided. They also noted that the handouts/homework assignments were helpful for integrating play skills at home and sharing training material with family and friends.

Several themes surfaced with regard to the usefulness and applicability of Child Parent Relationship Therapy in the parents' lives (Kinsworthy & Garza, 2010). Parents stated that they

had gained a better understanding of their children's feelings, wishes and developmental needs, and felt they had become more empathic towards their children (that is, they understood better *and they expressed this empathy* to their children). The parents expressed that learning the skills also made it easier to face their own feelings and those of their children regarding their experiences of domestic violence. Another theme discussed by parents was that learning the specific skills assisted them in recognizing more beneficial ways to communicate with and discipline their children. By practicing the skills, parents learned through experience that treating their children with respect and conveying their feelings through calm verbal statements rather than screaming and/or slapping resulted in better responses from their children. Parents expressed confidence that giving choices led to positive results, and they also felt it was less necessary to control their children's behavior after the training. Participants indicated that their improved effectiveness as parents and the support group format greatly reduced their stress about parenting (Kinsworthy & Garza, 2010). Once the stress decreased, parents developed an appreciation of their children's personalities, and enjoyed new relationships with their children. Participants also reported that they felt empowered in sharing the learned material with family and friends, that they were more accepting of their own imperfections, and that they wished "they had this" as a child and were glad they could provide it for their children. Parents found that they began to use CCPT principles with their other children. Finally, these parents expressed comfort that the training would help them end the cycle of violence in their families.

Kinsworthy and Garza (2010) concluded that CPRT was beneficial to these parents (survivors of domestic violence) educationally because they learned parenting skills that were new to them and useful with their children; and emotionally because they developed more understanding, respect, trust and enjoyment in relationships with their children.

Sangganjanavanich, Cook and Rangel-Gomez (2010) also carried out a study with the purpose of learning about parents' experiences in Filial Therapy (FT). Their participants were four monolingual Spanish-speaking mothers, three of whom were immigrants from Mexico, and one from Peru; all had lived in the United States for at least seven years. The authors stated they used a 5-week program adapted from the 10-week Landreth FT model (Landreth, 2002) and described the five consecutive weekly sessions as follows. Weeks one and two consisted of training in CCPT skills and education on reflection of feeling, identifying children's emotions and responding therapeutically, and encouraging the development of positive self-concept in children. Demonstrations and role-plays were included in the 2nd session, and weekly videotaped home play sessions were to begin after that meeting. Weeks three through five involved group feedback, support and supervision; during this time each mother had three of her videotaped sessions viewed and discussed during the group meetings. Sangganjanavanich et al. (2010) reported that group sessions were led by an English-speaking trainer and a translator and that the post-treatment interviews were done in the same manner. The researchers stated that qualitative data was collected via 90 minute, individual, semi-structured interviews enquiring into the FT training experience of each parent. They noted that interviews were coded by the third author who had not participated in the trainings, to verify themes in parents' responses.

Sangganjanavanich et al. (2010) discovered several themes regarding parents' experiences of participating in the 5-week Filial Therapy program. Parents described a sense of safety within a group of peers: they felt they would not be viewed negatively by group members, they trusted each other and thought they worked well together. Parents expressed difficulty in understanding the language of non-directive skills and principles; one parent stated it was harder than to learn than English. They also stated that it was hard to find the time to do play sessions at

home. Parents reported mild changes in their parent-child relationships. They attributed these changes to spending more time with their children and listening more. Finally, parents noted minimal improvements in their children's behavioral problems. Of the four parents, one mother stated that her child still cried a lot but admitted she did not use the new skills, a second mother said there was no change in her child's behavior, the third mother complained that her child had regressed, and the fourth reported improvement in the form of less crying and verbal outbursts. Sangganjanavanich et al. (2010) concluded that the parents did not learn the skills or principles presented in the training. They suggested that a full ten weeks may have been needed to allow time for parents to understand CCPT concepts and develop the skills. The authors reported that some improvements still occurred in parent-child relationships, and they noted that the lack of change in child behavior was not in keeping with results from similar studies.

Multicultural considerations. *Cultural values of family and community.* Several authors of studies reviewed in this chapter have mentioned the group format of FT as relevant to various cultural values of family and community. Parents in both qualitative studies said they felt comfortable training in groups (Kinsworthy & Garza, 2010; Sangganjanavanich et al., 2010). Sangganjanavanich et al. (2010) commented that many Hispanic cultures have a strong value of family and community. The parents in their study reported a feeling of safety within the group of monolingual Spanish-speaking mothers. Kinsworthy and Garza (2010) noted that parents from both their English-speaking and Spanish-speaking groups expressed appreciation of the group format. Parents in their study also expressed pride in sharing training materials with their friends and family. These researchers suggested that FT may be an appropriate format for parents of multiple cultures (Kinsworthy & Garza, 2010). Jang (2000) noted that the Korean mothers in her study bonded as a group through the filial training and informed her that they

intended to continue to meet together each month. The mothers in Jang's (2000) study also reported that the training changed various relationships in their families and extended families, in part because they shared the content of the meetings with family members, leading to increased communication. Glover and Landreth (2000) initially felt that a group training regarding parenting would feel culturally and socially acceptable to the Native Americans in their study, due to their cultural value of community parenting. Ironically, they found that the parents' reduced attendance was due to a culture-based value that prioritizes the immediate, daily needs of family and friends over appointments, school or work. Glover and Landreth (2000) suggested that filial trainings for Native Americans could be offered to whole-family groups, so that one adult member of the family or extended family could attend the training for each young child. The authors stated this would be a better match for the Native American cultural tradition of extended-family parenting. These researchers further noted that Native Americans might be more likely to attend FT if it was presented as a community event, with food, child care and transportation provided (Glover & Landreth, 2000).

Language. Three of the studies described above presented FT or CPRT in a non-English-speaking format (Jang, 2000; Kinsworthy & Garza, 2010; Sangganjanavanich et al., 2010). This is worth noting because FT (Guernsey, 1964; Landreth, 2002), CPRT (Landreth & Bratton, 2006) and the principles of Non-Directive (Axline, 1964) and Child-Centered Play Therapy (Ray, 2004) upon which they are based were all originally developed in English. Thus, providing FT in other languages requires accurate and meaningful translation. Jang (2000) does not mention this issue in her article, but the study was undertaken in Korea, Jang is Korean and her fellow researchers attended or were affiliated with Korean universities. Therefore, one would presume that the training and materials were presented in Korean. The participants in

Jang's (2000) study indicated that the skills were harder to learn than they expected, but the article does not indicate there was any problem with the language of the training.

Kinsworthy and Garza (2010) and Sangganjanavanich et al. (2010) both provided FT/CPRT to Spanish-speaking parents in the United States. Kinsworthy and Garza (2010) reported that they held two groups, one in English and one in Spanish. The Spanish-speaking group was run by two fluent bilingual speakers of English and Spanish and all the materials and handouts were translated. The results of this study showed very positive results for both the English and Spanish-speaking groups; the researchers noted that the parents in both groups built a clear understanding of non-directive or child-centered principles, were able to use the skills effectively, internalized them to the point of using them in daily life with their other children, and expressed that the handouts were useful for sharing training concepts with family and friends (Kinsworthy & Garza, 2010). Sangganjanavanich et al. (2010) presented their FT training to monolingual Spanish-speaking parents through an English-speaking group leader and a translator. The participants in this study stated that the non-directive language was very difficult to learn, as one mother stated, even harder than English. This reader found it challenging to understand the translations of the parents' comments written in the article. There seemed to be a particular focus on the importance of gender-specific words used in Spanish that have no equivalent for gender-neutral words in English. Sangganjanavanich et al. (2010) concluded that the parents did not learn the material and suggested that the abbreviated form of training (a total of five sessions) did not give parents long enough to understand the concepts and practice the skills. However, it seems important to consider how these monolingual parents may have felt about receiving the training through a translator, rather than sharing their personal reactions with someone who could truly understand them. This writer also wonders how Kinsworthy and Garza

(2010) conducted the CPRT training in Spanish so successfully, without any parent comments about difficulty with the language. In conclusion, research appears to show that shortened or condensed forms of treatment make it harder for parents to learn skills in Filial Therapy (Jang, 2000; Sangganjanavanich et al., 2010), but that language may also become a factor if the training is provided through a translator (Sangganjanavanich et al., 2010), rather than held directly in the language of the participants (Jang, 2000; Kinsworthy and Garza, 2010).

Cultural bias in empirical testing. Two of the articles previously examined in this section included information about the potential for cultural bias to reduce the accuracy of quantitative test instruments (Glover & Landreth, 2000; Jang, 2000). Jang (2000) reported that the parental stress self-test may have produced results based on the need of Korean mothers to impress an instructor, due to the intense pressure regarding intellectual functioning in Korean culture. In other words, the test instrument did not measure the parents' actual feelings of stress, but produced results affected by Korean culture.

Glover and Landreth (2000) reported that dominant-culture value assumptions in the children's self-concept test appeared to create inaccuracies in results. The researchers found that all the children in the study, in both control and experimental groups, pre-test and post-test, scored very low on the Joseph Pre-school and Primary Self Concept Screening Test (JPPCST, Joseph, 1979 as cited in Glover & Landreth, 2000), yet their behavior as observed by filial trainers and researchers did not indicate low self-esteem, and parents did not describe their children in this way. Upon further review of the test instrument, Glover and Landreth (2000) discovered five items based on dominant-culture societal values that were not applicable to the Native American children. For example, an item showing pictures of two children, one with mud on their clothes and one with clean clothes, was meant to indicate higher self-esteem if the

children identified themselves as the clean child. However, as Glover and Landreth (2000) pointed out, Native American culture places significant value on people connecting with the natural world, and Native American parents encourage their children to play freely in nature. Therefore, a Native American child might select the picture of the child with mud on their clothes as representative of their enjoyment of nature, indicating cultural pride, and the test score would reflect this as low self-esteem. The researchers determined that the JPPCST inaccurately assessed low self-concept in these Native American children. When viewed from the perspective of Native American culture, the children's answers reflected an enjoyment of nature, a minimal focus on competitiveness, and a tradition of having multiple names. Glover and Landreth (2000) also cautioned that other testing scales may not be accurate measures of improvement in Native American cultures.

From this body of work, an overall picture of Filial Therapy emerges; a treatment process that involves parents and children in a dynamic change process, enhances the parent-child relationship and often leads to improved individual outcomes for participating parents and children, as well as improved relationships with other family members. The next section will review literature regarding the use of this family-based treatment in families affected by attachment disorder.

Filial Therapy for children with attachment disorder. This writer did not find any empirical studies on the treatment of Reactive Attachment Disorder using Filial Therapy (FT). As mentioned in the previous chapters, the low frequency of RAD in the general population (Boekamp, 2008) makes it very difficult to create sample sizes sufficient for empirical measurement (Bratton, Ray, Edwards & Landreth, 2009). The peer-reviewed literature discussing these children and their treatment was found in the form of case studies in which

therapists described their individual therapy with the child (see Chapter IV: Corbin, 2007; Hough, 2008; Kim, 2010; Ryan, 2004; Yi, 2000). As shown in the prior section, research on the effectiveness of FT and CPRT is primarily focused on parents and study samples consist of groups of parents engaged in the training. Such studies are not organized based on the diagnoses' of children, because the treatment does not focus directly on children's problems (Guerney, 2000; Landreth, 2002). However, some literature describes the use of individual family FT with caregivers or parents and children with RAD. Two case vignettes illustrating the use of individual FT for children with serious attachment difficulties will now be provided.

Ryan (2007) presented the case of Casey, a young foster child with severe attachment difficulties. Casey had been in placed in foster care at the age of three. She had been removed from her first foster home due to persistent aggression towards her two younger siblings, and was thereafter was placed without her siblings. Ryan (2007) reported that Casey had had "several placement breakdowns" during the following year (p. 652). At intake, Casey was 4 years old and had recently been placed with a single foster parent who had no young children. Mandy was able to manage Casey's aggression and swearing appropriately but was having a hard time developing any emotional closeness to her. Casey's serious attachment difficulties included inhibited symptoms showing avoidance, vigilance and resistance to comforting: "Casey was aloof, watchful and spiteful towards Mandy, and seemed highly defended against forming a closer relationship with her" (Ryan, 2007, p. 652). In addition, she showed indiscriminant social behavior towards anyone who visited the home, directly and insistently seeking attention and physical contact.

Mandy was provided individual family Filial Therapy (FT) training (Ryan, 2007). At the outset, she expressed considerable concern about allowing Casey to choose all her own activities

in the play sessions, with minimal limit-setting. Mandy feared that she would completely lose control of Casey's behavior, both in sessions and at home. The filial therapist empathized with Mandy's fears and offered to teach her child-centered/filial style limit-setting skills earlier in the treatment process than usual. The therapist also agreed to discuss behavioral issues affecting Mandy's relationship with Casey each week, collaborating with her on ways to promote Casey's capacity for developmentally-appropriate responsibility, self-control and independence (Ryan, 2007).

Ryan (2007) stated that the initial plan called for six sessions of FT to be held in the therapist's office for direct supervision. The primary interactive pattern observed was of Mandy trying to set limits and Casey challenging those limits, especially at the end of sessions. Through direct support the therapist helped Mandy learn to express empathy and acceptance of Casey's feelings while using minimal limit-setting. As the therapy progressed, Casey initiated imaginary play, and enlisted Mandy in the role of caregiver, while she played the "naughty baby" (Ryan, 2007, p. 652). In this way, she was able to process her feelings with regard to self-image, lack of behavioral responsibility, and dependency needs, directly within the new caregiver-child relationship. Towards the end of the six sessions, Casey began showing appropriate affection towards Mandy. In a progress review following the first six sessions, the filial therapist, Mandy's foster support social worker, and Casey's social worker agreed with Mandy to add four more directly-supervised play sessions before moving FT to the foster home. This extension was provided in response to Mandy's expressed needs for continued support during play sessions and feedback from the therapist after play sessions, as well as Casey's new attention-seeking behavior towards Mandy at home and tentative steps towards emotional connection with her in

play sessions. It was also felt that Casey needed more time to prepare for the play sessions to be moved to her placement setting (Ryan, 2007).

Ryan (2007) concluded that this case demonstrated the ways in which individual family FT can be adapted to the needs of children with serious attachment difficulties and their caregivers. Filial Therapy provided additional support and a longer period of directly-supervised sessions as appropriate intervention to the challenges faced by Mandy in developing her relationship with Casey and supporting her attachment and developmental needs. The directly-supervised FT sessions provided the therapist an opportunity to observe problematic interactional patterns, empathize and collaborate with the caregiver. The therapist promoted the caregiver's understanding of the child's attachment-related behaviors and needs; the caregiver developed the ability to respond therapeutically and in a manner that could enhance her relationship with the child. When Casey demonstrated anxiety about emotional closeness and an increased need to control her most-recent caregiver, Mandy responded with empathy and clear limits. When Casey felt safe enough to seek warmth and attention, Mandy engaged her affectionately (Ryan, 2007).

VanFleet (2006) conveyed an example of an adoptive mother exhausted by the very challenging and aggressive behavior of her daughter who had Reactive Attachment Disorder. This mother had spent two years seeking successful treatment. VanFleet (2006) reported that that another professional had told the mother that play therapy would not work with her child, and had convinced her to participate in a coercive holding technique. VanFleet (2006) stated that both mother and daughter had been traumatized by that previous experience. The child had been placed in therapeutic foster care after her behavior became a danger to the other children at home.

When individual family Filial Therapy (FT) was offered, this mother had her doubts, and asked that the therapist try out the play therapy with her daughter first to see if it could have a positive effect, stating that she would take on FT if results looked promising (VanFleet, 2006). The therapist developed a multi-modal approach, engaging the child in CCPT and more directive trauma interventions, and collaborating with the foster mother and the adoptive mother on consistent behavior management approaches. The girl in this case spent 35 sessions with the therapist processing severe trauma and attachment issues. As therapy progressed, her foster and adoptive parents (whom she visited on the weekends) reported considerable improvements in the child's behavior. At this point, the adoptive mother participated in FT training and held 10 sessions of CCPT with her daughter. The child was then able to rejoin her adoptive family. VanFleet (2006) stated that this process provided the adoptive mother with a necessary respite and the child was calmer. The adoptive mother continued the CCPT sessions at home and enrolled her daughter in an intensive social skills play group. VanFleet (2006) concluded that a combination of FT, foster respite, parent behavior management skills and several types of play therapy successfully intervened in this difficult clinical situation. The researcher further reported that the adoptive family demonstrated improved attachment relationships that remained strong several years after treatment (VanFleet, 2006).

The Possible Use of Filial Therapy in the Case of Dibs

In prior chapters, material taken from book *Dibs: In Search of Self* (Axline, 1964) was used to describe a young child with Reactive Attachment Disorder and illustrate his successful treatment in Non-Directive Play Therapy. This section will revisit the case of Dibs to consider how Filial Therapy (FT) might have been used to help his family.

Appropriateness of Dibs' parents for Filial Therapy. Based on their first two meetings, Axline described Dibs' mother's emotional state as tense, guarded, anxious, and fearful. Axline quoted the mother's depiction of Dibs' father as "A brilliant man! But remote. And very, very sensitive" (Axline, 1964, p. 65). Dibs' mother explained to Axline that both she and her husband came from families in which intellectual success was prized and emotional expression was discouraged. Their intellectual focus and successful professional careers (he was a scientist, she a surgeon) were important shared values in their happy marriage. From Axline's descriptions, it appears that both of Dibs' parents were intelligent, did not suffer from any major mental health problems, and were not intensely angry. This is the short list of parent conditions for which modern filial therapists caution against using FT (Guerney, 2000; Landreth, 2002; Ray, 2006). Thus, Dibs' parents would not be restricted from participating in FT based on psychological or organic factors.

Parent-child relationships. Dibs' mother eventually shared with Axline (1964) that she and her husband had always had difficulty parenting Dibs. The major challenges she described are also commonly mentioned by filial therapists as typical of parents who can be successful in FT training. These situations include: a lack of understanding of the child (Guerney, 1964; Landreth, 2002); parental stress related to worries about the child, and guilt about causing the child's problems (Guerney, 1964; Johnson et al., 1999; Kinsworthy & Garza, 2010; Landreth & Lobaugh, 1998); lack of awareness of developmental needs and misguided judgments of the child's motivations (Guerney, 1964; Kinsworth & Garza, 2010; Landreth, 2002); inability to connect empathically with the child and discomfort with the child's expressed emotions (Guerney, 1964; Landreth, 2002; VanFleet, 2006); problematic styles of parent-child interaction

and inappropriate forms of discipline (Guerney, 1964; Kinsworthy & Garza, 2010; Landreth, 2002; Ray, 2006; VanFleet, 2006)

As detailed in Chapter III, Dibs' mother had a very negative reaction to Dibs' even as an infant. She and her husband had not planned to have children, she had felt it necessary to give up her career to raise the child, and she was ashamed of getting pregnant. She also felt her husband had become angry with her because of the pregnancy. The situation became worse because Dibs' appeared to have some kind of delay (this is unclear in the book) and the parents perceived him as being mentally deficient. The mother stated that she and her husband were completely ashamed to have a child that was mentally retarded, in particular because of the utmost importance they placed on intelligence. In addition, Dibs' mother told Axline that she did not understand her son or his behavior. She said she knew nothing about children when he was born and was too embarrassed to seek suggestions or information about parenting. Clearly, multiple forms of parental stress were present in this family.

Axline's (1964) meetings with Dibs' mother showed that both parents had great difficulty connecting with Dibs empathically or withstanding his emotions. Dibs' mother stated that she was very worried about Dibs, because she thought that she had tried to develop a relationship with him and failed. After Dibs had begun therapy, he started to spend more time with her, and this made her intensely uncomfortable. She said: "He stands around, looking at me, always so silent....And whenever I speak to him, he runs away. Only to return and regard me with such tragic sorrow in his eyes" (Axline, 1964, p. 64). Dibs' mother described her experience of this behavior as "...asking for something that I cannot give." Axline (1964) suggested that this mother was uncomfortable with her own emotions and those of her son, due to her upbringing.

Dibs' mother had described her family of origin as valuing intellect above all else, and avoiding emotional displays; as a result, she was unable to connect empathically with Dibs.

Interactions between Dibs and his parents, as described by Axline (1964), were often problematic, and demonstrated a rigid, authoritarian, controlling, negative and punitive style of communication and discipline. For example, as Dibs was trying to talk to his father, his father responded: "Can't you stop that senseless jabber?" Dibs' mother, in her attempt to remediate his perceived mental problems, trained him to read at a very early age (see Chapter III for description). Her teaching was successful, which suggests that she had found a developmentally-appropriate educational method. Unfortunately, her single-minded focus on Dibs' perceived inadequate intellect led to a lack of emotional attunement and created a barrier to attachment (see Chapter III). Dibs' mother also told Axline (1964) that Dibs was often locked in his room when his behavior was unmanageable.

Dibs' parents experiences with mental health providers. In 1964, when Guernsey wrote his first article in defense of Filial Therapy, he refuted the commonly-held belief that children's emotional disturbances are usually the result of having parents with mental health problems. Unfortunately, Dibs' parents had negative, painful, shaming experiences in the mental health system when they sought help for Dibs. Dibs' parents misperceived their son as having mental retardation, schizophrenia or autism. His mother stated that a neurologist found no organic problems, so they took Dibs to a psychiatrist. The psychiatrist required several interviews of Dibs' parents, together and separately. In addition, they were interviewed by social workers. Dibs' mother gave the following description of that experience:

They probed without mercy into our very personal and private lives.

When we felt they were going far beyond any professional need in their

questionings, the social workers told us we were being hostile and resistive. They seemed to take a sadistic pleasure in their insensitive, cruel persecution. (Axline, 1964, p. 66)

Once the interviews were concluded, the psychiatrist told Dibs' parents that he did not find any symptoms of organic or intellectual disorders in Dibs; he stated that Dibs' was "rejected and emotionally deprived" and that both his parents should engage in their own courses of therapy (p. 66). Dibs' mother told Axline that both she and her husband had been shocked and that it nearly ruined their marriage.

In Filial Therapy, parents are offered empathy and support when seeking help for their children (Guerney, 1964; Landreth, 2002). Rather than inducing shame and guilt, filial therapists tell parents that they can become a healing force in their children's lives (Guerney, 1964; Landreth, 2002). It seems clear that Dibs' parents could have been spared considerable suffering if their experience with the psychiatrist had been replaced by a meeting with a filial therapist. Also, Dibs might have received help sooner, because after their shocking experience with the psychiatrist, Dibs' parents did not seek further treatment for him. Another difficult year of his young life went by before his school referred him to Axline (1964) for therapy.

Dibs' mother's response to non-directive therapy. Axline (1964) used a non-directive style when meeting with Dibs' mother. This is the same way manner in which filial therapists engage parents (Guerney, 1964; Landreth, 2002). Dibs' mother responded well to this method, and in ways often seen with parents in FT. Namely, the therapist's empathy and acceptance allowed mother to openly discuss feelings of guilt and concern related to parenting. The mother gradually developed changes in her attitude and perspective of Dibs. The mother came to view

herself and her husband as imperfect, but acceptable. The relationship between Dibs and his parents improved. Admittedly, Dibs' was receiving Non-Directive Play Therapy at that time, and some of mother's changes were due to observing his improvements (Axline, 1964). What can be stated is that Dibs' mother was apparently comfortable in a non-directive treatment environment, despite her previous negative experiences with mental health providers.

This section has described various factors indicating that Dibs' mother could have been a suitable candidate for Filial Therapy. Dibs' parents were not mentally ill and were quite intelligent. The types of parenting problems that affected this family are typically amenable to FT. The mother's negative reactions to the psychiatrist evaluation and positive responses to Axline's (1964) non-directive method indicate that Dibs' mother was better suited to the non-directive style. Given the severity of Dibs' difficulties and the extent of mother's shame and fear it is likely that direct supervision (either group or individual) and a moderate duration of treatment would be needed to provide proper support for mother and time for parental change, improvements to parent-child relationship, and Dibs' recovery. Perhaps 20 sessions of VanFleet's (2006) individual family FT or six months of Guerney's (1964) group FT would be sufficient. It seems likely that if Dibs' parents had been engaged in FT at the time of the psychiatric review, it might have served as a combination of intervention for the problems assessed at that time and prevention of the additional suffering and worsening of symptoms that likely occurred in the following year. In addition, the idea behind FT that parents can train to become therapeutic change agents to their children (Guerney, 1964) might have appealed to Dibs' mother, due to her intellectual pride. She might have experienced challenges in the learning the affective skills, but many parents discussed in FT research have overcome similar difficulties (Garza, Watts & Kinsworthy, 2007; Stover & Guerney, 1967; Jang, 2000; Kinsworthy

& Garza, 2010; Landreth, 2002). Finally, Axline noted that Dibs' parents had isolated themselves from family and friends due to their shame about Dibs. Participating in a FT group might have been beneficial as way to connect with other parents and experience acceptance, encouragement, understanding and support (Garza et al., 2007; Kinsworthy & Garza, 2010; Sangganjanavanich et al., 2010).

Filial Therapy for Children with Attachment Disorders and Their Families

Hutton (2004) stated that FT is focused on resolving attachment difficulties by placing the therapeutic intervention directly inside the parent-child relationship. The actions of the parent demonstrating empathy, acceptance, appreciation and warmth towards the child create the conditions necessary for secure attachment between the parent and child (Guernsey, 2000; Ryan, 2007). VanFleet (2006) reported that the use of FT with families promotes "...a network of healthy, secure attachment relationships" (p. 149).

Practitioners have indicated numerous aspects of FT that make it suitable for children in populations at risk for attachment problems (Bratton, Ray & Moffit, 1998; Kolos, Green, & Crenshaw, 2009; Ryan, 2007; VanFleet, 2006). Children in the foster or adoptive system with histories of abuse, neglect and multiple placements often display multiple problems including attachment difficulties, trauma and other emotional and behavioral issues (Ryan, 2007; VanFleet, 2006). The skills and principles of FT: verbal structuring, non-directive style, empathic responding/reflection of feeling, sharing of imaginary play and emotionally sensitive limit-setting, have specific benefits matching the needs of children with attachment disorders during treatment (Ryan, 2007; VanFleet, 2006). Specific adaptations to FT have also been developed for more effective treatment of attachment problems (Ryan, 2007; VanFleet, 2006). In addition, FT training creates several benefits for parents and caregivers of children with attachment

disorders, and is suitable for use in different caregiving and treatment settings (Ryan, 2007; VanFleet, 2006).

Therapeutic aspects of Filial Therapy for attachment disorders. Verbal structuring helps children understand how new situations may be different from prior life experiences, and assists them in adjusting to changes that occur in daily life with a sense of control and safety (Ryan, 2007; VanFleet, 2006). The non-directive style of responding reduces feelings of powerlessness and enables children to develop self-confidence (Ryan, 2007). Also, non-directive play experiences increase children's trust in their caregivers (VanFleet, 2006). Caregivers' use of empathic listening, reflection of feeling, and tracking play, demonstrates interest, desire to understand feelings, thoughts and experiences, and acceptance of their children (Ryan, 2007). The experience of genuine empathy and acceptance from primary caregivers instills a feeling of emotional safety and can enhance self-acceptance and self-esteem (Ryan, 2007; VanFleet, 2006). In turn, feelings of trust, safety, confidence and control create a comfortable relationship in which to process trauma and attachment issues (Ryan, 2007; VanFleet, 2006).

Another important treatment aspect of FT is the caregivers' participation in imaginary play as initiated and directed by their children. Play is a developmentally significant, nonthreatening medium of self-expression, communication and self-exploration for children (Axline, 1964; Landreth, 2000; Ray, 2004). The combined safety provided by caregivers' empathic responses and the displacement of symbolic play encourages children to process and release trauma, anxieties, and emotional and attachment issues (Axline, 1964; Ryan, 2007; VanFleet, 2006). Additionally, the reciprocal sharing of creative play enhances the relationship between caregivers and their children as they come to understand and appreciate each other and

enjoy each other's company (Johnson, Bruhn, Winek, Krepps & Wiley, 1999; VanFleet, 2006). In FT, parent-child pretend play is a primary means of building attachment (Ryan, 2007).

Ryan (2004) stated that empathic limit-setting is a core foundation for secure attachment relationships. Several writers have emphasized the importance of sensitive attunement when requesting behavior change from children with attachment disorders (Axline, 1964; Boekamp, 2008; Corbin, 2007; Hough, 2008; Yi, 2000). Limit-setting that is clear, calm, firm, respectful and consistent establishes the caregiver as the fair authority providing supervision, protection and physical safety (Axline, 1964; Ryan, 2007; VanFleet, 2006). The limit-setting skill taught in Filial Therapy serves these functions and includes acknowledgment and acceptance of children's feelings (Landreth, 2002; Ray, 2006; Ryan, 2007; VanFleet, 2006). This combination of behavioral expectations and emotional support promotes the development of emotional and behavioral self-regulation so critical for children with attachment disorders (Ryan, 2007; VanFleet, 2006).

Adaptations of Filial Therapy to fit the needs of children with attachment disorder.

FT is a comprehensive treatment that allows children to work on clinical, developmental and relationship issues at the same time (Ryan, 2007; VanFleet, 2006). Even in serious cases involving children who have experienced physical, emotional or sexual abuse and/or neglect, and multiple caregiving placements, individual family FT can be used to "address emotional, social, behavioral and parenting issues...as a single, systemic intervention" (VanFleet, 2006, p. 155). VanFleet (2006) regularly provides psychoeducation to adoptive parents regarding attachment and related trauma, emotional and relationship issues, and attachment-disordered behavioral symptoms. He also helps parents understand the meaning of their children's play themes when observed during directly-supervised filial sessions. Children with attachment disorders often

exhibit intense behavioral or trauma symptoms in play sessions (Axline, 1964; Yi, 2000; Ryan, 2007; VanFleet, 2006). An individual family filial therapist may hold additional demonstration play sessions with the child so the parents can observe how to respond to the more extreme behaviors in a therapeutic manner, and be prepared for the more intense emotional content they may experience with their children in FT (Ryan, 2007; VanFleet, 2006). As result, parents comprehend their children's experience of the world more fully and are better able to provide for their children's needs in therapy, and provide a healthier home environments for children with attachment disorders (Ryan, 2007; VanFleet, 2006). Ryan's (2007) case of Casey illustrated this process; when Mandy developed an understanding of Casey's attachment related behaviors and needs, she was better able to provide for them.

Parents and caregivers of children with attachment disorders may need higher levels of empathy, support and encouragement than other parents, as well as flexible, collaborative treatment plans (Ryan, 2007; VanFleet, 2006). As seen in both cases presented earlier, parents seeking help for children with attachment disorder may arrive in crisis; immediate training in parenting skills and behavior management may be warranted (Ryan, 2007; VanFleet, 2006). The number of directly-supervised play sessions may also be increased to add further support for caregiver and child before starting sessions at home (Ryan, 2007; VanFleet, 2006). VanFleet (2006) described situations in which additional intervention modes may be required. He stated that when caregivers' physical and emotional strength are already depleted, when a child needs crisis intervention or when parents cannot bear to witness the child's intense trauma-based play, other services may be added to the treatment. VanFleet's (2006) case, presented earlier, illustrates the use of multiple types of intervention along with FT. In conclusion, individual

family FT can adapt to the specific needs of children with attachment disorders and their families (Ryan, 2007; VanFleet, 2006).

Benefits of Filial Therapy for parents and caregivers. Parents and caregivers who successfully learn to provide FT, experience increased confidence in parenting and improved emotional attunement with their children (Hutton, 2004; Kinsworthy & Garza; Landreth, 2002). Filial Therapy helps caregivers reduce their stress, improve their sensitivity and build more adaptive relationships with children affected by attachment disorders (Ryan, 2007). VanFleet (2006) pointed out that FT gives empathy, encouragement and support to parents, and allows them to use CCPT skills, an improved understanding of their child and "...insight about their own feelings and reactions to change their own attitudes and behaviors, resulting in more satisfying relationships with their children" (p. 152-153). Filial Therapy trains parents in skills that can continue to be used with their children's changing developmental needs (VanFleet, 2006). Ryan (2007) noted that foster parents trained in FT can use it with each new child in their care. Further, FT enhances attunement between parents and children, and consequently improves parents' ability to provide for children's emotional and psychological needs (VanFleet, 2006).

Application of Filial Therapy to multiple care settings. Filial Therapy can be used in a variety of settings and with different types of caregivers. Ryan (2007) has presented examples of foster parents caring for children with attachment disorder, and paraprofessionals trained to provide FT to children in residential treatment due to a severe trauma and attachment conditions and needs. She stated that children, who have experienced maltreatment/multiple caregivers, can utilize non-directive play sessions with their current caregivers to resolve serious emotional and behavioral attachment difficulties, and process traumatic memories and losses. While some

mental health professionals feel that children should not develop attachments to temporary caregivers for fear they will be traumatized when that relationship ends, VanFleet (2006) argued that each experience of healthy attachment improves a child's "template" for how a healthy relationship is supposed to feel and work. For children whose early history is marked by abuse, neglect and multiple caregivers, FT may give them their first experience of true empathy, promoting their ability to empathize with others. Children with attachment problems often remain in the foster system for long periods of time. VanFleet (2006) contended that the experience of healthy attachment is so important to child development that children should not be made to wait until adoption before secure attachment is encouraged. Foster or kinship caregivers engaging children with disordered attachment in FT provide them with an experience of being fully accepted for who they are. This demonstrates to these children that they are valued, which, in turn can help counteract feelings of rejection, isolation and low self-esteem common in these children (VanFleet, 2006). Furthermore, VanFleet (2006) pointed out that FT can help stabilize foster placements. Children in foster care may engage in behavior that replicates the unhealthy relationships they endured with abusive caregivers in the past; FT prevents this by providing appropriate nurturance that fulfills children's security and attachment needs. Once these needs are met, attachment-related problematic behaviors recede, and the potential for placement failure decreases (VanFleet, 2006).

In addition, VanFleet (2006) has successfully used FT to support children through transition between foster placements and adoption. Both sets of caregivers participate in the filial training, and engage the child separately, with the frequency of foster play sessions decreasing and those with adoptive parents increasing towards the day of the move. This allows the child to have continuous support of play therapy, gradually let go of one relationship and

develop an attachment to the adoptive parents during the transition process. As a result, transition anxieties are reduced and adoptions start off more smoothly. A further benefit of VanFleet's (2006) individual family FT is the reduction of competition and sibling rivalry between birth siblings and adopted children; each child gets play sessions of their own with a parent and the whole family participates together, promoting family identity, trust and cohesion. This experience is especially important for newly adopted children with attachment disorders as it increases these children's feeling of belonging to the family and that the whole family is attached to each other (VanFleet, 2006).

Multicultural issues. This writer did not find any mention of multicultural needs as they effect treatment for children with attachment disorders and their families. The issues presented in the empirical research section of this chapter may well be applied here. First, practitioners of FT would be wise to consider cultural family and community values in connecting with all families (Jang, 2000; Glover & Landreth, 2000), including those raising or providing care for children with attachment disorders. Second, research suggests the importance of the therapy being conducted in the families' primary or preferred language, rather than through a translator (Kinsworthy & Garza, 2010; Sangganjanavanich, Cook & Rangel-Gomez, 2010). Third, researchers should take care when using standardized empirical tests that may contain inherent dominant cultural values (Jang, 2000; Landreth & Lobaugh, 1998).

Conclusion

This chapter reviewed the history, theory, practice and empirical research of Filial Therapy; a comprehensive, widely-applicable, culturally sensitive, evidence-based intervention that improves parent-child relationships by training parents to carry out Child-Centered Play

Therapy sessions with their children. Cases and literature were used to demonstrate the benefits of Filial Therapy for children with attachment disorders and their families.

The next chapter will discuss several issues related to the needs of children with attachment disorders and their families, and the comparative and collaborative features of Child-Centered Play Therapy and Filial Therapy in providing treatment for these children. In addition, further multicultural considerations will be mentioned. Finally, some topics that require further research will be noted.

Chapter VI

Discussion/Conclusions

In this chapter, the theoretical and practical aspects of Attachment Theory and Reactive Attachment Disorder, Non-Directive Play Therapy/Child-Centered Play Therapy, and Filial Therapy will be drawn together. It will begin with a brief review of the key points of Attachment Theory and the main characteristics of Reactive Attachment Disorder in preschool age (3-5 year old) children. This will be followed by a summary of the central theoretical and practice principles of Non-Directive Play Therapy/Child-Centered Play Therapy (CCPT) and Filial Therapy (FT). The experience of a young child with attachment disorder in Non-Directive Play Therapy and possible differences in that experience if the treatment provider is a therapist (CCPT) or a parent/caregiver (FT) will then be analyzed. The ways in which the two types of practice complement each other in developing new comprehensive, individualized treatment strategies will then be discussed in three parts. The first part will cover situations in which CCPT with a therapist is more appropriate, along with possible ways to involve parents in their children's treatment. The second part will point out several considerations regarding specific RAD populations when contemplating the appropriate use of CCPT and/or FT. This will culminate in a suggested comprehensive program for RAD assessment and treatment utilizing both treatment methods differentially based on the specific needs of individual families. Several multicultural considerations that may apply to children with RAD and their families in treatment will then be described. The chapter will conclude with information about the strengths and

limitations of this paper and recommendations for further research, social work practice and policy.

Attachment Theory and Reactive Attachment Disorder

According to Bowlby's Attachment Theory, an ideal caregiving relationship provides secure attachment in infancy which results in positive functioning with regard to affect regulation, self-regulation, social relationships and sense of self in toddlerhood and early childhood. Two types of insecure attachment, avoidant and ambivalent/resistant, lead to mild problems in attachment-related functioning. The third form of insecure attachment, disorganized/disoriented attachment, is caused by caregiving experiences that the child found frightening and unpredictable (i.e. caregiver was abusive, neglectful). This type of attachment leads to moderate problems in emotional regulation, sense of self and social relationships. Finally, children with Reactive Attachment Disorder (RAD) show severe problems in those areas of functioning, caused by two types of early caregiving experiences: "pathogenic caregiving" related to severe abuse and neglect; or lack of opportunity for attachment due to institutional caregiving environments, or frequent changes in caregivers, such as in the foster care system. "Internal working models" (IWMs) are expectations for care developed by children over time in interactions with their primary caregivers. While securely attached infants anticipate that caregivers will provide interest, concern, and empathy, and that they can successfully communicate needs and maintain attachments, children with attachment disorders build IWMs based on their experiences of insufficient or depriving caregiving. Attachment disordered IWMs result in two types of behavior: inhibited and disinhibited symptoms. Children with inhibited attachment are withdrawn, hypervigilant, and show ambivalent/conflicting approach/avoidant behaviors and "frozen watchfulness." They prevent themselves from seeking comfort and will

resist it when offered, even when they feel threatened or distressed. Children with disinhibited attachment demonstrate indiscriminant approach to any potential caregiver, lack of caution with strangers, seeking of physical contact, and sometimes a willingness to follow any adult who acts kind or offers something the child wants. Fortunately, many children with attachment disorders can develop secure attachment and/or improve in functioning if provided with a healthy, supportive, empathic caregiving environment. The less time the child spends in the pathogenic environment, and the sooner they receive attuned, attentive caregiving, the better the prognosis.

Two problematic issues regarding the diagnoses of Reactive Attachment Disorder in the DSM-IV-TR were discussed in this paper. First, the majority of children with RAD show a mixed pattern of inhibited and disinhibited symptoms; symptoms of indiscriminant social behavior are especially prevalent. Second, RAD is sometimes associated with symptoms of other major psychiatric disorders including Posttraumatic Stress Disorder, Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, and Pervasive Developmental Disorders, as well as co-occurring problems related directly to institutionalization or severe deprivation in infancy and early childhood, most commonly aggression, stereotypies, and language delays. Solid scientific research has demonstrated that these other diagnoses and/or deprivation-related conditions may sometimes occur with RAD, but they are not caused by attachment issues, and not every child with RAD will develop them. Danger arises when clinicians expect aggression and oppositional behaviors to occur in all children with pathogenic backgrounds, and focus on that behavior as the only presenting problem and changing it as the only goal of treatment. In particular, “attachment therapists” that tell parents that all children who have been abused or institutionalized have RAD, and that all children with RAD are severely “disturbed,” will develop significant “problem behaviors,” and that they cannot feel love, empathy or develop any

conscience. There is no scientific evidence or even peer-reviewed clinical literature to support such theories. Children with abusive/neglectful, multi-caregiver or institutional backgrounds should be assessed and diagnosed carefully and appropriately based on their currently-presenting inhibited and disinhibited symptoms. For children with true attachment disorder, appropriate intervention consists of a stable, secure-attachment caregiving environment and/or therapy that addresses their emotional attachment needs. If other diagnoses, organic or mental conditions are present they should be addressed via interventions appropriate to those conditions. In young children (3 - 5 years old is the population reviewed by this paper) intervention or treatment should always focus on the emotional and psychological needs of attachment disorder first. If there are behavioral issues they are likely to remit with proper care, and thus should be focused on later.

Non-Directive Play Therapy / Child-Centered Play Therapy

The importance and relevance of play to child therapy can be stated as follows: Children naturally use play to learn about the world and themselves; they communicate more effectively via concrete, symbolic play than through words; and they more easily process psychological issues and trauma through displacement in imaginary play. Virginia Axline (1947) created Non-Directive Play Therapy (NDPT) based on the same theory as Carl Rogers' (1942) Non-Directive counseling for adults. These therapies are based on a theory of personality that expects that each individual has an inner drive for maturity and self-actualization; the therapist's task is to create the appropriate conditions in which the person can achieve this growth. The most important aspects of NDPT therapy include: total acceptance, empathic responding, reflection of feeling, and minimal limit-setting to ensure safety. The child is given the freedom to self-direct the therapy; the therapist respects the child's ability to make choices, solve problems, and set the

pace. The therapist strives for exact, active attunement in timing, emotional expression and understanding.

The modern version of Non-Directive Play Therapy is most commonly called Child-Centered Play Therapy (CCPT). The principles and practice follow Axline's therapy quite closely, but have been broken down into specific trainable verbal and nonverbal skills. The method of limit-setting used in CCPT is called the A-C-T limit-setting model, which stands for acknowledging the child's feelings, communicating the limit and targeting an alternative. The purpose of this limit-setting style is to simultaneously ensure safety and teach children affective and behavioral self-regulation. The modern practice of CCPT includes a focus on attachment; the rapport developed between therapist and child is meant to simulate a secure attachment relationship. Modern practitioners of CCPT have also come to recognize the importance of parental involvement in children's therapy.

Filial Therapy and Child Parent Relationship Training

Filial Therapy (FT) was created by Bernard Guerney in the 1960s, who theorized that given the proper training and supervision, parents could be successful "therapeutic agents" for their young children. Guerney pointed out that children already have an important relationship with their parents, and that most young children's presenting problems stem from unhelpful interactive patterns within the parent-child relationship. For these reasons, he felt that FT could have even stronger results than treatment with a therapist. FT and the most recently developed 10-week model, Child Parent Relationship Therapy (CPRT), use the same principles and skills as Non-Directive or Child-Centered Play Therapy (CCPT). A Filial Therapist trains small groups of parents to carry out sessions of CCPT with their own children. Training includes didactic and group-processing aspects. Parents are trained in the skills, they have role-plays, they videotape

sessions at home with their children and receive feedback on their use of the skills. Group time is also devoted to parents' opinions about child-rearing and emotional reactions that arise when they endeavor to take on the role of a child-centered therapist. With successful training, a dynamic series of changes occurs within the parent, the child and their relationship. Parents learn about the emotional and developmental needs of their children. They develop understanding, attunement and appreciation for their children. They learn how to engage their children in a respectful, enjoyable manner, and how to discipline through developmentally-appropriate, healthy and effective strategies.

Research has reported that decreases in parental stress and increases in parents' and children's self-esteem, self-efficacy and confidence are often seen in FT programs. Most importantly, FT has been shown to significantly improve parent-child relationships in a wide variety of parent populations (ie. incarcerated parents, Head-Start programs, homeless parents, domestic violence survivors, custodial grandparents) and cultural contexts (ie. Native American, Spanish-speaking, Korean). FT is also used with individual families. Both parents and all the children participate in sessions of CCPT together to build a system of secure attachment relationships within the family. Individual family FT has been used successfully with foster parents, adoptive families and children transitioning from foster placements to adoptive homes.

The (Theoretical) Experience of a Child with Reactive Attachment Disorder in CCPT

The theory and practice of CCPT are the same whether provided by a therapist or a parent/caregiver properly trained by a filial therapist. This section will describe how the behavior of the therapist or caregiver during CCPT may be experienced by a child affected by attachment disorder. The capability of this therapy style to provide for the child's attachment

needs will be demonstrated. In this section, the therapist, parent or caregiver engaging the child in CCPT will be referred to as the provider.

Verbal structuring lets the child know what to expect in this new situation, and provides a feeling of safety and confidence in being able to predict the situation. For example, when the provider states “You and I have an hour to spend together, here in the playroom,” this lets the child know he/she is not going to be abandoned.

The combination of non-directive style, tracking of child’s actions and statements, and reflection of ideas and feelings used by the provider serves several purposes. It communicates acceptance of the child just as he/she is, helps the provider develop an understanding of the child, allows the child to feel understood, demonstrates empathy for the child’s needs and feelings, and creates attunement and emotional security. Children with attachment disorders act differently from children with positive attachments. Their attachment-disordered behaviors were adaptive to survive emotionally insufficient or depriving caregiving conditions, and in CCPT are accepted and respected as such. In general, these behaviors were used by the child in attempts to procure as much comfort and safety as possible and avoid as much physical and emotional pain as possible. In therapy, withdrawn and conflicting approach/avoidance behaviors may be seen with considerable silence, watchfulness or giving the impression of “ignoring” the provider. The child adopted these behaviors to try to protect himself/herself from an unpredictable, abusive and/or neglectful caregiver, while still maintaining physical proximity to an attachment figure. Such a child is equally afraid of approach and abandonment by an attachment figure. In CCPT, the non-directive and accepting attitude of the provider do not overtly approach the child, and do not expect or require any type of interaction, but offer connection when sought. The child is never rushed, but may take his/her time to size up this potential attachment figure from a safe

distance. However, the provider also demonstrates that they are always “there with” the child through attunement and empathy.

Alternatively, the child may present a false happy affect, and attempt to please or charm the provider. This adaptive behavior was used to fill attachment needs in a situation where interchanging caregivers were infrequently available; the child maximized the total amount of social connection they had access to, by approaching every caregiver with the hope of filling some little part of their attachment needs. In this situation, while the principles are the same, the child experiences something different. The provider is interested in everything the child has to say and follows along with maximum attention. With a non-directive style and correct attunement, the child eventually discovers that he/she does not have to act in a particular way to gain the provider’s positive responses and acceptance. The child is free to express how he/she truly feels, and gradually dares to accept comfort through empathy for those real feelings. In both cases, once the child’s attachment needs are met they will gradually give up the unneeded coping style of “disordered” behaviors and progress in development.

Once a sufficient level of attunement, emotional security and trust have developed, the child feels safe to play out all of the psychological issues and traumas disturbing him/her. The provider endeavors to respond in ways that make the child feel comfortable, safe, encouraged and respected. When the provider succeeds in creating a therapeutic level of empathy and attunement, the child feels that the provider shares his/her experience moment-by-moment. The child uses this “feeling-together” support and the medium of imaginary play to process trauma.

The experience of limits being set when safety is a concern demonstrates to the child that the provider will ensure protection from danger. A child with attachment disorder may repeatedly test these limits to reassure himself/herself that the situation with the provider is safe.

The provider's use of the A.C.T. limit-setting technique maintains attuned empathy, reflects the child's feelings and provides a safe outlet for them. The child must have proof that, unlike other caregivers in his/her past experience, this adult will not hurt him/her physically, verbally or emotionally, and will provide a developmentally-appropriate level of supervision/protection.

In conclusion, CCPT provides all the conditions for secure attachment, and creates an opportunity to rewrite internal working models of disordered attachment. In addition, the combination of freedom and support inherent in this therapy experience gives children a way to learn about themselves, resolve internal conflicts, and experience growth in all areas of development.

Differences between CCPT and Filial Therapy in the Child's Experience

This section will look at the differences in how a child with RAD may experience CCPT with a therapist compared to with a parent or known caregiver. Issues with regard to developing rapport, the skill level of the provider, termination of therapy and specific benefits of each experience will be discussed. At the beginning of therapy, the child is brought to an unfamiliar place to meet a new person. A child with attachment disorder may initially react to this situation with anxiety and stress, and may take longer to develop rapport. In FT, the child has play sessions with a parent or caregiver who is already known, typically in a familiar environment, the residence they share. The child may find this situation more comfortable, unless he or she has had negative past experiences with this parent/caregiver and/or the home environment. If the child has already built up defenses against this specific caregiver, rapport may take longer to develop. In terms of CCPT skill, the therapist would be expected to have a superior ability, given that the parent has only recently received training. This being the case, a therapeutic level of attunement and empathy with the child may be achieved more rapidly by the therapist than by

a parent or caregiver. On the other hand, the experience, for the child, of a significant change in the way the parent/caregiver responds to him/her, may be a powerful one. It may be just as well for parent and child to share this monumental shift in their relationship together gradually. At the end of therapy, the child must process the loss of the relationship with the therapist. When handled well, termination can be a healthy process. It is hoped that a child with RAD who has completed CCPT with a therapist will have rewritten internal working models of attachment, and will be able to generalize secure attachment to their primary caregiver. In the case of FT, it is presumed that the parent or caregiver who provided the therapy *was* the primary caregiver. Therefore secure attachment can be created directly between the caregiver and the child. Furthermore, this caregiver may be the child's permanent or long-term caregiver, and the child does not have to lose the relationship. In general, CCPT with a therapist could be seen as a more immediately intensive treatment for severe clinical issues including trauma and attachment. An important benefit of FT training is that it helps parents and caregivers create the best possible home environments for children with RAD. The question then, is whether a child with Reactive Attachment Disorder has a more urgent need for clinically intensive treatment, or a safe, supportive caregiving atmosphere at home. The answer will be discussed at length, in the next section.

RAD Treatment: CCPT with a Therapist or Filial Therapy or Both?

CCPT with a therapist. There are several situations in which CCPT with a therapist may be more appropriate than FT. When the child has significant trauma symptoms or is grieving, the parent may not be able to cope with the intense content of child's play in therapy. Children with RAD often have psychological symptoms of trauma due to abuse/neglect and may grieve the loss of biological parents or other previous caregivers. The raw emotion evident in

children's play when processing trauma or grief can be difficult for parents to witness. The circumstances when both parent and child have been traumatized by the same event or are suffering the loss of a close family member may require individual therapy for the parent and the child. Each family member needs a place to express their feelings regarding the event without worrying about the effect of their words on the other family member. Separate therapy for the parent and child is also needed when the parent's functioning is hampered by a major mental illness. This is not meant to indicate that all parents with a mental health diagnosis cannot provide FT for their children. If the parent has received the needed treatment, remaining symptoms may not always prevent the parent from engaging in FT. At times, the child may have extreme behaviors or significant emotional disturbance and the parent's stress level may be so high that the parent-child relationship or caregiving placement is in crisis. The appropriate course of action may be to provide the child with individual therapy and the parent with intensive support. Finally, parents sometimes express unwillingness or discomfort when FT is suggested due to issues of guilt, resentment, time, money or effort. In these situations, it may be helpful to view the parent as "not ready" to engage in FT training; in the meantime, the child would receive CCPT with a therapist.

In all cases, parents should be involved in their children's treatment, as much as they willing and when they are ready. Minimally, the therapist can have meetings with parents to discuss their child's process and progress in therapy, and help parents better understand the child and his/her needs. A moderate level of involvement might include parents observing the child's therapy sessions from behind a one-way glass and meeting with the therapist afterwards to discuss their observations, ask questions and express concerns. In most situations, once children's clinical symptoms have lessened, parents have replenished their personal resources

and the parent-child relationship is not in crisis, FT may be a reasonable way forward. This is particularly true for children with attachment disorders, who need the support of a reliable, attuned relationship with their current caregivers.

Treatment considerations based on different populations with RAD. Reactive Attachment Disorder affects several different populations of children and their parents or caregivers. The next section will contemplate the treatment needs and benefits of CCPT with a therapist and FT for a variety of child populations with RAD. The ability of three categories of caregivers/parents to provide Filial Therapy for children with RAD will then be evaluated.

Children with Reactive Attachment Disorder. Children with Reactive Attachment Disorder are not a homogenous group. They may display inhibited or disinhibited symptoms, or, most commonly, both. It is unknown whether children with primarily one set of symptoms responds differently to treatment versus an improved caregiving relationship than the other. The relative effectiveness of CCPT or FT for children with a mix of inhibited and disinhibited attachment behaviors would be especially useful to understand. Two types of early caregiving experiences are implicated in the development of RAD including: abuse and neglect by the primary caregiver and situations in which the child has no consistent primary caregiver available, typically in a large orphanage or due to repeated changes in foster placements. As mentioned earlier, children in all these categories may sometimes also be diagnosed with other psychiatric disorders and delays in various types of development. Given the diagnostic problems with RAD it may be better to seek a comprehensive treatment that could assist children with more of their needs. CCPT and FT operate at all mental levels of children's functioning, and create conditions in which children can process trauma, learn about themselves and progress generally towards developmentally-appropriate behavior. The evidence that CCPT provides treatment for many

areas of emotional/behavioral disturbance and developmental issues at once may therefore indicate its proper use with children diagnosed with RAD. This may also be true of FT, depending on the appropriateness of the parent providing it.

Another area to consider is the true similarities and differences of attachment issues between children raised in large institutions, and those who had multiple placement changes in foster care. These two groups are placed together in the DSM-IV-TR, which assumes that their attachment problems are both caused by the unavailability of a single, consistent primary caregiver. However, it is worth considering the many possible differences in these children's caregiving experiences. Research on children raised in institutions (see Chapter III) described a large orphanage with a small, frequently rotating staff, in which many children stayed in the same room together for most hours of the day. Notably, these children had all been placed in the orphanage at six months of age and remained there until and throughout the duration of the study. Thus, these children were consistently in the same environment with the same children for several years. Children who have switched foster care placements multiple times, on the other hand, have experienced frequent changes in their entire caregiving situation. This means that each time they moved to a completely new environment, with new people, new rules, and quite possibly, nothing that looked familiar to them. It might be useful to know what effect these differences have on children in terms of attachment, development and treatment response. Specific questions to ponder might include the following: Do the children in the orphanage have some sense of stability and predictability due to spending all their time in the same environment with the same children? Do these children develop some kind of bond with the each other? Do they compete with each other for attention from caregivers? If they are adopted and go to school, what might their reaction be to a large room full of children? For that matter, how

strange must it feel to them to be adopted into a home with two adults and few children? For frequently moved foster children, what is the psychological effect of not only changing caregivers but complete changes of the environment and everyone around them? How might these issues play out in therapy?

In addition, children raised in orphanages do not always suffer from specific trauma, but are often affected by extreme deprivation (ie. lack of sufficient food, intellectual stimulation, and medical care). Most foster children that have experienced multiple placements have been subjected to abuse and/or neglect in their family of origin, and possibly within the foster system. These children may therefore have trauma symptoms but less severe issues related to deprivation.

All of these differences raise further questions with regard to the appropriate use of CCPT with a therapist and FT. Would children with more extreme histories and/or more severe attachment and developmental problems benefit more from CCPT than FT? Would CCPT be more helpful to traumatized children than FT? What other co-occurring diagnoses and deprivation-related conditions may respond better to CCPT versus FT? Finally, what kind of expectations, understandings, and interventions might be more useful to parents with children adopted from institutions compared to those coming from abusive biological families and/or multiple foster placements? These are all important points to consider when providing treatment to children with attachment disorders and their families.

Next, evaluations of different parent populations who may be more or less appropriate to provide Filial Therapy to children with RAD will be presented.

Biological parents/Child's family of origin. Most cases of RAD in the general population come to light when child welfare workers investigate biological parents or original

caregivers on allegations of abuse or neglect. Social service workers have the unenviable task of determining when children are safe in their current homes, and when they must be removed. The legal definition of good enough parenting, that is, caring for children well enough that they will not be taken away, requires that parents provide food, clothing, shelter, medical care, supervision and protection, and do not abuse their children. However, children may develop RAD due to abuse, neglect of physical needs OR a lack of care for emotional needs, including comfort, stimulation and affection. There is no way a case worker can be sure whether or not parents are providing for the emotional needs of their children. This may be inferred if the child is not being fed, is left unsupervised or is abused. However, even when parents take care of their children's physical needs and practice discipline that does not leave physical evidence of abuse, their children may still be at significant risk of developing unhealthy patterns of attachment, due to a lack of empathic connection and comfort. Dibs is a case in point; his parents provided amply for his physical needs and his education, tried to get him mental health care, and were not physically or sexually abusive, but the emotional situation in the parent-child relationship was so severe that he was traumatized and developed attachment disorder.

There are many types of parent-child relationships and the exact types that can result in attachment disorders have not been delineated. Child welfare workers are on the front lines; they are the people that visit homes to try to ensure that children are receiving appropriate caregiving. However, it is unlikely that they can determine the style of emotional caregiving in the home or whether it has or could adversely affect attachment, unless the child is already showing severe attachment or trauma symptoms.

This writer suggests that the use of CCPT and/or FT may be appropriate to assess for adverse parent-child relationships, and provide proper treatment to improve them. Guerney's

original FT trainings were successful with critical, negative, harsh biological parents and their children with serious emotional disturbances. When starting out in FT, parents often indicate that they do not understand or value their children, do not have emotional connections with them, and sometimes admit to, or defend the use of, physical discipline. By the end of training, these same parents have become emotionally attuned to the needs and personalities of their children, they have significantly improved relationships with them, and they provide healthy, respectful, developmentally-appropriate caregiving environments for them. The potential for FT training to create significant, positive changes in parental behavior, parent-child relationships and caregiving environments is evident. It is possible that even parents who have been abusive, neglectful and/or have not provided emotional caregiving for attachment needs can change; even change enough to become successful “therapeutic agents” for their children. Since CCPT provides for the emotional/attachment needs of children with RAD, and FT training can create empathic, supportive parents and dynamic changes in parent-child relationships, the argument can be made for the careful implementation of FT training for the biological parents/original caregivers of children with attachment disorders.

Several aspects of FT can be tailored to the training needs of parents who have adverse or harmful caregiving behaviors. FT is presented as training: the didactic focus indicates to parents that the group leaders see them as capable of learning, rather than in need of mental health care. FT places the focus of intervention on the parent-child relationship. Parents are not blamed or shamed for how they act with their children, and they are not asked to use the training skills at home, except for 30 minutes per week. Parents are also encouraged to openly discuss all their attitudes about their children and parenting, and their feelings are accepted and respected, even while unhelpful ideas are reality-tested through the group discussion. When parents are focused

on negative aspects of their children, empathy can be used regarding the parents feelings, and then the group discussion returns to the didactic goals of the training. For example, when parents complain about their children's behavior, the group leader would empathize with parents' feelings about the behavior (ie. frustrated, angry), and then move back into explaining the principles and skills of CCPT.

The two facets of FT that create the most change in parents' treatment of their children may be emphasized in a program for parents with adverse caregiving styles. First, FT requires parents to use CCPT skills to genuinely demonstrate empathy and acceptance to their children. For these parents, developing empathy for their children is likely to gradually create an awareness of the pain they may have caused their children, resulting in strong feelings of sadness and guilt. In a group of parents with similar caregiving styles, these difficult feelings will be normalized, and the parents will offer each other support and empathy. When parents have these reactions, they need not feel embarrassed or ashamed, as the group will reframe personal issues as challenges that are part of the learning process.

The second aspect of FT that assists parents in making dynamic levels of change is that most of the learning is experiential and generalizes over time. FT specifically adapted to the needs of this population would include a lot of demonstration, role-play and directly-supervised play sessions. Group leaders could offer support during observed play-sessions, for both the parent and child, as needed. Having parents' first several play sessions with their children held in the training office would also give ample opportunities for group leaders to take note of problems in the parents' training process, and attempt to intervene. Parents would not be allowed to carry out sessions at home until the skills were demonstrated correctly with their own children. This would ensure that the experiences in play sessions would be therapeutic for

children, and corrective for caregivers. Parents would experience, possibly for the first time, positive interactions with their children. Over time, the power of these positive experiences in demonstrating empathy, engaging in play as requested by the child and using appropriate limit-setting, would generalize naturally to improved parent-child relationships. It seems likely that parents properly trained in FT as described, would discontinue abusive or neglectful treatment of their children, in favor of a new attachment-supportive and developmentally-appropriate style of caregiving.

Foster caregivers. Literature has made an argument for children with RAD in the foster care system to receive FT from their temporary caregivers in order to have experiences of healthy attachment relationships. This may help build internal working models of attachment different from the disordered ones carried from the original “pathogenic” environment, and improve social functioning and self-regulation of affect and behavior. FT allows the foster caregiver to better understand the child and his/her needs and provide more appropriate care for them. As a result, the child’s behavior improves and the quality of the caregiver-child relationship is enhanced. An especially significant advantage of this process for children with RAD is that it can stabilize foster care placements, reducing the number of caregiver switches these children sometimes endure and potentially lessening the severity of attachment problems. Another benefit of training foster parents in FT is that they can use the treatment with any children they foster in the future; the experience of FT training also improves empathic parenting and limit-setting skills in these caregivers who may be responsible for the well-being of many children over time. What is not known is whether there is an actual positive cumulative effect for children with RAD engaging in FT with a series of changing caregivers. Perhaps attachment needs would be better served if FT was provided by a case worker who remained with the child

throughout his/her time in the foster care system. When an adoptive family was finally found, individual family FT could be used to transition the child's attachment from the case worker to the adoptive parents.

Adoptive parents. In Chapter III, several case studies were presented in which children with RAD received CCPT or a similar treatment from a therapist. Of these children, those in insecure placements or pre-adoptive families showed considerable difficulty managing the anxiety and stress caused by not knowing if the placement was to be permanent. In CCPT they demonstrated many play themes in this regard, along with difficult affective experiences and had trouble making use of the therapy to resolve these concerns. In all cases the situation improved as soon as the adoption was final. It seems relevant to consider whether these children would have processed these placement insecurity issues in FT with an adoptive parent, or whether they would have been guarded with their feelings out of fear of losing the placement. On the other hand, perhaps the opportunity to communicate these concerns to their adoptive parents through play therapy, and the empathic and accepting responses given by those parents would have helped ease their worries sooner.

FT appears to be very useful for adoptive families raising children with attachment disorder. The successful use of multiple, overlapping sessions of FT with the previous caregiver and the new adoptive parents has been described. Whole family FT in particular seems like a valuable method for building secure attachment throughout the family system, reducing sibling rivalry, creating family unity, and ensuring that the adopted child with RAD feels that they belong with the family.

Needs common to all parents/caregivers of children with RAD. In reviewing case studies demonstrating the use of CCPT with a therapist or FT for children with attachment

disorders, several needs of parents/caregivers raising or caring for these children are apparent. All of these caregivers can benefit from an explanation of attachment and its importance to child development. Due to the differences among populations of children with RAD, global descriptions of symptomatic behaviors, additional psychiatric diagnoses and deprivation-related conditions that sometimes appear with RAD are not likely to be helpful. Parents should be warned away from websites that provide long lists of supposed “RAD behaviors” and other false information that will only increase anxiety and tension in the family. Instead, parents should be provided with accurate information specifically relevant to the background and actual emotional, attachment, trauma-related and developmental needs of their individual child. Social workers and mental health professionals will best serve these families via careful assessment, and a positive, supportive, collaborative, comprehensive and practical approach to treatment. Assisting parents in understanding their children and encouraging as much parental involvement as possible in the treatment is crucial for children with RAD. Finally, many parents of children with attachment disorder find the support and common understanding of parent groups invaluable. In particular, groups of parents raising children with RAD and/or FT in the group format may be especially beneficial.

A comprehensive suggested program for RAD assessment and treatment. What appears below is a systematic plan for assessment and treatment of Reactive Attachment Disorder, based on the benefits of individual CCPT and FT. Many of the considerations mentioned above are worked into this potential program. It is suggested that all parents that come to the attention of child welfare workers or request mental health treatment for the attachment-related issues of their children could benefit from at least some part of this program way. The ideal goal would be to have as many parents successfully trained in FT as possible,

with assessments and supervision to ensure that parents are ready for the training, and children are receiving appropriate treatment.

Assessment. Assessment would include contact with the parent/caregiver and evaluations of the child's needs, the parent's needs and the current condition of the relationship between the child with RAD and his/her primary attachment figure. Initial contacts would seek to gauge the parent's stress level, to get a sense of the interactive patterns present in the parent-child relationship and determine whether the child's placement is currently at risk. The social worker or mental health provider would offer parents empathic support, and attempt to engage them in the treatment of their children. CCPT with a therapist would be used to assess the child for symptoms of attachment, trauma and other psychological issues. Play sessions between parent and child would be observed to reveal the quality of the relationship and the appropriateness of the parent's caregiving style. Additional types of testing would be recommended based on the child's history of severe deprivation (esp. institutionalization). The assessment period could potentially overlap with social welfare investigations of abuse or neglect in the household. The information found in the investigation and the results of attachment-related assessments could be combined to create a clearer picture of the situation in the home and immediate needs of the family.

Constructing a collaborative and comprehensive treatment package. The most crucial aspects of building successful treatment plans for children with RAD and their families include parental involvement and a flexible, multi-modal, comprehensive treatment package to serve the changing needs of the parent and the child. After the assessments are complete, the conclusions should be shared with the parents in an honest, but also positive, supportive and empathic manner. Every attempt should be made to involve parents in the welfare of their children, and

help them feel they are partners in the process. The next step, depending upon the outcome of the assessments and/or child welfare investigation, would include crisis intervention as needed. If the parent has exhausted all personal resources in seeking help, if the child's mental health presentation is severe, and/or if the caregiver-child relationship is functioning very poorly, the placement itself may be at risk. At such times, the child may be moved to a therapeutic foster home temporarily, and the parent could receive respite, support, appropriate information about attachment, trauma and the child's developmental needs, and possibly training in developmentally-appropriate, emotionally sensitive, limit-setting skills.

If the situation is not serious enough to require crisis intervention, or the once the crisis has level has been reduced, and if deemed appropriate based on the assessment, FT training would be offered to the parent. If the parent declined or was otherwise found not ready for FT, CCPT with a therapist could be provided for the child, and the parent could be offered their own therapy and/or access to a support group of parents raising children with attachment issues.

Period of comprehensive, multimodal treatment. Parents who agreed to try FT would be engaged in a small group (4 -6 parents) training program for parents/families of RAD children. Depending on the severity of parent-child relationship problems found in the assessment, plenty of time should be allowed for parents who need to make large changes in order to accept and learn how to use the principles and practices of CCPT. As usual in FT, didactic training sessions should take place within a non-directive support group providing empathy for parents' experiences and challenges in learning and adopting their new role as therapeutic agent to their children. A variety of opportunities for experiential learning should also be included, such as: demonstration sessions by therapist with parents' children, role-plays, and videotapes of Filial Therapy done correctly (not parent videos at this stage). This initial period of learning and

processing should last as long as necessary to ensure proper training before parents attempt sessions with their own children.

Children who may have begun CCPT with a therapist during the crisis intervention stage, or during a period when the parent was not yet ready for FT, can continue this treatment during the first stages of FT parent training. In addition, CCPT or Theraplay group therapy could be offered at the same time and location as the parent-training. This would allow children to engage in small group treatment that may assist with attachment issues, social skills and other developmental needs. Further, it would provide therapists the opportunity to observe the children and note any positive or concerning changes each week. It would also serve as child care for the parents.

The next stage would add directly-supervised, in-office parent-child CCPT sessions viewed by group and discussed at length. There are several reasons for the first few sessions between each parent and child to be directly supervised. Parents of children with RAD may find the sessions more difficult than they expected, especially if the child expresses strong emotions towards the parent. Parents may need support during the sessions to maintain their CCPT stance and not fall back on previous habits of negative parent-child interactions. At times, the direct intervention of the therapist may be needed if the child exhibits trauma or attachment-disordered symptoms or appears overwhelmed. These sessions may also provide an opportunity for the therapist to gauge whether FT is appropriate for the particular parent-child pair, whether a longer training period should be engaged before play sessions can be moved to the home, or the child is too traumatized to benefit from FT, and needs CCPT with a therapist instead.

When parents have demonstrated successful CCPT sessions with their children under direct supervision, these sessions may be moved to the home. All home sessions would be

videotaped and discussed in the continuing FT parent group. Children could continue in group play therapy to encourage social skills, and provide opportunity for ongoing assessment of children's progress and remaining treatment needs.

As treatment progresses, improvements in parent-child relationships should be apparent in play session videos. Children may show decreasing emotional and psychological symptoms, or, they may be actively engaged in processing past trauma through the therapeutic process of imaginary or symbolic play. The parent group would continue to process play session videos, with a focus on how to respond therapeutically when children show trauma-based play. It can be pointed out to the parents at these times, that this play is healthy, and demonstrates that their children have come to trust them to provide support for their therapy work. Discussion can also gradually move to generalization of CCPT skills into daily life with the child, including proper caregiving and discipline for children with RAD. Parents should be encouraged to talk about any new experiences they are having with their children, and how their feelings about their children and their relationships may have changed.

Alternatively, individual family FT may be used, especially with adoptive families and/or children in transition from foster home to adoptive home. An additional support group for parents of children with RAD would complement this otherwise comprehensive treatment.

This suggested treatment program demonstrates the use of both CCPT with a therapist and FT as appropriate at different times and in different situations for children with RAD and their families. It includes numerous opportunities to provide individual support and ongoing assessment to ensure that parents and children can have positive, therapeutic experiences tailored to their specific needs and challenges.

Multicultural Considerations

An attempt should be made by therapists to understand and incorporate the cultural values of families. Certain cultures place a high value on kinship and extended family participation in parenting. In these families, information about a child's attachment and developmental needs and FT training could be offered to all members of the extended family indicated by the primary caregiver. Whenever possible, assessment and treatment should be conducted by therapists who are fluent in the primary or preferred language of the family. Practitioners/researchers should use caution when using standardized assessment instruments; they may not be appropriate or may not measure success accurately when dominant cultural values are different from those of the family. Play materials used in CCPT or FT should include culturally-relevant toys that allow children to accurately represent their view of the world. When adopted children come from a different culture this can create additional stress and challenges; in cases where parents adopt children from large orphanages in Romania, Russia or China, the child likely experiences culture-shock and may not be able to speak or understand English. It would be useful to have a therapist or at least a translator who can understand the child's language. The many concerns of Mexican/Mexican-American families affected by immigration and deportation are beyond the scope of this paper. However, the frequent, sometimes sudden, and potentially lengthy separation of parents and children due to these situations may bear relevance to attachment problems that may present for treatment in the United States.

Strengths and Limitations of This Study

This study improves understanding about two types of comprehensive treatments with the potential to provide for many psychological, attachment and developmental needs that may affect children with attachment disorders and their families. CCPT and FT can be used to

involve parents more or less directly in the clinical and caregiving needs of their children. A comprehensive, individually-tailored, assessment-based treatment plan has been suggested to provide support to caregivers, improve parent-child relationships and help parents create conditions for secure attachment that were lacking in children's early life experiences.

This paper represents a limited exploration, not an exhaustive study. The methodology of this study limited the search to treatments appropriate for pre-school age (3-5 year old) children with attachment disorder and did not look at all types of treatment that have been tried with children with RAD. Not all types of diagnostic issues for attachment disorder were covered in this paper; only two key concerns were discussed. Further, the research on diagnostic issues and discussion of attachment disorders presented in Chapter III was based on DSM-IV-TR (APA, 2000). The diagnosis for attachment disorders was changed with the recent publication of DSM-V (APA, 2013). Studies and literature related to this change were not reviewed in this paper. This is due to the fact that the case studies describing the treatment of RAD had based their definitions of the disorder on DSM-IV-TR or prior editions.

Research, Practice and Policy Recommendations

The treatment program outlined above could also be used for research purposes with different populations of children with RAD and parents/caregivers, and in different settings and situations. The program includes several opportunities for assessments that could measure treatment effects over time. In addition, qualitative or exploratory research describing the experiences of children with attachment disorder and their families, before, during and after treatment with CCPT and FT could be very enlightening.

Several gaps in the existing research have been noted. Large studies have been presented with regard to the plight of children raised in large orphanages and the resulting diagnosis of

attachment disorder, and other conditions related to the severe deprivation in such institutions. Follow-up research involving their adoptions and treatment were not found in any peer-reviewed literature; this may be the population that is least-well understood by adoptive parents, leading to various problems in adoptive families. In addition, the lack of peer-reviewed articles on treatment of these children and the warnings of researchers regarding treatments based on over-generalized definitions of attachment problems not founded on any scientific evidence, suggests that these may be the children most commonly exposed to coercive, abusive treatments that traumatize children who need understanding and positive attachment experiences in order to have the best possible quality of life with their adoptive families. Peer-reviewed treatment articles for children with attachment disorders resulting from early experiences in large institutions, even qualitative and case study presentations could shed some light on the problems and solutions for these families.

Some literature has suggested that children with who may remain foster care for long periods can benefit from FT from each new caregiver, with the theory put forth that multiple secure attachment experiences can have a cumulative effect on a child's attachment style. It would be appropriate to attempt to prove this theory through research, especially via longitudinal studies that could provide information on long-term outcomes. Longitudinal studies could also be used to try to determine whether individual, long-term CCPT with a therapist can improve the overall development, self-efficacy and mental health outcomes for children with RAD who have no permanent caregiver.

In the area of practice, social workers should take responsibility to prevent a pessimistic and negative attitude towards children with attachment disorders. Children with attachment disorders and their families need support and hope. Certain, unproven clinical theories and

websites discuss “RAD kids” as a homogenous group from whom terrible behavior, lack of conscience and inability to love should be expected. Social workers should protect these children by warning their caregivers about this easily-accessible and exceedingly unhelpful material. Children with attachment disorders deserve appropriate assessment and treatment for their observable, individual emotional, attachment and trauma issues. Caregivers need accurate information, specifically relevant to their children, presented in a practical, realistic and positive manner. Social workers should reassure parents that there are treatments to help their child and family without resorting to coercive “attachment therapies.”

Adoptive parents whose children have an attachment disorder are likely to have considerable difficulties understanding their children’s unusual behaviors, and often feel disheartened or hurt when a feeling of love and closeness is difficult to achieve. Even the most sensitive, ideal and experienced caregivers may be at a loss when interacting with and trying to develop a relationship with children who have no experience with a positive attachment style, and have, in fact, spent their lives adjusting to the experience of attachment needs that have never been met adequately. The situation may be magnified when children are adopted from large orphanages and/or from other cultures. These parents may require extra support to develop acceptance and understanding for their adopted children with RAD.

In regards to policy, this writer argues that assessment for children’s emotional and attachment needs should be included in child protection procedures. The crucial role of attachment in many areas of child development has been common knowledge for at least forty years. Yet, current child protection laws and practices cannot ensure that children have secure attachments to their parents, or even reasonably healthy parent-child relationships. The use of observed play sessions with parents and children to assess emotional relationships, and the

offering of FT to parents could be used as part of child welfare investigations. A parent's inability to succeed in FT training, after being given a solid opportunity, might indicate a serious attachment risk for the child. On the other hand, observable improvements in parent-child relationships would demonstrate that attachment needs were being met.

In addition, assessment/intervention with CCPT and/or FT could be built into other areas of service likely to encounter children with moderate to severe attachment difficulties, such as in foster care and new adoptive families. The possibility of maintaining one case-worker with a child throughout the foster system, and of having FT training for those case workers, might have a significant effect on the attachment–health of a child who remains in foster care for a considerable period of time and has multiple placement changes. The use of FT during foster-adoption transitions, and with new adoptive families to secure the attachment of adopted children is also recommended.

In conclusion, Attachment Theory brought attention to the emotional needs for security and affection in children. Research in large orphanages has provided considerable information on the plight of children who have no access to a caregiver to provide for attachment needs. Cases of attachment disorder among the general population demonstrate that even children who have a primary caregiver present may suffer attachment problems if their emotional needs are not met adequately. The situation is worse for children whose basic physical needs are ignored and/or who are abused, as well as those shifted through multiple placements in the foster care system. CCPT and FT are directly-experienced therapies that operate at all mental, psychological and emotional levels of children's functioning. CCPT and FT provide therapy for attachment, trauma and developmental needs in children with attachment disorders. FT instills this experience within the relationship between the child and caregiver. The dynamic process

teaches the parent to understand the child and best provide for attachment and developmental needs in daily life. As such, it may well be one of the best interventions for attachment disorders. Many areas regarding caregiving situations and parenting styles, experiences of children with attachment disorders, improved diagnostic information and individualized treatments remain to be researched. It is hoped that the treatment needs of children with attachment disorders, and the attachment needs of children in general can be better provided for through changes in policy and practice that demonstrate a value of strong parent-child relationships.

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