DEVELOPMENTAL FILIAL THERAPY: Process-Outcome Research on Strengthening Child-Parent Relationships through Play in a Setting for Victims of Domestic Violence

by

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ABSTRACT

The present research study was conducted in partial fulfillment of the dissertation requirements for the degree of doctor of philosophy. The small scale pilot process and outcome study examined: (a) the therapeutic efficacy of intensive (i.e., daily) filial therapy for victims living within a domestic violence shelter; and (b) the dynamic processes of child-parent enactments within Melanie Klein's (1932/1975, 1950) theoretical constructs and clinical interpretation on object relations, and that of developmental stage theory (e.g., symbiosis, differentiating, practicing, rapprochement) in early childhood (Mahler, 1952, 1968; Mahler, Pine, & Bergman, 1975) and adulthood (Bader & Pearson, 1983, 1988, 1990) interpersonal relationships. In doing so, the hallmarks play therapy and therapeutic principles of filial therapy (VanFleet, 1994, 1999a) were examined and evaluated by means of both quantitative (e.g., treatment outcomes) and qualitative (e.g., process-orientated interpersonal) measures. Four (4) mother-child dyads participated in the study, which was undertaken on-site at a local domestic violence shelter in Calgary, Alberta. The study was based on accounts of treatment interventions with children and mothers conducted by the present author, a clinical psychologist and registered play therapist/supervisor. The study also includes the author's specifically developed and designed instrumentation for investigating interpersonal processes, and for which interrater measures were obtained. These results suggest supportive findings on both the level of filial treatment efficacy and for an integrative theoretical foundation linking a developmental interpretation and understanding of intrapersonal and interpersonal human processes.

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CHAPTER I – INTRODUCTION

Ever imagine what happened to the playfulness of your childhood? For years, psychologists and clinical practitioners have encouraged adults to discover or rediscover their own *inner child*; that is, to have adults focus on developing a deeper understanding of their child within. Although typically employed as a therapeutic modality in working with children, there is increasingly emerging research to suggest that play therapy techniques also have merit in providing clinical mental health service to adult populations (Bergmann, 1993; Bodrova & Leong, 1998; Chick & Barnett, 1995; Mahon, 1990; VanFleet, 1997).

In addition, parents and paraprofessionals can help to enhance their relationship with their *outer child*. Increasing interest has been given toward investigating how parents and caregivers can enhance their interpersonal relationships with children. Parent-child relationships can be strengthened in a variety of ways. For example, positive results have been reported by employing play therapy techniques to improve verbal communication between parents and children (Mogford-Bevan, 1994; Sweeney & Landreth, 1993). Another way parents can strengthen the nonverbal bond with their children is through practicing play. Play offers a powerful, multicultural tool (Henniger, 1995) and parents who take a genuine interest to actively engage in their children's play activity can increase their child's self-esteem, autonomy, social skills, as well as help them to develop self-control and mastery and to acquire a sense of safety and security (Axline, 1948; Landreth, 1991; McGuire & McGuire, 2001).

That spontaneous play activity begins as a natural process in early childhood development, it evolves into an enrichment of applied life skills demonstrated over the life span of all individuals. Positive play experiences in early childhood can facilitate

creativity and imagination, encourage children to explore their immediate environment (e.g., home, family) and, gradually, these skills can be transferable in later life toward achieving successful experiences in new settings (e.g., from home to school) and new interpersonal relations (e.g., from family to peers, from dating to marriage).

Today, many parents and paraprofessionals may find it difficult to find time to play with children. Indeed, some adults themselves may have lost even their capacity to play. Yet, for children, play is a symbolic process that represents both the real and the imaginary, both their inner and their outer worlds. Play is as natural for children as verbal conversation is for adults. It is cause for some wonder, then, why so many parents find it so difficult to communicate effectively with their children. For adults, play can conceivably decrease grownup stress, enhance interpersonal relationships with their children, coworkers, and even spouses. For parents, play can renew their interest to learn and discover as well as their yearning to have fun, too.

A particular area of interest in play therapy research is called *filial therapy*. Filial therapy includes directly the participation of parents and adult caregivers in the therapeutic and developmental work with children. This approach addresses the needs of today's ever-changing family. The dynamics and needs of any one family are unique, for example, in cases of separation and divorce, domestic violence, and single parent and blended family households. Dr. Risë VanFleet (1994, 1997, 1999a), among others, has observed the value that meaningful involvement from parents can contribute in the therapeutic work with children. She proposed that through facilitating the primary goal of providing children an opportunity to experience play, filial therapy through parent education and direct, experiential involvement can positively enhance these change processes in children. VanFleet (1994) presented the principles of filial play therapy as:

(a) recognition of the importance of play in child development to be a primary avenue for gaining greater understanding of children; (b) the belief that parents are able to learn the skills necessary to conduct child-centered play sessions with their own children; and (c) recognition that a psychoeducational model has merit when evaluating and intervening with children and parents. In short, filial therapy is a flexible approach that elicits parental involvement and "uses a psychoeducational intervention model which is based on client-centered, dynamic, behavioral, and family systems principles" (VanFleet, 1994, p. 65) that can potentially empower both parents and children.

Teaching parents and adult caregivers the meaning, the merits and the fundamental techniques of child-centered play is at the heart of filial therapy. In child-centered play, the child is in charge of the play. The child selects the toys and the play activities; parents learn to respond to the child in ways that symbolizes the child's developmental and emotional needs and desires. Opening this door and opportunity for free play allows children to express themselves, their experiences and their true feelings and actions, all at their own pace.

Through play children's actions and feelings are continually supported by the adults' *empathic attunement*. That is, the parents' abilities and capacity to employ empathic skills when relating to their children helps convey sensitivity and understanding, as well as acceptance of the children's feelings and needs (VanFleet, 1994). With the enthusiasm captured in a child's first 'peek-a-boo' experience, imagine a child's delight in feeling genuinely heard and understood when the parent conveys undivided attention and empathically responds, "Playing with you is fun," or, "Playing makes you smile and laugh." This gives the child the permissive message that it is alright to act playfully and be himself or herself and this, in turn, can build the child's self-

esteem and ability to develop healthy interpersonal relationships. Moreover, parents too can feel empowered in the ability to communicate and connect with their children at such a visceral and experiential level.

Without a doubt, parent-child interactions can be extremely enriching and rewarding. Parents can purposefully create positive play experiences with their children and engender healthy facets for human development. Play allows opportunities for children to discover and explore both their inner and outer worlds. Simultaneously, parents too can unearth the playfulness of their own inner child, perhaps inert or long-lost and forgotten, to meet and appreciate their own sense of self together with the shared emotional and physical experiences of their child's outer world.

Statement of the Problem

Children are affected by others in multiple ways. Most children are fortunate to grow and develop in a healthy and nurturing environment. These children have the potential to develop a healthy and mature sense of self and to develop healthy, enriching interpersonal relationships. Less fortunate children, such as those who experience the physical, emotional, and sexual affects of domestic violence, harbor lifelong fears and anxieties and have a far lesser potential to develop a healthy sense of self or interpersonal relatedness to others. Children of domestic violence experience acute feelings of separation and loss, and they have difficulty coping with their feelings in a healthy fashion (Alessi & Hearn, 1998). Children who witness violence often blame themselves for the violence, and are negatively affected through manifestations of internalizing and externalizing behaviors such as low self-esteem, lack of impulse control, short attention span, an inability to control anger, physical aggression and verbal abuse, passivity and withdrawal, and possibly pseudo-maturity, as well as

encountering academic problems (Kot, Landreth, & Giordano, 1998). Young bystanders of domestic violence are frequently isolated and struggle with issues such as nightmares, night terrors, bed-wetting, tantrums, biting, kicking, or excessive anger or fear (Layzer, Goodson, & Delange, 1986).

Rationale for Research: The Outer Child

Children need not experience domestic violence first hand to suffer from psychosocial concerns or exhibit problematic behaviors. Of course, not all children do manifest negative symptomatology. Some children, even those subjected to some of the most severe abuse develop sufficient skills and coping mechanisms to form a resiliency in later life. Children who find themselves in shelters, however, are put involuntarily into crisis. They are removed from the familiar surroundings of their homes and placed in unfamiliar, albeit safer, environments.

Domestic violence is a serious social, economic and legal problem (Canadian Centre for Justice Statistics, 2000). Shelters often represent the first safe haven for children and their mothers with more than 1200 shelters and 800 children's programs in the United States and 433 shelters in Canada (Lehmann & Carlson, 1998). Many research studies suggest that the negative effects of domestic violence are long-term and far-reaching. The intergenerational transmission of domestic violence indicate that while female children are more inclined to learn powerlessness thereby developing an increased risk of becoming victimized, males who witness wife abuse are at a higher risk to become abusive in their interpersonal relationships (Kot et al., 1998), running away, or exhibiting suicidal ideation (Lehmann & Carlson, 1998). In recent years, there has been a dramatic increase in the access to domestic violence shelters. However, shelter

work tends to be typically defined by treating adult victims with little appreciation for the children as victims (Alessi & Hearn, 1998).

Responding to the need to provide treatment to traumatized children who have experienced domestic violence, researchers have indicated that crisis interventions (Lehmann & Carlson, 1998) and play therapy techniques are promising (Geffner, Jaffe, & Sudermann, 2000; Gil, 1991, 1996a; Landreth, 1991; Stephens, McDonald, & Jouriles, 2000). The rationale for using play therapy in treating children is based on developmental considerations (Kot et al., 1998; Lehmann & Carlson, 1998) in that toys and play activities provide children with a symbolic language and a natural medium for self-expression (Axline, 1947; Landreth & Homeyer, 1998; Landreth, Homeyer, Glover, & Sweeney, 1996). Early research on play therapy has even suggested that it could be used to assess and treat learning problems in children, for example, reading difficulties, in that play materials emphasize the importance of emotionalized attitudes in contributing to academic difficulties (Axline, 1949). Current research continues to support the use of play therapy techniques to assist children with learning behavior problems (Fall, Balvanz, Johnson, & Nelson, 1999), speech and language difficulties (White, Flynt, & Jones, 1999), and in the neurodevelopment of young children (Perry, Hogan, & Marlin, 2000). In the last several decades, play therapy has indeed positioned itself as viable intervention in treating the diverse needs of children. With the intergenerational transmission of domestic violence, it seems salient to integrate the principles of play therapy into a clinical framework for treating children and their parents or primary caregivers.

Research Questions

The theoretical underpinnings of object relations and developmental theory represent the conceptualization for investigating and evaluating the psychotherapeutic processes of filial therapy. Heavily influenced by the principles and techniques of play therapy and filial therapy, and psychological developmental theory, the present research study represents an integrative treatment modality to investigate the following research questions:

1. *Does intensive filial therapy provide therapeutic efficacy and enhancement of strengthening child-parent relationships for victims living in a domestic violence shelter?*
2. *Do the interpersonal processes of child-parent enactments parallel the theoretical and clinical foundations of object relations and developmental stage theories of childhood and adulthood interpersonal relationships?*

To initially address these research questions, let us turn to the following research on the history of child psychotherapy, childhood development, play and family play therapy, as well as review the significance of the problem and justification for conducting clinical investigations within domestic violence and battered women shelters. While introduced on in the following chapter, subsequent sections will address in detail the many methodological issues and empirical challenges facing clinical scientists in conducting process outcome clinical research.

CHAPTER II – REVIEW OF THE LITERATURE

Selfobjects at Play: Treatment and Development

From childhood into adulthood, we derive personal meaning from our intrapersonal and interpersonal experiences. Beginning in infancy, human beings innately seek consolation and security from others such as their mothers or primary caregivers. The biological existence and onset of these early dyadic relationships unfolds through untold interactions and exchanges with others. "Yet all relationships must necessarily contain elements of all previous relationships" (Bradway, 1979, p. 31). Whether within the therapeutic context of client-therapist (S. M. Saunders, Howard, & Orlinsky, 1989) or child-parent (Burgoon, le Poire, Beutler, & Bergan, 1992) interactions, the human self emerges through an interplay of varied psychological processes (e.g., transference, countertransference, empathy) that are intimately guided by a progression of developmental stages of intrapersonal and interpersonal relatedness.

Literature on process outcome psychotherapy research over the past decade and the evidence attesting to the effectiveness of integrative psychotherapy treatments have suggested the need for research efforts to bridge together the developmental features of both child and adult psychotherapies (Kazdin, 1995). Historically, traditional psychoanalytic theory provided a robust theoretical framework on human development, in which interpersonal theories of relatedness closely followed, such as object relations theory and attachment theories of childhood development. Largely stemming from the psychodynamic perspective, the theoretical framework of object relations and advancements on our understanding of therapeutic processes, such as transference and countertransference (Weisberg, 1998b), and play (Alvarez & Phillips, 1998), have enhanced our understanding of dyadic selfobject relations in human development and

interpersonal relatedness (Weisberg, 1997b). Other empirical examples on dyadic processes and interpersonal relatedness have included investigations of childhood development suggesting that the stages of early child-parent relationships closely parallels the developmental stages of adulthood relationships and couplehood development (Bader & Pearson, 1983, 1988, 1990; Barabash, 1995) which have also emphasized the importance of empathy (Gilhotra, 1993; A. G. Kaplan, 1983; Weisberg, 1997a) in intrapersonal processes and interpersonal relationships. Chazan (1995), for example, emphasized that the "development of empathy is crucial to the development of mutual understanding" and any interference or deficiency present a "major obstacle to positive parent-child relationships" (p. 32).

Theoretical frameworks of play therapy, human development, and interpersonal relationship enhancement models provide the central backdrop for present research study. It is illustrated here how many of the fundamental tenets and approaches of play therapy in child psychotherapy can be enlarged to examine that of all human interpersonal relationships. For example, many of the principles of relationship enhancement in couples therapy (B. G. Guerney, 1991; B. G. Guerney, Coufal, & Vogelsong, 1983; L. F. Guerney, 1993) have been extended to building positive relationships in families (B. G. Guerney, 1984; B. G. Guerney & Guerney, 1988) and enhancing the interpersonal relatedness between children and parents (Andronico, Fidler, Guerney, & Guerney, 1969; Bavin-Hoffman, Jennings, & Landreth, 1996; B. G. Guerney, 1964; L. F. Guerney, 1991, 1997; McGuire & McGuire, 2001; VanFleet, 1994) through conjoint child-parent play therapy techniques, also commonly known as filial therapy or filial play therapy.

Of central aim here is to provide the rationale and justification that integrates the principles of child psychotherapy through a developmental perspective of psychotherapy towards a transtheoretical approach of interpersonal relatedness befitting a child-parent psychological treatment model. The presentation begins with a discussion on the history of child psychotherapy and its roots toward gradually developing and utilizing play as a primary therapeutic vehicle for working with children and, later on, for working with adults. Next is a discussion on the transtheoretical features of selfobject relationships in human development, which has been heavily influenced by the contributions of psychodynamic treatment in child and adult psychotherapies within the theoretical framework of object relations. Following a broad definition of play therapy, its characteristics, and its processes, a discussion is provided on the following major play therapies: psychoanalytic, Jungian, cognitive-behaviorism, and nondirective or client-centered approaches. The features of individual play therapy are then integrated and presented on interpersonal play therapy modalities such as family play therapy and filial therapy. Finally is a discussion on the neurodevelopment, treatment, and psychological effects of traumatized children in the contexts of domestic violence. Let us now begin with an examination of the roots and history of child psychotherapy.

History of Child Psychotherapy

Despite the oft fragmented existence between Freudian camps and the basic principles of psychoanalysis that have entered mainstream twentieth century thought (Ehrenwald, 1991), the most dominant and most enduring approach to clinical child psychotherapy has been play-orientated psychotherapy, which is largely rooted in psychodynamic theory (Kazdin, 1988; Koocher & D'Angelo, 1992). Although not directly fulfilling a caseload in working with children, Sigmund Freud regarded play as a means

by which children could express their thoughts and feelings and accomplish cultural and psychological achievements (Bettelheim, 1987a). Reviewing Freud's clinical case notes on "Little Hans," Koocher and D'Angelo (1992) accredited him with establishing the initial guidelines for psychoanalytic treatment in that he encouraged Little Han's father to "join in" the therapeutic process thereby underscoring the importance of permitting the child to develop fantasy themes and metaphors as a means to facilitate communication. It might also be observed that this case illustrated one of the first accounts on the therapeutic value in adopting a nondirective approach to working with children:

> ...Freud clarified that whenever the father asked too many questions and more forcefully directed the lines of inquiry, Hans would resist, producing clinically meaningful material. Freud cautioned that the analyst/father had to be patient with his child so that Hans might generate his own thoughts and elaborations about his fantasies. (Koocher & D'Angelo, 1992, p. 460)

During the 1920s, other child psychoanalytic techniques began to emerge. In contrast to Freud's emphasis on 'talk therapy,' however, Hermine von Hug-Hellmuth applied psychoanalytic principles in home-based observations of children at play recognizing that a child's own toys and games could generate valuable analytic material. Nonetheless, von Hug-Hellmuth "tended to dismiss her play techniques as merely preliminary strategies to be used in the initial phases of treatment" (Koocher & D'Angelo, 1992, p. 460), for example, rapport building toward enhancing the therapeutic alliance with the child.

During the 1940s, traditional psychotherapy models based on drive theories or passive treatment modalities (e.g., behaviorism) began to recognize the therapeutic benefits for children and adults who become active participants in the therapeutic process, and that the potential for psychological growth could be extended beyond the

individual client. Allen (1942) argued that psychological treatment of infants and children must be tailored to the developmental level of their functional, interpersonal relationships with other human beings, as well as meet their intrapsychic needs such as security and satisfaction. Gradually, an ecological perspective was developed and gained momentum whereby biological and social growth processes were considered partial aspects in the totality of human development. Within the therapeutic milieu, some clinicians began to develop creative and spontaneous therapeutic techniques as a means of developing processes of separation and individuation through differentiation (Mahler, 1968; Mahler et al., 1975) from others.

Following the World War I postwar period, women predominately headed child-focused techniques. Anna Freud is recognized for establishing Vienna as one of the child analysis centers (Mayes & Cohen, 1996). Solnit (1983) attributed A. Freud's work in terms of her role as: (a) guardian and advocate of and enriching contributor to her father's creation of psychoanalysis; (b) a pioneer in establishing child psychoanalysis; and (c) an original, natural scientist and psychoanalyst. A. Freud's conceptualization of the developmental lines in human life (Solnit, 1984) contributed to our understanding of children and adults and helped span the gap between theory and practice that have pioneered many current theories and techniques of child psychoanalysis (Solnit, 1997).

On the other hand, Melanie Klein, who trained with Sandor Ferenczi, established in Berlin another group of child specialists (Koocher & D'Angelo, 1992). Considered by many to be a pioneer in the field of child psychotherapy, Klein (1932/1975) provided groundbreaking work on the fundamental concepts of anxiety in children. One of the most important concepts presented by Klein was her analytic interpretation of the child's relationship to the mother's own body (object), and its analogous concept of the child's

own relationship to his or her own body (self). In classical object relations theory, the child's mental processes assimilates and integrates these self-object concepts to advance ego-development. The greater the child's capacity to take in knowledge, the better his or her ability to reorganize and bring order to mental processes, whereas the child's inability or inhibition to do so results in increased anxiety from both of these sources. For Klein, anxiety and aggression results from the infant's early satisfactions and disappointments with the mother's body (e.g., nurturing or withholding) and with the degree of symptoms experienced depending on the infant's degree of early frustration.

In treating children, Klein initially attempted to use the "Little Hans" techniques, developed by S. Freud, in her original home observations. Responding to investigations on some of the family dynamics that created a hostile environment, however, Klein gradually introduced traditional child analytic observations and techniques to her consultation room. Klein's early work provided interpretations on the child's generation of play themes and permitted a more standardized basis for inferring meaning from metaphors through games and kinesthetically-stimulating toys, such as sand and water tables (Koocher & D'Angelo, 1992).

Klein (1932/1975) believed that symbolism was only part of psychoanalytic treatment, however, and argued that to understand child's play correctly it must be in relation to its whole behavior in that a single toy or single bit of play can have many different meanings. She further postulated that infants possessed from birth an intricate psychic system upon which highly sophisticated fantasies could lead to complicated psychological conflicts. Accordingly, she explained that play techniques and metaphorical interpretation could be used to induce fantasy in children and, thus, reduce a child's anxiety (Klein, 1950). Klein (1932/1975) wrote:

> The archaic and symbolic forms of representation which the child employs in its play are associated with another primitive mechanism. In its play, the child acts instead of speaking. It puts actions—which originally took place of thoughts—in the place of words; that is to say, that 'acting out' is of utmost importance for it. (p. 9)

While still maintaining some of the classical Freudian principles that focused on both primitive defenses and transference to the analyst, Klein argued that psychic anxiety in children is more acute, and that play allowed an opportunity for the anxiety experienced by a child to be expressed differently.

Other pioneering investigations of play therapy in clinical practice were generally favorable (Gitelson, 1938), which prompted new directions in the field including major topics such as defining new terms and concepts, aims and technical difficulties, fitness for child guidance organizations, suitability for use in children's agencies, as well as qualifications of the play therapist (Gitelson et al., 1938). To assess the efficacy of play, the Finke categories represented an early attempt to develop a quantifiable measure of the psychotherapeutic properties of play therapy processes (Lebo, 1955). Other early investigations in structured or directive (e.g., Hambidge, 1955) and nondirective play therapy (e.g., Fleming & Snyder, 1947) were encouraging, although many of these interpretations remained closely tied to the traditional adult psychoanalytic paradigm. That is, play therapy models were typically divided into either of two types: (a) controlled standardized and (b) free or spontaneous. Early observers noted the therapeutic benefits of play as an opportunity to enhance the therapeutic relationship, as an opportunity for the child to act out conflicts, and as an educational opportunity for the child to develop intrapsychic insights (Newell, 1941).

Other early interpretations of children's play primarily took the form of direct verbal statements about the representations of the metaphors in both primitive defenses

and transference to the analyst and became the focus early in the course of treatment (Koocher & D'Angelo, 1992). Although gradually entrusting more in the power of play processes in later years, Klein (1932/1975) was careful not to distance herself too far from the emphasis on interpretation in classical Freudian analysis. On denoting children's surprising willingness to easily accept analytic interpretation, Klein (1932/1975) elaborated on her position:

> The reason probably is that in certain strata of their minds, communication between the conscious and the unconscious is as yet comparatively easy, so that the way back to the unconscious is much simpler to find. Interpretation often has rapid effects, even when it does not appear to have been taken in consciously. Such effects show themselves in the way in which they enable the child to resume a game it has broken off in consequence of the emergence of an inhibition, and to change and expand it, bringing deeper layers of the mind to view in it. (p. 9)

While Klein's treatment approach emphasized metaphorical interpretations and traditional analytic techniques, such as transference, Anna Freud questioned assertions that considered children's play to be a parallel process to that of an adult's ability to 'free associate' (Marans, Mayes, & Colonna, 1993). Rather, the transference relationship was considered by A. Freud as an opportunity for a "corrective emotional experience" in which children and adolescents could "have an intense, interpersonal experience that can undo the deviations of past experience and make up for these deficiencies in early libidinal experience" (Koocher & D'Angelo, 1992, p. 467). While A. Freud also elaborated on her father's "Little Hans" techniques by consulting frequently with the parents to effect clinical change, she indicated increasing divergence from classical psychoanalysis and joined the impressions of other clinicians (e.g., Winnicott) who believed that the environment could significantly impact a child's development of neurosis. Moreover, A. Freud's views on the developmental lines and on the unfolding of instinctual life, which

were rooted in direct observations of infants and young children, were afforded a rethinking of the developmental stage theory model (Mayes & Cohen, 1996).

In addition to the likes of Klein and A. Freud, Koocher and D'Angelo (1992) noted how the evolution of child psychotherapy was influenced by the 1932 development of the child guidance service for the Vienna Psychoanalytic Society, headed by the major contributions of A. Aichorn who perceived of his work as both a branch of child psychoanalytic techniques and education. Accordingly, social deviance and delinquency in children subsequently emerged from disturbances and disruptions in early object relationships, that is, the earliest child-parent relationships (Koocher & D'Angelo, 1992). Consequently, the primary basis of therapeutic intervention evolved after further refinement and development of corrective efforts to treat children and adolescents through emphasis on the importance of enhancing the therapeutic working relationship. With increased focus and emphasis on the relationship that exists between the child and the therapist, play-orientated approaches also gave rise to other relational treatment approaches that emphasized 'working through' past and present interpersonal relationships.

Seldom acknowledged for the philosophical and wide-ranging contributions to that of relationship therapy approaches, Moustakas (1959) further outlined the essentials of child psychotherapy in treating normal, disturbed, creative, and handicapped children. Demonstrating on the importance of making therapy a living experience, other early therapeutic modalities focused on interpersonal relationships to facilitate the child's discovery of "real feelings" and the capacity to find uniqueness as an individual, that is, a sense of self. Early relationship enhancement models were noted for their

effectiveness in enhancing interactions between the therapist, the school, and the therapist supervisor with students.

During the 1950s, a contrasting conceptualization of play began to emerge, which revealed a major shift away from psychoanalytic thought. Carl Rogers, for instance, wrote a series of letters to his daughter concerning a toilet training problem, which were then touted by some as reflecting the 'modus operandi' of play therapy (Fuchs, 1957). In another contrasting departure from psychoanalytic interpretation, Piaget (1951, 1951/1976a, 1951/1976b) later introduced play as a cognitive representation within the growth structure of children and their interpersonal interactions. Rather than viewing play as an opportunity for children to express 'cathartic' emotions, play came to be viewed a smore a function of thought processes within a class of intellectual or cognitive operations. For Piaget (1951), child's play was:

> ...therefore that of the symbolic function itself considered as a mechanism common to the various systems of representations and as an individual mechanism whose existence is a prerequisite for interaction of thought between individuals and consequently for the constitution or acquisition of collective meanings. (p. 4)

Piaget's (1951) complex schemas of cognitive assimilation are represented by three successive stages complemented by numerous subfunctions and bidirectional processes. *Sensory-motor activity*, the first stage, involves the equilibrium of sensory-motor intelligence whereby the individual mediates between primacy of assimilation over accommodation (play) and primacy of accommodation over assimilation (imitation). *Egocentric representative activity* is the next successive stage, which involves the intellectual capacity to perform abilities of symbolic play, creative imagination, preconcepts and intuition, reproductive imagination, and representative imitation.

Finally, the third stage of *operational activity* involves the enactments of constructional games, operations, and reflective imitation.

In that Piaget's theory of play was closely bound by his account of intellectual growth, others began to assimilate the cognitive principles of childhood development. An educational equivalent of the psychological child guidance movement, practical advice on learning or behavioral difficulties was sought by educational professionals (Millar, 1974). The 1970s and 1980s were especially influenced by interests in helping children with behavioral and emotional difficulties within school settings (Hartmann & Rollett, 1994; A. J. Smith & Thomas, 1992), although play therapy in private practice and the agency sector managed to retain much of its original recognition and support (Campbell, 1993). At the height of this period, however, psychodynamic theory and play-orientated approaches gave way to behavioral techniques that placed greater emphasis on brief, solution-focused interventions, for example, behavior therapy and behavior modification techniques.

Perhaps sparked by the Piagetian-psychoanalytic debate, other competing theories on childhood development and infant-mother relatedness began to emerge. Mary Ainsworth's (1964, 1969) classification of children's behavior focused on the quality of their internal working models as displayed in the children's attitude toward significant attachment figures. Although overlapping in some aspects with object relations ethological theories, the intertheoretical elements of attachment-based theory focused attention on the following differences and concepts: (a) genetic biases; (b) reinforcement as compared with activation and termination of behavioral systems and with feedback; (c) strength of attachment behavior vs. strength of attachment; (d) inner representation of the object; (e) intraorganismic and environmental conditions of

behavioral activation; and (f) the role of intraorganismic organization and structure. The now famous "strange situation" techniques developed by Ainsworth and her colleagues (Ainsworth & Bell, 1970; Ainsworth, Blehar, Waters, & Wall, 1978) investigated the exploratory attachment behavior of human infants and nonhuman primates to their maternal caregivers. The Ainsworth approach suggested that when infants were separated from their mothers, they were observed to increase such behaviors as crying and maternal searching. When the infants were reunited with their mothers, proximity-seeking and contact-maintaining behaviors were heightened. In a substantial proportion of the infants, contact-resisting behaviors were also heightened in the reunion episodes usually in conjunction with contact-maintaining behaviors, thus suggesting ambivalence. Some infants also displayed proximity-avoiding behaviors in relation to the mother in the reunion episodes. These researchers concluded that while the presence of the mother infants were encouraged in their exploratory behavior, the mother's absence led to depressed exploration, and heightened attachment behaviors such as anxiety and insecurity.

Further inspired by the work of Ainsworth and her colleagues, John Bowlby extended his interest on maternal care and mental health. Concepts of attachment have been solidly embedded in developmental psychology and in Bowlby's secure base theory involving the trilogy of attachment (Bowlby, 1969), separation (Bowlby, 1973), and loss (Bowlby, 1980). In Bowlby's (1988) child-parent attachment theory, behavior was conceived of as "any form...that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world" (pp. 26-27). By discarding S. Freud's secondary-drive theory and the Kleinian alternative view of the child's tie to the mother, he reformulated conceptualizations and

views of attachment and interpersonal relatedness which suggested a "fundamental form of human behavior with its own internal motivation distinct from feeding and sex, and of no less importance for survival" (Bowlby, 1988, p. 27). Some have argued, however, that attachment theory is more "in tune with present-day concerns about the quality of interactive processes" toward a paradigm of "contextual (nonlinear) thinking" (Maier, 1994, p. 35). Other formulations of attachment theory processes have suggested that early attachment bonds can greatly impact in later life adulthood relationships (Hansson & Carpenter, 1994; Karen, 1994; Nemiroff & Colarusso, 1990) and in biosocial formulations of romantic love of adult partners (Hazan & Shaver, 1987).

In psychotherapy scientific research, however, it seems no sooner does a new or reworked theory present itself that followers invariably meet their opponents. Sutton-Smith (1966), for example, strongly criticized Piaget for attempting to reduce play activity to a restricted class and function of intellectual operations. For instance, Piaget's "copyist notion" of imitation and replication of concepts deprives play of any genuinely constitutive role within thought. Observing the Piaget/Sutton-Smith debate, Vandenberg (1981) suggested the raised issues served as points of departure for discussing the role of play in development and from cultural-evolutionary and ontogenetic-historical perspectives. Further, Roopnarine, Johnson, and Hooper (1994) observed that children's play is indeed culturally influenced in that it "is biologically based and is sustained as an evolutionary contribution to human development" (p. 4). Hence, the varied historical conceptualizations and interpretations of play did little to simplify or develop a unified definition on the importance or characteristics of play.

The evolutionary and historical developments on child psychotherapy and treatment efficacy were now opened up for strident debate. In perhaps one of the

strongest critiques ever considered, Leupnitz (1988) considered the fundamental tenets of traditional psychotherapies of all types offer at best a "weak strategy for creating social change" (p. 28). Drawing out at least some of their commonalities, the author did nevertheless point to some converging lines between traditional psychotherapy and feminist theory in noting that both aim to "help individuals not only resolve specific symptoms but also the complexity of their ability to think about relationships" and to treat clients "with respect and dignity" (p. 29). Toward effecting change and another brand of therapy, Leupnitz (1988) proposed that the traditional cybernetic metaphor of fixing malfunctioning parts be replaced with a feminist psychoanalytic theory that views and strives toward the healing of whole persons.

Sayers (1989), on the other hand, suggested that the evolutionary lines of psychoanalysis in general and Klein's contributions in particular marked not only advancements in child psychotherapy techniques but also provided a pivotal shift forward for feminist theory. In that Klein's development of psychoanalysis involved a shift away from Freud's father-centered theory and practice toward a more mother-centered approach, Sayers (1989) concluded that Kleinian theory in fact extended:

> ...our knowledge of female sexuality, primitive mental mechanisms, and infantile phantasy, its rootedness in biological processes, internal and external object-relation ramifications, and for the psychoanalytic treatment of...symptoms in adults as well as children. (p. 373)

Commenting further on the mother-infant debate, Stern (1987, 1985) postulated that the mind acts like a cross-referencing system so that all the sensory images of a person (the encoded affects of the object) can be partially uncoupled from the other components of the representation and be "restored" or reintegrated to form strictly sensory part-representations or affective part-representations. The author asserted that infants are able to reverse the elements of a representation with relative ease through

uncoupling, integration, disassembling, and recoupling. In contrast to the formulations proposed by earlier theorists such as Winnicott and Mahler, among others, who believed that infants form and ultimately unite representations of 'good' and 'bad' mothering, Stern asserted that the representation formations of infants are fluid, and different configurations may be disassembled and reassembled. Suggesting deeper contrasts to the likes of Mahler and Klein, Stern (1987, 1985) contended that whatever the nature of experience is thought to be, the order of the developmental sequence and focus on the developmental sense of self should not be encumbered with or confused by issues of the development of the ego or id.

Not to be outdone by the critique of others, attachment theorists and developmental psychologists have also been targeted by oppositional viewpoints. Karen (1990, 1994), for instance, proposed counter-arguments on the contributions of Ainsworth and Bowlby. In contrast to these traditional attachment theorists, however, the author noted that dependency and attachment could be represented in different realms of relatedness. For example, symptoms of attachment can be considered synonymous with love and symptoms of dependency with neurotic anxiety. Moreover, for Ainsworth and Bowlby, attachment itself should not be confused with attachment behavior. That is, the love expressed by a seemingly attached, but strongly anxious child exhibiting signs of heightened crying, seeking, clinging, cannot be considered any more or less attached than a child exhibiting ambiguous signs of attachment. Similarly, in adulthood, signs of seeming attachment between two adult partners, for example, enmeshment or 'undying love,' could be considered very unhealthy if exhibited by behaviors of dependency, jealousy, or a need to control. That is, if one adult partner is lacking in security and knowledge about the other's availability and responsiveness, the

exploratory behavior of both partners and the unified growth of the relationship becomes stunted. Newirth (1996) further critiqued traditional attachment theories and argued that developmental arrest is not at the core of the damaged or deprived child's need for compensatory maternal love and nurturance, but rather marks a failure in the child's development of the capacity for symbolic experience.

Providing criticism on developmental theories, Stern (1985) posited that developmentalists generally work within the tradition of observational and experimental research, and that it is a mistake for psychoanalytic developmental theories to continually make inferences about the subjective experiences of infants. It is also mistaken assumption within developmental psychology, Greenspan (1997) argued, to believe that all individuals "can use a highly differentiated representational system to perceive, interpret, and work through earlier experiences and conflicts" (p. 8). Psychotherapy conceptualizations must therefore be clinically derived and work from a number of developmental levels or processes simultaneously.

The challenge remains, then, for a salient theoretical model to embrace both childhood and adulthood developmental processes. Eyer (1992) argued that discourse about notions of sharp transitions between childhood and adulthood, for example, separation/individuation, has been largely reified by Western culture. On the mother-infant processes of bonding and attachment, Eyer (1992) remarked:

> Bonding is, in fact, as much an extension of ideology as it is a scientific discovery. More specifically, it is part of an ideology in which mothers are seen as the prime architects of their lives and are blamed for whatever problems befall them, not only in childhood but throughout their adult lives. (p. 2)

To better understand human developmental processes our current thinking must explore other possibilities.

Working toward an integration of these theoretical frameworks, Stern-Bruschweiler and Stern (1989) contended that a more salient framework for investigating infant-mother interactions and interpersonal relationships would need to permit for systematic descriptions of different therapeutic approaches. For example, the model could consist of four interdependent elements in constant dynamic equilibrium: (a) infant's overt interactive behavior; (b) mother's overt interactive behavior; (c) infant's representation of the interaction; and (d) mother's representation of the interaction. In empirical investigations of child-parent interrelatedness, these authors proposed the need for an integration of therapeutic approaches that included a synthesis of psychoanalytically oriented therapy, interactional coaching, a behavioral pediatric and behavioral approach, as well as a family therapy approach. These researchers argued further that traditional child-parent models could be changed sufficiently through both a direct focus on therapeutic action and an indirect approach to focusing on clinical information.

Others have instead attempted to rework the formulations and typologies of traditional attachment theories (Fraley & Waller, 1998). Main, Kaplan, and Cassidy (1985) presented a new attachment framework that focused on representation and language and permitted conceptualizations of attachment for not only infants but also older children and adults. Traditional attachment theory, these researchers argued, is not able to effectively characterize individual differences in attachment relationships such as differences between children and adults; nor can it account for individual differences of mental representations of self. Extending the framework to include attachment over the course of a human lifespan, Main, Kaplan, and Cassidy (1985) contrasted their view with that of traditionalists as follows:

> We define the internal working model of attachment as a set of conscious and/or unconscious rules for the organization of information relevant to attachment and for obtaining or limiting access to the information, that is, to information regarding attachment-related experiences, feelings, and ideations. Previous definitions of individual differences in attachment organization, for example, secure, insecure-avoidant, and insecure-ambivalent, have relied on descriptions of the organization of the infant's nonverbal behavior toward a particular parent in a structured separation-and-reunion observation, the Ainsworth Strange Situation. (pp. 66-67)

To support their position, these researchers observed how adult participants were considered "secure" in their internal working models of relationships, despite unfavorable early experiences and reported "rebellion" during adolescence. It appears, then, that through a reconceptualization of the tenets of a conventional theoretical model, in this case, attachment theory, we are able to move steps closer toward that of a "good enough" (to use a Winnicottian phrase) transtheoretical framework, in this case, a more fitting integration of attachment theory, human development, psychodynamic theory, and self psychology. More importantly, such a reconceptualization moves us closer toward a more clinically relevant framework for both clinical researchers and practitioners. Let us now consider some of the theoretical constructs and intrapersonal processes involved in investigating interpersonal relationships.

Toward a Transtheoretical Approach of Interpersonal Relatedness

Toward developing a transtheoretical approach of interpersonal relatedness, the therapeutic constructs and issues of transference, countertransference, and empathy must be first examined within the context of the therapeutic setting and the client-therapist working alliance. Many of the empirical and clinical research issues on transference and countertransference will be discussed later in the section on process outcome research. As we shall see, many of the interpersonal processes observed to occur within the therapeutic setting parallels that of the theoretical framework and

clinical research conducted on child-parent relationships and family systems. Thus, the development of an innovative conceptualization that adopts a transtheoretical framework of interpersonal relatedness can begin to emerge.

As the psychotherapy movement gained increasing momentum, "therapy wars" (Saltzman & Norcross, 1990) ensued, marked initially by efforts to step outside the psychoanalytic box, and some contemplated the future of psychotherapy and wondered if the major psychotherapeutic approaches and threads of contention and divergence could be interwoven. For instance, Heinz Kohut, better known for his contributions to self psychology, and Carl Rogers, better know for his humanistic approach to helping people, would seeming be at odds in their theoretical viewpoints. Kegan (1982) contrasted and challenged (in Rogerian and psychoanalytic terms) conventional developmental theory of individuation and differentiation. It was argued that the emphasis should be placed on development of "autonomy" and of "differentiation," and that it was not crucial to know something about the history of these developments. Further, it makes little sense to focus on separation when the focus is on adaptation, that is, the matter of differentiation and (a traditionally devalued) integration. Kegan (1982) declared that psychoanalytic discussions suffer to a degree from an outdated approach to our biological reality in that psychoanalytic approaches tend to focus too heavily on the energy systems within the individual (intrapsychic or intrapersonal) rather than the energy systems within which the individual interacts (interpersonal relations).

Advocating instead for a neo-Piagetian perspective, Kegan (1979) focused on the processes of personality and their implications for counselling and psychotherapy. He suggested that what may lie at the heart of Piagetian theory are neither 'stages' nor 'cognitions' nor 'child psychology' but rather a process of evolution as a meaning-

constitutive activity. Four speculative elaborations on Piaget's basic discoveries were presented: (a) the consideration of the subject-object differentiation as the "deep structure" of Piagetian and neo-Piagetian theories; (b) the suggestion of a scaffolding for stages of ego development rigorously tied to the Piagetian framework; (c) the recovery of a process- or activity-conception of development; and (d) a framework for considering the goals and processes of counselling and psychotherapy.

Yet, as we shall see in the following, the works of Rogers and Kohut can indeed be both appreciated and integrated into a transtheoretical approach toward developing a 'scaffolding' of stages in human development. To begin, on processes of human development, both Kohut and Rogers hypothesized that individuals, young and old, are born with innate psychological needs, or selfobject needs, such as the need to be mirrored, to be listened to, to be cared for, to be understood, to be treated with positive regard, to be treated genuinely, to have someone to idealize as a source of calming strength, and the like (Kahn, 1989a, 1989b). Other convergences between Kohut and Rogers can be found in using the principles of transference, countertransference, and developmental processes as basic elements can provide an ideal theoretical framework and clinical model working with children and adolescents (Iencarelli, 1996). Further, the perspectives of self psychology and person-centered systems theory can be provide a valuable backdrop for inquiry into the processes of therapeutic change ranging from within (intra) family variables (Murrell, 1970) and between (inter) interpersonal relationships of children and their parents (Kazdin & Wassell, 2000). Unfortunately, as pointed out earlier, Lubimiv (1994) considered that many children face a lack of acceptance and supportive relationships, which is why the child-therapist relationship

can be so intense and so subjected to therapeutic issues such as transference and countertransference.

The importance therapeutic processes and the emergence of play therapy techniques has been exemplified in the research conducted by Cohen (1993) and Cohen and Solnit (1993). These researchers identified three intertwined processes related to the therapeutic action in child psychotherapy: therapeutic alliance, transference, and the role of the child therapist as a real person. Such therapeutic processes and meanings of play have ramifications throughout adolescence and well into adulthood (Solnit, Cohen, & Neubauer, 1993). In Johnson's (1995) interpretation of Winnicott's (1971) formulations on playing and reality, it was argued that play in adulthood could be viewed as a characteristic of health. This suggests the possibility that adults who enter into therapy do so because they may have spent a substantial part of their lives in the presence of an inhibitor, that is, a parent or primary caregiver who was not able to play 'well enough.' It has been further posited that the role of transference is in fact the adult equivalent of play (Mahon, 1990).

In addition to the role of transference, the study of empathy would help enhance our understanding of human development and the experiences of emotional problems as it becomes integral to developing our understanding of treatment for both children and adults. Technical investigations into the psychological organizations and ongoing developmental processes of humans can be conceptualized and fittingly coordinated with the requirements of psychoanalytic tradition and thought (Abrams & Solnit, 1998). Both considered descendents of the psychoanalytic tradition offering their own perspective on human development, the works of Winnicott and Kohut have been selected here to further illustrate some of the convergent and divergent considerations of child

development, child psychotherapy, and the interpersonal processes of selfobjects. Winnicott's developments on the capacity for concern are considered important features in social life and childhood development, and this complex problem became the primary focus of his later work and how these maturational processes could best be facilitated (Fromm & Smith, 1965, 1989).

Winnicott's contributions to developmental theory have helped to shape formulations of transitional phenomena, potential space, object use, and true self-experience, as well as helped to conceptualize the functions of play and theory in therapeutic practice (Borden, 1998). By creating a "holding environment" in his clinical work with children, Winnicott suggested that empathy is a state of psychological merger between mother and infant that does not end with physical birth (Lanyado, 1996) that is not unlike the state of physical merger (B. L. Smith, 1989a). Gradually, it is replaced by the experience of the infant as becoming separate and distinct from the primary caregiver.

Conversely, in the tradition of self psychology, Kohut conceived of empathy as a fundamental human capacity, that is, as an inborn mode of perception much like taste, touch, vision, and so on (B. L. Smith, 1989a). Kohut defined it as the capacity to know the feelings of other via introspection. Although the maternal selfobject and the infant are dissimilar because of their greatly differing psychic structures, empathy can be experienced by both and is therefore experienced bidirectionally. The mother knows empathically when and how to respond to her child and provides him or her with both needs fulfillment and calming presence. In an empathic response to the mother's calm state, the infant experiences a merger with the omnipotent selfobject. It is in this way that the role of empathy plays itself out in the child-parent relationships.

Although both Winnicott and Kohut agreed that empathy holds important therapeutic value, they differed somewhat in their emphasis on how empathic responses are transmitted. First, Winnicott believed that infants are born basically in a state of unintegration or undifferentiation. Winnicottian theory holds that children primarily acquire empathic responses through early interactions in their environment, and thus form the foundation of early transference relationship patterns. Winnicott (1966/1986) remarked "what you teach can only be implemented on what capacity is already present in the individual child, based on early experiences and on the continuation of reliable holding terms of the ever-widening circle of family and school and social life" (p. 149). Kohut, on the other hand, argued that (a) negative transferences are learned from unempathic parental figures, and that (b) positive transferences are inborn in infants. Thus, the early relationship patterns of transference are acquired both through experiential learning (negative transference) and through maturational development (positive transference).

Second, Kohut's assertion that empathic responses are innate suggests that we all are born with at least a nominal capacity for empathic understanding. Transference as it exists within the psychological domain must therefore persist in the conscious rather than, as Freud suggested, in the unconscious. Third, the assertion that transference responses are innate and conscious carries with it some very serious implications for classical psychoanalysis. That is, if the central objective is to bring to the forefront (make conscious) the patient's repressed feeling of transference (from the unconscious), then, conceivably, no matter how skilled or masterful the psychoanalyst, all therapeutic interventions could be considered to have been thwarted and futile.

In sharp contrast with classical psychoanalysis, Winnicott and Kohut believed that developing a working alliance between self and others was not considered contraindicated. Rather, processes of transference, countertransference, and empathic attunement were encouraged, and strident efforts were made to encourage therapists to appear less astute and authoritative in the face of their clients. In the therapeutic context at least, there became a growing belief that there was therapeutic value if the therapist appears to the client as genuine, as real, and as human as possible. Work within the family context was later conceived of developing a working alliance between therapist and family members as opportunities for therapeutic change in efforts to facilitate transferences and learning opportunities between individuals. Moreover, gradually it was envisioned that parents could be trained as partners in the therapeutic process to facilitate opportunities for empathic responses and learning in clinical work with children. The evolution of clinical work in child psychotherapy was integrated with interpersonal relationship enhancement models such as couples therapy and family therapy.

With Kohut's extensive treatment and analysis on the construct of empathy, some have further suggested that the tenets of self psychology provide the optimal bridge between psychoanalysis and humanistic psychology (Duke & Nowicki, 1989; Kahn, 1989a, 1989b). Carl Rogers (e.g., 1963, 1987) is probably best known for his substantial contributions to the humanistic movement of psychotherapy. Although Rogers and Kohut differed in some respects, both are similar in that they focused on the relationship between the therapist and the patient (or client, as Rogers preferred) as a primary source of psychological healing. Whereas Kohut spoke of the need for transmuting

structuralization and psychotherapeutic ambiance, Rogers spoke of a drive toward self-actualization and unconditional positive regard (Duke & Nowicki, 1989).

On the technical grounds of child psychotherapy outcome research, Shirk and Russell (1996) contended that the traditional approach of "matching treatment brands with diagnostic entities...fails to conceptualize both treatments and disorders in terms of component psychological processes" (p. 80), thereby lacking common conceptual ground. On the technical elements of explicating the basic therapeutic change processes in child psychotherapy, these authors emphasized the need to view these elements "in the context of a body of research whose central concern is the *analysis of change,* namely, research on developmental processes" (p. 138). In sum, these authors stated the challenge for child psychotherapy research was to identify the essential psychological processes that constitute both therapeutic interventions and variations in childhood maladjustment that are based on and augmented by variations of basic developmental change mechanisms.

The development of a transtheoretical framework of child development and interpersonal processes gave way to the technical applications of training parents to become therapeutic agents and alliances in the therapeutic process. Slade (1995) and Slade and Wolf (1994) noted how many of the features of play therapy can help bridge the gap between clinical and developmental psychology and help define common interests by developing areas of interface and interrelatedness as applied to children's play behaviors. From a self psychology perspective, investigations of playful interchanges that occur in the context of child-parent relationships can thus provide the scaffolding for evolving representations of both self and other and self with other (Bergman & Lefcourt, 1994).

A broader transtheoretical model for scientific research in general involves "a description that captures both separation and connection, within a context of evolution" thereby capturing "a larger meaning" (Dickerson, Zimmerman, & Berndt, 1994, p. 11). Play sets a naturally occurring, broader context and foundation of current developments in scientific psychology (J. L. Singer, 1994). Toward developing a working, transtheoretical model for child psychotherapy are conceptualizations of human developmental processes such as individuation, interpersonal relatedness, and empathic attunement. In short, the integrative features and clinical processes for investigating human development can be conceptualized by merging the theoretical spheres of Margaret Mahler's (1952, 1968) and Mahler, Pine, and Bergman's (1975) research on childhood development with that of Bader and Pearson's (1983, 1988, 1990) research on adulthood relationships through the natural language of play techniques. Doing so represents a solid effort and theoretical framework for conducting empirical investigations on child-parent interpersonal relatedness. As such, a constellation of these theoretical frameworks and integrative features will be presented later in the discussion on methodological procedures and implementation.

In sum, there have been many major converging and diverging theoretical and technical influences that have shaped today's field of child and adult psychotherapies. The importance of those contributors presented here, and those of many, many others not mentioned, cannot be overstated. Nevertheless, some have argued that most important contribution to the evolution of child psychotherapy stemmed from the influence of the 'relational revolution' which was most definitively fueled by the evolving theories of psychoanalysis and object relations (Weisberg, 1997b, 1998a). Thus, the history and legacy of child psychotherapy were centrally founded on the principles and

contributions of psychoanalytic and psychodynamic thought. Klein, for her contributions to object relations theory and innovations on interpersonal relationships, communicative styles, and interactional qualities, and A. Freud, for her specific value in consulting with parents or caregivers as essential to the education and psychosocial development of the child, which greatly influenced the history of child psychotherapy and the many innovations on play therapy techniques (Weisberg, 1994). Moreover, Winnicott, for his theories on maturational and developmental processes, helped pull together our understanding of a child's natural tendency toward reorganization (Neubauer, 1993), and Kohut, for his contributions of empathic listening and empathic attunement in self psychology (Weisberg, 1997a), also helped shape the "developmental observations" in which the "therapist assumed a role as intermediary between the child and the environment" to facilitate in the child becoming "better able to merge self-expression with self-control, with a corresponding improvement in self-respect" (Koocher & D'Angelo, 1992, p. 469).

Due in large part to the many historical influences that emerged in the field of child psychotherapy, there has been robust interest in the varied play techniques and applications. Currently, there is a blended interest in the many facets of play therapy techniques. Present-day play therapy techniques include wide-ranging applications of individual child (Cattanach, 1995; Gavshon, 1989; Landreth & Homeyer, 1998; Levenson & Herman, 1991) and family (Carey, 1991; Gil, 1994; Rotter & Bush, 2000; Sweeney & Rocha, 2000) therapy. Moreover, play therapy techniques have been found effective for enhancing relationship dyads such child-parent (L. F. Guerney, 1997; L. Johnson, 1995; Kraft & Landreth, 1998) and child-teacher (B. G. Guerney, 1970; Isenberg, 1998; White, Flynt, & Draper, 1997), as well as adult couples (Blatner & Blatner, 1997; Metz & Lutz,

1990; Scott, 1999). There has been also renewed interest in play techniques among educational professionals, for example, in assisting children whose coping skills hinders their personal learning (Fall et al., 1999), in so-called 'labeled' children with secondary learning problems (L. Johnson, McLeod, & Fall, 1997), and for acquiring social skills and language (Trawick-Smith, 1998). The hallmarks of play and the major play therapy approaches will be discussed later in detail.

Conceptual Interlude

From an evolutionary perspective, interpersonal theories on child-therapist and child-parent relatedness models have strongly influenced emerging conceptualizations on the course of developmental and life cycle patterns of relating. For instance, childhood theoretical models on attachment (Simpson & Rholes, 1998; Sperling & Berman, 1994) and developmental perspectives of object relations (Bader & Pearson, 1983, 1988, 1990) have suggested that our early childhood experiences and interpersonal relationship patterns closely parallels that of our adulthood interactions and intimacy relationships. In other words, situations that evoked feelings of anxiety and insecurity in young individuals during childhood are likely to be replayed consciously, or, more frequently, subconsciously, in their adulthood relationship patterns.

In an overt presentation, such an example is a child who experiences fear, anxiety, and senses of helplessness from witnessing his father physically assault his mother. Although the greatest impact of psychological harm is if the trauma or domestic violence occurs during infancy (Perry, 1999a, 1999b), an infant may develop physiological responses to similar or even dissimilar traumatic events without having any conscious connections or memories about them. As the child grows, often depending on his age and frequency of family violence incidents, some conscious memories about

witnessing domestic violence may begin to emerge. Based on these memories of early childhood, he may perpetuate the cycle of family violence, or he may make a conscious decision to never physically assault another human being. Nevertheless, in response to other adult life situations that evoke in him physiological sensations such anxiety and insecurity, while not engaging in behaviors of physical violence, he may have unconsciously learned and developed a pattern of other integrated coping strategies such as the ability to control his environment by means of manipulating others through covert verbal behaviors or through overt verbal abuse (vs. physical abuse). With a dysfunctional representation of an internal working model for healthy relationship, the boy now a husband, may perpetually exist in a pool of anxiety and insecurity and thus have strong, desperate needs to control his spouse's behavior through whatever means possible. The boy, now a father, would also not have the interpersonal skills necessary to communicate and develop a healthy relationship with his son and daughter. There is some suggestion that external factors such as the boys' attention to punishments associated with violent acts can positively influence the men's choice to seek alternatives to acting violently in their own intimate relationships (S. M. Harris & Dersch, 2001).

As such, any transtheoretical and intergenerational model of human development suggests that *all* interpersonal relationships can be conceptualized as a "process of receiving and providing care" that "requires repeated interactions which, viewed as a whole, create a relationship" (West & Seldon-Keller, 1994, p. 1). In that interpersonal relationships pervade our very existence, identity, and behaviors, the challenge for psychotherapy researchers is to develop a well-grounded, theoretical framework built on a paradigm containing the richness of human interactions and processes of interrelatedness. Beginning from birth, interpersonal relationships pervade

throughout our lifetime in forms of functional and dysfunctional patterns of relating, and the challenge for psychotherapy clinicians is to develop an enriching treatment modality that is universally accessible and easily employed by individuals of nearly any age or life experience. The impetus for treating children "stems from the notion that troubled or sick children grow to be troubled or sick adults (the continuity hypothesis) and that treatment of trouble or sick children will reduce the incidence of troubled or sick adults" (Politano, 1993, p. 375).

On an additional note: some males and fathers may be easily struck by the glaring omission in the early literature on child psychotherapy that minimally discusses their role and influence in childhood development. Prior to the last decade, literature on childhood development was almost exclusively conducted on infant-maternal attachment and interactions. Even today, the prevalence of literature on childhood treatment and development pays little regard to the role of fathers, and oftentimes only tangentially to discussing the role of mothers. Nevertheless, it is noteworthy that Winnicott (e.g., 1964) was one of the scarcely few to impart some early reflections on the importance of fathers. The present author shares in the following: "It is hardly possible to begin to describe the ways in which a father enriches the life of his children, so wide are the possibilities" (D. W. Winnicott, 1964, p. 116). For readers who wish to venture beyond the scope of the present paper, they are encouraged to review some of the emerging literature on fathers (e.g., Booth & Crouter, 1998; Cath, Gurwitt, & Gunsberg, 1989; Lamb, 1997; Marsiglio, Day, & Lamb, 2000; Scull, 1992). Rather than enter into the maternal-paternal debate, the emphasis throughout the paper is intended to focus on human development and treatment of child-parent interpersonal relationships. For the

purposes presented herein, the undifferentiated term 'parent' will be used predominately to indicate either mothers or fathers.

Moreover, the present author, and many others (e.g., Barnes, 1996; Freysinger, 1998; Gil, 1991; Landreth, 1991; Perry et al., 2000; Solnit, 1998; Terr, 1999; VanFleet, 1994), believe that the hallmarks of play therapy offer not only many of the psychotherapeutic principles of an efficacious, universally accessible treatment model, but play also offers a natural, process orientated approach that could enrich the interpersonal experiences and well being of individuals at any chronological age or developmental preparedness. As Strauss (1999) emphasized:

> Kids don't usually want to talk about the bad things that have happened to them. For many distressed children and adolescents, participating in therapy is more aversive than cleaning the bathroom. Enraged, sullen, anxious, or confused, they are sent they are sent to our offices and endure the hour as squirmy hostages and clock-watchers. They *will not talk* about their feelings; some are even wary of chit-chat. (p. 10)

Thus, the therapeutic benefits and efficacy of play techniques have been chosen to provide the central focus and emphasis of the present research study. Let us now turn our attention to the treatment of children and the healing powers of play.

The Hallmarks of Play and Play Therapy

A former student of Carl Rogers, Virginia Axline (1947, 1964) is generally acknowledged as imparting and advancing some of the most important and influential work on play techniques in child-centered psychotherapy. As the shift toward increased emphasis on the therapeutic alliance emerged, and as psychoanalytically-based developmental hypotheses shifted away from drive theory, Axline gained increasing recognition for her contributions to the nondirective of treatment children through play (Koocher & D'Angelo, 1992). Axline (1947) envisioned play therapy as a "natural medium for self-expression" in that it provides an opportunity for the child to "play-out" feelings

and problems, similarly as in certain types of adult therapies in which grownups "talk-out" their difficulties (p. 9). Moreover, early play therapy techniques were also believed to show promise in relieving racial tensions and conflict (Axline, 1948).

Axline's strong position on the nondirective approach further revealed her belief that "there seems to be a powerful force with each individual which strives continuously for complete self-realization...characterized as a drive toward maturity, independence, and self-direction" (p. 10). Similar to Klein's (1950) theoretical formulations on children presenting with various symptoms at different ages, Axline (1947) posited, "growth is a spiraling process of change—relative and dynamic" (p. 10). Moreover, although Axline's nondirective approach and personality structure theory was based on her work with children, parallels can also be drawn from the perspectives of Kohut (1977) and Rogers (1963) and their emphasis on the importance of establishing a positive therapeutic alliance involving empathic attunement toward facilitating the individual's own capacity for self-determination. When individuals attain sufficient self-confidence to achieve complete realization of the self, they are said to be maladjusted and become content to grow in self-realization vicariously rather than directly through more constructive and productive directions (Axline, 1947).

These early contributions in child psychotherapy paved the way for more rapid and prolific collections of published articles on play therapy, although most of these were based on case studies or anecdotal accounts with few systematic investigations of the efficacy of treatment strategies and techniques (Koocher & D'Angelo, 1992). Nevertheless, Axline did for the psychotherapeutic treatment of children what the benchmarks of psychoanalysis did for adult psychotherapy and analysis. In presenting a commentary on Axline's 1947 landmark book on play therapy, Winnicott (1960s/1989)

envisioned the potential merits of play as a whole as an opportunity for enlargement, synthesis, and growth of the psychoanalytic profession. While encouraging the need for ongoing modification and development of the highly guarded "rules" often upheld by those wholly psychoanalytically trained, Winnicott (1960s/1989) also recognized that change and psychotherapy integration was not only inevitable but also vital to the field and the clients it serves. Winnicott (1960s/1989) wrote:

> ...psycho-analysts miss something very important if they do not join up with the work of other psychotherapists and, in fact, they will find, as in the case of Miss Axline, that the work they read about corresponds closely to the modified analysis which they must do in certain cases if they are to get anywhere at all. The other thing that psycho-analysis avoids is the question of social need and social pressure. Psycho-analysts have to justify themselves socially in other ways than be meeting social pressure and they may be able to help those who are doing satisfactory work or very good work indeed by giving back where they feel that the work is genuine and depends on the real principles of childhood development and need. ...The great thing that is different between play therapy of Miss Axline's variety and psycho-analysis is that the therapy stops short at the point where the therapist mirrors the child as he actually is. In other words, the complication of psycho-analytic interpretation is absent. (pp. 495-498)

So influenced was Winnicott, both professionally and personally by the works of Axline (1947), that he prepared his own treatise on developmental reality and play. Thus bridging a working relationship between his largely psychoanalytic training and clinical practice, Winnicott's inquiry into play therapy seemed to have been refreshingly simplified by the very modality for which it was intended. With almost childlike innocence and brevity, Winnicott (1971) offered the following to point to the parallels that can be drawn on the processes of psychotherapy in general and play therapy techniques:

> Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play. (p. 38)

Many contemporary views of child psychotherapy and play as therapeutic action have ensued since the formulations of these early play pioneers. Acknowledging the remarkable influence of the child psychoanalytic movement and play, Mayes and Cohen (1993) wrote:

> From its inception, child psychoanalysis has used fantasy play as a window to both the content and the process of children's inner worlds. Because of the link to action whereby the link to action and primary process, young children's imaginary play is rich in symbolic expressions that facilitate analytic interpretive interpretations addressing the conflicts impeding development. There are inevitable tensions between allowing play to emerge as a therapeutic process in its own right and the usual psychoanalytic emphasis on clarification, verbalisation and, above all, interpretation with and about transference. For many children, the very act of playing carries much of the therapeutic work aimed toward facilitating their return to developmentally appropriate and adaptive psychic functioning. (p. 1243)

Regardless of the many historical debates, play therapy has now become a well established and a popular modality for treating children. Fundamental questions about how it works, however, have seldom been asked or raised (Schaefer, 1993). Ryan (1999) posited that our study of a child's transition from concrete to symbolic play contributes to our understanding not only of delayed or damaged children's development, but also provides additional information on the capacity of normal childhood development. Play is not a means to an end but a means to greater understanding and hope (Bishop, 1986a) and fantasy may be a means for both health and change (Bishop, 1989). Pretend play, the capacity to create miniature, possible and real worlds, is a critical feature of the healthy development of any child (J. L. Singer, 1994). From of a cultural perspective, and with the stresses of adult life now much more commonplace in its affect on children, the most powerful tool available to children is play (Henniger, 1995). From a social perspective, deprivations or inadequate opportunities for healthy play experiences can also be seen as factors of violence and antisocial behaviors among juveniles (Frost & Jacobs, 1995; Frost

& Woods, 1998). Before we attempt to study the subject of play, however, we must first attempt to define it. Following these broad definitions and characteristics of play, the four major play therapies (e.g., psychoanalytic, Jungian, cognitive-behavioral, child-centered or nondirective) and the role of play in neurodevelopment will be considered.

Definitions of Play and Play Therapy

We all know what it feels like to play. To derive theoretical statements about play, however, involves a process in which there is little agreement, much ambiguity, and can make us "fall into silliness" (Sutton-Smith, 1997, p. 1). Broadly defined, psychotherapy is communication of person-related understanding, respect, and a wish to be of help (Reisman, 1971). Reisman and Ribrody (1993) highlighted its process-orientated effects in noting that "psychotherapy is best defined according to what those who make use of this method do, rather than what they intend or hope to accomplish" (p. 6). In a general sense, these definitions promote the development of psychotherapy as a form of everyday communication. Play therapy is a developmental activity that can be put into a developmental hierarchy (Bishop, 1982) through which children explore their identity in relation to others (Cattanach, 1992). Borrowing on a more contemporary definition of play, the Association for Play Therapy (2003) defined play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (http://www.a4pt.org).

Offering a playful twist on Freud's study of instinct theory and Piaget's insights on cognitive development, Mahon (1990) considered play a the crucial organizer of pleasure principles and cognitive development; that is, play offers children "a dress

rehearsal for the theatre of reality the child faces every day" (p. 26). Another relatively fitting characterization of play may be found in the definition provided by Marans, Mayes, and Colonna (1993) in observing that play activities and scenarios "form coherent representations of what is uppermost in children's minds and most available in their repertoire of modes of expression" (p. 9).

While some researchers have argued that traditional adult therapeutic paradigms can be sufficiently modified to work with children (Erdman & Lampe, 1996), others have argued that the natural communication medium of verbalization of adults is insufficient in working with children (Chethik, 1989; Landreth, Baggerly, & Tyndall-Lind, 1999). Early exceptions to this trend of downwardly extending adult psychotherapy models to treat children were Axline's (1947) play therapy and Moustakas's (1959) relationship therapy. Further, emerging contemporary definitions of play therapy must reflect the complexity of the behavior and the process. While playing, children use symbolism through internal representations of reality to imitate and accommodate complex adult actions and speech to reshape and assimilate in novel ways their existing memory schemas (D. G. Singer, 1994). Children engage in play to investigate the unfamiliar and to make it known (Cass, 1971), and play activity facilitates the child's natural medium of communication and self-expression (Sweeney, 1997).

Mahon (1993) defined "play as one of the unique communicative modes of childhood, a semiotic skill that merges action and symbolism..." (p. 229). Neubauer (1993) posited that the acquisition of one semiotic skill (language) and play (action) "go hand in hand," although "one semiotic avenue joining another in complex intersections that are as yet poorly understood" (p. 74). Yet, if anyone were to believe that ongoing debates to define play were fenced in by mostly historical players, it appears that the

pinnacle of the debate on the importance of play may be emerging once again. For instance, contemporary conceptualizations include linking play to mental processes and literacy activities in cognitive, ecological, and cultural perspectives (Roskos & Christie, 2000), and neurodevelopmental views consider that the pleasurable principles of play and early childhood experiences are crucial for healthy and sequential development of the brain (Perry et al., 2000).

Adding to the challenge of fashioning an adequate definition of play, some believe that children and adults tend to view play differently. Environmental influences by the media, parents, and teachers influence the development of sex-differentiated play, and early sex differences in play activities may play a role in the development of certain sex-differentiated cognitive abilities (Sprafkin, Serbin, Denier, & Connor, 1983). As Goldstein (1994a) pointed out, just as anthropologists tend to observe culture from two perspectives—from the inside and from the outside—play too can be viewed from the inside world of the participating child, or from the external world of the observing adult. For example, international studies have indicated that children are able to distinguish between aggressive play and real violence (Fry, 1990; J. Goldstein, 1995; Jukes & Goldstein, 1993; Sutton-Smith, 1988), and when occurring within an enriched and elaborated setting, war toys and play can provide children with the same benefits of dramatic play (Carlsson-Paige & Levin, 1990). However, it seems parents and teachers who view children's play from a distance are less able to make these types of distinctions (J. H. Goldstein, 1994b).

Moreover, not every voluntary action can be assumed as play (Sutton-Smith, 1987). In that children's language development often lags behind their cognitive development, toys help children transfer their anxieties, fears, fantasies, shame, and

guilt to symbolic objects rather than to significant love objects (e.g., parents, teachers). Play allows children to solve problems in a systematic and purposeful way (Fagen, 1975/1976) and it provides a balance between interpersonal relations and abstract and symbolic thought processes (Werth, 1984). For adults, however, play can be an exceedingly complex and even perplexing interplay between linguistic self-expression and cognitive development.

It is play in the context of interpersonal relationships and the sustained empathic immersion of the child's subjective experience, be it through play activity, silence, or verbalizations, that is therapeutic (Gotthold, 1996). Reflecting on the words of Winnicott (1971), Neubauer (1993) argued that to reduce play and its technical implications "to only the historically determined conditions and employ it just to reconstruct earlier experiences is to strip play of its creative element" (p. 45). Others have argued further that the play creativity and activities of children and their modes of expression can indeed be discussed in relation to the creativity of adults as well (Marans et al., 1993). From a therapeutic perspective, the processes of play provide children with a safe environment to express feelings and reactions and distance themselves form traumatic events and experiences (Landreth, 1991, 1993; Landreth & Homeyer, 1998; Thurston, 1994). In children, and in adults, therapeutic play constitutes a representation of the external (interpersonal) world or of one's (intrapersonal) own body.

In sum, it seems that any attempt to adequately define play therapy can be approached only by continually generating new definitions to fit current conceptualizations (Werth, 1984) as well as current theoretical positions and clinical applications. From the diversity of prospective play definitions, Sutton-Smith (1997) considered that there are three kinds of play: (a) from a participant's view, players have

their own *play experiences* and functions; (b) from an investigative standpoint, theorists draw from the research literature *intrinsic play functions*; and (c) *extrinsic play functions*. For our purposes here, we shall chiefly draw from and concern ourselves with the latter two definitions of play (b and c).

Characteristics of Play and Play Therapy

Play is therapeutic (Gladding, 1993; Landreth, 1991; Schaefer, 1993). Play is also an elusive and complex process. Play is also in the heart. As Hellendoorn, van der Kooij, and Sutton-Smith (1994) pointed out:

> Those who do use play, often testify to the gratifying feeling that not only has something happened to the child, but also to themselves and their relationship with the child. Not because they idealize play, but because the childlike qualities may have their impact on all human beings. (p. 225)

Play is the child's natural form of communication and toys are the words children use to express emotion (Campbell, 1993). Play is important (Landreth, 1991; Perry et al., 2000), including fantasies and daydreams, toward providing some "of the most constructive things a growing child can do" and developing his or her sense of self or "inner life" (Bettelheim, 1987a, p. 37), and "one of the best activities to keep childhood stress at a manageable level is the quality of play experience" (Henniger, 1995, p. 7). From an outsider's perspective, play provides a 'window' for others to understand a child's perception of the world (Oaklander, 1978) through consolidating existing organizational hierarchies of old conflicts and impaired object relations from the past (Abrams & Solnit, 1998). Although "some communicate and socially relate more easily than others, no one's inner world can be taken for granted or easily entered" (Bromfield, 1997, p. 72).

From both psychoanalytic and developmental psychology perspectives, artistic creativity and daydreaming serve as similar psychic functions for adults as imaginative play serves for children (Marans et al., 1993). From an evolutionary context, Bruner

(1972/1976) identified the major functions of play: (a) as a means of minimizing the consequences of one's actions and of learning thereby minimizing the risks of a situation (e.g., social play); and (b) as an opportunity to try combinations of behavior that would, under functional pressure, never be tried. From observed behaviors performed by primates to human beings, "play and ritual...are saturated heavily with symbolism" in which "symbolic means" have "certain language-like properties" and "communicative function" for use in preparing the "young for culture" (pp. 48-49).

Play is not exclusive in human behavior, either. Fascinated by the inherited instinctual patterns of animals, Groos (1896/1976) noted the appearance of play in higher orders of evolutionary advancements of intelligence and hypothesized that animals with complex forms of adaptation required youthful play to practice a variety of behaviors for which inherited instinct might not be wholly adequate. Groos (1901/1976) later extended this interpretation to include human beings and hypothesized that play is practice for more serious and complex behaviors. Commonplace 'teasing' occurs, for instance, "when there is not occasion for an actual testing of their powers, children and adults turn their belligerent tendencies into a means of amusement" giving way to "playful attacks, provocations, and challenges..." (p. 68). Play is a biological function "of the struggle for survival" which reinforces "organism's variability in the face of rigidifications of successful adaptation" (Sutton-Smith, 1997, p. 231).

While it would appear that play serves a function for most species, there also appears to be an optimal balance of play. Suomi and Harlow (1971/1976) conducted experiments on monkeys reared in "sterile environments" without physical contact with other monkeys. These findings suggested that wire-cage reared infant monkeys with no playmates to provide motor stimulation were incompetent in virtually every aspect of

social activity; they also developed compulsive and stereotypic rocking behaviors strikingly reminiscent of the human autistic child. These researchers concluded that monkeys without play were "very socially disturbed" and that "all work and no play makes for a dull child" (Suomi & Harlow, 1971/1976, p. 492). Argued even more strongly, insufficient opportunities for play experiences in human infants can lead to stunted or dysfunctional neurological development. That is, "play and exploration grow the brain—healthy play and exploration grows healthy brains" (Perry et al., 2000, p. 3).

Singer and Singer (1990) argued that imaginative play can be viewed across the human species in the context of cognitive-affective psychology, and to do so broadens our view on human motivation considerably. Through play, we all seek: (a) to reexperience or to reconstruct events, interactions, or thoughts that have evoked the positive emotions of *interest-excitement* or *joy* (e.g., smiling, laughter); (b) to avoid in action or thought those situations that have evoked the specific negative emotions of *anger, fear-terror, sadness-distress* (e.g., weeping), of the complex of *shame-humiliation-guilt*; (c) to *express* our emotions as fully as possible; and (d) to *control* emotional expression where our social experience suggests it is necessary. These authors concluded that opportunities or "situations that permit the experiencing and expression of positive emotions or allow for the appropriate control of negative emotions will intrinsically be positively reinforcing" (Singer & Singer, 1990, p. 25).

Even cultural experience starts as play (D. W. Winnicott, 1986). Play and symbolic development act as mediators between biology and culture in early childhood (Gardner & Wolf, 1987) and become deeply rooted in the adaptive functioning and creative processes of children (S. W. Russ, 1998) and of mature adults (Gardner, Phelps, & Wolf, 1990). Early investigations found that men played more games of physical skill,

while women tended to play more games of strategy and chance (Sutton-Smith, Roberts, & Kozelka, 1963). Both intra-culturally and cross-culturally, games and toys can be viewed as tools of growth, self-moving machines, family bonding gifts as well as consumer objects (Sutton-Smith, 1992).

From a cultural-ecological perspective of play behavior and development, Roopnarine, Johnson, and Hooper (1994) emphasized that there are three important interacting and environmental influences on play: (a) physical and social aspects of children's immediate settings; (b) historical influences that affect the way children (and adults) conceptual play; and (c) cultural and ideological beliefs relative to the meaning of play for subgroups of children. "Hence, the overall environment of influences is defined widely and includes social and economic realities that have an impact on families as mediators of children's experiences" (Roopnarine et al., 1994, p. 4).

In Western societies, some have even suggested that there has been a repressed approach to play marked by several centuries of seriousness, hard physical labor, unquestioning respect for authority and tradition in which playfulness, imagination, and spontaneity were devalued and had little place in mainstream socioeconomic processes (Blatner & Blatner, 1997). In preindustrial societies, by contrast, playing and learning appears to have specific and special relevance. As children grow into adulthood, for instance, "play is smoothly and informally transformed into work" (Leacock, 1971/1976). A small African child, for example, plays with a small gourd filled with water and attempts to balance it on his head; as he learns, gradually the load is increased and the play activity turns into a general contribution to the household water supply. Using another example, children around the world can view 'playing house' universally as a rehearsal for adult roles.

Clearly, the characteristics and context of play can deftly impart a theoretical framework and a therapeutic vehicle for developing imaginations. That is, the multivaried characteristics of play appear to impart a salient approach to help individuals 'work through' their emotionality and issues in a manner so as to be not excessively confrontational to their cognitive schema. Koocher and D'Angelo (1992) provided a review of the evolutionary characteristics of play. These researchers suggested that the characterizations and techniques of play therapy emerged essentially from four fundamental and interrelated principles of child psychotherapy. First in the evolution of child psychotherapy was the emphasis on the therapeutic alliance. These authors cited several historical figures (e.g., Aichorn, Klein, A. Freud, Hoffer, Allen) for their contributions in elaborating the role of transference in the therapeutic relationship with children. In adult psychotherapy, it was viewed that transference was both revealed and repeated in past experiences. Emerging from the Vienna Psychoanalytic Society, conceptualizations of transference became viewed as an opportunity for therapists to develop intense, interpersonal experiences with children and adolescents as a primary medium by which early object relationships could be experienced and thus be corrected in a positive therapeutic alliance. With the emergence of child psychotherapy was greater emphasis placed on (a) developmental observations (b) the current relationship, and (c) fostering a nurturing environment to facilitate a child's self-discovery of needs. The therapist's role was redefined as an intermediary and through the use of toys children "became better able to merge self-expression with self-control, with a corresponding improvement in self-respect" (Koocher & D'Angelo, 1992, p. 470).

Establishing a positive therapeutic alliance is, of course, only a preliminary step in treating children. A second construct that emerged as a characteristic of child

psychotherapy was the use of therapeutic interpretation. "Interpretations were considered to be one important element in the sequence of 'uncovering' processes in child psychotherapy...which were similar in nature to the work of adult psychoanalytic psychotherapy" (Koocher & D'Angelo, 1992, pp. 470-471). Traditional interpretive processes later shifted to address social problems (e.g., delinquency) and a wider range of emotional problems in children. Theoretical and philosophical changes to the interpretive treatment sought to capitalize on children's play and their enjoyment. Children with more severe emotional (e.g., borderline, psychotic) disorders were considered to benefit from more active therapist involvement in producing fantasy and reality coupling (D. W. Winnicott, 1971). Nevertheless, for the most part interpretation was designed to maintain the therapeutic relationship (Koocher & D'Angelo, 1992).

The third characteristic leading to the evolution of play as therapy was a growing appreciation of developmental issues among child psychotherapists. Traditional interpretations shifted away from psychoanalytic drive theory and "almost adult-like, psychic life" of interpretations toward a "more accurate focus on the nature of developmental issues in child treatment" (Koocher & D'Angelo, 1992, p. 471). Shaping the appreciation of developmental issues in children were the contributions from work with latency-age children to conceptualizations based on pre-latency issues and developmental investigations (e.g., Erikson, 1972/1976; Mahler, 1952, 1968; Piaget, 1951) based on growing knowledge of cognitive, emotional, and interpersonal aspects of childhood. The early psychoanalytic framework of 'free association' as a powerful therapeutic tool for probing the unconscious and the growing acceptance of the natural growth impulse of human need for self-expression helped pave the way for nondirective approaches in child treatment (e.g., Axline, 1947, 1964).

Finally, as with adult psychotherapeutic practice, the evolution of the child guidance movement was "influenced by social movements, the way societal problems were conceptualized, and how institutions were developed to address these difficulties" (Koocher & D'Angelo, 1992, pp. 473-474). Delineating perhaps the earliest characteristic features of clinical methods and social contributions of applied psychology and education, Witmer (1909) proposed the concept of "orthogenics" in working with children to investigate retardates and deviates, which eventually led to the applications and statistical methods developed by Cattell et al. (Cattell, Cattell, & Rhymer, 1947) and Thorndike (1951a, 1951b) in identifying children with lesser abilities and in developing standards of normal intellectual functioning and retardation. An example of Witmer's (1909) psychotherapeutic strategies in a school-based setting was to utilize "assistant trainers" to help children "label the affective state and relate for the child to its consequences, suggesting that when those feelings occurred, they should be immediately identified so that greater control could be exercised" (as cited in Koocher & D'Angelo, 1992, p. 474). Thus, these pioneering educational models marked some of the earliest characteristics of reflective listening and empathic attunement with young children. The rise of the urban industrial society during the late nineteenth century has also been cited as instrumental in formalizing the "social service" movement and child treatment casework in which, a century later, health maintenance organizations and managed health care programs of the 1980s eventually evolved in response to increasing health care costs and socioeconomic forces (Koocher & D'Angelo, 1992).

Since pioneering play techniques were advanced, almost seamlessly, multiple variations of play therapy techniques began to emerge. Play has "became a vehicle for the child to concretely experience the world within the confines of an accepting and positive

environment (Koocher & D'Angelo, 1992, p. 473). From a neo-Pigetian perspective, Heidemann and Hewitt (1992) suggested that play development in young children follows basically along three interrelated pathways: play with objects, social play, and sociodramatic play. *Play with objects* centers around the child's ability to manipulate and explore toys through sensorimotor, constructive, and dramatic activities. *Sensorimotor play* refers to repetitive movements and changes with the developmental maturity of the child. For instance, infants spend their waking hours pressing, poking, prodding and turning objects. Toddlers demonstrate sensorimotor skills by jumping and dumping toys, while preschoolers may stir sand, pat playdough, or pour water. *Constructive play* tends to begin with simple tasks such as stacking wooden blocks, and may gradually develop to assembling a tower or castle from small, intricate building blocks. *Dramatic play* involves representational skills and role-playing. Demonstrating abstract thinking abilities, a child's understanding that one item may be used to represent another is referred as *representational* skills. In addition, an important part of dramatic play is the child's ability to role-play through imitating the behaviors of others, whether the model is real or a fantasy character. Moreover, in sensorimotor play, children also begin to learn that games have rules.

Social play involves children playing in contact with others. In social play situations, children develop cooperative skills such as compromising and sharing. Incidents of social play involve five different types. *Play with adults* begins with parents during infancy and involves interactions of repetition, rhythm, and conversational tone. A young child engages in *solitary play,* and may watch the play of other children from afar until developing the social skills necessary to engage in *parallel play,* which is characterized by the way children play side-by-side, but not yet coordinated,

interactions. *Associated play* involves peer related, group activities in which children may play with the same materials, but their creations remain separate. Beginning with simple back-and-forth patterns, *cooperative play* involves a coordinated reciprocity of interactions in that two individuals may partake in the same activity and create themes together.

Finally, *sociodramatic play* involves a child's ability to integrate object (dramatic) play skills with a higher level of interpersonal (social) skills. Elements of sociodramatic play include imaginative role play, make-believe with objects, make-believe with actions and situations, interaction, verbal communication, and persistence. As these authors pointed out, the representational skills associated with sociodramatic play prepares children for many life experiences and are essential to children's ability to conceptualize (e.g., language, reading, sciences) and strengthen (e.g., creativity, relationships) many things. While some early research indicated that play therapy may not be suitable for children aged over 12 years because the toys restrict the expressiveness of older children (Lebo, 1956), others have encouraged flexibility in play therapy techniques and have further suggested that play techniques could be used for adult populations (H. Greenwald, 1967) to help adults develop a playful and healthier approach to life (Blatner & Blatner, 1997).

On associated matters of play characteristics, Eifermann (1972/1976) investigated the commonalities and dynamics underlying the 'natural' processes of children in their selection amongst games and play activities. These results suggested "steady games," as opposed to recurrent, sporadic, or one-shot games, "function in reducing anxiety by giving the child an opportunity to reduce, symbolically and on a lower scale, conflicts which he is not able to successfully cope with in real life. The

constant attraction of steady games would then exactly lie in the fact that in them the child is able to control the level of conflict so that it both remains a meaningful substitute and retains its resolvability" (Eifermann, 1972/1976, p. 454). Steady games were defined as those that are played more or less constantly with little variation in intensity. The therapeutic value of 'constant' and 'intense' play echo many of the hallmarks discussed earlier on child psychotherapy and the development of play techniques as treatment.

Focusing more on the therapeutic characteristics rather than cognitive or developmental processes of play, Cattanach (1995) described that there are several additional play patterns among children. Once children begin to form relationships with others, a style of play begins to emerge as stories of play are repeated and become part of a ritual or expanded and changed as the play gains in complexity. Examples of *developmental play* are the embodiment of play, which includes pre-verbal explorations a baby makes in the immediate sensory world, sniffing, touching, looking and hearing. Children engaging in *projective play* begin to explore toys and objects outside themselves and start to play out experiences by using these external mediums. *Dramatic play* tends to develop through family play, the re-structuring of events, and the making and listening of stories. By age four, children can role-play and make believe play with other children. Children constructing arrangements or patterns with objects and substituting items where actions require props is characterized as *object-dependent play*. Object-independent children can create stories and tend to play from non-existent elements, and can incorporate objects and actual events changed to be part of their imaginative play. The two styles can be described as play patterns versus play dramatists. In symbolic play, the child makes acts of representation through which they can interpret or re-interpret their own experiences by playing imaginary worlds. When children

experience alternative reality play, they can experiment with make-believe play, assign a variety of functions and roles to objects and people, there is a possibility that individuals can transcend and transform their experiences. They create a place to explore the boundaries between self and other, inside and outside, hurt and nurture. The psychic space between child and therapist is the potential space between child and mother. In the therapeutic space, children can experiment with ways of being that can help and heal.

In sum, several decades of clinical research and practice have been dedicated to refining and reifying child psychotherapy and play therapy techniques. Providing a fulcrum for advancing a contemporary viewpoint, Solnit (1993) provided the following developmental and clinical considerations as guides to developing certain theoretical assumptions and technical advances of play:

1. Play begins toward the end of the first year of life, encouraged and fostered by playful attitudes of the care-giving adults.
2. Play in childhood, with rare exceptions, includes physical and mental activity.
3. Considered parallel processes, play is trial action for younger children as thought is trial action for latency children and onward.
4. Play in childhood can be traced into adulthood as playfulness. In adults, however, play is often supplemented as grownups become self-critical of its regressive aspects and also because the notion of playfulness becomes more palatable taking on the forms of thoughts, fantasies, and imaginings—that is, efficient, socially useful, and private.
5. Play in adults tends to take on special forms such as drama, dance, and music with all the mental and physical combinations of gratifications of aesthetics and of a socially approving audience.
6. Play and playfulness, at any age, are inviting because they review the past, reflect the present, and provide constructive expression of curiosity that enables the 'players' to prepare for further challenges and opportunities.

Currently, however, Perry (2000) sorely remarked that society as a whole typically dismisses or misses important opportunities for promoting healthy child development. The author argued for the need to adopt a proactive (vs. reactive) approach in that "we typically wait until a child is so impaired and dysfunctional, acting out and failing in school, before we initiate services" (p. 3). Advancing our understanding of play and its characteristics and its implementation seeks to engage a proactive approach to promote healthy human development.

Processes of Play Therapy

The processes of individual play therapy are generally based more on the experiential quality of the therapeutic relationship than on the pointing of the theoretical compass or therapeutic techniques. Norton and Norton (1997) detailed an interactional, stage-based model based on the client-therapist relationship from which the dyadic processes of play therapy can be viewed within the context of most any theoretical framework. Bear in mind, however, that without "appropriate responses on the part of the therapist it will be impossible to reach each stage, thus hindering therapy" (Norton & Norton, 1997, p. 6).

Accordingly, the Nortons (1997) described that there are essentially five stages or distinctively evolving processes within play therapy interactional patterns. The first is called the *exploratory stage,* and the child can be observed exploring the playroom setting as well as 'checking out' the therapist. During this initial stage, it is imperative that the therapist be fully attentive, accepting, and nonjudgmental, in short, be ever 'present' and in honoring the child. In terms of the level of presenting problem (conceived as a horizontal line), the child shows rapid, albeit temporary, improvement during this phase. As the working relationship establishes and builds trust and respect,

the child begins to sense a dissipation of isolation and frustration and an increase of hope. Unfortunately, parent during this period can feel threatened by the amiable responses or attachment conveyed by the child toward the therapist. Thus, it is equally important that the therapist not only prepare parents for these behaviors in the child but also offer them support and encouragement.

During the second phase, the *testing for protection stage,* the child will want to make certain that the 'honoring process' is still intact. Perhaps at times a bit wary, the child will test the therapist's respect and reverence through varied conditions and behaviors. For instance, a child may 'act out' in socially inappropriate ways to be assured that his or her emotionality will be protected. Such behaviors may be observed in the playroom as well as in the home as reported by the parents. In terms of the child's behaviors, it may appear that any improvements had peaked as indicative by deteriorations or even a return to the baseline of presenting problems. During this stage, it is important for the therapist to have established credibility and already discussed this predicted downturn with the parents; not doing so increases the likelihood of premature therapy termination or attrition. Once the therapist has passed the test and child feels protected and safe in the working relationship, therapy begins.

The next two stages are the working stages: dependency and therapeutic growth. In the *dependency stage,* the child begins to express needs through disclosures of traumas, pains, and struggles by adding content to the play. As this process intensifies, the child wrestles with emotions and may become fearful that the feelings will get out of control. When this occurs, the child will temporarily stop the play or shift the theme in order to assess and reassess the level of safety, security, and protection. The child will look to the therapist to evaluate and reassess the level of safety. Once feeling safe enough

to do so, the child returns to the play. "Through these repetitions of safety determinations, the child is finally able to confront the pain and trauma of violations that have happened to her" (Norton & Norton, 1997, p. 9). As if a continuation from the previous stage, the downward trend of the child's behavior stays the course and submerges below the baseline of presenting problems. The fourth stage, or the second phase of working through, involves *therapeutic growth.* Upon successfully completing enactments of emotionality and confrontation, issues become less imposing for the child and the level of functioning becomes elevated nearer to the short-term improvements observed during initial phase of treatment. Improvement gains during the working through stages are more stable, however, as the child's self-identity becomes integrated with the empowerment experienced in externalized play, thereby developing an *internalized* sense of empowerment and sense of self. In short, play has served for the child a "rehearsal-for-adult-life style" (Norton & Norton, 1997, pp. 10-11).

Once the child gains in sense of well being, control, dignity, and empowerment are assessed to have achieved a chronological and developmental level of appropriateness, it is appropriate to introduce the fifth and final phase of treatment, the *termination stage.* Commonly coinciding with the child's diminished desire to be in the playroom, closure is carefully introduced to the child and the parents. In doing so, it is important that the therapist be mindful of what it may mean for a child to say goodbye to a safe environment and relationship. Some children may even react to the termination by briefly returning to some of the play behaviors noticed at the time of referral. "As the child accepts the loss of the relationship and realizes her own empowerment, she will quickly return to her elevated level of functioning" (Norton & Norton, 1997, p. 10).

It is noteworthy that the therapeutic processes discussed here are centrally applicable to the dynamics of individual play therapy sessions, or child-therapist dyads. While many of the major play therapies have differed in their theoretical framework and fundamental approach, most have generally strived to provide a play space for the child that embraces a "contextual holding capacity" (J. S. Scharff, 1989b; D. W. Winnicott, 1971) for the child to listen thoughtfully, to engage, to be affected, to tolerate anxiety, to reflect upon experience, and to communicate understanding of intent. Experiential therapeutic processes also may be viewed similarly within the therapeutic contexts of family therapy or child-parent dyads, the interpersonal processes and dynamics may be vastly different and more complex. Nonetheless, the experiential stages of individual play therapy can be essentially considered as a relatively unified constellation of therapeutic processes that generally emerge and become resolved in the course of child psychotherapy, although each theoretical perspective may emphasize, manage, and respond to each of these process stages differently. Keeping in mind this general framework on the therapeutic processes of play therapy, let us now turn to some of the major individual play therapy approaches which have definitively influenced and advanced the fundamental principles of contemporary play therapy.

Play as Therapy: Major Theoretical Approaches

There are essentially two schools of thought of practicing play therapy: directive and nondirective (Rasmussen & Cunningham, 1995). Expanding the landscape to discuss other differences between contemporary child psychotherapies has been the focus on differences between interpretations of verbal and nonverbal behavioral observations within sessions or, even more commonly, differences in emphasis of such interpretations (Jellinek, 1992). Russell and Shirk (1998) compiled a review of the 50-year history on

child psychotherapy process research and identified the most prominent psychological theories as psychodynamic, client-centered, cognitive and cognitive-behavioral and the key treatment areas as emotional, interpersonal, and language/cognitive processes.

The following discussion presents an overview of some of the leading child psychotherapy and theoretical perspectives that have been most influential and adopted for use with contemporary play therapy modalities. Those orientations presented here include: classical psychoanalysis, Jungian analysis, cognitive-behavioral interventions, and client-centered/humanistic or nondirective. These major contributing approaches to the field of play therapy are followed be a discussion on play from contemporary neurodevelopmental perspectives. The section concludes with a discussion on these varied applications and integrative features toward developing an eclectic approach and application of play therapy techniques.

The Psychoanalytic Approach

Beginning with classical Freudian analysis, the psychological domain consisted primarily of and was governed by innate sex drives and aggressive instincts. However, both analytic descendants and ardent critics eventually challenged many of Sigmund Freud's fundamental tenets on human development. During the initial phases of his career, nonetheless, Freud's conceptualization of childhood development and emphasis on the manifestations of rapid transference patterns in children "had an early and significant influence on the development of child psychotherapy" treatment, "including with play" (Koocher & D'Angelo, 1992, p. 458).

Child psychodynamic therapy was described by Fishman (1995) as the aim to help children look inward in facilitating a deeper understanding of their emotions. The goal for psychodynamic play therapists is to utilize interpretation by unearthing the

origins of problems. Sources of clinical psychoanalytic interpretation are presented through observations of symbolic forms children use to communicate wishes, fantasies, and conflicts with overwhelming anxiety. The most ardent approach is classical psychoanalysis, which generally involves intensive weekly sessions of about four or more per week. Due to its extremely high cost and time-consuming nature, it is seldom used with children. Psychodynamic therapy, on the other hand, involves one or two weekly sessions and is most likely to take several years.

Some have maintained that analytic child therapy techniques can be viewed as modified adult psychoanalytic techniques, such as interpretation and verbalizations (Frankel, 1998). One "major difference between adult and child psychotherapy is the patient's *form* of bringing...affective material" to the session, in which adults use verbalization and children utilize play (Chethik, 1989, p. 48). From a psychoanalytic viewpoint, "play is a complex and changing phenomenon" (Herzog, 1993, p. 252) that takes many forms. Play can be seen as a unique capacity for combining thinking and acting by which these processes can flow into each other with a looser connection than is usually permitted (Solnit, 1987). Play psychoanalysts seek to understand children's language through expressions of innermost fantasies and emerging relationships with others (Marans et al., 1993).

Traditionalists believe that children's perceptions of psychic reality and adaptability begin about age four, or at the oedipal stage (Target & Fonagy, 1996) when the child begins to understand that individuals can have different feelings and different thoughts about the same external reality (Fonagy & Target, 1996). Newly developed play modalities in child psychoanalysis posit that through the "action language of doing, redoing, and undoing" (Herzog, 1993, p. 252) play creates an openness in the child's

representational world, in components of intrapsychic change, and in new experiences and subsequent refigurations of reality (Herzog, 1996). For the most part, psychoanalytic impressions of play have tended to focus on specific developmental periods of play among children, arguing that play takes place mainly in childhood and typically drops off in adulthood. In other words, it would be most unlikely that a classically trained psychoanalyst would use play techniques in working with adults. Currently, however, there has been some renewed interest in play and playfulness among adults (Solnit, 1998).

Among child psychoanalysts who do use play techniques, they would generally consider the ultimate aim is to have the child talk directly to the analyst and analyze with the analyst because play only produces abreactions (i.e., simple discharge of feeling) and will not lead to structural and permanent change in the ego or superego (Maenchen, 1970). Play, in child psychoanalysis, is conceptualized primarily as a two-stage process. The first stage enacts play as a facilitative vehicle, an 'ice-breaker' of sorts, toward building a relationship alliance with the therapist, and toward building of the second stage, the development of the quality of play 'sets the stage' for the therapist's critical abilities of intervention, utilization, interpretation.

Keeping with a psychoanalytic interpretation, Chetnik (1989) described that there is a familiar sequence in the development of children's play. First is *an initial period of nonengagement,* or, *setting the stage,* in which the child may not play, or plays alone, or the play is unintelligible or not useful, often leaving the child psychoanalyst "puzzled and noncomprehending." Second, in the *early phase of affective engagement,* the therapist "slowly becomes orientated" to the child's play and can begin to share in its meaning and metaphors. The next stage involves the *emergence of central fantasies* as the child

elaborates through play important themes and fantasies. In that this stage follows several sessions, it may also involve the parents' reports of observed changes in the child (e.g., symptom relief, escalation of anxiety, behavior improvement or deterioration). Finally, the fourth stage is the *period of working through.* Through the therapist's integration of the varied meanings of the "unfolding material," interpretive interventions help either to stabilize the gains or to control the process.

Other traditionalists have argued, however, "play, in itself, will not ordinarily produce changes in the therapist's office any more than it will in the schoolyard" (Chethik, 1989, pp. 48-49). Gavshon (1989) emphasized that playing takes on special meaning within the analytic relationship, but noted that not all play in analytic training is intended as communication. The child must first become therapeutically engaged in the analytic process so that "playing can be used to communicate, consciously or preconsciously," whereby the "treatment alliance is strengthened by the expectation that the therapist will understand, accept and respond to whatever the child brings" (Gavshon, 1989, p. 48).

Lee (1997) considered there are numerous potential pitfalls encountered in psychoanalytic play therapy. Given the cognitive limitations of young children, it would be unreasonable to expect a child to use play in the same way adults might use the analytic task of free association. Second, in that interpretation of transference is the essential tool to "derive its mutative effect" (Lee, 1997, p. 55), child analysts must be experienced in transference manifestations and partial transferential reactions. Third, child analysts need to be experienced in dealing with the myriad of possible resistances a child may present. Fourth, it is vital for child analysts to choose carefully the time and setting when interpretations are offered to the child. Finally, although not typically

emphasized in traditional psychoanalytic play therapy, underscored is the importance of the need to build a working alliance with the parents (mother) toward ameliorating the pathology of the child.

Responding to such criticisms, some notable shifts have emerged in contemporary psychodynamic treatment. Watchel (1994) affixed a psychodynamic framework of integrative perspectives for exploring and understanding the systemic dimensions of a child's difficulties. Specifically, the author argued that increased anxiety typically arises in each family member's developed coping mechanisms, adaptational styles, defenses, and in the family's dysfunctional (or, inadequate functionality) patterns of relating. Accordingly, increased understanding about the specifics of the family's dynamics was coupled with an equally important understanding of the child's intrapsychic conflicts and unconscious wishes. To address these issues, the author offered multiple psychodynamic interventions, some formulated on conventional treatments (e.g., avoiding overstimulation of regressive urges) and some not so traditional techniques (e.g., play baby).

In addition, Trad (1993) illustrated how brief psychodynamic techniques could be employed to assess interpersonal conflicts, strengths, and weaknesses within parent-infant dyads. The author argued that a short-term parent-infant psychotherapy model marks a considerable departure from traditional theoretical models in that conflict is viewed relationally in models of object-relations, interpersonal, and theories of self. The treatment goal in short-term parent-infant therapy "is to rapidly establish an alliance that will allow the therapist to question the patient's resistances and defensive styles" (Trad, 1993, p. 21). Assessment targets sources of disruptive conflict that interferes with the dyad's smooth adaptive functioning. By means of assigning specific tasks to address

the child's developmental profile (e.g., anxiety), the major goal would be to emphasize symptom relief through amelioration of relationship patterns of conflict and dysfunction in the infant-parent dyad.

In sum, the use of play techniques in child psychoanalysis was perhaps not so much an innovation as much as it was an evolution of techniques for facilitating child-therapist relationships. Moreover, indicative of some of the emerging directions within the psychodynamic perspective, contemporary parent-infant psychotherapy models appear to represent an integration of theoretical frameworks such as relational theory and working within family systems. In that advancing brief or time-limited techniques have been advocated by some traditionalists signifies, at least to some degree, elements have emerged in contemporary psychoanalytic trends and practice to meet the demands of increasing socioeconomic constraints (e.g., duration of therapy, attrition) and sociocultural forces (e.g., single parents).

The Jungian Approach

In contrast to S. Freud's emphasis on sexual drive theory, Carl Jung (1954) believed the unconscious mind was contained in the main drive of the psyche and, similar in view to Kohut's (1977) concept of the self, humans have a unique potential toward wholeness, growth, and individuation. The human psyche, according to Jung, is a self-regulating structure capable of healing itself through unlocking the creative process such as writing, painting, drawing, sculpting, and by means of 'working through' inner symbols and fantasies. As illustrated by Allan and Brown (1993), the Jungian psyche consisted of three main areas: (a) ego, the conscious mind; (b) the personal unconscious, consisting of all personal experiences that are repressed or stored below the level of awareness, including undeveloped potential; and (c) the collective unconscious,

containing various archetypes. Jung distinguished between those aspects of the transference that are "archetypal," or fundamentally intrapsychic organizing principles, from those that are "personal," as reexperiencing of specific content through early relationships within therapy (Corbett, 1989). The Jungian soul itself "is the reaction of the personality to the unconscious and includes in every person both male and female elements, the animus and the anima, as well as the persona or the person's reaction to the outside world" (Ehrenwald, 1991, p. 348). In the Jungian approach, "the language of archetypes is the language of symbols and imagery" (Allan & Brown, 1993, p. 31).

Allan (1997) emphasized the ultimate goal in Jungian psychotherapy is to activate the individuation process in the child. Encompassing Jung's concept of the self's internal struggle for uniqueness, "this means helping the child to develop his or her unique identity, to overcome or to come to terms with his or her losses or traumas while accepting and adapting to the healthy demands of family, school, and society at large" (Allan, 1997, p. 105). The therapeutic goals in Jungian analysis are described as: (a) activating the self-healing potential in the child's psyche; (b) strengthening the ego-self, that is, the connection and flow between the conscious and unconscious; (c) stimulating and developing creativity and imagination; (d) healing and transcending wounds; (e) developing an interior life; (f) developing a sense of competency and mastery; (g) developing the skills to cope with future problems; and (h) understanding the complexity of life and be open to change. The ultimate goal in "Jungian psychotherapy is to activate the individuation process so the client can live in relationship with himself or herself and the outer world" (Allan, 1997, p. 105).

Though Jung never worked directly with children, his theory and treatment techniques have offered much to child psychotherapists (Allan, 1997). One of the most

powerful and highly regarded play therapy tools is the sandtray for its illumination on and interpretation of the child's (or adult's) inner world. Unfortunately, the extensive training and its heavy reliance on symbolism also makes sandplay work one of the more highly skilled play therapy techniques. Sand often acts as a "magnet" for individuals "to balance and mediate between inner drives and the outer world" (Allan & Berry, 1993). Sandplay reveals the unconscious (Carey, 1990) with a language that enacts the child to freely express feelings and difficulties (Zhang, 1998) within inter- and intrapsychic worlds (Carmichael, 1994). However, interpretation of any sandplay 'picture' requires one to have "a fairly solid understanding of Jung's work with imagery and the archetypes of the collective unconscious, a background in normal and abnormal child developmental theories, and a working knowledge of play therapy, drama therapy, and art therapy" (Carey, 1990, p. 197).

A training analyst at the Jungian Institute, Bradway (1979; Bradway & McCoard, 1997) illustrated the procedures of sandplay. In a box of specific dimensions (approximately 19 x 28 x 3 in.) containing either dry or damp sand, individuals are allowed to select whatever things they wish from shelves holding hundreds of miniatures of human figurers, animals, building structures, vehicles, plant life, sea life, bridges, wells, fences, garden and farm implements, stones, shells, mosaic pieces—whatever the therapist has collected for this purpose. Although individual therapists vary their involvement during the sandplay process, client-therapist verbal interactions are typically minimal while the client constructs their fantasy within the boundaries of the box. The therapeutic process of sandplay provides a vehicle and a means for individuals to live out their fantasies and an opportunity for them to make a permanent visual record of their journey.

As Dundas (1978) observed, to develop understanding of the process of sandplay therapy requires that the therapist always try to be sensitive to the feelings of the child—to be empathically attuned. Often the miniature figures that are chosen, even the figures that are returned, and they way they are situated in proximity to other figures and within the dimensions of the sandtray itself, can be very telling. If the therapist becomes puzzled, however, sometimes it is simply best to ask to child the meaning of a figure. For example, sometimes "A tree belongs in the forest," or, "A tree may be a secret hiding place," whereas a rock may be specifically placed to protect a favorite animal, or to protect the self. "The answers are clues to the child's feelings and to *his* meaning of the symbol. ...For both very open and very closed children, the sandtray allows deeper symbolic messages to become quite clear" (Dundas, 1978, pp. 3-4). The ultimate goals in sandplay therapy are for individuals to develop and bring to consciousness a deeper understanding of self through symbols and myths, even those dark and frightening, and to communicate their feelings through connections to others. As Bradway and McCoard (1979, 1997) observed, feelings expressed through sandplay interactions of transference and countertransference, or "co-transference" as they prefer to denote the co-working relationship *with* (vs. *against*) the therapist, are necessarily determined by both earlier and current relationships.

In sum, more than a means to an end, Jungian therapy and techniques such as sandplay are ultimately about personal journey, shared experiences and personal process. "Through their own creative process, they find the road opens to lead them out of their difficulties. ...Whatever place the individual reaches through sandplay therapy, one fact remains: somehow the psyche is touched and healing takes place" (Dundas, 1978, p. 5). Miller and Boe (1990) described interpersonal child-therapist sandplay work

as both an intimate and powerful mutually shared experience between two individuals; image, they argued, the potential for it can to become even more so when such relatedness and intimacy is shared between a parent and a child.

The Cognitive-Behavioral Approach

In contrast to psychoanalytic or Jungian treatment approaches, Fishman (1995) described the aim of cognitive-behavioral therapy as training children to look outward in order to perceive the world differently and to change behavioral patterns. Cognitive-behavioral approaches are rooted in experimental psychology and thus are dedicated to the rigors of scientific inquiry and data gathering and measurement techniques. Clients (vs. 'patients') are viewed by cognitive-behaviorists as having a specific broken part that is in need 'fixing' and thus specific problems become the target or focus of interventions. Because cognitive-behavior therapy is targeted at alleviating a specific symptom or group of symptoms, its duration tends to be much briefer (about four months to one year) when compared to psychodynamic approaches.

Rather than focus on personality theory and development, cognitive therapy is based on a model that involves an interplay of emotional disorders among cognitions, emotion, behavior, and physiology (Knell, 1997). Underlying the methods of traditional cognitive-behavioral therapy is that individuals' interpretations of environmental conditions can differ as well as their subsequent behavior to mediate the conditions (Reisman & Ribrody, 1993). Thus, individual differences in children can lead to a variety of interpretations regarding the specific causes of certain events ranging from ameliorated or stimulated experiences to distorted or disturbing perceptions. Common cognitive-behavioral interventions practiced with children include *self-instruction, self-talk,* and *problem-solving skills and training*. Common behaviors exhibited by children

who are potential candidates for cognitive-behavioral interventions include those with presenting problems of impulsivity/distractibility, fears and anxieties, misattributions, perspective taking, social relating, and problem solving.

In that traditional cognitive-behavioral techniques are aimed primarily at treating children who present with problems of anxiety, the techniques and applications tend to be wide-ranging. Francis and Beidel (1995), for instance, employed the term "cognitive-behavioral" strategies to represent an integration of cognitive, behavioral, affective, and social strategies for change. These authors recommended a variety of integrative cognitive-behavioral strategies: (a) *exposure-based strategies,* which requires that the child is introduced to recognized a hierarchical presentation of anxiety-provoking situations either imaginably or *in vivo* (gradual exposure to real life situations); (b) *systematic desensitization,* consisting of relaxation training, construction of the anxiety hierarchy, and pairing of relaxation with gradual presentation of anxiety-provoking situations; (c) *flooding,* which involves repeated and prolonged exposure (imaginal and *in vivo*) to the feared stimulus with the goal of extinguishing the anxiety response, while the child provides self-reports on anxiety ratings; (d) *contingency management,* or operant conditioning (e.g., positive reinforcement, shaping, extinction, punishment) procedures are used to modify antecedent and consequent events that may influence the acquisition and/or maintenance fearful or anxious behavior; (e) *modeling,* a social learning theory construct that upholds an anxious child can benefit from observing a model approach and cope with a feared situation; (f) *cognitive strategies,* which includes techniques in self-instruction training, problem-solving, and altering maladaptive self-talk; and (g) *integrated cognitive-behavioral programs.*

Some have argued that cognitive-behavioral strategies alone are inherently limited to treating symptoms, such as anxiety, in children. As a result, some have turned their focus to integrating child psychotherapy treatments and the merits working within a framework of the therapeutic relationship. Kennedy and Moran (1991), for instance, noted that when the child's symptoms are dystonic (e.g., in phobias, nightmares, or distress), the child's wish for relief of suffering can be mobilized through establishing a treatment alliance. In young children, however, such an alliance may be threatened by a tendency to externalize repudiated wishes if they expect the therapist to condemn or punish aggressive acts or behaviors. In such cases, when the therapeutic alliance is threatened in the early stages of treatment, these authors suggested that the therapist aim to foster the child's view of him or her as a trusted and helpful adult (e.g., therapist, teacher, parent).

While not exactly integrating the principle features of play, Pellegrini, Galiniski, Hart, and Kendall (1993) provided a cognitive-behavioral treatment guide for working with children and adolescents. These authors posited that the comprised symptoms of anxiety and fear in children arise from three domains: (a) subjective reports of distress and discomfort; (b) physiological reactions, including sweating and increased heart rate, respiration rate, and muscular tension; and (c) behavioral responses including avoidance, escape, and/or tentative approach. Although parents and teachers may enhance the behavioral profile for a child suspected to suffer from fears and anxieties, of crucial importance to gaining a more complete picture is the child's description of subjective feelings of anxiety-producing or fearful situations. Equally important is the child's self-statements or internal dialogues about a given situation or problem-solving strategy.

Others have emphasized that traditional cognitive-behavioral approaches can be ideally suited when enhanced by play therapy techniques. Knell (1993, 1997, 1998) provided a conceptual framework for cognitive-behavioral play therapy (CBPT). For CBPT to be effective, Knell (1997) emphasized the importance for treatment goals to be structured and directive while simultaneously "allowing the child to bring spontaneous material to the session" (p. 97). In CBPT, for instance, a child's inappropriate or ineffective social skills may be the primary focus of treatment. Therapeutic interventions are based on both nonverbal and verbal communicative processes. Directed at specific cognitive and behavioral interventions, through the use of play cognitive change is communicated indirectly and adaptive coping skills are modeled by the therapist as more adaptive behavioral strategies are introduced to the child (Knell, 1997, 1998). At the core of CBPT is the child therapist's ability to 'model' effectively developmentally appropriate interventions. In addition to modeling, behavioral techniques may include positive reinforcement and shaping, as well as cognitive techniques such as identifying/changing maladaptive beliefs, learning positive self-statements, and bibliotherapy. In addition to directing structured interventions with the child, CBPT usually involves the parents. In contrast to the traditional psychoanalytic approach to enlist parent involvement for formulating hypotheses about the child's psychopathology, parent involvement and interviews in the CBPT model are encouraged on a regular basis to gather assessment data, to participate in treatment planning, to monitor the child's progress, and to offer support to the parents.

Other researchers have applied even greater efforts to bridge cognitive-behavioral strategies with other theoretical frameworks (e.g., A. D. Pellegrini & Jones, 1994) and play therapy techniques. For example, contemporary cognitive-behavioral play

techniques or interventions may take the form of using puppets to prepare children for a variety of medical procedures. Borrowing from psychoanalytic interpretation, Nelson (1993) described how puppet therapy has been be used to prepare children for a variety of medical procedures. "The underlying assumption is that such strategies enhance a cathartic release, which lessens psychic tension and enhances the child's mastery of overwhelming experiences" (Nelson, 1993, p. 352). Caution was suggested, however, against helping pediatric pain patients by integrating cognitive-behavioral with traditional individual psychotherapy techniques, noting that, "employing empathy may actually exacerbate pain by positively reinforcing such complaints" (Nelson, 1993, p. 352). Moreover, Ryback (1971) reported on the use of standard token-reinforcement procedures for amelioration of cognitive deficits, and noted successful results especially when combined with filial therapy techniques. In another study in which a five-year-old boy exhibited problems of enuresis, Johnson and Thompson (1974) illustrated how behavioral modeling interventions were coupled with filial treatment procedures (accidentally introduced by the mother) which reportedly played a major role in the successful treatment.

In sum, cognitive-behavioral approaches in working with children and adolescents have been primarily driven in the form of intervention and strategies that target specific, maladaptive and typically observable behaviors. Cognitive-behavioral strategies also have been integrated with other traditional therapeutic features, such as those which provide an emphasis on strengthening the client-practitioner therapeutic alliance. In some therapeutic forms, cognitive-behavioral techniques have also been integrated with a variety of play therapy techniques, but many of these approaches remain primarily directive in nature rather than child-centered or nondirective.

Moreover, many of the principles of CBPT have been generally adapted from the principles of cognitive therapy as delineated with adults, and modified for young children. In contrast to nondirective therapy, however, CBPT seeks to correct distortions in the child's thinking through direct discussions about the child's difficulties (Knell, 1993). In contrast to other more traditional play therapy approaches, cognitive-behavioral play therapy typically involves "a carefully planned treatment regimen in which irrational thinking and imaginings are first translated into concrete self-statements that the child is taught to recognize and to use as signals to engage in more adaptive coping private speech, imagery, and overt coping behavior" (Nelson, 1993, p. 352).

The Child-Centered or Nondirective Approach

While many psychotherapy approaches emphasize psychological treatment protocols or psychological tools, others focus more on the importance of the therapeutic relationship. Although play materials remain important in child-centered play therapy, they are considered secondary to the therapeutic process. It is the relationship between the child and the therapist that is the "single most creative force in healing" and the "key to growth" and personal development (Sweeney & Landreth, 1993, p. 354). Contemporary positions on child-centered or nondirective play therapy have since captured a very prominent and influential position in the field for those who provide therapy to children.

Child-centered play therapy, not unlike client-centered psychotherapy for adults, holds at its solemnity the individual's therapeutic needs of developmental preparedness and interpersonal relatedness. Child-centered play therapy grants the individual "permissiveness" and "accepts that self completely, without evaluation or pressure to

change" (Axline, 1947, p. 15). Axline (1947) elucidated nondirective play therapy by the following therapeutic encounter:

> This type of therapy starts where the individual is and bases the process on the present configuration, allowing for change from minute to minute during the therapeutic contact if it should occur that rapidly, the rate depending on the reorganisation of the individual's accumulated experiences, attitudes, thoughts and feelings to bring about insight, which is the prerequisite for successful therapy. (p. 15)

With the presence of an accepting, understanding, friendly environment, together with few limitations placed in therapeutic encounters, nondirective play therapy facilitates exploration for the child to experience permissiveness and security to enhance opportunities for individual growth, thus unblocking exterior forces that formerly presented psychological resistance (Axline, 1947).

For the child, nondirective play therapy offers an opportunity to test out situations based on fantasy and reality; for the therapist, it is an opportunity to test out hypotheses based upon a positive theory of the individual's presenting problems and abilities. The experience and the therapeutic relationship established in nondirective play therapy allow the child opportunities to express his or her real self and experience independent thoughts and actions. In psychoanalytic terms, the child's experiences a 'cathartic release' of feelings and attitudes that have been 'repressed' or pushing to get out into the open. Another hallmarks of nondirective play therapy is that it implicitly and sufficiently renders therapeutic change processes in way that "it does not seem to be necessary for the child to be aware that he has a problem before can benefit by the therapy session" (Axline, 1947, p. 22). Another oft-reported benefit of child-centered play therapy is that of approaching children in nonthreatening and accepting ways where directive techniques could easily fail. For example, behind the façade of aggressive and defiant children are usually feelings of fear and vulnerability. The nondirective approach

accepts children's acting out behaviors of hostility, and offers a possibility of change through play techniques and conjoint participation (J. Carroll, 1995; Dogra & Veeraraghavan, 1994).

Landreth and Sweeney (1997) considered the ultimate goal in child-centered play therapy is for play therapists to "relate to the child in ways that will release the child's inner directional, constructive, forward-moving, creative, self-healing power" (p. 17). Accordingly the theoretical framework of child-centered play therapy centers around three central constructs. First, within the *person* is the child's whole being including thoughts, behaviors, feelings, and physical being. The child's inner and outer worlds, or total system, are continually in flux and changing to meet the continuous dynamics of interpersonal interactions and experiences. Second, in client-centered theory the personality structure is viewed within a *phenomenal field* in which all experiences, conscious or unconscious, are acknowledged and understood as representative of the child's reality. Thus, the therapeutic climate is genuine, nonjudgmental, and empathic. Third, portions of the *self* are experienced through the interactions with significant others from within the total phenomenal field, which can facilitate in the child a gradual process of individuation through an interplay of separation and differentiation. Many of the theoretical constructs central to child-centered play therapy are largely founded on an integration of Rogerian theory, which holds that all individuals have a need to feel understood and accepted, and Axlinian theory, which contends that through play all children can be empowered by experiencing and understanding their own unique self.

More than a therapeutic approach or theoretical framework, child-centered play therapy can be regarded as a personal philosophy and a way of being. In the words of Landreth and Sweeney (1997):

> Client-centered play therapy is not a cloak the play therapist puts on when entering the playroom and takes off when leaving; rather it is a philosophy resulting in attitudes and behaviors for living one's life in relationship to children. It is both a basic philosophy of the innate human capacity of the child to strive toward growth and maturity and an attitude of deep and abiding belief in the child's ability to be constructively self-directing. Child-centered play therapy is a complete therapeutic system, not just the application of a few rapport-building techniques. (p. 17)

Needless to say, for any child-centered play therapist to live out such philosophical beliefs in clinical practice would require a deeply rooted sense of trust in the therapeutic process, in the inner abilities of both children and adults, as well as in the therapist's own self and abilities. Consistent with entrusting in the therapeutic process is the fact that in child-centered therapy terms such as 'goals' or 'cure' are essentially avoided. Rather than employing outcome measures of change, therapeutic progress or direction are instead evaluated by processing and developing a deeper, shared understanding of the child. Essentially, in child-centered play therapy "the same principles of psychotherapy apply to all children, regardless of their presenting problem, degree of normality, or extent of personal adjustment" (Landreth & Sweeney, 1997, p. 43).

On the child-centered play therapy model, however, some have criticized its general principles and processes arguing that it is too heavily focused on the child-therapist relationship with shortcomings of accessing other potentially helpful resources such as the family or teachers (L. B. Golden, 1985). Further, a cognitive-behaviorist may critique nondirective play therapy on grounds that such unfocused or unstructured techniques are unrealistic in terms of cost, duration, and effectiveness. Responding to some of these criticisms, Conn (1989) conducted a 50-year retrospective account of numerous play therapy studies and concluded that improvement could occur typically after only a few nondirective play therapy sessions. Moreover, Landreth (1998) argued that significant therapeutic gains could be observed in a few 30-mintute play sessions.

Despite some popular myths that child-centered play therapy is a slow process that requires long-term commitment, Landreth and his colleagues (1993; Landreth, Strother, & Barlow, 1986) have argued that such notions are in essence unfounded. Moreover, child-centered play therapy research findings appear especially encouraging for professionals in educational settings suggesting that nondirective play interventions can help children develop more positive self-concepts in a time-limited fashion and thus improve their academic and social problems (Landreth et al., 1986). In contemporary child psychotherapy practice, client-centered or nondirective techniques remain strong and influential forces that continue to contribute to and share much with the theoretical orientations of humanistic, psychodynamic, and cognitive-behavioral approaches. For example, many of these techniques have been integrated and underlie interpersonal relatedness models such as in Relationship Enhancement (RE) and couples therapy, filial therapy, and family therapy (B. G. Guerney, 1984).

In sum, current literature has indicated overwhelming support on the varied applications of child-centered play therapy. For example, the self-directed nature of the child-centered approach and the universality of play itself are uniquely suited for children who share varied developmental delays, cognitive abilities, family of origin, familial structure, as well as for those children from varied socioeconomic strata and ethnic backgrounds. Specifically, the literature indicates child-centered play therapy provides a fitting and efficacious approach to treat children with speech and language difficulties (Cogher, 1999; Davidson, 1998), as well as those with learning (L. F. Guerney, 1979) or developmental or physical disabilities (Carmichael, 1993; de Moor, van Waesberghe, & Oud, 1994; Ferland, 1997; Nakken, Vlaskamp, & van Wijck, 1994). In addition, the general principals of child-centered play therapy techniques can be

specifically tailored to treat severe psychological problems or symptoms, for example, trichotillomania (compulsive behavior of pulling out one's hair) that leads to complete baldness (Barlow, Strother, & Landreth, 1985). While Landreth and Sweeney (1997) noted that child-centered play therapy is more widely used with children about 10 years of age or younger, they emphasized that positive results have been obtained with early adolescents, adults, and with "specific cases of adults who have a child alter personality" (p. 25).

A Neurodevelopmental Perspective of Play

Throughout childhood and adolescence, psychological growth proceeds sequentially through progressive hierarchical organizations (Abrams & Solnit, 1998). Fine (1982), for instance, reviewed Piaget's (1951) genetic system of psychology and argued that biological, behavioral, social, and other modern forms of therapy can also be anchored in play and family skills. Resch, Pizzuti, and Woods (1988) successfully integrated psychoanalytic and neuropsychologically-orientated play therapy approaches to facilitate the symbolic functioning of a 10-year-old autistic girl to internalize a new transitional object, a teddy bear. Other psychobiological viewpoints that have emerged include considerations that the brain is a building or modifying internal model of itself and of its environment and, "whether in adjusting for the growth of the body or in learning to interact with new objects in the environment, is seen as building and changing its internal models, continually solving what engineers call the *identification problem*" (Fagen, 1975/1976, p. 98).

Another emerging perspective has been on the importance of play on early neurodevelopmental experiences on the brain and its functions in mediating all of our thoughts, feelings, and behaviors. Perry, Hogan, and Marlin (2000) have argued that "it

is becoming increasingly clear that it is the experiences of early childhood that play a key role in determining the foundational organization and capabilities" to grow and "become a dynamic ever-changing biological system which gives us the capacity to love, create, communicate, and think. Our brain becomes a product of our genetic potential and our history of experience" (Perry et al., 2000, p. 1). We are only beginning to understand how repetitive, consistent, and predictable experiences such as play affect early brain development, and how these experiences help nurture the underlying potential of every child. On the neurodevelopmental benefits of play, Perry, Hogan, and Marlin (2000) wrote:

> If the child's world is safe, nurturing and rich in social, emotional and cognitive opportunities, he or she will flourish. Central to a child's healthy development is the opportunity to act on their natural curiosity—to explore, to play, to learn. ...Play, more than any other activity, fuels healthy development of children—and, the continued healthy development of adults. (pp. 1-2)

Accordingly, the neurodevelopmental perspective parallels many of the historical observations related to play. For instance, most perspectives of play hold that when play activity and exploration are pleasurable it increases the likelihood that an individual will engage in repetitive experiences and practice, which leads to a sense of mastery, accomplishment, and confidence. The greater a child feels comfortable and secure with the world, the more likely he or she will explore, discover, master, and learn. Thus begins the cycle of curiosity that drives exploratory play in humans and in animal species as well.

From a neurodevelopmental perspective a number of additional core concepts and principles can be introduced. First, *sequential development* of the brain begins at birth in a hierarchical fashion growing toward increasingly more complex functions and responsibilities. In other words, play opportunities match a child's natural

neurodevelopmental process in key areas of physical/motor, behavioral, emotional, social and cognitive domains.

The second neurodevelopmental principle holds that normal organization of any brain centers around *use-dependent development*. That is, neurodevelopment of the brain is dependent upon the presence, pattern, frequency and timing of experiences. With increased patterned activity (e.g., music, reading, conversation), " the more the brain regions responsible for these tasks will organize and be functionally 'healthy.' ...Patterned repetitive activity results in patterned neural activity that *changes* the brain" (Perry et al., 2000, p. 2, italics added). Admittedly, acknowledgement and the suggested implications of such principles are profound. For instance, children reared in consistent, predictable, nurturing and enriched environments will have increased chances of health, while children who are exposed to neglect, chaos, and traumatic environments will have significant problems in all domains of functioning (see Perry, 1999b, 2000b, 2000c). Accordingly, play encapsulates a crucial role in providing opportunities for repetitive experiences and expressions that can potentially improve and actively change all areas of the human brain.

Finally, *windows of opportunity* hold the third neurodevelopmental principle. Because much of the sequential and use-dependent development of the brain occurs during early childhood development, this underscores the fact that early childhood experiences "have the most powerful and enduring effects on brain organization and functioning!" (Perry et al., 2000, p. 3). Such findings offer strong encouragement to other helping professionals (e.g., teachers, parents, caregivers) toward dedicating and directing their attention in noting that the pleasure of play itself is the most "inexpensive and efficient means to help children develop" (Perry et al., 2000, p. 3).

Eclecticism in Play: Perspectives and Applications

Since many of these major players posited their conceptual and theoretical frameworks and notions of therapeutic play, others have offered their own perspectives and applications of play and its therapeutic powers. Over the years, play in the literature has been represented in a variety of ways. Play has been characterized as a form of education and socialization (Bettelheim, 1972), life rehearsal (Koste, 1995), as formally operationalized procedures in play therapy (Axline, 1947; Landreth, 1991), and as transactional "games" (Berne, 1964) or dramatic roles (Blatner & Blatner, 1997) through enactments and reenactments of healthy and unhealthy relationships. While play activities are generally emphasized as important for children, play is also important for the personal growth and development of adolescents (Cattanach, 1994; Gladding, 1993) and adults (Ackerman, 1999; Blatner & Blatner, 1997; Chick & Barnett, 1995; Terr, 1999) in their ability to develop and maintain healthy human relationships. Play provides children, adolescents, and adults alike with opportunities to demystify, resolve, and integrate stressful experiences by repeatedly acting out difficult experiences and can enhance their perspective of control (Gray, 1989). Play therapy can be considered in the overall treatment plan for children with developmental and health disabilities (Carmichael, 1993) and for dying children (Gray, 1989). In the adult world of physical illnesses and diseases, play therapy techniques can have a positive impact on parents of children with chronic illness (Glazer-Waldman, Zimmerman, & Landreth, 1992; Tew, Landreth, Joiner, & Solt, 2002) and can contribute as "a highly significant component in healing" among female breast cancer survivors (J. N. Saunders, 2000, p. 77). Other researchers further identified the quality of children's interactions with adults and the

subsequent relationships formed as the most important therapeutic agent (Shirk & Saiz, 1992) rather than the introductions of any specific tutoring during play activities.

Advocating for a multivaried approach, O'Connor (1997; O'Connor & Braverman, 1997) presented an integrative, ecosystemic model of play therapy. As such, it was illustrated how a variety of helping child professionals (e.g., psychiatrists, psychologists, social workers, nurses, and counsellors) at all levels of training and experience could collaborate and elucidate their specialized treatment areas with Jason, a seven-year-old boy who exhibited behaviors of explosive anger, unresponsiveness to discipline, and was recently arrested for fire-starting.

Considered unlikely bedfellows at first, some have considered that narrative play therapy tracks more closely to that of psychodynamic play therapy. In that play psychoanalysts seek to understand children's play through self-expressions and verbalizations, narrative play therapists use narrative play techniques such as stories of hope and change to communicate with and encourage communication in children (Buchsbaum, Toth, Clyman, Cicchetti, & Emde, 1992), and in a time-limited fashion (Bruce, 1995). Freeman, Epston, and Lobovitis (1997) elucidated some of the basic tenets of collaborative narrative play therapy and techniques. These authors presented on how serious problems can be viewed and reshaped through narratives, for example, "grow up and shrink the problem down," "get the better of Trouble," and "catch Sneaky Poo before it sneaks out" (J. Freeman et al., 1997, p. 37). Advocates of narrative play therapy approaches use storytelling to work closely with other family members to treat a child's problem(s). It is imperative, however, that the presenting problem be viewed differently from the child. By perceiving the child apart from the problem, then, this may relieve the child's feelings of blame and guilt and create a hopeful atmosphere that can focus on the

young person's unique qualities and ideas. On the other hand, when a problem clouds the meeting of the child, the therapist should proceed by attempting to put the problem temporarily aside. "Getting to know the young person apart from the problem can give us coordinates and set us on a playful adventure of change" (J. Freeman et al., 1997, p. 37). Here, emphasis is placed on the importance and benefit of establishing a working alliance with the child and the parents and, if appropriate, other family members.

Pointing to another eclectic form of play therapy, Cattanach (1995, 1996) promoted the use of drama techniques with young children. Dramatherapy appears to provide flexibility within contexts of play and recognizes the variety of ways and different styles of playing in children. Important concepts in play and drama include: (a) the centrality of play as the children's way of understanding their world; (b) the fact that children move back and forth along a developmental continuum in exploring their identity; (c) the concept of play as a symbolic process; and (d) the fact that play happens in its own special play and time. Offering a Kohutian or self psychological perspective, Doyle (1998) suggested drama therapy is essential for the therapy to be empathically attuned to roles that emerge in therapy toward facilitating the goals: (a) of developing and refine roles that aid in self-consolidation and the building of self-structure; and (b) of integrating role repertoire and affect into a cohesive experience of self.

Promoting eclecticism in therapy, Strauss (1999) emphasized that clinical therapists need to develop an entirely new clinical language, especially in their work with children and adolescents. The author proposed that *no-talk therapy* bridges the interpersonal and developmental worlds and offers children, through empathy and respect, someone with whom to connect closely and something for which they can be proud. "No-talk therapy goes beyond traditional approaches with an emphasis on

individual connection, competence, and creativity. It works when we give up on our obsessive need to dwell on problems and find, instead, something to cheer about" (Strauss, 1999, p. 10). While no-talk therapy has at its core many of the hallmarks central to child-centered play therapy approaches, such as lots of "cool stuff" to provide the client with opportunities for success and empowerment, another interesting adjunct is the introduction of food. "No-talk therapists feed clients" (Strauss, 1999, p. 98), metaphorically and literally, and side-by-side activities involving food demonstrates "both the symbolic and real kinds of 'feeding' that people do; relationships can be nourishing in many ways" (Strauss, 1999, p. 99).

Not surprisingly, play therapy techniques have also been introduced to the high-tech world of microcomputers. While children participate in play therapy activities such as LOGO turtle graphics, painting with a computer via a graphics pad, and computer art therapy (R. G. Johnson, 1984, 1993), they cannot only improve their learning skills but they can also discuss their feelings about their work. Similarly, Kokish (1994) described the therapeutic merits of some other software applications, but cautioned that the computer be viewed merely as a therapeutic tool in play therapy; that is, it is the use that the therapist makes of it in the context of the therapeutic relationship that makes the difference for each child. The emphasis on facilitating and enhancing the relationship in play therapy whether using a microcomputer or traditional toys remains an important one. That is, the caring and undivided one-to-one attention that a child receives is of the utmost importance and should be the primary focus in professional work with children. Caution is also advised against encouraging children to play 'head-to-head' via competitively designed computer or video games; these sorts of activities tends to be

more passive or indirect in building relationship alliances, not to mention the highly intense competitive nature that is usually evoked in the individuals.

Play therapy techniques have also been integrated with organic function. In a somewhat controversial area on brain organization and development, the majority of research on Attention Deficit Hyperactivity Disorder (ADHD) has focused on the brain's inability to mediate or self-control behaviors (Barkley, 1990, 1997; Hallowell & Ratey, 1994). However, there remains an ongoing debate on treating its symptomatology. Sounding an alarm on the overuse of psychostimulants emerging as a societal problem, Panksepp (1998) expressed concerns about an increasing problem in our intolerance of natural childhood playfulness. Other researchers have suggested that characteristic ADHD symptoms can be effectively mediated using psychotherapeutic techniques such as enhancing the individual's self-efficacy through play therapy (Kaduson, 1997).

Maté (1999) argued that children and adults with symptoms of Attention Deficit Disorder (ADD) parallel the symptomatology of attachment-based conditions. That is, ADD symptoms can result when the neurobiological circuitry of the brain fails to develop the psychological pathways necessary for adequate emotional self-regulation and attention control. In other words, symptoms of distractibility and low self-esteem are psychological products of life experiences rather than inherited traits of biological illness. "Guilt, shame and self-judgment," for example, "are commonly heard in interviews of adults with attention deficit disorder" (Maté, 1999, p. 236). Twoey (1997) further noted that children with ADHD exhibit primary deficits in social and interpersonal skills. Moreover, Johnson, Franklin, Hall, and Prieto (2000) described how Parent-Child Interaction Therapy (PCIT), a technique modeled after filial therapy in which parents and children interact with one another during session, has therapeutic

merit in counselling the family in treating children exhibiting ADHD symptoms and oppositional-defiant behaviors. Thus, it has been suggested that children with ADHD can benefit from treatment in social skills training and education focusing on structured activities involving play, modeling, and other group administered activities (Kaduson, 1997).

Other play therapy models have poised themselves somewhere between psychoanalytic and child-centered models. There is a phenomena involved in participatory play when focusing on the interpersonal dynamics and processes of change (Bishop, 1987). Adlerian play therapists, for example, use toys and play media as the basis for children to communicate and explore their views of themselves, others, and the world, and for building a therapeutic relationship with the child (Kottman, 1997; Kottman & Johnson, 1993). While beyond the scope of the present paper, readers may be find interest in some of the other approaches to play therapy techniques such as Gestalt (F. Carroll & Oaklander, 1997; Wolfert & Cook, 1999), ecosystemic (O'Connor, 1997; O'Connor & Ammen, 1997), Ericksonian (Marvasti, 1997), Adlerian (Kottman, 1997), and symbolic expression therapy techniques such as dance (Dosamantes-Beaudry, 1999), and music (Scheiby, 1999).

In a review on the relationship between dramatic play and creativity in young children, Mellou (1995) investigated the relationship between dramatic play, that is, all pretend play, and creativity among young children can be seen as operating under three conditions: interaction, transformation, and imagination. Research on the relationship between dramatic play and creativity among young children suggested that as young children repeat dramatic play many times they lead themselves to increasingly accurate perceptions and understanding of objective reality thus creating a new reality. Children

who engage in role reversal, for instance, learn how to break free from established ideas, put ideas together in new and unusual ways, creating their own ideas, enhancing individual freedom, and developing divergent thinking abilities. Further, training in dramatic play is a significant causal force in the development of children's creativity and that play training supports children's cognitive growth.

Other researchers have argued more expressively that play therapists *need* eclecticism in their approach (Greben, 1988; O'Connor & Schaefer, 1994). Rather than implement one play therapy approach over another, an effective play therapist must bridge both the realms of an understanding of psychodynamic theory as well as applied clinical skills of nondirective play therapy (Telford & Ainscough, 1995). Moreover, nondirective play therapy alone may not be very effective in treating sexually abused children and abuse-reactive children and may require the implementation of focused (e.g., cognitive-behavioral) techniques (Rasmussen & Cunningham, 1995). In contrast to nonthematic play, thematic play involving either free play, directed play, or modeling has been associated with reducing anxiety in young children and thereby increasing the children's mastery and quality of play (Milos & Reiss, 1982).

With perhaps exceptions given to the seminal penchant for food, in adulthood development and in adult interpersonal relationships it seems grownups somehow, in some way, lose their ability to play. Psychodrama techniques have been advocated as a means of bridging the spheres of childhood and adulthood. "Psychodrama is an especially rich approach to psychotherapy that combines imagery, imagination, physical action, group dynamics, and a mixture of art, play, emotional sensitivity, and clear thinking" that "involves clients *enact* specific scenes related to their life problems instead of merely talking about them" (Blatner, 1999, p. 125). On the potential efficacy of

psychodramatic techniques and role-playing in adult psychotherapy, A. Blatner (1990, 1999) and Blatner and Blatner (1997) described a systematic approach to help individuals reclaim their imagination and spontaneity. Common among adults, Blatner and Blatner (1997) noted, is the inhibition of play stemming at least in part from distortions in the experience of play in childhood and adolescence. The prevalence of the problem often leads to adult psychological and cultural problems such as the tendency toward addition or fixation on a narrow range of sources of gratification; shyness and discomfort in group settings; awkwardness around others; forms of vague and generalized mild depression; as well as an inability to play with young children which may manifest in feelings of envy or irritability, even with well-behaved or exuberant children. These authors examined several factors that can potentially contribute to play inhibitions, from individual differences, cultural resistances to spontaneity, and psychological disturbances. *Repression*, for example, is a Freudian term associated with unconscious ideas and memories. A rather primitive and immature defense mechanism, repression is described as a mental maneuver or form of self-deception in which the mind compartmentalizes unwanted emotions, files them away, and forgets them. In processes of human development, unhappy experiences can be unconsciously repressed but remain within the individual as residual characteristics, affect, and behavior (e.g., anger, uncaring, apathy, insecure). *Suppression*, on the other hand, is a more mature defensive mechanism in which individuals consciously put aside uncomfortable feelings and thoughts, and perhaps deal with the emotions or ideas at a future time when more support and strength is available. As these authors noted, "a curious feature about repression is that it simply does not work well enough" in that "needs are always seeking some expression, and so they leak out" (Blatner & Blatner, 1997, p. 96). Through

psychotherapy or other forms of personal growth, adults can learn to cope and work through their repressed issues.

Among repressed adults, play can symbolize a threat to loss of control and the possibility of escaping naughty feelings or thoughts, and can represent a longing for the loss of one's inner child. In relating to a child, a parent may devalue or overgeneralize play and attempt to stop or refuse an invitation from a child to play; in turn, this form of communication invalidates the role of play can lead children to devalue their own play. Underlying adults' needs for control are complex and pervasive sociocultural issues, Blatner and Blatner (1997) wrote:

> Repressed people tend to generalize their fears so that any spontaneous and exuberant activity provokes a need to contain and subjugate it. This confusion of "childlike" and "childish" has led to rationalizations of patronization and exploitation of preindustrial cultures, women, and other groups. Fears of loss of control on a collective level are expressed as needs for unquestioning respect for tradition and authority. The element of naughtiness in play is sensed as a challenge to social conventions, and so societies based on repression tend to be less tolerant of playfulness. (p. 99)

Thus, repressed adults can develop, at an unconscious level, a sense of losing their inner child. Becoming unable or inflexible to accessing a full range of emotional potentialities, adults can develop manifestations of envy and hostility toward natural playfulness and the playfulness of others. In its bleakest and most serious condition, Blatner and Blatner (1997) further emphasized that some adults:

> ...who consciously love or even just like children nevertheless may harbor some unconscious feelings of envy, hostility, and associated defense mechanisms in proportions to the degree they (unconsciously) believe themselves restricted from enjoying life as mush as it seems children do. Furthermore, these dynamics may become elaborated into irrational behaviors, including an unconscious form of sadism. (p. 100)

While these authors clearly noted the harshness of the term sadism, they carefully qualified its usage as sexual perversions in identifying how it may be more fully

elaborated to include any form of child abuse, neglect, or mistreatment. At the very least, such characterizations on the importance and complexity of play commands a solemn context for conceptualizing such a seemingly innocuous and natural human behavior.

In sum, play constitutes a curiously paradoxical challenge: when improperly channeled or communicated play can manifest itself in unsuspecting and caustic ways, but play without repression is an excellent way to learn healthy self-control and to transform interpersonal relationships. As many researchers have thus pointed out, the psychosocial benefits of spontaneous and imaginative play are multilevel and wide-ranging and spans from early childhood (Pugmire-Stoy, 1992) well into adulthood (Blatner & Blatner, 1997; Terr, 1999).

Summary

"Psychologists have played the game of play research in some curious, even defensive, ways" (D. Cohen, 1993, p. 8). On the A. Freud – Klein debate, the history of this scientific controversy can be traced to traditional child psychoanalysis. A. Freud has been accredited for her basic theory of instincts and their successive levels of organization in early childhood development and for her dedication to fostering nurturance in the therapeutic alliance. On the other hand, in that Klein viewed infants capable of developing fantasies and thereby a psyche immediately after birth, her theory rests on, and in part engendered, departures in metapsychology. Some have argued that the apparent "victory" of the Kleinian theory may have been the result of professional politics and power rather than of it intrinsic merit (Bruemann, 1996). Further, rather than through a reconstruction of the past, as is suggested in Kleinian theory, the most important facet in the therapeutic process belongs to the client's reenactments of transference situations in the here-and-now (Bourne, 1996). Regardless of the personal

and theoretical differences or critiques of others, it is from collaborative work Anna Freud and Melanie Klein "that the basis for much of child psychotherapy emerged" (Koocher & D'Angelo, 1992, p. 465) by which variants of both that have significantly influenced present-day play therapy techniques.

In Jungian analysis, play therapy is that of a symbolic expression whereby the self's ego operates through logical and deductive thinking. The role of the therapist is active as facilitator and interactor but not as a leader. The Jungian play therapist accepts the child's play and communication with unconditional positive regard and recognizes individual differences in that some children will utilize fantasy while others may express themselves more full through art or other types of play (e.g., clay, dance, music, sand). It is the Jungian therapist's "judicial use of transference, countertransference, and interpretation" that helps "create a bridge between the images and experiences of pain, destruction, healing, and power" (McCalla, 1994, p. 4). Although interpretation remains an important part of the therapeutic process for the Jungian play therapist, it is the therapist's presence and the building of a positive therapeutic alliance that is the most important facet in play therapy, Jungian style.

McCalla (1994) concisely provided comparisons between psychoanalytic, Jungian, and client-centered play therapy approaches. Children are believed to become emotionally disturbed when manifestation of the "inner drive is thwarted, thereby setting up resistance, friction, and tension" (McCalla, 1994, p. 5). Accordingly, not unlike psychoanalysis with adults, psychoanalytic child therapy is based on analysis of resistance and transference. Psychoanalytic play interventions with children serve primarily as a means to establish contact, a venue for observation, a source of information, and a way for children to communicate wishes, fantasies, and conflicts

without overwhelming anxiety. Most importantly, interpretation remains the "main vehicle whereby the therapist aids the child towards a more adaptive resolution of his conflict" (McCalla, 1994, p. 2). The psychoanalytic play therapist acts as a participant-observer with the goal to facilitate in the child verbalizations to gain insight about affect and resolution of conflict. In other words, play is viewed as a means to an end and thus the play materials themselves are kept simple, nonmechanical, and geared to the child's affective and cognitive development.

In client-centered or nondirective play therapy, children are believed to hold the ability to solve their own problems and have an innate striving for mature rather than immature behavior. Axline's (1964) theory holds that children possess within themselves forces that drive the need for self-actualization. In child-centered play therapy the goal for the therapist is to help resolve any imbalance between the child and environment the may impede the self-actualizing growth within the child. Symptoms of emotional disturbance within the child are replaced with evidence of an emerging sense of self through self-acceptance, independence, and acceptance of others. In contrast with psychoanalytically-derived play therapies, child-centered play therapy is considered as not an end but a means to greater understanding and hope (Bishop, 1986b).

While some client-centered play therapists may consider interpretation in play therapy inconsistent with the values to follow the lead of the child, O'Connor (2002b) contended that the use of interpretation in fact "facilitates the child's use of language and greatly enhances the generalization of the gains children make in session to their day-to-day lives" (p. 527). Whereas interpretation and insight are emphasized in the psychoanalytic play therapy in order to increase in the child verbalizations and communication, in child-centered therapy the child's emotional release and personal

growth are emphasized. Jungian play therapy techniques appear to be an integration of both psychoanalytic and Jungian play therapy in its emphasis on the power of play while attending to and/or interpreting the child's verbalizations and developing insight. Finally, for the psychoanalyst the use of toys is more as a tool toward building a therapeutic relationship with the child, whereas both Jungian and child-centered play therapists utilize toys as a means to facilitate self-expression in children and as a means for children to communicate and release feelings and anxiety through toy representation and order.

On the efficacy of child psychotherapy, there exists considerable diversity between child psychotherapy approaches (e.g., treatment duration) and many of these factors can have important implications when interpreting the results of clinical research. As Fonagy and Target (1994) pointed out, most child psychotherapy studies examined brief interventions and thereby identified only those children who benefited from treatment in the short term. These researchers argued that there may have been several others in those samples who would have benefited from treatment had it continued. In recent years, literature on child psychotherapy has continued to grow rapidly as child psychotherapy as a whole becomes more eclectic "because most good clinicians agree that doctrinal purity doesn't get the job done" (Fishman, 1995, p. 32).

Play, then, in any shape or form, provides a universally natural medium for all humans to fully express and explore feelings, thoughts, experiences, and behaviors. Rather than leading to interpretations or problem solving situations, the role of the child-centered play therapist is to facilitate for the child a safe and empowering environment to grow. In doing so, the child-centered play therapist becomes an active participant in the session through continually reflecting back nonjudgmental verbal

comments and nonverbal behaviors to convey correctly what the child may see, hear, or believe. In the company of a caring, listening adult, children decide the selection of toys that are meaningful in order for them to achieve a sense of mastery and order in their inner and outer worlds.

In sum, the easy part should be to find the therapy models, approaches, and techniques that fit the play therapist's own personality and style (Lubimiv, 1994); the challenge remains in how to integrate these techniques and apply them in a cogent and artful manner. Regardless whether one adopts a psychoanalytic or cognitive-behavioral or child-centered orientation, as Singer (1994) remarked, any skilled play therapist "not only provides the child an opportunity to identify and work through specific problems but also enhances the child's development of the capacity for play, a powerful tool for further enhancement of a sense of self and individuation as well as a continuing private theater for developing new scripts of affiliation and attachment" (p. 37). In contrast with the past, play techniques have become much more enterprising and eclectic. While some play approaches remain within the guise of traditional child psychotherapy approaches, others have clearly departed from traditional models, and all with maintaining a vested interest in helping others. Let us now turn to the use of play therapy in family systems and dyadic models.

Play as Therapy: Interpersonal Approaches

During the 1930s to 1940s, the child guidance movement witnessed an increase in the number of family referral cases (vs. agency referred) for child and parent interpersonal psychotherapies (Koocher & D'Angelo, 1992). Thus, psychoanalytic movements increased focus on treating parent-child relationship difficulties in which attempts were made to understand parents and assist them as a means of getting them to

discuss and work out important factors themselves thereby reestablishing their confidence in themselves and their own maturity (Allen, 1930; Dawly & Allen, 1949). Traditionally, child-parent interpersonal treatment centres required the participation of the parents (chiefly the mothers). Traditionally, however, while the child received play-orientated psychotherapy, the mother engaged in separate individual treatment (Koocher & D'Angelo, 1992). Toward developing a deeper understanding of the intrapsychic issues of individuals, in the past few years there has been a strong movement toward developing a deeper understanding of the roots of individuals of all ages and to view their problems through relational lenses (Kaslow, 1993).

Any contemporary, broadened approach to psychotherapies must take the perspective of viewing the individual's behavior in interpersonal relationships, such as those within and outside the context of families. Many of the therapeutic processes of client-therapist interactions can be viewed further as parallel processes in child-parent interactions. While adults "can be viewed as operating in one sphere, [and] children operate in another" (Gil, 1994, p. 38), the therapeutic task is to merge these two spheres through play. Elkind's (1992, 1994) demonstrated how client-therapist interpersonal interactions function as relational partners, child-parent dyads can be viewed similarly; that is, both dyadic arrangements often elicits anxiety in both parties. In resolving relational impasses, the author suggested that the ultimate goal is not to eliminate vulnerabilities or "relational knots," but to help individual understand and develop new ways of responding to them. Resolving relational stalemates involves "enlarging the paradigm in which an expert...applies a specific technique" for which "impasses may have a better chance of being worked with constructively..." (Elkind, 1992, p. 87).

For many parents, the notion of resolving impasses with their children through play offers a new paradigm for which they can view their children's and family problems differently. Even if many of today's parents recognize the importance of children's play and the window it provides to enriching their understanding, some parents may tend to minimize their responsiveness to actively engage in their child's play. The lesson learned for the child of an aloof or reluctant parent to engage in play activity is diminished enjoyment and a reduced capacity of play in the development of the child's intelligence and personality (Bettelheim, 1987a). A child's capacity for fantasy play draws upon numerous mental actions, including the ability to appreciate and try out the subjective nature of interpersonal relationships, identifications, and new solutions (Mayes & Cohen, 1993). Fantasy is where learning compounds meaning and the subjective themes become functionally active, germinating, in process, an understanding which brings about changes that account for and solve the stresses of daily living (Bishop, 1989). Echoing Winnicott's earlier position on fantasy and creativity in early childhood development and the importance of primary caregivers, Marans, Mayes, and Colonna (1993) noted:

> ...playing reflects a recapitulation of children's earliest experiences of omnipotence in their relationship with their mother. ...If parents are unable to support this domain of pretend and creativity or if their own conflicts actively discourage or disrupt the child's pleasure in playful activities and imaginative play, then a significant avenue for expanding object relationships may be closed to the child. (p. 19)

It would appear, then, that developing a unified definition of parenthood is no less difficult than it has been to arrive at a unified definition of play. In fact, Mahon (1993) has suggested that the history of parenthood could be told, "it would probably be as frightful and frightening as the history of parenthood itself, a nightmare we have only

begun to waken from..." (p. 228). On the importance of parents communicating with children in their own language, Mahon (1993) further wrote:

> ...if we define parenthood as an object relationship in which a mature person gets down on the floor to meet the needs of an immature person, it will quickly become obvious that without play and playfulness the dialogue between Gulliver and the Lilliputians could never take place. (p. 228)

Toward facilitating the communication between parents and children, many of the general principles and basic tenets applicable to the psychotherapist (e.g., empathic attunement) can be specifically applied to the principles of parent education and training. That is, "the steps of listening, understanding, clarifying, and articulating alternate perceptions of and solutions to the difficulties in the parent-child interaction are similar to the same steps used in relation to issues of personal adaptation" (Heinicke, 1990, p. 717). Some of the first pioneering approaches to integrate play therapy techniques within an interpersonal context, that is, outside the traditional therapist-client milieu, involved techniques in family play therapy.

Family Play Therapy

Traditional family systems therapists believe that it is the whole family unit that is malfunctioning rather than any one individual family member. In family systems therapy the symptomatology or presenting problems and not any one family member is viewed as the 'identified patient' (IP); that is, the family unit itself represents the 'client' and the focus of treatment is on facilitating changing within the family structure (Fishman, 1995). Traditional family systems theory typically has its roots in cybernetic theories involving feedback systems and on cultural anthropology. Many family systems therapy approaches borrows on the principles of both cognitive-behavioral and psychodynamic theories and, consequently, therapy can last somewhere between one or two sessions to several years in duration.

On the importance and power of investigating interpersonal relationship patterns within family systems, Napier and Whitaker (1978) remarked that a child entered into individual psychotherapy "comes...with an almost automatic deference, a sense of dependence and compliance" and "seeking guidance from a parent figure" (p. 11). "Families," however, "come into therapy with their own structure, and tone, and rules," and within the framework of the "family crucible," the therapist must shape and form the family members (Napier & Whitaker, 1978, p. 11). Shaping the growth of a family system, Early (1994) asserted how play therapy techniques in conjoint family orientated treatment sessions can help children and their family achieve developmental and structured goals. Moreover, through sequential and timely introduction of toys and meaningful play activities, family play therapy can help influence and restructure the movement of family boundaries toward and improved and healthier family structure. Not unlike the parallels drawn from coexisting characterizations that can operate within family structures (e.g., perpetrator, victim, rescuer), Haen and Brannon (2002) observed how dramatic play techniques can be effectively employed with teaching children the roles of strength (superheroes), destruction (monsters), and vulnerability (babies).

Nichols (1996) suggested that the features of an integrative family therapy framework consists of a psychodynamic "emphasis on an intrapsychic perspective" and an emphasis on the "interpersonal conceptions" (p. 34) in object relations theory, as well as behavioral techniques that "emphasize that family therapy should be a learning experience for all the family members who are involved in the therapy" (p. 39). Moreover, new and emerging "state-of-the-art" clinical techniques on family therapy have supported an integration of eclectic developmental theories (Nichols, Pace-Nichols, Becvar, & Napier, 2000). While child treatment and family therapy have been largely

developed from divergent theories and methods, the concepts and contributions of each can benefit children and families presenting with wide-ranging clinical problems (Cordell & Allen, 1997). In working within a family systems framework, "adults must stop inflicting adult interactions on children and making demands that children participate in ways they cannot successfully negotiate" (Gil, 1994, p. 37). An integrative framework of family therapy involves all the expressive psychotherapies in a unified family systems package, although assessment and treatment may include the whole family, small groups or dyads, and individual family members.

From an object relations perspective, play in the family communicates the quality of each family member's capacity to supply holding for each other. According to Scharff (1987, 1989a, 1989c), one of the features of object relationship family therapy is built upon the supposition that within the inner life (sense of self) of each family member are needs to feel safe and secure, and that these psychological needs are often best understood within the context of the family that contains and supports them. The most important interactions or messages between family members occur through absorption of family transferences and in the therapist's countertransferences. Selfobject interpersonal enactments are best understood by paying close attention to expressions of feelings and momentary identifications stirred up by the family in the course of a session and over time. As family members play and talk, they also listen, and through their interactions and play activities they develop a shared understanding and meaning of the family's dilemmas. In object relations family play therapy, then, the ultimate goal is to develop an understanding of the group as a whole as it struggles with individual needs and interpersonal relationships and with the difficulty of balancing one person's need for love and understanding with those of others.

With the goal of developing understandable metaphors for both children and their parents, family play therapy can change the face of family dynamics. According to Harvey (1990, 1997), many of the integrative features of family play therapy can be achieved through a reinterpreted psychodynamic model. On the dynamic therapeutic processes of working with families, Harvey (1997) wrote:

> As family members engage in mutual playful exchange, they create an expressive momentum with each other. This allows parents and children to thoroughly engage in a creative mutual reverie or emotional state with each other. Such play allows individual family members to step outside their own sense of control and emotional conflict and give themselves over to the positive co-creation of a mutually developed positive state. (p. 365)

Dynamic family play therapy objectives are facilitated through directive techniques such as developing specific game plots and scenarios created by the therapist and family members to specific conflict areas, or through nondirective techniques by means of encouraging family members to generate their own games and stories to facilitate new play themes more representative of unconscious interactive dynamics and family rules. Through encouragement of verbal and nonverbal interactions, family members engage in play activities such as interactive-game formats using simple props (e.g., balls, parachute, stretch ropes, dolls, stuffed animals), developing dramatic imagery, and through storytelling and sharing. The "trouble pit," for example, encourages a child reserve a space in the room to act out a difficult behavior or situation whereby the parents may help pull the child out with ropes or by coaching. The "telling ball" is an exercise in which a ball is rolled in turn toward different family members; when the ball is received, the individual must tell or draw a problem. The major focus of treating the interactive emotional dynamics involves assessing themes of attachment, for example, personal boundaries, expressions of intimacy and psychological needs for protection and

security, as well as the development of independence, empathic attunement, self-regulation of affective states, and self-mastery.

The ultimate goal of dynamic family play therapy is to have children engage with their parents in creative ways of 'telling things' through their unconscious derivations, transformation of rules, mistakes, and other communication modalities. Theoretically, within the dynamic family play therapy framework are representations underlying the family dynamic and individual members such as deeper levels of difficulty with attachment issues, interactive conflict and affective communication. The therapist's role is to help make conscious for family members sources of intra- and interpersonal conflict as issues emerge, and thereby help them to make better choices in resolving them. Choice refers to the therapeutic processes—selection of artistic, movement, or dramatic elements involved in game process—rather than implying an end product or specific solution. In dynamic family play therapy, it is the experience of choice within interpersonal relationships of autonomy and intimacy in a more cooperative process that allows for therapeutic and structural change.

Ariel (1997) described the principles of a strategic family play therapy (SFPT) model. Borrowing on several play and family systems models, SFPT is founded on concepts and methods based on cognitive-scientific (information processing) and semiotic (theory of signs) approaches. The central features of SFPT focus on family systems theory and therapy, with an eclectic theoretical mix of structural, strategic, and symbolic-experiential and narrative family therapy approaches, as well as psychoanalytic play therapy, cognitive-scientific, ethnological, and anthropological theories of play. Some of the advantages of SFPT include its emphasis on 'make-believe' play, thereby providing a rich and flexible medium of expression and communication that is easily

accessible to all family members, including young children. Make-believe play, it is argued, is the main vehicle that involves projective and expressive techniques to expose covert and unconscious thoughts, feelings, and relationships.

> In strategic family therapy, the therapist takes the family to a journey in Wonderland. It is a weird place, very different from their own world, and yet strangely familiar. They chance upon the most wonderful places, wild jungles, unexplored planets, dreamlike cities. The meet people of the past and of the future, unknown creatures and supernatural beings. They themselves can be transformed into any of these, whatever they feel like. They can go through any adventure contrived by their imagination, and their emotions bounce up and down like a rubber ball. Big black bugs crawl among them, but their have only to play to bust them. They come back from this journey better people. And if they want to go back there, they can, on their own. They do not need the therapist to take them there. (Ariel, 1997, p. 394)

Play in the SFPT model is a "precision instrument" in that it is used to obtain diagnostic information and, as such, interventions are sometimes extremely condensed to produce immediate change. The term 'strategic' is employed as a general treatment plan to develop a 'tactic' plan of a particular intervention.

Not all family play therapy approaches have been founded on systems theory, however. Closely built on theories attachment and the potential therapeutic merit of physical contact, Mitchum (1987) introduced developmental play therapy (DPT) as an opportunity to help children form trusting relationships with at least one significant adult figure. Further, Brody (1997) described a touch-based family therapy model in which the initial role of the child therapist is as a surrogate mother figure for the child to initiate and communicate a touch dialogue in creative, playful, and intimate ways. In that it recreates an enactment of an infant's first bonding experience, DPT has been described as "the first play therapy because it provides the basics needed for symbolic play" (Brody, 1997, p. 161).

Similarly, Jernberg and Booth (1999) and Koller and Booth (1997) detailed the techniques of an attachment-based play approach directed primarily at parents and attachment-disordered children through facilitating enactments of nurturance and intrusion/engagement. *Theraplay* includes the framework of a filial therapy model that utilizes play techniques combined with empathy and "emotional intuitiveness" to promote more secure attachment in children and the healthy characteristics of a healthy parent-infant relationship, which "introduces an element of joy and excitement that is essential to the development of zest for life and energy for engagement in all children" (1999). One of the unique features of theraplay is the 'physical interaction' that takes place between the child and adult as a means of replicating a playful and engaging experience. Distinguished from other child treatment methods, some of the characteristics of theraplay include a playful but structured approach with no toys, few props and few questions, and the encouragement of physical contact with the therapist to encourage in the child regression and to enhance parent-child attachments (Koller & Booth, 1997).

While directly training child therapists and parents (or primary caregivers) to utilize physical touch in building relationships with their children may have merit in helping some children build trusting relationships, some strong criticism can arise in that the underlying principles of close, physical contact may be contraindicated in the course of individual treatment. For instance, for any play therapist to make close, physical contact, albeit under the well-intended guise of therapeutic intervention, with a child who had been sexually molested by a perpetrator could potentially cause greater psychological harm that far outweighs any of its potential therapeutic benefit. Moreover, suggestions encouraging therapist-client physical contact at best ignores many of the

fundamental tenets of conventional therapeutic processes such as transference and countertransference. For similar reasons, Carmichael (1992) cautioned against the use of anatomical dolls in play therapy treatment because they could potentially retraumatize the posttraumatic experiences and symptoms in children thereby strengthening their defense mechanisms and impeding any therapeutic process.

Regardless of theoretical orientation, an integrative model of family play therapy must include therapeutic techniques that synthesize, assess, and treat the many varied levels and needs of the family. Moreover, the treatment protocol must be readily accessible and easily learned by the varied ages and developmental levels of all individual family members. In that play is a natural language for all human (and, even nonhuman) existence, family play therapy can offer many of the necessary integrative therapeutic features.

Gil (1994) presented on the integrative features and techniques of family play therapy as the ability: (a) to determine the content or theme so as to create and reframe meaning; (b) to create new interactions with the context of the family's metaphor, for example, using two puppets who have not spoken to reflect family conflict or distance; (c) to wonder out loud; (d) to pose questions; (e) to challenge the believe system of the family and the (f) to outcome events of the family's story; (g) to comment on the story-telling system, noting behavioral observations, such as ambivalence, in the family members; and (h) to look for expectations about the recurring themes within intra- and interpersonal interactions and reactions. Play, in family therapy, "can be very powerful and can successfully change therapy that has become flat or stifled, in which individuals remain disconnected and uncommunicative, use rigid or superficial communication, or

prefer intellectualized reasoning that has not facilitated dynamic change" (Gil, 1994, p. 52).

In that family play therapy techniques can be implemented only once a therapeutic relationship is established and the clinician has "entered" the family's metaphor, family play therapy also stresses the importance of establishing a therapeutic alliance by adopting a 'family-centered' approach. As an effective process that creates a dynamic, fluid, and challenging atmosphere that frees family members to love, forgive, and support each other, family play therapy increases the ability of families to be more open to communicate and listen, to foster the development of each individual's unique potential, and to stimulate a sensitivity and capacity for understanding (Anderson & Reynolds, 1996). Family play therapy can help build resiliency and coping skills among all participating family members (Seymour & Erdman, 1996) thereby restructure and impact the entire family system. The rationale for integrating play therapy with family therapy is that both of these therapeutic approaches can enhance each other and thus become strengthened (Early, 1994; Gil, 1994; Rotter & Bush, 2000).

In sum, family play therapy is itself a dynamic process that borrows from many fundamental play techniques, such as (psychoanalytic) interpretations, (Jungian) metaphors, (cognitive-behavioral) reframing, and (narrative) restructuring and story-telling, as well as encourages the effective use of play toys (e.g., puppets). From a clinical viewpoint, play interfaced with family therapy enables clinicians to assess the family dynamics (Sweeney & Rocha, 2000) through observations of transferences and countertransferences (D. E. Scharff, 1989), and as a means of extending and training parents to become cotherapists and communicate to their children a psychological play space (J. S. Scharff, 1989a) through nonthreatening (C. W. Smith & Renter, 1997) and

creative ways (J. Freeman et al., 1997). One of the strongest benefits of family play therapy techniques is its emphasis on the need to understand how children express themselves differently from adults (Rotter & Bush, 2000). To address some of the presenting issues within the context of adults and couples therapy, an increasing number of clinicians are also pointing to the therapeutic benefits and the inclusion of young children as a means of enhancing the relatedness of adult couples (Moustakas, 1975; Scott, 1999; Sweeney & Rocha, 2000). Moreover, current research investigating play therapy techniques within the contexts of families (Berger, 1994; Busby & Lufkin, 1992; Early, 1994; Gil, 1994; Rotter & Bush, 2000; VanFleet, 1997) and stepfamilies (Berger, 1994; B. G. Guerney & Guerney, 1988) generally supports its treatment efficacy.

Filial Therapy

"Although typical images of parenting include teaching, guiding, protecting, and providing, the most significant ability that parents can possess is that of *acceptance*" (McGuire & McGuire, 2001). "Parent training is one of the most powerful tools, if not *the* most powerful tool, in ministering to the needs of children" (Sweeney, 1997, p. 163), but to bestow "*rules without relationship equals rebellion*" (Sweeney, 1997, p. 166). Founded on an integration of multiple theoretical frameworks, *filial therapy* (FT) techniques were introduced in the 1960s (B. G. Guerney, 1964). "Filial therapy gives parents the tools to strengthen their relationships with their children and to create a healing environment" (Sweeney, 1997, p. 165). The word *filial* comes from the Latin words *filia,* meaning "daughter," or *filius,* meaning "son." Central to the rationale of filial therapy is an integrative model of applied educational training involving programmatic instructions and supportive involvement of the parents thereby leading to powerful conditions in the psychological treatment of children, as well as enhance the fundamental relatedness of

children and their parents. "Quite simply, children will accept direction and correction much better from a parent or teacher whom they respect. Children respect those who take time to cultivate relationships with them" (Sweeney, 1997, p. 167). Moreover, in that parents have an already established and implicitly intimate relationship with their own children, "they do not have to be as skilled as the therapist to get the same results" (VanFleet, 2003).

Filial therapy has evolved somewhat differently from other child-parent models, however. In A. Freud's psychoanalytic-orientated home-based interaction techniques with children, for example, parents traditionally were not encouraged to participate in regular training and supervision sessions with a professional, nor did parents share their experiences in a support-group format (Sweeney, 1997). Stover and Guerney (1967) suggested that emerging filial therapy techniques held several important advantages in comparison with traditional child psychotherapy models. In contrast, filial therapy: (a) is more time and cost efficient for both professionals and the parents; (b) lessens potential dependencies created by child-therapist relationships, and thus can also lessen the potential anxieties or perceived threats in parents; (c) can reduce the feelings of guilt, helplessness, or inadequacy parents may encounter in having to seek help from a professional or 'expert;' and (d) tends to offer parents a future-orientated model to help them deal with their children's maladaptive behaviors in the future, thus empowering parents and reducing their need to access psychotherapy treatment for their children, or even for themselves. "Filial therapy is notably different from most other forms of parent training, the majority of which are exclusively didactic in nature and form primarily on helping parents learn to control their child's behavior through behavioral methods" (S. C. Bratton, 1998, p. 554).

Since its inception in the 1960s, Bernard and Louise Guerney have been instrumental in shaping and extending decades of clinical research and endeavor in investigations of interpersonal theories and treatment. While many of these contributions overlap greatly, B. Guerney predominately focused on interpersonal relatedness models of Relationship Enhancement (RE), which has since provided the principal focus for L. Guerney toward advancing the theory and techniques of filial therapy. A better understanding of the theoretical framework leading to filial therapy may be achieved by first presenting the rationale of the RE model.

B. Guerney (1977, 1984, 1991, 1994) described numerous features and benefits of developing an interpersonal relations treatment model. RE therapy, programs, and educational services were designed to enhance interpersonal relationships, especially those within family systems. From the perspective of mental illness, mental functions are viewed as "deranged" or "disequilibriated" because of "damaged" interpersonal relationships and possibly other central factors such as biochemical imbalances, genetic predispositions, as well as maladaptive life-styles, "particularly ones ill-suited to avoiding and handling anxiety and stress" (B. G. Guerney, 1977, p. 3). Underlying the rationale of RE models is that in dysfunctional interpersonal relationships individuals lack understanding or, worse, have misunderstanding, of self and their relatedness to others. The fundamental goal of the RE model "is to increase understanding of one's self and of one's partner along dimensions directly pertinent to the relationship" (B. G. Guerney, 1977, p. 12).

One of the primary vehicles for enhancing interpersonal relatedness between self and other is by means of facilitating opportunities and developing a high degree of empathic attunement. The fundamental blocks of empathy are necessary and essential

toward building any "better" interpersonal relationship. B. Guerney (1977) expressively defined an empathic relationship as:

> ...one wherein the participant more frequently exercise compassionate understanding of their own and the other's thoughts, needs, wishes, and feelings. In an empathic relationship, each person can view and express the issues and emotions in their relationship more openly: with relatively little defensiveness, guilt, and blame. Each of them is more in touch with [the self's] own values, needs, and feelings regarding the relationship so that [the self] is engages in fewer self-deceptions and employs fewer psychological defense mechanisms. Each of them relates to the other [the self's own] values, needs, and feelings regarding the relationship with greater clarity and directness. Each of them does this in a manner as to reduces as much as possible the other's psychological pain and the other's tendency to respond to such communication with defensiveness or counterattack...an empathic relationship also promotes and helps to sustain other qualities and feelings that many people value highly [such as] the feeling of being secure, ...a feeling of general well-being, happiness, and confidence. It seems to raise a person's self-esteem and ego-strength, and to promote confidence in [the self's] ability to earn the respect and affection of other people in general. This in turn seems to make it easier for people either to live with, or to overcome, what they may previously have regarded as serious deficiencies in their personal make-up. (pp. 14-15)

In filial therapy, conceptualizations of empathic attunement and the climate of personal and interpersonal growth also have been strongly emphasized in Rogerian theory (B. G. Guerney, 1977, 1984; Snyder, 1989) and, as we have also seen, such attitudinal orientations have been extensively addressed and advanced by other theorists such as Kohut in adult-orientated therapy, and by Axline and Landreth in child-orientated play therapy techniques, among others. Moreover, many of the general techniques for enhancing interpersonal relationships also span several seemingly divergent theoretical frameworks such as *influencing client attitudes* and *graded expectations* (cognitive-behavioral); *demonstration, modeling* and *social reinforcement* (social learning); *structuring* (family systems); *reinforcement* (behavioral); *equal opportunity* (humanistic); and *administrative guidance* (programmatic).

Other advances on the RE model have also helped bridge it with a developmental psychology perspective. That is, evolving from the rationale of the RE model came itself a description and rationale for filial therapy. By "taking a long-range view," clinical interest emerged on notions that relationship enhancement treatment methods "may have potential as a preventative measure of building a foundation in childhood for better mental health and self-realization in adulthood" (B. G. Guerney, 1964). Moreover, from a perspective of Kohutian self psychology, the efficacy of the RE model has been influential to significant increases the functional and basic levels of differentiation of self and in the quality of relationship, with significant negative correlations found between differentiation of self and anxiety (Griffin & Apostal, 1993). More recently, RE theory has been described as therapy-driven, powerful, and versatile (Cavedo & Guerney, 1999) involving an eclectic integration (Snyder, 1991) of therapeutic processes including psychodynamic, behavioral, humanistic and interpersonal principles and strategies within a skills-training, multilevel systems framework (B. G. Guerney, 1988, 1994) in marital, family and filial relations (B. G. Guerney, 1984). In addition to restructuring dysfunctional family patterns of inmates and their wives (Accordino & Guerney, 1998), other empirical investigations based on the RE model have suggested that the interventions can facilitate rehabilitation in community residential settings (Accordino & Guerney, 1993) and in persons with severe mental illness (Accordino & Herbert, 1997). Thus, the RE model and derivations thereof (e.g., filial therapy) can be viewed as highly integrative, or perhaps even eclectic, in terms of philosophical and transtheoretical orientations and highly broad-based in terms of wide-ranging techniques and potential for intergenerational applications.

Back in the 1970s, from the RE model emerged many of the tenets of filial therapy. L. Guerney (1976) observed that children are often not aware of their own needs and feelings, or are simply unable to effectively communicate their needs and feelings to their parents. Thus, children's natural language of play was integrated with the emergence of RE theory. The rationale for suggesting an integration of play therapy techniques with conceptualizations of enhancing child-parent relationships was based on three principles. The first principle was to create a situation in which the child may become aware (make conscious) certain feelings not previously recognized (unconscious). Based on communicative models of empathic attunement, an enriching environment that promotes acceptance and respect will provide opportunities for self-expression of feelings and needs. Second, play therapy approaches build the children's feelings of trust and confidence in other persons, or, in this case, with the parents. If an effective communicative modality is to be imparted, in this case through play, then there is increased likelihood that the children will feelings and experiences more openly and honestly. Third, building confidence in children's sense of self will eventually lead them to experience greater feelings of self-trust and security in making responsible, mature decisions. When integrated and implemented effectively, these principles can lead a child to experience himself or herself "as a more worthwhile and likeable person, which is the key ingredient not only to self-confidence, but to good adjustment to and in relation with...other people" (L. F. Guerney, 1976, p. 220).

Since these early investigations of integrating individual play therapy techniques and RE theory, there have been several variations presented on child-parent treatment models. While references to relationship enhancement and child-parent models can be found throughout the literature, the term 'filial therapy' appears yet to capture unified

usage. Landreth (1991), for instance, commonly referred to filial therapy as Child-Parent Relationship training using play therapy skills (or, CPR for Parents). Eisenstadt and her colleagues (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993) coined the term Parent-Child Interaction Therapy (PCIT) for involving parents in the treatment of children with behavioral problems. Even the Guerney's have since toyed with finding a coveted name for child-parent treatment models, including the PARD program for parents and their adolescents (B. G. Guerney, Coufal, & Vogelsong, 1981), Child-Relationship Enhancement (CRE) (L. F. Guerney & Guerney, 1989), later to be followed by Child Relationship Enhancement Family Therapy (CREFT) (L. F. Guerney, 1991), and then a return to the simplified derivative of its origin, relationship enhancement (L. F. Guerney, 1993). Nevertheless, current references (L. F. Guerney, 1997; Sweeney, 1997; VanFleet, 1994) of child-parent treatment models appear to now widely and fondly use of the term 'filial therapy.' Regardless of the name ascribed to child-parent play therapy approaches, most researchers pay homage to B. Guerney for the fundamental tenets of the RE model and to L. Guerney for the direct integration and application of established filial therapy techniques. We will now turn to the rationale, formulations, and therapeutic techniques for conducting filial therapy.

Although many of the filial therapy techniques were derived from the client-centered approach, some of these have been specifically structured or reformulated to include techniques that offer training to others. For instance, Guerney (1967) elucidated how underprivileged or disadvantaged parents could be educated to motivate their children for learning through demonstrations of role-playing and positive reinforcement, and by holding group meetings. Within school settings, teachers can be trained on becoming therapeutic agents (B. G. Guerney, 1970; Isenberg, 1998) and groups of

behaviorally disturbed (Rosal, 1993) and aggressive (Stewart, McKay, & Robichaud, 1995) children can be trained techniques in locus of control, or as a proactive measure in teaching children social and communication skills (Tomori, 1995). Recently, *Kinder Therapy* (KT), developed by White, Flynt, and Draper (1997, 1999), appears to have therapeutic benefits training classroom teachers to become therapeutic agents in order to develop more encouraging, effective relationships with children. Moreover, filial play therapy shows promise as an effective treatment to providing direct services to Head Start programs by means of addressing the needs of children, families, teachers, and staff (L. Johnson, Bruhn, Winek, Krepps, & Wiley, 1999).

Not all child-parent treatment models can be viewed as having evolved from filial therapy, however. In contrast to conjoint family therapy models, for instance, Chazan (1995) suggested the *simultaneous treatment* (ST) model does not focus on the understanding of traditional family systems models. Rather, ST:

> ...is a natural extension of the process of ego psychoanalytic supportive-expressive psychotherapy, integrated with concepts formulated by learning theory, developmental psychology, and attachment theory. This approach accepts the concept of treatment as individually based, with the traditional analysis of transference, resistance, and defense. However, it adds the additional dimension of examination of the parallel events that occur when parent and child are treated concurrently by the same therapist. (Chazan, 1995, p. 8)

The ST model most closely addresses the concerns of attachment theory and models of *parent-infant* psychotherapy (e.g., D. N. Stern, 1995; Stern-Bruschweiler & Stern, 1989; Trad, 1993) in that the treatment focus is emphasized within the matrix of the earliest relationships.

Nonetheless, L. Guerney (1997) emphasized that past and present approaches of filial therapy have always maintained the use of "didactic and dynamic" principles of learning and behavioral theories indicating the model's "duel commitment to the

forthright teaching of play sessions and simultaneous focus on parents' feelings as players and on parents as parents" (p. 131). However, filial therapy "adds what strictly behaviorally orientated psychoeducational training programs do not have—the nesting of the training in new behaviors within a humanistic approach to change. ...With these key components of empathy and acceptance, resistance to change and to learning new behaviors is reduced" (L. F. Guerney, 1997, p. 157). "Teaching, rather than fixing, builds resources already existing" (Ginsberg, 1989, p. 443). "This new creative dynamic of empathic responding by parents becomes the creative process through which change occurs *within* parent and child and *between* parent and child" (Landreth, 1991, p. 339).

Additionally, VanFleet (1994) emphasized that filial therapy applications can bee presented as a psychoeducational intervention model that is based on client-centered, dynamic, behavioral, and family systems principles. In filial therapy, therapists teach, supervise, and empower parents in the conduct of child-centered play sessions with their children. In this way, clinical issues are addressed in tandem while strengthening the relationships between children and parents. Underlying the principles of effectively working with parents, it is important that filial therapists themselves: (a) recognize the importance of play in childhood development; (b) believe parents are capable of learning the necessary skills; and (c) have a stronger orientation for educational versus biological models of evaluation and treatment. Moreover, therapists must also be mindful of the modeling they are continually providing not only to children but to their parents as well. "Empathic listening skills are used liberally to demonstrate understanding of the parents' concerns prior to providing further explanation and rationale" (VanFleet, 1994, p. 12).

In keeping with a child-centered model, it should also be noted that the child is also given "top priority" over the parents' feelings or personal concerns. Essentially, parents are trained to 'join in' the play activity of children as means of enhancing communication and empathic responses; the goal is *not* to train parents to become child therapists. Instead, parents should be viewed as therapeutic partners or therapeutic agents (Kraft & Landreth, 1998). L. Guerney (1997) defined the goals of filial therapy in the following points:

1. To reduce problem behaviors in children.
2. To help parents acquire the skills of the play therapist for applications in the playroom and ultimately to use as applicable in everyday life when relating to their children.
3. To improve the child-parent relationship. As children experience their parents in the role of play therapist, they and their parents will feel more positive toward each other.

Goals one and three are essentially achieved through the fundamental principles of a child-centered driven model if effectively implemented and therapeutic gains should occur regardless of the therapist's interventions. In addition, bidirectional gains—for both children and parents—are anticipated as positive outcomes from parental involvement and interpersonal interactions.

The target number of sessions in filial therapy, usually about 10 to 12 sessions, is determined at the outset in discussions with the parents and may be determined by other factors such as health care plan demands or time commitments. Session length can vary, although the actual duration of child-parent play interaction tends to be between 30 and 45 minutes. The logistics of filial play therapy typically follow along four stages, with an additional fifth stage if time permits. Many have adopted or since modified (Kraft & Landreth, 1998; Landreth, 1991; Sweeney, 1997) Guerney's (1997) the traditional

approaches to these filial therapy stages. Nevertheless, the general protocol for implementing filial therapy techniques is as follows:

1. Stage 1—*Training* (2-3 sessions). This stage includes therapist demonstrations of play therapy with their own children as well as other instructional activities to teach how to conduct child-centered play sessions. The rationale for the methods and the particular behaviors of the adult are explained fully.

2. Stage 2—*Practice Play* (1-2 sessions). Parents practice play sessions without the children.

3. Stage 3—*Filial Play* (6-8 sessions). Parents conduct play sessions with their children. The play sessions are followed by feedback from the therapist. Feedback includes the parents' feelings about the process as well as instruction and information-gathering about the children's behavior outside the playroom. The number of sessions is determined by the children's progress through the expected stages of child-centered play therapy.

4. Stage 4—*Transfer and Generalization* (1-2 sessions in the form of 4-5 partial sessions that included opportunities for providing parents with feedback of their playing with the children, which usually starts about the 4th session). Parents transfer and generalize training and play session experiences to life outside the playroom.

5. Stage 5 (optional)—*Formal Evaluation* (1-2 sessions). Treatment progress is evaluated, which may involve a discussion of changes on parent responses to items on questionnaires that are readministered posttherapy, more discussion on how to preserve positive changes, and guidance for any areas where parents are not fully satisfied with changes or certain changes are as yet undeterminable (e.g., ADHD symptomatology, family reintegration).

If time constraints are a concern, the training and practice of parents may take place within group formats. It has been suggested that married or cohabitating parents participate in the parent training as individuals or, if necessary, as a couple; separated or divorced parents may involve themselves in separate sessions. Upon having reached a a moderate level of competency employing play techniques without requiring instant feedback (as evaluated by the therapist), then parents can be encouraged to conduct play sessions at home as well as the treatment site.

During the introduction of practice play sessions (Stage 2, or about Session 3) to the parents, Landreth (1991) suggested that a set of specific interpersonal and communicative skills should be explained the some of the basic principles of play therapy. That is, as much as possible, during these special playtimes parents are encouraged to adhere to the rules provided in the following outline (Landreth, 1991, pp. 346-347):

DON'T	***DO***
▪ Don't criticize any behavior.	▪ Do set the stage.
▪ Don't praise the child.	▪ Do let the child lead.
▪ Don't ask leading questions.	▪ Do track behavior.
▪ Don't allow interpretations of the sessions.	▪ Do reflect the child's feelings.
▪ Don't offer information or teach.	▪ Do set limits.
▪ Don't preach.	▪ Do salute the child's power and efforts.
▪ Don't initiate the activities.	▪ Do join in the play as a follower.
▪ Don't be passive or quiet.	▪ Do be verbally active.

Sweeney (1997) provided additional observations and guidelines for conducting filial therapy. For instance, although it is believed that training can benefit all parents, it is strongly advisable to screen out parents who have significant emotional problems themselves (e.g., severe depression, psychosis). Filial therapy is ideally suited for most any other parents, including first-time pregnant parents and grandparents, as well as for most any child or adolescent. The author further suggested that the group training approach for parents has secondary benefits over individual training because it is reassuring for parents to know other parents struggle with similar issues.

Similar to the findings on family play therapy, filial play therapy appears to extend beyond the primary target of child-parent dyads toward having secondary benefits in a variety of other interpersonal relationships and dyads; that is, not only can the relationships between children and their parents be enhanced, but the relationships of adult partners themselves also can be enhanced. It is not uncommon to hear feedback

that parents trained in filial therapy have had success using the techniques in their marital relationships and their jobs, as well. As Sweeny (1997) remarked, "investing in relationships works" (p. 175).

Literature on the efficacy of filial therapy looks promising. Following completion of a course in filial treatment, Cleveland and Landreth (1997) interviewed children and their parents about their impressions and memories. Five children (aged 3-8 years) and two parents who had completed filial therapy training completed semi-structured interview questionnaires. These findings indicated that significant positive change in the lives of the children and their parents. While some of the younger children were unable to adequately verbalize the changes occurred from filial therapy, these authors contended that this observation marks precisely the benefits and success of the filial model in that children are allowed to express themselves through play rather than words. In another study, Bavin-Hoffman, Jennings, and Landreth (1996) investigated the perceptions of participating parenting couples (N = 20) that completed a 10-week filial therapy program and responded to two interview questions. Analysis of qualitative data determined parents reported improvements in child-parent communication, children's behavior, as well as increased unity between married partners and general enthusiasm among family members.

Among a sample of single parents (ages 19-47 years), Bratton and Landreth (1995) investigated the effectiveness of a 10-week filial therapy prevention and intervention program. The experimental group (N = 22) was comprised of 20 mothers and two fathers, and 10 girls and 12 boys. Statistical (ANCOVA) procedures revealed that the parents significantly increased both their attitude of acceptance and their empathic behavior toward their children, significantly reduced their level of stress related to

parenting, and reported significantly fewer problems with their children's behavior. In addition, Bratton, Ray, and Moffit (1998) applied filial therapy techniques as an intervention for custodial grandparents and their children. By training grandparents to convey acceptance, empathy, encouragement, and effective limit setting, these authors concluded that healthy grandchild-grandparent relationships could be fostered through the basic methodology of child-centered play techniques. Such findings lend further support to the intergenerational capacity and reach of filial techniques.

Harris and Landreth (1997) conducted a study on the effectiveness of filial therapy to enhance the relationships of incarcerated mothers and their children. Incorporating only a five-week filial play therapy program, these results supported its effectiveness as an intervention for enhancing these child-parent relationships. For instance, incarcerated mothers were reported to have increased their empathic responses and established more positive attitudes toward their children, as well as reduced levels of stress related to parenting. It should be noted, however, that studies of any child-parent treatment model on such populations may be subjected to methodological criticism. For instance, one might expect the relationships of incarcerated parents and their children be improved simply by means of increased opportunity; that is, it is conceivable that most imprisoned adults would welcome increased opportunities to interact with the outside world, especially if it were with their own children.

Similarly, Landreth and Lobaugh (1998) employed filial therapy techniques to investigate it effectiveness in training a group of incarcerated fathers. These authors assigned the 32 men (aged 22-46 years) to either a control group or an experimental group; each father selected one of their children (aged 4-9 years) to be included in the treatment program. From the data collected over a 10-week period, analysis of

covariance (ANCOVA) was performed. In comparison with the control group, the results on the experimental-group fathers indicated that they held significantly higher attitudes of acceptance and empathic attunement toward their children, as well as significantly lower stress related to parenting and identified child problem behaviors. Additional statistical t-test procedures revealed that the self-concepts of the experimental-group children also increased significantly.

From a family systems viewpoint, that there is intergenerational transmission in effecting positive change among and between family members should not be surprising. Change and crises significantly affects all family members. As Seymour and Erdman (1996) emphasized, children are at risk for current and future problems when faced with multiple life transitions. Moreover, it appears that intergenerational transmissions in family systems are far from unique to western culture. In Arabian families, for instance, El-Islam (1983) cited the hierarchical structure of intergenerational relationships and noted the importance of filial relationships over marital relationships. In that intergenerational conflict can result in loss of family support, the author emphasized the importance of facilitating communication among family members as prevention of "reprecipitating" illness in the family.

On interpersonal relationships between therapists/parents and their own children, however, Golden and Farber (1998) conducted a study to investigate these dynamics or processes. These results suggested that children of therapists described positive feelings toward their parents' abilities to be empathic and tolerant, and the children valued their parents' expertise in handling problems. However, the children also reported negative feelings about their parents' tendency sometimes to 'therapize' at home, as well as their tendency to work long hours. These authors concluded that there

are benefits for children of child therapists but cautioned parent/therapists not overuse their clinical skills at home.

That there may be certain features of play that are not universal across cultures, parenting practices may vary widely. Some may then wonder about the multicultural issues and responsiveness of filial play therapy in child-parent relationships various origins around the world. Hamilton (1996) investigated the Chinese-American life cycle, determined that the Chinese-American family system is typically structured after the Confucian philosophy, which is guided by such aspects of the cycle as timing of tasks and rituals. Interestingly, associated features of Chinese-American families were noted as specific privileges and responsibilities is the emphasis placed on gender and birth order positions, as well as the responsibility of adult children to care for their parents, known as *filial piety*.

Penot (1998) argued that invested in filial piety is the hidden power of disavowal of reality, which can gradually make itself felt in treatment. In the psychotherapeutic process, an adult induced to assume a parental attitude can be reproduced in a 'community of disavowal' that, in reality, belongs to their unrecognized history. The theoretical implications can lead to possible difficulties regarding (a) the difference between negation and disavowal of reality and (b) the way that the disavowal tends to hamper process of symbolization necessary for the deployment of fantasy. For the 'sandwich generation' of adult children (i.e., those with young children and aging parents), for example, disavowal poses some unique challenges and issues (e.g., transference and countertransference) in treating such an intergenerational mix of clients. The author concluded that clients experiencing disavowal could be helped by

means of a filial therapist's modeling and ability to adopt a different perspective on the disavowal dynamic.

Chau and Landreth (1997) investigated the effectiveness of a 10-week filial therapy treatment program with American-Chinese parents. Analysis of covariance (ANCOVA) statistical procedures were performed on the data, and these results indicated that the experimental group parents experienced significant increases in their level of empathic interactions with their children, in their attitude of acceptance toward their children, and reductions in their level of stress related to parenting. Further, Cui and Zhang (1994) reported on the use of child-center play therapy and its curative effects with Japanese children. Thus, these results lend additional support to notions of the universality of play as well as the universality of applied filial therapy techniques in its effectiveness to treat interpersonal problems across multicultural families. Nevertheless, more research is necessary to investigate the effectiveness of filial play therapy for treating combined cultural and intergenerational issues, such as disavowal, within multicultural families.

While contemporary views have indicated strong support for family play therapy and filial play therapy techniques, not everyone has advocated on the full merits of these approaches. On certain pragmatic considerations of conducting family or filial play therapy, Ellinwood (1989) remarked that not every therapist may feel comfortable in working with young children. Still, the suggestion has been made that there is potential merit in helping parents build the foundation for an enhanced communication system with their children. That is, having parents learn and engage in the therapeutic and experiential processes of play may provide them with some newly developed skills to introduce on their own to the home environment.

Moreover, while Busby and Lufkin (1992) advocated the therapeutic merits of play therapy techniques in general, they argued that neither child-centered play therapy nor filial therapy are sufficient in that they are too narrowly focused. Instead, greater therapeutic potency lies in conducting play therapy within family systems. Therapists must encourage "adults to play for their own purposes and therapeutic progress" (Busby & Lufkin, 1992, p. 440). However, such positions implicitly suggest that the problems children present with are manifested primarily in the parents' inability to communicate effectively with children in the language of play. While it may be that many parents are lacking in their ability to communicate in an effective play language, it seems unlikely to suggest that the maladaptive emotional or behavioral problems of children could be resolved if only parents knew how to play. While teaching therapeutic play skills to parents would most certainly improve their ability to communicate with their children, and thus facilitated empathic attunement and enhance their interpersonal relatedness, the development of play therapy skills should be viewed as a panacea for the complete and effective parenting.

Summary

Whereas individual play therapy focused primarily on the therapeutic processes and techniques of individual children, interpersonal play therapy techniques such as family play therapy and filial therapy transcend the intrapersonal world of children and adults. First, parents can be trained to create an environment in which children believe that their feelings and behaviors are acceptable and valid. Second, parents can be coached and encouraged to acknowledge and identify aloud the feelings of their children, and do so in an empathic manner without criticizing their children or denying the existence of maladaptive behaviors or problems. Third, parents can be taught effective

techniques to respond the their children's language and activities involved in playing out their feelings of anger, aggression, dependence, as well as their needs for nurturance and approval or their needs and expressions of separation and individuation. In that children are allowed to experience an enriching environment that promotes safety and their well-being, children will feel the parallel processes of less anxiety and stress and more self-confidence and security. Therapeutic child intervention is best accomplished with the work of the parents (Chethik, 1989).

Current views in the mental health field are that filial therapy is rapidly becoming the therapeutic model of choice for enhancing parent-child relationships (Kraft & Landreth, 1998; VanFleet, 1994). Another advantage of filial therapy, although not extensively researched, is its highly "process-orientated" approach that promotes change through child-parent interactions in a way that is ongoing and progressive (Ginsberg, 1989). Moreover, filial therapy implicitly holds a "developmental" approach to investigating individual relatedness in that it utilizes methods for the particular developmental stages of the child, parent, or family. Further, another important consideration is that filial therapy "begins to alter intergenerational habit systems that may no longer be appropriate and that create difficulty and stress in the family system" (Ginsberg, 1989, p. 452).

In sum, the therapeutic benefits of filial therapy have been widely supported in outcome research studies in suggesting that filial therapy techniques offer an effective and natural bridge for individual child treatment and family systems therapy (Busby & Lufkin, 1992; L. Johnson, 1995). Filial therapy as an extension of play therapy uses the behaviors of the client-centered play therapist in a family skills training paradigm (Glazer-Waldman et al., 1992). As a means of facilitating the separation-individuation

process between boy and his mother, filial therapy techniques can be effectively integrated with traditional psychoanalytic techniques (Marshall, 1993). Even while filial therapy was in its early stages of research and development, the potential for relationship enhancement benefits were being touted and applied in combinations of didactic and interpersonal dynamics (Andronico et al., 1969), and in structured learning environments to motivate children's academic performance through increased parental involvement (B. G. Guerney et al., 1967) or to help teachers and parents obviate the behavioral problems of emotionally disturbed children (Andronico & Guerney, 1967). Moreover, the therapeutic efficacy of play and filial therapy techniques appear to have effectively addressed to a large degree some of the demands of time-limited or brief therapy considerations (e.g., socioeconomic constraints) in that mother-child relationships have been positively enhanced in as few as four play sessions (Stover & Guerney, 1967), or can be delivered in either intensive (daily) treatment applications (Kot et al., 1998) or group settings (Ginsberg, Stutman, & Hummel, 1978; VanFleet, 1994).

Play as Therapy: Child Trauma and Domestic Violence

In the preceding discussions, the characteristics and therapeutic benefits of play with children and adults were presented. Individual child psychotherapy models were discussed and evaluated, as well as interpersonal play therapy models such as working with family systems and through encouraging and training parents to become active therapeutic agents. However, much of the discussion to this point has been limited to considerations of child psychotherapy models and the therapeutic benefits of treatment and intervention within the context of status quo family systems and dynamics. As pointed out earlier, Leupnitz (1988) commented on the need to reinterpret traditional

psychotherapies from a broader context does more than drive home the point about the "psycho-tyranny" that has existed throughout history in favor the patriarchical legacy of psychoanalytic thought and teachings. "If there is anything that history can teach family therapists, it is that the 'normal family' has not been a social formation equally protective to all its members" (Luepnitz, 1988, p. 9). From this viewpoint, then, it is imperative that practitioners "develop methods for treating problems such as wife battering, incest, [and] eating disorders..." (Luepnitz, 1988, p. 29). Such qualified statements reflect not only the social ramifications and clinical implications for women, but they also speak strongly to the population of maltreated children. Children far too often become the innocent witnesses or personally afflicted victims of domestic violence.

There are a vast number of factors to consider when evaluating the child psychotherapy treatment programs and providing protection for these children. Regardless of maladaptive emotional and behavioral conditions manifested intrapersonally in children, external acts imposed on children in interpersonal relationships oftentimes involve horrific and unspeakable forms of physical abuse, sexual abuse, neglect, emotional abuse, or ritual abuse.

Shedding some historical light on children and trauma, Carmichael (1992) noted that the roots of child welfare point to the fields of mental retardation and special education. Specific interests on the effects of trauma and abuse began circa 1799 and gained particular momentum as other child guidance movements emerged in the early 20th century. Some of the most important child protective milestones ever headed were the establishment of 1871 Society for the Prevention of Cruelty to Children, the 1909 White House Conference on Children, the enactment of the Child Abuse Prevention and

Treatment Act in 1974, as well as the assembly of the National Center on Child Abuse and Neglect.

A psychoanalytic view of child abuse or psychological trauma can be examined as a relationship between external events and subjective experience (Solnit, 1994). Observing the interplay between environmental influences, Winnicott (1960) and others recognized how these can have detrimental effects on infants and young children, and strongly emphasized the importance of the "good enough holding environment" and the need for intervention in the earliest stages "of personal and environmental influences in the development of the individual" (p. 585). As Bromfield (1997) observed, contemporary investigations on the effects of childhood trauma and child psychotherapy treatment are no less crucial than they were decades ago:

> Like a good harbor, the child therapist offers the besieged child physical shelter, tolerance of her defensive preoccupation, and a rare opportunity to let down her guard and rest. Just as a sinking hull must be righted and secured before more lasting repairs can be made, therapy can help a child enduringly heal only after she has been spared further abuse and neglect. (p. 3)

The following section will examine some of the current literature on the theoretical and developmental perspectives of psychological trauma and its effects on children. However, the aim here is not intended as an expansive literature review on psychological trauma and children. Indeed, this is a far-reaching and complex topic of its own. Rather, the pertinent issues to be presented here will begin with discussions on children and trauma and the effects of domestic violence on children. To begin the effects of childhood trauma and victimization will be evaluated, followed by a focus on the effects of domestic violence. In doing so, the therapeutic benefits and applications of play therapy will be discussed within the contexts of these specific conditions and environments settings.

Children and Trauma

When something spectacular happens that is not welcome to the self, anxiety appears which functions to discipline the individual's attention but can also gradually restrict personal awareness (Sullivan, 1947). Landreth, Homeyer, Glover, and Sweeney (1996) defined *psychological trauma* as "an extremely stressful event or happening that is usually atypical in the life experiences in the child and is distressing to the point of being overwhelming" (p. 241). As Terr (1990) remarked, "trauma...is not particularly translatable to metaphor.... It remains literal" (p. 240). In addition to the genesis of stress and trauma occurring from life events such as war-related (Saigh, 1998) or natural disasters (Azarian & Skriptchenko-Gregorian, 1998), children and adolescents are assuredly vulnerable to the effects of wide-ranging traumas including family violence (Gil, 1996a; T. W. Miller, Veltkamp, & Raines, 1998), family conflict and divorce (Johnston & Roseby, 1997) and peer victimization (Beane, 1998).

It is noteworthy to observe, however, that not all children who experience conflict or potentially traumatic events subsequently manifest behavioral problems or emotional symptoms. Parent-child relationships are likely to vary with the patterns of violence, and children of different ages and gender are affected differently (Johnston & Roseby, 1997). Carmichael (1992) reported the impact of abuse on children depends on many variables: age at time of occurrence, regularity of abuse, severity, relationship to perpetrator, degree of threat, level of family functioning, status of mental and emotional health prior to abuse, amount of guilt carried, the gender of the victim, as well as the parents' response to the victimization. Other reasons for such individual differences in response to domestic violence can be found in associations between perceptions and maintenance of affective-cognitive interactions in that "individuals reconstruct and interpret their

experiences differently, despite objective similarities between them" (C. E. MacKinnon, Lamb, Belsky, & Baum, 1990, p. 1). Among such individual differences, others have observed that the need to conceptualize traumatizing events occurs along a continuum in that what may not be traumatizing in one stage of life may not become traumatizing until another life stage (B. James, 1989, 1994; Sweeney, 1997).

Since early studies began on the effects of trauma in infancy, some have questioned the notions about the internalization and representational structures of infants and young children. Current research suggests that the effects of trauma and abuse are greater for infants and younger children than are the effects on older children (Carmichael, 1992; Perry, 2000a). Understanding and effecting treatment, however, has not been easy. For children sexually abused in early childhood, Perry (2000a) remarked that even though infants might not have cognitive memory of the experience and a complete unawareness of the source of their fears, they can be negatively impacted in later life. Further, van der Kolk (1996) pointed out that "as children mature, they gradually become less vulnerable to over-stimulation and learn to tolerate higher levels of excitement" (p. 186) and can develop a decreasing need of physical proximity to primary caregivers. Dysregulation of traumatic experiences in infancy and early childhood can manifest themselves in affective states such as anger, anxiety, and sexuality, as well as characterological adaptations that include problems with self-efficacy, shame, and self-hatred. Further, dysregulation of trauma makes people vulnerable to engage in a variety of pathological attempts at self-regulation such as self-mutilation, eating disorders, and substance abuse. In extreme cases, arousal is accompanied by dissociative experiences and the loss of capacity to put feelings into words.

Moreover, the effects of abuse tend to continue and worsen with the degree of the seduction and/or brutality and with the closer the relationship child has to the perpetrator, and societal demands placed on males tends to lead to more serious problems and greater psychopathology (Carmichael, 1992). As children grow older, failed attempts to establish a sense of safety and security also lead to problems of intimacy and interpersonal relationships. When the roots of betrayal begin in infancy, therapeutic efforts become more difficult. Compounding these efforts and difficulties in treating child-at-risk cases arises from the systemic nature of the problem. MacKinnon (1998) described the problems in this way:

> ...families in which a child is abused are more dysfunctional or pathological than families presenting for more ordinary problems. The multitude of problems that arise in doing therapy are seen to be simply as a result of the difficulties of effecting change in extremely dysfunctional parents. (p. 10)

When social support systems, including parents, fail to respond to the victimized child, there is increased likelihood that adjustment in adulthood will become seriously compromised and the impact is realized in physical, emotional, and intellectual impairment (Veltkamp & Miller, 1994).

Regardless of the child's age during exposure to traumatic events, cumulative and repetitive trauma requires treatment approaches that emphasize building ego structure and repairing object relations (Gallagher, Leavitt, & Kimmel, 1995). Terr (1991) described that traumatized children exhibit four primary characteristics: (a) strong visualizations or otherwise repeatedly perceived memories of the trauma; (b) repetitive behaviors; (c) trauma-specific behaviors; and (d) changed attitudes about people, aspects of life, and the future.

Childhood trauma can be divided into two basic types. Type I trauma involves single and sudden unexpected stressors, and was described as leading to full, detailed

memories such as "omens" and misperceptions. Type II trauma, involving long-standing and repeated exposure, can lead to behaviors such as denial and numbing, self-hypnosis and dissociation, and rage. In that the characteristics of both types of childhood trauma can coexist, such crossover conditions of childhood are typically manifested in characterization of perceptual mourning and depression, as well as childhood disfigurement, disability, and pain. While the leading precipitating event to Posttraumatic Stress Disorder (PTSD) in children is the death or illness of a significant caregiver, family violence and violent crime, but not accidents, can also result in symptoms of PTSD (McCloskey & Walker, 2000).

Children sexually molested are often victimized at the hands of a perpetrator who is older, in a position of power or control, and more commonly by a male (Veltkamp & Miller, 1994). Consequently, victims of sexual abuse may find it difficult to develop a trusting relationship with another adult. The implications and ramifications for working with sexually abused children through touch-based therapies are alarming. Treating any child who has been sexually molested through techniques involving direct or indirect physical contact, even in a therapeutic setting with a highly skilled child therapist, the potential risks of retraumatizing the child cannot be overstated. As Brayner Iencarelli (1996) remarked on this scarcely researched topic, it is an illusion to think that all "supposedly-analyzed analysts" are free from countertransferential eroticism in child and adolescent treatments. Clearly, judicious and sensitive clinical practice is paramount in the decision-making and implementation of any form of child therapy or play techniques.

From a developmental perspective, psychological trauma can severely interrupt the normal progress of human development. As Finklehor and his colleagues (1986)

observed, the needs of sexually abused children and their environments "change with different developmental stages, so...researchers need to isolate risk factors by developmental stage" (p. 83). Pearce and Pezzot-Pearce (1997) also suggested that developmental issues of child maltreatment should be considered within a "stage-salient" theoretical framework. Children are confronted by specific developmental tasks at each developmental stage in which optimal development requires children to successfully negotiate the progression to more advanced stages. In other words, this position can be considered as neo-Piagetian in that development of later competencies is dependent on the competence and adaptation of earlier competencies. In addition to a number of other factors, an environment involving maltreatment can have a significant negative impact on this progression. Addressing some of Finkelhor's (1986) recommendations, Pearce and Pezzot-Pearce (1997) conceived of two major types of effects that arise from child victimization and interfere with developmental tasks or "dysfunctionally distort" their course. *Developmental effects* are related to victimization experiences that tend to have a deeper and generalized impact to the individual's future functioning. *Localized effects* are related to specific traumas and are not likely to have major developmental ramifications.

Similarly, Johnson (1998) suggested that childhood critical incidents and maladaptive behaviors could be viewed in the context of specific developmental stages. Accordingly, traumas that occur in specific developmental stages can create special vulnerabilities for children and adolescents. For example, if the traumas adolescents experienced in early childhood remain unconscious or unresolved, at times of stress or anxiety-provoking situations adolescents are particularly vulnerable to underlying issues of identity versus identity diffusion. Maladaptive behaviors may involve feelings of self-

consciousness, lack of commitment, as well as overwhelming feelings of mistrust, guilt, or feelings of inferiority. Thus, "trauma produces psychological disequilibrium that is anxiety provoking. Attempts at coping with this anxiety affect the child's ability to tolerate the normal anxiety created by developmental transitions" (K. Johnson, 1998, p. 81). From a lifespan perspective, then, maladaptive behaviors and feelings, if untreated, are also likely to impair severely healthy psychological development and interpersonal functioning in adulthood as well. "Adult children of trauma often become locked in unhealthy and addictive relationships" (Middelton-Moz, 1989, p. 4).

In that the intergenerational transmission and effects of trauma can be caustic and profound, psychological trauma in the context of human attachment theory has provided an area of particular interest. Breaking the deadly embrace of child abuse involves providing parents with appropriate coping strategies, support, and training in interpersonal skills such as empathy and reflective listening (Jorgensen, 1992). In attachment abuse, the primary builder of the individual's sense of self is destroyed and the potential capacity of attachment bonds become impaired, subverted, distorted, and damaged (Stosny, 1995). An extensive researcher and knowledge provider on the treatment of attachment-related trauma, James (1994) wrote:

> The attachment relationship is typically established with the context of a family, be it single-parented, adoptive, foster, tribal, or nuclear. But it *is* a family—it is the matrix that provides the child with the necessary feelings of safety and a place in which to grow. It is every child's birthright. (p. 1)

Further down the developmental continuum, Gil (1996b) described the power of intergenerational effects on abused adolescents. Adolescents with histories of victimization:

> ...sustained emotional injuries that may affect their sense of identity, their future orientation, their feelings of safety, their ability to trust, and so forth. They may continue to live in environments that are unrewarding, non-nurturing, or

> nonprotective, and because of their age and the perception of others that their risk is now decreased, they may have to 'make the best' of their situations. (Gil, 1996b, p. 187)

Given such crucial implications on the effects of victimized children and adolescents, the future ramifications for these young adults and their passage into adulthood may categorically be perpetuated in their interpersonal relationships by a continued sense of hopelessness or by an augmented by apathy in the perceptions of others.

Secure attachment-based relationships that involve a loving relationship are caring, are reciprocal, and develop over time. Thus, a healthy attachment relationship provides nurturance and guidance to foster in children gradual and appropriate self-reliance, leading to mastery and autonomy. A trauma-bonded attachment relationship, on the other hand, is a relationship based on "terror." Trauma-based attachments are characterized by goals of submission and obedience. The perpetrator experiences needs as being in total control and feelings that their lives are in danger. It is not uncommon for the victims of trauma-bonding attachment relationships to experience feelings of gratitude toward the abuser when not killed. Before any serious work can begin in the treatment of a trauma-bonded attachment relationship, five essential conditions are needed: safety, a protecting environment, therapeutic parenting, clinical skills, and a therapeutic relationship. Once these conditions are satisfactorily established, Gil (1996b) suggested treatment approaches of attachment and trauma-related problems must address five key areas: (a) education, (b) developing self-identity, (c) affect tolerance and modulation, (d) relationship building, and (e) mastering behavior. In other words, the suggestions and treatment ingredients presented here appear closely to resemble the varied recipes and techniques discussed earlier on play therapy.

Play therapy with abused children offers a developmental activity through which they can explore their identity and relation to others (Cattanach, 1992). In responses to trauma, Landreth, Homeyer, Glover, and Sweeney (1996) described the role of play as:

> ...the natural reaction of children...to reenact or play out the traumatic experience in an unconscious effort to comprehend, overcome, develop a sense of control, or assimilate the experience. This repetitive playing out of the experience is the child's natural self-healing process. (p. 241)

Webb (1999c), however, noted that if the posttraumatic play takes the form of secretive, ritualized, or monotonous play, it is likely to fail in helping the child resolve traumatic experiences. Psychotherapeutic reconstruction of traumatic experiences should help children obtain relief from guilt and fear associated with the traumas. Moreover, in working with children from chaotic living conditions (e.g., poverty), Levy-Warren (1994) highlighted the fact that play therapists and the therapist are likely to come from different cultures and socioeconomic conditions. For instance, ethnocentric differences may lead play therapists to consider that their work is not symbolic and thereby does not have therapeutic merit. Once again, the therapeutic relationship was emphasized as ultimately being the most valuable experience for children in crisis.

Perry, Hogan, and Marlin (2000) also emphasized the importance of creating a safe, predicable and healthy environment to optimize play and learning in young children. An empathically attuned environment will provide children with a world that is predictable, consistent, and attentive thereby allowing children to develop a healthy sense of self and form healthy attachment relationships to others. "Anxiety kills curiosity" (Perry et al., 2000, p. 4), and unpredictable worlds make children feel anxious and decreases the likelihood that they will engage in spontaneous and enriched play experiences. As a guide in working with abused and traumatized children, Carmichael (1992) suggested that play therapists: (a) realistically remove from children the

responsibility and guilt of being victimized; (b) create an atmosphere where children can feel safe and explore what is therapeutically meaningful; and (c) help children to develop a realistic plan to avoid future victimization.

White and Allers (1994) performed a review of the play therapy literature related to studies conducted with abused children. The results pointed to seven characteristic play behaviors of maltreated children have emerged along two common play themes. Abused and neglected children's play behaviors were described as follows: (a) *developmental immaturity,* which may be manifested as either a loss of recently acquired skills or a failure to learn developmentally appropriate behaviors; (b) *opposition and aggression* may be represented in the absence of interpersonal skills resulting from limited or emotionally impoverished interactions with parents and others; (c) *withdrawal and passivity* to novel or stressful situations in sexually abused children, but behaviors were not more negative or antisocial; (d) *self-depreciating and self-destructive* manifestations turned inward such as low self-esteem and self-perceptions of being 'bad' or incapable; (e) *hypervigilance* manifested in greater levels of fear and anxiety for sexually abused children as compared with physically abused or neglected children; (f) *sexualized* behaviors or images of themselves or of others (including the therapist) in children sexually abused, but was not found to be characteristic in physically abused or neglected children; (g) *dissociation* manifested in behaviors such as appearing disconnected from the immediate environment, unaffectedness by external stimulation, in a dream-like state, or may describe themselves as becoming the embodiment of a favorite teddy bear, blanket, or another item that was nearby when the incidents of abuse occurred. Two of the basic play themes of abused and neglected children included: (a) *unimaginative and literal play* presented in flat or depressed

affect and lacking the capacity to play freely, to laugh, or to enjoy themselves in an uninhibited fashion; and (b) *repetition and compulsion* manifested in a rigid set of play behaviors repeatedly and unconsciously acting out the expressed traumas for children physically and sexually abused, but not necessarily for those children experiencing neglect only.

In addition, White and Allers (1994) cited that some of the problems cited with the research on play therapy and abuse and neglect included: (a) inadequate or inconsistent working definitions of play therapy, and of abuse and neglect; (b) nonstandardization of play materials and modalities; (c) reliance on nonstatistical observations of single cases or small group samples (e) inadequate or flawed statistical designs; (f) variability in the definition and training of professionals using play in clinical and research settings. These researchers concluded that "although identification of maltreatment may be improving, evidence of the successful use of [play therapy] with abuse and neglect remains elusive" (White & Allers, 1994, p. 393).

It appears, however, some contemporary researchers have responded to some of the earlier recommendations and continue to make vital inroads using play therapy techniques with abused and neglected children and adolescents. Essentially, there exists a wide range of play therapy methods for working with traumatized children and children in crisis. In a recent review of the play therapy literature with this population, Webb (1999c) described that some of the major play techniques have included: art, doll play, puppet play, storytelling, and board games. *Art therapy* techniques range from visual portrayals of feelings and encouraging the child to adequately express them verbally to Winnicott's (1971) early, yet infamous, "squiggle technique" as an 'ice-breaker' whereby the therapist and child take turns making pictures out of each other's

scribbles. Other art techniques may involve modeling clay to provide the child a safe outlet for aggressive behaviors. Art therapists are oftentimes called upon to look for indicators of trauma and sexual abuse in children's drawings (Trowbridge, 1995).

Doll play (Webb, 1999c) is another technique that has captured particular interest in working with children immersed in chaos. While latency-age boys appear to prefer miniature doll figures (e.g., soldiers), indications are that doll play activity can appeal to preschool children of both sexes and to latency-age girls. Combined with carefully sequenced questioning, anatomically correct are now routinely used in investigations of sexual abuse as a vehicle for children to demonstrate victimized experiences. It is especially crucial, however, when utilizing anatomically correct dolls to reenact sexually abuse experiences, as with any other form of play, that it be contained in an established and psychologically safe environment (Klorer, 1995).

Similar to doll play, *puppet play* (Webb, 1999c) techniques rest on the following assumptions in the child's ability: (a) to identify with the doll or puppet; (b) project feelings onto the play figure; and (c) displace conflicts onto the doll or puppet. Another important feature of the use of puppets in play therapy is the child's opportunity to repeat a traumatic experience repeatedly to enable openings for various different outcomes. The implicit distancing that occurs between the child and a puppet allows the child to create a separate identity to facilitate indirect expressions of thoughts and feelings.

In that *storytelling* (Webb, 1999c) also involves distancing, identification, and projection, it allows children to exercise power of their imaginations and envision others coping with similar situations as their own, regardless of the modality (e.g., told, read, or watched). Storytelling techniques may involve adaptation in which children are provided

with a storyline or theme and they are encouraged to express themselves through verbalizations or writing. Another storytelling technique may involve opportunities for the therapist to respond the child's story to uncover related themes, conflicts, or feelings.

Play therapy activity, however, need not always involve sensory-motor function. *Board games* (Webb, 1999c) can have special appeal for latency-aged children and can assist the therapist in refining diagnosis through observations of the child's game playing (e.g., rule integration), ego functions (e.g., mastery of frustration and tolerance), and as a natural opportunity for the child to practice social skills. While they typically do not elicit extensive fantasy material, board games can provide opportunities for enjoyable interactional experiences, can assist in facilitating interpersonal relationships, and can be ultimately ego enhancing to the child. An additional advantage for the use of board games and activities with sexually abused children is the benefit of a relatively structured and nonthreatening environment for discussing potentially difficult or embarrassing topics (Celano, 1990).

Another effective play therapy technique in working with traumatized children has included sandplay. Compared with nonclinical children, Grubbs (1995) concluded that the processes of sandplay offer sexually abused children a natural mode of self-expression and cathartic release of deeply buried trauma that connects the child to his or her true self. Other variations of these play therapy techniques have been recommended in treating abused and neglected children (Carmichael, 1992; Gil, 1991; Pearce & Pezzot-Pearce, 1997; Purcell, 1996; van der Kolk, Perry, & Herman, 1991), traumatized and attachment-trauma problems in children (B. James, 1994; L. K. MacKinnon, 1998; Perry, 2000b; van der Kolk et al., 1991), and in working with children living in crisis and family violence (Gil, 1996a; Perry, 1999b; Webb, 1999a, 1999b).

In sum, play therapy with abused children and adolescents helps them heal their distress and helps them make sense of their experiences through expanding their own creativity in play (Cattanach, 1992). Games and activities of all sorts can permit children to deal with specific problems such as locus of control and help them to internalize this from persons and situations in the environment (Fatout, 1993). Play is an especially important medium for helping abused children because it encourages children to try out different personifications or practice behaviors with are troublesome and causing problems. Further, denoting the shroud of secrecy that typically surrounds sexual abuse issues, it is not uncommon for sexually abused victims to just begin to deal with their victimization when they enter adulthood. Treating adult survivors of trauma and childhood sexual abuse (Evans & Sullivan, 1995) has become another pervasive topic unto its own (Davies & Frawley, 1994), as there has been some attention given to helping women (Bass & Davis, 1994) and men (Lew, 1990) and partners "outgrow" their pain together (Gil, 1992).

Children of Domestic Violence

Children are very vulnerable and can become easily threatened by internalized feelings and self-perceptions about what goes on around them, regardless of whether they become the direct victim or vicarious witness of violent actions. Even households in which there is at least an appearance of tranquility and cohesiveness in the family system, seemingly benign problems can potentially lead to persistent dysfunctional interpersonal patterns.

Kashani, Daniel, Dandoy, and Holcomb (1992) suggested that family violence typically falls into one of four categories: violence toward children, women, elderly, and siblings. In a report that focused on the first three types, the Canadian Centre for Justice

Statistics (2000) compiled statistical profiles on family violence in Canada. According to the 1999 General Social Survey on Victimization, an estimated seven percent of people married or living in common-law relationships experienced at least one incident of violence by a partner within the last five years. Although the rate of violence for women (8%) and men (7%) was about the same, women were more likely to report what could be considered more severe forms of violence and report repeated victimization. Women, for instance, were more than twice as likely as men to report being beaten or being threatened by or having a gun or knife used against them; they were five times more likely to report being choked. Men were more likely than women to report acts of violence such as being slapped, having something thrown at them, or being kicked, bitten, or hit. Of those 65% of women and 54% of men who reported being assaulted by a partner on more than one occasion, individuals who reported being assaulted more than 10 times were 26% and 13%, respectively. The severity assaults resulted in three times more women than men reporting injuries, with five times the likelihood that the injuries sustained required medical attention. Not surprisingly, men (15%) were less likely to report incidents of violence to police compared with women (37%).

The effects and perpetuation of violence does not end with adult partners. When examining the effects of domestic violence, 95% percent of women compared with 78% of men reported to have suffered negative emotional consequences from the violent incidents, for example, fearing for themselves and their children, symptoms of depression or anxiety attacks, sleeping problems, and lowered self esteem (Canadian Centre for Justice Statistics, 2000). Accordingly, approximately half a million Canadian children have heard or witnessed a parent being assaulted during the 5-year period. According to the 1999 Incident-based Uniform Crime Reporting (UCR2) Survey

conducted from a sample of 162 police departments, children and youth under the age of 18 constituted 60% of all reported cases on sexual assault victims and 20% of all physical assault victims. Fifty-two percent of the children and youth were victimized by acquaintances, followed by 24% were family members and 19% were strangers. Parents were more likely than other family members to commit violent acts against children and youth, constituting 66% of physical assaults and 42% of sexual assaults.

Data collected on the Homicide Survey indicated that in the past 20 years, one third of homicide victims were related to their killers. Overall, however, these results seem to indicate that the homicide rate perpetrated by an adult partner has been gradually declining; for women, the rate declined from 15 per million couples in 1979 to seven per million couples in 1998; for men, the rate has been less dramatic from a high of five per million in 1987 to two per million in 1998. There appears to be an inverse relationship between the child's age and the risk of being killed by a parent. From 1979 to 1998, 70% of the children killed by their mothers and 55% of the children killed by their fathers were three years of age and younger. Although emotional (and financial) abuses against older adults were topics for investigation in the General Social Survey on Victimization, reports on the effects of emotional abuse against children and youth were not studied.

Survivors of multigenerational domestic violence, sexual abuse, and physical abuse suffer from a myriad of symptoms including complicated chronic depression with dissociative symptoms, substance abuse, impulsivity, suicide, and self-mutilation (T. W. Miller et al., 1998). Integrative (Attala, Bauza, Pratt, & Vieira, 1995) and empirical (Kolbo, Blakely, & Engleman, 1996) literature reviews on the effects of children who have witnessed adult interpersonal domestic violence suggest that children suffer serious

negative effects associated with symptoms of emotional, behavioral, and learning problems, with children's susceptibility affected by developmental level, chronicity of exposure, physical proximity to the incident, and emotional bond to the victim (Edleson, 1999; Margolin, 1998).

Other evidence has pointed to the existence of gender differences among children's response to domestic violence. In a women's shelter sample, physical violence and other forms of marital aggression correlated positively with children's externalizing and internalizing problems (Jouriles, Norwood, McDonald, Vincent, & Mahoney, 1996). Consistent with previous findings among children from single-parent households, Cummings, Pepler, and Moore (Cummings, Pepler, & Moore, 1999) reported that boys more than girls have higher levels of externalizing behaviors, suggesting that boys become "warriors" and girls become "worriers." By contrast, among the children who reside in shelters for battered women, girls more than boys tend to have higher levels of externalizing and internalizing symptoms. Reportedly, girls are more affected by domestic violence at the time it occurs and immediately after leaving a violent partner. Once battered women make the transition to becoming a single parent, however, the externalizing behaviors of boys may develop more rapidly than for girls.

Patterns of intergenerational domestic violence, even nonphysical forms (Jouriles et al., 1996), have been linked to amplified aggression (Avakame, 1998a), substance abuse (Corvo & Carpenter, 2000), depression (Qureshi & Maloney, 1997), negative peer relationships (Dawud-Noursi, Lamb, & Sternberg, 1998), and antisocial behaviors (Simons & Johnson, 1998), with the risk of victimization increasing in situations involving bidirectional marital violence (Jankowski, Leitenberg, Henning, & Coffey, 1999). Interpersonal problems involving power and dominance are important mediating

factors in the developmental pathway linking family-of-origin violence to intimate partner violence (Murphy & Blumenthal, 2000), with father-to-child violence contributing greater to children's maladjustment than mother-to-child violence (Grych, Jouriles, Swank, McDonald, & Norwood, 2000). While family stress in general does not appear to be a very good predictor of violence among couples, some of the better predictors are indicated by: (a) greater frequency and severity of partner abuse; (b) poor quality of father-child relationships; (c) higher levels of aggressive behaviors in children; and (d) lower relationship satisfaction of mothers (O'Keefe, 1995). Of course, there are many other factors that will ultimately determine the effects of domestic violence. For instance, the effects of domestic violence vary in magnitude and nature and depend not only on the type of domestic violence but rather on whom reports the information on the child's adjustment (Sternberg, Lamb, Greenbaum, & Cicchetti, 1993).

From a macro perspective, the literature and statistics on family violence are alarming enough. From a micro perspective, for even one child or adult to suffer the effects of family violence is too much. There exist varied positions on domestic violence and varied suggestions for ending it. Hedeen (1997) asserted that if only violence against women were to end, then its impact on children would also end. Advocating on the benefits of working within a family systems framework in effort to treat and disrupt the intergenerational transmission of family violence, Lehmann, Rabenstein, Duff, and Van Meyel (1994) suggested that models for treating children and their mothers who have survived violence include incorporating theoretical and clinical issues from the child witness-to-violence field, the field of traumatic stress, and feminist family therapy. These authors further suggested that clinicians and researchers focus their attention on the assault, dealing with accountability, and engaging in open family discussions. They also

suggested working with larger systems, addressing the posttraumatic responses to assault behaviors, and the rebuilding of relational imbalances among family members. Other suggestions for interventions on domestic violence have included mediation through social constructivist approaches (Markward, 1997) and focus on self-control and direct social learning effects (Avakame, 1998b; Hedeen, 1997).

It has also been said that family violence exists because society condones it. Not only is the impact from families who abuse profound but also is its underlying precipitating effects greatly contribute and increase the systemic conditions of the problem. Efforts to shape our understanding on the effects of domestic violence on children should be organized around their own intrapsychic world (Demos, 1999). For instance, suggestions have been made to encourage conceptualizations of intergenerational family violence and trauma within a Kleinian theoretical framework of intersubjective models of parent-infant interactions (S. Seligman, 1999) and negative maternal attributions involving parent-to-child projective identification interactions (Silverman & Lieberman, 1999). Developmentally play-based family therapy interventions offer opportunities to address the systemic impact of abuse and improve children's adjustment by strengthening both their internal and external worlds (Van Meyel, 1999). Through the interpersonal interactions with the therapist, the child who witnesses or exhibits violent behaviors experiences catharsis, reduction of troublesome affects, redirection of impulses, and a corrective emotional experience (Clark, 1995).

Shouldering the tremendous responsibility of protecting children from family violence oftentimes befalls on the mothers. Desperate and disparaged, many of these women and their children eventually find themselves in need of assistance and protection from family abuse and arrive at the doorsteps of battered women's shelters.

There appears to be, however, some divisions among helping professionals on serving the best interests of these clients. As Gardiner (1992) pointed out, women's shelter programs typically struggle between: (a) insisting that mothers are independently responsible for their children; and (b) assisting women with the care and management of their children. Advocating from a feminist perspective, the author favored the latter perspective in that it helps women develop supportive connections with various systems and thereby engenders them with empowerment. In that domestic violence programs are designed to help women achieve safety and decide how to stabilize their lives, there exists a simultaneous need to preserve childhood for the children also residing in shelters (Williams, Weil, & Mauney, 1998).

Emphasizing the tremendous responsibility of trying to alter harmful and potentially lethal behaviors, Gil (1996a) argued that the issue of family violence must be addressed from within the family organization. Rather than treat victims only or treat victims only as victims:

> ...a systemic approach regards abuse as a manifestation of underlying dysfunctions and prioritizes children's safety and a restoration of appropriate and secure uses of power and control. Furthermore, systemic treatment empowers victimized individuals by setting firm limits on misuses of power, advocating for disempowered or injured individuals, and providing clear alternative responses to abuse behavior. (Gil, 1996a, p. 120)

Accordingly, interventions of a systemic treatment model of family abuse become twofold: (a) systemic interventions are designed to address the climate that contributes to the emergence of abuse; and (b) eclectic or a variety of interventions is directed at behavior, attitudes, and social/cultural factors. From reviewing the efforts of those in the past, Stephens, McDonald, and Jouriles (2000) suggested that there is a wide range of variability in the needs of domestic violence children's programs, such as children's needs, limited funds and resources of clients and shelter programs, and "the short and

often predictable amount of time that more families reside in a shelter make the development, implementation, and evaluation of services for children a complicated and challenging endeavor" (p. 158).

Pearce and Pezzot-Pearce (1997) outlined several principles and goals in treating abused and neglected children. Suggestions to guide our theoretical understanding, strategies and interventions include: (a) treatment must be comprehensive and ecologically based; (b) treatment of the effects must have a developmental focus, must be developmentally sequenced, and must be developmentally sensitive using either directed or nondirected techniques; and (c) treatment must be culturally sensitive. Although treatment plans should be individualized to the needs of each particular child, some of the common goals of therapy include helping children: (a) acknowledge the maltreatment and express the associated feelings and cognitions; (b) develop more adaptive ways of expressing feelings regarding the maltreatment; (c) reformulate the meaning of the maltreatment; (d) modify internal working models; and (e) develop greater feelings of mastery and self-efficacy over the maltreatment to reduce feelings of fear, powerlessness, helplessness, and low self-esteem.

Even within so-called 'functional families,' Bettelheim (1987b) observed a particularly pervasive problem in noting that oftentimes these parents do not to take a child's request to play as serious. Looking for approval, children usually want to show their parents what they know through play and even children not typically prone to attention-seeking behaviors may pretend that an emergency exists get the attention of their parents. For example, a child may be encouraged to seek parental approval by the recent milestones achieved in riding a bicycle without the aid of training wheels. After several failed attempts to capture the undivided attention of parents to show-off these

skills, the child may feign a bicycle riding accident or 'play up' the seriousness of a real injury as an attempt to gain the undivided attention of the parents. For children, playing is their reality; a common mistake for parents is to react to a child's play as if it is not real (Bettelheim, 1987c).

Within so-called 'dysfunctional families,' Purcell (1996) examined the phases of grandiosity play within family systems involving domestic violence. It was argued that such families are considered "upside down" in their organization. For children living in chaos, for example, their unmet needs for mirroring and grandiose assertion will lead them to experience anxiety and endure a split between defensive compliance and a turbulent, trauma-ridden inner life. The intrapersonal world of the child fixates on power fantasies and dreams of possessing or controlling his or her objects. Purcell (1996) cited that upside-down families typically pass through four phases: (a) reenactment of trauma vignettes; (b) restoration of appropriate grandiose and mirroring themes; (c) restoration of rudimentary empathic abilities and empathy longing; and (d) the search for an appropriate parenting object. Untreated or unresolved, these reenactments are passed on from one generation to the next. It becomes exceedingly important for children living in chaos to have created for them an environment that has "potential" openings and "play" spaces (Charles, 1998).

Hence, many of the hallmarks of individual play therapy and filial play therapy begin once again to reemerge. There have been several recent studies investigating the effectiveness of play therapy techniques in the arena of domestic violence and battered women shelters. Of course, several treatment implementation and methodological design considerations need to be considered in serving and investigating clients residing in shelters. For example, some studies which have focused primarily on families living in

domestic violence shelters included varied treatment protocols such as intensifying treatment (Kot et al., 1998), crisis intervention (Lehmann & Carlson, 1998), group play treatment (Alessi & Hearn, 1998; Huth-Bocks, Schettini, & Shebroe, 2001; Tyndall-Lind, Landreth, & Giordano, 2001), and program evaluation of comprehensive treatment services (Jeffrey, Frisone, & Owens, 1999).

The emphasis thus far has been primarily on outcome research on child psychotherapy and on individual play therapy and filial therapy treatments. These areas of interest have provided the much of the theoretical framework, justification and rationale for conducting the present research project. Moreover, many research studies have been conducted on treating children in domestic violence shelters and are also of particular interest here as they have helped provide the theoretical underpinnings, contextual setting and methodological framework for designing and implementing an investigation into the therapeutic efficacy of filial therapy within a domestic violence setting. Hence, the next section provides a collection of selected research studies upon which the present research study and aspects of its methodological design and procedures were fashioned.

Selected Research on Treating Victims within Domestic Violence Shelters

The following research investigations into play therapy techniques with children who have experienced domestic violence have been selected below for comprehensive review. Collectively, these studies have provided the exacting basis, rationale, and methodological considerations for the present research study in conducting an empirical investigation on using play and filial therapy techniques with victims of domestic violence. Hence, the methodological designs and findings of these selected studies are reviewed and discussed in the following section.

Research Study 1

The researchers of the first study focused their attention on conducting intensive, or daily, child-centered play therapy with child witnesses of domestic violence. Kot, Landreth, and Giordano (1998) highlighted some of the methodological considerations and difficulties typically encountered in conducting scientific investigations with clients residing in domestic violence shelters. "Due to the unstable and transient nature of families experiencing domestic violence," as these authors pointed out, "traditional once-a-week play therapy sessions do not meet the unique needs of these children" (Kot et al., 1998, p. 21). Thus, these researchers employed intensive (i.e., daily, or near-daily) play therapy sessions with the children, which amounted to an entire duration of about two weeks.

The purpose of the study was to determine the effectiveness of intensive (i.e., daily) play therapy as a method of intervention for child witnesses of domestic violence. Specifically, these researchers designed the study to explore the effectiveness of intensive play therapy with child witnesses of domestic violence to: (a) improve their self-concept; (b) reduce internalizing behavioral problems (e.g., withdrawal, somatization, anxiety, depression); (c) reduce externalizing behavioral problems (e.g., aggression, delinquency); (d) reduce overall behavioral problems (e.g., social problems, thought problems, attentional difficulties); and (e) improve play behavior in the areas of affection, contact, physical proximity, self-direction, aggression, play themes, and food nurturing themes.

Method

Participating families were selected from those who entered one of three domestic violence shelters. Through information obtained during individual interviews

with the mothers, screening and the potential participation of the children were based on the following criteria: (a) a current resident of one of the domestic violence shelters; (b) between the ages of four and 10 years; (c) must have consent from the mother to participate in the study. Screening and selection procedures took about six months.

Of the 40 children who were initially selected to participate in the study, some the families had already been discharged from the shelters, which left 22 children ($N = 22$) remaining at the time of implementation of the initial play therapy sessions. Children assigned to the experimental group continued to live in the shelters during the two-month period after the children from the control group had moved out of the shelters, and thus were offered post-study treatment. There were 11 children in the control group, consisting of seven girls and four boys, which ranged in age form four to nine years with a mean age of 5.9. These children were Caucasian (15%), Hispanic (15%), and African American (70%). For the duration of the study, there were no changes in personnel, policies, or programs provided by the shelters (i.e., experimental and control group children received the same basic services).

Treatment effectiveness was assessed by pre- and posttest measures based on identified variables and changes in symptomatology of the children. In doing so, these researchers utilized three standardized instruments to measure the investigated variables. The Joseph Preschool and Primary Self-Concept Scale (JPPSST) was used to measure the self-concept of the child using pictures to stimulate responses from the child. In addition, the Child Behavior Checklist (CBCL) was used to measure the behaviors and competencies of children, as observed and reported by their mothers. Finally, the play behavior of children was measured using the Children's Play Session Behavior Rating Scale (CPSBRS), which was developed by the principal investigator

through an extensive review of children's behaviors in play therapy. Based on 5-point Likert scale of specific behavioral descriptors, the CPSBRS is a direct observational instrument designed to measure the behavior of children based on the following eight dimensions: (a) Affection, (b) Contact, (c) Physical Proximity, (d) Self-Direction, (e) Aggression, (f) Mood, (g) Play Themes, and (h) Food Nurturing Themes.

Data were collected from pretest and posttest measures based on this battery of instruments. Children in the experimental and control groups participated in an individual 45-minute pre-play therapy session that was videotaped for analysis using the CPSBRS. While the 11 children in control received no further treatment pending completion of the study, the 11 children in the experimental group received 12 play therapy sessions (including the pre- and post-measure sessions) over a period of 12 or more days. However, both the participating experimental and control group children continued their involvement in existing, regularly scheduled shelter programs including family violence awareness, sexual abuse prevention, identifying feelings, and developing self-esteem. Two graduate student therapists and one doctoral student therapist, each having requisite play therapy skills and training, conducted play therapy sessions with the experimental group of children.

Results and Discussion

Interpretation of these results involved scores obtained from the pre- and posttest battery of instruments (e.g., CBCL, JPPSCS) and included interrater observations of the videotapes using the CPSBRS. Data were submitted for statistical procedures using analysis of covariance (ANCOVA). These results indicated that participating children from the experimental group scored significantly higher than children in the control group on measures of self-concept based on the JPPSST [F (1, 19)

= 48. 96, $p < .001$] and in the areas of Physical Proximity and Play Themes [F (1, 19) = 12. 18, $p < .01$] on the CPSBRS. Further, as measured by the CBCL, mothers of children in the experimental group reported their children exhibited significantly fewer Externalizing Behavior Problems [F (1, 19) = 4.39, $p < .05$] and significantly fewer Total Behavior Problems [F (1, 19) = 9.56, $p < .01$]. These authors concluded that the study positively demonstrated the efficacy of intensive child-centered play therapy with child witnesses of domestic violence.

Research Study 2

The above study presented on the merits of intensive, individual client-centered play therapy with child witnesses of domestic violence residing in battered women shelters. Focusing their attention on group treatment, Alessi and Hearn (1998) conducted a similar study to investigate the effectiveness of play therapy techniques with multiple children who reside in shelters for battered women. Play techniques included encouraging children to express their feelings and family situations through art, puppetry, dramatic play, creative writing, music, and creative movement.

Similar to earlier studies, these researchers noted the existence of specific obstacles in working with this particular population. Providing treatment to children in battered women shelters must consider the following:

1. The population is transient. Families are there for varying lengths of time (i.e., a few days to several months).
2. The age range of the children is wide (i.e., infants to adolescents). This results in a variety of developmental stages.
3. The availability of shelter staff to provide treatment is often limited (i.e., due to fiscal restraints, time constraints, knowledge and experience).
4. An appropriate place to provide treatment is often hard to find (i.e., due to issues of privacy, limitations of space and accessibility).

Recognizing that certain treatment obstacles exist in serving population living in domestic violence shelters, these researchers considered providing services to this shelter population using a group play therapy format. The rationale, it was argued, was that group formats could provide treatment to greater numbers of children in a time-limited fashion. In contrast to individual therapy, they argued that group delivery can further provide individuals with a secure environment that enhances their feelings of support and acceptance. Toward that end, they designed a "highly structured, time-limited, intensive" play therapy group model.

The group play therapy model was derived from three essential components. First, the *crisis component* was believed important to allow children to vent their feelings, establish equilibrium, and focus on problem solving skills. Second, an *accelerated model component* was introduced to center the treatment in a time-limited model with an "ahistorical" here and now focus with an avoidance of the mental illness model and, rather, an emphasis on children's self-responsibility and potential for problem solving in the future. Finally, an *educational component* was considered essential to help children cope with their presenting problems in healthy ways. Yalom's (1995) model of group processes and curative factors (e.g., imparting of information, universality, interpersonal learning, catharsis) was cited for its inclusion to provide a psychoeducational component in the treatment of children.

Method

This study included children between the ages of eight to 16 years. Members of the shelter staff were screened for their expertise and availability to provide treatment services to the children. For instance, the childcare coordinator's expertise in childhood development was teamed with a clinical social worker's expertise in providing treatment

to children in groups. The treatment goals for the children in the shelter were defined as follows: (a) have the necessary support to resolve the crisis they were experiencing; (b) learn to identify and express feelings; (c) learn problem solving skills; and (d) learn modes of healthy coping behaviors.

Treatment was comprised of a sequence of six sessions, each with its own particular focus: (a) the identification and expression of feelings; (b) violence; (c) unhealthy ways to solve problems; (d) healthy ways to solve problems; (e) sex, love, and sexuality; and (f) termination and saying goodbye. The purpose each of these sessions was explained to the children and observational accounts of their responses were described. For instance, the purpose of the *violence* session was to give children an opportunity to explore and express their feelings about the violence in their families and how they have been affected. Treatment of the session involved having the children create a mini-drama about family violence. The goal of the *healthy ways to solve problems* session was to teach children to develop skills and impressions of healthy interpersonal relationships. Children were encouraged express their thoughts and feelings and to develop healthier solutions to solving problems (e.g., seek the assistance of a trustworthy adult, write stories or poems).

Results and Discussion

In the discussion of the study results, little information was provided on the implementation and effectiveness of short-term group play therapy among children residing in domestic violence shelters. For instance, no empirical evidence on the analysis of the data was offered for discussion or critical review. Rather, these researchers appeared to emphasize the importance of qualitative data collection and analyses. The development of an intensive group play therapy treatment model, they

argued, is essential and timely. In short, the study focused its attention on reaching out and providing en mass (i.e., group) treatment to children within their family systems, thereby illustrating qualitatively the effects of psychological trauma and intergenerational transmission of domestic violence.

Research Study 3

Lehmann and Carlson (1998; see also Lehmann & Mathews, 1999; Lehmann et al., 1994) proposed a conceptualization of a multidimensional, developmental model for investigating the traumatic experiences of child witnesses of domestic violence. These researchers argued that shelter-based child advocates are in a unique position to observe and respond to the immediate crisis needs of child witnesses, for which they should be familiar with and alert to the possibility that children entering shelters may be in crisis and/or exhibiting trauma-related symptoms. Focusing their attention on children who already resided in shelters for battered women, these researchers proposed a developmental stage-theory model of crisis intervention to serve the needs of this population.

The subgroup of particular interest in their research was children who meet the diagnostic criteria of posttraumatic stress disorder (PTSD). According to the American Psychiatric Association (1994), three diagnostic criteria are essential to warrant a diagnosis with PTSD. First, there must be exposure to a traumatic stressor that results in a response of fear, helplessness, horror, or, in the case of children, agitated or disorganized behavior. A trauma or traumatic stressor is defined as an experience that involves the threat or perceived threat of death or serious injury. Symptomatology of responses occurring within one month involve a diagnosis of Acute Stress Disorder,

while a diagnosis of PTSD included the following three clusters of symptoms must be experienced for at least one month:

1. reexperiencing of the traumatic event (e.g., repetitive play, upsetting dreams, or psychological and physiological distress in response to reminders of the traumatic event);

2. avoidance of stimuli associated with the trauma and emotional numbing (e.g., avoiding thoughts or feelings connected with the event, a sense of foreshortened future, or restricted affect); and

3. symptoms of arousal (e.g., angry outbursts, irritability, or difficulties sleeping).

From a crisis intervention perspective, these authors proposed that developmental theory and the perspective on trauma share a number of commonalities, and have certain implications as a modality for treating traumatized children. A developmental perspective for treating traumatized children was suggested as follows:

1. the management of trauma symptoms is time-limited and present-orientated;

2. interventions are intended to relieve the child of traumatic stress reactions and increase self-competence and positive coping efforts;

3. expression of feelings is facilitated; and

4. the person who intervenes must be actively involved and directive.

Method

The proposed crisis intervention model followed an adaptation and integration of the Crisis Intervention Model (Roberts & Roberts, 1990; Roberts & Schenkman, 1990) and the developmental model forwarded by the Child Traumatic Response (Pynoos & Nader, 1989). Thus, a stage-theory approach of crisis intervention with traumatized children was presented. In the model presented, it was suggested that crisis intervention with traumatized children generally progress through five developmental transitions or stages. As noted, many of the presenting problems and symptoms, as well as the

interventions (e.g., roles and activities) employed by the child advocate, tended to be ongoing and differed depending on the chronological age of the child (e.g., preschool, school-aged, adolescent).

According to this reinterpreted crisis intervention model, all children generally progress through five developmentally related stages. While children within these three developmental age groups may present with different behavioral problems or manifest their symptoms differently, it was suggested that children can be assessed in terms of the criteria of the five developmental stages. Stage I involves establishing rapport and assessing danger. Depending on the developmental stage of the child, problems and symptoms may be exhibited as passivity or withdrawal, helplessness, fear of new environment, confusion, anxious attachment (preschool children); responsibility and guilt, fear of new environment, confusion, safety concerns; concern for others (school-age children); or anger at having to be at the shelter, embarrassment and shame, fear of new environment, confusion, protectiveness toward mother (adolescents).

Stage II begins the process of identifying symptoms and problems. Preschoolers at this stage tend to reexperience symptoms such as avoidance and arousal, and engage in behaviors involving fantasies. The processes and behaviors for school-age children and adolescents at this stage are similarly manifested as those of younger children.

Stage III marks a period of providing support and addressing feelings. The play of preschoolers involves posttraumatic themes or behaviors involving regression such as issues of disrupted patterns of sleep, eating, or toileting concerns. School-aged children can also be observed engaging in posttraumatic play involving distractibility or disrupted sleep patterns, somatization, or fear of feelings. Adolescents can also engage in posttraumatic play, but typically they manifest posttraumatic symptoms as acting out or

aggression toward others, sleep disturbances, somatization, or embarrassment and shame about fears.

Stage IV involves exploring alternative action plans. For preschoolers, these authors suggested that the observations of these children during this stage (and the next) are minimal. In working with school-aged children, on the other hand, require close monitoring of the mother's behavior, as well as of the experiences of fear and confusion over grief responses and over the absence of the missing parent. Adolescent also require close monitoring for self-destructive behavior, acting older than chronological years (e.g., parentification), a sense of hopelessness and depressive symptoms, as well as of the experiences of fear and confusion over grief responses and over the absence of a missing parent.

Finally, Stage V involves a follow-up or review of the processes and experiences of trauma. For both school-aged children and adolescents, this period tends to be marked by anger at being in the shelter, or leaving the father, or returning home, or a generalized anxiety over an unknowing future. In this conceptualization of a developmental, stage-theory approach to crisis intervention with traumatized children, these authors offered child advocates working with this population a detailed set of interventions, techniques, aids, and activities. While these may vary somewhat, depending on the age group of the child, many of the inventions focus attention on enhancing therapeutic and interpersonal relationships in a supportive, safe, and stable environment. Many of the therapeutic objectives were identified as helping children to 'work through' their traumatized experiences and can be viewed as an integration of directive and nondirective play modalities such as story-telling, clay modeling, establishing limits and personal boundaries, as well as encouraging expression of feelings and fantasies.

Results and Discussion

The crisis intervention model presented here suggests that a multidimensional, stage-theory approach is ideally suited for conceptualizing and investigating the traumatic symptoms of child witnesses of domestic violence. In that a developmentally based model can help recognize the multiple ways children's posttraumatic responses can be influenced by the nature of varied traumatic stressors, the child's subjective responses to these events, as well as the existence of other concurrent stressors that are associated with the traumatic stressor, can be examined. Based on these findings, these authors provided suggestions for child advocates and others on how the model can be theoretically interpreted through developmental processes and fundamentally applied to posttraumatic symptoms exhibited by preschoolers, school-aged children, and adolescents. Although beyond the scope for review here, these authors also provided two case examples to illustrate how such a multi-staged, process-orientated model can be applied for specific populations residing in domestic violence shelters.

Research Study 4

Filial therapy techniques also can be specifically applied within domestic violence shelters to address the special needs of these populations not typically served. Ramos (in press) noted that while mothers typically decide to move into a shelter for the best interest of their child(ren), following their decision they often have little time, or emotional energy, or simply lack effective parenting skills to attend to their child(ren's) adjustment needs. Indeed, focusing on basic needs and issues such of relocation, finances, and medical attention, battered women may not be able or motivated to effect change in their own issues, for example, depression, anxiety, interpersonal struggles, and child management. In that filial therapy is action-orientated it helps "hook" mothers and

children into the therapy and healing process. Further, filial therapy can uniquely fill the gap between addressing the child's needs by developing mutual nurturing and attachment as well as the needs of the parent by facilitating a sense of mastery in parenting skills. In addition, filial therapy offers parents opportunities to implement skills involving less punitive strategies such as spanking (Leben, 1997; Ramos, in press).

Method

The population in this filial therapy study included a wide-range of ethnic backgrounds including African Americans, Hispanic, Orthodox Jews, Caucasian (European decent) and Immigrants. A hired child advocate conducted initial assessments and follow-up interviews. Whenever possible, simultaneous engagement (e.g., art therapy) on an informal basis was conducted with any other child(ren) not directly involved in the participation of the child-parent filial play therapy sessions.

The structure and implementation of the filial therapy sessions was the same as for therapy with other populations; that is, initial group parent training sessions without children were followed by dyadic filial therapy sessions with the child. Parent training and filial therapy sessions took play in a separate office for outpatient clients. Reportedly, parents were considered ready to conduct play sessions at home after conducting five or six sessions with their child. The typical residential stay in the shelter for families was between two to three months. While fathers readily available (i.e., not prevented by distance, incarceration, or enrollment in rehabilitation facilities) were also invited to participate in the parent skills training, none attended.

Specific attention was given to how battered women, not surprisingly, tend to be most reactive to their children's aggressive play. In other words, it was reported that battered women tended to discourage it, became defensive themselves, or reprimanded

aggressive play. As Ramos (in press) pointed out, the women's reactions to their children's aggressive play is understandable and can be interpreted by them as a contraindicated approach to breaking the cycle of violence. These researchers, echoing much of the literature on child's play, emphasized the importance of allowing child's full expression of feelings even though it may be perceived as unpleasant or even horrific. That is, it was explained to mothers that when contained in context a child's expressive channeling of aggressive feelings and behaviors could actually result in the child being less aggressive or argumentative toward peers, siblings, and parents. To address such potentially anxiety-provoking issues, parent training included demonstrations involving aggressive imaginary play, stories and, whenever possible, humor, to help desensitize women to this form of play. If needed, during treatment sessions the filial therapist would actively intervene and engage with the child in a 5-minute demonstration to model for the mother techniques to defuse the aggressive play.

Results and Discussion

The research also pointed to some of the specific challenges encountered in conducting on-site research in a domestic violence setting. It was noted, for instance, that battered women who had already separated from their abusers were more likely to complete the training program. Others withdrew their participation following their discharge and relocation (i.e., about 2 months) from the shelter, or simply left the shelter without providing a forwarding address. Even those who initially expressed enthusiasm sometimes withdrew their participation for reasons such as they were too stressed themselves or too fearful that too much knowledge about the child or family situation would be revealed. Additionally, putting into practicing limit-setting skills without employing punitive measures (e.g., spanking, yelling) were reported as particularly

challenging for these mothers. In such cases, face to face meetings were arranged with women who expressed such concerns in order to facilitate trust. Alternatively, mothers were also offered alternative treatment approaches (e.g., individual or group treatment and/or ongoing case management) or referral to outside services and resources.

For those who completed filial training and treatment, Ramos (in press) concluded that most parents reported a positive experience. Some of the specific therapeutic benefits of filial intervention in a domestic violence shelter were illustrated in the presentation of two clinical cases. While details about the data collection procedures and analyses (e.g., quantifiable outcome measures) were not provided, the reported findings indicated that mothers developed increased knowledge about how their children express themselves through play and, in particular, noticed that their children were less irritable, restless, and aggressive. It was also reported that mothers who successfully completed their participation also appeared to increase their resolve not to return to an abusive relationship. The latter finding is particularly interesting in that it attests to similar reports that filial therapy not only empowers children but parents too.

Summary

In summary, it appears that the developmental perspective offers a salient working model for conceptualizing and treating traumatized children, such as those affected by domestic violence. Moreover, play and filial therapy techniques appear ideally suited to providing therapeutic services to domestic violence populations not typically or readily served. The efficacy of these forms of interventions appears to extend to both the intrapersonal and interpersonal needs of battered women and their children. In addition, filial therapy can also assist parents to develop and implement less punitive

strategies for dealing with the psychosocial (e.g., irritability, aggressiveness, withdrawal) behaviors child victims of domestic violence typically display.

Moreover, many of the techniques and features of individual play therapy and filial therapy have been distinctly encapsulated in the above procedures. For instance, play therapy is highly a process-orientated modality that is accessible to children's present situations or affective state, and play and filial therapy techniques can be effective in reducing the child's anxiety and distress, in enhancing opportunities for self-expression, in increasing the child's sense of self, and thereby facilitating and enacting opportunities to develop positive interpersonal relationships. Finally, one of the most unique features of filial therapy, at least from a child's perspective, seems to be that the primary therapeutic relationship or the active therapeutic change agent is primarily centered with the child's parent. Thus, filial therapy, particularly if conceptualized from a developmental perspective, appears to have considerable merit in working with children who are adversely affected by domestic violence.

On the existence of interpersonal and therapeutic processes occurring within any therapeutic context, most would agree. On the *what* and *how* and *when* to measure the processes of psychotherapy, however, it still appears to be very much a matter of an individual's theoretical orientation, investigative interests, conceptual framework, research question(s), resources, as well as the social and economic climate of the field. Despite some intensive efforts of many to skillfully integrate the psychotherapy community on bases of research and clinical practices, and despite some consensus on the wide-ranging merits for doing so, many have argued that the bridge toward unifying and standardizing clinical research and clinical practices has fallen down. On the other hand, as we shall see, a few critics of psychotherapy in general have become strong

advocates of the 'spontaneous remission' theory and have simply implied that the bridge toward developing any such working alliance is out.

Process Outcome Research in Psychotherapy

The ultimate goal of psychotherapy is individual growth and change through eclecticism, integration, and synthesis of effective treatments across diverse sets of presenting conditions. Many of the traditional approaches of therapeutic science themselves have been undergoing some very discerning changes. For instance, a relatively recent movement to serving clients' needs and interests has focused increased attention on the differential change processes involved in client-treatment interactions and monitored during the course of several therapeutic encounters. Traditionally, psychotherapy research has evaluated the efficacy of a psychotherapeutic treatment based primarily on pretest (prior) and posttest (outcome) measures. However, some emergent research has focused greater attention to understanding the active ingredients or change processes (e.g., contextual) involved during the course of psychotherapy. Today, traditional psychotherapy is undergoing a metamorphosis toward of psychotherapy integration and eclecticism paralleled with a merge between research and clinical practice efforts on investigating the processes involved not only before and after but also *during* therapeutic encounters.

The aim here is to examine and present an overview of the literature leading to the psychotherapy integration movement, as well as investigate some of the methodological issues and procedures identified in evaluating process outcome research in psychotherapy. The literature presented here is intended as an overview of the field of psychotherapy, in general, and for inquiry into the matters of psychotherapy process-outcome research, in particular. There are certain aspects and issues in which

psychotherapy studies and principles converge, thus spawning the psychotherapy integration movement, while other psychotherapy studies have had very specific or somewhat diverse questions in mind. Although the central emphasis here to demonstrate, delineate, and review some of the core methodological issues and strategies of process outcome research, it begins with an overview on the evolution of psychotherapy and the psychotherapy integration movement.

Scientific Inquiry in Psychotherapy

Critics of psychotherapy scientific inquiry have often pointed to the proliferating gap between psychotherapy research and practice. One of the fundamental courses of criticism resides in strong alliances that have developed between the two differing camps of clinical research and clinical practice. Clinical and contextual meaning, it is argued by the practitioners, is frequently bled dry in methodologically rigorous attempts to advance research studies. On the other hand, scientific researchers contend that their results are not reaching clinical practitioners. Much of the basic force underlying these deliberations rests in discriminating measurement techniques and data analyses to evaluate treatment efficacy and in the therapeutic processes leading to outcome measures. The future of scientific inquiry in psychotherapy rests on the imperative need for "theory, research, and practice be intimately connected and interactive" (Mahoney, 1991, p. 63).

Several researchers have responded to the essentials of process outcome research through developing and integrating novel strategies to investigate the structure of, and changes in, aspects of client and therapist discourse and in the course of treatment plans. Scientific inquiries into therapeutic outcomes have ranged from pure statistical analyses involving quantitative, factor-analytic techniques (Russell, 1995; Shoham-Salomon, 1990) to contextualized, single-case research designs (Hilliard, 1993b). Other

researchers have turned their attention and efforts toward developing a deeper understanding of the processes of individual change stages (Prochaska, DiClemente, & Norcross, 1992), therapeutic changes (Rhodes & Greenberg, 1994; Shoham-Salomon & Hannah, 1991), and exploratory processes of in-session changes (Hill, 1990).

While some have remained steadfast in their attention to researching and developing a deeper understanding of a particular theory upon which psychotherapy processes rest (Luborsky, Barber, & Crits-Christoph, 1990), others have instead turned their attention on developing more pragmatic applications of treatment (Beutler, 1991; Omer & Dar, 1992). With increasing attention given to the issues of discovery-orientated psychotherapy process research (Garfield, 1990a) have come certain departures from the traditional theory-driven comparative analyses in outcome studies (Kazdin, 1986). However warranted are the efforts to effectively integrate the clinical issues of process and outcome in psychotherapy, researchers and practitioners appear to have been far less successful in attaining many of these desired objectives. Shoham-Salomon and Hannah (1991) concluded that:

> Attempts to account for therapeutic outcomes by either client characteristics or therapeutic features alone are conceptually unsatisfactory and yield weak results. Moreover, when taken alone, neither one of these types of variables can offer persuasive explanations regarding how therapeutic changes take place. Clearly, any attempt to predict and explain therapeutic outcomes and mechanisms must consider the interaction between client and therapeutic characteristics. This requires combining correlational and experimental research traditions and supplementing these with theories and qualitative observations. The often undifferentiated findings from comparisons among therapies, seeking as they do only main effects, are based on an unwarranted assumption that therapies function the way one expects them to, regardless of who the client is and what influence he or she exerts on the therapeutic process. But clients do not seek out and remain only in particular types of therapies; they also affect the course of the therapy. (pp. 223-224)

While measurement in the physical sciences has now become a "fairly straightforward matter," in the social and behavioral sciences the situation is

fundamentally different (Green, 1981/1992). While some envision a unified psychotherapy treatment, the challenge for others is arriving at a consensual definition of psychotherapy itself. Marmor (1990) rose to the challenge of the latter position and provided the following broad-based definition of psychotherapy:

> Psychotherapy is a process in which a person who wishes to change symptoms or problems in living, or who seeks personal growth, enters into a contract, implicitly or explicitly, to interact verbally or nonverbally in a prescribed way with a person or persons who present themselves as helping agents. (p. 20)

With respect to the issue of treatment efficacy, it seems at least some clinical practice and traditional approaches have evolved to meet today's current demands, such as socioeconomic constraints. Marmor (1987, 1990), for example, argued that classical psychoanalysis can be practiced in a focused and time-limited fashion, despite common and often wide-spread criticism that psychodynamic approaches are too demanding in terms of time and costs. Despite some contemporary changes within psychodynamic approaches, the contributions and fundamental tenets of the psychoanalytic doctrine and techniques categorically set the stage and standards—both convergent and divergent—for the evolution and scientific inquiry of all psychotherapies.

The primary objectives of psychotherapy research in general are to formulate, investigate, advance and, if necessary, reformulate the current body of knowledge. Today, it appears there are many individuals speaking about the freshness afoot prompting the psychotherapy integration movement and its emphasis on process outcome measures. Owed to many of the movements, interests, developments and directions highlighted in current psychotherapy are many of the prominent and traditional approaches and influential figures from which the psychotherapy field has evolved. Let us now review briefly the evolution of psychotherapy.

Evolution of Psychotherapy

In what has been dubbed the "Woodstock" on the evolution of psychotherapy, Jeffrey K. Zeig (1987, 1992, 1997) spearheaded three conferences that united some of the leading clinical practitioners and theorists in the field. The addresses and presentations included psychoanalytic, cognitive-behavioral, contemporary, Ericksonian, experiential, family therapy, as well as philosophical approaches to the evolution of psychotherapy. These publications attest to the long and tumultuous history of the field of psychotherapy in which belies much diversity in theoretical orientations, eclecticism, dissension, and considerations for the future of clinical research and practice. In the proceedings of the third conference, however, there appeared to be some noticeable trends building amongst these different voices with different views.

For the present paper, the psychodynamic orientation has been selected primarily to illustrate some of the principal convergent and divergent areas in the evolution of psychotherapy. In the opening chapter of *The evolution of psychotherapy: The third conference,* Otto Kernberg (1997), who is often regarded as the most important figure in contemporary psychoanalysis, illustrated some of the major areas in contemporary psychoanalytic technique and psychoanalytic psychotherapy. He wrote:

> ...I think it is possible to detect certain areas of major convergences of technique affecting Kleinian, ego-psychology, British Independent (what used to be called the "middle group"), French mainstream (non-Lacanian), interpersonal (earlier called "culturalist") and self psychology literature. Growing divergences in other areas of technique continue to separate some of these orientations from others. (p. 4)

In contrast to Kernberg, however, the present author argues that the psychoanalytic perspective represents primarily a point of origin for discussing the evolution and convergence of psychotherapy. In the pages that follow is a presentation and discussion on the current psychotherapy integration movement leading the way toward even greater

unification of seemingly diverse orientations and multiplicity of techniques, in particular, the contributions of cognitive-behavioral and brief therapies, as well as client-centered and family, relationship and child psychotherapy approaches.

Kernberg (1997) identified the main areas of psychotherapy convergence as: (a) transference; (b) countertransference; (c) character analysis; (d) the here and now; (e) increasing focus of translation of unconscious conflicts into object relations terminology; (f) increasing focus on patient's affective experience; (g) stress on multiplicity of "royal roads" to the unconscious; increasing concern with "indoctrination" of patients; and (h) increased questioning of linear concepts of development. Divergent trends in psychotherapy, on the other hand, were identified as: the "real" relationship and transference-countertransference issues; the therapeutic aspects versus resistance aspects of regression; psychoanalysis and psychoanalytic psychotherapy; the role of empathy; "historical truth" versus "narrative truth;" technical neutrality and cultural bias; and, the reconstruction and recovery of preverbal experiences. It is not appropriate to discuss each of these issues in detail; suffice to say that many of them focus heavily on the therapeutic alliance and lead either to or from issues of transference, countertransference, and the role of affective responses in the therapeutic relationship.

On transference developments, Kernberg considered that the "heightened stress and early focus on the transference is moving the technique of ego psychology, for example, closer to that of object relations theories" with increased emphasis "on both early and systematic analysis of the unconscious meanings of transference developments" (Kernberg, 1997, p. 5). Accordingly, many recent works point to a Kleinian orientation with more attention given to resistances, transference relations, and analysis of associative (vs. direct) references to the genetic material. In contrast to

interpreting the unconscious past in transferences, it appears there is increasing emphasis on interpretation of unconscious meaning in the "here and now" and on affective experiences. However, differences in the interpretation and approaches continue to persist among differing schools of thought. For instance, there exists controversy between some object relations theoreticians who continue to support classical Freudian notions of instinctual drive theory (e.g., Jacobson, Mahler, Klein, Kernberg) from those who consider self and object representations more compatible with corresponding drive derivatives or its affective expression (e.g., Sullivan, Fairbairn, Mitchell, Greenberg).

Countertransference developments within ego psychology and Kleinian approaches (e.g., Heimann, Winnicott, Kohut) have been expanded from the "narrow sense (as the analyst's unconscious reaction to the patient or the transference) into the broader sense of the total emotional reaction of the analyst to the patient" shifting from what signaled "a negative—what one might even call a phobic—attitude toward...an important instrument for investigating the transference and the total patient-analyst interaction" (Kernberg, 1997, p. 7). There are marked differences, to be discussed later, in how much emphasis is given to attaining optimal levels or degree of countertransference, for example, applications of "role reversal" (i.e., the actualization or enactment of past conflicts) and "role responsiveness."

Today, in psychotherapy, there appears to be increasing attention on the affective experiences of the therapeutic relationship in that effective interpretation of affective states and content of material is generally accepted "almost universally" to be the most critical entry point in the treatment process. "The ongoing exploration of the relationship between dominant themes in the transference, affective dominance in the total material

presented by the patient, and affective dominance in the countertransference, represent, at an operational level, the concrete analysis of transference and countertransference developments in each session" (Kernberg, 1997, p. 8).

With psychoanalysis has been represented in over a century of refinement, it appears that even from a contemporary and seasoned insider's view, served here by Kernberg, there remain several controversial challenges and issues under current evaluations and ideals. Such fundamental and inexact principles underlying the 'progress' of the science brings to attention what are the current crossroads facing the field of psychotherapy in general. Strong (1991) suggested clinicians have developed an aversion to theory-driven science and instead often opting for naïve empiricism. In that theory-driven science considers the relations among the elements in events, all events are lawful with the purpose of research driving to test and evolve theories.

Gelso (1991) suggested that theory-driven science should be seen complementary to discovery-oriented sciences in that the latter ought to help build the former. For example, it was illustrated how the contributions of Galileo and Aristotle helped point to how discovery-oriented visions and conceptualizations helped shape the theory-driven empirical sciences and, eventually, changed our understanding of our existing universe. Strong (1991) and Gelso and Fassinger (1990) were in agreement on the importance of the field of psychotherapy "fostering an interplay" between laboratory and field research. Efforts toward integrating psychotherapy theory and research include attending to issues of process outcome measures, diagnosis and assessment, training and supervision, as well as trends of producing integrative reviews and theoretical formulations, the valuing of external (or ecological) validity, openness to alternative methodologies, increased

quantitative sophistication, and attention to issues of diversity (Gelso & Fassinger, 1990).

Finally, while not so much questioning the fundamental tenets of psychoanalysis, even ardent psychoanalysts have started to question the linear sequencing or structure of developmental stage theories, in particular Freud's childhood stage theory from oral to anal to genital and oedipal conflicts. Kernberg (1997) wrote:

> The current trend is for the analysis of transference paradigms to operate with an oscillation between the analysis of highly condensed, synchronic structures that incorporate disparate aspects of the past, and the analysis of any particular diachronic line of development that temporarily emerges within those condensed structures. (pp. 9-10)

Having given rise to these and other questions about some of the fundamental tenets or linearity of earlier psychological structures, it gives some credence to question the developmental lines or linear sequencing of other developmental models of relatedness (e.g., Mahler).

Barkham (1996) summarized that substantive quantitative findings and methodological issues of psychotherapy stretch across three overlapping generations. Spanning the period 1950s to 1970s, the first generation posed separate outcome ("Is psychotherapy effective?") and process ("Are there objective methods for evaluating process?") questions. Indicating some of the trends of psychotherapy integration and scientific rigor, the next generation spanned the period 1960s to 1980s and asked process questions, for example, "What components are related to outcome?" The third and current generation spans from the 1970s to the present and addresses integrative outcome questions, such as, "How does change occur?" Clinical researchers have responded to such questions in a variety of ways. In response to one of the most clinically relevant questions, "Is this treatment working?" seems to have some resiliency to finding

definitive answers. Eysenck's (1952) early critical unveiling on the value of psychotherapy some forty years ago prompted an ongoing and contemporary debate by some (Eysenck, 1993; Szasz, 1990, 1997) as to whether psychotherapy is no better—and in some cases worse—than a placebo effect or spontaneous remission.

Additionally, children have presented special complications and considerations to clinicians and researchers. Consequently, "child psychotherapy lags a good ten years behind the treatment of adult mental disorders and way behind physical medicine" (Fishman, 1995, p. 30). For instance, while transference and countertransference phenomena are regarded as characteristic work with adults, these therapeutic processes are less acceptable or understood in work with children (Lubimiv, 1994). In clinical child work, Koocher and D'Angelo (1992) accredited the earlier techniques of psychodynamic theory and its contributions of play-orientated approaches as the most dominant and enduring approach to child treatment. Early theories of childhood development were strongly influenced by prominent psychoanalytic figures such as Sigmund Freud, Anna Freud, Melanie Klein, Donald Winnicott, among many others. The evolution of child psychotherapy has been attributed as having been shaped by many psychotherapy factors. In addition, the changing roles of the children in families, changes in Western society, theoretical developments, and economic forces that "have each exerted powerful influences on child treatment" (Koocher & D'Angelo, 1992, p. 458).

Similar to the evolutionary lines of adult psychotherapy, the field of child psychotherapy techniques can be traced as having evolved from organized constructs of therapeutic alliance, use of interpretation, integration of developmental issues, evolution of the child guidance movement, and influences of instructional and social policy. Further, increased interest in human development and increased emphasis on the

importance of children's relatedness to significant others in object relations theory formulated by early psychodynamic theories and techniques helped shape current models of eclectic play therapy techniques in clinical child psychotherapy.

With the speed of some of today's technological advances and scientific discoveries, for example, the possible existence of water on Mars, the completed mapping of the human genome, we are faced sometimes on a daily basis with new information and thus are compelled to change our current framework from theory-driven to discovery-oriented models, or perhaps vice versa. Seldom as neatly unified as some of the empirical discoveries of astrophysics or neurophysiology, nevertheless, many of the psychological threads of mental health and the human condition have evolved to set the epitome for psychotherapy integration.

Evolution of Psychotherapy Integration

Over the decades, we have witnessed a proliferation of psychotherapies. Notwithstanding, just as many of these psychotherapies have evolved throughout history, scientific inquiry into and the problems facing psychotherapy research have also continued to be advanced. Early reviews served well for the basis of determining and driving the future of psychotherapy research (Ellis, 1964; Paul, 1967; Strupp, 1964) and evaluative measures (Crown, 1968; Luborsky, Mintz, & Christoph, 1979; Mintz, Luborsky, & Christoph, 1979). Today's emerging directions of empirical investigations on psychotherapy have sought to integrate fundamental theory (Prochaska & Diclemente, 1992; Prochaska & Norcross, 1994) with therapeutic activity (Howard & Olinsky, 1972) and its social, cultural, and psychological system contexts. In sum, efforts toward "psychotherapy integration" must involve eclecticism from different orientations as well as theoretical synthesis from different schools of thought (Newman & Goldfried, 1996).

An eclectic fusion of theoretical orientations toward psychotherapy integration has evolved from a synthesis of cognitive, behavioral, and psychodynamic interventions (Goldfried, 1995) and continues to be fueled by growing pressures from managed care (Goldfried, 1999b) and from escalating socioeconomic constraints by imparting questions about the value of lengthy versus briefer psychotherapy (Cooper, 1995). Goldfried and Newman (1992) reviewed the annals of historical attempts of psychotherapy integration, and concluded that initial efforts can be traced back to the early 1930s. For example, considered unthinkable in the past, and likely even by some today, French (1933) proposed that parallels could be drawn between the two seemingly different disciplines of Pavlov's studies and concepts and the phenomena and doctrines of S. Freud's psychoanalysis. With earlier discussions on psychotherapy integration leading to issues of evaluation of outcome in psychotherapy, notable interest in the early '70s (Garfield, Prager, & Bergin, 1971a, 1971b) set the future of psychotherapy research inquiry into motion. During the 1980s, increased interest on the therapeutic processes captured psychotherapy interest and led toward integrating investigations of both outcome and process measures, thus making "a significant advance as a defined area of interest—indeed, a movement" (Goldfried & Newman, 1992, p. 60).

The core crisis confronting modern psychotherapy has been in integrating the aim of process research to determine what psychotherapy "is" with that of outcome studies and the evaluation of what psychotherapy "does" (Orlinsky, 1994; Orlinsky, Grawe, & Parks, 1994). Norcross and Newman (1992) proposed a "common factors approach" for psychotherapy integration. It was argued that psychotherapy integration involves determining "the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based

on those commonalties" (Norcross & Newman, 1992, p. 13). Kopta, Lueger, Saunders, and Howard (1999) declared that while psychotherapy has been proven generally effective, many researchers and clinicians would be hard-pressed to explain why. On evaluating the progress of the psychotherapy movement, these researchers identified three major areas of apparent turmoil: (a) theory development for psychotherapeutic effectiveness; (b) research design; and (c) treatment techniques. In addition, Goldfried and Newman (1992) cited that the most important points of contention for psychotherapy integration remain: (a) in the ability to establish the goals of therapy; (b) in the ability to describe differing perspectives on reality; (c) the role of the unconscious in therapy; and (d) on emphasizing the importance of transference and the therapeutic alliance.

Others have questioned the usefulness of a psychotherapy integration movement all together. For instance, some are doubtful whether the players are capable of change themselves (Jacobson, 1999a) and have argued that such directions will continue to be plagued by their lack of contextualized meaningfulness (Jacobson, 1999b). Many others, on the other hand, have argued that concentrated efforts to integrate diverse psychotherapy models and effective techniques is timely (Castonguay & Goldfried, 1994; Sperry, Brill, Howard, & Grissom, 1996) if clinicians are to be accountable in an age of rising health care costs (Wells, Burlingame, Lambert, & Hoag, 1996), if the clinical work is to achieve social validity (Foster & Mash, 1999), and if harmful and cost-ineffective outcomes are to be avoided (Mash & Hunsley, 1993). The development of practical indicators for evaluating psychotherapy treatment is imperative for defining clinical significance in psychotherapy outcome research and social validation (Tingey, Lambert, Burlingame, & Hansen, 1996). Moreover, only recently has the psychotherapy

integration movement captured the interests of therapists and researchers in the area of child clinical psychotherapy (Goldfried, 1998).

With greater emphasis on "evidence-based medicine" and cultural and socioeconomic contexts driving medical models of mental health (Fonagy, 1999), many goal-orientated psychotherapies and techniques appear to be the major approaches driving process outcome research. Some of the current brief therapy approaches that have risen to the challenge of integrating psychotherapy research and practice have included cognitive-behavioral techniques (Goldfried, 1995), brief group psychotherapy (MacKenzie & Livesley, 1986), as well as psychoanalytic traditions with an emphasis on short-term or time-limited techniques for adults (Sifneos, 1990, 1992; Strupp, 1990) and children (Koocher & D'Angelo, 1992). If driven by nothing more than socioeconomic constraints, however, only effective psychotherapy treatments will be covered by mental health insurance organizations (Horowitz, 1994). The need to develop practical indicators and measures of therapeutic change has provided the major impetus for the psychotherapy integration movement.

Strongly influenced by the socioeconomic climate, some have argued that the psychotherapy integration movement would best be served by enlarging and interfacing the techniques brief or goal-orientated psychotherapy approaches. Cooper (1995) concisely described the integrative features and principal techniques of cognitive-behavior, brief, and brief dynamic psychotherapy approaches. First, *cognitive-behavioral* treatments establish mutually determined goals. Prescribed treatments are based on a variety of empirically based techniques, for example, social learning paradigms. Thus, the ultimate goal in cognitive-behavior therapy is an increase in the client self-efficacy and relief of current problems derived through the therapist as

challenging faulty cognitions and behavioral correlates. Second, *brief therapy* commonly integrates various therapy forms, and it is characterized by the planned and purposeful use of specific concepts and principles. It additionally emphasizes efficiency and efficacy through a shared set of clinical features and value orientations. Finally, *brief dynamic therapy* is generally distinguished by the selection of self-motivated, functional clients. The emphasis in brief dynamic therapy is on the techniques of transference and countertransference, on confrontation and interpretation of foci, on intrapsychic conflict, and on the psychological importance of termination.

Abernethy (1992) borrowed from Beck's (1976) cognitive therapy techniques operating on principles of the "here-and-now" and integrated these with traditional psychodynamic approaches of the genetic reconstruction, transference analysis, and working through. The integrative cognitive-dynamic techniques were described as: (a) encouraging the patient to write statements about him- or herself that are confidence-building as a challenge to the reflexive self-derogatory or dependent statements the patient will make when anxious or depressed; and (b) challenging the use of imperative verbs that reinforce dependency and undermine autonomy and self-confidence. Others have provided further suggestions for bridging the conceptual modalities of psychology and psychoanalysis (Barron, Morris, & Wolitzky, 1992) with trends of integrative reviews, theoretical formulations, the valuing of external validity, openness to alternative methodologies, increased quantitative sophistication, and attention to diversified issues (Gelso & Fassinger, 1990). Another innovative goal-orientated treatment, seemingly unto its own, is Shapiro's (1995, 1997) somewhat unconventional, goal-orientated therapeutic treatment of *Eye Movement Desensitization and Reprocessing (EMDR).*

That brief psychotherapy generally takes a more active and directive therapeutic stance, it directly targets developing a deeper, more concise understanding of the therapeutic processes in a session-by-session fashion. With an accent on each client-therapist meeting, greater emphasis is placed on deliberate treatment planning in that brief psychotherapy "may be seen as a series of first sessions, bound gently but firmly (not rigidly) by a treatment focus" (Cooper, 1995, p. 33). The purposeful features and intent to develop a deeper understanding of the therapeutic processes in therapeutic encounters reflects many of the aspirations of the current psychotherapy integration movement toward developing a deeper understanding of the therapeutic processes involved in longer-term, traditional approaches. Many of the cardinal psychotherapy principles of longer-term psychotherapy, however, are still highly valued; that is, the presence of resistance (e.g., transference), the value of interpretation, and the importance of a strong working alliance. The development of a working alliance between the client and therapist is also essential in that it "promotes positive therapeutic change" (Horvath, Gaston, & Luborsky, 1993; Horvath & Greenberg, 1994). It would appear, then, that clinical researchers and practitioners of goal-orientated or time-limited therapeutic techniques have made the greatest strides to embrace the efforts of process outcome research the psychotherapy integration movement. So, just what are those processes of psychotherapy?

Processes in Psychotherapy

A broad definition of psychotherapy process draws attention to three main characteristics: (a) the presence of a therapist-patient relationship; (b) the interpersonal context of the psychotherapies; and (c) therapies are conducted according to a model that guides the therapist's actions (Roth & Fonagy, 1996). Henry, Schacht, & Strupp

(1986/1992) noted that current psychotherapy research has tended to emphasize antecedent client and relationship variables and has generally ignored investigating the unique effects of therapist variables. Fostering a departure from traditional psychotherapy research, which these authors argued has been primarily based on research outcome findings, these researchers made a case for a split between the psychotherapy process and outcome factors into three categories: (a) patient antecedents; (b) therapist techniques; and (c) relationship (so-called "nonspecific") variables. Further highlighting the potential complexities involved in investigations of psychotherapy research, Greenberg and Pinsof (1986) observed that measurable differences in therapeutic outcomes can be distinguished infinitely between immediate outcomes (little o's) and distant outcomes (big O's).

Messer (1992) and Messer, Tishby, and Spillman (1992) argued that measures of ecological (or external) validity have also been ignored in psychotherapy process research, and that integration efforts are needed to address the sequential and contextual nature that have eluded past investigations of psychotherapy. In response to such problems, these researchers proposed a micro-analytic approach called the "events paradigm" targeting client or therapist events and their immediate antecedents or consequences. They further argued that traditional research methods that rate therapist and client behaviors have done so without considering the context, and therefore cannot fully capture emergent process dimensions, such as transference. Understanding of the active therapeutic processes in context naturally involves the clinician as an observer, the participant as a player (Goldfried, 1999a), and must naturally account for the interactional processes that take place between them in temporal interrelations (Czogalik, 1991).

"Research psychologists typically favor concepts that represent stable entities, perhaps because such concepts are easier to measure and to incorporate into theories that are processes. Yet it can be fruitful to view presumably stable concepts in dynamic terms" (Wicker, 1985/1992, p. 45). Stiles and Shapiro (1995b) investigated the "active ingredients" by means of process-outcome correlations of psychotherapy to develop an integrated understanding of the structure and dynamic properties of generally successful therapies (brief psychodynamic-interpersonal and cognitive behavioral) by focusing on the responsive processes. These researchers suggested that our understanding of psychotherapeutic processes could be enhanced through examination of a distinctive set of flexible, responsive procedures by which the therapist and client interact rather than traditional attempts to understand a fixed mixture or sequence of verbal (or other) ingredients. In doing so, they presented their case by illustrating how two seemingly contrasting psychotherapy treatments could be represented through integration of a "broad range" of therapies.

Some of the specific processes of the client-therapy interactions were investigated by Shoham-Salomon and Hannah (1991). These researchers identified contextual differences between research objectives that are heuristically orientated and those that are pragmatically orientated. Whereas the former strives primarily for construct validity, the latter strives primarily for predictive validity. An optimal match between client and therapy includes the "identification of a good differential predictor" as "the primary goal" (Shoham-Salomon & Hannah, 1991, p. 221). Although it may be of some interest, these researchers argued that in outcome research a thorough understanding of the theoretical underpinnings of the predictor is not crucial for pragmatic purposes; rather, of primary

importance is that the predictor be highly and differentially correlated with outcome, and that it can be reliably measured.

Considering the vicissitudes of transference and countertransference processes involved in therapeutic relationships, Greben (1988) identified three ways in which the processes of transitional objects enter into the clinical setting. First, the history of transitional objects in the patient's life can be explored in the treatment. Second, both patient and therapist relate in transitional ways to the contents of the presenting problems and the therapeutic alliance. Third, the therapist serves as a transitional object for the patient, a "solacing figure through whom change comes about in the patient because of experiencing and dealing with the therapist in that role" (Greben, 1988, p. 447).

Therapeutic differences or change can be highlighted between heuristic and pragmatic research orientations in that distinctions can be made between therapeutic effect and therapeutic efficacy. Whereas the former refers to specific events and processes that are produced or activated "en route" to the final outcome, the latter pertains to overall success in goal attainment. Accordingly, then, pragmatically driven research concerns itself mainly with predicting efficacy or treatment outcome, whereas heuristically driven research is concerned more with identifying the client characteristics that predict specific effects. Some examples of heuristically driven psychotherapy research include the effects of fantasy or unconscious processes and reality testing in psychotherapeutic narratives (Diemer, Lobell, Vivino, & Hill, 1996), interpretation of dream content (Diemer et al., 1996), and interpersonal processes in relationship episodes (Luborsky & Crits-Christoph, 1990).

In a similar fashion, psychotherapy that utilizes play as its primary modality has as its hallmark an interplay between fantasy and reality. As mentioned indicated earlier, Piaget (1951), in positing his renowned contributions on the cognitive processes of childhood development, also proposed a systematic and representative approach to investigate the structure and symbolism of children's games and dreams, and the movement from sensory-motor schemas to conceptual schemas. Other clinical researcher on childhood development, for example, Winnicott (1971), posited that transitional objects in childhood development constitute the principles of dreaming, fantasizing, and living.

In the remainder of this section, the purpose is to present some of the key theoretical concepts and dynamic processes frequently cited as important in psychotherapeutic encounters. In doing so, a brief overview of the theoretical underpinnings of transference and countertransference is presented and examined. Constituting the dynamic process of psychotherapeutic encounters is a complex set of behaviors between two (or more) individuals. Not unlike the interpersonal processes of a child and parent, many of the dynamic processes of interpersonal client-therapist relatedness can be, and indeed have been, conceived of and interpreted in terms of a developmental framework. The client's assimilation of problematic experiences and eventual improvement are said to be best understood in terms of the psychotherapist's interventions by promoting and facilitating developmental change processes (Stiles, Shapiro, Harper, & Morrison, 1995). Thus, a closer examination of the posited and interpreted theory of object relations is provided to illustrate the importance of interpersonal processes in issues such as fantasy, conscious and unconscious process,

transference and countertransference, and to illustrate some of the convergent and divergent forces guiding classical to contemporary viewpoints.

Principles of Psychotherapy Processes

The roles of the unconscious and transference within the therapeutic alliance hold important integrative features and functions in processes of psychotherapy (Goldfried & Newman, 1992). Stated even more strongly, Greenberg (1996) argued that "everything" that takes place in a therapeutic setting is either an action or part of an interaction—expressed or unexpressed, conscious or unconscious. To achieve a deeper understanding of the complexities of the dynamic processes involved in the therapeutic alliance is perhaps the most necessary and the most challenging endeavor for both clinicians and researchers alike.

For early researchers of outcome psychotherapy, the problems of and opportunities for better understanding the interpersonal processes of therapeutic encounters simply could not be ignored. Strupp (1963) posted a challenge to be reckoned in his remarks that both intratherapeutic observations and interpersonal performances should be systematized and objectively revisited in psychotherapy research. It was argued that the association of the client's quality of relationship and the therapist is closely linked to the client's associations with others and the client's adaptation to reality. Criterion-generating situations leading to difficulties encountered in the therapeutic alliance were identified as: (a) problems of conceptualizing, specifying, and quantifying the multidimensional observations made in therapy; (b) the therapists' reliability as an O (by which is meant more than countertransference); and (c) limitations inherent in the 2-person setting that provide representative, but incomplete, data about the interpersonal interactions. Ultimately, the client-therapist dyad and

bidirectional interactions thereof are triggered or mediated by the mechanisms that will ultimately determine successful and unsuccessful therapeutic outcomes (Giacomo & Weissmark, 1992).

Dynamic Processes of Interpersonal Relatedness

When individuals enter into psychotherapy, it is usually with the intended hope and desire that they will learn or develop insight from their experience, and that this will lead directly to changes in their behavior or indirectly through changes in the behavior of others. Accordingly, a client's developing insight can be viewed an intrapersonal process, consciously or subconsciously. During psychotherapy, the client's interactions with the therapist constitute an interpersonal process involving resolute dialogue and nonverbal interactions. The dynamics of interpersonal exchanges can involve an intensity of communication, rapport, feelings and emotions. Client-directed interfaces are known as *transference*, and conversely, the transferred process of earlier experiences that clients can incite on the part of the therapist is known as *countertransference*. In this way, the client-therapist dyadic relationship parallels the interplay of child-parent relationships. Although the shared bonds often vary in breadth and intensity—and can be overt or covert—therapeutic relationships and child-parent relationships are bidirectional. Just as a child learns from a primary caregiver through positive (or negative) interactions of relating, sharing, and modeling, a client experiences emotions and develops skills through verbal and behavioral interactions.

Traditionally, psychotherapy research has fostered a view of the therapeutic relationship as being comprised of discrete patient, therapist, and relationship variables (Henry et al., 1986/1992). Contemporary views, however, suggest that there is much

learning to be captured in the contexts of interpersonal transaction patterns and relationships. As Lubimiv (1994) noted:

> In our relationships, there are two main dimensions at work. One is our behavior and the other is our feelings. As we interact, these two are in continual play; our feelings often having an overriding influence on how we act. (p. 39)

According to Kiesler (1992), interpersonal theories and key relationship concepts (e.g., the therapeutic alliance, social reinforcement, resistance and counter-control, transference, and countertransference) form an integral part of the conceptualization and assessment of important constructs derived from various psychotherapy theories. Interpersonal transaction patterns should become a fundamental unit of empirical psychotherapy process research (Henry et al., 1986/1992; Kiesler, 1982).

Issues of Transference

The talking cure, as psychoanalysis is sometimes referred, involves the client describing his or her symptoms to the therapist. The therapist listens intensely to the patient, and what Josef Breuer termed *transference*, may develop whereby the client's earlier feelings about early objects (i.e., important figures, especially parents--known as *parental transference*) are transferred over to the therapist (Hothersall, 1990). Feelings originally directed toward early objects are displaced onto the psychotherapist, who becomes loved or hated much as the original object was loved or hated (Wong, 1989). In transference, however, sometimes the lines of any given relationship pattern becomes blurred, as boundaries between reality and fantasy fuse together. Discussions about transference in psychoanalytic theory or psychoanalysis are probably the most common and the best understood.

On the basics, Sigmund Freud had agreed with Breuer on the importance of transference in a therapeutic relationship. Freud, however, believed that transference

resulted from the patient's sexual problems and repressed sexual memories (Hothersall, 1990). Freud based his conclusions upon seeing the erotic attachments 'Anna O' had formed toward Breuer, her psychotherapist (Hothersall, 1990), and through analyzing 'Dora,' Freud's own clinical case (Hughes, 1989). Freud argued that the patient's feelings were not directed toward his colleague personally, but rather, were projections toward a fantasy figure. Freud further argued that if friendly and hostile transferences were made conscious, then they could be turned into and account for the progress of the analysis (Hughes, 1989). Seeing transference as a useful tool for allowing patients to project (free associate) hidden patterns or feelings toward the therapist, Freud recognized that an added dimension of anonymity could facilitate the transference relationship even further; he then instilled the practice of having patients lie on a couch with him appearing (unseen) behind a blank screen. Gradually, the emphasis in psychoanalytic treatment moved from the analysis of dreams, fantasy figures, and the overcoming of resistances toward opening up therapist-patient communication through the analysis and elucidation of the transference relationship.

Through the formation of a functional transference relationship, it was believed the patient can overcome resistances from recollections of past painful experiences. However, earlier relationships that remain unresolved are reactivated with some of their original vigor and, gradually, patients see themselves as they really are, with unfulfilled and contradictory needs (Wong, 1989). If childhood patterns of mental organization persist in adult life, it implies that the past is repeating itself in the present (Gabbard, 1990). In the Freudian view, then, transference occurs when the patient's entire psychological system is in conflict; that is, his or her consciousness resists awareness of the libidinal (sexual and aggressive) impulses, as well as the awareness or memory of the

original conflict (Butler & Strupp, 1991). The inability to work out and the repetition of conflict results in the patient's compulsion to transfer (i.e., repeat) the intense feelings of early experiences that are then projected onto the therapist. In other words, a patient's repression of psychological conflict results in either a maintained homeostasis or the tendency is to 'act out' or repeat early attitudes and emotions.

Although transference was first recognized among adults, other forms of transference have also been identified. Nemiroff and Colarusso (1990) described two multigenerational forms of transference as (a) *peer* or *sibling transference*, whereby the patient reacts to the therapist as though he or she were a spouse, friend, or sibling; and (b) when the usual transference paradigm is reversed, *son* or *daughter transference* is said to have occurred, whereby the client reacts to the therapist as if he or she was the client's child. Sharpe (1990) further identified a form of *marital transference*, which takes the form of each partner perceiving the other (via projection) as the reembodiment of a critical, controlling, demanding parent and experiencing the self as a small, ineffective, unheard cry against the other's omnipotent power.

After nearly a century of clinical interpretation and usage, Freud's observations about transference were empirically validated for the first time in an ambitious study originally conducted by Luborsky (1976) and collaboratively by Luborsky and Crits-Christoph (1989, 1990), and then later enhanced by Luborsky and Luborsky (1995). The method known as the *core conflictual relationship theme* (CCRT) integrates Horowitz's (1989) *role relationship model* (RRM) and provides both a reliable measure of a person's recurring central relationship pattern and a guide to exploring that pattern within psychodynamic therapy, and even within all other talking therapies. At the center of the CCRT is the ability to analyze therapeutic interaction patterns expressed in terms of a

client's wishes, the reactions of others to these wishes, and a client's response to these reactions. Thus, the CCRT lends support not only to Freud's conceptualization of transference, but also to the enactments of the *processes* of transference. Central to developing a clearer and deeper understanding of transference, the attributes of the CCRT can identify clients' interpersonal behaviors as "core patterns" that: (a) are pervasive across relationships, including relation to the therapist; (b) present in different modes of expression (e.g., dreams, waking narratives); and (c) provide useful aids to the therapists as a guide to beneficial interpretation.

Issues of Countertransference

In countertransference, it is essentially the therapist's own unresolved feelings and wishes which are projected onto the client. Classical-trained psychoanalysts generally consider countertransference as being conceived as a breach of the therapist's objectivity and neutrality. That is, the goal for any therapist is to achieve and maintain an objective point of view (Butler & Strupp, 1991). Gradually, early research on the understanding the therapists' feelings in dynamic psychotherapy interrelatedness (Howard, Olinsky, & Hill, 1969) led to more contemporary views on the complexities of the therapists' processes of intrapersonal (Bacal & Thomson, 1998), experiential (Elliott & Greenberg, 1995; Maher, 1990; Malone & Malone, 1990) and emotional-change (L. S. Greenberg & Safran, 1990).

Contemporary psychodynamic perspectives such as object relations theory and self psychology have since challenged the orthodox view that countertransference experiences are counterproductive and contraindicated. There is an emerging belief that the therapist's personal and direct involvement with the patient can provide very useful information for understanding and empathically relating to the client. That is, the

affective components of the therapists' capacity of empathy and optimal responsiveness to the client emerged as the framework for selfobject relatedness reactions of transference. Since both the client and the therapist are engaging in a newly developed therapeutic relationship, compounded by experiences of their past relationships, it follows that countertransference in the therapist and transference in the patient are essentially identical processes—each unconsciously experiences the other as someone from the past (Gabbard, 1990). Thus, processes such as transference and countertransference can be essentially conceptualized and studied from a stage-theory driven or developmental perspective.

Transference in Object Relations Theory

American psychoanalysts are showing increasing interest in 'object relations,' a term introduced by Karl Abraham. The term 'object' had been used earlier by Freud to denote the person (or thing) required to mediate the instinctual discharge. In object relations theory—unlike in classical psychoanalysis—the self is distinguished from the ego. Whereas the frame of reference for the ego referred to the specific intrapsychic agency and action in relationship to the superego and the id, the proper frame of reference for the self is in the relationship to the notion of an object (Wong, 1989). *Object relations theory*, however, is in itself a source of some confusion. As Smith (1989b) pointed out, it has been used variously to refer to any set of formulations about psychological functioning that is based on interpersonal relationships (Kernberg, 1997; Kernberg & Clarkin, 1994) such as in terms of 'internal object relations', and, more narrowly, to those who described their work as an object relations theory of personality. Stated in its simplest terms, object relations theory encompasses the transformation of

interpersonal relationships into internalized representations of relationships (Gabbard, 1990).

Melanie Klein (1932/1975, 1950) is generally acknowledged as one of the foremost pioneers of object relations theory. Klein is best known for her studies on the developmental vicissitudes of the superego, elaborating on the fantasies and behaviors of severely disturbed children with an analysis of the child's intrapsychic world and its development (Wong, 1989). In her clinical work with children, Klein proficiently translated Freud's concepts of transference in adults to transference in children. In contrast to classical Freudian psychoanalytic transaction, however, Klein (1932/1975, 1950) viewed the superego as developing independently of biological influences; it is also heavily influenced by the nature of the child's relationship with the parents and the problems of primary instincts. For Klein, then, it is the aggressive drives, rather than Freud's emphasis of sexual drives, which are preeminent during the earliest stages of development, and the presence of these aggressive drives and sadistic impulses and the fear of retaliation that give rise to the primitive superego (Nagler, 1972).

Also in contrast to Freud, Klein postulated that the 'object-relation' was not simply in relation to an external object; it exists from the beginning of postnatal life, which is typically viewed as a relation to the mother (although focusing primarily on her breast) imbued with love, hatred, fantasies, anxieties, and defenses (Hughes, 1989). According to Klein, primary relationships compose the instinctual drives in development. Internal objects (the individual's intrapsychic) are neither good nor bad (Wong, 1989) and though not exact replicas of external objects and experiences, fragmented part properties eventually become integrated into realistic representations (Blatt & Lerner, 1991). The individual, however, is unable to distinguish clearly between

external and internal objects because external object relations are influenced by the projective content derived from the internal object relations. Further, Klein questioned the implications of Freud's dictum that individuals who suffer from narcissistic neuroses had no capacity for transference and, hence, lacked the prerequisite for psychoanalytic treatment. According to Klein, there is no instinctual urge, no anxiety situation, no mental processes that did not involve objects, external or internal (Hughes, 1989). Rather, Klein's departure from classical psychoanalytic thought paved the way for others (e.g., Mahler, Kohut) in that it is a narcissistic personality disorder that impairs an individual's capacity for transference so that he or she is handicapped in profiting from therapy (Schoenewolf, 1989).

A medical doctor, a psychoanalyst, a teacher, and considered by many an innovator and an influential contributor to object relations theory, Donald W. Winnicott's theories also can be viewed as being influenced by but departing from classical Freudian and Kleinian thought (B. L. Smith, 1989b; Wong, 1989). Winnicott's (1959/1989b, 1962/1989a) theory is characteristic with Klein's notions of the existence of an inner world, internal objects, primitive greed, and the importance of fantasy. However, Winnicott disagreed with Klein's belief that object relations are derived from inherent, constitutional sources; rather, he focused mostly on the conditions that make it possible for a child to develop an awareness as a separate person (C. Winnicott, Shepherd, & Davis, 1989; D. W. Winnicott, 1959/1989a, 1960).

From a Winnicottian perspective, the infant begins life in a state of "unintegration" with "unconnected" and diffuse experiences, and the mother provides the relationships that enable the incipient self of the infant to emerge (Wong, 1989). For Winnicott, child development occurs in stages, and if a child displays immaturity during

development, then these immaturities are considered residues of earlier immaturities and the child is believed to be 'stuck' in a particular developmental stage. Winnicott conceived of the mother-infant relationship as reciprocal and complex, and because of this reciprocity, he believed that he was under no obligation to elucidate on the developmental stages or specify what was influencing what at any given moment (Hughes, 1989).

Displays of immature behavior or regression best conveyed Winnicott's ideas about transference. The analyst and the analytic setting represent in the transference of the environment-mother, the background mother of holding and handling, rather than the mother who is the object of drive (Fromm, 1989a, 1989b). The failure of the environment-mother is not readily known to the patient, but registers it as an intense reactiveness. Transference occurs, Winnicott claimed, because the analytic setting necessarily repeats maternal care. Winnicott argued that a patient's resistance to treatment is due to the affects of countertransference and not, as Freud had argued, transference of intense feelings and fantasies associated with represses wish systems (D. W. Winnicott, 1962/1989b). Accordingly, resistance results when the analyst fails to meet the need arising naturally and legitimately in the evolving analytic setting and relationship.

In other words, Winnicottian representations of transference can be viewed in the individual's movement toward differentiation (Fromm, 1989b). As an individual slowly tests the reliability of the analytic setting, the analyst, and the techniques used, he or she opens up and allows for increasing vulnerability and experience of dependency. If things go well in the transference relationship, the patient gradually begins to sense the therapist as a new and separate person and the environment as different—that is, more

reliable than early environmental provisions. Thus, through "fantasmatic destructiveness," the analyst becomes a useful provision for the patient in the real and current world (Fromm, 1989b).

According to Winnicott, essential to the provision of the analytic work is the real, inevitable *failures* in the treatment process. Winnicott emphasized that it is sometimes useful for the patient to experience the analyst's impingements or disruptions in treatment because only then can transference be differentiated. It is the analyst's failures to touch upon aspects of the early environment that can now be known, and about which anger can now be felt (Butler & Strupp, 1991; Fromm, 1989b). This point of view foreshadows the work of Heinz Kohut (1977) in that it provides a solid foundation for the concept of empathic attunement. That is, the client can witness and experience the foibles encountered during therapy as being congruent with early maternal experience, or 'selfobject,' thereby viewing the analyst as a real, genuine, wholly understanding being. The analyst thereby enters the analytic process as a real person and not merely as a transference object (Detrick, 1989) in which the client's growth or changes in therapy are due primarily to a positive dyadic relationship involving empathic communication between the client and the therapist (A. G. Kaplan, 1983).

Also influenced by earlier object relations theorists, Kohut (1977) conceptualized of two categories of transference: *negative transferences* and *positive transferences*. Negative transferences are completely learned in early development from unempathic parental responsiveness, which are usually manifested in the form of anger and hostility. The patient intrapsychically displaces onto the therapist feelings of anger or hostility when the therapist, in some inevitable, minor way, is unempathic or is just carrying out the natural analytic process such as setting time limits, collecting fees, or perceived by

the patient as having relatively more power, and so on (Kahn, 1989a). Positive transferences, on the other hand, originate from the individual's inborn selfobject needs. Innate psychological needs were identified as the need to be mirrored, to be treated genuinely with positive regard, to be consistently cared about, to have someone to idealize, and so on. Kahn (1989a) summed up positive transferences in this way: they originate from innate psychological needs which have been either optimally satisfied (as in reasonably healthy development) or insufficiently or inconsistently satisfied (as in developmental arrest).

What Kohut saw as fundamental to the self was not biological drives but rather the desire for a sense of relationship with and responsiveness from others; eventually, he too challenged Freud's biological speculations about human nature (Bouson, 1989). Kohut's early position on transference was that the patient needed only supportive and soothing responses from the therapist, and that analysis was not necessary (Kahn, 1989a). For the most part, however, Kohut (1977) reserved making judgment on his original position that narcissistic transferences were transferences in the strict metapsychological sense of the world.

Kohut (1977) also managed to broadened the definition of the self, thus describing its function as "an effective independent center of initiative and as a focus of perceptions and experiences—including those of heightened or lowered self-esteem" (p. 94). Kohut's concept of the self has been compared with that of a Jungian interpretation because of references to an inner program with a purpose of its own (Wolfe, 1989). Transference, Kohut (1977) concluded, is an expression of inborn psychological needs, for which he formulated there are two types: the paternal, *idealizing transference*, and the maternal, *mirroring transference*. In describing the former, Kohut used a case

example whereby the son's needs were not met because the father was "a self-absorbed man" depriving his son "of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the self-object's shortcomings" (Kohut, 1977, p. 52). In the latter form, certain layers in the (maternal) mirroring transference have activated the pathogenic responses the son experiences in later life.

By adopting a view of observer-participant in his clinical work, Kohut gradually found himself in a strange, archaic interior world where self and other meld together whereby his patients experienced him not as a separate, autonomous object, or person, but rather as a need-satisfying object of self-extension to be controlled and used (Bouson, 1989). Before Kohut, the narcissistic patient was generally considered unanalyzable in the process of classical psychoanalysis. However, Kohut's analytic work with the narcissistically disturbed led him to derive his theory of the self and slowly fit together the pieces and processes involved in the dramatic and "tragic" individual's puzzling condition (Bouson, 1989). Nevertheless, Kohut's legacy was eventually accredited for influencing the attitudinal change that transformed the quasiauthoritarian psychoanalytic milieu into a more egalitarian and empathically sensitive ambience that focused on changing the client-therapist relationship (Wolf, 1991). Moreover, as Chethik (2001) suggested, play in its structure to the early parent-child relationship furnishes the parallel processes of transference:

> An important quality of play in childhood is the capacity of "letting go." Within play, children can (up to a point) abandon themselves. They experience a sense of freedom and are less bound by the demands of reality. This "letting go" has its parallel in the transference regression. [Letting go is] both for gratification, but also discovery. The parallel letting go in [parent-child relationships] mirrors the healthy regression interplay that children use. (p. 19)

From a Clinician's View

Some clinicians might consider targeting investigations into specific psychotherapy processes, such as transference, countertransference and empathy, as an insufficient or inadequate approach to developing a deeper understanding of its working parts. Goldfried (1980) issued a call to psychotherapy practitioners in general, and wrote:

> To the extent clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases. (p. 996)

Although supportive of its ideal, Greenberg (1994) presented a somewhat pessimistic view about the possibility of bridging research and practice. Confounding the effects of our efforts are advances of new processes, new hypotheses, and new data to explain new occurrences. She lamented:

> Each participant in the process constructs a new hypothesis that he or she thinks explains the occurrence of various events. But as we move up the therapeutic /supervisory chain, these hypotheses are no longer seen simply as explanations. Rather, they are seen as events, as elements of interaction, *that themselves require explanation.* This underscores why we cannot really say that the therapist, supervisor, and consultant are looking at the same data. The theory of each is built upon a different observational base; the theories will be difficult to compare because they will address different phenomenon. (J. Greenberg, 1994, pp. 8-9)

In any psychotherapeutic relationship, as Gabbard (1990) pointed out, over the course of therapy the therapist distinguishes in the client a certain pattern (a) of outside relationships and then links it to (b) transference patterns and to (c) antecedent relationships with family members. However, in object relations theory the client's resistance tendencies are not viewed as necessarily maladaptive. Rather, resistance is viewed as essential and adaptive in the context of predominantly supportive psychotherapy. In object relations terms, patterns of resistance triangulate around a

recurrent self-object-affect constellation that appears in transference, in current extratransference relationships, and in memories of past relationships. Similarly, in self psychological terms, the pattern may be the expectation of mirroring or the need to idealize others (Gabbard, 1990).

Schools of psychotherapy differ however in the balance and emphasis placed on constructs such as transference in psychotherapeutic relationships. In object relations theory, issues of transference are related to the patient's resistance to the therapist, called *transference resistance*. Resistances can be understood as the client's unconscious tendency to cling tenaciously to a particular (earlier) internal object relationship; they are usually manifestations of defensive structures in which the therapist is repeatedly related to as someone else, thus resulting in a therapeutic stalemate (Gabbard, 1990). The composition of the client's inner world is that which is a composite of the internalized and the fantasized, the good and the bad experiences with past objects; when these objects are projected onto the therapist, the 'real' relationship with the therapist is distorted (Butler & Strupp, 1991). Greenberg (1995) introduced the concept of an "interactive matrix" that is continually shaped by the personal characteristics (e.g., beliefs, commitments, hopes, fears, needs, and wishes) of both participants.

From a Researcher's View

There are several considerations from the perspective of conducting clinical research. Individual biases, theoretical orientation, issues of validity and reliability can all influence the evaluation and interpretive findings of clinical studies. Further contributing to the complexities of investigating the psychotherapy processes are methodological issues such as considerations of client-therapist interactions being influenced by competencies of the therapist, or the "complementarity" of the general

interpersonal communication strategies. Svartberg and Stiles (1992) sought to investigate clinical interpersonal skills in a pilot study and concluded that therapist competence evaluation methods could a: (a)

client problem presentation, (b) therapist expert understanding, (c) therapist intervention, and (d) client cooperation.

Therapist experience and training can also influence research interpretation. For instance, there can be considerable diversity in the therapists' experience of practicing psychotherapy; experience can range from graduate (master's and doctoral) programs to practitioners with several years postgraduate experience, internships, or specialized training. Somewhat surprising are the findings of a meta-analysis that indicated the relationship between therapists' level of experience and psychotherapy outcome is meager (Stein & Lambert, 1984). Lambert (1989), on the other hand, argued that there is widespread evidence supporting the importance of individual therapists; rather than considering the therapist's contributions as an integral part of the change process,

however, the unique influence exerted by individual therapists should be viewed as "error" variance. Nevertheless, it seems there will always exist other research considerations in which certain tradeoffs or issues of practicality (e.g., cost-savings, time constraints, therapist availability and scheduling, opportunity for gainful experience) could potentially lead to problematic findings or be subjected to critical review (e.g., research biases, therapist's experience and qualifications, questionable reliability, ecological validity or limitations of generalizability).

Toward Working Alliances

Developing a working therapeutic alliance with the client and a comprehensive understanding of the therapeutic processes in context is an essential prerequisite to the success of any therapy. From the standpoint of developing a working relationship between researchers and practitioners, there is at least some common ground from which both must operate, that is a fundamental theory. For a behaviorist, for instance, gain in knowledge results from only that which is directly observable (interpersonal or external) behavior. On the other hand, a psychoanalyst is primarily interested in the interpretive meaning underlying the subjective (intrapersonal or internal) experience. Thus, though somewhat opposed in their views, each employs the formulations of an applied theory and each makes inferences and decisions based on its principles. There exists, then, a strong relationship between research and theory, and theory and practice. Integration of research and practice, however, becomes more challenging and increasingly problematic in the attempts to unify a fundamental theory befitting the accord of both.

In reviewing the preceding, one might ask, "How do the processes of transference and countertransference affect individual *learning processes* of human development?" It

seems that any answer to similar questions would depend upon which school or perspective is most revered. For instance, the original inceptions of Breuer and Freud the treatments of transference and countertransference have since varied greatly. Even today there are many clinicians and theoreticians who remain steadfast in their loyalty to fundamental perspectives, principles, and practices. Veterans in the field of classical psychoanalysis, for example, would rarely consider humanistic psychology or cognitive-behaviorism for their similarities, and indeed would consider them very distinct and very dissimilar schools of thought. From the perspective of behaviorism, psychotherapy requires a theory of "structured learning" in that it involves more than the classical reflexology principles advanced by Pavlov, Watson, and Skinner (Cattell, 1987).

Contrary to popular opinion, however, much of the psychoanalytic conceptual and theoretical underpinnings of transference have indeed helped to shape the humanistic psychology movement and deepen our understanding of other essential psychotherapy processes of transference and related interpersonal processes. Presently, the majority of schools generally emphasize transference projections and distortions, issues of countertransference, as well as issues of emotive expressions in the therapeutic encounter such as empathic attunement. In process outcome research, it is necessary to consider not only the issues and means for building practitioner-researcher working alliances, but it must also take into account the coexisting interpersonal relationship variables in practitioner-client therapeutic alliances.

Moreover, Binder and Strupp (1997) suggested that client-therapist alliances are often overestimated and that they are naturally unstable and continually in flux. Moreover, negative processes in this dyadic formulation can be attributed to incidents of "interpersonal conflict," citing examples of hostile interchanges between clients and

therapists. Further, Greenberg and Elliott (1997) argued that empathy is not a unitary construct and suggested that a more componential view of empathic responding is required. The benefits of establishing a positive working therapeutic alliance continue to be explored within the context of several applications, for example, in working with couples (S. M. Johnson & Greenberg, 1989) and adolescents who express a need to break away from childhood dependency (J. Johnson & Alford, 1987).

Developing a "mutually interactive bond" is an essential and necessary component of the therapeutic alliance in that it furnishes an ongoing capacity for empathy (Meissner, 1996). For empathy to work effectively in the therapeutic alliance, however, therapists should not strive for an idealized state of "perfect" empathic attunement. Rowe and Mac Isaac (1991) suggested that perfect empathy in a client-therapist working alliance is impractical, unrealistic, and contraindicated. In object relations terms, for the development of empathic attunement in the therapeutic process it is important that clients not perceive the therapist as an "idealized selfobject" (i.e., "idealized parent") and thus be "unable to express their hurt and disillusionment" whereby "treatment would merely be a replay" of their childhood experiences (Rowe & Mac Isaac, 1991, p. 168).

Although establishing a good therapeutic alliance is generally considered an important contributor to achieving a positive outcome, some differ in their views about how it should be investigated in the psychotherapeutic context. As indicated by Abernethy (1992), establishing any contact with the client's family members was generally considered to jeopardize the therapeutic working alliance in that it distorts transference, threatens confidentiality, and may lead to a lack of self-confidence in the client. In dynamic therapy, moreover, the treatment focus is on inquiry into the client's

internal conflicts and contact with family members may compromise the therapeutic frame by going outside the client's perception. The psychotherapy integration movement has further questioned such prohibitions in recognizing that "there may be problems in therapy that can be rather quickly removed by contact with a family member or significant other" (Abernethy, 1992, 29).

Summary

To say the least, Breuer's original formulation of transference was greatly advanced through Freud's exacting, extensive early contributions to psychoanalytic transaction. Since, classical psychoanalysis and psychotherapy have evolved toward at least moderately integrative conceptualizations and advances. Through Winnicott's treatment of transference and, especially, countertransference in object relations, many clinicians have gradually begun to view the processes of psychotherapy as highly complex, bidirectional, contextual, and not unlike the processes involved in early childhood development and child-parent interrelatedness. Many schools now consider countertransference as both desirable and appropriate forms of displacement onto clients in the treatment plan. The later developments of Kohut's self psychology and Rogers's humanistic psychology emphasized empathy in the form of interpersonal, as opposed to intrapsychic, factors in the psychotherapeutic relationship, eventually led practitioners to privilege empathy in clinical practice. To say the most, from any perspective, and from any context, there is vital learning in better knowing and understanding transferences of the self. Nonetheless, the theoretical positions on the constructs of transference and countertransference are historic and have been subjected to a multitude of interpretations and reinterpretations.

Underlying the efforts of psychotherapy integration is the ability to effectively integrate a unified theory "that each believes best describes the most important variables and relationships" (Eichelberger, 1989, p. 264). In that the researcher and clinician have different requirements, Luborsky (1994) considered some of the gap between them as inevitable. Chasms in the gap are bridged in the general principles that each of them holds and considers key to their ultimate objective. Practitioners draw general principles from their clinical capacities and knowledge. For the researcher, general principles are meaningful to the extent they are comparable to clinical lore. "To be helpful a general principle must aid the therapist with a formulation that fits the individual patient and even assists in deciding which part of the formulation is most relevant for interpretive intervention at a particular moment" (Luborsky, 1994, p. 178). The working of a unified theory rests in the extent researchers and clinicians are able to reconcile their formulations and interpretations of research views as well as their ability to intervene and guide the processes of treatment.

Toward developing a working alliance between clinical research and practice is perhaps more a function of establishing an applied, unified theory. Many of the principles of a fundamental theory are conceptualized in the generalizations we make about them, and the formalizations or 'labels' we choose to apply to theory are frequently based on nothing more than a collection of hypothesized constructs. For instance, according to the *Diagnostic and Statistical Manual for Mental Disorders—Fourth Edition (DSM-IV)* published by the American Psychiatric Association (1994), one may say that a person suffers a Major Depressive Episode when specific diagnostic criteria (e.g., depressed mood, loss of interest or pleasure in all activities) converges with an arbitrary time period (i.e., at least 2 weeks). To present another example, in the absence

of a standardized definition of intelligence, we might conclude that a battery of subtests from the *Wechsler Intelligence Scale for Children—Third Edition (WISC-III)* (Wechsler, 1991) can provide an apt measurement or unified profile of a child's cognitive capacity and intellectual functioning.

A common ground for developing a unified theory in psychotherapy is perhaps more dependent on building a unified, fluent language, spoken or unspoken, by both clinical researchers and clinical practitioners alike. Luborsky and Crits-Christoph (1990), for instance, conceptualized of a unified theory veiled in the elements of transference and countertransference as "...our contrasting low-level, experience-near, and common, *clinical* theory...of resistance and defense, of anxiety and conflict and compromise," and "...of self and object representation." In addition, "...it is at this level that clinical constructs could be put to the kind of empirical study and test that will determine the extent to which...we are indeed fashioning a body of science that in turn can guide our clinical therapeutic work ever more precisely" (Luborsky & Crits-Christoph, 1990, p. ix). While the general purpose of clinical research is to enhance our understanding of human functioning (Kazdin, 1992), Greenberg (1994) pointed out there will always be alternative approaches to investigating the human condition in that psychotherapy, "precisely because it approaches the issues from a novel perspective, will always be part of the debate" because psychotherapy research "is fundamentally different by design and in intent from research in the hard sciences..." (p. 16).

While it is unlikely that psychotherapy integration will ever reach the level of a grand, wholly unified theoretical consensus, intensive integrative efforts can lead to intervention strategies associated with real clinical problems (Goldfried & Castonguay, 1992). The renewed interests on the constructs of the therapeutic relationship and

empathy appear promising and essential to advancing the current psychotherapy integration movement. Toward providing a unified psychotherapy integration model, Bohart and Greenberg (1997) argued that empathy, and our increased understanding of its constructs and development in the therapeutic context, has provided a vital trend toward bridging several theoretical perspectives ranging from psychodynamic to cognitive-behavioral interventions, from client-centered to experiential, feminist, and humanistic approaches, and from cross-cultural to postmodern and developmental and self psychology. Moreover, traditional therapeutic alliances can be conceptualized and characterized in the form of new object relationships through which developmental experiences involving play may be revivified (Chethik, 2001).

Meaning Making in Psychotherapy Research

To obtain meaning and unification in psychotherapy, the ability to define operationally the therapeutic conditions becomes increasingly important. Therapeutic constructs should have in common aspects of similar fundamental therapeutic values and conditions. A unified theory of unconditional positive regard, for example, would seemingly have the implicit theoretical constructs of empathy, warmth, and genuineness. In an early study on empathy, however, Garfield and Bergin (1971) reported that no discernable relationship could be found between these three therapeutic conditions. That is, while the conditions of empathy and warmth were positively correlated, both were negatively correlated with genuineness. Perhaps these less than anticipated results were as much a reflection of the difficulties encountered in the measurability of theoretical constructs as they were in the testability of therapeutic conditions of empathy. Apparently, making clinical research more meaningful in clinical practice is not always an easily integrated process.

Making Research Applicable to Clinical Practice

Fundamentally, theories have almost never been constructed developmentally, that is, from the 'bottom up.' The characteristics underlying many of our most cherished theoretical tenets originated from broad generalities rather than from responses to specific observations. Psychoanalysis, for example, continues to flourish even though its foundation is grounded largely in "make-believe" and the available "data" are stored primarily in the minds of practicing analysts (Spence, 1994). Psychotherapy research has not been more useful to practitioners in that the findings are typically attempts to validate vague preconceived ideas that can never be "disconfirmed" or they tend to provide support of grandiose or comforting generalizations. Fundamental research in the field of psychotherapy has chiefly been dominated and spurred on by broad generalities rather than specific testable hypotheses.

Paving the way for the future study of interpersonal processes in psychotherapy process outcome research, Kiesler (1979) presented an early conceptual and empirical analysis of relationships in human behavior and in psychotherapy. The processes identified were based on the following six statements: (a) relationship occurs in psychotherapy primarily through nonverbal messages; (b) relationship is the momentary and cumulative result of reciprocal messages; (c) relationship can be operationalized and measured; (d) interactants continuously negotiate relationship issues of affiliation, status, and inclusion; (e) abnormal behavior is inappropriate or inadequate interpersonal behavior; and (f) the tasks of psychotherapy are to decode and identify the predominant self-defeating style of the client. In short, this theory reinterpreted "parataxic distortions" and "transference/countertransference" as reciprocal verbal and nonverbal behaviors communicating encoder-decoder evoking and decoder-encoder

impact messages. It was concluded that these messages are integral and pervasive components of relationship and deserve a prominent place in the theory, research, and practice of psychotherapy.

To derive clinical meaningfulness in practice, clinical research must provide a therapeutic context for its interpretation (A. O. Ross, 1981; Talley, Strupp, & Butler, 1994). In an ambitious undertaking, Orlinsky and Howard (1986) sought to transform variables familiar to practitioners into small, but perhaps seemingly too different for purposes of empirical evaluation or integration, into conceptual categories germane to researchers. These researchers developed a "generic model" of psychotherapy framework in which they distinguished three broad types of research variables: (a) *input* variables, which determine the form and content of psychotherapy; (b) *process* variables, which describe the events of therapy itself; and (c) *output* variables, which specify the consequences of therapy (including consequences and feedback from clients).

Another way to make research more meaningful to clinical practice is to engage in process research within the context of the therapeutic environment (e.g., clinical office, playroom) rather than within an artificial setting such as a laboratory. In this way, the relationship and processes involved in treatment effectiveness and outcome events can be better generalized and applicable to natural environments. Rising to meet many of these challenges, process-outcome research within contextualized settings has become one of the "fastest growing areas in studies of psychotherapy" (Orlinsky, 1994, p. 104).

Data Handling in Psychotherapy Research

To arrive at an agreement between researchers and practitioners on the selection of meaningful observational measures is a daunting challenge, indeed. According to Shapiro (1989), psychotherapy "is the work of particulars, not generalities. It follows the

patient's interests and concerns in the particulars" of presenting problems in which the therapist responds "session by session to the patient as he seems at the time" (p. 204). In that changes in psychotherapy occur in a subtle rather than dramatic fashion, Strupp (1989) agreed on the need for examining the particulars of data, but argued also for the need to consider complete data sets in that "change events must necessarily be seen in a broader context" (p. 721).

From a contemporary perspective of developmental psychology and interpersonal relationships, Valsiner, Branco, and Dantas (1997) noted there exists an interesting dichotomy in that explanations of human development are typically either by intrapersonal factors or by the person's embeddedness in a social context. These authors argued that the dichotomy has the same underlying structure entailed by the traditions of the "nature-nurture" counterpositioning. As a means of maintaining a joint focus on the personal and social sides of human development, these authors suggested that the use of a co-constructionism model. As such, child-parent interactions can be viewed as complementarity and bidirectional process of *filiating*. The concept of filiating:

> ...entails a complex phenomena that simultaneously reflect the constancy of the child's relationship with the parent, and the processes of active counterregulation of parenting efforts. From the basis of the guaranteed role of "the son or daughter of X," the child acts in goal-directed ways relative to parents' actions. The background frame of the particular relationship creates the field of possible actions toward parental efforts. ...The basis for filiating cannot be reduced to "internal working models" of attachment perspectives. The latter are insufficiently differentiated as to the nature of the relationship (as those working models have become treated as properties of child). Rather the filiating basis entails the child's basic feeling for how the relationship is organized. Surely that basis emerges in the ontogenetic history of the child-parent relations. (Valsiner et al., 1997, p. 290)

Thus, it was argued that human development and interactional processes can be studied within person-environment relationships, which necessarily entail the view of two-parallel processes—parenting and filiating—and of the study of semiotic mediational

devices that regulate those processes, such as beliefs and values (e.g., conditional and unconditional love).

Moreover, Chazan (1995) described the importance of *parallel processes* as events that signal shared therapeutic experience. These parallel events "form the basis for communication that can lead to the development of empathy and intersubject validation" (p. 27). To investigate the parallel processes of client-therapist interactions, the earlier described CCRT model has been employed in individual sessions and enlarged to a wider variety of contexts and procedures. Luborsky and Crits-Christoph (1990) traced the pioneering methods of the 1976 CCRT model (Luborsky, 1976) with wider applications of plan diagnosis (Weiss, Sampson, Caston, & Silberschatz, 1977), plan analysis (Grawe & Caspar, 1984), quantitative methods of structural (Benjamin, 1979) and configurational (Horowitz, 1979) analysis of social behavior, as well as qualitative analyses based on observations of interpersonal relationships (Hiltz, Johnson, & Turoff, 1986; Kiesler, 1987).

In sum, deriving meaning from data based on observational paradigms of interpersonal relationships allow us to rethink and investigate more carefully particular aspects of our world and those of others (Spence, 1994). In that observational models are instructive for studying certain kinds of processes, they can enhance our present understanding of psychotherapy and interpersonal processes, for example, current developments in the field of mother-infant interactions (Spence, 1994). Based on unifying the developmental constructs of object relations theory and the separation-individuation processes of parent-child dyads, the groundwork for an observational paradigm and coding system was piloted to investigate and measure the theoretical

framework of couplehood development based on the parallel processes of childhood development and interpersonal relations (Barabash, 1995).

Methodological Issues in Psychotherapy Research

Literature on clinical psychotherapy has largely been studied only in clinical practice (T. Shapiro & Emde, 1995). Psychotherapy research "necessarily and inevitably changes the nature of the therapy it investigates—quantification requires a compromise between the usual procedures of the clinic and the demands of scientific inference" (Roth & Fonagy, 1996, p. 13). To the degree that we can make decisive conclusions about treatment efficacy and that the changes have actually occurred in therapy requires meaningful measurement of the key therapeutic processes obtained in contextual settings (Sonnanburg, 1996). Froyd, Lambert, and Froyd (1996), for instance, reviewed 21 major journals published between January 1983 and October 1988 containing studies on psychological treatments on practices of psychotherapy outcome measurement. The most important and typical assessment strategies used to measure key therapeutic processes were identified as: (a) behavioral intrapersonal content; (b) descriptive technology (e.g., interpersonal measures); and (c) self-report sources.

However, even the most standardized techniques in clinical research can be subject to criticism. As Freeman and Munro (1990) pointed out, rating scales measuring change in psychotherapy enter into the thousands with virtually no agreement on the outcome measures among users. Representing some of the foremost trends of psychotherapy integration (e.g., psychodynamic, behavioral, and experiential therapies), Goldfried, Greenberg, and Marmar (1990) proposed that researchers instead focus their attention on developing methodological designs that uphold the multifaceted processes of therapeutic change and outcome events.

Measuring Key Psychotherapy Processes

The central intent of psychotherapy process (versus outcome only) research is to capture the context or measurement of some aspect(s) during the midpoint(s) of therapy; that is, to not rely solely on traditional pre- and posttest measures. In other words, psychotherapy process research includes the need for at least three points of measure: one at the beginning of therapy (pretest, or baseline), others around the middle of therapy (midtest), and one at the termination of therapy (posttest). Some researchers have employed several midpoint measures. Svarberg, Seltzer, Stiles, and Khoo (1995), for instance, included two pretest (baseline) measures, one midtest, one posttest, and three follow-up measures. Diemer, Lobell, Vivino, and Hill (1996) included three standardized measures of process research, and two follow-up measures. Svartberg (1989) and Svartberg, Seltzer, Stiles, and Khoo (1995) investigated symptom improvement in dynamic psychotherapy in terms of continuous (temporal) processes and argued for the need to view change in terms of symptomatic distress (or improvement) and as incremental change rather than traditional evaluative measures of differences between pre- and posttest measures.

To measure therapeutic processes in psychotherapy, investigators have relied heavily on multiple scales for assessment. Some have strongly encouraged therapeutic action by means of psychological testing in the earliest phases of psychotherapy (Appelbaum, 1990) citing the arguments of responsibility and accountability in clinical practice. While others have suggested there is considerable recognition that scales can be ubiquitous for psychological research (Dawis, 1987/1992), some have sought to develop new psychological tools of measurement while others tended to utilize previously published instruments (e.g., self-reports, Likert scales) or some combination thereof. To

investigate context in psychotherapy, for example, Messer, Tishby, and Spillman (1992) used trained raters and a 7-point scale to evaluate therapeutic progress or stagnation. Depending on the specific nature of the investigation, clients, therapists, or both may complete measurement instruments, and evaluative measures can be derived from questionnaires or ratings through to observational coding measures.

With increasing interest in and emphasis on the measurement of process variables, one might wonder why so few researchers have included midpoint measures during the course of therapy and clinical research. It stands to reason, then, that more information could be gathered on the therapeutic processes simply by implementing more data collection procedures in the methodological design, for example, by administering self-report instruments during the course of therapy. While some have argued for an integrative research approach developed from a unified theory built on investigation of therapeutic processes, such views may not be very realistic or pragmatic. In clinical research, Kazdin (1992) argued, a theory need not reflect an all-encompassing, fully developed view of how the entire phenomenon operates; rather, it is only necessary for theoretical research to focus on specific relations of interest. He provided good reason for his position:

> An idea or set of ideas provides a framework for understanding the possible bases or reasons for the connections among variables. There is an endless array of facts or data that could be generated by research; presumably, the interrelations among all conceivable variables of interest in clinical psychology might be studied. Theory helps to sort out those variables that may be of special interest, relevance, and importance. (p. xxii)

Granted, sound clinical research procedures could considerably increase the research workload with wider considerations given to data handling. Nevertheless, meaningful data gathered on therapeutic processes could conceivably enrich our understanding of psychotherapy.

The Quantitative Approach

An often-heard criticism of quantitative analysis in psychotherapy research is that it lacks contextual meaning. Others have argued that external validity should not be the uppermost consideration in quantitative research designs. Providing an argument in favor of internal validity, Greenwald (1975/1992, 1976/1992) concluded:

> The between-subjects design may be preferred even in some situations for which the within-subjects design may have greater external validity, because the between-subjects design may allow cleaner tests of theoretical hypotheses. (p. 165)

When grounded in solid theory and research, however, correlational (quantitative) methods and designs can provide a useful tool for the investigative purposes of process variables (Hayes, Castonguay, & Goldfried, 1996). Quantitative data analyses on the processes of therapeutic alliances and interpersonal relationships have involved a variety of standardized factor analytic statistical procedures.

Suggesting that there exists an optimal level of therapeutic alliance, Saunders, Howard, and Orlinsky (1989) developed quantitative measures using the Therapeutic Bond Scales (TBS) to assess the quality of the client-therapist relationship. The therapeutic bond was measured from the client's perspective on aspects of (a) working alliance, (b) empathic resonance, and (c) mutual affirmation. The results indicated that all TBS measures were significantly correlated with session quality. Moreover, the therapeutic bond was significantly correlated with termination outcome in both a linear and curvilinear fashion suggesting, at least initially, that the therapeutic relationship can be too high or too low. Such accounts pointing to an 'optimal' level of therapeutic bond resemble Kohut's (1977) emphasis on the importance of mirroring in client-therapist relatedness as well as Rowe and Mac Isaac's (1991) caution against striving for a 'perfect' therapeutic alliance.

Quantitative analyses have also been employed for inquiry into individuals' relatedness and the cognitive-affective and experiential processes to significant others. A quantitative approach on the separation-individuation processes and psychological adjustment of late adolescents was conducted by Holmbeck and Leake (1999). Utilizing standardized psychological instruments, 428 undergraduate students were assessed on measures of the Separation-Individuation Test of Adolescence (SITA) and psychological adjustment using the Minnesota Multiphasic Personality Inventory (MMPI). It was reported that separation anxiety, engulfment anxiety, and dependency denial scales on the MMPI/MMPI-2 were both quantitatively and qualitatively highly associated with maladjustment than were the other SITA scales. The assimilation model has been utilized in investigations of process-experiential psychotherapy involving case study designs and quantitative analyses of independent sets of ratings on schema of individuals' problematic experiences (Field, Barkham, Shapiro, & Stiles, 1994) and qualitative analyses of conventional outcome criteria (e.g., client's transcripts) of individuals' problematic experiences (Honos-Webb, Stiles, Greenberg, & Goldman, 1998).

Clarkin, Hull, and Hurt (1993) investigated the hypothetical constructs of clients' interpersonal relationships by providing inquiry on the conceptual coherence of the borderline personality disorder (BPD) based on *DSM-III-R* diagnostic criteria. These authors argued that these criteria might indicate possible underlying causal personality and relationship issues and, hence, provide the possible treatment foci. In doing so, they factor analyzed the eight criteria of borderline personality disorder, and isolated three factors of BPD symptoms: (a) the identity factor, (b) the labile mood factor, and (c) the impulsivity factor. The results indicated empirical support via quantitatively derived

factors for the diagnostic correlates of BPD. Additionally, these authors indicated that these data appeared to have face (i.e., surface) validity.

Others have proposed bridging the realms of both quantitative and qualitative clinical research. Wilson and Hutchison (1991) proposed an integration of hermeneutics for its uniqueness of shared meanings and common practices, and grounded theory for its conceptual framework useful for planning interventions and further quantitative research. To test treatment efficacy for small samples, the "generalized least squares method," a time-series multiple-regression analysis, can capitalize on repeated measures and thus simultaneously assess treatment efficacy and qualitative process correlates of outcome (Gaston & Marmar, 1989). Represented in the psychotherapy process are the "paradigmatic" and "narrative" approaches that currently remain the two fundamental approaches to inquiry of the human sciences (Toukmanian & Rennie, 1992). Others have argued that the process-outcome correlation paradigm will always be implicitly flawed if researchers rely too heavily on the drug metaphor and its corollary, the correlational design (Stiles & Shapiro, 1994, 1995a) and continue to offer relatively little guidance to practicing therapists (Goldfried, 1993).

Some psychotherapy field researchers, however, have chosen a less ardent approach in extenuating their views of applying conventional quantitative techniques to assess the processes and effects of psychotherapy. There is more to the art of psychotherapy than what is said by the therapist and client; there are also meaningful data in the processes of what is unsaid. Sandell (1987) argued that estimating psychotherapeutic goals and change through quantitative analyses are restricted by the acquisition of "desirable surface traits." Rather, investigation on processes of psychotherapy demand a metapsychological approach based on thought dealing with

concepts extending beyond the limits of psychology as an empirical science. Taking note of the seeming imbalance in the literature in favor of clinical, quantitative research, Vogelsong and Guerney (1982) suggested the need for greater emphasis on obtaining clinical reports containing more meaningful, qualitative data.

The Qualitative Approach

Historically, traditional case study designs have provided a venerable approach to psychodynamic treatment research (Spence, 1993) thereby enriching the contextual information. Single-case designs in psychotherapy can generally be differentiated into three basic ways: (a) single-case qualitative experiments, (b) single-case quantitative analysis, and (c) case studies (Fonagy & Moran, 1993; Hilliard, 1993a). The features of single case studies appear to have particular merit for investigating integrative (cohesive) psychotherapies and objectives. "Qualitative data analysis processes...are not arcane, obscure, or ineffable" (Miles & Huberman, 1984, p. 28). Empirical investigations of psychotherapy processes require firm grounding in theoretical structures and treatment efficacy requires firm grounding in research training and data collection (Kernberg & Clarkin, 1994). For some, however, psychotherapy remains too artful and any attempts the "manualize" treatments and inferences in psychotherapy tend to be premature and immense (Drozd & Goldfried, 1996).

No matter the methodological procedures favored, no matter the theoretical orientation and treatment modality employed, psychotherapy process outcome research comes with a blending of suggestions. When it comes to using statistics in psychological research Cohen (1990/1992) argued that "less is more" when advocating for procedures with few independent variables and even fewer dependent variables, and that "simple is better" when selecting the statistical procedures to represent, analyze, and report data.

Speaking for the qualitative camp, on the other hand, Forsyth and Strong (1986/1992) emphasized the need: (a) to link together therapeutic and interpersonal variables (vs. focusing exclusively on application); (b) to attend to specific time/space events or transitions of therapy (vs. of a study); and (c) to generate theories generalizable to a host of interpersonal situations (vs. therapeutic settings only).

Toward developing a 'goodness of fit' model for understanding the relationship between person and environment and for describing the evolution of behavior disorders and temperamental factors, Chess and Thomas (1984) remarked that "qualitative analyses are the product of routine methods involving a minimum of judgment and evaluation" (p. 64). In providing another favorable report for qualitative research, Elliott and James (1989) conducted a literature review and proposed that there is an increasing need for psychotherapy researchers, theoreticians, and practitioners to better understand clients' experiential processes during therapy, pertaining to intentions, feelings, style of self-relatedness, style relating to therapist, and other central concerns.

Responding to the oft criticism of staunch number-crunchers, Polkinghorne (1994) argued that data analyses in qualitative process outcome research can indeed meet the demands of rigorous empirical investigation and, moreover, can be carried out with creativity. Based on a review of eight qualitative studies that adapted "grounded" theories and methods in their design, the researcher concluded that data collection could be positively evaluated with constructivist criteria (e.g., intense interviews, triangulation, theoretical sampling). Moreover, commenting on the diversity of self-identity across Chinese, Japanese, Taiwanese, and American cultures, Phinney (2000) argued that human development is a process of continual change that occurs in a complex,

multilayered world that even large-scale quantitative multivariate studies cannot take into account all the factors needed to explain developmental outcomes.

If theories are not unified and well grounded, discernment and evaluation of the therapeutic change processes (e.g., narratives, verbalizations) may become less favorable or easily confounded in the analyses of the treatment conditions. Perhaps the telling signs of a unified theory are best established after the results of a study are compiled, in other words, from the bottom up. In working with children, however, narratives or verbalizations are oftentimes not readily available, or sometimes not particularly fruitful. For instance, developing a methodological design for investigations utilizing play therapy techniques presents additional challenges for clinical researchers. Specifically, random movements, self-adaptive patterns, and kinetic pleasantness typically conform to nonlinear patterns across time within play therapy sessions (Burgoon et al., 1992) with the relatedness of nonverbal communication and others' responsiveness based on required factors, expectations, and desires (Giles et al., 1999).

Defining, Selecting, and Evaluating Treatments

Despite the diversity represented in psychotherapy research field, many of the empirical findings have tended to indicate favorable therapeutic outcomes "in the range of 70 to 80 percent" (Ehrenwald, 1991, p. 574). The methods for defining study objectives, selecting participants, and evaluating treatment varies considerably, however. For instance, the implications of validity and reliability in evaluating psychotherapy changes and outcomes have also been the subject of review. Conclusions about treatment efficacy and external validity sometimes reflect simply what would be expected because of regression toward the mean effects attributable measurement error (Hsu, 1989) and the consequences of this statistical problem are often ignored by methods used to

evaluate pre- to post-therapy score changes (Hsu, 1995). In defense of external invalidity, however, the validity of generalizations tested by their success to predict outcome add "nothing to naturalness, representativeness, or even nonreactivity of investigations on which they rest" (Mook, 1983/1992, p. 134).

On the whole, there exist countless psychotherapy studies in which sound methodological procedures were employed that are befitting good, scientific sampling procedures (Durlak, Wells, Cotten, & Johnson, 1995). In the case of client selection procedures, it seems there exists implicitly a means for 'hand-picking' participating individuals in both clinical practice and research. Although typically differing in rationales for doing so, some studies appear to have employed preferential criteria with respect to sampling procedures to find the best 'suitable' participants. For instance, participants may be screened for pathologies such as psychosis, organic brain syndrome, or serious substance abuse and then be considered not appropriate for receiving a particular treatment. For example, Lutz, Martinovich, and Howard (1999) suggested that "adaptive treatment planning" include random coefficient regression models to account for individual differences and to determine the 'best fit' for determining the patients' responsiveness to psychotherapy. In other research studies, participants were selected based on their specific interests, for example, undergraduate students seeking to fulfill course credits. It is likely, then, that such finite selection procedures in clinical research could lead to far less generalizability (Diemer et al., 1996) and external validity.

Brief or short-term psychotherapy approaches, in particular, appear especially rigid in the selection criteria of participants. For example, sometimes subjects are judged "inappropriate" for short-term insight therapy (Havik, 1982). That is, brief psychotherapy practitioners in particular routinely and frequently engage in a selection

process that accepts only those clients who will optimally and potentially gain from the prescribed treatment experience, thus generating selection criteria that are more likely to result in successful outcomes in research and in practice. In general, many practices in psychotherapy appears to not only screen-out clients for serious pathologies (i.e., those who are not likely not respond well to psychotherapy), but it also appears to be an accepted practice to screen-in clients, as well. Other examples leading to selection biases include researcher bias or theoretical orientation, clinical experience, therapeutic alliances, prognosis or responsiveness to a particular treatment.

In assessing a client's responsiveness to psychotherapy treatment, Svartberg, Seltzer, Stiles, and Khoo (1995) conceived of a global personality trait measured as "ego rigidity;" that is, the capacity to vary control of emotional and motivational impulses as a function of the demands of interpersonal contexts involving combinations of ego concepts (e.g., resiliency and ego control). In other words, the response of an overly ego-rigid patient would typically be "stereotyped, controlled, and unemotional way across situations and would appear rigidly repetitive under stress" (M. Svartberg et al., 1995, p. 244). A client low on ego rigidity, by contrast, tends to "invoke the flexibly of his or her available repertoire of behavioral strategies and would generally appear more curious/exploring and expressive/emotional" (M. Svartberg et al., 1995, p. 244). Accordingly, the prognosis appeared more positive for clients lower on measures of ego rigidity than were clients who scored higher on the same personality trait.

Even well intended measures to addresses certain methodological issues could potentially lead to other problems in the research design. For example, when selecting and training interrater observers in the research analysis, Luborsky and Crits-Christoph (1990) suggested that good reliability could be obtained if: (a) raters have some clinical

training and were interested in the treatment modality; (b) raters were well studied in the treatment processes and had a clear understanding of the evaluative instructions; and (c) training of the raters includes several practice cases with feedback provided by the research supervisor. While such methodological practices appear to be reasonable, they could also potentially lead to critical review. For example, while methodologically it makes good sense solicit raters that are familiar with and experienced in a particular clinical application, it also opens up the possibility that the raters' theoretical orientation may lead to implicit experimenter or expectancy biases (i.e., Rosenthal or Pygmilion effect).

Client or participant selection in psychotherapy research generally observes one of three treatment levels: individual therapy, group therapy, and dyadic therapy. Participant selection can be further identified for either child or adult therapy. Additional variations of combinations of these groupings can also be considered, for example, individual-adult therapy, or child-group therapy. When the processes and outcome measures of psychotherapy are further defined by these treatment offerings, the findings can become exceedingly more difficult to discern. Other variations of process outcome evaluations have included, for example, studies on marital and family therapy (Alexander, Holtzworth-Munroe, & Jameson, 1994) and the defensiveness styles of marital therapist's (Waldron, Turner, Barton, Alexander, & Cline, 1997), relationships between parents and adolescents (Noller, 1994), the development domestic violence for mediation protocols (Landau, 1995), crisis intervention (Lehmann & Carlson, 1998) (Lehmann & Mathews, 1999), as well as in the brief eclectic (combined cognitive-behavioral and psychodynamic) psychotherapy treatment for police officers with posttraumatic stress disorder (Gersons, Carlier, Lamberts, & van der Kolk, 2000).

In child psychotherapy, process outcome research studies have included group treatment (Alessi & Hearn, 1998) with children in shelters for battered women, intensive individual play therapy with children who witness domestic violence (Kot et al., 1998) and time-limited, individual play therapy with maltreated children (Reams & Friedrich, 1994). The importance of familial characteristics, nature, and level of parental psychopathology and characteristics of relatedness to others (e.g., children, spouse) have also been emphasized (Durlak et al., 1995), and the future status of family-based process and outcome research can be determined by the availability of well-designed studies with diverse populations (Diamond, Serrano, Dickey, & Sonis, 1996, 1998).

Feldman and Powell (1992) additionally identified some of advantages and limitations of individual, family, and group therapy. Some of the notable advantages of individual therapy include its provisions of a valuable context, in-depth assessment, a valuable source of hypotheses about interpersonal problems and strengths, and provide a particularly valuable setting for the establishment of a therapeutic alliance. Limitations of individual therapy exist, however, in its over-reliance on one-to-one relationships, the setting as the sole context for clinical assessment and therapeutic intervention, and the inability to observe the client interact with anyone other than the therapist.

Some of the notable advantages of family therapy (e.g., couples, dyads, and multigenerational families) include its ability to provide a valuable context for observing and assessing interactional problems, opportunities for consensual clarification, as well as sources of hypotheses about individual problems and strengths and intrapsychic problem stimulation and reinforcement processes. Limitations of family therapy conjoint meetings include the potential unwillingness of participating members raise or discuss

issues, observe participants outside the context of the dyad or family, and in its ability to facilitate intrapsychic change processes.

Finally, the advantages of group therapy are similar to family therapy in that it offers a particularly valuable context for assessing interpersonal problems and strengths. Additionally, group experience provides direct and indirect learning through others, provides members with a "normalizing" function for members to perceive commonality in their life experiences, is an empowering experience in that group members serve as change agents and facilitators, and the group setting can offer a safe, contained area in which various feelings, thoughts, and behaviors can be explored and modified. The sharing liberating experiences of group members can make some feel inhibited by the presence of others, and time constraints can limit the amount of time available for each persona and limit the opportunities for in-depth exploration of transference reactions to the therapist. For effective evaluation of groups, Delucia-Waack (1997) suggested that field studies address the following questions: (a) What is to be measured? (b) What instruments are available that measures the construct? (c) Is there reliability and validity information on the measure(s)? (d) For what population has the measure been designed? (e) Has the measure been shown to change over time in a group situation? and (f) When is the appropriate time to give the measure?

In an early study measuring the change processes during group therapy, Watson (1972) used a "modified repertory grid technique," which provides measures on verbal behaviors. Perhaps not too surprising were the results that indicated measurable changes were greater among patients than among the therapists. Later applications of the repertory grid techniques and the findings of Caplan, Rohde, Shapiro, and Watson (1975) indicated that measures of verbal behavior were considered both statistically

significant and psychologically meaningful among eight psychotherapy group members. Perhaps more even interesting, at least from an object relations perspective, was evidence that the interactions of group members closely paralleled the reenactments of earlier patterns of family relationships. For individuals in the group, speaking, being spoken to, and introducing several kinds of topics into the group discussion had significant associations with grid variables implicating self-esteem and patterns of identification with parents. The correlation patterns between the patients themselves, however, varied.

Similar events-based approaches have been proposed for couple and family research. Greenberg, Heatherington, and Friedlander (1996) proposed that goal-setting in couples and family therapy lies not only in the clinician's ability to assess in-session goals or events at any particular moment in treatment, it also requires the clinician's to figure out how those goals will be best achieved. It was suggested that the events-based approach to process research is a way to identify important events that promote change and to study the steps in the process that lead up to that change. In other words, when promoting clinical research involving clinical practice and identification of contextualized it is important to attend to the events and transitional/relational structures or steps of the therapeutic process.

Kazdin and Wassell (2000) investigated the therapeutic changes in children, parents, and functioning of intact families. Outcome was evaluated by measures of changes in children (multiple syndrome domains), parents (symptoms, stress), and family (relationships, functioning, support, marital satisfaction). It was concluded that the benefits of child therapy were significant in all three levels, and that the magnitude of improvement was larger for child outcome measures than for parent and family.

Whether participants are involved in individual, family, or group psychotherapy research, several additional methodological issues arise in that individuals involved in one form of treatment may have been previously involved in some different form of treatment or intervention. Thus, such possibilities may also compromise issues of reliability and validity if the individuals first received one form of treatment, for example, first receiving psychodynamic-interpersonal therapy, and then later receiving cognitive-behavioral treatment (Stiles & Shapiro, 1995b).

From implementation of its principles and treatments to evaluation of its effectiveness, psychotherapy integration on any level will not come easy, if at all. There is yet another evaluative consideration in process outcome psychotherapy research that remains. How much therapy is really enough, and what is the dose-effect relationship? Clinically significant changes in adults were investigated by Kadera, Lambert, and Andrews (1996) using the Outcome Questionnaire (Wells et al., 1996), which assesses client functioning in terms of major psychiatric symptoms, social-role functioning and interpersonal relationships. These results indicated that approximately 25% clients improve after one (1) session, and 50% after eight (8) sessions. Interestingly, in child psychotherapy there appears to be less evidence for the dose-effect relationship (Andrade, Lambert, & Bickman, 2000; Salzer, Bickman, & Lambert, 1999).

In addition, the sense of time or "duration of psychotherapy affects the emergence, intensity, and meaning of all occurrences throughout the psychotherapeutic process (Engelmann, Day, & Durant, 1992, p. 136). Tan (1995) concluded that strongly linked with positive outcomes in psychotherapy are longer treatment duration, the therapeutic bond, and therapeutic realizations. Perhaps no one person is better able to convey meaning to or construe meaning from outcome events than the consumer.

Seligman (1995) cited support for the findings in a *Consumer Report* review. The results from a survey of 2,900 people from various mental health professionals indicated: (a) that patients benefited substantially from psychotherapy; (b) that long-term treatment did considerably better than short-term treatment; and (c) that psychotherapy alone did not differ in effectiveness from medication plus psychotherapy. To derive greater meaning in psychotherapy research findings involves a greater understanding of the interdependent relationship that exists between researcher and theory, as well as the relationship between the practitioner and consumer. In the end, it is the "general-type" approach of psychotherapy research that will provide practitioners with more meaningful insights, but only if the data is more "idiographic" and the information more "context-sensitive" (Safran & Muran, 1994).

Standardization and Integration

Clearly, in psychotherapy research there is much for practitioners to consider in researching and evaluating process-outcome measures. From an insider's view of participant-observer, H. Sullivan asserted that the study psychotherapy is a study of culture and interpersonal relationships involving:

> ...processes that involve or go on between people. The field of [psychotherapy] is the field of interpersonal relations, under any all circumstances in which these relations exist. It was seen that *a personality* that can never be isolated from the complex of interpersonal relations in which the person lives and has his being.... (Ehrenwald, 1991, p. 305)

Similarly, and in contrast to traditional Freudianism, E. Fromm argued that psychotherapy:

> ...is based on the assumption that the key problem of psychology is that of the specific kind of relatedness of the individual toward the world and not that of the satisfaction or frustration of this or that instinctual need per se; furthermore, on the assumption that the relationship between man and society is not a static one. (Ehrenwald, 1991, p. 305)

As evidenced thus far, conducting process outcome psychotherapy research can become exceedingly complex and demanding. Some of the issues researchers have faced included considerations of therapist-client interrelatedness, interrelating treatment processes, and measurement of outcome events. Following their own 'vision' of study, some researchers or practitioners have had to utilize already established and published standardization instruments (e.g., questionnaires, Likert scales) or statistical procedures (e.g., correlational designs, factor analysis) in the evaluation of the results, while others have set out to develop their own measurement tools (e.g., observational coding systems).

The ability to draw quantitative inferences from chiefly qualitative findings presents further challenges to develop a viable means for standardizing, contextualizing, and investigating the efficacy of psychotherapy treatment. The challenge remains for psychotherapeutic research in general to develop its own set of observational paradigms that will identify critical aspects of the treatment process and study them in a systematic manner (Spence, 1994). Treatment standardization in psychotherapy research increases objectivity of the outcome data and of treatment evaluation; standardization of psychotherapy treatment leads to increased critical understanding of the processes through which therapeutic changes occur.

Inherent in every theory we embrace are biases and hypothesized conjectures we deem as important contribution to enhancing our understanding. Consequently, biases sometimes find their way into the research methodology and interpretation of the results. The process of selecting and describing observational measures requires that researchers and practitioners be aware of and carefully consider the way in which variables are identified, labeled, and operationally defined (Sproul, 1988). It is with this

in mind that in every research discipline there are times one "must reevaluate its method for generating and certifying knowledge" (Serlin & Lapsley, 1985, p. 73). Once a particular treatment has been shown to produce therapeutic change, Kazdin (1991) recommended that we dismantle the components of treatment strategies so that the basis for the change can be analyzed. Individual components of a treatment are then eliminated or isolated within the treatment by means of a top-down approach. Research conducted by means of dismantling a therapeutic treatment helps the necessary and sufficient components (variables) of the treatment become more easily identified.

Nevertheless, many of the pitfalls cited here are common to psychotherapy research in general. For the psychotherapy researcher, the challenge rests in the decision-making processes involved in selecting sound methodological designs and procedures. In doing so, inevitably there are many issues for the researcher to consider. In addition to practical considerations of developing sound methodological design (e.g., timelines, economics), there are further considerations of instrumentation, variable selection and isolation, measurement, and data analysis. Deimer, Lobell, Vivino, and Hill (1996), for example, commented on the difficulties they encountered in their attempt to isolate extraneous variables. It was concluded that the "effects of any intervention in therapy" are "cumulative with everything else that occurred with therapy, a criticism that can be leveled at much of the process research in counseling and psychotherapy" (Diemer et al., 1996, pp. 110-111).

No less bounded by client-therapist interpersonal relatedness and interactions (e.g., transference and countertransference) are the processes and variables that are contextually bound within the psychotherapeutic environment. Shoham-Salomon (1990) argued that process variables: (a) have fixed meaning; (b) directly contribute to outcome;

and (c) have a decontextualized *net worth,* evaluated by their correlations with outcomes. Central to the suggestion here is to develop a standardized approach that is a "transactional conception" that sees change processes as mutually defining rather than interacting with each other. The proposal for holistic approach for investigating process variables is one that examines changes of pattern in addition to patterns of change. The transactional model of inquiry into psychotherapy processes serves as a research strategy that can be viewed as both theory-driven and discovery-orientated.

Toward developing a systematic approach for analysis methods, Miles and Huberman (1984) asserted that it is crucial we trust our own personal visions; that creativity remains central in the design of display modes; and, most importantly, that results of both are shared with colleagues. A systematic research inquiry into interpersonal relationships between clients and therapists, for example, could provide practitioners with an essential empirical account of the fundamental theoretical constructs and processes of transference. Similarly, a standardized approach to investigating the cognate set of separation-individuation process variables, as well as the developmental stages hypothesized to occur in childhood development, would most assuredly assist in developing a deeper understanding of child-parent dyadic relationships and of the object relations model.

Other standardized procedures for evaluating therapeutic change processes have been presented in investigations involving family functioning and parent-child relationships. Some of these findings indicated significantly less family dysfunction in the treatment of anxiety disordered children with no significant differences were found between intact and single-parent families (G. Bernstein, Svingen, & Garfinkel, 1990). However, there did appear to be differences in the parents' perceptions of childhood

problems and family dysfunction within these households. Interestingly, on measures using the Family Assessment Measure (FAM), Bernstein and Borchardt (1996) found that mothers of single-parents reported significantly more family problems than mothers living with the children's fathers. Two areas of family problems identified in the single-parent households were role performance and communication. Children in both groups reported normal family functioning on the FAM. Further, the parents' adjustment to family functioning appeared to differ between mothers and fathers. That is, compared with mothers, fathers reported more symptoms of somatization, depression, and phobic anxiety on the Symptom Checklist 90-Revised (SCL-90, Revised).

It is noteworthy, however, that sometimes professional practice and accepted standardization procedures are not always compatible with ethical practice or in the interest of advancing clinical research. For instance, it stands to reason that therapists be cognizant of personal limitations in their knowledge and/or experience and, when necessary, make appropriate referrals. In this way, practitioners are morally and ethically bound to enter into a process of 'hand-picking' clients for their caseload. In scientific research, however, such an exclusive selection process for studying participants would certainly limit the findings and generalizability of outcome studies. Similar ethical dilemmas can be cited when developing standardization procedures for experimental and control groups. Largely, the integrative features offered to both psychotherapy researchers and practitioners will determine the future of clinical research securing a more prominent place in the clinical setting.

Emerging Directions in Psychotherapy Research and Practice

Despite growing recognition or intention to integrate psychotherapy research and practice, the gap between the two, in fact, may be widening (J. Greenberg, 1994).

Mahoney (1991) did not envision of an "imminent development of a 'grand unifying theory' or methodology" toward resolving differences between basic researchers and practitioners (p. 63). He cited that since the 1970s, an increasing proportion of psychologists specializing in therapeutic services have outstripped the decline in the number of psychologists who have chosen careers in research or academia. In 1988, for instance, the majority of the APA members rejected a reorganization plan "designed to heal the schism between clinical and research psychologists (Holden, 1988, p. 1036).

Not all professionals in the psychotherapy field are equally despairing in their views, however. Over the past three decades we have emerged from earlier beliefs that 'research can *not* influence research' and emerged to resolve that 'research can *now* influence practice' (Luborsky, Docherty, Miller, & Barber, 1993) and learned to appreciate the practical implications and potential merits for doing so. It is recommended that all psychologists ensure they are knowledgeable well-grounded in the basic scientific principles of a broad-based interdisciplinary approach (Denmark, 1989; Fox, 1994) in which attention is given to broad-based applications rather than areas of specialization (Matarazzo, 1987). The quest to ensure that acquired learning skills in the education and training process of psychotherapy practitioners (Stein & Lambert, 1995) is no less interdependent than the need to determine treatment efficacy in the process of developing integrative psychotherapy research skills. Employing techniques of both qualitative and quantitative designs, Alter and Evens (1990) provided a guide for novice and seasoned clinical social workers to encourage self-assessment techniques and practice evaluation.

As discussed earlier, functions of the client-therapist relationship and dyadic exchanges that occur within are an exceedingly important component in researching the

dynamics of psychotherapy treatment and in the evaluation of treatment efficacy. At least to some degree, process outcome measures of the therapeutic alliance can be perceived as interdependent on the therapist's training and competency level. Svartberg and Stiles (1992) examined the prediction of client change from initial session ratings of therapist competence and therapist-client complementarity. The specific goals for facilitating a positive therapeutic relationship were suggested as: (a) the relative importance of competence and complementarity in predicting client change from pre- to mid-treatment and from pre- to post-treatment; and (b) the potential for client change could be predicted by interactions between therapist competence and client-therapist complementarity.

The emphasis on and emergence of the interrelatedness of clinical settings are multifaceted and multidimensional. The first consideration is the context of the setting, and the actions and inactions of those within it. Second, there is the diversity of experiences and learning capacities of the individuals engaging in a therapeutic encounter. Third, psychotherapy processes are highly complex, subtle or overt, can vary in intensity, and frequently are unstable or temporal in their occurrences. Fourth, the principles of measurement in psychotherapy studies are sometimes elusive or too idealistic. Fifth, measures of identifiable outcome data are routinely confounded by interactions of other intervening variables. Sixth, psychotherapy integration involves the challenge of effectively bridging diverse disciplines and treatment modalities. Lastly, concurrence of working alliance between researchers and practitioners is no less a consideration in psychotherapy integration than is the therapeutic relationship itself which is established between clients and therapists.

Investigation into the aforementioned emergent goals of psychotherapy integration could conceivably facilitate more clinically meaningful outcome data and more enriching information on the processes of psychotherapy research. For some, however, this may mean the development of a new approach and a new working model. The methodological issues in measuring therapeutic processes and defining clinical meaningfulness are multipart: types of process measures, their psychometric properties, the implications of decisions regarding when and how to assess process, tips for using nonparticipant judges, and issues in data collection (Lambert & Hill, 1994). Child therapists, for example, "need to be more creative in developing comprehensive treatment plans that integrate the realities of a child's life" and they "must be more open-minded as new information about human development, genetics, and psychopharmacology indicates a multifactorial basis for psychopathology (Jellinek, 1992, p. 220).

In a commentary, Howard, Orlinsky, and Lueger (1994) provided a summary of the essential features for new clinical research models of individual psychotherapy and methodological designs. It was emphasized that new psychotherapy models include generalizability as well as constructive replication of findings. They recommended that future psychotherapy research utilize quasi-experimental, case-study designs that use continuous assessment and objective data, provide a model of problem stability, include diversity and heterogeneity of samples, and provide clear evidence of an effect that can be measured for magnitude and treatment applicability.

For psychotherapy researchers and practitioners alike, within the growing interests in process research belies the particular challenges, complexities, and demands for more rigorous outcome research. The diversity of the topic becomes increasingly

complicated by the variety of different scales used, the theoretical constructs investigated, the investigation of single versus multiple process variables, and the relative lack of replicated studies have made integration of findings exceedingly difficult (Garfield, 1990b). Current trends in psychotherapy outcome research and applied personality and change include measures in depression, anxiety, self-concept, and other general issues (Lambert & Supplee, 1997). Another future direction is on client-centered research and the pressing need to consider and emphasize the client's contribution to treatment outcomes (Iberg, 1990; Lambert, 1986; Sanford, 1990). Marmar (1990) suggested that future directions of psychotherapy process outcome research include greater attention to construct validity measures, the relation of process to phase-specific outcome criteria, and the continuing development of multivariate data analytic strategies to take into account Client X Treatment interactions as well as the sequential dependency of process data. The identification and measurement of process-outcome variables may be bound by the methodological limitations of scientific research in psychotherapy, but the diversity of suggestions for integrating research and practice appear virtually boundless.

Integration versus Eclecticism in Psychotherapy

At least one overriding challenge toward developing a unified psychotherapy model of integration and eclecticism remains in bridging the belief structures of different psychological languages. The development of a 'generic model' of psychotherapy (Orlinsky & Howard, 1986) in itself offers a thought-provoking and eclectic departure from tradition clinical research. If, as Messer (1992) pointed out, the phenomenologist uses terms like "the phenomenal sense of self," the psychoanalyst, "the self-system" or "self-object," and the social learning theorist, "self-efficacy," how are we to understand

each other, and develop a common framework? The prospects for a common, neutral language resides anywhere from abandoning our familiar language commonalities to developing a unified superordinate language system of psychological dictum. Toward developing a unified view of psychotherapy integration and eclecticism:

> ...it would seem that both behavior therapy and psychoanalytic therapy have become more humanistic in outlook, whereas humanistic therapy has deepened and refined its concepts even while remaining basically romantic in both its theory and therapeutic process. ...It appears that humanistic therapists generally have been willing to forego the potential advantages of an integrative vision. They have not compromised on their strong allegiance to the romantic vision but instead have concentrated on developing even further within it. (Messer, 1992, p. 147)

Integration of psychotherapy chiefly involves identifying the commonalities of the change processes, regardless of therapists' differing orientations and eclecticism in the field. As Goldfried, Castonguay, and Safran (1992) argued, it is important that "these commonalities have more of a theoretical and clinical basis that a direct empirical derivation" (p. 599). These points of commonality for psychotherapy were summarized in the following ways: (a) *basic structure of therapy* occurs within a relatively delineated setting, with separate stages or phases; (b) *function of therapy* and the overriding goal should be to decrease demoralization and increase a sense of self-mastery, along with the acquisition of new ways of thinking, feeling, and acting; (c) *nature of therapeutic interaction* involves an interpersonal influence process characterized by the therapist's concerns and involvement, as well as a working alliance based on open communication, shared goals, and agree-upon methods; and (d) *common clinical strategies* should include feedback from the therapist to facilitate and enhance clients' awareness, encourage risk taking, and facilitate ongoing reality testing.

Despite any perceived compatibility between psychotherapy research and eclectic psychotherapeutic practice, there is little evidence that eclectic psychotherapies are

being carefully researched (Lambert, 1992; Norcross, 1990). Goldfried, Castonguay, and Safran (1992) reviewed some of the future directions and core issues in psychotherapy integration. It has been argued that perhaps the greatest task remains in the ambiguity or lack of consensus in defining the "ultimate goal." Toward developing a promising future in the field of psychotherapy, some of the major themes and core issues identified were: (a) integration and/or eclecticism; (b) converging trends within orientations; (c) complementarity among orientations; (d) common factors; and (e) empirical support for the psychotherapies. Recent advances in psychotherapy research design have attempted to integrate identified core issues may provide a transition that will bring psychotherapy closer to becoming a unified paradigm with an acceptable theory of effectiveness (Kopta et al., 1999). Rather than generating new treatment techniques, it has been suggested that eclectic models of child treatment integrate existing forms of family and couples therapies, behavioral interventions, parent guidance, and various types of child psychotherapy to address child-focused problems (Koocher & D'Angelo, 1992).

Integrative Psychotherapy: A Transtheoretical Approach

As we have seen, psychotherapy is more a collection of value systems than scientific statements. The success of integrating psychotherapy research with efficacious psychotherapy treatment and practice belies in the conceptualization, model building, and effective measures of therapeutic processes and outcome data. Rutan and Groves (1992) eloquently provided both a value-based and contextually-driven model for conceptualizing and conducting psychotherapy:

> In our sect, the healing (or soothing, or education) that occurs happens through and by virtue of relationships. This is not to imply that all relationships are healing. There are destructive relationships as well. But certain relationships represent the most powerful healing and maturing agent that we know for psychological pain. (p. 15)

Others have suggested that therapeutic efforts and research goals could be better served if clinicians and researchers were to draw on work in the fields of developmental psychology and developmental psychopathology in child psychotherapy (Cicchetti & Toth, 1992; Durlak et al., 1995; Toth & Cicchetti, 1999) as a way of integrating information about human development (Vernberg, Routh, & Koocher, 1992) by utilizing empirically supported developmental theories (Vernberg, 1998). In other words, an empirical investigation into the transtheoretical lines of a well-grounded theory of human development and the interpersonal processes of human relatedness would serve well as an offering to the scientific literature on both psychotherapy integration and process outcome research.

Intra- and Interpersonal Relatedness of Selfobjects

With both inherited and environmental determinants, individuals are interdependent on and interrelated with their contextualized experiences. The benefits to enhancing interpersonal skills have been studied widely within the conceptual and theoretical frameworks of developmental and stage-theory models. Moreover, the relatedness of individuals to others has been researched in a variety of contexts from traditional object relations investigations on the intrapersonal processes of an infant's attachment to a primary caregiver through to the dyadic interpersonal relatedness of adulthood relationships (Bader & Pearson, 1988) and group processes (Gottman & Levenson, 1992). The basic techniques for facilitating and enhancing relationship skills were presented and largely developed by B. Guerney (1977, 1991, 1988) and Guerney and Maxson (1990) and L. Guerney (1976, 1989).

Providing much of the impetus for investigations on relationship enhancement therapy were the therapeutically favorable conceptualizations of empathy and the

contexts of working alliances. Snyder (1989, 1999) illustrated how the relationship enhancement (RE) model can provide couples with both a structure and a method for deepening understanding of both self and other. Accordingly, the power of "shared subjectivity" is based on an integration of Rogers's therapeutic constructs of unconditional positive regard and the active use of empathy in congruence with Gregory Bateson's systems constructs in which "self" is defined, experienced, and evolved in relationship to others and to the world. The role of emotional (B. G. Guerney, 1994), empathic and expresser skills of the RE model serve to enhance autonomy (awareness of the as the agent of his or her own existence) simultaneously with interpersonal relatedness. It places high value on each person's separate experience of experience, and it supplies the essential structure and tools for mutual respect of that separating experience. Snyder (1993) also illustrated how the principles of the RE model could be modified and organized around time-limited constraints and implemented in brief couples and family therapy.

The effectiveness of the RE model has been shown to be superior to the non-RE or other therapist's preferred therapies (E. R. Ross, Baker, & Guerney, 1985). According to Cavado and Guerney (1999), the effectiveness of the RE model is in its set of therapy-driven, powerful and versatile therapeutic tools, identified and described in the following characteristics: expressiveness, empathic, discussion and negotiation, facilitative (coaching), problem or conflict resolution, changing-self, helping others-change, transfer and generalization, and maintenance. Other merits of the RE model are on building relationship skills in families and para-family (e.g., foster parents, step parents) teams (B. G. Guerney & Guerney, 1988) with helping troubled children and youth. In addition to its psychotherapeutic properties, the RE model utilizes a psychoeducational or skills-

training approach to effectively implement the therapeutics of RE, it is suggested that researchers acquire new methods and practitioners acquire new attitudes in working with and empowering family members as therapeutic agents in effecting change within family settings.

The theoretical framework of the RE approach can also be viewed as a model in terms of psychotherapy integration. First, a dyad or family is viewed in terms of a "system." Second, each member within the system develops behaviors that take into account the thoughts, attitudes and feelings of other(s). Third, each anticipates tangible antecedents and psychological rewards and punishments as likely consequences of behavior. Fourth, concepts of self and of other(s) are based in large measure on the history of interactions. Finally, significant changes in the behavior patterns of one member are very likely to affect other(s) both psychologically and emotionally.

Interestingly, the RE model also borrows from and integrates many aspects from various theoretical orientations. A brief description of these features is provided and summarized below:

IDEAS INCORPORATED	***IDEAS REJECTED***
1. Classical behaviorist theories (Thorndike/Skinner)	
▪ Reward and reinforcement are major determinants of interpersonal behavior	▪ All that is necessary to understand and change interpersonal behavior is to analyze stimulus/response relationships
2. Social learning theory (Dollard and Miller)	
▪ Fears associated with repressed thoughts and feelings can be "deconditioned" through unconditional acceptance and social support	▪ _____
3. Interpersonal theory (Sullivan/Fromm)	
▪ Avoidance of anxiety is a major factor in determining interpersonal behavior ▪ "Personality" is best understood in terms of interpersonal relationships; interpersonal relationships shape personality and personality shapes interpersonal relationships ▪ We, in effect, *train* others to treat us in a certain way while others, in turn, train us to treat them in a certain way	▪ Anxiety is the only or the *root* cause of interpersonal behavior or pathology

4. Personality theory (Adler)	
▪ People are primarily goal-directed, future anticipating beings	▪ _____
5. Psychoanalytic theory (Freud)	
▪ Making the unconscious conscious is often an important factor in producing positive change ▪ People are often strongly motivated to keep certain thoughts and feelings out of awareness ▪ Certain preconditions must be met before these are admitted to oneself and still other conditions must be met before admitted to others ▪ Emotional catharsis can sometimes be a positive force in promoting self-awareness and positive change ▪ The desire to express repressed thoughts and feelings persists for long periods of time	▪ Probing, directives, suggestions, advice, interpretations are a useful way to help the client make the unconscious conscious
6. Person-centered psychology (Rogers)	
▪ The best way to help people is to bring to their awareness what has been previously blocked, to overcome defensiveness, and to bring about positive change is to provide a warm, empathic, and accepting (loving) environment ▪ Threats to self-concept are the most important generators of reality distorting defense mechanisms ▪ The desire to express repressed thoughts and feelings persists for long periods of time	▪ Growth that takes place in an atmosphere of acceptance results from a mysterious drive toward self-fulfillment

In addition, many others have cited the therapeutic benefits of targeting treatment in the contexts of relationships, such as family systems and interpersonal relationships between self and other. Stepping just outside the conventional framework of the RE model and into object relations theory, Rankin-Esquer, Burnett, Baucom, and Epstein (1997) found that spouses whose partners encouraged in them both greater autonomy and enhanced relatedness reported higher levels of marital adjustment and relationship satisfaction. It was argued that if partners are unable to encourage autonomy as an expression of their commitment to relatedness, it posed a threat to the relationship. Further, these findings suggested that therapy may function better when conceived as providing a dual focus on both the relationship (interpersonally) and the individuals (intrapersonally) in the relationship. That is, the therapeutic goal of increasing relational closeness may benefit and be better served from simultaneously

promoting the personal autonomy and well-being of each individual. The therapeutic features of relationship enhancement can also be considered for a variety of settings or treatment applications such as filial, marital, and family therapies (B. G. Guerney, 1984) and the therapeutic processes driven by a client-centered approach can serve well for improving the interpersonal relationships of children through play (B. G. Guerney, 1988; L. F. Guerney, 1993).

Developmental and Psychotherapy Processes: Selfobjects at Play

Many child psychotherapists have tended to rely heavily on play therapy techniques, which have become an invaluable therapeutic tool in the treatment of children. Understanding that parents too can become valued therapeutic agents in their work with children, Guerney and Guerney (1989) proposed two approaches for improving child-parent relationships: Child Relationship Enhancement Therapy and the Parent Skills Training Program. These models were based on earlier relationship enhancement (RE) programs directed at parents and adolescents, and include many of Axline's (1947, 1964) reflections and pioneering work on child-centered play therapy. In an early study investigating the interpersonal processes between children and parents, Guerney, Coufal, and Vogelsong (1981, 1983) assigned 108 mothers (mean age 40 years) and daughters (mean age 13.4 years), mostly low in educational and socioeconomic status to one of three treatment groups: Parent Adolescent Relationship Enhancement, discussion-oriented treatment, and a control group (no treatment). These results indicated that individuals who received treatment following the relationship enhancement approach improved significantly and reached higher levels than individuals in both other treatment conditions, with those receiving no treatment showing no improvement. Moreover, individuals from both treatment groups improved:

(a) specific communication skills; (b) general communication patterns; and (c) general quality of the relationship. These findings further indicated that the individuals in the relationship enhancement group improved significantly and reached higher levels than those individuals who received traditional discussion-oriented treatment. At least in working with adolescent populations and their parents, it was concluded that the RE model is a superior treatment to other traditional models.

In an empirical investigation of individual child psychotherapy, Rosen, Faust, and Burns (1994) employed Howe and Silvern's (1981) observational research assessment instrument called the Play Therapy Observation Instrument (PTOI). The study involved 14 children ranging in age from four to six years. Approximately half the children received psychodynamic play therapy and the others received client-centered play therapy. The PTOI was used to score the (1-8) videotaped sessions based on 19 items, and the data was reduced to three clusters: emotional discomfort, quality of interaction with the therapist, and beneficial fantasy play. Although no significant differences were obtained between therapeutic approaches, these researchers concluded that the PTOI scales offered clinicians a method of reviewing, tracking and assessing the process and outcome measures of individual child play therapy.

The study of 'Daryl' presented by Childs and Timberlake (1995) provided a case illustration of in-session clinical progress during six months of psychodynamic play therapy. The study was focused on the developmental aspects of abused/neglected children as related to their deficits in processes of separation and individuation. The conceptual framework of their investigation included: (a) two defensive/adaptive coping mechanisms—dissociation and splitting—through which children respond to abuse or neglectful of environments; (b) the developmental deficits of abused/neglected children

as related to failure in separation-individuation; and (c) the treatment stages within the psychodynamic play therapy model with abused/neglected children. Advancing process outcome research for the single case methodological design, these researchers helped chart changes in defenses and developmental themes, identified degrees of goal achievement, and clinically observed treatment stage progression.

Observing in-session measures of change only, Childs and Timberlake (1995) operationalized the independent variable as the number of weekly play therapy sessions and absences for the study period. The dependent variables (DVs) under study were reflected in the in-session clinical social work goals. The DVs were defined as qualitative measures of: (a) *splitting,* dichotomous positive/negative self-images organized in representations of self or identified objects; (b) affective *guarding against dissociation* through use of environmental and object structures to effect containment and avoidance of regression or suppression of reality; and (c) *remediation of developmental failure in separation-individuation* processes of growth and integration of self structure grounded on reality. Reparation of the self was measured through marked "achievement of distinct separateness from and valued connectedness to object and environmental representations" with "levels of achievement depicted qualitatively in narrative descriptive form" (Childs & Timberlake, 1995, p. 299).

Moreover, this single subject experimental design utilized a stage-theory, process approach which explored the clinical issues of play therapy at three levels: Stage I Non-Engagement, Stage II Engagement, and Pattern Search. The dependent variables and therapeutic themes defined by treatment progression were defined as Daryl's ability to: (a) establish and maintain a therapeutic alliance; (b) reprocess and master abuse/neglect trauma and sequelae; (c) demonstrate awareness, understanding, and realistic

representation of self, other, and social environment; and (d) cope with integrated whole self-in-environment. The qualitative analysis involved identifying patterns among the informational units in process recordings were matched with an operational template. Thus, treatment progress was defined as "the degree of congruence between actual and ideal changes in clinical issues and therapeutic themes" (Childs & Timberlake, 1995, p. 301). In this case study on the processes of separation-individuation, Childs and Timberlake (1995) concluded that the "increased sophistication" of both clinical practice and research:

> ...underlines the importance of explanatory theory, theoretically-framed stage models of long term intervention, and multimodal research methodology identifying change targets, understanding the therapeutic change process, documenting change, and assessing the meaning of interim and final therapeutic outcomes. Specifically, the explanatory and change theories provide the basis of setting goals, selecting data to be collected, and drawing the meaning from the findings. The multimodal research method provides a systematic means of generating data and analyzing findings. Ultimately, the findings either ground the theory or point to the need for alternative rival hypotheses to explain the practice phenomena observed. (p. 313)

Even the concepts of selfobject function and empathic attunement were explicated by Gilhotra (1993) in terms of Kohut's theory of human development. Clinical applications of the therapist's empathic understanding of dyadic interactions are the first step in "teaching" them how to accomplish the same process between themselves. In that empathic attunement is synonymous with affective attunement, empathic understanding can be taught by the therapist and learned by the client. It stands to reason, then, that a parent can be effectively "trained" to respond to and resonate with a child's emotional experience and developmental needs. As mentioned earlier, teaching parents to respond empathically and to be empathically attuned to the emotional needs of their children also is the essence of filial therapy techniques.

Other studies have investigated selfobject relational structures (J. Greenberg & Cheselka, 1995) through a temporal course of treatment utilizing time-series designs (Barabash, 1995; Gaston & Marmar, 1989). With parallels drawn from childhood developmental theory (L. J. Kaplan, 1978; Mahler et al., 1975), Bader and Pearson (1988) presented the theoretical constructs in object relations around a framework of a developmental couples therapy model, which provided rich, contextualized qualitative diagnostic criteria for investigating the patterns of relatedness in adults. Founded on well-developed, fundamental developmental theory, perhaps, but Bader and Pearson's couples therapy model was irresolute on empirical data. Barabash (1995) piloted an empirical investigation into the hypothesized constructs of early childhood developmental stages (symbiotic enmeshed, symbiotic hostile-dependent, differentiating, practicing, and rapprochement) and process variables in terms of the developmental relatedness of couples along two dimensions (sense of self, sense of relatedness). The formulated observational measures and outcome data were central to the investigation for which seven positive (A^+ - G^+) and seven negative (A^- - G^-) attributes were ascribed to measure each of the relational dimensions. In short, the study provided an emergent empirical model of selfobject interrelatedness and the key interactional processes that underlie the theoretical constructs of object relations theory.

It is suggested by the present author that the conceptual framework of object relations can provide an empirical vehicle to examine the psychotherapeutic processes of transference, countertransference, and empathy in a child-parent filial model, thus providing an integrative transtheoretical and psychotherapeutic model for working with and treating children and their parents. It is further proposed that the psychotherapeutic processes of such a dynamic child-parent treatment model and the relational structure

and temporal course of nondirective, child-centered filial therapy can be empirically evaluated through a session-by-session observational coding system.

Summary

"Play therapy is a well-thought-out, philosophically conceived, developmentally-based, and research-supported approach to helping children cope with and overcome the problems they experience in the process of living their lives" (Landreth et al., 1996, p. xiii). Others, on the other hand, have argued that as "a serious scientific enterprise, play therapy is still in poor shape" (Hellendoorn et al., 1994, p. 217). Sutton-Smith (1995), a key historical player and an influential figure in contemporary play circles, offered some concluding remarks on the future of play theory and play therapy. He wrote:

> ...if we add from the self theories the somewhat compulsive character of the desire that underlies play and that allies the willful enactment of that desire to the demonstrations of instantiating collective rituals in festivals, and then keep in mind the material dealt with in the section on power, we may say that the self at play either individually or collectively aspires to a ritualistic and timeless involvement in mythic redress for the inadequacies of being unempowered by ultimately of being mortal. And if there is anything adaptive about this, then possibly it is in the increased assurance that life has a currency and future and can be lived. ...just as play has a dialectical relationship with it contexts, so do rhetoric and theory have a dialectical relationship with each other, and up to this point in the twentieth century there has been too much emphasis on theory and insufficient emphasis on context of rhetoric in which that theory was embedded. (pp. 291-292)

From the technical standpoints of conducting psychotherapy research, scientific investigations on highly process-orientated and interrelated events such as play activity and interpersonal processes can pose a host of challenges and considerations for psychotherapy researchers.

In exploring and researching play therapy, Neubauer (1993) discussed the technical considerations under four headings: (a) the role of displacement in play; (b) the participatory role of the therapist in play; (c) play as a preparation for the next step

in development; and (d) play and playfulness in adult analysis. Weisz, Donenberg, Han, and Weiss (1995) performed meta-analyses of laboratory outcome studies and concluded that the results indeed revealed beneficial effects of psychotherapy with children and adolescents. However, when analyses were performed on clinic-based studies the results indicated markedly poorer outcomes than research on therapy studies. The conclusions drawn by the findings suggested a need to bridge the long-standing gap between outcome researchers and clinicians. In doing so, these authors proposed and illustrated: (a) enriching the research data base on treatment effects by practitioners in clinical settings—including private practice and health maintenance organizations; (b) identifying features of research therapy that account for positive outcomes and applying those features to clinical practice; and (c) exporting laboratory tested treatments to clinics and assessing their effects with referred clients. By widely adopting these bridging strategies, real progress might be made toward merging treatment efficacy in clinical and research practice.

Phillips and Landreth (1995, 1998) surveyed over one thousand play therapy professionals and examined their practices and perceptions of play therapy as well as some clinical issues and demographics within this population. These results indicated that practitioners in this field are predominately females by a margin of three to one. Both genders, however, reported successful outcomes in about 80% of the children treated. The characteristics of the children treated by this sample of professionals tended to range in age between three to 11 years with only a slightly higher number of boys than girls who received treatment. Presenting problems of the children cited as most amenable to play therapy treatment included physical/sexual abuse, depression/withdrawal, acting out/impulse control difficulties, and school

adjustment/academic difficulties. Both female and male play therapists reported utilizing eclectic approaches in terms of the specific theories relevant to their practice. In addition, there was consensus reported among play therapists for advanced training in play therapy at a graduate level toward developing some standardizations of clinical practice.

Gladding (1993), however, suggested that there are also several inherent limitations of play therapy. First, with exception to professional journals that focus on children and adolescents, related research has been sparse and not well formulated. Too often, the results and presentation of data are anecdotal records or tend not to be well documented. A second limitation of play therapy is that it may give clients a "false idea" of the therapeutic process thereby diverting their energy away from productive problem solving or personal exploration. A third drawback of play therapy is possible resistance in clients who want immediate results or in older adults even though, increasingly, play is becoming recognized as a therapeutic tool for facilitating understanding and change regardless of any age. Resistance to play therapy may lead to premature termination. Conceivably, play therapy may not be appropriate for any client who mainly wishes to target a specific issue or behavior. Finally, a fourth limitation of play therapy is that it must be closely linked to "process" for it to have therapeutic potency. *Process* implies that both therapists and clients must be active and committed in assessing how certain play procedures currently affect the client's life. Moreover, as Holmes (1997) elucidated, psychotherapy endings can be introduced either "too soon" or "too late" in the course of treatment; accordingly, such clinical decisions also parallels attachment theory. Played out by both the therapist and the client in the transference-countertransference matrix,

attachment-informed approaches to therapeutic endings are often based on distinctions between avoidance and ambivalence.

How play is perceived and delivered appears to be an important factor and determinant to its potential efficacy. In a study that examined the relationship between therapeutic change processes and treatment completion (outcome measures) among children (N = 304; ages 3-13 years) referred for aggressive and antisocial behaviors, Kazdin and Wassel (1998) reported that 40 to 60 percent drop out of treatment prematurely. Not only were children who dropped out less likely to show improvement, these authors noted that outcomes of more severe cases might not have differed whether or not the child completed treatment. Moreover, of those children who showed improvement, they were considered "less deviant and less impaired" at the start of treatment and their parents reported less dysfunction, stress, and fewer barriers to treatment. Of the subset of children who dropped out, however, both parents and therapists rated them as improved while in therapy. It was argued that parents' perceptions of initial relief in "crisis symptoms" might have led to false beliefs that the child's difficulties were resolved.

Kazdin and Wassel (1998) further cautioned clinicians to forewarn parents of the pervasiveness of some types of problems and encourage them to support their children to stay in treatment beyond the initial stage of relief. These findings reaffirm how parental influence and commitment to the therapeutic process are important considerations when delivering treatment. In other words, whether parents are active participants of their child's treatment (e.g., filial therapy) or not, therapists must still work toward building an alliance with parents if children are to receive optimal benefits from any form of psychotherapy.

Certain limitations notwithstanding, there is increasing interest in play therapy and usage of play tools in the treatment of children increases the responsibility and accountability of the all involved helping professionals. The demands of the judicial courts, for instance, are increasingly turning to the opinions of mental health professionals to address child sexual abuse allegations, investigations, and testimonies. Often confronted by misinterpreted or a lack of tangible evidence, there is increasing reliance within the courts on and interpretation of the child's use of play tools. While art therapy is effective in working with sexual abuse survivors (Brooke, 1995), Cohen-Liebman (1995) illustrated the complexities involved in using children's drawings as judiciary aids in child sexual abuse litigation. Suggesting consensus among clinical researchers and practitioners, composite list of 27 graphic indicators were associated with sexual abuse with depictions of genitalia as the most common. The author concluded, "The appearance of several graphic indicators in a drawing in a drawing presents the possibility of abuse and further exploration is advocated" (Cohen-Liebman, 1995, pp. 481-482). While some continue advocated for use of play material (e.g., puppets and dolls) in working with child victims of sexual abuse (Bromfield, 1995), others have questioned why anatomical dolls have been barred from some court proceedings (1992). Such findings underscore the problems associated with of subjective clinical interpretation and judgment. Nevertheless, nondirective play therapy techniques "can provide evidence which meets the current stringent requirements of the courts, and it a fruitful and accurate source of information concerning the child's wishes and feelings" (Ryan & Wilson, 1995, pp. 171-172).

In an expansive review of the current state of play psychotherapy research, Russ (1995) provided some recommendations for its future directions. First, specific-

processes research on play and cognitive/affective processes are suggested through continued research on traditional play in child development. Second, focused-play intervention research is needed to develop a body of studies that focus on different aspects of play intervention. Play researchers should focus on: (a) specific play interventions with specific populations and specific situations; (b) refining specific play techniques; and (c) research with play intervention modules that focus interventions for different populations. For example, children experiencing domestic violence could benefit from an intensive (e.g., daily) play therapy while residing in family violence prevention shelters that specifically focuses on serving battered women and their children. Third, wherever possible, quasi-experimental studies in clinical practice are needed through integrating assessment and evaluation and single-case designs, in spite of the fact that controlled laboratory conditions cannot be achieved. Such seemingly counterintuitive approaches to scientific research was originally presented by Kazdin (Kazdin, 1993a, 1993b) and colleagues (Kazdin, Bass, Ayers, & Rodgers, 1990) in which arguments suggested that the primary goal of clinical research is to isolate variables, the primary goal of clinical practice with children and adolescents is to manage and treat individual cases. In doing so, the emphasis was placed on the importance of methodological procedures to assess ongoing and repeated measures over time, that is, the need for process outcome psychotherapy research. The fourth future direction in play research emphasized the importance of developing a closer relationship between the clinic and the laboratory, with a reciprocal and unified relationship between the clinical case study and the experiment. This is consistent with the call for the need to develop a programmatic series of "interrelated consecutive and simultaneous" (A. O. Ross, 1981) that are both methodologically rigorous and clinically relevant. Finally, research on the

measurement of play requires reliable, valid, and standardized measures of play processes and outcome events. While there are a few instruments currently available, there is a need to develop additional instruments in particular for measuring the different components of play, such as affective processes. For example, the Affect in Play Scale (see S. W. Russ, 1993) was reported to have good interrater reliability, internal consistency, and good stability of scores across different populations, could be used for affective measures of empathic attunement. Another conceivable use for the Affect in Play Scale might include investigations into a child's interpersonal relatedness to others and sense of self-efficacy through techniques of filial therapy. This is also consistent with the concepts raised earlier by Kazdin (1999) on the importance of evaluating the clinical significance of therapeutic change through key measures and innovative ways.

In sum, Russ (1995) suggested the implications of play research for current clinical practice include: (a) building in assessment and evaluation procedures of the play process and the child as much as possible in therapy, for instance, by means of single-case studies in clinical work; (b) decide beforehand how play will be used and tied to the treatment goals and assessed, for instance, by means of play-assessment instruments or by the observation; and (c) being focused and active in an inherently active, process-orientated treatment modality. "As we develop a more solid empirical base for the importance of play in child development, we need to think broadly and flexibly about how play interventions can be carried out" (S. Russ, 1995, p. 387).

CHAPTER III – METHODOLOGY

Restatement of the Research Questions

To reiterate, the research questions for the present study were stated as follows:

1. *Does intensive filial therapy provide therapeutic efficacy and enhancement of strengthening child-parent relationships for victims living in a domestic violence shelter?*
2. *Do the interpersonal processes of child-parent enactments parallel the theoretical and clinical foundations of object relations and developmental stage theories of childhood and adulthood interpersonal relationships?*

Childhood Development into Adulthood Relationships

Healthy interpersonal relationships, from any perspective, can be encouraged through fostering in each individual personal growth and developmental maturity. However, while one individual could be assessed to be within one particular developmental stage, it may that another individual has developmentally progressed at a different pace from others. That is, each individual within a dyadic relationship potentially may coexist and be within differing developmental stages. In adulthood development, for instance, Bader and Pearson (1988) posited a theoretical model to illustrate how each individual in an interpersonal relationship can coexist at different developmental stages. Accordingly, if one individual is diagnosed within the symbiotic stage, or in the first developmental stage of couplehood, then the other individual can conceivably be diagnosed as being within the differentiating (second) stage or practicing (third) stage. Cited as the most common relationship diagnostic types were the following: symbiotic-symbiotic (enmeshed or hostile/dependent), symbiotic-

differentiating, differentiating-differentiating, symbiotic-practicing, practicing-practicing, and practicing-rapprochement.

Interestingly, Bader and Pearson (1988) reported that they had never encountered in clinical practice any adult interpersonal relationship whereby the individuals were diagnosed to be more than two stage-levels apart. For example, while a symbiotic-practicing or differentiating-rapprochement diagnostic relationship is plausible, a symbiotic-rapprochement is not. Reasons for this, they argued, are that relationships cannot endure or withstand the internal and external strife that implicitly exist in interpersonal relationships that more than two stages apart and, normally, the individuals will go their separate ways. In a child-parent dyad in which the individuals are diagnosed more than two stages apart, while not likely to be physically estranged when the child is young, interactions could conceivably be riddled with increasing conflict and stress in later years. If the child were preadolescent or adolescent, for instance, then perhaps the child might test the boundaries of a physical separation (e.g., run away from home) in an effort to exercise individuation and differentiation from the family. The integrative framework of a transtheoretical model of childhood into adulthood, as suggested in the present research study, while speculative, is still in keeping with the fundamental tenants of clinical research based on human development and interpersonal relationships.

An Integrative Framework: A Transtheoretical Developmental Approach

Beginning at birth, infants demonstrate a curious relationship or connection with significant adults, which form an "emotional linkage" in the development of interpersonal relationships and on cultural and sociological aspects (Sullivan, 1947). Play, too, is a developmental process in that it helps "create nuclei for consolidating the

foundation of the mind" (Abrams, 1993, p. 228). Many cogent theoretical models have been based on, were explicated from, and have been integrated with, the works of earlier developmental and object relations researchers. In this section, we were examine the theoretical constructs developed by Margaret Mahler (1952, 1968) and Mahler, Pine, and Bergman (1975) based on their contributions to the psychological birth of the human infant. We were then consider Bader and Pearson's (1983, 1988, 1990) developmental theory of adulthood for comparison and contrast with the theoretical framework of its forerunner in childhood development. In presenting and characterizing these developmental stages, it is hoped that readers will better understand and appreciate the parallels that can be drawn from childhood developmental theory leading to the inception and conceptualization of a child-adult model of filial play therapy.

Theory Relevant to the Developmental Model

The processes of human development and the forces of psychotherapy have long provided a source for scientific inquiry. Many of the psychological theories and investigations of human development have stemmed from developmental psychology and the study of the human infant. One such overriding sister-theory of psychoanalysis and developmental psychology is that of object relations theory. In object relations theory, the conceptual framework for childhood development was pioneered in the mid-century by British scholars such as Melanie Klein (1932/1975, 1975) and Donald Winnicott (1959/1989a, 1968/1989), among numerous others. Whether in familial relationships or in psychotherapeutic relationships, human beings often move through both attachment and separation processes that are a part of relationships with transitional objects through which, in turn, successful resolution of conflict between these can lead to personal change, growth, and maturation (Greben, 1988). Some of the

early research on object relations was eventually extended to include parent-infant (Ginsberg, 1989; B. G. Guerney, 1964; D. W. Winnicott, 1960, 1961/1989) and familial (Norris-Shortle, Colletta, Cohen, & McCombs, 1995; D. E. Scharff, 1989; D. W. Winnicott, 1964) relationships. The self is extremely important in psychiatry and in everyday life, and through mastery of personal awareness; the self can facilitate or restrict growth. In interpersonal relations, it is in the learning of these processes that the self is evolved through the instrumentality of anxiety and in the interest of power (Sullivan, 1947).

In North America, Margaret Mahler (1968; Mahler et al., 1975) helped pioneer and advance object relations theory and developments in the field of mother-infant interactions. She and her colleagues proposed an integrated theory of childhood development marked by transitional stages of separation and individuation. More recently, Bader and Pearson (1983, 1988, 1990) proposed a similar developmental stage-theory model for interpreting and investigating couplehood relationships and other adulthood interpersonal relationship formations. Psychodynamic inquiry has done much to contribute to the generalizations of object relations theory itself, but since its inception, many of the core building blocks supporting the fabric of many of its theoretical constructs have chiefly eluded the rigors of empirical investigation.

Developmental Stages of Childhood

Widely acknowledged for her work as a scientist, a psychoanalyst, and a psychoeducational teacher, Mahler's contributions on child psychotherapy have indeed inspired a great many. Nowhere has her work been more recognized than in the area of early childhood psychopathology. From an object relations viewpoint, Mahler (1968) postulated that the child's relationship with his or her parents—the first primary objects

in the child's life—plays a significant role in psychopathology (e.g., depression). An individual's inability to learn to cope psychologically, for example, in the case of clinical depression, may be the result from early developmental failures such as nature or nurturing. Mahler's research showed that a child's absolute emotional and developmental dependence on parents affects his or her psychological capacity to mourn and grieve and recover and, therefore, invariably affects the child's self-esteem and sense of helplessness (Mollica, 1989).

Mahler's (1952) early clinical work on autistic and symbiotic infantile psychosis was impelled by her recognition that psychosis was not confined to adults alone. She believed that the survival instincts of newborns are underdeveloped and unreliable. Further, the neonate is "an almost purely biological organism with instinctual responses to stimuli not on a cortical level essentially on a reflex and thalamic level" (Mahler, 1952, p. 286). Because the somatic corollary of ego development is the central nervous system and is in a very immature or rudimentary state at birth, Mahler argued that the undifferentiated ego has to take over the role of adaptation to reality that the id neglects. Critical during this "undifferentiated phase" of development is the psychobiological rapport between nursing mother and baby. Vitally essential to the young infant's survival is the mother's important ministrations (intrauterine process); during the postnatal period, this "parasite-host" relationship must be replaced in the mother's nursing care (extrauterine matrix) to form a kind of *social symbiosis*.

Through direct observation and research on mothers and infants, Mahler delineated the separation-individuation subphases of child development. According to Mahler, the separation-individuation processes in childhood development and its resolve profoundly impacts on adult personality, psychopathology, and implications for an

analytic treatment process. Mahler's childhood developmental process commences with *symbiosis*. At the peak of the symbiotic stage begins the separation-individuation process. Gradually, the infant turned toddler moves from need-satisfaction relating to object relationships. Mahler, Pine, and Bergman (1975) postulated that the psychological birth of the human infant (separation-individuation process) resides in a set of developmental concepts, which run from about four to five (4-5) months until thirty to about thirty-six (30-36) months. In the separation-individuation process, the child establishes a sense of separation from and relation to the world of reality outside his or her own self. The core of the process consists of securing a sense of separateness of one's own body from the external world as that world is experienced through the infant's experience with its representative, that is, the "mothering" one who serves as the infant's primary love object. Once movement toward symbiosis has begun and the separation-individuation process has crested, it can be further distinguished by the following four subphases: differentiation, practicing, rapprochement, and constancy.

Autistic stage

Prelude to the symbiosis process is normal autism, which takes place from birth to about two (0-2) months. It consists of an objectless phase in which the infant is not aware there is a mothering agent. Satisfaction of the infant's needs is primarily experienced as coming from within his or her own orbit. This early life phase is the first beginning of the symbiotic relationship, which is marked by primary narcissism in the infant. Using predominantly somatopsychic mechanisms, the challenge for the child in this phase is to maintain homeostatic equilibrium outside the womb. Because there exists already a stimulus barrier, the child responds almost totally to internal needs and the infant's physiology is consumed by sleeplike periods of arousal.

Symbiosis

Symbiosis occurs between the ages of three to six (3-6) months. During this phase, the child is described as experiencing a state of undifferentiation. That is, the 'I' is not yet differentiated from the 'not-I', but gradually the inside and outside perspectives are sensed as being different. Accordingly, symbiosis forms the foundation for emotional attachment and relationship. This stage was described as:

> The normal symbiotic phase marks the all-important phylogenic capacity of the human being to invest the mother with a vague dual unity that forms the primal soil from which all subsequent human relations form. (Mahler et al., 1975, p. 48)

The symbiotic infant is in a psychological symbiosis in which he or she dimly perceives that satisfaction of needs comes from a need-satisfying object (the mothering one). Objects are perceived as part-objects, sources of satisfactions, rather than as whole objects (whole persons) (Nichols, 1988). According to Mahler (1968), only when the infant is able to wait for and confidently expect satisfaction is it possible to speak of the beginning of an ego, and of a symbiotic object as well. Gradually, then, learning by conditioning is replaced by learning through experience.

Optimal human symbiosis makes up the vicissitudes for a healthy separation-individuation process (Mahler, 1968). The developmental progression in children's affect, both pleasurable and unpleasurable becomes increasingly differentiated and focalized while the diffuse infant-mother body boundaries give way to awareness and separateness (Pine, 1971). This period of focal separation is inherently an unstable one; stability is achieved when a reliable and remembered object relationship serves to replace the earlier symbiosis and to fill the gap of the separateness felt by the child between himself or herself and the mother.

Differentiating

In the first subphase of childhood development, *differentiation* occurs between six to nine (6-9) months. It is signified by a shift in the child's perception of the self toward the external world, and there is an acknowledgement in the child of the separate existence of another person. The child learns to define his or her own boundaries with an increased awareness of fingers, toes, arms and legs. It is in this stage that the child pulls away from the mother and begins to differentiate the primitive self-image from the wider, outside or external world. The differentiation stage is marked by the infant's "hatching" from a common symbiotic orbit that he or she shares with the mothering one (Nichols, 1988).

Practicing

In the second subphase of the child's development, *practicing* occurs between ten to sixteen (10-16) months. Crawling or walking has characteristically begun when the child reaches the practicing stage. Excited by his or her own newly developed abilities and with the capacity to do things away from mother, the child begins to escape the still-existing symbiotic bond or attachment. Still absorbed in his or her own narcissistic pleasures, the infant begins to busily explore the world around. Thus, the child becomes increasingly aware of his or her separateness from the mothering one, and the need for acceptance and renewed participation in his or her own life. The practicing stage is marked by the extensive emotional "refueling" actions of the developing infant (Nichols, 1988).

Rapprochement

Rapprochement occurs in the third subphase of childhood development, when the child is between seventeen to thirty-five (17-35) months. This stage is usually the

most difficult for the child. Excitement diminishes and an emotional attachment to the mother redevelops, but the child is confused between the wants and needs of having mother emotionally available. The mother often finds this a difficult time, as well. Noticing the state of her child's confusion, she too struggles between wanting to nurture by drawing in the child or to encourage individuality in her child by withdrawing. Unsuccessful completion of the rapprochement phase is at the core of borderline pathology. Leading to this course of development are two opposed outcome patterns. The first pattern is characterized by complete withdrawal from the mother at the times that the child is moving away. The second pattern occurs when the child needs or simply wants emotional availability from mother, and the mother reciprocates "smotheringly." Thus, the child is rejected for independence and associates autonomy with abandonment. It is therefore most important during this phase that the mother be emotionally congruent and emotionally available with the child wants and needs, otherwise the child may drain developmental energy in trying to make her always available.

This stage is typically described as a time of "rapprochement crisis" (Nichols, 1988). Increasingly, the infant is aware that he or she is physically separate from others and that the love objects (mother and now father) are separate individuals. Renewed approach behavior on the part of the toddler toward the love objects is very significant in laying the foundations for subsequent mental health or psychopathology. The toddler avoids intimate bodily contact and engages in "shadowing and darting away patterns" (Nichols, 1988, p. 61). Danger signals here are significant increases in separation anxiety. The kind of acceptance or rejection, availability or nonavailability of predictable and

benign love objects establishes patterns of trust and feelings of reliability, or feelings that love objects are not reliable and trustworthy.

Constancy

Finally, the fourth subphase occurs when the child turns approximately thirty-six (36) months. If successful completion of the rapprochement stage has been achieved, then *constancy* has been attained. Constancy was well described by Kaplan (1978) as:

> ...the enduring inner conviction of being me and nobody else. When constancy prevails, we are able to respect and value the separateness of others. We go on loving them even when they cannot fill us up with a perfect harmony of unconditional love. Through constancy, the perfect is united with the real. Every move into separate selfhood from birth to three years makes a distinctive contribution to constancy and brings with it new potential of love and hate, mastery and fear, trust and suspicion, elation and disappointment. (p. 35)

The formation of mental representations of the mothering one that are physically available to the toddler makes constancy possible. Given such mental representations, the child becomes able to stay away from the mothering one for longer periods of time and still remain able to function independently (Nichols, 1988). Accordingly, then, successful consolidation and completion of each of these developmental phases during our formative years were determine the healthiness of our future conception of self and our relation to others. The theory on childhood development born out of Mahler et al. (1975) befalls an innovative theoretical framework that closely parallels the interpersonal relationship patterns found in adulthood development.

Developmental Stages of Adulthood

Based on the developmental stages of childhood outlined by Mahler, Pine, and Bergman (1975) and Kaplan (1978), Bader and Pearson (1983) launched their theoretical constructs for the developmental stages of adulthood. Their early groundwork provided conceptual formulations and framework for Bader and Pearson's (1988, 1990) research,

enabling them to provide therapists with the diagnostic tools and interventions in their treatment manual, *In Quest of the Mythical Mate: A Developmental Approach to Diagnosis and Treatment in Couples Therapy*. Accordingly, the developmental stages of couplehood discussed here are: symbiosis (enmeshed and hostile/dependent), differentiating, practicing, rapprochement, and mutual interdependence.

Symbiosis

Bader and Pearson's (1988, 1990) theory on couplehood begins at the second stage of childhood development, that is, *symbiosis*. Accordingly, the symbiotic relationship is marked by merging lives, personalities, and an intense bonding between two lovers. During this stage of introduction, it is not uncommon for the couple to be amazed at the sameness they share in thoughts, feelings, and behaviors. If both individuals are diagnosed to be in the symbiotic stage of couplehood, then the two types can further distinguish their relationship: *enmeshed* or *hostile/dependent*. In both types of symbiotic relating, the couple's relationship is 'stuck'. It is marked by a source of personal identity loss (either one or both individuals), whereby the relationship is surrounded by feelings of fear or anxiety about the relationship. These individuals are unable or unwilling to manage conflict or disagreement. On the one hand, if the relationship is of the symbiotic-enmeshed type, then it is characterized by a relationship in which there is virtually no conflict, or by conflict-avoidance. In this scenario, the couple goes to great lengths so as not to 'rock the boat,' or, 'burst the other's bubble.' On the other hand, if the symbiotic phase is marked by hostile-dependent behaviors, then a type of love-hate relationship develops whereby the individuals can live neither with nor without the other. Characteristic in the symbiotic-hostile/dependent relationship is

blame in which often one individual tries to change the other to become more like one's self. In this way, one individual's issue thus becomes a conjoint problem.

An adult symbiotic relationship was well described by Nichols (1988). A symbiotic relationship differs from a "host-parasite" form of attachment in that the former is characterized by one individual providing something the other lacks. Accordingly, the kinds of sharing adult individuals seek in their relationship represents a biological-interactional prototype of original mother-child symbiosis. The mother-infant bond functions "as a common psychobiological unit in which the egos of the two are related through highly permeable boundaries" (p. 64). Whereas the child may fantasize about wielding unlimited power over the mother, reality is such that the mother actually possesses the physical and decision-making power. In adulthood symbiosis, on the other hand, when two adults fuse together it is a temporary relationship condition. When things are working well, neither individual is forced into dependency or helplessness. Each meets the other's needs without the autonomy of either person being threatened.

Nichols (1988) further identified two types of symbiotic relating: (a) the *character object relationship*, and (b) the *symptom object relationship*. The former not only consists of total involvement between the individuals, but it is necessary for the stability of the relationship. The latter consists of only partial involvement whereby, in an effort to maintain their own psychic stability, the individuals form attachments to certain facets of the other's personality. For example, an individual can experience a fear of deep intimacy when attracted to the other's strength, while simultaneously being fearful of getting too close; hence, the individual acts clingingly while remaining emotionally withdrawn toward the individual.

Differentiation

Bader and Pearson's (1988, 1990) second stage of adulthood development is called *differentiation*. In the differentiation phase, at least one or both of the individuals begins to view their relationship more objectively. At this point, the blended relationship becomes one of individual differentiation. Thus, much to the dismay of the undifferentiated individual, at least one of the individuals begins to challenge former boundaries of the relationship as he or she becomes increasingly aware of different or changing personal feelings. Differentiating individuals begin to sense their individuality and that they are unique from their partner. Many couples may find the differentiating stage very unsettling because it marks the possibility that their relationship could end dramatically and abruptly. However, if the differentiation process is approached with care, the individuals can gradually begin to make mental comparisons about their individual differences as well as their similarities, even before these are verbalized. The ability for one or both individuals to differentiate from the other allows for movement to the next stage of relatedness.

Practicing

The third phase of adulthood is the *practicing* stage. No longer "empathically attuned" to each other, here the individuals become clearly self-centered, and issues of autonomy and individuation are primary. Of central importance is the individuals' feeling of self-efficacy, self-esteem, and individual power, as individuals place emphasis on developing the self rather than developing the relationship. As the individuals strive toward feelings of independence, one or both individuals may choose to participate in separate activities outside the relationship. Individuals may engage in separate activities such as sports, increased time with individual friends, and putting in long hours at work.

As conflict intensifies, there is an increasing need for the couple to maintain a healthy process for conflict resolution in order to facilitate their emotional connectedness while developing their own self.

Rapprochement

The fourth stage of development in an adult's interpersonal relationship is *rapprochement*. Though vulnerability reemerges in each individual, he or she is more assured about his or her own individuality. The rapprochement stage is similar to earlier stages when individuals seek comfort and assurance in each other, but feelings of anxiety are more relaxed and issues more quickly resolved through alternating periods of increased intimacy and reestablished independence. Both have a clearer understanding about what it means to be engulfed in the earlier symbiosis, and feel less afraid by its threat. Bader and Pearson (1988) summed up the rapprochement relationship as individuals "having developed a clear sense of identity" and "the sensitive balance between 'me' and 'we' have become more firmly established" as a result of "greater resolution of childhood issues interfering with successful coupling" (p. 11).

Mutual interdependence

In the fifth and final phase of couplehood development, *mutual interdependence* can be attained through constancy. Through the encouragement of external contacts and extra-curricular activities, the individuals experience both individual and mutual growth. This helps create a deeper bond in the relationship that is further strengthened by the assurance in knowing that one mate is loved by the other. In contrast to earlier stages, the rapprochement phase is marked by an increased awareness in the couple whereby the perfect is reconciled with the real. For adults successful in attaining a relationship of mutual interdependence, it is characterized by "two well-integrated individuals who have

found satisfaction in their own lives, have developed a bond that is deep and mutually satisfying, and have built a relationship based on a foundation of growth rather than one of need" (Bader & Pearson, 1988, p. 12).

Interactional Patterns of Play

The dyadic interpersonal processes of humans can also be observed in therapeutic settings. Based on the observations of various interactional play patterns, Lubimiv (1994) developed a systematized model for conceptualizing and reviewing the interactional stances that take place between children and therapists. During the initial stages of therapy, for instance, children typically react differently to the therapist and play themes when contrasted with the end of therapy. Based on observations of these child-therapist interpersonal transactions, the author posited a variety of common elements existing on a theoretical continuum. From the possibility of investigating multiple interactional patterns, Lubimiv (1994) limited the model to five core categories: (a) Following/Chasing; (b) Leading/Dragging; (c) Independence/Isolation; (d) Challenging/Hostility; and (e) Mutuality/Enmeshment. These processes of Adaptive/Maladaptive stances were observed through a variety of play mediums, for example, sandplay and puppets.

Lubimiv (1994) further emphasized the importance that assessment of any interactional stance involves observation of several sequences thereby observing consistency of patterns. In the Following/Chasing stance, the child's ability to follow or lead the therapist through play activities is assessed. Following behaviors in this stance include the child being unable to follow or being very anxious and overly ready to please, or being overly concerned about how the therapist may react or feel. Adaptive behavior, on the other hand, would indicate the child's ability to demonstrate appropriate

questioning or asking for clarification of any decisions made during the session. Alternatively, the stance may include the child engaging in absent behaviors. For example, the child does not allow any choices to be made, the child engages in opposite behaviors, or the child gives no responses. Common themes to be observed during this stance include safety/trust, identity, belongingness, and power/control.

In the Leading/Dragging stance, maladaptive identifying behaviors in leading involves the child making choices independently, challenges the interests of other. Adaptive identifying behaviors include the child's ability to move from leadership to another stance easily. Other maladaptive identifying behaviors include the child creating rules or not considering or tolerating the needs of others through "forcing" self-needs, desires and wishes. Absent behaviors involved in this stance include the child's inability to demonstrate any sense of power, or remaining stuck in another stance. In addition to the common elements of power/control and safety observed earlier, this stance also includes themes involving anger, self-esteem, and fear.

Independent/Isolation behaviors to be identified involve assessing the child's ability to play without others, to acknowledge separations, and to reengage easily. Behaviors of isolation includes the child's inability to play or interact with others, or constant attempts to exclude others from his or her play. In the absence form of the stance the child is unable to play alone. Common elements of this interactional stance include issues of safety/trust, belongingness and fear, as well as enmeshment and relationships.

The identified behaviors of the Challenging/Hostility stance include the child's ability to appropriately compete or disagree with others, and appropriately express anger or disappointment. Maladaptive, hostile behaviors, may include the child engaging in

frequent patterns of conflicts exhibited by, for instance, setting up situations to "win." The child's response to conflict is usually expressed with inappropriate amounts of affect (e.g., anger) in which the he or she may break toys or hurt others. Absent behaviors of the child may include having difficulty winning, attempting to please or nurture others, or refusing to challenge and becoming anxious if a situation arises. Safety/trust, fear, power/control, and belongingness, as well as self-esteem, anger and hurt are common themes presented during this stance.

Finally, adaptive behaviors in the Mutuality/Enmeshment stance include the child's ability to play or interact with others as equals, initiate conversation, and identify and accept others for their differences. On the other hand, maladaptive identifying behaviors include the child perceiving others as an extension of self, taking on the characteristic traits of others, or having difficulty separating from others or a favorite play activity. Absent behaviors identified include the child's inability to interact with others as a "friend," or the child may perceive other or toys (e.g., puppets) as threats. Common themes observed in this stance include identity, self-esteem, power/control, and safety.

Summary

The investigative models and theoretical frameworks above were presented to provide an enhanced understanding of the integrative features for the present research design and methodological procedures. Common themes reviewed in the preceding section included an object relations theoretical framework, developmental processes and stage-theory, self other interpersonal relations of children and adults, as well as an observational account of the common themes involved in the interactional stances of

play therapy. A synthesis of these scientific efforts will provide the cornerstone for the present research study and its methodological design.

Research Design

The research design and methodological procedures are represented in this section. Several of the principle mechanisms to conduct the research and delivery of the present research study include a discussion on the methodological rationale and representation, methodological implementation (e.g., study setting, characteristics of study population, sampling design and procedures, and the calendar of events), use of standardized and nonstandardized instruments and tools for measuring variables, as well as treatment and treatment implementation.

Methodological Rationale and Representation

The Guerneys and others (B. G. Guerney, 1977, 1984, 1991, 1994; B. G. Guerney et al., 1981, 1983; B. G. Guerney & Maxson, 1990; L. F. Guerney, Stover, & Demeritt, 1968) have provided some of the most ardent research investigating the processes and treatment of interpersonal relationships. These clinical researchers have suggested that "improved" interpersonal relationships can be conceived of and investigated empirically through evaluating low to high levels of empathy. However, several years ago B. Guerney (1968) recognized that empathic interpersonal relationships are ultimately a value judgment and, thus, empirical investigation of empathy through reason or methodological representation will likely never be answered. Nonetheless, it was suggested that society must consider the probable consequences of low and high empathy in interpersonal relationships and that its existence is answerable in terms of one's own values. On investigative matters of empathy and interpersonal relationships, B. Guerney (1977) later wrote:

> Clearly there is immediate and direct value in establishing a more empathic relationship for the many, many people who value truth and compassion, who dislike verbal as well as physical violence, and who dislike deceit and oppression. ...[An] empathic relationship also promotes and helps to sustain other qualities and feelings that many people value highly. These would include the feeling of being secure in a relationship and being relatively free of anxiety due to the fear of loss of love or fear of termination of the relationship. [An] empathic relationship with someone also promotes a feeling of well-being, happiness, and confidence. It seems to raise a person's self-esteem and ego-strength, and to promote confidence in [one's] ability to earn the respect and affection of other people in general. This in turn seems to make it easier for people either to live with, or to overcome, what they may previously have regarded as serious deficiencies in their personal make-up. (p. 15)

More than simply espousing the importance of empathy in interpersonal relationships, Bratton and Landreth (1995) conducted an empirical investigation measuring the effects of a 10-week filial therapy treatment program on single parents. The experimental group of single parents included 20 mothers and two fathers, ranging in ages from 19 to 47 years. The children participating in filial therapy with their respective parents were about equally represented by each gender ranging in ages from three to seven years. Pre- and posttest measures were obtained on the single parents' attitude of acceptance and empathic behavior toward their children. Results of analysis of covariance (ANCOVA) that the experimental group of single parents significantly reduced their level of stress related to parenting, and reported significantly fewer problems with their children's behavior. Moreover, it appears the efficacy of filial therapy can be enlarged to adult behaviors as well. Bavin-Hoffman, Jennings, and Landreth (1996) reported that that married parents who participated in filial therapy with their children significantly improved their communication with their adult partner.

For some, parent-child relationships involve empathic processes and responses that are not unlike the therapeutic processes (e.g., transference, countertransference, empathic attunement) encompassed in bilateral therapist-child interpersonal

relationships (D. E. Scharff, 1989; J. S. Scharff, 1989b) and the quality of the child's affective relationship (Shirk & Saiz, 1992). Other researchers have further reported significant findings on the efficacy of interpersonal parent-child treatment approaches (Funderburk , 1998; Glazer-Waldman , 1992; Landreth & Lobaugh, 1998). From a multicultural perspective, significant findings were also reported on the efficacy of filial therapy techniques in treating Native American (Glover & Landreth, 2000), Chinese (Chau & Landreth, 1997) and Korean (Jang, 2000) families. While most registered play therapists reported multicultural competency in a recent survey, they also recognized that any multicultural training they had received was less than adequate (Ritter & Chang, 2002).

Notwithstanding, play therapy as a viable psychotherapy intervention has not been without its criticism often citing a general lack of empirical research base leading some to question its utility and efficacy. In a recent response to critics of play therapy interventions, however, Ray, Bratton, Rhine, and Jones (2001) conducted a meta-analysis of 94 research studies focusing on play therapy, filial therapy, and combined play and filial therapy techniques. These researchers reported that meta-analysis revealed for both clinical and nonclinical populations a large positive effect on treatment outcomes in children across treatment modality, age, gender, settings, and theoretical schools of thought. In addition, positive play therapy effects for children were found to be greatest when there was parental involvement in the treatment.

In that filial therapy encompasses multifaceted play therapy techniques, an integration of these approaches can facilitate for individuals of all ages creative problem solving techniques as a resource for everyday coping and adjustment. Other researchers have clearly recognized a need for systematic programming integrating laboratory

research on play therapy techniques and interventions. For instance, several clinical researchers have recognized the importance of play in human development (P. Slade, 1995) and have suggested future investigations of play representation (A. Slade & Wolf, 1994) examine the underlying dimensions of attachment in self-object or parent-child relationships (Bergman & Lefcourt, 1994) and symbolic or separation-individuation processes (A. Slade, 1986) which may serve a variety of both adaptive and defensive interpersonal functions. Other researchers have suggested that empirical investigations on play therapy need to include specific populations (S. W. Russ, 1998) and attend to social as well as clinical impact of empirically supported treatments (Kazdin, 1999) developed for children and adolescents (Kazdin & Weisz, 1998). While some researchers purport that in general child psychotherapy research has "sound design features and that outcome research has improved significantly in methodological quality over time (Durlak et al., 1995, p. 147), a review of a 50-year history of child psychotherapy process research (e.g., emotional, interpersonal, language and cognitive processes) concluded that there are major methodological flaws in the literature (Russell & Shirk, 1998). In short, by bridging child, adolescent and adult psychotherapy (Kazdin, 1995) and by drawing on clinical practice for investigating treatment efficacy (e.g., therapeutic outcomes) and clinical processes (e.g., therapeutic change) may reduce the "hiatus" between clinical research and practice and place clinical work on a stronger empirical footing (Kazdin et al., 1990). Moreover, conceptualizing and investigating the therapeutic processes (e.g., resistance of character, transference, affective past) of play "serves both developmental and analytic goals" (Abrams, 1993, p. 221).

Investigations of play therapy from a developmental perspective can further build on the bedrock necessary for strengthening the attachment bond between parent-child

dyads. Since these procedures are always geared to the developmental level of the individuals, both children and adults can saliently and systematically access the modality. Borrowing on the principles of theraplay (Jernberg & Booth, 1999; Koller & Booth, 1997), Kevin O'Connor (1997, 2002a) posited that play therapy, conceptualized from an ecosystemic approach, offers a salient developmental framework that aims to provide therapeutic mediation and intervention from multiple perspectives such as metasystems (e.g., world community, political and culture), other systems (e.g., church, social services, medical, legal and mental health systems), familial systems (e.g., nuclear and extended family), as well as at interactional (e.g., child-parent) and representational (e.g., internal working model of self, internal working model of relationship) levels.

In short, these latter levels of interpersonal relationships denoting child-parent interactions are the primary focus for the present research study. In that parents are naturally trained to regulate the level of arousal in children, children can maximize opportunities for attachment and optimizing their potential for learning. For example, infants are incapable of self-regulation whereby parents must provide basic needs for their children such as choosing foods and clothing. With the developmental progression of older children, parents need to be cognizant of the developmental needs and readiness for responding to and providing developmentally appropriate challenges for their children. For example, the parent teaching and child learning to tie his or her own shoes can strengthen the attachment bond. Introducing developmentally appropriate challenges for children, while increasing some level of arousal, can empower their sense of self and interpersonal relatedness with others. Power struggles, on the other hand, should be avoided at all costs. Thus, implementing parent-training techniques such as those employed in filial therapy in a structured and contained environment can assist

children to experience lower levels of arousal and anxiety. Only then can children begin to learn and entrust that the world is predictable and safe.

Methodological Implementation

The present methodological implementation aims to provide intensive therapeutic services to populations experiencing domestic violence and employed a quasi-experimental research design. Further, the methodological design can be classified as a primary-direct, single-subject research design. Toward that end, a single-case, changing-criterion design was chosen to be implemented in a time-series fashion. Moreover, it is suggested that the research design is quasi-experimental in nature in that it offers both a qualitative and quantitative investigation.

First, the qualitative component involves a consolidation of Lubimiv's (1994) observations on interactional patterns of play and the observational measures and diagnostic criteria of interpersonal relationships provided by Bader and Pearson (1988) in their model on developmental couples therapy. Second, the quantitative component involves the development and implementation of the Developmental Filial Therapy Coding System (DFTCS). The design and development of the DFTCS (see below) involves observation and analysis of parent-child interpersonal processes through the implementation of a quantitative coding system. It was believed that an integration of these two theoretical representations and their constructs can provide a fundamental approach to investigate the therapeutic efficacy and processes of developmental filial therapy.

Location or Setting in Which the Study Takes Place

The present research study took place at the YWCA Sheriff King Family Violence Prevention Centre located in Calgary, Alberta. The reasons for conducting the present

study within a local domestic violence shelter were much more than matters of mere convenience. "Therapy is a process of challenging how things are done" (Fraser, 1995, p. 85). Further, De Maio (1995) pointed to the challenges of breaking multigenerational histories of abuse requires intrafamilial treatment approaches. Moreover, treatment needs to occur within settings that facilitate an understanding in working with multiple embedded systems with a goal to reconnect relatives who have been cut off. To impose a powerful influence in working with children in families at risk therapists need to consider bridging and working within "larger systems as well as within the reunifying family" (Bicknell-Hentges, 1995, p. 330).

Since 1983, mental health professionals at Sheriff King have been providing services to individuals who were experiencing crisis situations involving domestic violence and abuse. The mandate at Sheriff King includes providing women and their children who were experiencing domestic violence a safe and therapeutic residential setting to assist them in enhancing their sense of self and autonomous functioning. Additional services include clinical children's programs, as well as an adjunct men's counselling program to assist males who abuse. An additional aim of the present research study was to enhance the therapeutic services currently offered by Sheriff King.

A further mandate at Sheriff King is to provide the community with services that formidably involve crisis intervention and programming while maintaining a short-term, intensive treatment focus. That is, the average residential stay for any mother and/or her child(ren) is 16 days, while the maximum stay is limited to 21 days. For these reasons it was considered salient that the methodological design and treatment implementation of the present study include an intensive (e.g., daily, or near-daily) treatment model.

The direct clinical services that Sheriff King offers to children involves providing therapeutic services to young persons who witness domestic violence or who themselves have experienced various forms of abuse first hand. In other words, the filial therapy treatment services of the present study were offered as an adjunct to other primary children's clinical programs. The clinical setting for children's services includes the availability of two playrooms complete with an appropriate collection of toys and materials. The design of each playroom includes the availability of an adjacent observation room fitted with a one-way mirror and the equipment necessary for audio- and videotaping the treatment sessions.

General Characteristics of Study Population

The general characteristics of the study population include mothers and their children residing at the YWCA Sheriff King Shelter and Family Violence Prevention Centre. These families had already undergone the structured Sheriff King intake procedures and thus already met the necessary criteria for admission into the shelter. Children selected for participation in the present research study were within the age range of 8 to 11 years; they were represented by both genders. There were no age limitations placed on the characteristics of the mothers selected for participation. In addition, all participants were potentially representative of any ethnicity or cultural background.

Sampling Design and Procedures

As Kazdin (1992) pointed out, clinical research with "clinical populations in applied settings" that "focuses on complex interpersonal variables" often requires "fine-grained analysis of small number of cases" (p. 470). As such, a sample size including a total of four (4) mother-child dyads was considered for participation in the present

research study. Participation in the study was limited by the selection of those who were already residing at Sheriff King during the proposed data collection period. Prior to a formal consideration of their participation, mothers were required to take part in a semi-structured interview to assess their willingness (i.e., informed consent) to participate in the study; as well, any general questions the mother may have about the study were addressed. In addition, should the mother be the primary caregiver of two or more siblings residing at the shelter, and should more than one sibling meet the study characteristics (i.e., age range) for participation, then their mother were encouraged to select only one of her children to participate in the study for purposes of data collection. In other words, it is considered that to have one mother participate with two or more of her children may potentially confound the results, for example, if any one mother had an increased opportunity to practice filial techniques with more than one child. Finally, once a mother has provided written consent to have herself and her child participate in the study, then a meeting was arranged to obtain written consent and verbal assent from the potentially participating child.

To help ensure the relative appropriateness of individuals considered to participate in the present study, consultation also took place with Sheriff King staff to discuss any potentially serious concerns observed in the potential participants. For example, possible exclusion criteria may include language and/or communication difficulties, serious neurological disorder or brain injury, severely impaired cognitive functioning, severe mental illness, current substance abuse, or other safety concerns such as suicide ideation. If for any reason a mother and/or her child was unable (e.g., exit the shelter) or unwilling (e.g., withdraw consent) to continue with their participation in the study, then another mother-child dyad residing at the shelter was considered for

interview and study. Once it was determined that a particular mother-child dyad had met all of the requirements for the participation in the present study and procedures, administration of the intake instruments (i.e., pretest measures) were completed.

Calendar of Events for Carrying Out the Study

The data collection period for the present research study took place during the months of July and August 2002. One particular advantage offered by this calendar of events was that children typically were not attending school during these summer months, which allowed for flexibility and feasibility of the research design involving intensive (i.e., daily) treatment implementation and data collection.

Standardized Instrumentation, Tools for Measuring Variables

The following includes information on the standardized instruments and other published materials for inclusion in the present research study. As much as possible, the standardized procedures of administration, scoring procedures, and interpretation of these results were conducted in strict accordance with any accompanying manuals.

Behavioral Assessment System for Children (BASC)

Originally published in 1992, the Behavioral Assessment System for Children (BASC) was later refined by Reynolds and Kamphaus (1998). The BASC instruments were intended for use with the present research study to obtain both pretest and posttest outcome measures. BASC is an integrated, multidimensional system designed to facilitate the differential diagnosis and classification of a variety of psychosocial (i.e., emotional and behavioral disorders) for preschool children aged two and one-half to five years (P-forms), school-aged children aged six to 11 years (C-forms), or adolescents aged 12 to 18 years (A-forms). Psychosocial measures can be obtained from ratings provided by parents (PRS), teachers (TRS), as well as from self-reported (SRP) measures of

children aged eight to 11 years and adolescents aged 12 to 18 years. The information gathered by administration of these forms is typically used to aid in the design and implementation of individual treatment plans for children. It is suggested, however, that the information provided from analysis based on one component of this system should not provide the sole basis for making important diagnostic or treatment decisions. The scales of the parent (PRS) and the teacher (TRS) forms survey a broad range of behaviors, both positive (adaptive) and negative (clinical) as observed in home, school, and community settings. These authors suggest that the items and constructs being measured on the PRS and TRS are so similar that any wide-ranging and significant discrepancies of their results require careful attention.

The BASC forms can be administered via self-report or interview. Each BASC form consists of several items, ranging from just over 100 items to nearly 200 items. All the three levels of the TRS and PRS items are presented with a Likert-type, 4-point response format: *Never, Sometimes, Often, Almost Always*. The items on both SRP forms have a force-choice response format: *True, False*. The BASC instruments can be scored manually or with the available microcomputer software. Accordingly, interpretation of these scores was as follows: any score within the Clinically Significant range suggests a high level of maladjustment; scores within the At-Risk range identify either a significant problem that has the potential to be severe enough to require formal treatment or indicate a potential of developing a problem that needs careful monitoring.

In part, the characteristics of the sample population considered for the present study were in part determined by the standardization and administration procedures outlined in the BASC test manual. That is, the present study includes the administration of the Parent Rating Scale for Children (PRS-C) which is designed for use with children

aged between six and 11 years, and the Self-Report of Personality for Children (SRP-C) which is designed for children aged eight to 11 years. Thus, given the standardized procedures outlined for the SRP-C protocol, the age characteristics for the children considered for the present study was limited to children eight to 11 years old.

Technical information on the BASC indicates that the general norms are "based on a large national sample that is representative of the general population of U.S. children with regard to sex, race/ethnicity, clinical or special education classification, and for the PRS, parent education" (Reynolds & Kamphaus, 1998, p. 8). These norms have been subdivided by age combining females and males. Clinical norms were established to identify children's problems in comparison to the general youth population. Normative scores are provided in two scales, *T* scores (i.e., indicate the distance of scores from the norm-group mean) and percentile ranks (i.e., indicates the percentage of the norm sample scoring at or below a given raw score).

Reliability measures reflect "the accuracy with which a test can place individuals along some dimension such as a trait or domain of behavior and, thereby, differentiate people from one another" (Reynolds & Kamphaus, 1998, p. 129). Three types of reliability measures were the focus of potential error sources on the BASC instruments. For purposes here, the following discussion reports technical information on the PRS only; readers are encouraged to refer to the BASC technical manual for further information. *Internal consistency* indicates the degree to which the items of a particular scale measure the same domain of behavior. These authors reported internal-consistency reliabilities in the middle .80s to low .90s for all three age levels and for both genders. The consistency of ratings by the same parent over a brief time interval, or *test-retest reliability*, indicate correlations in the upper .80s for the preschool level to the low .90s

for the child level, while the adolescent level was in the low .70s. Interestingly, these authors further observed that "retest reliabilities tend to exceed internal-consistency reliabilities at the preschool and child levels" which "suggests that parents are consistent over time in how they interpret the items, and that children tend to show little change over a one-month period..." (Reynolds & Kamphaus, 1998, p. 131). Interrater correlations were reported to be within the moderate range with values in the high .40s to the high .60s; these authors noted that a mean correlation range of about .60 was also found between parents reported in similar parent rating scales (e.g., Achenbach's CBCL).

Evidence of validity on the PRS was discussed by three types: (a) by scale grouping supported into composites provided by factor analysis; (b) the pattern of correlations of scale and composites with scores obtained on other behavior measures; and (c) profiles of groups of children with particular diagnoses. Using statistical procedures of covariance structure analysis (LISREL VI program), the final structural model for the parent rating scales, child form (PRS-C) identified scales of intercorrelations matrices on three composites or levels of functioning: *Externalizing Problems*, identifying measures involving Conduct Problems, Hyperactivity, and Aggression; *Internalizing Problems,* including problems of Anxiety, Depression, and Somatization; and *Adaptive Functioning,* involving measures of Adaptability, Social Skills, and Leadership. Intercorrelations of other clinical scales (i.e., those not included in any composite) on the PRS-C include Atypicality, Withdrawal, and Attention Problems. The final structural model for the self-report protocol, child form (SRP-C) identified scales of intercorrelations matrices also on three composites, but with slight variations on the levels of functioning: *School Maladjustment*, identifying measures involving Attitude to School and Attitude to Teachers; *Clinical Maladjustment,* including

problems of Atypicality, Locus of Control, Social Stress, and Anxiety; and *Personal Adjustment,* involving measures of Relations with Parents, Interpersonal Relations, Self-Esteem, and Self-Reliance. Intercorrelations of other clinical scales (i.e., those not included in any composite) on the SRP-C include Sense of Inadequacy and Depression.

Three additional indices of validity are provided in scored response sets that may warrant attention in judging the quality of any one completed BASC form. The *F* index included on all of the BASC rating-scales and self-report form is a measure of the respondent's tendency to be excessively negative about the child's behaviors or self-perceptions and emotions. For instance, an inordinate number of low ("Never") or high ("Almost Always") responses on the PRS or force-choice responses ("True" or "False") on the SRP may indicate an *F* index that warrants cautionary interpretation. The *L* index, included on the SRP adolescent form only, measures the individual's tendency to give an extremely positive picture of him- or herself, that is, "faking good." In addition, both the child and the adolescent forms of the SRP includes a *V* index, which is made up of five or six nonsensical or highly implausible statements (e.g., "Superman is a real person") to provide a basic check on the validity scores and thereby the individual's understanding of the responses items in general.

Parent-Child Relationship Inventory (PCRI)

Rather than assess the so-called problem individual or "identified patient" (IP), a unique feature of the Parent-Child Relationship Inventory (PCRI) is its focus on assessing the parents' attitudes toward the role of parenting and toward his or her child(ren). Developed by Gerard (1994), the PCRI is intended for use in the present research study to obtain both pretest and posttest outcome measures of parents' attitudes. As a quantifiable description of the parent-child relationship, the PCRI is

designed to complement other assessment instruments used in clinical evaluations of children and families. "Rather than replacing qualitative evaluation of parent-child interactions, the PCRI helps to put qualitative impressions in perspective by making normative comparisons possible" thereby identifying "specific aspects of the parent-child relationship that may cause problems, as well as giving an overall picture of the quality of the relationship" (Gerard, 1994, p. 1). In that there are no presently available "generally agreed upon standards for evaluating parenting skills" and "the subtle nuances of the parent-child relationship" (Gerard, 1994, p. 17), the PCRI offers a multidimensional, standardized instrument that identifies and quantifies, from the parent's own perspective, specific areas of difficulty arising between parents and children.

PCRI norms were established from parents living in the United States, with cultural sensitivity given to the individuals' ethnicity. Separate norms and rating scales were established for mothers and fathers. The PCRI is a 78-item, self-report questionnaire that has a fourth-grade reading level and can be administered to an individual or in a group setting. All of the items include a Likert-type, 4-point response format: *Strongly Agree, Agree, Disagree, Strongly Disagree.*

Similar to the BASC instruments, items on the PCRI are multidimensional. PCRI results are based on seven content scales that reflect major features of parenting and the parent-child relationship: *Parent Support (SUP), Satisfaction with Parenting (SAT), Involvement (INV), Communication (COM), Limit Setting (LIM), Autonomy (AUT),* and *Role Orientation (ROL).* In addition, the PCRI provides two protocol validity indicators: *Social Desirability (SOC)* and *Inconsistency (INC).* Administration and scoring of the PCRI can be conducted either manually or with a microcomputer. While high scores on

the PCRI scales are intended to reflect good parenting skills, low scores typically indicate areas of difficulty.

Technical information available on the psychometric properties of the PCRI includes two measures of reliability. First, internal consistency procedures involving covariation of the scale items indicated no value below .70, and a median value of .82. Second, indicators of test-retest reliability were based on empirical investigations suggesting that the inventory has good temporal stability with a mean scale autocorrelation between .55 and .81. Three forms of validity were also reported on the PCRI. Content validity was established in a series of factor-analytic studies using a preliminary item set as well as through a panel of experts rating items for their relevance, simplicity, and cultural fairness. Construct validity measures indicated a pattern of moderate intercorrelations among the identified scales and the instrument as a whole. Finally, predictive validity findings suggest good predictive validity with moderate correlations among related measures.

Filial Play Therapy (FPT) Instructional Videotape and Parent Handbook

As mentioned earlier, a key to filial therapy involves employing a psychoeducational component to teach or train parents on the value of basic play therapy skills and to enhance their interpersonal relatedness with their children. In addition to educating mothers about filial therapy techniques and treatment interventions using conventional teaching methods (e.g., verbal instruction, clarification), treatment implementation also involves having the mothers participate in group sessions to review a parent training videotape and to provide parenting support and positive feedback for each other.

A registered play therapist and supervisor with the Association for Play Therapy, registered psychologist, and founding director of the Family Enhancement and Play Therapy Center, Dr. Risë VanFleet brings over 30 years clinical experience specializing in child, family, and play therapy practice. In addition, she offers clinicians in their work with parents some groundbreaking and highly informative training tools. The instructional 4-hour videotape, *Introduction to Filial Play Therapy* (VanFleet, 1999a), is accompanied by a clinician's manual, *Introduction to Filial Therapy: Video Workshop Manual* (VanFleet, 1999b), as well as a parent manual, *A Parent's Handbook of Filial Play Therapy: Building Strong Families with Play* (VanFleet, 2000a). These resources served as the primary psychoeducational materials for teaching and training parents on the basic principles and techniques of play and filial therapy.

Under the supervision and instruction of a qualified clinician, these materials can provide an integrative and highly effective approach to train parents to conduct special child-centered play sessions and to incorporate mutual problem-solving techniques with their own children. The video presents parents and children engaging in wide-ranging child and family problems while presenting effective implementation of therapeutic interventions by utilizing both real-life participant vignettes and therapist-child mock role play examples. Some of the topics covered include an overview and purpose of filial therapy, basic principles of child-centered play therapy, sequencing, goals and observations, toy selection and play setting, process feedback and evaluation, understanding children's play themes, and generalization of techniques.

As indicated below, the schematic outline of the research design suggests review of the filial therapy training videotapes be introduced to the mothers following collection of the two baseline interpersonal unit measures (IUMs) (B1 & B2) and prior to beginning

the first treatment session (T1). Conjointly, the present researcher and each mother separately viewed all three videotapes in one sitting. During and following viewing of the videotapes, each of the participating mothers was given further opportunities to discuss the content and address any questions or concerns. In addition, participating mothers were supplied a copy of the parent handbooks on filial therapy for their future reference.

Observational Considerations to Diagnosis and Treatment

In addition to structured diagnostic tools, *observation* serves as an essential focus of any diagnosis (Bader & Pearson, 1988) and treatment considerations (Kazdin & Wassell, 1998). Sometimes these observations can be made in response to the undirected interactions of the persons, and sometimes in they can be made response to structured interventions. The following offers only a brief acknowledgement to the considerations and the richness of information that can be obtained through observational techniques.

Climate. By focusing on the interaction of the interpersonal relationship, the *climate* within a relationship can be characterized by the following: Is the relationship loving and growth promoting for each individual? Does it exhibit signs of aggression and continual eroding of each any one individual's self-esteem? Is connectedness allowed, or is any depth sacrificed for "looking good?" Does one individual promote growth in the other? Does the relationship require one individual to squelch himself or herself, thus inhibiting individual growth in order to build up the other and ensure the relationship continues (i.e., fear of attachment separation)? Are these individuals trying to find themselves through the other (i.e., loss of individuated self)?

Body Language. The dyad's interactional climate is further revealed in their *body language*. It is important that the therapist closely observe how the dyad interacts as individuals, as a unique entity of an interpersonal relationship, and also how they

interact with the therapist. For example, the absence of eye contact, or minimal eye contact between the individuals, may be an important indicator of symbiosis, as well as of the level of difficulty that might ensue in working with the dyad. That is, the individuals may be operating from an undifferentiated position in which their earlier experiences are projected onto the other. For example, instead of "taking in" here and now cues from seeing what the other individual is saying or doing, the internal past experience dominates. One of the results of minimal eye contact between individuals is that they generally have to guess or invent their own version of how one individual is responding to the other. For instance, one individual may look at the other but continue to talk about him or her in the third person as though talking to the therapist only. Another immediate source of diagnostic data can come from the dyad's body language in their chosen sitting positions or relating positions. For example, if the adult predominately engages with the child in a 'towering position,' then it may be necessary to address these issues as the parent's need to control the situation or be perceived as an authority figure in the relationship.

Elements of body language, such as these, indicate the fluidity of the dyad's boundaries and difficultly for each individual to maintain a sense of self in the face of even a positive emotional exchange with the other. Indeed, there is a range of behaviors that individual's exhibit in their initial session, as they shift from directing their attention to the therapist to attending to the other. It is of critical importance, then, that the therapist be sensitive to multicultural differences of body language. For example, while the majority of North Americans may emphasize the importance of eye contact, First Nations people may downplay its importance or avert their eye contact almost entirely.

Additional behavioral responses can serve as an indication of how fast the dyad's system of interaction is going to be changed and how readily the individuals allow the therapist to exert an influence. For example, if the individual selves are completely unwilling or unable to bestow or receive empathically (i.e., empathic attunement), that is, do not relate or let the other in emotionally in a positive way, then the chances were high that they were not going to let the therapist in emotionally or in a positive way unless it is to create an ally.

Treatment

A filial therapist initially takes an active role in facilitating and implementing treatment. That is, the filial therapist is typically recognized as a principle therapeutic agent in that he or she becomes an active participant in the treatment toward facilitating positive interactions and experiences between the parent and child. In terms of object relations theory, during the early stages of treatment the filial therapist becomes determinedly triangulated in the parent-child relationship. Thus, the therapist's actions and interventions were purposeful so that any potentially negative interpersonal behaviors or affect can be channeled through the therapist. Theoretically, with each progressive treatment session and the therapeutic efficacy of a strengthened relationship, the therapist's participation and interventions become less central as the parent and child each develop skills and positive experiences of self-control and self-mastery. In other words, therapeutic efficacy leads to enhancement in each individual two mutually exclusive developmental paths: developmental sense of self (intrapsychic) and developmental sense of relatedness (interpersonal).

Considered by many a leader for his treatise and techniques in play therapy, Landreth's (1991) landmark book, *Play Therapy: The Art of the Relationship,* also

presents a chapter introducing the techniques of filial therapy. In *Filial Therapy: Strengthening Parent-Child Relationships through Play,* VanFleet (1994) offered practitioners one of the first and primary resources dedicated entirely to practicing filial therapy. To increase the potential for consistency, Landreth (1991) suggested that parent(s) work with only one child during filial training. Moreover, all sessions were to be conducted by the same parent to minimize interference of trust building and the development of themes across sessions. If appropriate, special times (e.g., baking cookies) were suggested to be scheduled for the participating child's siblings. Although some of the specifics have been modified (i.e., duration between each administered session generally suggested for weekly rather than daily or intensive treatment implementation), the clinical knowledge and expertise offered by these two key contributors have been integrated and synthesized to formulate a salient treatment adaptation for the present research study.

In practicing filial therapy, VanFleet (1994) pointed out four important skills that are necessary for parents to learn while conducting these special play sessions. First, to avoid potential problems, it is important that parents understand the *structuring skill* so they can inform their children about the general boundaries and framework of the play sessions. "Children learn through structuring that they will be relatively free to do as they please during the play session, but that their parents have authority if the boundaries are not respected" (VanFleet, 1994, p. 15). In addition, structuring allows children to recognize that the play activity is finite so that they can finish the session in a meaningful way. As noted, it is not unusual for children's play to change rather dramatically in the final few minutes of the session.

A second skill important for parents to learn is *empathic listening*. Training involves helping parents to understand how "this skill will help them show sensitivity and understanding to their children in a way that coveys acceptance of the children's feelings and needs" (VanFleet, 1994, p. 16). Parent education on empathic listening skills involve training parents to convey to their children the ability to provide undivided attention and genuine interest without dominating or leading the interpersonal experience. An example of an empathic listening skill is when a child holds up a drawing and the parent responds, "You're really proud of your drawing." Empathic listening skills (a) demonstrate to the child the parent's interest; (b) allow children to clarify any misunderstandings of intentions or feelings the parent may hold; (c) provide children with labels for their feelings and thus increases their ability to express their emotions in constructive ways; and (d) increases self-esteem in children by helping them to accept themselves when they feel accepted by their parents. In short, parents learn the "importance of identifying and reflecting the child's emotions in a brief, accurate, and natural-sounding manner" (VanFleet, 1994, p. 17).

Child-centered imaginary play is another important skill that teaches parents the value of engaging in play activity with their child in a nondirective manner. In that this skill "teaches parents how to act out various roles that the child might ask them to play" (VanFleet, 1994, p. 17), the child takes on the role of actor-director while the parent adopts the role of participating actor/actress. Accordingly, parent training about child-centered play is twofold: to help parents develop mastery of this skill by becoming more responsive and sensitive to the child's (sometimes obscure) cues and thereby increase their own comfort level while engaging in imaginary play with their child.

The fourth skill identified is possibly the most appreciative component of parent training as well as the most difficult for many parents, and many play therapists, to achieve. "Play therapy is a well-thought-out, philosophically conceived, developmentally based, and research-supported approach to helping children cope with and overcome the problems they experience in the process of living their lives...and the accompanying vital process of limit setting are not based on guessing, trial and error, or the momentary whims of the play therapist" (Landreth, 2002, p. 529).

It is commonly considered that there are two possible parenting approaches or extremes: one involves overly permissive parents who rarely, if ever, set enforceable limits, while the other extreme involves overly controlling or authoritarian parents who do little else other than set limits and enforce loud, harsh, or abusive consequences. "Parents at both ends of this continuum often feel as though their children are the ones in control" (VanFleet, 1994, p. 18). Underlying the *limit-setting* skill is the importance of consistency in order to provide children with boundaries essential to their sense of security. "Children are aware at some level that they are inexperienced and vulnerable, and when they see that they have control over their adult caretakers, their feelings of vulnerability can be increased" (VanFleet, 1994, p. 18). Accordingly, parent training of the limit-setting skill and rationale should focus on the following points (VanFleet, 1994, pp. 18 - 19):

1. Limit setting helps children learn that they are responsible for what happens to them if they choose to break a limit after having been previously warned of the consequences.

2. During play sessions, the parents keep limits to a minimum. This helps children remember them and fosters an atmosphere of freer expression of feelings.

3. When determining limits, it is important for parents to consider whether the limit is necessary for the child's safety, the safety of others, or the protection of valuable toys or property.

4. Limits need to be stated and enforced as consistently as possible so that the children learn that their parents 'mean what they say.' This helps reduce children's testing.

Following administration of each play session, it is generally recommended that the filial therapist discuss these in detail with the parents either individually or in group format. Although they typically take longer and can be more cumbersome logistically, administering the psychoeducational components of filial therapy in a group format can provide additional benefits through parental support, peer interaction, enhanced learning, and cost effectiveness (VanFleet, 1994). For the purposes of the present research study, a parent group format is suggested for the session-by-session psychoeducational delivery of the filial therapy training process. In doing so, parents were allowed to observe their 10-minute IUMs and were provided supportive feedback.

Supervision requires that the filial therapist (and parents when participating in group format) observe several things during the parent-child play sessions. Review of the play sessions includes providing parents with feedback of both effective (i.e., positive) and ineffective (i.e., negative) skills. Although the filial therapist may wish to point out any important themes that emerge in the child's play (e.g., intensity, repetition, rapid transitions), the primary purpose is to focus on the skills employed by the parent in order to facilitate and enhance her or his own skills development. Another unique feature of filial therapy is the opportunity during supervision for the filial therapist to employ and model many of the filial therapy training skills (e.g., empathic listening, positive feedback, avoiding criticism) that have been already delineated to the parents.

Below is a sample of the types of feedback that the filial therapist may observe and discuss with a parent (VanFleet, 1994, p. 32):

Child Behavior	Parent Behavior
Walked around room looking things over.	"You're checking this place out." (Good)
Punched bop bag, several times, harder each time; watched for mom's reaction.	Said nothing. (Discuss parent's feelings; need to listen empathically)
Shot dart gun at light.	"You like shooting that gun." (Good)
Shot gun from farther and farther away.	"You're still shooting." (Maybe, "You're trying to see if you can hit the light from farther away.")
"You can't shoot as good as I can!"	Said nothing. (Discuss possible listening responses: "You like to beat me," or "You're proud of your shooting.")

As noted above, the filial therapist's supervision includes close observation of parents' abilities to employ both effective use of skills and areas that need improvement. In addition, the filial therapist is responsible for guiding the parent-to-parent feedback discussions to ensure they avoid advice giving and criticism. Let us now turn to an overview of the filial therapy training process and filial therapy sessions.

Session 1

Session 1 marks the beginning of treatment and involves personal introductions of the therapist and participating family members. VanFleet (1994) recommended that the initial play session with the parent-child dyad be 20 minutes in duration, and that all subsequent treatment sessions be 30 minutes long. Parents were encouraged to attend to their children's needs and other potential disruptions (e.g., bathroom breaks) prior to beginning any play session. In addition, assurances are provided to the parents that there is really no way to predict how children will react to the initial play session. Upon entering the play room for the first time, VanFleet (1994) suggested that parents be

trained to offer the child the specific comment: "(Child's name), this is a very special room. You can do almost anything you want to do in this playroom. If there is something you cannot do, I'll let you know" (p. 15).

Goals and objectives, explained earlier to parents in separate training sessions, focus primarily on developing interpersonal sensitivity and empathic responsiveness in the parent-child dyad. The therapist, a direct participant in the session, may employ role-playing. In addition, at session end both the parent and child can be instructed on homework assignments, for example, identifying emotions such as anger, happiness, sadness, and surprise. Reflective responses to these feelings can be written down for later review (Landreth, 1991). Parents were additionally trained to provide children with two time warnings as the session end drawn near (VanFleet, 1994). For example, the parent says, "(Child's name), we have 5 more minutes left in the playroom today." At the one-minute interval, the parent tells the child, "(Child's name), we have 1 more minute to play here today." At session end, in a pleasant but firm tone of voice the parent says, "(Child's name), our time is up for today. We have to leave the playroom now." Parents received earlier training for dealing with the resistant child such as empathically reflecting the child's feelings and then restating firmly that the session is over, for example, "I know you're disappointed (Child's name), but we need to leave now." In addition, VanFleet (1994) suggested reminding parents that if they run into trouble during the play session that they always have the option of giving the 5-minute warning to the child early and then ending the session.

It is generally suggested that session cleanup after play therapy sessions is the responsibility of the parent, although children may assist if they choose. Moreover, the parent is responsible for ending the session and for setting the limits imposed are placed

on children to not continue play once time has ended. Thus, it is suggested that the child observes the parent being firm and having the ability to follow through. Parents were encouraged to take notes immediately following play sessions and record developmental themes, their own feelings and behaviors, as well as their perceived feelings and observed behaviors of their children. Parents were also encouraged to seek feedback from other participating parents. Moreover, they were encouraged to tell their children that they were meeting with the filial therapy therapist or other parents to 'learn how to play' with children.

Session 2

Review of homework assignments facilitates a review and elaboration of empathic responses. The therapist may need to demonstrate empathic responding to the participants. For instance, the parent is instructed to take turns being the parent and the child. Enactments may include use of the selected toys. If necessary, the therapist can demonstrate the special use of each toy. It is suggested that selected toys are limited for use in the playroom to enhance and preserve their special nature. This strategy also helps children delay gratification needs and provides parents with opportunities to practice firm and consistent parenting skills. The homework assignment includes a parent-child activity to select a special time (i.e., uninterrupted) and place (i.e., not a child's bedroom) in which they can conjointly put together their own toy kit. The central purpose of the guidelines for this activity is to convey and communicate to the child that he or she is important.

Session 3

The parent is further instructed on play therapy skills. If appropriate, the therapist can demonstrate many of these techniques through role-plays, live

demonstrations, or review of videotapes. Landreth (1991) suggested that the parent-child dyad engage in a specific homework assignment that involves making a sign which hangs on the door during future play therapy sessions, which reads: *Play Session—Do Not Disturb*. It is further suggested that parent training include a review of the following rules (Landreth, 1991, pp. 346 - 347):

Don't

1. Don't criticize any behavior.
2. Don't praise the child.
3. Don't ask leading questions.
4. Don't allow interruptions of the session.
5. Don't offer information or teach.
6. Don't preach.
7. Don't initiate new activities. (These first seven were taken from L. F. Guerney, 1976)
8. Don't be passive or quiet.

Do

1. Do set the stage.
2. Do let the child lead.
3. Do track behavior.
4. Do reflect the child's feelings.
5. Do set limits.
6. Do salute the child's power and effort.
7. Do join in the play as a follower.
8. Do be verbally active.

Session 4

Following the parent-child play therapy session, once again parents were provided support to discuss any feelings they experienced in the play sessions. Areas of difficulty were addressed with the therapist. If appropriate, participating parents may review a videotape of their play sessions with their children to enhance their training skills and enable opportunities for self-insight. The primary role of the therapist is to provide parent supportive feedback to the parents' responses and behaviors while correction and comment about specific training skills were kept to a minimum.

Sessions 5 through 8

These sessions adhere closely to the same general format of earlier sessions. Following treatment sessions, parents were encouraged to discuss their experiences, common problems, and feelings, interspersed with suggestions and instructions from the therapist and other participating parents. Session-end homework assignments included opportunities for parents to write and respond to the happenings of play sessions. Additional opportunities were provided to review play therapy principles through role-playing and skills enhancement. Parents were provided additional support for newly developed skills to enhance their coping skills and sense of personal empowerment. Additional homework assignments may be provided to encourage generalization of training skills. While attempts to minimize sidetracked discussions (e.g., attempts engage in individual therapy) were considered, other parental concerns about long-term and crisis-related child problems not related to special play times were addressed.

Session 9

This final session marks a movement toward termination of filial therapy. Parents were encouraged to review previous treatment sessions, discuss their experiences, and evaluate how their own and their children's behaviors have changed since beginning treatment. Parents were allowed to share their experiences with other participating parents. The therapist shared in these perceptions and discussions and highlighted points of reference for parents to evaluate their progress. While this session usually denotes a rewarding time for parents, those requesting further assistance were provided with opportunities for additional help and resources. The final session was followed by a treatment follow-up (TF) session and evaluative measure. However, due to time constraints in the residential stay for some participants (i.e., imminent discharge),

it was sometimes not possible to schedule a separate follow-up session and the last 10-minutes of the T9 session served for TF data analysis.

Developmental Filial Therapy Coding System (DFTCS)

The design of the Developmental Filial Therapy Coding System (DFTCS) is unique to the present research study. The purpose of the DFTCS (see Appendix E) was to provide a quantitative measure of qualitative parent-child processes through measurement of the participants' interpersonal verbal and nonverbal behaviors. Taking into consideration Lubimiv's (1994) interactional patterns of play, the following observational measures illustrate the developmental sequence characterized by intrapersonal patterns of sense of self and interpersonal patterns of sense of relatedness. In other words, the aim and implementation of the DFTCS suggests a pioneering attempt to identify and evaluate some of the fundamental bidirectional therapeutic processes essentially involved in parent-child interactions engaging in filial therapy. (See Appendix B for an overview of the developmental approach to filial therapy and its treatment processes.)

An all-intensive effort has been made to develop a feasible and sound methodology for evaluating developmental filial therapy. As delineated by Bader and Pearson (1988), the developmental approach to evaluating interpersonal relatedness can be characterized and highlighted by five distinct developmental stages. The final stage, mutual interdependence, is considered the most desirable. Once attained, then, theoretically it can be said that the individuals have reached a plateau and that their relationship can progress no further toward another (higher) developmental stage. Thus, the developmental stage of mutual interdependence has not been given a sizable consideration in outlined the methodology. Rather, of central importance in the present

study was the diagnostic and treatment measures as they were applicable in the first four developmental stages: symbiosis (enmeshed and hostile/dependent), differentiating, practicing, and rapprochement.

Accordingly, one of the unique features of the developmental approach to assessing interpersonal relationships is its ability to diagnosis the developmental stages of each individual involved in the dyadic relationship as well as diagnose the developmental stage of the interpersonal relationship itself. That is, diagnostic measures can be obtained for each individual's developmental stage (e.g., symbiotic, differentiating, practicing, rapprochement), and a further diagnostic measure can also be obtained for the dyadic relationship itself, which can be assessed as the relational stage of development (e.g., symbiotic-differentiating, symbiotic-practicing, practicing-practicing). The ensuing discussion presented below has been formulated on the diagnostic measures and developmental criteria (separation/individuation process and couples' relatedness) delineated earlier.

Developmental Filial Therapy Graph (DFTG)

Using the positive/negative (i.e., right-minus-wrong) formula developed for usage with the DFTCS, these quantitative results representing individuals' respective developmental stages can then be graphically illustrated on the Developmental Filial Therapy Graph (DFTG, see Appendix F). First is a measure of each individual's individuation or sense of self-identity. For the purpose of the present study, this diagnostic measure is referred to as each individual's *developmental sense of self*. Illustrated graphically in a two-dimensional system, the reader can visualize two real number lines intersecting orthogonally to each other. The horizontal number line (commonly known as the y-axis in coordinate geometry) constitutes a measure of each

individual's developmental individuation. Second, the vertical number line (commonly known as the *x*-axis in coordinate geometry) represents for each individual a developmental sense of relatedness. That is, the second line is a measure of each individual's satisfaction within the context of the developmental relationship.

Each point in the system can be identified by an ordered pair of real numbers (x, y), called coordinates. The origin has zero-defined coordinates (0, 0); that is, the origin is neither negatively nor positively defined. In this system, the origin is the immediate transition point from differentiation toward the practicing stage; in other words, the origin represents a neutral (0) sense of self and a neutral (0) sense of relatedness. The sense of self (*y*-coordinate) expresses distance to the left (i.e., lesser, if negative) or right (i.e., greater, if positive) of the x-axis. The sense of relatedness (*x*-coordinate) expresses the distance below (i.e., lesser, if negative) or above (i.e., greater, if positive) the y-axis. The horizontal line and vertical line divide the plane into four regions. Unlike common coordinate geometry, however, there are no conventionally ordered quadrants in this system. Instead, each of the developmental stages is represented in a linear, step-like fashion from the lower left (symbiotic) region toward the upper right (rapprochement) region.

Outward from the origin (0, 0) are the coordinates ranging from -20 to 20 on both the sense of self and sense of relatedness axes. First, beginning in the lower left-hand corner is the symbiotic stage that has the coordinate range -20 to -10. Moving upward and right toward the origin is the differentiation stage with coordinates ranging from -10 to 0. Moving again upward and to the right beyond the origin is the practicing stage with coordinates ranging between 0 and 10. Finally, in the top right-hand corner is the rapprochement stage with coordinates ranging between 10 and 20. In the case

whereby an individual's composite developmental score should result lesser than -20 or greater than 20, these shall be illustrated using -20 or 20 as 'floor' or 'ceiling' values, respectively.

These coordinates on the DFTG can be further distinguished by 'true' regions of the developmental assignments. Whereas 'true' developmental regions are represented by nonshaded areas, each developmental stage includes a shaded area to allow for variability in the results. The rationale for this presentation is that, theoretically, at least, without therapeutic intervention, individuals in the beginning stages of interpersonal relationship development will have little or no awareness of therapeutic or parent-training skills delineated in developmental filial therapy. For instance, while the greatest degree of variability is reflected in the symbiotic stage, these respective composite scores can deviate from the 'true' symbiotic -20 to -10 (nonshaded) range and beyond toward a composite score of 20 on both sense of self and sense of relatedness scales. However, as the individual attain greater levels of sense of self and sense of relatedness so should there be an increase in their awareness and effectiveness of skills and, thus, a decrease in the degree of variability in their responses. Consequently, as depicted in the DFTG, the progression toward the more desirable stages of differentiating and practicing includes a progression of lesser degrees of variability. Finally, as the individuals were diagnosed to have heightened awareness and improved effectiveness of skill implementation, then, increasingly, variability in the dyad's responses will likely diminish as they approach the even higher rapprochement stage.

In addition, diagnosis of each respective developmental stage is dependent on the specific measures of behaviors observed. For example, on the scale of sense of self (i.e., movement toward individuation), one individual's attributes can be described in the

following: low sense of individuality (symbiotic stage, enmeshed); expressed instability in mood and self-image (symbiotic stage, hostile-dependent); developing capacity to tolerate differences in other (differentiating stage); capacity for empathic response (practicing stage); and, the reemergence of vulnerability (rapprochement stage). On the other hand, developmental sense of relatedness scales (i.e., movement toward interpersonal exchanges) can be described in the following: ability to express own identity or separateness within context of relationship (symbiotic stage, enmeshed); effort to connect emotionally with other (symbiotic stage, hostile-dependent); ability to discriminate pertinent problem-solving issues (differentiating stage); relationship viewed as important as individuation process (practicing stage); and the ability to describe and support the other's growth needs and independence (rapprochement stage). An individual's increased (i.e., greater) sense of self or increased (i.e., greater) sense of interpersonal relatedness can be expressed and illustrated by the positive coordinates on the DFTG thus indicating individual tendencies toward the practicing and rapprochement developmental stages, respectively. Conversely, an individual's decreased (i.e., lesser) sense of self or decreased (i.e., lesser) sense of interpersonal relatedness can be expressed and illustrated by the negative coordinates on the DFTG thus indicating individual tendencies toward the differentiation and symbiotic developmental stages, respectively.

Plotting of these individual developmental coordinates on the DFTG is based on the observational measures based on the DFTCS. These scores were derived from observation of IUMs in which the parent-child dyad engages in a 10-minute problem-solving interaction. Each individual's self and interpersonal behaviors, both positive and negative, were coded and recorded. Thus, for each IUM, two combined coordinates (i.e.,

sense of self and sense of relatedness) can illustrate one composite developmental score for each individual. The composite developmental score is based on, first, a score on developmental sense of self, and, second, a score on developmental sense of relatedness.

For any given dyad, then, a developmental composite measure can be obtained for both Parent 1 and Child 1 through observational analysis of one 10-minute IUM. For example, the composite developmental score for Parent 1 may be -5 (sense of self) and -9 (sense of relatedness), while the composite developmental score for Child 1 may by -12 (sense of self) and -16 (sense of relatedness). By plotting these composite scores on the axes of the DFTG, Parent 1 falls into the differentiating stage, and Child 1 falls into the symbiotic stage. In short, then, the relationship itself is diagnosed and described in the differentiating-symbiotic stage of development.

Toward developing an acute method of evaluating developmental filial therapy, there is at least one important salient feature inherent in the real number line coordinate model discussed here. That is, for each of the participating dyads included in the study, the coordinate model has the ability to diagnose and track, simultaneously: (a) the developmental sense of self for Parent 1, and the developmental sense of self for Child 1; (b) the developmental sense of relatedness for Parent 1, and the developmental sense of relatedness for Child 1; and (c) the developmental stage of the dyadic relationship itself. The following sections describe the type and purpose of each of the observational variables, the rationale of the developmental filial therapy coding system, and the observational measures derived from the coding system.

Systematic measure of the developmental progress of the parent-child dyad was acutely dependent on implementing fitting observational measures, or variables, and on developing a reliable coding system. Adapted from Bader and Pearson's (1988)

developmental couples therapy model, an overview of these developmental measures have been determined to identify meaningful behaviors specific to each developmental stage of filial therapy. In the approach to developmental filial therapy, the whole or ongoing process can be distinguished by the treatment and intervention. That is, treatment or intervention has been identified and classified as one independent variable (IV). Denoting an individual's developmental disposition, consistent with the developmental approach to filial therapy, two dependent variables (DVs) have been identified: (a) *sense of self*, and (b) *sense of relatedness*. It was hypothesized, then, that the occupancy or manipulation of the IV (treatment) will cause or effect change in the outcome measurements of either one or both DVs (sense of self, or, sense of relatedness).

Observational measures have been developed and identified for each of the following distinguishable developmental stages: symbiotic (enmeshed and hostile-dependent), differentiating, practicing, and rapprochement. For each of the developmental stages, two headings (i.e., Sense of Self and Sense of Relatedness) have been assigned and labeled accordingly. Further, within each of these two headings, a set of variables denote either seven positive measures or seven negative measures, coded alphabetically A – G. Under the heading Sense of Self is a set of seven positive variables (A^+ - G^+) and a set of seven negative variables (A^- - G^-). Positive variables (A^+ - G^+) and negative variables (A^- - G^-) variables found under the heading Sense of Relatedness follow a similar coding system that includes an additional set of seven positive (A^+ - G^+) and seven negative variables (A^- - G^-).

For each of these variables, positive or negative, a brief statement of its corresponding observable measure has been included. That is, while any negative measure can be considered as disapproving or unwanted behavior, its corresponding

positive measure can be considered an acceptable or desirable behavior. While many of these observational measures were geared toward identified verbal behaviors or responses, many of them can be observed and interpreted as a nonverbal behavior, as well.

For example, an insecure parent diagnosed in the symbiotic stage of sense of self may have difficulties promoting the separation/individuation process in the child and express or convey negative messages (A^-) such as "I feel badly when I have to discipline my child," or, "I want to change, but I'm afraid my child won't love me anymore." In other words, the parent is pulled in the direction away from differentiation toward reestablishing a symbiotic bond with the other, thus losing ground in the ability to identify processes of self-individuation, or sense of self. On the other hand, a secure child enacting on separation/individuation responses may make positive statement (A^+) such as "I believe you can take care of me," or, "I love you, but I need to do something for myself." In these latter statements, the child is quite clear about needing to express his or her own self, as well as being committed to finding appropriate ways of self-expression. Thus, the parent can recognize the child's need for self-expression, the benefits of facilitating and acting out these interpersonal processes, and practice the behaviors. In other words, contrasted with earlier stages of symbiosis were the parent's efforts to engage actively with the child, communicative empathic responses, and facilitative processes of differentiation and self-identity.

Still using the previous example, the parent and child dyad may engage in observational measure that focus on sense of relatedness rather than a sense of self. During interactions of sense of relatedness, while the individuals may have not yet developed a successful conflict resolution or negotiating style (A^-), the desirable behavior

or goal is for the individuals to make a conscious effort toward working out their differences in manner which could be deemed mutually agreeable (A^+). For instance, the parent may respond to the child in a negative manner (A^-) with statements such as "Every time I tell you do something, you don't listen," or, "How can I feel good when you always make me angry?" In other words, an insecure parent can be easily led into attempts to lead the child into argumentative or combative interpersonal relations, thus pulling the parent-child relationship in the direction away from differentiation toward reestablishing dependent behaviors and a symbiotic interpersonal relationship. On the other hand, a secure child may respond toward his or her parent positively (A^+) with statements such as "I know you worry about me when I go to play with friends," or, "I want to stop fighting with you." In the preceding statements, the child is able make a sincere effort to quickly resolve conflict and interact with the parent more effectively. Thus, a differentiated individual not only accepts the other's differences, but he or she actively searches for ways in which both individuals can appropriately practice self-expressions in a mutually gratifying manner. (For a complete overview of the observational measures for both positive and negative measures of sense of self and sense of relatedness, as each pertains to the specific developmental stages, see Appendix C.) Having discussed these observational measures on the processes of developmental filial therapy, let us now turn to the implementation and interrater reliability of the coding system.

Scoring Procedures

The observational measures on the processes of filial therapy can be scored according to review of videotaped, 10-minute IUMs. In order to obtain an accurate and more reliable frequency count of each individual's behavior and interpersonal

interaction, each problem-solving unit was videotaped. All problem-solving units takes place at the beginning of scheduled sessions, prior to further instruction or treatment implementation. Analysis of each videotaped 10-minute problem-solving unit involves coding the measures observed for each individual on the DFTCS. To enable a more reliable frequency count the 10-minute interval was broken down further into 2-minute intervals.

Preparation for analysis of the problem-solving interactions was multistep. First, to improve reliability measures in the coding and data analysis, the videotaped IUMs were transferred from analogue videotape to digital media (e.g., CD-ROM). In this way the interrater observers had potentially greater control (e.g., viewing, reviewing, cueing, pausing) of the observational material for data analysis. Secondly, each of the 10-minute videotaped IUMs was previewed in its entirety. These interpersonal interactions were then reviewed in segments of 2-minute intervals and these observational variables were coded accordingly. At the end of each 2-minute interval, the videotape was paused to provide the observer an additional opportunity to review and reflect again on the entire list of variables. Frequency counts of these variables were obtained by means of observing the presence of either a positive or a negative measure. Each of the respective variables, whether positive or negative, was scored once only for each of the 2-minute intervals. However, if in the currently viewed 2-minute segment the respective variable was ambiguous or simply absent in either positive or negative form (i.e., not an issue), then no score was recorded. In short, for the duration of each 2-minute interval each of the respective variables were identified and scored positive (+1), negative (-1), both (+1, -1), or neither (i.e., no score was obtained).

Analysis of each 10-minute IUM, for both of the participants, included frequency counts obtained on both positive and negative observational measures for scales of developmental sense of self and developmental sense of relatedness. Once completed, the observational measures were tallied, and a total for both positive and negative measures is recorded. Following this procedure, both the positive and the negative observational measures were combined using a right-minus-wrong technique. That is, scores for positive variables (A^+- G^+) and negative variables (A^-- G^-) were combined to arrive at a composite developmental score (again using a right-minus-wrong technique) for each of the participant's developmental sense of self and developmental sense of relatedness. A composite developmental score consists of these two represented coordinates: first, one participant's sense of self; and, second, other participant's sense of relatedness. Each of the participant's composite developmental score was then plotted and illustrated graphically in accordance to the real number line coordinate graph described earlier (see Appendix F for the Developmental Filial Therapy Graph).

Treatment Implementation

As pointed out by Kot, Landreth, and Giordano (1998), therapeutic planning and implementation targeted for individuals residing in domestic violence shelters involves many unique methodological considerations. Typically, domestic violence treatments settings are highly unstable and transient in nature whereby traditional once-a-week treatment sessions will not meet the treatment needs of such a population. In other words, the residential stay for these individuals was relatively short-term, typically about two to three weeks. Thus, it was recognized that providing therapeutic services for individuals residing in domestic violence treatment settings require interventions that involve "intensive" treatment approaches.

The present research study aim was to meet many of the unique considerations for conducting research in a domestic violence shelter. While it is generally suggested that scheduling filial therapy sessions be structured and delivered in weekly sessions, as much as possible, it is of primary importance that "play sessions be regular and predictable from the children's point of view..." (VanFleet, 1994, p. 44). The scheduled outline for treatment implementation and data collection for the study was purposefully designed for the participants' involvement to be completed within two to three weeks, with data collection procedures for the entire sample to be completed within a few weeks. Treatment was targeted to include mothers and children who were currently residing in a domestic violence women's shelter. One treatment sample included data collection and analyses on multiple conjoint participation sessions involving a single mother-child dyad. For each mother-child dyad, participation and treatment implementation took place on a daily or near-daily intervention schedule. (See below for a Schematic Outline of Research Study.)

Prior to treatment implementation, an intake (I) interview with potential study participants was performed. The purpose of this interview was to evaluate the appropriateness of the potential participants in the study. Participants determined to meet the study criteria were requested to sign the participant consent form (see Appendix A). Following, pretest measures were obtained from the administration of two standardized psychological instruments (e.g., BASC, PCRI). In addition, any questions or concerns presented by the participants were addressed prior to the onset of data collection.

Following the intake interview, two baseline measures (B1 & B2) were conducted. For each of these unit measures, mother-child dyads participated in separate in 10-

minute videotaped interpersonal interactions. Baseline interpersonal units include the mother and her child only; that is, no therapeutic involvement from the present researcher was offered or implemented. Based on the observational variables delineated by the DFTCS, these videotapes were observed and analyzed by two independent interraters. In short, the interpersonal processes of baseline mother-child interactions were observed and analyzed by interraters and scored using the DFTCS to provide quantified measures of these interpersonal mother-child interactions prior to treatment implementation.

An additional interview took place with the mothers following the collection of the baseline measures, and prior to the first treatment implementation session (T1). All of the participating mothers partook in a psychoeducational (i.e., parent education) group session to discuss the nature of interpersonal relationships in general and the techniques outlined by filial therapy procedures in particular. For example, the hallmark of play therapy can be explained as a means of enhancing the child's perceptions of self and others, facilitating opportunities for the child to express a wide range of feelings, real life experiences, and reality testing of limits, as well as help the child develop a positive self-image, self-understanding, and opportunities for self-control and self-mastery. In short, mothers were taught basic interpersonal and play therapy skills and were encouraged to positively respond to their child's needs by becoming an active participant in the therapeutic sessions. As mentioned earlier, the psychoeducational group session includes viewing of VanFleet's (1997) instructional videotapes to help explain the rationale and techniques of filial therapy.

Treatment the following day, but only after the mothers indicated they had received satisfactory training on the techniques of filial therapy, and when they indicated

a sufficient understanding of its rationale and procedures. In individual treatment sessions, each mother-child dyad then partook in nine (9) daily or near-daily treatment sessions. In other words, whenever possible, mothers and their children engaged in daily treatment sessions. However, as Kot, Landreth, and Giordano (1998) indicated in their study, logistically it may not be possible for residents of a domestic violence shelter to participate in uninterrupted, daily treatment sessions and may have to skip a day or two for reasons of attend medical appointments, legal appointments, or employment opportunities. In such cases, implementations of the remaining treatment sessions were conducted in the following days. All treatment sessions (T1 – T9) took place within the predetermined time allowance for residential stay for each participating family (i.e., within 2 – 3 weeks).

Prior to each treatment session, each mother-child dyad participated in another 10-minute, unfacilitated parent-child IUM. Similar to the procedures of the baseline IUMs, each treatment IUM was videotaped. The purpose of these procedures was to provide session-by-session analyses of the process variables of mother-child dyadic interactions. These videotaped IUMs were later analyzed and scored on the DFTCS by interrater observers (to be discussed later). Following capture of each 10-minute IUM on videotape, a single filial therapy treatment session was conducted.

As much as possible, this treatment implementation format continued on a daily administration basis for each of the participating mother-child dyads until all of the nine treatment sessions (T1 – T9) had been completed. Following the daily administration of the treatment sessions for each of the participating mother-child dyads, as described earlier a psychoeducational supervision group convened to allow for opportunities for

the filial therapist and participating mothers to view each other's IUMs and provide feedback on the filial therapy training process.

Finally, prior to each mother-child dyad's exit (i.e., termination) from the shelter program, which may be one day to potentially several days since the administration of the ninth treatment (T9) session, a treatment follow-up (TF) measure was conducted. The follow-up measure involved videotaping of a final 10-minute IUM that was administered to assess the overall treatment efficacy once treatment intervention has been discontinued. In addition, other standardized instruments (e.g., PCRI, BASC) were administered to obtain posttest or quantifiable outcome measures of the filial therapy sessions.

Schematic Outline of Research Design

Day	Session Number	Description of Session
0	**Intake (I)**	• Informed consent and/or assent received from participants. • Participants' questions and/or concerns addressed. • Administration of BASC instruments (pretest measure). • Administration of PCRI instrument (pretest measure).
1	**Baseline 1 (B1)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Participants' questions and/or concerns addressed. • Interrater analysis of baseline session.
2	**Baseline 2 (B2)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Psychoeducational filial therapy session with mothers (i.e., review of videotapes, interventions, techniques) (ind./group format). • Interrater analysis of baseline session.
3	**Treatment 1 (T1)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with mother-child dyad (20 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
4	**Treatment 2 (T2)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with mother-child dyad (30 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
5	**Treatment 3 (T3)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with mother-child dyad (30 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
6	**Treatment 4 (T4)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with mother-child dyad (30 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
7	**Treatment 5 (T5)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with dyad (30 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
8	**Treatment 6 (T6)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with dyad (30 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
9	**Treatment 7 (T7)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with dyad (30 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
10	**Treatment 8 (T8)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with dyad (30 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
11	**Treatment 9 (T9)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Filial therapy session with dyad (30 minutes). • Training/review of IUMs with mothers (ind./group format). • Interrater analysis of treatment session.
12+	**Omitted**	• No therapeutic sessions scheduled. • Follow-up measure to be completed just prior to the family's discharge from the shelter
Exit	**Follow-up (TF)**	• Mother-child interpersonal unit measure (IUM; 10 min. videotape). • Administration of BASC instruments (posttest measure). • Administration of PCRI instrument (posttest measure). • Interrater analysis of follow-up session. • Preparation for termination from residential shelter program.

Technical Issues

Definition of the Most Important Terms and Concepts

The literature sometimes uses and applies the terms play therapy, filial therapy, and family play therapy interchangeably. For the purposes here, 'filial therapy' is defined as a qualified therapist providing direct, in-session treatment to parent-child dyads utilizing play traditional therapy techniques and models of parent education and training. The term 'play therapy' is reserved for discussing individual treatment approaches involving traditional therapist-client dyads. Family therapy, although conceivably can incorporate traditional play therapy techniques, is distinguished from these other treatment approaches in that it involves providing direct treatment to three or more family members, for example, two parents or guardians and one or more children.

The terms 'play' and 'play therapy' are widely varied. Solnit, Cohen, and Neubaurer (1993) considered the multiple roles of play as: (a) the ways in which *play expresses and represents the child's experiences* and then *communicates* them to others; (b) the functions of play in *weaving together* the child's past and present, as well as his or her future potentials; (c) the *therapeutic use of play* as it role as a window into the child's difficulties as well as it mobilization in therapeutic interventions; (d) the *affective qualities of play* as the pleasures in play as well as the special seriousness with which children may play; and (e) the ways in which children may use to *learn about and cope with unhappiness, conflict, and trauma.* Thus, "play takes on special meaning as a *window into the operations of child's mental functioning and self representation*" ... in which the therapeutic mediation of play has the "*potential power to help move development forward* by allowing the child to review his or her current situation,

explore new possibilities, experiment new solutions, and find new integrations" (Solnit et al., 1993, p. 2). While the preceding directs its attention primarily on the meaning of play for children, these authors expanded their interpretation and definition of play as the capacity for "both the child and the adult with a powerful instrument for figuring out and coming to grips with realities, with mysteries and hardship" (Solnit et al., 1993, p. 3).

Indeed, perhaps the most ubiquitous problem lies in defining the meaning of play itself. Nevertheless, some have suggested that play activity, and play as therapy, possibly more than any other therapeutic modality, appears to transcend many of the natural barriers that exist in treating diverse populations regardless of gender, age, and ethnicity, personal or cultural experiences. Play is emerging as an exciting trend in adult therapy (Blatner & Blatner, 1997; Landreth, 1991; Landreth et al., 1999; Terr, 1999). Rather than play turning into culture, culture manifests the character of play activity whereby "in the twin union of play, play is primary" (Ritvo, 1996, p. 237).

Confounding Variables

There is the potential for confounding variables to arise in any scientific investigation. Empirical investigation of any psychotherapy treatment and its efficacy is at least in part determined by the severity of the individual's psychopathology. For example, measures of treatment efficacy and outcomes for a child exhibiting mild to moderate internalized psychosocial behaviors (e.g., anxiety or withdrawal) may look differently than interpretation of the results for a child exhibiting externalized psychosocial behaviors in the severe range (e.g., conduct disorder). For child witnesses of domestic violence, possible suggestions for DSM-IV diagnoses have typically included Adjustment Disorder with Mixed Disturbance of Emotions and Conduct as well as Posttraumatic Stress Disorder (Kot et al., 1998).

Other examples of potentially confounding variables in social science research include the participants' motivation for change, standardization of treatment implementation, measurement, setting, as well as other demographic characteristics (e.g., gender, age, ethnicity, socioeconomic status, individual differences and experiences, etc.). Nevertheless, play therapy techniques appear to have merit in treating a multitude of maladaptive behaviors and psychopathology. Within the context of short-term (< 12 sessions), Johnson (2001) concluded play therapy is effective with children exhibiting a range of difficulties including abuse, neglect, aggression and acting out, emotional disturbances and schizophrenia, encopretic problems, fear and anxiety, grief, hearing impairment with behavioral difficulties, reading difficulties, social adjustment problems, speech difficulties, trauma, and withdrawal. Similarly, VanFleet (2000b, 2000c) concluded that short-term play therapy is effective for helping family systems cope with chronic illnesses. Certainly, the extent and complexity of accounting for potentially confounding variables is controlled and limited in the design and methodology of the research investigation. For the present research investigation, the challenge was to not only attend to such traditional methodological considerations in evaluating treatment outcomes but also execute methodological procedures to face additional challenges to investigate and analyze the intrapersonal and interpersonal processes of filial therapy.

As mentioned earlier, traditional filial therapy involves therapists as agents to actively and strategically engage in parent-child interpersonal processes as well as provide parents with a framework for education and training. For some, however, this may constitute a dual relationship for therapists and thereby perhaps confound the treatment efficacy and investigation. Some researchers (e.g., Eppler & Latty, 2001) have

instead divided these two roles between cotherapists. Filial therapy with cotherapists is described as one therapist providing individual play therapy treatment to the child while another provides psychoeducational instruction to the parents outside of the playroom, such as explaining the tenets of play therapy to help translate its function into action. It is suggested by the present author, however, that a cotherapist approach is not unlike traditional play therapy approaches in which a single therapist provides individual play therapy to a child as well as parent psychoeducation in separate sessions. Moreover, the very essence of filial therapy constitutes that a single therapist provide parents with both a primer of play therapy techniques and parent education as well as actively involve parents in the treatment sessions. In other words, the potential therapeutic alliance and relationship the filial therapist develops with these individuals is considered one of the hallmarks of its therapeutic efficacy rather than considering it a potentially confounding variable.

Additionally, any treatment intervention with a systems approach has an added benefit of suspending any perceived 'label' or formal diagnosis of family members. For instance, parents who enlist their children in therapy sometimes do so with a preconceived impression or hope that professional involvement will remediate or 'fix' the identified problem(s). That is, parents sometimes attribute their children, or more often one particular child, as the 'identified patient' (IP) rather than adopt a systemic focus on the family context or consider possible deficits in their own knowledge and parenting skills. Therapeutic modalities such as filial therapy which enlist the active and interactive participation of children and their parent(s), have the additional benefit of at least minimizing family members' perceptions and misperceptions of these so-called IP individuals.

Validity and Interrater Reliability

While a developmental model of filial therapy does not lend itself easily to rigorous empirical standards of scientific inquiry, a developmental approach of interpersonal relationships offers a promising model. Notwithstanding, consideration was given to certain limitations inherent in the present methodological design. Toward developing a credible research design, some of the following desirable features were considered: (a) that demonstrating a functional or interpersonal relationship between the intervention and behavior does not require withdrawing or temporarily suspending the intervention; (b) the intervention need not first be applied to one behavior and then eventually to others; (c) possible threats to internal validity such as lack of control for history and threat to instrumentation; and (d) possible threats of external validity such as complete control of interaction and testing. These were just some of the challenges and validity issues that were considered and addressed throughout the presentation and discussion of the emergent methodological design and procedures for the present study.

Another consideration for inclusion in the present study was interrater reliability. Interrater reliability reflects the level of agreement between independent ratings as measured by two individuals (e.g., two persons viewing the same videotaped segment). In addition the present author's interobserver analyses, two additional interobservers were assigned to partake in the study. The purpose of these interraters was to establish a reasonable level of reliability measures in the observation and scoring of the interpersonal unit measures and in the implementation of the Developmental Filial Therapy Coding System (DFTCS) and the Developmental Filial Therapy Graph (DFTG). It was proposed that one interrater observer predominately have professional knowledge and experience in conducting play therapy, while the second interrater observer

predominantly have knowledge and experience in conducting scientific research. It was further suggested that having two individuals with such areas of diverse knowledge and experience potentially enhances the interrater reliability of these measures.

Interrater training, conducted following data collection of all the 10-minute interpersonal unit measures, included review of these videotaped enactments. These observational measures were considered to be fundamental in the analysis of the dyadic interpersonal processes involved in developmental filial therapy (see Appendix C). Specifically, interobservers were trained on the theoretical underpinnings and characteristics represented in each of the developmental stages (e.g., symbiosis, differentiating, practicing, rapprochement). These developmental stages and the theoretical correlates described earlier were then discussed in terms of the overall organizational structure represented in the essence of intrapersonal characteristics (i.e., developmental sense of self) and analogous characteristics denoting parent-child relationship patterns (i.e., developmental sense of relatedness).

When each of the interobservers indicated sufficient understanding of the developmental filial therapy processes as well as the respective developmental stages, then they were presented with the already acquired videotaped parent-child enactments (i.e., 10-minute interpersonal unit measures, or IUMs). Interraters first received training on the same or similar (i.e., baseline sessions) videotaped enactments which included coding instructions for the observational measures on the DFTCS and DFTG instruments (as discussed earlier). When reliability among these interrater observers was found to be relatively high when based on the same or similar videotaped enactments, similar procedures were conducted on review of dissimilar videotaped enactments. For example, one interrater was required to complete coding based on observations from an early (i.e.,

baseline) session, while the other interrater was be required to complete coding based on more advanced (i.e., later treatment or follow-up) sessions. In short, when reliability among the interobservers was found to be relatively low (less than 20%) on dissimilar videotaped enactments, and their interratings were found to be relatively high (greater than 80%) on similar videotaped enactments, then the interrater reliability based on the observational measures was considered sufficiently robust. In total, each interobserver was required to review and code at total of twelve 10-minute videotaped enactments including two baseline sessions (B1 and B2), nine treatment sessions (T1 – T9), and one treatment follow-up (TF) session (10 minutes x 12 sessions = 120 minutes) for each of the four (4) participating parent-child dyads (120 minutes x 4 = 480 minutes).

Protection of Human Subjects

The present research study was unique in that therapeutic treatment involved the conjoint participation of parents and children. To the extent possible, the utmost considerations in developing the methodological design and treatment implementation have been contemplated for the present research study. While the protection of human subjects was of vital importance when conducting scientific inquiry with adult populations, this overriding consideration becomes paramount when working with minors. Reporting on special relevance issues of liability in conducting child therapy research, Dekraai and Sales (1991) emphasized that "psychologists engaging in therapy or research on therapy with children need to become knowledgeable about the law in their jurisdiction pertaining informed consent, confidentiality, and child-abuse reporting" (p. 859).

The process of obtaining *informed consent* in child therapy research involves a twofold process: the situation involves obtaining both child and parental (or guardian)

consent. While Dekraai and Sales (1991) denoted some exceptions, for example, the emancipated minor, obtaining parental consent was considered necessary prior to any child's participation in the present study. Moreover, parental consent involves not only obtaining consent for the participation of children but also consent for the active participation from the mothers themselves. That is, as mentioned earlier, the present study involves conjoint therapeutic intervention with separate mother-child dyads. Informed consent from children and their mothers was ensured and obtained in writing with the inclusion of their signatures secured on the Participant Consent Form (see Appendix A). Informed consent additionally includes verbal assent to be obtained from the children. Any parents and/or children may subsequently refuse to participate and withdraw from the present study even after written consent and verbal assent have been obtained. Moreover, it was explained that participation or nonparticipation in the present study would have no effect on their access to current or future counselling services.

Confidentiality issues were also discussed on the participants' permission form. Some of the specific features and procedures of the present study was further explained to the participants. For example, assurance was given that all information would be held in strict confidence and be used only to secure knowledge about scientific research. In addition, the purpose of videotaping (i.e., 10-minute interpersonal unit measure) prior to each of the therapy sessions was discussed conjointly with the mothers and their children. When considered to be no longer of use for scientific purposes these materials would be appropriately destroyed (e.g., videotapes erased). In addition, other matters of confidentiality discussed included efforts to maintain anonymity by using participant code numbers (e.g., no names). However, in an effort to maintain already established

interpersonal relationships between mothers and their children, it was explained that participants should continue to engage in their customary behaviors. For example, it would be contraindicated for participants not refrain from personal name usage during the treatment sessions or videotaped the interpersonal unit measures.

The third consideration to liability and conducting child therapy research is that of *child abuse reporting*. Mothers were informed of the limits of confidentiality during the parent intake interviews. Issues and discussions of confidentiality limits represent a rather unique consideration for the present study. That mothers and children participating in the study have already initiated access to services of a domestic violence shelter inherently suggests that these individuals have already been subjected to a range of effects involving interpersonal violence. As discussed earlier, children living in a domestic violence setting were most certainly affected by the harmful influences of domestic violence either overtly (e.g., emotionally, sexually, physically) or covertly (e.g., witness, neglect). This heartbreaking reality has been already acknowledged by the fact that these mothers sought refuge in a domestic violence shelter. Nevertheless, while residence in a domestic violence shelter may provide children a safer environment from some aspects of abuse (i.e., fathers), it must also be recognized it does not necessarily provide these children immunity from other potential instances of abuse (i.e., mothers). In other words, there naturally exists the unfortunate possibility that children have been subjected to various forms of abuse at the hands of either parent or custodial caregiver. It was considered the ethical and professional responsibility that mothers be fully informed about the limits of confidentiality. Thus, these conditions to the limits of confidentiality were explained as follows: (a) if any participant is in danger to self or others; (b) any child (persons under 18 years) is in need of protection; and (c) if court ordered,

participant file information may be subpoenaed. Should have any parent or child been in disagreement with any of the above, then their participation in the present study was to be excluded; however, this circumstance did not present itself.

CHAPTER IV – RESULTS

Research Participants

Four (4) mother-child dyads participated in the present research study. Following a preliminary interview with shelter staff, the present researcher interviewed those mothers who expressed interest in the study and met the basic criteria individually. The purpose of this semi-structured interview was to offer potentially participating mothers an opportunity to have all of their questions and concerns answered (e.g., purpose, treatment, involvement, timelines, issues of confidentiality). Mothers who maintained their expressed interest to participate were requested to invite their potentially participating child to also partake in the interview. When the mother and child each provided verbal assent to participate in the present research study, administration of the adult and child informed consent forms was completed. Finally, a schedule to begin daily or near daily data collection procedures was discussed.

The age range of the participants was between 28 and 44 years for the mothers and, for the children, there were two boys and two girls between 8 and 9 years. The families indicated that their previous access to domestic violence services varied between first time contact (Dyads 3 and 4) to previous contact two years ago (Dyad 1) to having previously received considerable treatment interventions and follow-up services (Dyad 2) such as family counselling, individual adult counselling and parent education, and individual child play therapy. The cultural background of the participants included Caucasian with European decent, Middle Eastern, and Aboriginal ethnicity. The mothers reported having received varying levels of education from incomplete high school diplomas to post-secondary education.

All of the participating individuals indicated having experienced and/or witnessed chronic (i.e., years) domestic violence. Moreover, presenting issues included multiple underlying issues (e.g., physical, emotional, sexual abuse) commonly reported by domestic violence individuals and in related research studies. During the intake interviews with the mothers, some of the presenting child psychosocial concerns included: self-blame (e.g., "If only I didn't cry when I was a baby"), blaming others, aggressiveness, hypersensitivity, hyperactivity, perfectionism, bedwetting, lying, tantrums, nightmares/night terrors, disordered eating, negative attention-seeking, learning disabilities, regressive and/or immature behaviors (e.g., thumb-sucking, "baby talk"), lowered self-esteem, withdrawal and/or poorly developed interpersonal skills, as well as insecure attachments denoting enmeshed (e.g., "clingingness," "jealousy") and hostile dependent (e.g., verbally and physically abusive) behaviors. All individuals initially interviewed for potential research participation eventually completed the study requirements to full completion; that is, there was no occurrence of attrition.

Treatment

Treatment implementation, or parent training, followed the data collection of the second baseline (B2) filial therapy session (10-minute videotaped interpersonal unit measure, or IUM) and was introduced prior to data collection of the first filial therapy treatment session (T_1).

Parent training sessions took place with each mother individually. Parent training involved introduction to and instruction of four basic filial play therapy skills: structuring, empathic listening, imaginary play, and limit setting. These skills were examined and demonstrated by means of reviewing filial play therapy sessions as discussed by Dr. Risë VanFleet (1999a) and presented via videotape format. For each

mother-child dyad, treatment implementation and delivery of scheduled baseline (B1, B2) and treatment (T1 – T9) sessions were generally conducted in daily or near daily (i.e., commenced the following day or two) sessions, or within 12 to 14 days from their original participation consent agreement.

Parent training utilizing these sample filial play therapy sessions was reviewed with the present researcher and each mother individually in the following two-part approaches: basic and advanced skills. The first parent training session included discussion of basic elements of filial therapy skills and review of two treatment sessions (i.e., sessions 1 and 4) involving a father and a 5-year-old girl who witnessed her mother's involvement in a serious car accident; the mother had been hospitalized for the better part of two years and could no longer identify the daughter as her own. Interestingly, while there was some apprehension about using a videotape training sample involving a father and his child in a domestic violence setting, all mothers expressed an appreciation for this opportunity. For example, one mother said, "It's nice to know that there are decent men out there, especially ones who will do this for their children."

This first part of parent training, which took four to five hours, also included a mock play therapy session in the research playroom whereby the present researcher enacted childlike behaviors so the trained parent could practice some of the basic filial therapy skills. Each mother was additionally provided with a personal copy of VanFleet's (2000a) filial play therapy parent training manual. Similar to these sample filial play therapy sessions, the IUMs collected from the beginning of each treatment session (T1 – T9) served as additional parent training opportunities for review and skills-building. When time and extraneous (e.g., childcare availability) conditions permitted, each IUM

was reviewed with a mother and the present researcher immediately following administration of the daily treatment session.

The second part of the parent training or the advanced training was introduced to each mother about the fifth (T5) or sixth (T6) treatment session. This parent training session took about one to two hours and included discussion and review of two videotaped sessions: the first involved VanFleet demonstrating filial therapy skills in working with a 7-year-old girl, and the second involving the girl and her mother. Some of the presenting concerns for this young girl included lots of uncertainty involving transitions (e.g., imminent family move, father working afar) and knowledge about her mother's live-threatening liver disease, which led to periods of extended hospitalization. In contrast with the first videotaped samples reviewed in parent training, this particular child exhibited some highly emotionally charged behaviors (e.g., physical and verbal aggression) with a very directive and controlling presentation in session. In short, the initial parent training session allowed mothers to develop and practice some of the basic filial play therapy skills, and the advanced parent training session provided them a context and implementation for further review and skills building.

Quantitative Results

As outlined above, the present research study included both quantitative and qualitative evaluative measures. These quantitative results, including pre- and posttest assessment measures obtained from the administration and scoring of the Behavioral Assessment Scales for Children (BASC) and the Parent-Child Relationship Inventory (PCRI) instruments, are presented in this section.

Instrumentation

Pretest measures were obtained from the participating families during the intake session and prior to administration of the first pretreatment baseline (B1) filial play therapy session. Pretest psychosocial measures of the child were obtained from the ratings obtained from mothers' responses on the BASC parent-child forms (PRS-Cs) and the children's responses on the BASC self-report child forms (SRP-Cs). Additionally, mothers completed the PCRI to assess their attitude toward parenting in general and their attitude toward their child in particular. These procedures were repeated following each dyad's successful completion of the final (TF) filial therapy treatment session.

Scoring and data analyses of the BASC quantitative results were conducted using the BASC Enhanced Assist computer software for Windows (version 2.1) (Stanton, 1999). These data collected from the BASC instruments and protocols were submitted to in-house (i.e., computerized printout) statistical procedures. These results provided clinical findings on the children's psychosocial profile and were interpreted by means of individual reports and multi-form (i.e., pre-and posttest) comparisons. To prevent potential researcher bias or bias in the treatment administration and delivery, no scoring of any participating individual's pretest instruments took place prior to the completion and collection of his or her posttest instruments. For all BASC instruments, the default confidence interval suggested in the procedures manual is .90 (i.e., 90%), thus establishing the criterion cut-off for clinically significant findings found in the characteristics of the general population. Data analyses of the PCRI were performed through hand-scoring procedures and interpretation using the tables provided in the technical manual (i.e., without the use of computer software). The PCRI findings provide a clinical picture on the mothers' attitude toward parenting and child rearing. These

clinically significant quantitative findings, obtained from measures based on both the BASC and PCRI instruments, are summarized and illustrated on Table 1 (Dyads 1 and 2) and Table 2 (Dyads 3 and 4). Further, Tables 3 – 5 provide a quantitative overview of these results based on multiform pre- and posttest *T*-scores comparisons.

Dyad 1

According to the self-reported SRP-C pretest ratings, Child 1 would be placed within the Average range (percentile rank, or PR = 80) on the overall Emotional Symptoms Index. (To explain percentile ranks another way, compared with a standardized group of other individuals about the same chronological age, overall ratings exceeded approximately that specified percentage of those individuals who scored below the individuals' raw scores.) Elevated individual psychosocial scales rated within the At-Risk range included measures of Attitude to School, Interpersonal Relations, Self-Esteem, and Self-Reliance. The overall Emotional Symptoms Index on the SRP-C posttest results was also indicated within the Average range (PR = 45). All individual psychosocial scales on the posttest SRP-C were within the Average range; that is, none was elevated or clinically significant. A multi-form comparison of these SRP-Cs (similarity coefficient = 0.79), however, indicated significant improvement or positive changes on the clinical scale of Depression ($p < .10$), as well as the composite scales including Internalizing Problems ($p < .05$) and the overall Emotional Symptoms Index ($p < .10$).

The PRS-C pretest ratings provided by Parent 1 would place her child within the Clinically Significant range (PR = 98) on the overall Behavioral Symptoms Index. Pretest results indicated elevated individual psychosocial scales within the At-Risk range including measures of Aggression, Conduct Problems, Anxiety, Somatization,

Adaptability, Social Skills, and Leadership; those within the Clinically Significant range included measures of Depression and Atypicality. Based on PRS-C posttest ratings, Child 1 would be placed within the At-Risk range (PR = 89) on the overall Behavioral Symptoms Index. Elevated psychosocial scales within the At-Risk range, based on posttest results, included measures of Depression, Withdrawal, Adaptability, and Leadership; those within the Clinically Significant range included measures of Atypicality. A multi-form comparison of these PRS-Cs (similarity coefficient = 0.10) indicated significant improvement or positive changes on the clinical scales of Depression ($p < .05$), as well as the composite scales including Clinical Maladjustment ($p < .10$), Personal Adjustment ($p < .01$) and the overall Behavioral Symptoms Index ($p < .01$).

According to the self-reported measures obtained from Parent 1, pretest results on the PCRI indicated that her attitude toward parenting was within the Average or Above Average ranges on measures of Satisfaction with Parenting, Involvement, Communication, Autonomy, and Role Orientation. Within the Low range, thus indicating areas of parenting difficulties or parental dissatisfaction were measures of Parental Support and Limit Setting. Posttest results of the PCRI for Parent 1, however, indicated that all measures were within the Average to Above Average range. Validity measures such as Social Desirability and the Inconsistency Score were both within acceptable limits.

Dyad 2

Based on the pretest results of the SRP-C, Child 2 would be placed within the Low range (PR = 11) on the overall Emotional Symptoms Index. In general, individual psychosocial scales on composites of clinical and school maladjustment were rated

within the Low to Average ranges, while those denoting perceptions of personal adjustment were rated within the High to Average ranges. In other words, these self-reported pretest psychosocial ratings indicated the perceived sense of self of Child 1 was highly adaptive with the absence of any clinical or school maladjustment. Posttest results of the SRP-C indicated very similar findings to pretreatment ratings. While the overall Emotional Symptoms Index was within the Average range (PR = 49), there also appeared to be fewer extreme (e.g., high, low) ratings with nearly all individual psychosocial scales rated within the Average range. However, a multi-form comparison of these SRP-Cs (similarity coefficient = 0.42) indicated significant improvement or positive changes on clinical scales of Attitude to School ($p < .05$) and Anxiety ($p < .05$), as well as the composite scales of School Maladjustment ($p < .05$) and Clinical Maladjustment ($p < .05$).

By contrast, the pretest ratings provided by Parent 2 on the PRS-C would place her child within the Clinically Significant range (PR = 99) on the overall Behavioral Symptoms Index. Within the At-Risk range included one psychosocial scale, that is, Aggression; within the Clinically Significant range were several psychosocial measures including Hyperactivity, Conduct Problems, Anxiety, Depression, Atypicality, Attention Problems, and Adaptability. According to the posttest ratings on the PRS-C, Parent 2 would place her child within the Average range (PR = 56) on the overall Behavioral Symptoms Index. Additionally, all individual psychosocial scales were rated within the Average range, with Somatization falling within the Low range. Derived multi-form comparison results (similarity coefficient = -0.37) on these PRS-Cs indicated that Parent 2 observed significant or positively enhanced differences in her child on clinical scales of Hyperactivity ($p < .01$), Anxiety ($p < .01$), Depression ($p < .01$), Atypicality ($p < .01$), and

Attention Problems ($p < .01$). Multi-form comparisons of the composite scales also resulted in significant differences on measures of Externalizing Problems ($p < .01$), Internalizing Problems ($p < .01$), and the Behavioral Symptoms Index ($p < .01$).

Both pretest and posttest measures on the PCRI indicated that the attitude toward parenting of Parent 2 was rated within the Average or Above Average ranges on all scales; that is, none of these measures was within the Low range indicating that Parent 1 holds relatively positive attitudes toward parenting and child-rearing and is perceives herself as being relatively satisfied with her parenting abilities. In addition, the validity measures were also within acceptable limits.

Dyad 3

According to the self-reported ratings obtained from the SRP-C pretest results, Child 3 would be placed within the Clinically Significant range (PR = 98) on the overall Emotional Symptoms Index. Within the At-Risk range included individual psychosocial scales such as Attitude to School, Atypicality, Social Stress, and Self-Esteem. Pretest psychosocial scales rated within the Clinically Significant range included measures of Sense of Inadequacy, Depression, and Relations with Parents, Interpersonal Relations, and Self-Reliance. SRP-C posttest results indicated that Child 3 would be placed within the At-Risk range (PR = 83) on the overall Emotional Symptoms Index. In particular, psychosocial scales within the At-Risk range included measures including Attitude to School and Sense of Inadequacy. Posttest psychosocial ratings within the Clinically Significant range included measures of Interpersonal Relations. SRP-C multi-form comparison results (similarity coefficient = 0.70) for Child 3 indicated significant differences or positively enhanced changes on clinical scales of Atypicality ($p < .01$) and Depression ($p < .01$), and on adaptive functioning scales of Relations with Parents ($p <$

.05) and Self-Esteem ($p < .10$). Moreover, significant differences were indicated on the composite scales including Clinical Maladjustment ($p < .10$), Personal Adjustment ($p < .01$), and the Emotional Symptoms Index ($p < .01$).

Similar to the self-reported findings obtained from Child 3, the PRS-C pretest ratings provided by Parent 3 indicated that her child would be placed within the Clinically Significant range (PR = 99) on the overall Behavioral Symptoms Index. Within the At-Risk range were psychosocial scales including measures of Hyperactivity, Somatization, Attention Problems, and Social Skills. Psychosocial scales rated within the Clinically Significant range included measures of Aggression, Conduct Problems, Anxiety, Depression, Atypicality, and Adaptability. Based on PRS-C posttest results, the ratings provided by Parent 3 would place her child within the Average range (PR = 82) on the overall Behavioral Symptoms Index. However, there remained several psychosocial scales based on the mother's ratings, which would be considered problem areas. Within the At-Risk range were individual psychosocial scales included measures of Atypicality and Attention Problems; those within the Clinically Significant range included measures of Conduct Problems and Adaptability. The multi-form comparison results obtained from these PRS-Cs (similarity coefficient = 0.81) indicated significant differences or positively enhanced changes on clinical scales including Aggression ($p < .10$), Anxiety ($p < .01$), Depression ($p < .01$), and Atypicality ($p < .05$). Additionally, significant differences were found on all composite scales, that is, Externalizing Problems ($p < .05$), Internalizing Problems ($p < .01$), Behavioral Symptoms Index ($p < .01$), and Adaptive Skills ($p < .10$).

According to the self-reported ratings obtained from Parent 3, pretest results of the PCRI indicated that this mother's attitude toward parenting would be within the

Average to Above Average ranges on measures of Satisfaction with Parenting, Limit Setting, Autonomy, and Role Orientation. Pretest measures within the Low range denoting areas of parenting difficulties or dissatisfaction included Parental Support, Involvement, and Communication. All PCRI posttest measures, however, were indicated within the acceptable range, with exception of the Parental Support scale which increased but was still slightly below the range indicating satisfaction. Once again, validity measures of Social Desirability and the Inconsistency Score were both within acceptable limits.

Dyad 4

Self-reported SRP-C pretest results, as obtained from Child 4, were found to be within the Low range (PR = 9) on the overall Emotional Symptoms Index. Moreover, the ratings for all individual psychosocial scales were indicated to be within the Low to Average ranges. Accordingly, these self-reported pretest psychosocial ratings indicated that the perceived sense of self of Child 4 was highly adaptive with the absence of any clinical or school maladjustment. Similarly, based on the SRP-C posttest results of the overall Emotional Symptoms Index, Child 4 would be placed within the Average range (PR = 23). Similar to the pretest findings, the posttest results of the individual psychosocial scales were once again denoted to be within the Low to Average ranges, although in the posttest findings fewer scales fell within the Low range when compared with the pretest measures. Moreover, the multi-form comparison based on these SRP-Cs results indicated that there were no significant findings on any of the individual clinical scales or composite measures.

According to the PRS-C pretest results, the ratings provided by Parent 4 would place her child within the Average range (PR = 82) on the overall Behavioral Symptoms

Index. On individual psychosocial scales, however, measures of Depression and Withdrawal were rated within the At-Risk range. Psychosocial measures of Anxiety were rated within the Clinically Significant range. On the other hand, the PRS-C posttest results indicated that the ratings provided by her mother would place Child 4 within At-Risk range (PR = 94) on the overall Behavioral Symptoms Index. Moreover, in contrast with pretest measures, the posttest results appear to reflect an increased number of elevated or maladaptive psychosocial ratings. That is, within the At-Risk range included psychosocial measures in the areas of Aggression, Depression, Atypicality, Withdrawal, and Adaptability; measures of Anxiety remained within the Clinically Significant range. While these findings appear to attest to an increase in the number or severity of elevated psychosocial measures between pretest and posttest ratings, the results obtained from the multi-form comparisons (similarity coefficient = 0.66) of these PRS-Cs indicated that there were no significant differences between these psychosocial ratings based on individual clinical and composite scales.

Finally, the pretest results of the PCRI based on the self-reported ratings obtained from Parent 4 indicated an Average to Above Average attitude toward parenting in the areas of Satisfaction with Parenting, Involvement, and Communication. Areas found to be within the Low range suggesting some parenting dissatisfaction included Parental Support, Limit Setting, and Autonomy. The findings of the PCRI posttest results, however, indicated positive improvement or enhancement in these scales, denoting that in all areas this mother was found to be within the Average range. Consistent with the findings of all other participating parents, validity measures of Social Desirability and the Inconsistency Score on the PCRI were again within acceptable limits.

Table 1. BASC (SRP-C and PRS-C) Ratings of Children's Psychosocial Measures within Clinically Significant and At-Risk Ranges and PCRI Ratings of Parents' Attitudes toward Parenting and Child-Rearing within Low Ranges (Dyads 1 and 2)

	BASC			PCRI	
	Pretest	Posttest	Multi-form Comparisons	Pretest	Posttest
Dyad 1					
Child 1 (SRP-C)	Attitude to School Interpersonal Relations Self-Esteem Self-Reliance		Depression * Internalizing Problems ** Emotional Symptoms Index *		
Parent 1 (PRS-C) (PCRI)	*Behavioral Symptoms Index* Aggression Conduct Problems Anxiety Somatization Adaptability Social Skills Leadership *Depression* *Atypicality*	Behavioral Symptoms Index Withdrawal Adaptability Leadership Depression *Atypicality*	Depression ** Clinical Maladjustment * Personal Adjustment *** Behavioral Symptoms Index ***	Parental Support Limit Setting	
Dyad 2					
Child 2 (SRP-C)			Attitude to School ** Anxiety ** School Maladjustment ** Clinical Maladjustment **		
Parent 2 (PRS-C) (PCRI)	*Behavioral Symptoms Index* Aggression *Hyperactivity* *Conduct Problems* *Anxiety* *Depression* *Atypicality* *Attention Problems* *Adaptability*		Hyperactivity *** Anxiety *** Depression *** Atypicality *** Attention Problems *** Behavioral Symptoms Index *** Externalizing Problems *** Internalizing Problems ***		

BASC psychosocial measures within At-Risk ranges and PCRI measures within Low ranges displayed in regular font; italicized font denotes BASC measures within the Clinically Significant ranges; the absence of any identified scales indicates that the findings for that particular measure or period were within Average ranges or acceptable limits.

Multi-form comparisons between pre- and posttest ratings indicate significant differences or positive improvement changes and are denoted as follows:
* $p < .10$; ** $p < .05$; *** $p < .01$

Table 2. BASC (SRP-C and PRS-C) Ratings of Children's Psychosocial Measures within Clinically Significant and At-Risk Ranges and PCRI Ratings of Parents' Attitudes toward Parenting and Child-Rearing within Low Ranges (Dyads 3 and 4)

	BASC			PCRI	
	Pretest	Posttest	Posttest-to-Pretest Comparisons	Pretest	Posttest
Dyad 3					
Child 3 (SRP-C)	*Emotional Symptoms Index* Attitude to School Atypicality Social Stress Self-Esteem *Sense of Inadequacy* *Depression* *Relations with Parents* *Interpersonal Relations* *Self-Reliance*	Emotional Symptoms Index Attitude to School Sense of Inadequacy *Interpersonal Relations*	Atypicality *** Depression *** Relations with Parents ** Self-Esteem ** Clinical Maladjustment * Personal Maladjustment *** Emotional Symptoms Index ***		
Parent 3 (PRS-C) (PCRI)	*Behavioral Symptom Index* Hyperactivity Somatization Attention Problems Social Skills *Aggression* *Conduct Problems* *Anxiety* *Depression* *Atypicality* *Adaptability*	Atypicality Attention Problems *Conduct Problems* *Adaptability*	Aggression * Anxiety *** Depression *** Atypicality * Externalizing Problems ** Internalizing Problems *** Behavioral Symptoms Index *** Adaptive Skills *	Parental Support Involvement Communication	Parental Support
Dyad4					
Child 4 (SRP-C)					
Parent 4 (PRS-C) (PCRI)	Depression Withdrawal *Anxiety*	Behavioral Symptoms Index Aggression Depression Atypicality Withdrawal Adaptability *Anxiety*		Parental Support Limit Setting Autonomy	

BASC psychosocial measures within At-Risk ranges and PCRI measures within Low ranges displayed in regular font; italicized font denotes BASC measures within the Clinically Significant ranges; the absence of any identified scales indicates that the findings for that particular measure or period were within Average ranges or acceptable limits.

Multi-form comparisons between pre- and posttest ratings indicate significant differences or positive improvement changes and are denoted as follows:
* $p < .10$; ** $p < .05$; *** $p < .01$

Table 3. Multiform (Pre- and Posttest) *T*-Score Comparisons of Children's Self-Perceived Psychosocial Ratings based on the BASC Self-Report of Personality—Child (SRP-C) Results

	Child 1			Child 2			Child 3			Child 4		
BASC Self-Report of Personality—Child (SRP-C)	**Pretest**	**Posttest**	**Sig.**	**Pretest**	**Posttest**	**Sig.**	**Pretest**	**Posttest**	**Sig.**	**Pretest**	**Posttest**	**Sig.**
Clinical Scales												
Attitude to School	61	53	NS	57	38	.05	68	68	NS	42	38	NS
Attitude to Teachers	49	44	NS	49	40	NS	53	53	NS	44	40	NS
Atypicality	54	51	NS	40	37	NS	69	46	.01	43	43	NS
Locus of Control	59	43	.05	41	36	NS	59	52	NS	36	39	NS
Social Stress	57	45	NS	51	42	NS	64	57	NS	39	42	NS
Anxiety	59	59	NS	49	34	.05	51	57	NS	40	38	NS
Depression	58	46	NS	43	43	NS	75	46	.01	41	46	NS
Sense of Inadequacy	47	44	NS	55	44	NS	78	67	NS	40	44	NS
Adaptive Scales												
Relations with Parents	57	57	NS	57	57	NS	22	45	.05	51	51	NS
Interpersonal Relations	40	53	NS	53	58	NS	18	26	NS	58	53	NS
Self-Esteem	40	57	NS	57	57	NS	34	52	.10	57	57	NS
Self-Reliance	32	51	NS	58	62	NS	28	43	NS	54	51	NS
Composite												
School Maladjustment	56	48	NS	53	38	.05	62	62	NS	42	38	NS
Clinical Maladjustment	58	49	.10	45	35	.05	62	53	.10	38	39	NS
Personal Maladjustment	40	56	.01	58	61	NS	18	39	.01	56	54	NS
Emotional Symptoms Index	59	47	.01	47	39	NS	74	60	.01	39	42	NS

T-score result are based on converted SRP-C raw scores, based on normalized standard scores for each respective participating child's chronological age and gender with a standard deviation of 10. The following is a descriptive aid for interpreting the above *T*-scores results and respective classification (Reynolds & Kamphaus, 1998):

Classification		
Clinical Scales	**Adaptive Scales**	***T*-Score Range**
Clinically Significant	Very High	70 and above
At-Risk	High	60 – 69
Average	Average	41 – 59
Low	At-Risk	31 – 40
Very Low	Clinically Significant	30 and below

Table 4. Multiform (Pre- and Posttest) *T*-Scores Comparisons of Parents' Psychosocial Ratings of their Children based on BASC Parent Rating Scales—Child (PRS-C) Results

BASC Parent Ratings Scale—Child (PRS-C)	Parent 1			Parent 2			Parent 3			Parent 4		
	Pretest	Posttest	Sig.	Pretest	Posttest	Sig.	Pretest	Posttest	Sig.	Pretest	Posttest	Sig.
Clinical Scales												
Hyperactivity	55	57	NS	92	57	.01	65	46	NS	49	57	NS
Aggression	62	57	NS	62	48	NS	73	57	.10	55	62	NS
Conduct Problems	60	56	NS	71	52	NS	83	83	NS	49	45	NS
Anxiety	69	53	NS	80	53	.01	86	53	.01	71	71	NS
Depression	77	60	.10	77	51	.01	93	51	.01	67	69	NS
Somatization	62	59	NS	53	39	NS	65	50	NS	50	53	NS
Atypicality	80	72	NS	84	42	.01	97	67	.05	50	67	NS
Withdrawal	57	60	NS	57	44	NS	57	41	NS	63	60	NS
Attention Problems	55	53	NS	71	50	.01	68	63	NS	45	47	NS
Adaptive Scales												
Adaptability	33	39	NS	27	44	NS	19	30	NS	44	39	NS
Social Skills	38	41	NS	48	48	NS	35	41	NS	54	57	NS
Leadership	35	39	NS	48	46	NS	41	52	NS	44	52	NS
Composite												
Externalizing Problems	60	58	NS	79	53	.01	78	64	.05	51	55	NS
Internalizing Problems	75	60	.05	76	47	.01	91	52	.01	66	69	NS
Behavioral Symptoms Index	73	62	.10	90	50	.01	93	59	.01	59	67	NS
Adaptive Skills	33	38	NS	40	45	NS	29	40	.10	47	49	NS

T-score results are based on converted PRS-C raw scores, based on normalized standard scores for each respective participating child's chronological age and gender with a standard deviation of 10. The following is a descriptive aid for interpreting the above *T*-score results and respective classifications (Reynolds & Kamphaus, 1998):

Classification		*T*-Score Range
Clinical Scales	**Adaptive Scales**	
Clinically Significant	Very High	70 and above
At-Risk	High	60 – 69
Average	Average	41 – 59
Low	At-Risk	31 – 40
Very Low	Clinically Significant	30 and below

Table 5. Multiform (Pre- and Posttest) *T*-Score Comparisons of Parents' Self-Reported Ratings of their Attitudes toward Parenting and their Children based on Parent-Child Relationship Inventory (PCRI) Results

	Parent 1			Parent 2			Parent 3			Parent 4		
Parent-Child Relationship Inventory (PCRI)	**Pretest**	**Posttest**	**Sig.**	**Pretest**	**Posttest**	**Sig.**	**Pretest**	**Posttest**	**Sig.**	**Pretest**	**Posttest**	**Sig.**
Clinical Scales												
Parental Support	38	40	*	47	58		33	38		16	45	*
Satisfaction with Parenting	48	52		66	66		50	54		57	57	
Involvement	72	55		55	55		37	52	*	52	47	
Communication	50	53		58	62		34	47	*	55	43	
Limit Setting	38	61	*	50	72		45	47		39	47	*
Autonomy	49	59		49	59		49	41		39	40	*
Role Orientation	55	59		57	59		66	55		62	59	

T-score results are based on converted PCRI raw scores, based on normalized standard scores for mothers with a mean of 50 and a standard deviation of 10. The following is a descriptive aid for interpreting the above *T*-score results and respective classifications (Gerard, 1994).

Classification		
Range	**Description**	***T*-Score Range**
Average	Attitude congruent with good parenting	40 and above
Low	Identified area of parental problems	30 – 39
Very Low	Serious parental problems	29 and below

Summary

These quantitative findings appear to indicate that in all cases except Dyad 4 there were significant differences or positive improvement changes in both the psychosocial measures of the children and the parental attitudes of the mothers. For instance, the SRP-C self-reported ratings from Child 1 at time of pretest indicated psychosocial problems within the At-Risk range on measures of Attitudes to School, Interpersonal Relations, Self-Esteem, and Self-Reliance. At time of posttest, however, there were no significant or elevated psychosocial measures in this child's self-reported ratings. A multi-form comparison of these pre- and posttest measures further indicated significant differences or positive improvement changes on scales of Depression ($p < .10$), Internalizing Problems ($p < .05$), and the overall Emotional Symptoms Index ($p < .10$). While the PRS-C pretest ratings from Parent 1 would place her child within the more severe Clinically Significant range on the overall Behavioral Symptoms Index, this same scale was indicated within the less severe At-Risk range when posttest ratings were provided. Additionally, other pretest psychosocial ratings provided by Parent 1 indicated another seven within the At-Risk range and two within the Clinically Significant range, while posttest psychosocial ratings indicated four measures within the At-Risk range and one within the Clinically Significant range. Moreover, multi-form comparisons between the pre- and posttest ratings provided by Parent 1 indicated significant differences or positive improvement changes on psychosocial measures of Depression ($p < .05$), Clinical Maladjustment ($p < .10$), Personal Adjustment ($p < .01$), as well as the overall Behavioral Symptoms Index ($p < .01$). On the PCRI, while the pretest results indicated measures of Parenting Support and Limit Setting were within the Low range, it appears Parent 1 did not perceive these as a significant problem at time of posttest.

The BASC and PCRI results obtained from Dyad 2 provide a parallel, albeit somewhat differing, clinical interpretation of these findings. For instance, on both the SRP-C pre- and posttest measures, the self-reported ratings obtained from Child 2 did not indicate any significant problem areas. Nonetheless, it is interesting to note that multi-form comparisons of these two measures indicated significant differences were achieved in the psychosocial areas of Attitude to School ($p < .05$), Anxiety ($p < .05$), School Maladjustment ($p < .05$), and Clinical Maladjustment ($p < .05$). These findings suggest that while the self-reported ratings provided by Child 2 were within the Average range when both the pre- and posttest SRP-Cs were administered, improvements were clinically significant on several of these psychosocial measures to support a statistical difference in these psychosocial scales and composites. Moreover, the pre-and posttest ratings provided by Parent 2 PRS-C indicated the most dramatic findings in that Child 2 at pretreatment exhibited a Clinically Significant overall Behavioral Symptom Index followed by seven psychosocial measures within the Clinically Significant range and one within the At-Risk range. At time of posttreatment, however, none of these psychosocial areas were statistically significant. No significant findings were indicated on the pre- and posttest PCRIs, thus lending a clinical interpretation that Parent 2 perceived herself as relatively capable in her parenting attitude and child-rearing responsibilities and that these self-perceptions remained relatively constant throughout her participation in the research study.

For Dyad 3, many of the aforementioned quantitative findings could be similarly presented and discussed. For instance, while specific psychosocial measures may differ, the pre- and posttest results obtained from self-reported ratings on the SRP-Cs and the PRS-C also indicated significant differences or positive improvement changes reflecting

that were fewer and less severe psychosocial problems exhibited by Child 3 at posttreatment. Similarly, pre- and posttest measures obtained from self-reported ratings on the PCRI also indicated that Parent 3 exhibited at least some positive changes in her attitudes toward parenting and child-rearing.

In contrast with the other participating children and parents, the quantitative results obtained on Dyad 4 provide a somewhat puzzling or confusing clinical interpretation. For instance, the findings on the self-reported SRP-C would suggest that Child 4 presented with no psychosocial problems at pretreatment, no psychosocial problems at posttreatment, and that there were no significant differences between the pre- and posttest periods. Based on these findings, one possible clinical interpretation is to suggest that Child 4 exhibited a relatively healthy psychological sense of self (intrapersonal) and sense of relatedness (interpersonal). Perhaps even more perplexing, however, is the fact at pretreatment the mother's ratings on the PRS-C indicated fewer and less severe than the ratings provided at posttreatment. These latter findings seem to suggest that any psychosocial problems Child 4 exhibited before the treatment in fact increased or worsened in their number and severity. This clinical interpretation of these results is further supported by the fact that multi-form comparisons of these instruments produced no significant findings. That is, the data analysis software employed here is specifically designed to verify significant differences within the realm of positive rather than negative improvement changes. Therefore, no significant findings were found in the multi-form comparisons for Dyad 4. On the PCRI, however, it appears that Parent 4 did indeed was improved or strengthen her self-perceived attitudes toward parenting and child rearing.

In summary, the aforementioned quantitative findings present a conundrum for not only the present research study, but for clinical research in general. In response to the first research question for the present study, we can say with some degree of certainty that these quantitative results suggest that filial play therapy positively enhances the psychosocial well-being of children as well as the self-perceived abilities of parents, and, thereby, strengthens the parent-child relationship. At the very least, to arrive at such inferences would be more compelling if similar, clearly delineated outcome measures were achieved for all of the participating families. While it appears such inferences may be reasonable when interpreting the results for Dyads 1, 2, and 3, it appears far less clear when interpreting the results for Dyad 4. As discussed earlier in the section on conducting meaningful clinical research, to arrive at such concluding remarks becomes exceedingly difficult when primarily considering pretreatment and posttreatment measures for interpreting research outcomes and for forming clinical decisions. Thus far, the present research study exemplifies the need for clinicians to move toward and develop empirical methods for constructing and conducting process-outcome research. It is hoped that the following section examining the quality of the treatment processes and intervening variables as well as the interpersonal processes of the participating families will better elucidate these quantitative findings.

Qualitative Results

This section on qualitative results aims to accentuate the quantitative findings discussed earlier. First, it begins with a discussion about some of the diagnostic and therapeutic observations that emerged during the participant interviews and data collection periods. In addition, parents, and sometimes children, offered comments about their thoughts and experiences, as well as provided some contextual information

about their current life conditions. For instance, during training sessions parents oftentimes offered anecdotal reports and observations about their child. Secondly, the results and interpretation of the qualitative instruments specifically developed and investigated for the present research study are presented and discussed. In addition to these therapeutic observations, the following section includes a brief discussion about the diagnostic procedures used to assess each the mother and child of each dyad, thus lending additional diagnostic information on the child-parent interpersonal relationship.

Diagnostic Impressions and Therapeutic Observations

Initial diagnostic impressions were considered by utilizing the information obtained the intake interview, the first baseline (B1) measure, and administration of the Paper Exercise (PE). The procedures of the PE (see Appendix D) examines each individual's: (a) capacity for self-definition; (b) management of boundaries between self and other; (c) recognition of the separate wholeness of the individual; (d) capacity to handle conflict; (e) ability to negotiate; and (f) capacity to give and receive. These integrative measures and diagnostic criteria provide the starting points for employing the observational coding measures of developmental filial therapy (see Appendix C).

Dyad 1

At the beginning of treatment implementation, the Dyad 1 participants were residents of the shelter. Some of the presenting concerns included the child low self-esteem, withdrawal or "escapism" by means of continuous television watching, as well as since birth having witnessed and being victimized by physical abuse, with some question of sexual abuse. In addition, some of the conditions of the mother's health required several previous hospitalizations. Based on the information gathered from the first baseline (B1) session and the Paper Exercise, Child 1 was diagnosed to be within the

Differentiating stage, and Parent 1 was diagnosed to be also within the Differentiating stage. Some of the qualitative behaviors observed in both individuals included: some willingness to negotiate with other, a modest capacity for self-definition, mildly defined personal boundaries, reticent recognition between self and other (e.g., occasional use of 'I' statements). Based on these criteria and therapeutic observations, the diagnostic impression for Child 1 was considered to be Differentiating, and Parent 1 was also considered to be within the Differentiating stage; thus, the child-parent developmental relationship for the respective Dyad 1 participants was diagnosed as Differentiating-Differentiating.

Following the second baseline (B2) measure, that is, before treatment implementation, Parent 1 reported observing positive behaviors in her child. For example, she mentioned that Child 1 was listening better and the bedtime routine seemed easier in that there was greater compliance. Once treatment (T_1) began, Child 1 expressed interest or curiosity about the mother's desire to "learn how to play." At about midpoint (T_5) of the treatment, Parent 1 expressed frustration and concerns about the welfare of nonparticipating family, also residing at the shelter. Moreover, these concerns seemed to reemerge in following sessions, and she described that she was emotionally affected by these recent events which involved child welfare services. Although these events did not directly involve the Dyad 1 family, they did prompt Parent 1 to take action and discharge the family from the shelter a few days early. Nonetheless, Parent 1 affirmed her interest and willingness to continue participation in the study, and reiterated her observations about the benefits of treatment. The early shelter discharge of Dyad 1 did not negatively affect the completion of data collection for the remaining treatment sessions; however, extraneous circumstances (e.g., childcare unavailability)

occasionally interfered with other research procedures (e.g., session-end parent training meetings).

The absence of the session-end parent training meetings with Parent 1 for some of the latter treatments (T6 – T7) appeared to negatively affect the treatment process. For example, there appeared to be a negative, qualitative difference in the skills ability and implementation of Parent 1, and in the responsiveness and enthusiasm of Child 1. This observation was mutually shared by Parent 1, and a commitment was made to ensure that the session-end parent training meetings occur for the remainder of their participation in the study. For the remainder treatment sessions (T8 – T9), the filial therapy skills for Parent 1 appeared to advance more easily and naturally. Child 1, initially appearing somewhat resistant to the mother's filial therapy techniques (e.g., some risk-taking and immersing herself in the role of play), gradually seemed to respond positively to the mother's interpersonal enactments. Finally, during the treatment follow-up (TF) there appeared to be a slight, but observable decrease in the quality of both the intra- and interpersonal processes of Parent 1 and Child 1.

Dyad 2

The individuals of Dyad 2, while not presently residents of the shelter, were referred to the research study given their previous residential involvement and their relatively extensive involvement with other intervention programs such as parent education, individual adult therapy, and individual child play therapy. At time of intake, Parent 2 expressed concerns about her child's "clingingness" or intense need to be "close" to her, as well as the "jealousy" she described that her child expressed when she divided her attention toward others (e.g., friends) or other activities (e.g., telephone conversations). Child 2 was reported to also experience some undiagnosed learning

difficulties (e.g., reading). Rather than adopt a passive-aggressive stance in response to these symbiotic behaviors, however, Child 2 was reported to "manipulate" and make overt demands to be closer to mother. Not surprisingly, Parent 2 further expressed some concerns about how the techniques of nondirective play therapy (e.g., empathic attunement) may actually increase her child's inability to appropriately "separate" from her. Based on this account and the information gathered from the first baseline (B1) session and the Paper Exercise, Child 2 was diagnosed to be within the Symbiotic (Hostile-Dependent) stage, and Parent 2 was diagnosed to be also within the Differentiating stage. Some of the qualitative behaviors observed in the child included: resistance or reluctance to negotiate with other, ill-defined capacity for self-definition and personal boundaries, negative attention-seeking, defensive stance with vague recognition between self and other. The mother, on the other hand, was observed exhibiting behaviors including: some willingness to negotiate with other, a modest capacity for self-definition, mildly defined personal boundaries, reticent recognition between self and other (e.g., occasional use of 'I' statements). Hence, the diagnostic impression for the Dyad 2 child-parent relationship was considered to be Symbiotic (Hostile-Dependent Type)-Differentiating.

During the administration of the baseline (B1 – B2) sessions and the first two treatment (T1 – T2) sessions, there did not appear to be any remarkable observations made by the present researcher or comments made by the research participants. Following third treatment (T3) session, Parent 2 expressed that she noticed observable differences in her child's behavior. For instance, she reported that her child seemed to be less argumentative, exhibited fewer worries and less anxiety, and there appeared to be an improvement in the child's bedtime routines. Many of the examples appeared to indicate

her child was feeling more secure to engage in independent activities (e.g., spending more independent time in own bedroom, allowing mother to complete tasks). However, she also expressed some uncertainty about her observations and posed some skepticism about the treatment itself (e.g., "Should I be noticing these changes so soon?").

Similar comments and observations were offered following implementation of the next two treatment sessions (T4 – T6). Moreover, at this point in the treatment process Parent 2 indicated that she could perceive how some of the parent training skills (e.g., empathic listening) could be generalized for use with others in adulthood interpersonal relationships (e.g., Marketing, Sales) and with significant others (e.g., boyfriend). Although Mother 2 expressed that separation-individuation processes in her child appeared to be sustained in the next treatment (T6) session, she raised other concerns central to the child's seeming "need to control." Reviewing the filial play therapy techniques and the fundamental principles of nondirective play therapy seemed to provide some at least some reassure for Mother 2, thereby permitting a reemergence in her ability to "trust the process."

The next two treatment (T7 – T8) sessions were marked by reports of continued gains in the original presenting concerns and behaviors of Child 2. For instance, regarding the child's ability to differentiate (e.g., "...no longer needing to sleep in my bed.") and verbalizations about looking forward to formerly aversive school situations (e.g., "I'm not going to have any trouble with substitute teachers this year."), Mother 2 described these examples as "huge." Additional comments included an increased ability in Child 2 to "focus" and a noticeable decrease in level of "frustration." Moreover, Parent 2 commented that others (e.g., boyfriend, friends) have additionally observed and commented about these positive changes in the behaviors of Child 2. However, in the last

treatment (T9) session, and, to a lesser degree in the follow-up treatment (TF) session, there was an observable and seemingly increased aggressive tendency in the play activity of Child 2. Further, it was observed during these final treatment sessions that there was increased potential for conflict in the parent-child relationship. For example, on several occasions Child 2 appeared to test the limits the mother imposed during the play activity (e.g., kicking the puppets) whereby she eventually put a complete stop to it. Interestingly, although it appeared the conflict would easily escalate, Child 2 responded to the limit setting and, slowly but steadily, many of the positive parent-child enactments were renewed.

Dyad 3

Dyad 3 participants remained shelter residents during their entire participation in the present research study. Parent 3 reported that her child, beginning at an early age, had undergone several years of severe physical, emotional, and sexual abuse, as well as witnessing incidents involving "severe family violence," pornography, and adult sexual activity. Child 3 was reported to exhibit behavioral concerns including immaturity (e.g., thumb-sucking, bedwetting, tantrums), lying, sleep difficulties (e.g., nightmares), aggression, and negative attention-seeking. Child 3 was reported to also experience some unspecified learning difficulties. In addition, Mother 3 later disclosed during the delivery of the advanced parent training that she identified closely with the videotape session sample; that is, she reported that she had been previously diagnosed with a terminal illness, a fact that had been previously shared with her child. These presenting concerns and the first baseline (B1) measure and the Paper Exercise assisted in providing the developmental diagnosis for Dyad 3. Accordingly, Child 2 was diagnosed to be within the Symbiotic (Hostile-Dependent) stage, and Parent 2 was diagnosed to be also within the

Differentiating stage. Qualitative behaviors observed in the child included: resistance or reluctance to negotiate with other (e.g., immediately grabs paper from other), ill-defined capacity for self-definition and personal boundaries, defensive stance with vague recognition between self and other, no attempt to negotiate. The mother was observed exhibiting behaviors including: some willingness or attempt to negotiate with other, a modest capacity for self-definition, mildly defined personal boundaries, expressed surprise or disappointment that child did not seek mutually agreeable outcome. Hence, the Dyad 3 child-parent relationship for was diagnosed to be Symbiotic (Hostile-Dependent Type)-Differentiating.

In terms of treatment observations, no remarkable observations or comments were presented during the administration of the baseline (B1 – B2) sessions. Following administration of the first treatment (T1) session, Mother 3 reported improved behavior (e.g., more settled) in her child's ability to follow-through bedtime routine and expectations. However, Dyad 3 later expressed a need to temporarily withdraw (i.e., couple days) their participation from the study considering notice received about the death of a family member. No remarkable observations or comments were presented during the administration of the second treatment session (T2).

The third treatment (T3) session involved a play activity involving Child 3 enacting an event involving domestic violence (e.g., dad hitting mother, pulling mother's hair). During the parent training session and review of the IUM, Mother 3 expressed unease about this particular session and experience. In the next treatment (T4) session, Mother 3 commented about how the play theme again reminded her of daily proceedings, and how she had difficulty employing the filial therapy skills (e.g., empathic listening) in the playroom because it reminded her of the night prior when "the children

trashed the bedroom." She also expressed unawareness that these skills could be and should be practiced outside the playroom, as well. In other words, she said that she had not been attempting to actively employ the parenting skills outside her participation in the study. During the review of the next IUM following treatment (T5), Mother 3 indicated that she had developed further insights into the therapeutic benefits of play therapy, and expressed that she personally found it "helpful to play." In the following treatment (T6) session Mother 3 provided some contextual examples common play therapy themes, for example, nurturance. Moreover, after having disclosed her own terminal illness condition, Mother 3 expressed a stronger conviction to improve her health and commitment to parenting (e.g., "They need me. I'm all they have."). Interestingly, at this point there also appeared to a noticeable change in the appearance of the mother and child (e.g., no longer arriving in pajamas and slippers). Mother 3 also expressed excitement about her finding new employment.

Not unlike the play themes depicted during presentation of the advanced training videotape sample, in the eighth treatment (T8) session Child 3 appeared to work through personal feelings involving the mother's terminal illness. For example, while not immediately apparent to Mother 3 during the filial therapy session, review of the IUM allowed her to perceive its power and her child's feelings of "worry" and "helplessness." While Mother 3 appeared sincerely touched by this newly acquired awareness, she also expressed feeling overwhelmed by it emotional content. In the final treatment (T9 – TF) sessions, it appeared that Dyad 3 was entering into a period of increased strain in their parent-child relationship marked by observable behaviors such as the child's oppositional behaviors and the mother's expressive feelings of stress involving imminent discharge from the shelter (e.g., employment and home relocation uncertainties).

Dyad 4

Dyad 4 participants remained shelter residents during their entire participation in the present research study. According to Parent 4, some of the presenting concerns her child exhibited included being "highly organized and goal orientated." In addition, Child 4 was described as being hypersensitive, "easily hurt," and as a child who "worries about a lot of things." In short, Parent 4 described many positive qualities about her child's abilities (e.g., academic achievements) and adaptive functioning skills. She also recognized that her child presented as highly anxious and sometimes engaged in behaviors such negative attention seeking (e.g., pushing and pulling others) and withdrawal from peer interests and activities. In contrast to previous Paper Exercise administrations with the other dyads, Child 4 nearly immediately offered the mother the piece of paper, then smiled and laughed about the decision in what could have been interpreted as a caretaking role. In doing so, the child queried the mother's interest or desire to have the paper, and tried to understand the mother's ascribed meaning of the paper. On the other hand, Parent 4 appeared equally surprised and touched by her child's offering. While the mother offered had little opportunity to self-define or negotiate her experience during the exercise, she said to her child, "I wasn't going to let you have it so easily." Hence, the Dyad 4 child-parent relationship was diagnosed to be Practicing-Differentiating.

Similar to other participating mothers, Parent 4 reported observable improvements in her child's behavior following administration of only the baseline (B1 – B2) sessions. Specifically, she reported that the bedtime routines were implemented more easily with noticeably more compliance in her child's willingness and ability to follow through expectations. During these pretreatment sessions, Child 4 was observed

as being highly directive and structured in her play activity. Following the first treatment (T1) session, Parent 4 expressed personal embarrassment and discomfort to engage in some of the play activities directed by her child (e.g., dress-up in play clothes). En route to the second treatment (T2) session, Child 4 appeared impatient by an older sibling's attempt to delay or perhaps sabotage the daily session. To this 10-year-old sibling's behavior, Child 4 said, "You're an adult—act like one!" Incidentally, similar challenges were encountered for nearly all other remaining treatment sessions in that oftentimes an older or a younger sibling (e.g., separation anxiety), or both, would make direct and intense demands necessitating the mother's attention and intervention. Overall, although Parent 4 described that she found the transition periods to begin the daily sessions as overwhelming and exhaustive, she further indicated when immersed in the sessions that she thoroughly appreciated the "alone time" with her child. Moreover, she expressed commitment to continue the remaining treatment sessions because she could observe the importance of "these special play times" for the child.

Following the third treatment (T3) session, however, Parent 4 expressed having some discomfort about dealing with some of the child's play activity and emerging themes. During a play house activity, for example, the mother said she was uncertain about how to engage her child while Child 4 made comments such as "Dad is no longer living at home," and, "Now, dad is on vacation." Additionally, Parent 4 expressed both in-session to her child (e.g., "I must really love you to do this") and during the parent training to the present researcher that she continued to have discomfort with the child's pointed instruction to engage in dress-up play activity. Interestingly, Child 4 seemed to be acutely attuned to the mother's discomfort with this particular play activity (e.g., "You

know don't have to if you don't want to"), and did not introduce dress-up play in future treatment sessions.

Following treatment (T4 – T5) sessions included play themes and activities involving nurturance (e.g., instructing mother to feed from baby bottle) and mutual child-parent reciprocity (e.g., child preparing meals for the mother). During the next treatment (T6) session, which took place a couple days later, Parent 4 reported an escalation in and having difficulty managing the behaviors of the participating child and siblings. For example, she described an increase in parent-child and sibling-sibling conflict involving both physical and verbal abuse. Incidentally, this break in the treatment also marked a period in which all the children visited their biological father, who, reportedly, was attempting to manipulate and coerce them and the mother. At T6 session end, the mother and child were observed in a long, tight embrace, and Child 4 was in tears. Parent 4 later said, "I haven't seen [child's name] cry in years."

During the next treatment (T7) session, Parent 4 interpreted her child's feelings (e.g., "sadness") and acting out behaviors as expressed unwillingness to the approaching termination of the filial play therapy treatment sessions. For example, the mother said, "It's [child's name] only stability." Moreover, she interpreted the escalation in the behaviors because "[child's name] has kept those feelings inside for so long." Despite several attempts, Child 4 seemed only moderately mollified by the mother's assurances about how "learning to play" could enhance opportunities to play in their future home environment. Interestingly, while there did not appear to be any overt concerns previously mentioned or observed, Child 4 later expressed an intense opposition to her mother having to discuss the T7 session with the present researcher (i.e., parent training follow-up). Following delivery of the next daily treatment (T8) session, however, Child 4

consented to discussing some of these presenting concerns with the mother and present researcher. Accordingly, Child 4 expressed fears about being subjected to abusive behaviors from siblings while not being closely supervised by the mother (i.e., during parent training sessions). Parent 4 later conveyed a newly developed understanding about the long-term effects of abuse and how these can be transmitted through intergenerations. For example, Parent 4 said she could envision the potential long-term benefits from filial therapy; that is, how Child 4 could employ these same skills in the interpersonal relationships of future generations (e.g., offspring).

During the termination treatment (T9 – TF) sessions, the presentation of Child 4 appeared to be expressed with much sadness and displeasure about the finality of the conjoint child-parent special play times. In contrast with earlier sessions, for example, Child 4 appeared less self-assured and more anxious while engaging in play activity. In response to these observations, Parent 4 provided continued assurances about plans to continue the special play times within the home environment. Further, she expressed her beliefs about how continued practice of the filial play therapy skills could potentially provide long-term benefits (e.g., increased self-expression, opportunities for problem-solving, reduced interfamilial conflict) for the entire family, including herself. Despite these assurances from the mother, however, Child 4 did not appear overly convinced about the potential for their merit or implementation.

Instrumentation

The following section provides the results on additional qualitative findings. These qualitative measures were obtained from the quantifiable intra- and interpersonal observations as defined using the observational measures of developmental filial therapy (see Appendix C). As discussed earlier, when reliability among the interrater observers

was found to be relatively low (less than 20%) on dissimilar videotaped enactments, and their interratings were found to be relatively high (greater than 80%) on similar videotaped enactments, each interrater conducted independent analyses of the 10-minute videotaped child-parent interpersonal enactments for each of the baseline (B1 – B2) and treatment (T1 – TF) sessions for each of the four dyads (Dyad 1 – 4). That is, the results for each respective interpersonal unit measure (IUM) were obtained from each interrater's quantifiable scores using the Developmental Filial Therapy Coding System (DFTCS). For each interrater observer, the results for each dyad were then transferred to the Developmental Filial Therapy Interrater Coding System (DFTICS). Table 6 below contains the mean composite developmental scores based on interrater agreement of successive interpersonal unit measures (IUMs). Additionally, for each participating dyad, Figures 1 – 4 below provide a graphic representation using the Developmental Filial Therapy Graph (DFTG) of these results, respectively. In short, these procedures and instrumentation measures can provide for richer interpretation of the filial therapy intrapersonal and interpersonal processes *and* session-by-session outcome data of these treatment results.

Dyad 1

As indicated numerically on Table 6 and depicted graphically on Figure 1, at baseline (B1 – B2) measures both the parent and child remained within the diagnostic stage of Differentiating where they remained until the second treatment (T2) measure. Throughout following treatment sessions, Dyad 1 participants progressed gradually toward the developmental stage of Practicing. Toward implementation of following treatment phases, both participants were observed to continue their positive progression from the Practicing stage toward the Rapprochement stage at the completion of their

study participation. In short, throughout their participation in the study, Child 1 and Parent 1 continued a positive trend in both measures of their intrapersonal (sense of self) and interpersonal (sense of relatedness) developmental ratings.

Other observations are noteworthy on Figure 1. For instance, while there were occasions in which each participant reverted backwards in developmental positioning, these negative changes were slight and temporary. It also appears that Parent 1 generally maintained a gradual, conventional progression through the elevated developmental stages. Child 1, however, on several occasions Child was rated within elevated ranges of sense of self. That is, child treatment measures T2, T3, T6 and T9 were observed to be outside the estimated limits of the specified developmental stages. Moreover, it is also interesting to note that subsequent treatment measures typically followed a trend toward a balanced sense of self and self of relatedness. Such observations and developmental trends will be discussed further in the summary of these results.

Dyad 2

Table 6 and Figure 2 depict the developmental measures and placements for Dyad 2. Accordingly, initial measures of baselines indicated Child 2 was placed within the Symbiotic stage and Parent 2 was placed within the Differentiating stage. In the following treatment sessions, both participants progressed positively or toward advanced developmental stages. At the time of concluding their participation (TF) in the study, both individuals were rated to be within the rapprochement stage, albeit the child only marginally at +10 on both scales of sense of self and sense of relatedness. For both individuals there were both positive and negative developmental trends observed between treatment sessions. Moreover, the most prominent gains were observed in Child 2 at the initial stages of treatment implementation.

Dyad 3

The results obtained from the observational measures of Dyad 3 similarly indicated positive gains for both of the participating individuals. As depicted on Table 6 and Figure 3, at time of baseline measures Child 3 was determined to be within the Symbiotic stage and Parent 3 was observed to be within the Differentiating stage. Both the child and parent were determined to be within the Practicing stage when they completed their participation in the study. While the primary trend for Dyad 3 indicated positive movement within the developmental stage pattern, there were occasions in which each individual was rated outside (i.e., higher or lower) the estimated limits of these developmental stages. Additionally, intersession measures for each of these individuals reflected some relatively dramatic or even precarious shifts in their ratings within these developmental stages.

Dyad 4

In contrast with all other participating dyads, Dyad 4 presented some rather unique and unprecedented results. For instance, Dyad 4 at pretreatment represents the only case in which the child was diagnosed to be at an elevated developmental stage compared with the parent; that is, Child 4 was diagnosed within the Practicing stage, while the diagnostic stage for Parent 4 was determined to be within the Differentiating stage. The developmental trend for Parent 4 appeared to follow a pattern similar to other participating parents, although there appeared to be an inverse relationship in the developmental trend for Child 4. That is, by the time they completed their participation in the study, Parent 4 was rated within an elevated stage of Practicing, while Child 4 was rated within the more moderate stage of Differentiating. The results developmental patterns for Dyad 4 can be reviewed on Table 6 and on Figure 4.

Table 6. Mean Composite Developmental Scores based on Interrater Agreement of the Interpersonal Unit Measures (IUMs) using the Observational Measures of Developmental Filial Therapy

Mean Composite Developmental Scores Based on Single Interpersonal Unit Measures (IUMs)		Dyad 1				Dyad 2				Dyad 3				Dyad 4			
		Parent		Child		Parent		Child		Parent		Child		Parent		Child	
	Developmental Axis	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR
	Baseline 1 (B1)	-6	-3	-3	-6	-4	-3	-13	-14	-5	-8	-14	-14	-8	-5	+7	+9
	Baseline 2 (B2)	-7	-4	-4	-8	+0	-6	-13	-14	-7	-12	-14	-15	-5	-3	+6	+3
	Treatment 1 (T1)	-5	-3	-8	-5	+2	+0	-14	-12	-3	-10	-13	-16	-7	-4	+7	+8
	Treatment 2 (T2)	+3	+3	+1	-3	+4	+6	-7	-11	-4	-8	-9	-16	+1	-2	+7	+8
	Treatment 3 (T3)	+5	+1	+8	-2	+5	+5	+1	-3	+1	+1	-3	-5	-2	+1	+9	+4
	Treatment 4 (T4)	+1	+0	+2	+5	+6	+11	+3	-2	-4	-6	-2	-3	+0	-1	+3	+3
	Treatment 5 (T5)	+7	+8	+5	+4	+8	+7	+3	+2	+4	+6	-3	+1	+1	+3	+3	-2
	Treatment 6 (T6)	+14	+14	+14	+7	+15	+12	+4	+6	+4	+4	+0	-1	+2	+3	-2	-4
	Treatment 7 (T7)	+12	+12	+15	+15	+15	+15	+10	+9	+0	+2	+6	-3	+7	+4	-4	-5
	Treatment 8 (T8)	+14	+13	+13	+11	+10	+14	+6	+11	+6	+9	+9	+6	-3	-3	-8	-7
	Treatment 9 (T9)	+17	+15	+14	+6	+10	+14	+8	+10	+10	+7	+3	+1	-4	+0	+1	+3
	Treatment Follow-up (TF)	+12	+11	+12	+11	+15	+15	+10	+10	+6	+7	+6	+5	+5	+1	-1	-1

For each respective participating individual and dyad, interrater observer mean scores were rounded either up or down for representation and plotting on the Developmental Filial Therapy Graph (DFTG).

Figure 1. Baseline (B1 – B2) and Treatment (T1 – TF) Process-Outcome Results for Dyad 1 based on Mean Interrater Observational Measures as Depicted on the Developmental Filial Therapy Graph (DFTG)

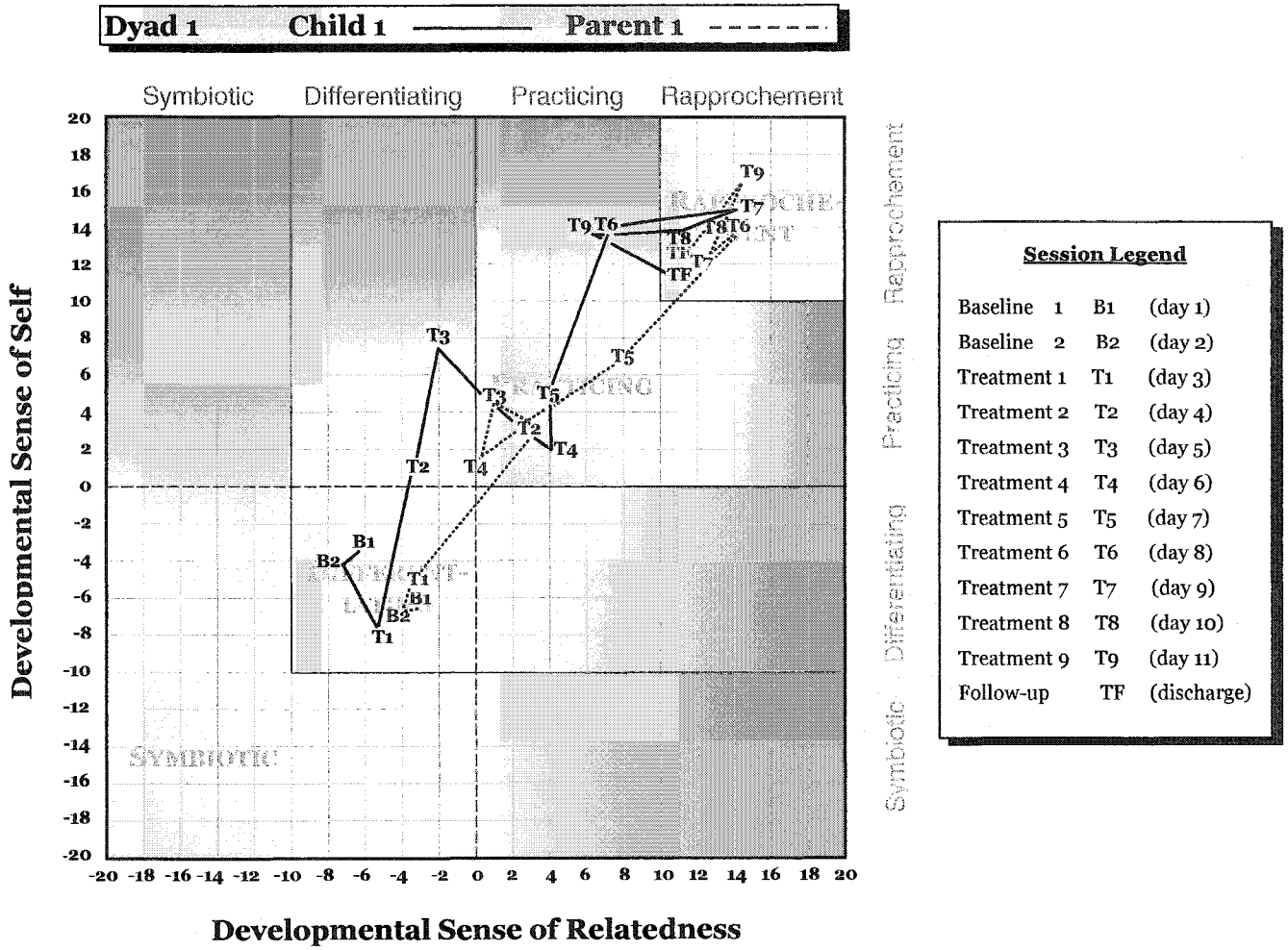


Figure 2. Baseline (B1 – B2) and Treatment (T1 – TF) Process-Outcome Results for Dyad 2 based on Mean Interrater Observational Measures as Depicted on the Developmental Filial Therapy Graph (DFTG)

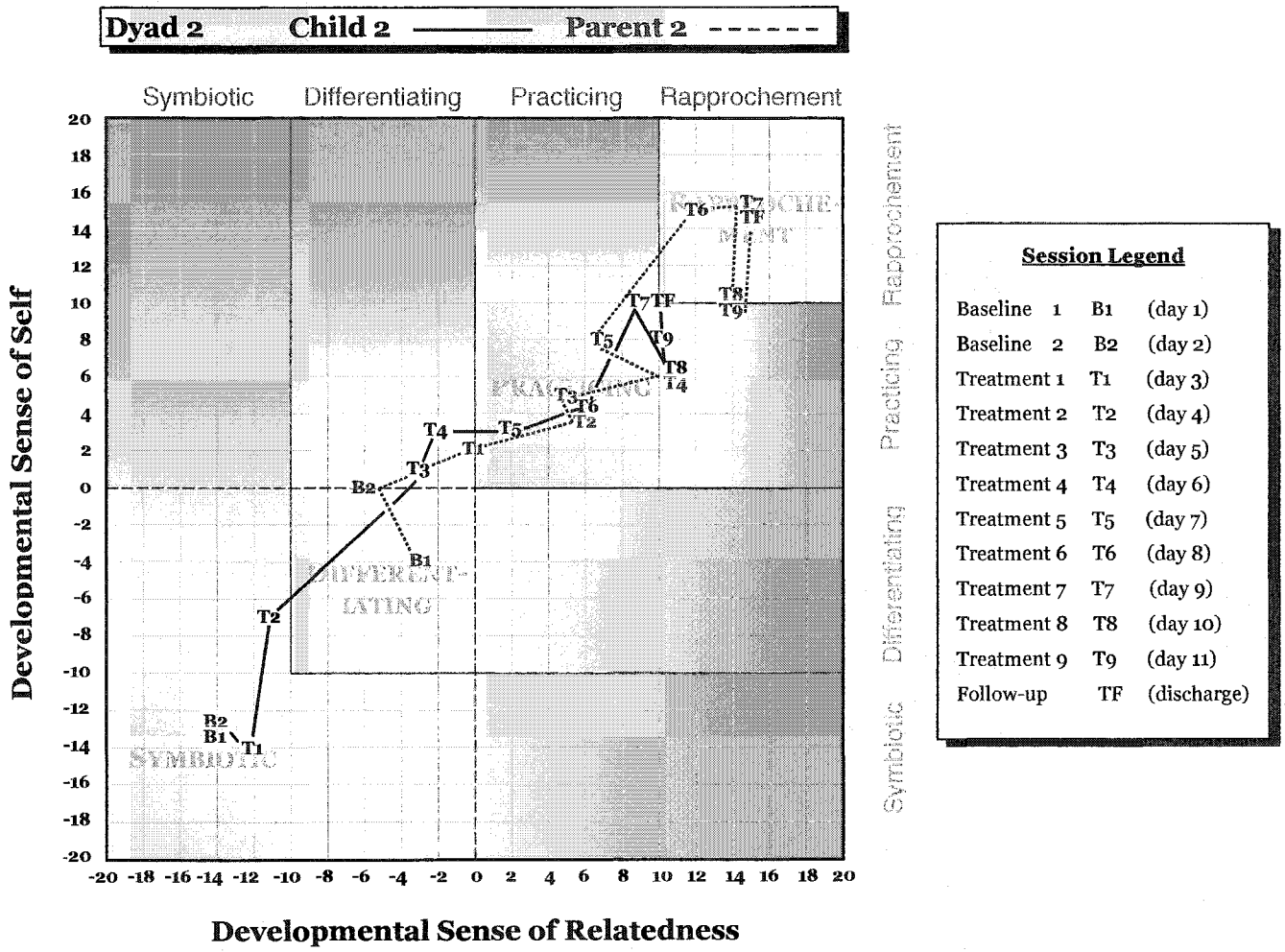


Figure 3. Baseline (B1 – B2) and Treatment (T1 – TF) Process-Outcome Results for Dyad 3 based on Mean Interrater Observational Measures as Depicted on the Developmental Filial Therapy Graph (DFTG)

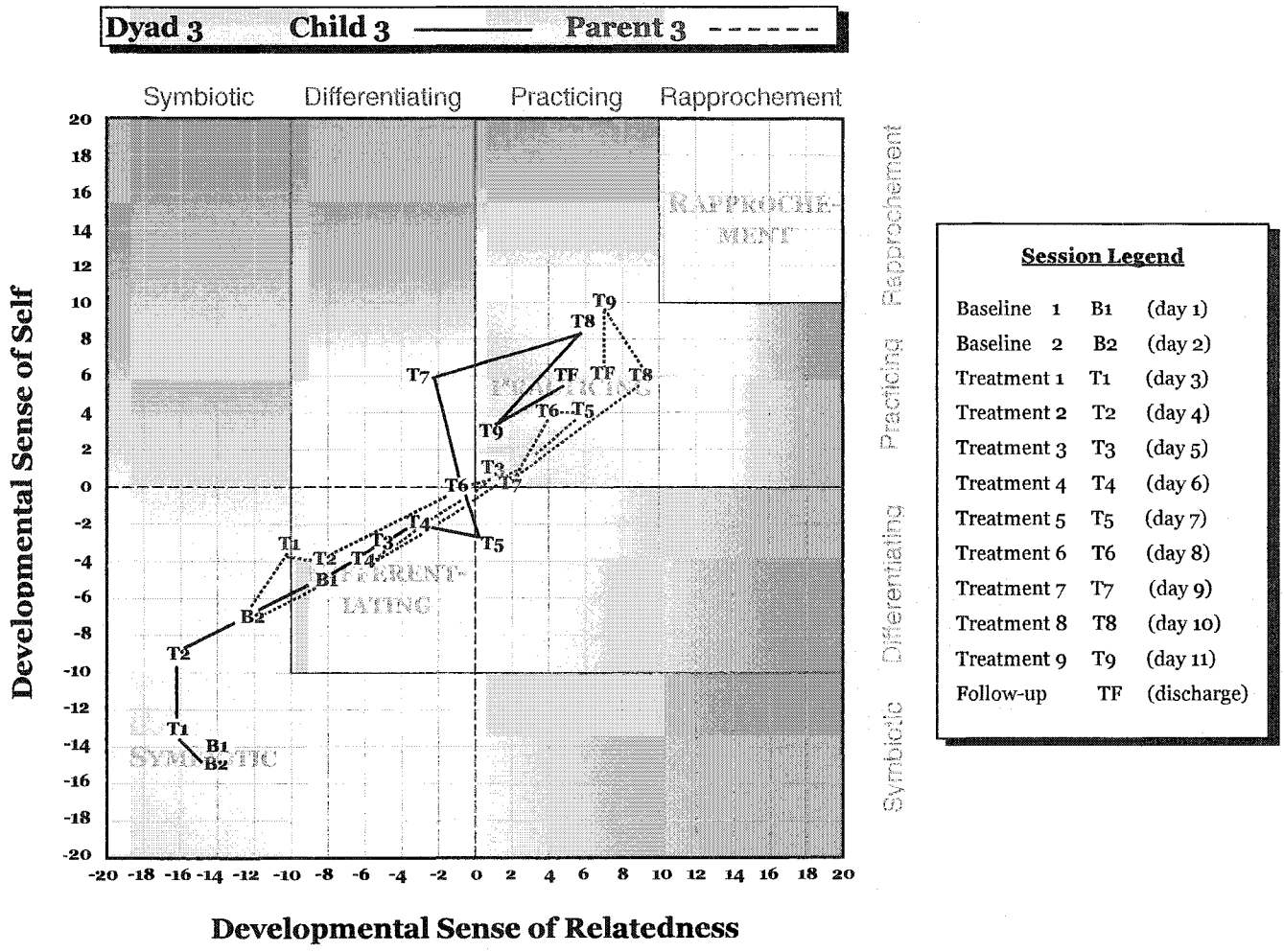
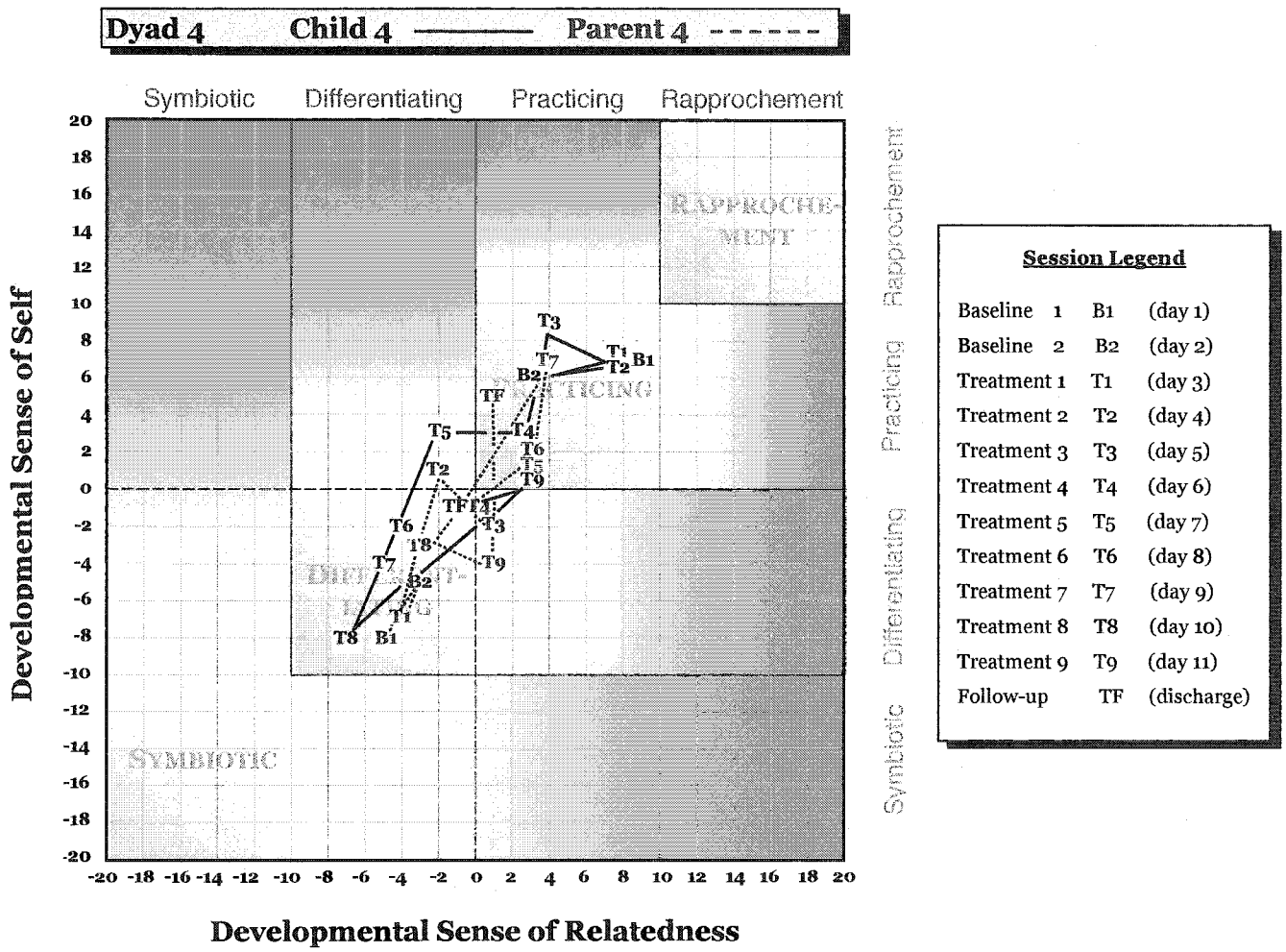


Figure 4. Baseline (B1 – B2) and Treatment (T1 – TF) Process-Outcome Results for Dyad 4 based on Mean Interrater Observational Measures as Depicted on the Developmental Filial Therapy Graph (DFTG)



Summary

It appears that the diagnostic criteria and devised instrumentation for studying dynamic process of the research participants can be supported in a variety of ways. For example, it appears that the diagnostic criteria and the quantified observational measures of these developmental processes provide for each dyad and its individual participants similar findings as the outcome measures obtained from the earlier quantitative results. Multi-form comparisons of the BASC instrumentation, for example, indicated significant improvements in the psychosocial measures for Child 1, 2, and 3. Moreover, PCRI pre- and posttest comparisons further indicated positively enhanced parental attitudes in Parent 1, 2, 3, and 4. In short, these qualitative results are not only supported by the earlier quantitative findings, but the developmental ratings based on these observational measures and instrumentation provides a richer context for interpreting the complexity of intrapersonal processes and the dynamics of interpersonal relationships.

Further, it appears that all parents began the study diagnosed within the differentiated stage. This suggests, for the most part, that all of the parents were at least somewhat emotionally available to their children. As mentioned earlier, the emotional availability or empathic attunement of the parent is an important determinant to the success of filial therapy. A parent diagnosed within the symbiotic stage, for example, is far less likely to identify specific problem areas or effectively integrate the parenting skills. On the other hand, the developmental diagnoses for the participating children were varied, ranging from Symbiotic, Hostile/Dependent type (Child 2 and 3), Differentiating (Child 1), and Practicing (Child 4).

It is a noteworthy reminder that the earlier quantitative results for Dyad 4 also reflected some unconventional developmental trends of relatedness when compared with other participating dyads. That is, the BASC outcome measures for Child 4 indicated deterioration or worsening on several psychosocial scales. On the other hand, the PCRI outcome measures for Parent 4 indicated improvements in several areas of the parenting scales. It appears then that the quantitative results for Dyad 4 obtained from comparisons between pre- and posttest measures similarly reflected the developmental trends of these participating individuals. In other words, similar to the quantitative findings, a comparison between pretest and posttest developmental ratings for Child 4 indicated a diminished developmental stage (i.e., Practicing to Differentiating), while Parent 4 was rated at an enhanced stage-level (i.e., Differentiating to Practicing).

Rather than instill blame on her child or the filial treatment itself, however, Parent 4 was fortunately able to recognize that there was therapeutic merit (e.g., catharsis) in encouraging her child's ability to express ultimately some seemingly highly guarded affect. For example, Parent 4 commented about not having witnessed her child "cry in years," and considered it important to continue facilitating in her child these expressions of feelings and emotions. Moreover, Parent 4 was receptive to observations and comments that indicated her child sometimes engaged in parentified or caretaking behaviors. During the first few filial play sessions Child 4 oftentimes engaged in activities involving teaching roles (e.g., frequent problem-solving) or offering the mother nurturance (e.g., cooking). For example, during initial treatment sessions Child 4 offered the mother repeated comments such as, "That's okay," or "We'll fix it."

By means of reviewing these videotaped interpersonal play enactments (i.e., 10-minute IUMs), Parent 4 considered that the implications of the observed present child-

parent role reversal. In doing so, she was able gradually effect change whereby her child could begin to develop an enhanced means of self-expression and enact more appropriate skills of interpersonal relatedness. It is likely that with continued treatment Child 4 would have progressed toward an enhanced developmental stage, as indicated by the developmental trend and ratings provided for concluding treatment measures (T9 and TF).

These procedures investigating the particulars of the developmental processes provided additional features for interpretation and examination. For example, it was observed that for all participating individuals there were instances in which the developmental ratings indicated a decrease or a negative change influence in their developmental standing. On possible interpretation of such findings is that in most any psychotherapeutic treatment there can be implicit expectations that individuals will progress, and digress, in the clinical evaluation of session-by-session outcomes. In other words, the 'working through' of one's intrapersonal and interpersonal problems essentially begins with the upset and magnification of thwarting self-perceptions and circumstances. While it would be impossible or speculative at best to determine the all of the aspects that contributed to any participating individual's decreased developmental rating, attending to such observations using the developmental coding system can highlight some of the possible risk factors.

For example, examination of the midpoint developmental processes for Dyad 4 (see Figure 4) indicated some interesting observations. Following T5, treatment implementation with Dyad 4 was discontinued for a couple days; it was reported that all siblings were reunited for a short period with the father, and that the mother also engaged in interactions with her former partner. Not surprisingly, the developmental

ratings provided for Child 4 decreased from T5 through T8, then climbed considerably for the latter two treatment sessions. Interestingly, while the developmental trend for the child was on the downswing, the developmental ratings for Parent 4 in fact climbed from sessions T5 through T7; there was a marked decrease in the developmental ratings for Parent 4 from T7 to T8. Interestingly, this interpersonal dynamic also reflects the condition that when one self (e.g., child) succumbs to engaging in negative behaviors, then the other (e.g., parent) is likely to engage in counteractions that effect change in an opposing direction. This interpersonal dynamic reflects the well-researched family systems principle, known as *homeostasis*. Another possible interpretation for the latter is that the parent was responding (negatively) to the child's increased demands for attention and behavioral presentations of noncompliance. For example, during this period the child intensely refused to allow the mother to review the session IUM with the present examiner. Initially, the child's behaviors were interpreted as intense separation anxiety from the mother (and possibly the father). However, following the next treatment session the child was able to appropriately express and discuss the issues that led to some of the behaviors. Accordingly, the child expressed fears about being left alone with other siblings who allegedly engaged in verbally and physically abusive behaviors when the mother was not present and able to supervise her family.

Similarly, many of the marked fluctuations in the developmental ratings for other participating dyads, either positive or negative, were also coupled with contextual information which oftentimes further enhanced the clinical interpretation of the participating individuals. For example, a decrease in the developmental ratings was observed in the many of the later treatment sessions for other participating dyads. For some, this observation could be interpreted as common termination anxiety as the

participants approached an end to the treatment. For others, it could be interpreted as an influence of extraneous variables such as expressed concerns about securing employment prior to being discharged from the shelter (Dyad 4) or about the imminent child apprehension involving another shelter family (Dyad 1).

Regardless of the reasons for any changes in the developmental ratings of the participants, from a clinician's viewpoint, interpreting them from a developmental framework of intrapersonal and interpersonal relatedness provided acute opportunities for treatment sensitivity and intervention. Thus, it would be contraindicated for the clinician to unsystematically promote growth in any one individual's sense of self or sense of relatedness outside the limits of any one developmental stage. For example, the best fitting ceiling for sense of self and sense of relatedness for any individual diagnosed within the Differentiating stage would be a score of zero (0); similarly, the ceiling for individuals within the Symbiotic stage or Practicing stage would be -10 and +10, respectively. Accordingly, a +20 score on the developmental sense of self scale and a -18 score on the developmental sense of relatedness scale suggests a profile of a highly self-centered or narcissistic individual. Conversely, any profile a -18 score on the developmental sense of self scale and a +20 score on the developmental sense of relatedness scale is indicative of an individual devoid of self-worth and heavily invested in pleasing others. However, a more balanced profile in which both of these developmental scales respective of the other suggests that the individual, while perhaps not within the most desirable developmental stage, is at least more amenable to clinical interventions. For instance, reflected in these results is the fact that occasionally one of both participating individuals temporarily fell outside these normative limits. The ultimate challenge and treatment goal for the clinician is to hold at all times this

developmental framework as a template to enact and manipulate the variables necessary for the individuals to internalize and develop a healthy, functioning intrapersonal and interpersonal relationship model.

Finally, the client satisfaction questionnaires (see Appendix I) administered at the completion the individuals' participation in the study further lends support for the efficacy of filial therapy. The following results (4 = Excellent, or Strongly Satisfied/Agree; 3 = Good, or Mostly Satisfied/Agree; 2 = Fair, or Somewhat Satisfied/Agree; 1 = Poor, or Not Satisfied/Agree) are mean scores to the following questions:

	Parent	Child
1. How would you rate the quality of the help you received?	3.75	3.50
2. Did you get the kind of help you wanted?	3.75	3.50
3. To what extent has the program met your needs?	3.75	3.25
4. If you knew others who needed similar help, would you recommend them to the program?	3.75	3.00
5. How satisfied are you with the help you received?	4.00	3.75
6. Has the program helped you feel better about your problems?	4.00	3.75
7. Overall, how satisfied are you with the help you received?	3.75	3.75
8. If you needed help again, would you come back to the program?	3.75	3.75

Further, the participating parents offered the following qualitative statements:

"It really helped me get closer to my child and develop strong, lasting bonds. We have a new understanding and respect for each other. It was awesome! Thank-you Ken for making such a great difference. It was one of the good things that came out of a bad situation."

"This helped me open my eyes and ears. It made me more aware of my son's expressions and feeling[s]. I have noticed changes at home that we can benefit from. I have a better understanding of our relationship and how to respond to my son. Thanks, it was a great opportunity."

"I don't think very much can change in 12 sessions. I wish it was longer."

"Very valuable. Never too late or too busy to learn, especially in crisis times. Thank-you."

In addition, two of the participating children offered these comments:

"When we left our dad, we should have stayed here instead of going to grandma's."

"I liked playing with the sand."

Rather than offer a verbal comment, another participating child drew a picture of a pig.

In addition to these formal invitations for participant feedback, additional follow-up information was obtained following the original data collection period. That is, informal, unsolicited feedback was provided (via telephone) by Parent 1 and 2 about two to three months following their participation in the study. Both parents reported that many of the positive changes and improvements reported during the treatment had been sustained. For example, each of the mothers provided anecdotal examples denoting positive enhancement in their child's self-concept, self-esteem, social skills, and attachment issues. Reportedly, many of these behaviors also had been observed by current educational personnel. Parent 2 reported the ability to implement and practice regularly scheduled (e.g., weekly) at-home special play sessions. Parent 1 reported having some difficulties implementing special play times on a regular basis, but added

positive results were attained through her ability to practice the skills during unstructured play times.

CHAPTER V – DISCUSSION

The present small scale pilot process and outcome study examined: (a) the therapeutic efficacy of intensive (i.e., daily) filial therapy for victims living within a domestic violence shelter; and (b) the dynamic processes of child-parent enactments within Melanie Klein's (1932/1975, 1950) theoretical constructs and clinical interpretation on object relations, and that of developmental stage theory (e.g., symbiosis, differentiating, practicing, rapprochement) in early childhood (Mahler, 1952, 1968; Mahler et al., 1975) and adulthood (Bader & Pearson, 1983, 1988, 1990) interpersonal relationships. In doing so, the hallmarks of play therapy and the therapeutic principles of filial therapy (VanFleet, 1994, 1999a) were examined and evaluated by means of both quantitative (e.g., treatment outcomes) and qualitative (e.g., process-outcome) measures. Four (4) mother-child dyads participated in the study, which was undertaken on-site at a local domestic violence shelter in Calgary, Alberta. The study was based on accounts of treatment interventions with children and mothers conducted by the present author, a clinical psychologist and registered play therapist/supervisor. The study also included the author's specifically developed and designed instrumentation for investigating interpersonal processes, and for which interrater measures were obtained.

Implications of Present Research

The present process outcome study and derived results suggests supportive findings: (a) on both the level of filial treatment efficacy in a setting for victims of domestic violence, and (b) for an integrative theoretical foundation linking a developmental interpretation and understanding of intrapersonal and interpersonal human processes. "There are significant connections in the origin of the play relationship

in early childhood with parents and in the therapeutic alliance with both children and adults (Chethik, 2001, p. 10).

First, through activating the healing power of play and symbols, we bring image into our consciousness and allow its energy to flow. Balance of the psyche can be achieved only through the integration of our inner and outer opposites. The psyche directs its energy toward individuation, and its vehicle—the symbol—carries us there by degrees. These patterns become known affectively and, through empathy, we attempt to understand the nuances of individual experiences and chain together old patterns of being and seeing which invite growth and development (Charles, 1999). For witnesses and victims of domestic violence, psychotherapeutic reconstruction through play of traumatic experiences can help individuals obtain relief from guilt and fear associated with these traumas (Webb, 1999c). The therapeutic relationship remains ultimately the most valuable experience for children in crisis (Levy-Warren, 1994), whether the relationship is filled with the expertise of a clinician or the heartfelt compassion of a parent. These interpersonal processes, complex at they are, appear able to be effectively changed for victims of domestic violence through the implementation of filial therapy.

Secondly, through observation of and focus on inherently active, process-orientated treatment modals, the present study extends the development of a more solid empirical base through the importance of play in child development and clinical interventions in child psychotherapy (S. Russ, 1995). The specifically developed and designed instrumentation, while intended for purposes here to investigate a developmental filial therapy model, could be extended to investigate a much wider scope of interpersonal relationships. In that these instruments have served to examine the interpersonal processes within the context of filial therapy, these observational measures

were robustly founded on a synthesis and integration of theoretical constructs and clinical research spanning decades of dedicated work involving theorists, scientists, developmentalists, clinicians, therapists, teachers, parents, and children. More than a matter of investigating the process-orientated variables active in the specific delivery of filial treatment, the instrumentation offers an opportunity for utilizing most any treatment modality to investigate the intrapersonal and interpersonal variables for individuals of all ages.

In that, the foundation of a sound theoretical model can help generate and explicate the formulation of testable hypotheses, empirical investigations into unified processes and outcome data can be considered more germane to guiding clinical practice. The traditional tendency has been to guide practitioners by means of restrictive or narrow theoretical orientations rather than by advancing a generalized, integrative theory. Toward developing a deeper understanding of the dynamics and relationship patterns between child-parent interactions, a revisit to the 'bottom up' approach of the theoretical underpinnings of object relations and its contributions to human development could provide an imperative paradigm for developing a deeper understanding and empirical evaluation of the interpersonal relatedness of self and other. In similar fashion toward integrating general theory with eclectic practice, past (Barabash, 1995) and present empirical investigations into the separation-individuation processes can offer practitioners a highly integrative theoretical model and operational research approach that stems from well-developed, generalized theories of interpersonal relatedness.

Limitations

In the eyes of scientific scrutiny, the most obvious limitation of the present study is its sample size. These results are based on the examination of highly complex formulations obtained within a highly structured, secure residential setting. The relatively small sample size makes it extremely difficult if not imprudent to generalize freely these findings to other clinical populations or treatment settings. Notwithstanding, the intent here was offer a meaningful, empirically-driven contribution to two key areas in which psychotherapy inquiry appears to have given rise: domestic violence and process-outcome research. It is believed that at least these two conditions have been attained. The ability to carry out more extensive, rigorous study thereby accessing wider, more diverse populations would certainly lend further support for these research findings.

The instrumentation utilized in the present study included both standardized and nonstandardized procedures. It would appear that the utilization of standardized instruments (e.g., BASC, PCRI) to measure pre- and posttest outcomes can provide some degree of certainty on the efficacy of treatment. There remains, however, considerable raison d'être to query the nonstandardized instruments (e.g., DFTCS, DFTG) utilized in the study. Even though empirically acceptable procedures (e.g., interrater observations) were taken to ensure some of these limitations could be minimized, these instruments mark only preliminary efforts toward providing an empirical investigation into a highly complex set of theoretical constructs and framework. Not unlike the aforementioned limitation of sample size, more extensive research investigations into developmental stage theories as well as intrapersonal and interpersonal relatedness to others would likely enhance our understanding of their rudimentary elements.

Another study limitation stems from the efforts to integrate the investigative properties of the nonstandardized instruments with a universally accessible treatment model. The techniques of play and filial therapy were specifically chosen to guide the treatment implementation in that the treatment modality needed to be accessible to and enlist participation of both children and adults. To command a single treatment modality that exacts therapeutic efficacy for individuals of all ages is a daunting challenge, indeed. Moreover, the integration and implementation of nondirective play therapy principles and procedures provided additional challenges. Of the two interrater observers, one possessed theoretical knowledge and was highly skilled in play therapy practice, while the other was not. Initially, it was thought that extensive play therapy experience would be an asset to understanding and utilizing the nonstandardized instruments. However, it appears that this may have in fact hindered the scoring abilities. For example, the developmental observation measures were heavily influenced by an object relations theoretical model and not on the guiding principles of nondirective play therapy. In some instances, this required an individual with play therapy experience to cast aside these guidelines of traditional nondirective play therapy and instead work from the theoretical framework of object relations. While some attempt was made to synthesize the developmental observation measures with a template of play therapy procedures, it is clear that more work in this area is needed.

Special Considerations for Conducting Research in Special Settings

To say the least, conducting the present study on-site of a domestic violence shelter posed some special considerations. At all times there was a constant need to be flexible, understanding, and accommodating to the needs of both study participants and shelter staff. Not surprisingly, the demands of working and living in crisis carry their

own emergent needs and conditions of behavioral responsiveness and developing mindset. On several occasions, for example it became necessary to alternate the daily treatment schedule so the members of one participating family could attend to other urgent matters. Sometimes it required that the daily treatment procedures (e.g., treatment implementation, parent skills training, review of the videotaped play enactments) be postponed and reintroduced at a later time. Other times the expectations of simple, day-to-day activities (e.g., meals, childcare availability) posed additional challenges in the data collection procedures. In short, the present author was constantly reminded of his signature motto back in the days when providing services to residential treatment programs—"Predict nothing, expect anything"—which certainly seemed befitting while conducting the present research study.

Directions for Future Research

Clearly, given the special considerations and rigorous demands of psychotherapy process-outcome scientific research might explain why some clinicians simply avoid it altogether. Indeed, the rigors of process-outcome research can be extremely demanding. Vachon, Susman, Wynne, Birringer, Olshefsky, and Cox (1995) surveyed 109 psychologists to enlist their reasons for refusing to participate in psychotherapy process research. The main reasons for opting out from participating included: (a) insufficient time; (b) unwillingness to audiotape clients; and (c) clients were often deemed inappropriate for the research. Any rationale or justification for conducting process outcome research requires a thorough understanding and development of a well-grounded, unified integration of standards involving both sound research and practice. Therapeutic outcomes, at the very least, must be viewed as arising from a complex interaction of patient, therapy, and relationships factors (Beutler & Harwood, 2002).

Decades of research continue to indicate that interpersonal processes in the therapeutic relationship envelope the foundation of our efforts to help others (Lambert & Barley, 2001). Frankel (1998) suggested that investigations into the essential processes of an integrative child psychotherapy model must include: (a) examination of the interrelated aspects of play as they occur in the emergence and integration of dissociated self-states, symbolization, and recognition and (b) the renegotiation of self-other relationships in action. Further, Kazdin (2002) suggested the state of child and adolescent psychotherapy in general could be advanced by: (a) understanding the mechanisms or processes through which change occurs; (b) drawing on developmental psychopathology research to inform treatment; and (c) expanding the range of questions that guide treatment research and the range of outcome domains on which treatment conclusions are based. Finally, Lambert and Barley (2001) concluded that common factors such as empathy, warmth, and the therapeutic relationship have been shown to correlate more highly with client outcome than specialized treatment interventions.

From a theoretical perspective, the legacy of Kleinian theory(Ciocca, 2000; Waska, 1999), as well as the earlier contributions of S. Freud and Mahler, among others (Buchheim, Schmuecker, & Kaechele, 2000) continue to leave their imprint on impressions of clinical reformulation and reinterpretation. Moreover, the clinical processes of transference and countertransference (Etchegoyen, 1999), and the constraining power of transference and its potential to attenuate violence are also derived from the contributions of A. Freud and Klein (de Oliveira Prado, 2001). It has been further argued that examinations of relational theory and the place of self-identification must take place within a contemporary intersubjective theoretical framework (S. Stern, 2002). Other internal working models, such as attachment theory,

have been offered as a conceptual framework to help illuminate how past experiences with caregivers might influence current transactions between therapists and clients (Meyer & Pilkonis, 2001).

Other ambitious undertakings in the field of psychotherapy research are likely to continue. Statistical procedures, for example, have been employed to investigate session-by-session belief schemas (e.g., self-understanding, empathy) in therapist-client interpersonal relationships can provide some fundamental steps for researchers using both growth curve and time series analyses (Hoffart, Versland, & Sexton, 2002). Meta-analyses were used to investigate the relations between measures of empathy and psychotherapy outcome from the perspectives of the client, therapist, and observer (L. S. Greenberg, Watson, Elliot, & Bohart, 2001). Understanding self and change relational processes in psychotherapy has also been examined by means of converging the theoretical perspectives and developments (e.g., emotion, communication, attachment, child development, intersubjectivity, and social constructionism) in literature (Muran, 2002).

Within specialized settings and among special populations, Maughan and Cicchetti (2002) examined the impact of child maltreatment and interadult violence on children's emotion regulation abilities and socioemotional adjustment and concluded there is a need for increased understanding of process relations in pathogenic relational environments. Lundy and Grossman (2001) reviewed the treatment efficacy of research on battered women and concluded that although there are more than 16 commonly used models, there is little clinical research that addresses their efficacy. These researchers suggested the need for a more integrated, multimethod model for clinical research and practice. Although a variety of interventions remain popular in working with abused

children, the effectiveness of treatments is supported by only a limited number of studies (S. James & Mennen, 2001).

Staudt and Drake (2002) suggested that future studies investigating treatments of and providing services to maltreated children and their families must: (a) examine the role of family preservation in the larger service system and explicate interagency linkages and service referral and use patterns of children and families; (b) examine treatment process variables, their interrelationships to outcomes; (c) examine treatment processes and outcomes for sub-groups of children and families; (d) specify and monitor the intervention; and (e) develop services that are consistent with knowledge about etiology of various forms of maltreatment. In a 30-year follow-up study of now adults, Massie and Szajnberg (2002) concluded that those who received effective care in infancy (e.g., empathy, consistency, control, thoughtfulness, affection, management of aggression) exhibited higher level of psychological defense mechanisms than those who received less effective nurturing. In that children internalize their mothers' own defense mechanisms suggests there is an effect of cumulative trauma on psychic functioning.

Finally, while others have chosen instead to champion traditional parent management training (PMT) models to develop prosocial behavior in children by using reinforcement, extinction, and punishment (Mabe, Turner, & Josephson, 2001), the call has been issued for a more refined process and outcome methodology evaluating the effectiveness of nondirective play therapy as an intervention for distressed and maltreated children (K. Wilson & Ryan, 2001). Regardless, it appears that many of the hallmarks of play therapy (Ray et al., 2001) and filial therapy (Athanasiou & Gunning, 1999; Ginsberg, 2002; Watts & Broaddus, 2002) will continue to offer a fitting vehicle for such investigations into psychotherapy processes and outcome well into the 21st

century (L. Guerney, 2000). While experimental research in humanistic play and filial therapy is not exhaustive, there exists enough viable hard evidence when compared with controlled populations to prove its efficacy as an intervention for helping children (S. Bratton & Ray, 2002).

Closing Thoughts

We have seen that play in vastly different modalities from vastly different theoretical can be used as a psychotherapeutic tool by psychotherapists from vastly different philosophical orientations. While traditional child psychotherapy models were typically built on and reconstructed from the scaffolds adult psychotherapies, the introduction of play techniques offer groundbreaking techniques and a therapeutic language easily and naturally accessible to people of all ages. In other words, rather than adopting a view of practicing child psychotherapy in terms of a downward extension of adult psychotherapy models, the introduction and conceptualization of play as therapy marked a notable paradigm shift in how we provide and deliver psychological treatment services to children.

In that play therapy can be considered no longer a top-down theoretical model based on adult psychotherapy, play therapy and interpersonal variations such as family play therapy and filial therapy could be conceived of instead as bottom-up theoretical models. That is, play therapy techniques offer an upward (vs. downward) extension from child to adult models (Landreth et al., 1999) of psychotherapy. As Politano (1993) observed, when "one enters the special treatment world of the child or adolescent, one learns quickly that this is not the same area inhabited by adults in treatment. In a somewhat 'fuzzy,' surrealistic way, the 'rules' that govern adult treatment seem to fit—but only partially" (p. 376). It appears, then, with the advances of play therapy and

clinical research that the psychotherapy pendulum may be swinging in the opposite direction as researchers and clinicians enter into psychotherapy and developmental models from the bottom up.

In that play therapy approaches are developmentally and universally based, the therapeutic benefits can far-reaching along a continuum of lifespan development for children, adolescents, and adults, as well as therapeutically beneficial across multivariate cultures and socioeconomic strata. For individuals of all ages, on the spirit of play the Blatners (1997) wrote:

> The significance and value of play in today's world lies also beyond the practical and social benefits, and includes deeper philosophical considerations. These have relevance in their applicability to most people's lives, for a vision of meaning in recreational experiences helps to balance overly materialistic tendencies in popular culture. (p. 145)

No matter, at the helm of advancing science are creative minds effecting and communicating thoughts and ideas to others. If you want to become a good writer, think like your reader. If you want to become a good computer programmer, think like your intended user. If you want to become a good clinician, think like your client. A therapist's ability to identify with the client's imagination, experiences and thoughts communicates an understanding of feelings, beliefs and attitudes. In other words, the principal constructs of empathy can be learned and conveyed in interpersonal processes of social behavior. Whether in therapeutic or social settings, there is little argument about the therapeutic and humanistic value of communicating empathy to others.

For therapists, play therapy, or anything else you wish to do well, must be an extension of yourself (Lubimiv, 1994). "Still, the creative potential of play therapists remains largely untapped" (Hall, Kaduson, & Schaefer, 2002, p. 521). Play therapy remains a process inextricably built on intrapersonal and interpersonal relationships. If

you want to be a good therapist, develop an optimal therapeutic alliance with your clients. If wanting to enhance in clients a positive sense of relatedness skills, these can be facilitated through techniques and training models of communication and developing empathic attunement between self and other. Take, for instance, the merits of facilitating in parents the skills of empathic attunement that communicate processes to enhance children's self-worth and mastery of the children's inner and external worlds. For children, the therapeutic merits of play therapy can help bridge the gap between concrete experiences and abstract thoughts in a relational world. For parents, the therapeutic merits of filial therapy are in bridging the relational gap between adults and children and by engaging parents to become the therapeutic agents essential to the celebrated techniques of play.

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APPENDICES

Appendix A—Participant Consent Forms

Participant Consent Form—Adult

DEVELOPMENTAL FILIAL THERAPY: Process-Outcome Research on Strengthening Child-Parent Relationships through Play in a Setting for Victims of Domestic Violence

You are invited to participate in a study entitled *DEVELOPMENTAL FILIAL THERAPY: Process-Outcome Research on Strengthening Child-Parent Relationships through Play in a Setting for Victims of Domestic Violence*. This research is to be conducted by Kenneth J. Barabash, a charted psychologist and a doctoral student at the University of Victoria. I live and practice in Calgary, AB, and you may contact me if you have further questions by calling (403) 270-8816. I am required to conduct this research as part of the requirements for a PhD degree. This research project is being conducted under the supervision of Dr. Geoff Hett, and you may contact him at (250) 721-7783. Additional information or verification of this research can also be obtained from the Associate Vice-President of Research at the University of Victoria at (250) 472-4362.

The purpose of this research project is to enhance your parenting skills and to strengthen your relationship with your child through parent education and using play therapy techniques. Research of this type is important because it is designed to enhance your parenting skills and strengthen the relationship or bond between mothers and children, especially with those who have experienced family conflict or domestic violence.

You and your child are being asked to participate in this study because both of you are current residents of the YWCA Sheriff King shelter and have expressed at least a verbal interest to participate. If you agree to voluntarily participate, you will be required to complete two questionnaires, both at the beginning and the end of the study. Your child will also be required the complete one questionnaire, both at the beginning and the end of the study. In addition, mothers are required to participate in parent training sessions involving watching videos and engaging in group discussions. Each mother and child is also required to engage in a total of 12, 10-minute videotaped segments involving mother-child interactions. These interactions will then be followed by 30-minute filial therapy sessions (non-videotaped) in you and your child will engage in a special play time and activities. The number of parent training and child-parent filial play therapy sessions is about 12 daily, or near-daily, meetings. In other words, your participation in the study will not exceed the time permitted for the average residential stay at the YWCA Sheriff King shelter (e.g., about 16 – 21 days).

The only inconvenience to you should be your personal time and involvement. However, it is recognized that in some instances you and/or your child may not be available on a daily basis (e.g., medical appointments, employment opportunities), and in these cases you and your child may continue your participation following day.

However, you should be aware that there are some potential risks associated with participation. Depending on the severity and duration of the domestic violence you and your child experienced, each individual will likely respond differently. For instance, even if you have a "good relationship" you're your child, there is a potential possibility that this could worsen or deteriorate with or without treatment. While the parenting techniques taught in the study have been found helpful for all kinds of children and parents, in all kinds of settings, there is of course no guarantee. Should you have any concerns, even after agreeing to participate, then you and your child may withdraw from the study at any time with no risk to receiving the regular benefits of other YWCA Sheriff King programs.

YOUR PARTICIPATION IN THIS RESEARCH MUST BE COMPLETELY VOLUNTARY. If you do decide to participate, YOU MAY WITHDRAW AT ANY TIME WITHOUT ANY CONSEQUENCES OR ANY EXPLANATION. If you withdraw from the study, any data collected (e.g., questionnaires, videotapes) will not be used and will be destroyed (e.g., shredded, erased). To ensure that you continue to consent to participate, Sheriff King staff and myself may occasionally

invite your input and/or feedback to make sure your participation continues to be voluntary. You do not need to indicate your decision to withdraw to myself; you may tell a Sheriff King staff member without any explanation at all. Please be reminded that your decision to withdraw from the study will in no way affect your ability to receive the other regular benefits of the Sheriff King programs, for example, parent education for yourself or play therapy for your child.

ALL INFOMRATION WILL BE IN STRICT CONFIDENCE AND WILL BE USED ONLY TO SECURE KNOWLEDGE about scientific research. No participant names or other personally identifiable information will be used. Your confidentiality and the confidentiality of the data will be protected by lock and key. All data collected (e.g., completed questionnaires, videotapes) will remain strictly confidential and appropriately destroyed (e.g., shredded, erased) when the study is complete. There will be no handwritten notes taken during the treatment sessions. It should be mentioned also that for cross-referencing reasons (i.e., establishing reliability) that the 10-minute videotaped segments will be reviewed two research assistants who are qualified mental health professionals and are sensitive to and similarly guided by practice issues of confidentiality, ethical behavior, etc.

Although the results of the study may be briefly summarized to the Executive Director of YWCA Sheriff King, or provided for research purposes, confidentiality will be maintained and no personally identifiable information will be presented. You should be reminded, however, that certain child protection laws limit confidentiality agreements. For example, all personal information is kept confidential, except:

a) If any participant is in imminent danger to self or others.
b) Any child (persons under 18 years) is in need of protective services.
c) If court ordered, and any participants' information is subpoenaed.

Potential benefits if you decide to participate in this research include the opportunity for you to learn and enhance your parenting skills. For example, you and your child will have an opportunity to receive individual attention and instruction in a playroom setting. In addition, your participation may lessen some of the negative effects of family conflict or domestic violence such as reduce a child's negative behaviors (e.g., anger, acting out) and thereby reduce the chances of family violence from one generation to the next.

Your signature below indicates that you understand the above conditions to participate and consent to have you and your child included in this research.

_____	_____	_____
Name of Adult Participant	*Signature*	*Date*
_____	_____	_____
Name of Child Participant	*Signature*	*Date*

To be completed upon consultation with researcher and participants:

Anticipated start date: _____ Anticipated end date: _____

Daily session to take place on _____ at YWCA Sheriff King Shelter
(time) (location)

A copy of this consent will be left with you, and a copy will be kept by the researcher.

Participant Consent Form—Child

DEVELOPMENTAL FILIAL THERAPY: Process-Outcome Research on Strengthening Child-Parent Relationships through Play in a Setting for Victims of Domestic Violence

Hi, my name is Ken Barabash. To help me with my school requirements, you and your mother have been invited to participate in a research study. Both you and your mother will have an opportunity to have some special play time together. The special play time will take place in a Sheriff King playroom. Your special play time will include only yourself and your mother, and me. This special play time will occur about once a day, and will continue for about the time you stay at Sheriff King. About 10 minutes of the special play time will be videotaped, and you will always be told when the videotaping is occurring. By watching these videotapes, your mother will meet with some other mothers to learn how to play with you, but she will not be asked to talk about you specifically.

You will also be asked to complete one questionnaire at the beginning of the study and one questionnaire at the end of the study. For these questionnaires, you will be asked to answer either "True" or "False" to some questions, and an adult will help you complete them.

YOUR PARTICIPATION IN THIS RESEARCH MUST BE COMPLETELY VOLUNTARY. Even if you do agree today that you want to spend some special play time with your mother, you may stop at any time without any consequences or any explanation. This means that if you want to stop participating in the study, you may tell your mother or somebody else at Sheriff King. You do not need to tell any of them your reasons for wanting to stop, and your decision will not affect any of the other things you can normally do at Sheriff King, for example, play therapy.

All information collected (e.g., questionnaires, videotapes) will be kept private or confidential. In other words, other children or people in the Sheriff King shelter do not need to know what you are doing for this study. You should know that there is some information that cannot be kept private or confidential. This includes:

a) If somebody is in danger of harming himself/herself or others.
b) When any child (persons under 18 years) is in need of professional help.
c) If a judge in a court asks for specific information.

Your signature below indicates that you understand and agree to participate in these special play times with you mother and in this study.

_____	_____	_____
Name of Child	*Signature*	*Date*
_____	_____	_____
Name of Mother	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be kept by the researcher.

Appendix B—Overview of Developmental Filial Therapy and Processes

Stage	Description of Stage: Developmental Task	Description of Stage: Developmental Stalemate	Diagnosis	Treatment
Symbiotic-Symbiotic (Enmeshed) "We are one"	▪Bonding ▪Emphasis on similarities ▪Nurturing ▪Establishing "oneness"	▪Consuming need to merge; inseparable ▪Dependency ▪Loss of trust ▪Loss of individuality ▪Fear of abandonment ▪Behavior becomes passive and reactive rather than self-initiated ▪Interactions focused on masking differences ▪Ego-syntonic ways of relating	▪Nonverbal manipulative communication designed to mask or obscure problems or differences ▪Use of *we* and *us* rather than *I* in therapeutic sessions ▪Severely symptomatic child, or severe symptoms in one individual who is the "identified patient" (IP) ▪*Paper Exercise:* Swiftly evokes clear pattern of enmeshed interaction; marked lack of self-definition with excessive efforts to obscure conflict	▪Establish initial treatment contract focused on dyad's view of the problem ▪Establish "no-quit" contracts when indicated ▪Build an alliance with dyad (family) and then facilitate self-responsibility taking in each individual ▪When working with a family, use projective art techniques that elicits each member's perception of the family as a whole ▪When appropriate, begin shifting from the family as a whole to the dyad's relationship ▪Use genogram techniques in working with family-of-origin issues ▪Facilitate differentiation between individuals ▪Homework assignment includes identifying emotions and reflective responses

OVERVIEW OF DEVELOPMENTAL FILIAL THERAPY AND PROCESSES

Stage	Description of Stage		Diagnosis	Treatment
	Developmental Task	**Developmental Stalemate**		
Symbiotic-Symbiotic (Hostile-Dependent) "I can't live with you, and I can't live without you"	▪Bonding ▪Emphasis on individual differences & problems ▪Nurturing ▪Establishing "filial connectedness"	▪Conflict & aggression used to maintain distance and emotional contact ▪Poorly developed sense of self; little differentiation ▪Emerges when symbiotic fantasy begins to crumble ▪Common pattern in borderline and narcissistic personalities ▪Open and ongoing expressions of anger, bitterness & blame ▪Competitive, escalating interactions often ending in violence ▪Unable to negotiate ▪Unable to perceive impact of own behavior; little self-responsibility ▪Strong projection of feelings and assumptions onto other ▪*Paradoxical patterns of interaction:* Demands nurturance yet rejects it when offered ▪Simultaneous fear of abandonment & engulfment ▪Pronounced separation anxiety adamantly denied ▪Positive responses of other interpreted as manipulation or rejection	▪In therapeutic sessions, extremely difficult for individuals to identify and articulate feelings, needs & thoughts ▪Rapid escalation leading to regressive behavior ▪*Paper Exercise:* Competitive, angry, escalating transaction without any negotiation or give-and-take	▪Diffuse conflict ▪Establish limits & behavioral agreements when indicated ▪Keep individuals thinking when angry & channel anger through therapist ▪Teach individuals to complete or follow through transactions ▪Signal confrontations ▪Predict or anticipate future fights ▪Provide support & positive reinforcement for individuals during sessions ▪Help individuals learn how to apologize ▪Facilitate direct, positive interactions ▪Develop consistent, caring behaviors ▪Encourage cooperation & joint activities ▪*Once conflict contained:* Help individuals develop & maintain a vision of a better future ▪Help individuals develop empathic processes ▪Use humor ▪Homework assignment includes identifying emotions and reflective responses

Stage	Description of Stage		Diagnosis	Treatment
	Developmental Task	**Developmental Stalemate**		
Symbiotic-Differentiating "Don't betray me"	*Symbiotic individual* (see above) *Differentiating individual* ▪Learning to express self clearly & openly ▪Shift toward internally defining sense of self with independent feelings, needs & thoughts ▪Reestablishment of boundaries ▪Developing the capacity to tolerate individual differences ▪Learning to risk expressing one's differences ▪Learning to define clear areas of responsibility & authority	▪System becomes unbalanced *Symbiotic individual* ▪Feels threatened & betrayed ▪Attempts to tighten the symbiosis via 'clinging' behavior ▪May be characterologically passive ▪Little empathy for other's needs *Differentiating individual* ▪Feelings of guilt ▪Anger toward individual needs & differences ▪Increased efforts to define self-identity	▪Expressions of anger, grief, or despair at disillusionment of individual limitations ▪*Symbiotic* individual tends to focus more on similarities & highlights bonding ▪*Differentiating* individual tends to focus more on differences & disillusionment ▪*Paper Exercise:* Symbiotic individual does not define what the paper is and tends to relinquish it rapidly to the differentiating individual, who defines it	▪Help individuals resolve loss ▪Help individuals identify & express feelings, needs & thoughts ▪Help individuals tolerate anxiety inherent in recognition of differences ▪Encourage *differentiating* individual's movements toward self-expression ▪Interrupt *symbiotic* individual's dependency patterns ▪Establish clear lines of self-responsibility taking ▪Generate motivation for change by stressing personal benefits ▪Help individuals learn to appropriately express & tolerate anger ▪Homework assignment includes identifying emotions and reflective responses

Stage	Description of Stage: Developmental Task	Description of Stage: Developmental Stalemate	Diagnosis	Treatment
Differentiating-Differentiating "I'll change if you change"	▪Similarly to above, actively help individuals work out how to manage their differences that exist in personality styles, goals, & fears	▪Successful negotiation of individual differences not yet developed ▪Use of projection & manipulation to push the other toward change ▪Ongoing hassling	▪Help individuals reflect on how they have successfully managed conflict in the past ▪Help individuals develop a workable style of conflict resolution ▪Facilitate development of individual boundaries ▪*Paper Exercise:* Individual effort spent in examining the *process* of deciding who gets the paper	▪Use of nonstructured involvement to create therapeutic environment that provides autonomy in the unfolding of individual differentiation ▪Use of facilitative techniques (e.g., questions, observations) to help individuals identify, understand, & articulate feelings ▪Bring pertinent intrapsychic issues into awareness ▪Facilitate conflict management via use of 'initiator/responder' techniques ▪Provide positive role model for individuals ▪Discriminate between problem-solving issues & issues involving complex factors (e.g., unknown future) ▪Provide larger context for viewing specific problems ▪Identify familial, societal, & cultural factors that may inhibit differentiation process

Stage	Description of Stage: Developmental Task	Description of Stage: Developmental Stalemate	Diagnosis	Treatment
Symbiotic-Practicing "Don't leave me; leave me alone"	*Symbiotic individual (see above)* *Practicing individual* ▪Attention directed to external world, independent needs, activities & relationships ▪Rediscovery of self as individual ▪Consolidation of self-esteem & individual power ▪Development of healthy conflict management ▪Blossoming of individuation process whereby individual learns to express self creatively in the world	*Symbiotic individual* ▪Feelings of betrayal & abandonment ▪Attempts to intensify enmeshment ▪Fear of loss of relationship escalates into angry & demanding behavior	▪Previous history of mutually satisfying symbiosis ▪Minimal differentiation between individuals; few mechanisms to handle conflicting feelings, needs, & thoughts ▪An unexpected developmental shift in one individual resulting in increased demands for independence ▪*Paper Exercise:* Elicits characteristics described under developmental stalemates described earlier	▪Help individuals learn how to manage differentiation & develop ways to support independence in other ▪Therapist balances opposing therapeutic goals ▪*Symbiotic individual* wants other & thing to be way used to be ▪*Practicing individual* wants to continue self-expansion unimpeded ▪Initial establishment of discrepant goals is sometimes necessary ▪Expose common grief that underlies individuals' reactive anger ▪Help individuals structure time together ▪Help *practicing individual* set self-directed limits that circumscribe scope of activities ▪Help *symbiotic individual* initiate activities that are self-directed & self-focused

Stage	Description of Stage: Developmental Task	Description of Stage: Developmental Stalemate	Diagnosis	Treatment
Practicing-Practicing "I want to be me"	(See above)	▪Energy over-invested in self-development & self-expression ▪Connectedness viewed as secondary ▪Staunch defense of individual boundaries ▪Fear that greater connectedness will lead to loss of self ▪Power struggles characterized by "*I*-want" demands ▪Use of projections & transference under emotionally charged circumstances ▪Repetition of early script decisions ▪Situations intensify without dyad's foundation of positive bonding & active differentiation	▪Marked lack of emotional connectedness throughout session ▪Defensive presentation of each individual's side; polarized views ▪Competitive dialogue leading to impasses in problem-solving ▪Practicing-practicing individuals who have differentiated will still have power struggles, but with decreased intensity ▪*Paper Exercise:* Both individuals are well-defined about what the paper represents, but often are unable to give to the other or compromise; often exercise is not completed in allotted 5 minutes	▪Focus on process rather than content ▪Help individuals learn ways of projecting separate individualities with resolving conflict ▪Help individuals learn to manage differentiated selves ▪Help individuals identify & express feelings ▪Help individuals identify & resolve intrapsychic issues ▪Help individuals develop a decision-making process that involves giving with provoking anxiety

Stage	Description of Stage		Diagnosis	Treatment
	Developmental Task	**Developmental Stalemate**		
Practicing-Rapprochement "One foot in, one foot out"	*Practicing individual* (see above) *Rapprochement individual* ▪Return shift toward relationship for connectedness & emotional sustenance ▪Reemergence of vulnerability ▪Greater ease in negotiating ▪Balance between "I" and "Other" becomes more firmly established ▪Ongoing utilization of skills learned ▪Capacity to respond with consistency ▪Capacity to give to other even when inconvenient to do so ▪Further resolution of remaining impasses that interfere with successful connectedness	*Practicing individual* ▪Fear of putting self second ▪Equating concession with sacrifice ▪Over-compromising reduction of options ▪Conflict over self-expressions of empathetic attunement with other versus personal needs and individuation *Rapprochement individual* ▪Alternates successfully between periods of connectedness & efforts to reestablish autonomy ▪Ability to manage potential conflict over supporting other's growth & independence versus seeking to gratify personal needs & autonomy	▪*Paper Exercise:* Elicits characteristics described under developmental stalemates described earlier	▪Identify temporary impasses of respective stages ▪Explore each self's needs by exploring the other's viewpoint; facilitate empathic attunement ▪Use future focus to evoke mutual image of connectedness that combines both individuals' needs ▪Teach balance of self feelings, needs & thoughts with other

OVERVIEW OF DEVELOPMENTAL FILIAL THERAPY AND PROCESSES

Stage	Description of Stage		Diagnosis	Treatment
	Developmental Task	**Developmental Stalemate**		
Rapprochement-Rapprochement "Homeward bound"	(See above)	▪At this advance stage of development, stressors to the relationship usually come from external sources (e.g., unknown future) ▪Intra- and interpersonal processes are generally highly developed & integrated	▪Diagnosis at this level occurs primarily through the elicitation & observation of what is *right* in the relationship ▪All the strengths & abilities in the relationship are present & operative ▪*Paper Exercise:* Elicits characteristics described under developmental stalemates described earlier	▪Therapy at this level is primarily facilitative rather than treatment-orientated ▪Individuals are mostly empathically attuned, even when vulnerable ▪Individuals willing to give to other even when it is not convenient ▪Future relationship focus via developing mutual purpose, goal-setting, & achieving empathic attunement

Appendix C—Observational Measures of Developmental Filial Therapy

OBSERVATIONAL MEASURES OF DEVELOPMENTAL FILIAL THERAPY

Stage	Sense of Self		Sense of Relatedness	
	Positive	**Negative**	**Positive**	**Negative**
Symbiotic (Enmeshed) "We are one"	**A**+ Sense of individuality or ability to self-define needs	**A**- Loss of individuality or presents as anxious	**A**+ Expresses own identity in relationship; separateness	**A**- Consuming need to merge; inseparable
	B+ Secure in possibility or seeks opportunities for separation from other	**B**- Exhibits insecure behaviors (e.g., fear of abandonment)	**B**+ Trusting of other	**B**- Loss of other's trust
	C+ Capacity to initiate self-reliant behaviors (e.g., problem-solving)	**C**- Dependency on others; intense need for bonding	**C**+ Nonverbal communication highlights differences	**C**- Nonverbal manipulative communication designed to mask or obscure differences
	D+ Behavior is self-initiated & nonreactive	**D**- Behavior becomes passive & reactive (vs. self-initiated)	**D**+ Interacts openly, able to identify differences	**D**- Interactions focused on masking differences
	E+ Personal responsibility taking	**E**- Severely symptomatic or exhibits intense behaviors (e.g., tantrums, inappropriate crying)	**E**+ Attempts to relate empathically toward other	**E**- Ego-syntonic (e.g., narcissistic) ways of relating (e.g., maladaptive interpersonal skills)
	F+ Initiates opportunities for self-expression	**F**- Marked lack of ability to self-define	**F**+ Makes appropriate use of *'I'* statements (vs. than *we & us*) or individualized behaviors	**F**- Use of *we & us* (vs. *'I'* statements or individualized behaviors)
	G+ Independent thoughts and/or behaviors	**G**- Intense need for approval from others (e.g., attention-seeking)	**G**+ Identifies or shows respect to other as separate individual	**G**- Emphasis on similarities between each other

OBSERVATIONAL MEASURES OF DEVELOPMENTAL FILIAL THERAPY

	Sense of Self		Sense of Relatedness	
Stage	**Positive**	**Negative**	**Positive**	**Negative**
Symbiotic (Hostile/Dependent) "I can't live with you, and I can't live without you"	**A**+ Defined sense of self; identified differentiation	**A**- Poorly developed sense of self; little differentiation	**A**+ Makes an effort to connect emotionally with other	**A**- Conflict/aggression used to maintain distance or emotional contact with other
	B+ Differentiation is maintained, even in light of reality	**B**- Maintains unrealistic expectations or symbiotic fantasy	**B**+ Interacts with individual in nonthreatening manner	**B**- Competitive, escalating interactions often ending in violence
	C+ Expresses stability in affect (e.g., mood) & self-image	**C**- Common pattern in borderline & narcissistic personalities	**C**+ Exhibits some ability to negotiate with other	**C**- Unable or resistance to negotiate with other
	D+ Expressions of thoughtfulness, personal responsibility, and/or understanding	**D**- Open expression of anger, bitterness, & blame	**D**+ Able to perceive impact of his or her own self behavior on other	**D**- Unable to perceive impact of his or her own behavior on other
	E+ Makes effort toward relatedness, while still maintaining differentiation	**E**- Simultaneous fear of abandonment & engulfment	**E**+ Makes use of '*I*' statements (vs. assuming or blaming feelings of other	**E**- Strong projection of feelings and/or assumptions onto other
	F+ Secure in participating in individualized activities	**F**- Pronounced separation anxiety that is adamantly denied	**F**+ Unconditionally accepts positive responses offered by other	**F**- Demands nurturance yet rejects it when offered from other
	G+ Behaviors and emotions remains composed and relatively stable	**G**- Rapid escalation into regressive or defensive behavior	**G**+ Able to identify or define other's expressions of thoughts, feelings, or needs	**G**- Unable to identify or define other's expressions of thoughts, feelings, or needs

OBSERVATIONAL MEASURES OF DEVELOPMENTAL FILIAL THERAPY

	Sense of Self		Sense of Relatedness	
Differentiating "I'll change, if you change"	**A+** Exhibits efforts to employ skills to express self clearly and adequately	**A-** Feelings (e.g., guilt) or reluctance to express sense of self	**A+** Attempt to resolve conflict in mutuality satisfying manner (e.g., negotiation)	**A-** Focused on escalating conflict or dismisses other's attempt to negotiate
	B+ Ability to define internal sense of self with independent feelings, thoughts, & needs	**B-** Anger, grief, or despair at disillusionment of having own way	**B+** Respect in allowing other to express or change at own pace (e.g., not control)	**B-** Use of projection and manipulation to control or push other toward change
	C+ Attempts to reestablish individual boundaries	**C-** Ill-defined personal boundaries	**C+** Sincere effort toward better managing ongoing conflict or differences	**C-** On-going conflict (e.g., hassling, bickering, belittling)
	D+ Developing a capacity to identify and tolerate differences	**D-** Anger or denial of differences	**D+** Reflective in learning how individuals have managed or negotiated conflict thus far	**D-** Unable to reflect or resists other's attempts to manage conflict
	E+ Takes risk to express sense of self (e.g., feelings, thoughts, needs)	**E-** Inability to express or suppression or denial of self feelings, thoughts, needs	**E+** Able to define personal boundaries toward a workable means of conflict management	**E-** Unable to identify the principles of a workable conflict resolution style
	F+ Attempts to define areas of self-responsibility acknowledges rules/authority	**F-** Avoids taking self-responsibility or dismisses rules/authority	**F+** Attempts to establish self and other activities or responsibilities (e.g., boundaries)	**F-** Inability to establish boundaries via separate activities or responsibilities
	G+ Increased efforts to define sense of self (e.g., identity)	**G-** Avoidance or reluctance to define sense of self (e.g., identity)	**G+** Able to discriminate potential opportunities for problem-solving issues	**G-** Important problem-solving issues not clearly defined or ignored

	Sense of Self		Sense of Relatedness	
Practicing "I want to be me"	**A**+ Open to opportunities that require personal give & take	**A**- Stance of stubbornness & self-centeredness	**A**+ Exhibits emotional connectedness or attunement with other (e.g., engaging)	**A**- Lacks emotional connectedness to other; withdrawal
	B+ Demonstrates capacity for empathy	**B**- Loss of capacity for empathic response	**B**+ Sense of relatedness perceived as equally important in promoting other's individuation	**B**- Emotional connectedness with other viewed as secondary
	C+ Considerate balance between self-expression and personal development	**C**- Energy over-invested in self-development or self-expression	**C**+ Not threatened by other's need for self-expression or emotional connectedness	**C**- Exhibits resistance or suspicion towards other's attempts to emotionally connect
	D+ Openly defined or clear presentation of personal boundaries	**D**- Unclear or staunch defense to establish personal boundaries	**D**+ Potential for power struggles are successfully resolved or met with decreased intensity	**D**- Power struggles characterized by defensiveness or blame statements
	E+ Affirms ideal that greater relatedness need not be incompatible with individuation process (i.e., both equally desirable)	**E**- Exhibits fears or anxiety that greater relatedness will lead to loss of self (i.e., both are incompatible)	**E**+ Proactive (vs. reactive) attempts to resolve emotionally charged situations	**E**- Use of projections and transference under emotionally charged situations
	F+ Able to identify or define the mechanisms used to express sense of self (e.g., thoughts, feelings, needs)	**F**- Unclear or misuse of mechanisms used to express sense of self (e.g., thoughts, feelings, needs)	**F**+ Encourages a balance between positive bonding (e.g., relatedness) and active differentiation (e.g., individuation)	**F**- Defensive presentation of the other's point of view (i.e., polarized views between individuals)
	G+ Exhibits satisfaction or confidence in sense of self (e.g., level of independence attained)	**G**- Makes overt or increased demands for independence or self-expression	**G**+ Effective dialogue or interaction established with other leading to successful problem-solving	**G**- Competitive dialogue or interaction with other leading to impasses in problem-solving

	Sense of Self		Sense of Relatedness	
Rapprochement "Homeward bound"	**A+** Stable and consistent sense of self expressions (e.g., feelings, thoughts, needs)	**A-** Inconsistencies in sense of self expressions (e.g., feelings, thoughts, needs)	**A+** Ability to describe and follow-through in supporting other's feelings, thoughts, needs	**A-** Slight indifference toward describing or supporting others growth and autonomy
	B+ Emerging recognition or willingness to take risks toward becoming vulnerable	**B-** Protective or defensive stance to maintain established gains in sense of self	**B+** Actively seeks opportunities to promote and support relatedness activities	**B-** Hesitates or indicates some resistance to opportunities to strengthen relatedness activities
	C+ Intrapersonal processes are generally highly developed and integrated	**C-** Slight ambiguity in defining or demonstrating intrapersonal skills	**C+** Interpersonal processes are generally highly developed and integrated	**C-** Slight ambiguity in defining or demonstrating successful interpersonal skills
	D+ Demonstrates clear and firmly established ability to appropriately employ *'I'* statements (vs. *we* or *us*)	**D-** Slight ambiguity in ability to effectively employ *'I'* statements (vs. *us* or *we*)	**D+** Ability to recognize potentially arising conflict, and effectively diffuse (e.g., negotiate, limit setting)	**D-** Exhibits difficulty or reluctance to manage potentially arising conflict
	E+ Willingness to further resolve intrapsychic issues and impasses of individuation processes	**E-** Avoidance or tentativeness to opportunities to explore deeper self-issues	**E+** Exhibits capacity to respond to other with consistency	**E-** Responds to other in an inconsistent manner
	F+ Ongoing utilization of skills learned or exhibited in earlier stages (e.g., empathy)	**F-** Regression toward behaviors exhibited in earlier stages (e.g., lack of self-responsibility)	**F+** Capacity to give to other, even when inconvenient	**F-** Gives to other conditionally, or with reluctance
	G+ Future orientated and primarily focused on personal potential	**G-** Tendency to focus on past areas of personal dissatisfaction	**G+** Demonstrates greater ease in negotiating with other	**G-** Attempts of negotiation leading to unsuccessful resolve or dissatisfaction in other

Appendix D—Paper Exercise (PE)

Paper Exercise (PE)

The *Paper Exercise* was adapted from a technique developed by Susan Campbell (1980). The purpose of the *Paper Exercise* is to provide spontaneous information about how the individuals currently interact with each other. It provides the therapist with a diagnostic tool and is useful to help dyads engage in their own process of evaluation. The verbal directions given to the dyad reads as follows:

> *This piece of paper represents something important to you* (looking at one member of the dyad), *and something important to you* (looking directly at the other member of the dyad). *I want you to hold this paper between you, and you will have up to five minutes to decide who gets the paper without ripping or tearing it. You can do it verbally or nonverbally. You can do it any way you choose, and you will have up to five minutes to decide who gets the paper.*

With exception of a one-minute warning to signal the end of time is drawing near, no additional information is provided to the dyad, even if questions are asked. The *Paper Exercise* is designed as a projective tool, and is therefore unstructured. Focusing in on how the dyad manages their time, the therapist focuses in on the following area:

1. Capacity for self-definition
2. Management of boundaries between self and other
3. Recognition of the separate wholeness of the individual
4. Capacity to handle conflict
5. Ability to negotiate
6. Capacity to give and receive

Less important is the content of the exercise rather than the way the dyad handles the process. By observing the process in the context of the six categories listed above, the therapist is able to determine the skills that an individual and dyad must develop in order to evolve beyond the current impasse.

Appendix E—Developmental Filial Therapy Coding System (DFTCS)

DEVELOPMENTAL FILIAL THERAPY CODING SYSTEM (DFTCS)

Dyad No.: _____	Session: _____	Day No.: _____	Date: _____

Parent (_____) Stage: _____

Interpersonal Unit Measure (IUM) (10 minutes)	Developmental Sense of Self														Developmental Sense of Relatedness											
	A+	A-	B+	B-	C+	C-	D+	D-	E+	E-	F+	F-	G+	G-	A+	A-	B+	B-	C+	C-	D+	D-	E+	E-	F+	F-	G+	G-
0 - 2 minutes																												
2 - 4 minutes																												
4 - 6 minutes																												
6 - 8 minutes																												
8 - 10 minutes																												
Positive/Negative Measures																												
Combined Pos./Neg. Scores																												
Composite Dev. Score (plot)																												

Child (_____) Stage: _____

Interpersonal Unit Measure (IUM) (10 minutes)	Developmental Sense of Self														Developmental Sense of Relatedness											
	A+	A-	B+	B-	C+	C-	D+	D-	E+	E-	F+	F-	G+	G-	A+	A-	B+	B-	C+	C-	D+	D-	E+	E-	F+	F-	G+	G-
0 - 2 minutes																												
2 - 4 minutes																												
4 - 6 minutes																												
6 - 8 minutes																												
8 - 10 minutes																												
Positive/Negative Measures																												
Combined Pos./Neg. Scores																												
Composite Dev. Score (plot)																												

Appendix F—Developmental Filial Therapy Interrater Coding System (DFTICS)

DEVELOPMENTAL FILIAL THERAPY INTERRATER CODING SYSTEM (DFTICS)

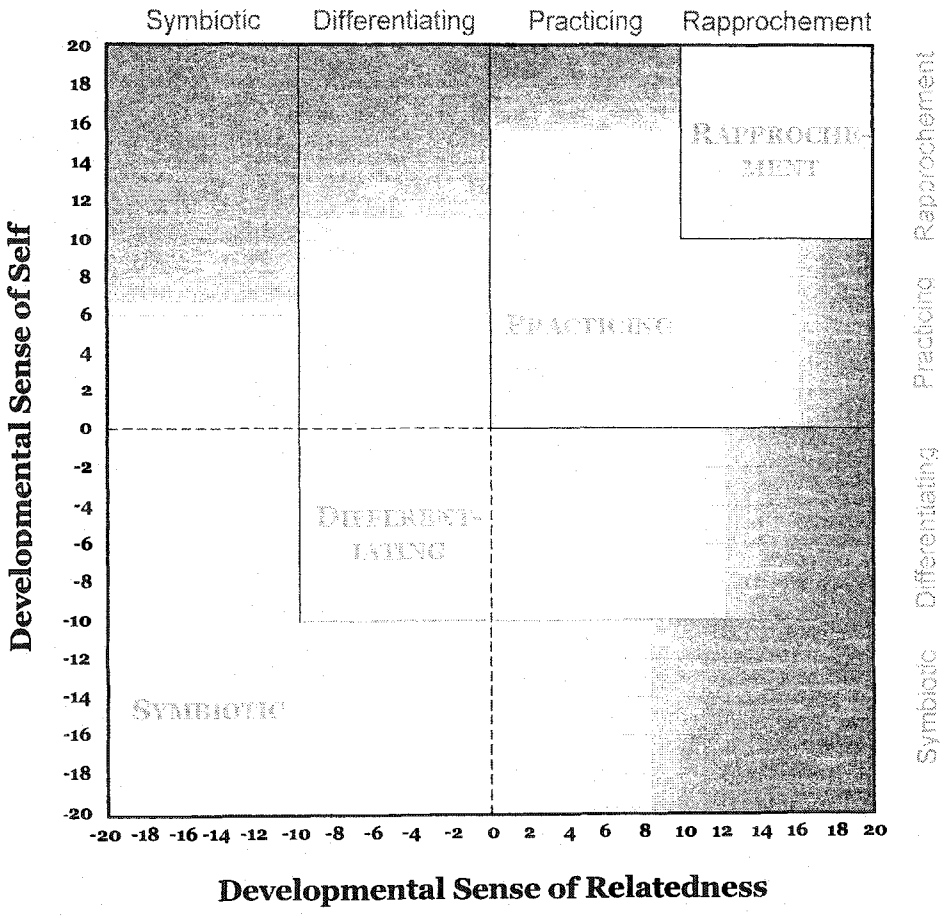
Interrater Observer Name: _____	Interrater Observer No: _____

Mean Composite Developmental Scores Based on Single Interpersonal Unit Measures (IUMs)		Dyad 1				Dyad 2				Dyad 3				Dyad 4			
		Parent		Child		Parent		Child		Parent		Child		Parent		Child	
	Developmental Axis	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR	DSS	DSR
	Baseline 1 (B1)																
	Baseline 2 (B2)																
	Treatment 1 (T1)																
	Treatment 2 (T2)																
	Treatment 3 (T3)																
	Treatment 4 (T4)																
	Treatment 5 (T5)																
	Treatment 6 (T6)																
	Treatment 7 (T7)																
	Treatment 8 (T8)																
	Treatment 9 (T9)																
	Treatment Follow-up (TF)																

Appendix G—Developmental Filial Therapy Graph (DFTG)

DEVELOPMENTAL FILIAL THERAPY GRAPH (DFTG)

Dyad No. ____ Adult No. ____ Child No. ____



Session Legend

Baseline 1	B1	(day 1)
Baseline 2	B2	(day 2)
Treatment 1	T1	(day 3)
Treatment 2	T2	(day 4)
Treatment 3	T3	(day 5)
Treatment 4	T4	(day 6)
Treatment 5	T5	(day 7)
Treatment 6	T6	(day 8)
Treatment 7	T7	(day 9)
Treatment 8	T8	(day 10)
Treatment 9	T9	(day 11)
Follow-up	TF	(discharge)

Appendix H—Permission to Use Copyrighted Materials and Services

Appendix I—Client Satisfaction Questionnaires (CSQ)

Client Satisfaction Questionnaire (CSQ-8)—Adult Form

Please help me improve the program by answering some questions. I am interested in your opinion, whether they are positive or negative. *Please answer all the questions* and *do not write your name.* I also welcome any additional comments and suggestions (which can be written on back). Thank you, I really appreciate your help. ***Please circle your answers:***

1. How would you rate the quality of help you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of help you wanted?

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes, definitely

3. To what extent has the program met your needs?

4	3	2	1
Very much	Mostly	Not really	Not at all

4. If you knew others who needed similar help, would you recommend the program?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the help you received?

1	2	3	4
Not at all	Don't know	Mostly satisfied	Very satisfied

6. Has the program helped you feel better about your problems?

4	3	2	1
Yes, it helped a lot	Yes, it helped	Not really	No, not at all

7. Overall, how satisfied are you with the help you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Not sure	Not satisfied

8. If you needed help again, would you come back to the program?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Please write any additional comments on the other side of this form.

Adapted from Clifford Attkisson, Ph. D. © 1978, 1985

Client Satisfaction Questionnaire (CSQ-8)—Child Form

Please help me improve the program by answering some questions. I am interested in your opinion, whether they are positive or negative. *Please answer all the questions* and *do not write your name.* I also welcome any additional comments and suggestions (which can be written on back). Thank you, I really appreciate your help. ***Please circle your answers:***

9. How would you rate the quality of help you have received?

4	3	2	1
Excellent	Good	Fair	Poor

10. Did you get the kind of help you wanted?

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes, definitely

11. To what extent has the program met your needs?

4	3	2	1
Very much	Mostly	Not really	Not at all

12. If you knew others who needed similar help, would you recommend the program?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

13. How satisfied are you with the help you received?

1	2	3	4
Not at all	Don't know	Mostly satisfied	Very satisfied

14. Has the program helped you feel better about your problems?

4	3	2	1
Yes, it helped a lot	Yes, it helped	Not really	No, not at all

15. Overall, how satisfied are you with the help you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Not sure	Not satisfied

16. If you needed help again, would you come back to the program?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Please write any additional comments on the other side of this form.

Adapted from Clifford Attkisson, Ph. D. © 1978, 1985