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Filial therapy is the process of training parents in the ideas and techniques of play therapy, so that they can continue therapy at home. Extending the same idea to the school would reach less severely disturbed children who might not otherwise receive therapy, and would expand the therapeutic community to reach many more children. Teachers, as therapists, would work preventatively, feel better equipped to discuss problems with parents, and probably benefit in overall classroom technique from the training. The 11 teachers from the Jesse Selover Elementary School in Sayreville, New Jersey, were trained in filial therapy techniques and worked with withdrawn pupils from their own classes, grades kindergarten through five. Each teacher met with the experimental pupils 45 minutes once a week for 17 weeks, and met once a week in group discussion. Significant differences were found between experimental and control groups, the experimental reaching regular classroom average in social behavior. (BP)

Pupil Discovery Training

SAYREVILLE PUBLIC SCHOOLS
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SAYREVILLE, NEW JERSEY

THE APPLICATION OF FILIAL THERAPY TO THE TEACHER-STUDENT RELATIONSHIP

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Dickie: Look what you did!' Look what you did to my snake!

Therapist: You told me to try and trick you, and then when I did you didn't like it.

Dickie: No, I don't like it. Now you fix my snake's head back on. Now you give it first aid.

Therapist: You want me to fix it again since I was the one that knocked its head off.

Dickie: I want you to do what I say.

Therapist: You like to boss me around.

Dickie: (laughing suddenly) This is fun. I really don't care about the old clay snakes. I'm just playing. (He waits until the therapist has fixed his snake, then he picks it up by the tail and mashes it all up in a ball. Then he goes over to the shelf and gets the soldiers and begins another battle, with his back to the therapist this time.)

Therapist: You're having quite a battle.

Dickie: Why don't you keep still?

Therapist: You want me to stop talking when you tell me to.

Dickie: Yes. Why don't you? (Therapist does. Dickie peers around at the therapist and looks very pleased with his

success at silencing her.) Can I come back again?

The rapist: Yes, if you want to.

Dickie: I'm really just playing with you. You s[illegible] I co[illegible] play any way I wanted to.

Therapist: Yes. That's what I said. I meant it.

Dickie: I can say anything I want to say to you, too?

Therapist: Yes.

Dickie: I could even swear in here if I wanted to?

Therapist: If you want to.

Dickie: (laughing hilariously) When can I come again? Every day.

Therapist: You may come every Wednesday at this same time.

Dickie: You're a grown-up lady and I can say anything I want to say to you (laughs).

Therapist: You think it's fun to say anything you feel like to a grown-up.

Dickie: Yeah. (grins) Shut up, Mrs. X (the house-mother's name). Shut up Mrs. X.

Therapist: You would like to tell the house-mother to shut up sometimes.

Dickie: Shut up, Mr. M. (the superintendent of the Home). Shut your damn big mouth!

Therapist: You sometimes feel like telling Mr. M. to shut his "damn big mouth." (Axline, 1947, pp. 175-176).

Henry: I think I told you about my feeling had about not

being invited to parties, didn't I?

Therapist: Yes.

Henry: That's what I thought. Well, I decided it wasn't just that. So, I tried to think back about how I felt at the time. Do you know what I was craving?

Therapist: No. Do you want to tell me?

Henry: Well, it's very hard to put into words, but it s sort of a feeling of importance. I wanted to feel important, that's all. That's what I've been craving all along.

Therapist: You have really found out something about yourself.

Henry: Yes. It was that feeling of importance. You know, when I first started coming to you I had so many worries. Now I have just one big worry: how to keep myself from worrying. I have a fear that the Devil will sort of seep into my mind. I don't really believe in the Devil, but in a way I do. I'm afraid he might seep into my mind. It's sort of a vague feeling. I can't express it.

Therapist: It's uncomfortable to think of his taking control of you, is that it?

Henry: Yes. How can I prevent it? That's something I haven't quite figured out. Do you know how?

Therapist: No, but I guess it's pretty puzzling for you.

Henry: Yes, it is. I was afraid to tell you, but I feel better now.

(Dorfman in Rogers, 1951, pp. 251-252).

The above two dialogues are excerpts from client centered

play therapy sessions. It was hoped that by presenting these examples, the reader could discern the essence of this type of therapy--the accepting, friendly, understanding, handirective attitudes of the therapist, and the resulting freedom of expression and possible self-realization on the part of the child.

The present study concerns play therapy, a method of working with disturbed children. Play therapy puts the child in his own environment, with tyos, his own tools for self-expression. He is therefore more at ease in a play atmosphere than he would be in an interview situation.

Over the years, several trends have developed in the area of play therapy. In order to trace these trends fully, one could go back to the writings of Aristotle and find that he believed play to be an emotional outlet for anxieties(Mitchell & Mason, 1948), However, this account will begin with Freud and psychoanalytic treatment. Freud presented a rationale for the existence of an unconscious aspect of the mind, which he believed contained the repressed fears, passions and urges which govern the conscious thoughts and actions of man. (Ruitenbeek, 1964). In adult psychonalysis Freud maintained that freedom from these repressed tortures could only be obtained by finding the cause of the symptoms and having the patient release the suppressed emotions through "abreaction." Two major techniques used to lift repressions and bring out the unconscious thoughts of the patient are "free association,"

the spontaneous emissions of related words and ideas, and "transference," or the development of intense affection for the therapist which facilitates personal and emotional expression.

In the 1920's Anna Freud (1928), in an attempt to apply physhoanalysis to children, found no transference and very little cooperation in free-association on the part of the children. However, in an effort to gain the confidence of the children and establish a positive personal relationship with them, she played with them and let them express themselves freely.

At about the same time, Melanie Klein (1937) advanced a different view concerning play, suggesting that the child's activities were in themselves important sources of unconscious motivational expression. She followed psychoanalytic tradition in her "Play Analysis," interpreting the observed behavior in terms of the past. She found the child's play to be as meaningful as an adult's free-associations or dreams, and explained the childs behavior to him with the same aim of reducing anxieties as would be the case with adults.

A fundamental change in psychoanalytic thought was introduced by Rank (1936) in the form of Will Therapy: "We must again refer to the process of becoming conscious, in contrast to interpretation or explanation. As long as one makes the feeling experience, as such, in which the whole individual is revealed, the sole object of the explanation and understan-

ding, one ... allows the patient to understand himself in an immediate experience which ... permits living and understanding to become one (p. 38) ." Rank stressed the importance of the therapeutic relationship, believing it to be intrinsically curative. His ahistorical approach deemphasized content analysis and sought pure emotional expression, with the therapist providing some control and direction.

Taft (1933), convinced that the patients must "bear their own burdens and solve their own problems (p. 4)," applied Rankian theory to play therapy. She recognized the person's right to come and go as he pleased; she accepted his positive and negative actions and efforts: she maintained her own rights and limitations; and she respected his necessity to work out his own problems and face his own limits. She believed that "therapy is potentially present whenever the therapeutic attitude is maintained (p. 19)." She did no analyzing of unconscious content and tried to recognize and spontaneously respond to her client's immediate feelings. However, she did direct many of the child's activities. For example, a child asked, "You make me four shrimps," and she replied, "You make one yourself, Jack. You are making me do all the work (p. 251)." Despite this, she does give the child a considerable amount of freedom and a friendly, accepting atmosphere in which to work out his own problems.

Elaborating further on the ideas of Rank and Taft, Allen (1942) noted that "The therapist begins where the patient is

and seeks to help him to draw on his own capacities toward a more creative acceptance and use of the self he has (p. 49)." In the therapeutic situation, "the very telling (patient's talking) gains therapeutic meaning, not merely for what is told, significant as that may be, but by the fact of the patient's acquiring a freedom to tell and to share (p. 54)." Allen also pointed out that for a child to be accepted as he is, is quite a new experience for him and is curative in itself. As the child comes to see himself as a worthy person with feelings of his own who is capable of establishing a meaningful relationship with another person, his fears and ancieties would lessen and hopefully vanish.

Client-centered therapy, developed by Carl Rogers (1940) set forth a clear, specific methodology for creating the therapeutic relationship sought by Rank, Taft, and Allen. Rogers was seeking a therapy which would be applicable and helpful to all men at all times--tapping human nature.

We have known for centuries that catharsis and emotional release were helpful...We have known...that insight, if accepted and assimilated by the client, is therapeutic...But we have not known or recognized that in most if not all individuals there exist forces, tendencies toward self-actualization, which may act as the sole motivation for therapy. We have not realized that under suitable psychological conditions these forces bring about emotional release

in those areas and at those rates which are most beneficial to the individual (Rogers, 1946 in Ruitenbeek, 1964, pp. 173-174)."

In client-centered therapy, also called nondirective therapy, the attitude of the therapist is as important, if not more important, than the method. The nondirective approach requires the therapist to develop the art of listening and observing. The therapist must see each person as having dignity and worth in his own right. He must honestly respect each client, accept the client's right to select and choose his own values, and recognize the individual's capacity to direct his own life. Then, "Armed" with this sincere attitude, the therapist must convey his deep and honest understanding of the client's feelings to the client. He can do this by using sensitive reflection and clarification of the client's verbalizations and actions. It is expected that through this atmosphere of approval the client will be freer to express his feelings and will be able to explore them and resolve conflicts. With his new, clearer perceptions of himself, he will be able to use his own initiative to set new goals and behave in a more mature, more realistic, and more integrated manner (Rogers, 1951).

Axline (1947) has done considerable work in play therapy using Rogerian theories and methods. Whereas Taft and Allen allowed a wide range of freedom to the child and engaged in friendly conversation, Axline used understanding restatement

of behavior and permitted the child almost complete self-direction. Axline feels that each person is constantly striving to reach that level of maturity and independence which would enable him to completely understand and respect himself. This process requires an atmosphere of love, security, and belongingness in order to develop and thrive. Children who have not grown in such an atmosphere, or who for some other reason have lost their self-respect, or who are laden with overpowering anxieties, have difficulty in developing and thriving. Nondirective play therapy, crediting the child with the ability and motivation to solve his own problems, provides the therapeutic atmosphere with the permissiveness and acceptance that allows the child to be himself. The child plays out his aggressions, fears, and desires and thus brings them to the foreground where a skilled therapist can reflect and accept them.

Alexander (1964) explained that the "therapeutic situation actually serves as a demonstration experience exposing the child to the possibilities that can emerge from a sincere relationship...The child has less need to defend or to withdraw. He learns to value the truly human aspects of relationships (p. 259)."

Because play is so natural for the child, he even has an advantage over the adult engaged in nondirective therapy. The child need not even know that he has a problem in order to benefit from the therapy. He could likely view the sessions

as free play periods. He need not worry that the therapist is trying to "get something out of him" or is interpreting whatever he does or says.

Dorfman (in Rogers, 1951) has furthered the idea that the child has the capacity for self-help. Just the fact that so many children have been helped through play therapy without the parents also receiving therapy, fosters trust in the child's ability.

Moustakas (1956) lists faith, hope, and respect as the three basic attitudes required in client-centered play therapy. With these attitudes sincerely held, the therapist can even work with normal children and have them benefit from a preventative mental hygiene program.

In addition to the development in psychotherapy and play therapy from an historical, analytical, directive approach to an ahistorical, nondirective, nonanalytical approach, Guerney, Guerney, and Andronico (1966) point out two other trends in therapy. The first is concerned with the object of the problem, and thus the aim of the treatment. Freud stressed that the conflicts and anxieties existing within the individual's own psyche were the causal factors of all that person's troubles. The patient was studied in relation to himself--his ego, id, and superego.

More recently, emphasis has shifted from considering man as a whole unto himself to considering him as a product of his interpersonal relations. The growth of group psycho-

therapy, marriage counseling, and family group therapy are evidence of this trend. Alexander (1964) has found that the greatest number of children who are referred to the play therapist are sent because they have trouble in their relations with other people. The teacher is often the referrant since he observes the child's daily interpersonal relations. He frequently reports children as "hostile, withdrawn, or possessed of an atypical perception of their environment (p. 257)."

The other trend highlighted by Guerney et. al. (1966) is that the present supply of therapists and techniques is falling short of the needed supply. New techniques or sources of therapy are needed to permit the professional therapist to make better use of his time and facilities.

These trends--the effectiveness of nondirective play therapy, the emphasis on improving interpersonal relations, and the need for new ideas to facilitate better use of professional services--have led to the development of a new type of therapy for treating disturbed children, known as Filial Therapy. Filial therapy is a method of teaching parents of troubled or problem children to relate empathically to their children for a prescribed period of time; that is, to be nondirective play therapists with their own children. The child is free to work through his problems via play in the therapeutic atmosphere of parental empathy. The parent uses client-centered techniques while the child takes the lead in initiating all play activities.

Guerney (1964) enumerates eleven propositions in support of the Filial Therapy approach. These are summarized below.

1. Troubled intra-family relations are frequently shown to be a primary source of child maladjustment.
2. The traditional methods of aiding the child are:
   a. the therapist working separately with the child to resolve the conflicts, and
   b. the therapist working with the parent to alter problem-causing family relations.
3. Traditional play therapy techniques are presumed effective because:
   a. the therapist supplies respect and concern which improve the child's self-concept,
   b. the therapist's attitude and communication of understanding and acceptance allows the child to lower his defenses and thereby work through his repressed conflicts and eliminate his anxieties, and
   c. the therapist serves to provide the child with more favorable perceptions of other people.
4. Utilizing parents are therapists would give the parents the feeling that they are of use to the child and not a destructive force.
5. Parents can be taught this clearly defined role fairly easily, especially when receiving corrective feedback from the therapist and from other parents who are in the process of learning the same thing. No deep understanding

of personality theory is needed in order to be an effective Filial Therapist.

6. The Filial Therapy technique may serve as a source of insight to the parent concerning his own values of child rearing, his inflexibilities as a parent, and his inabilities to respond to the child's needs.

7. Using a new method of relating and responding to the child, even briefly, may help the parents to change negative patterns of interaction with the child.

8. The parent's close and concentrated observations of his child in the therapy session during which the child is displaying an increased freedom in expressing himself, gives the parent a chance to understand himself and his child realistically.

9. Even if the parent doesn't perform his role adequately, his voluntary attention and devotion to the child's needs should alone be therapeutic by providing the child with an increased sense of security and warmth.

10. Any success achieved by the parent in playing the role is more than would have been achieved by a therapist doing the same because:

    a. attention and affection from the parent himself is more therapeutic than that from a substitute,

    b. the child's problem developed in the presence of the parent and thus it should be more easily worked out in the same environment, assuming that the parent

has learned his new role, and

c. the positive change in parental behavior can allow the child to make positive rather than negative generalizations toward others.

11. The interpersonal techniques learned by the parents during therapy can serve them in their family relations even after formal therapy has ended, with the child in question as well as with other children in the family.

Although the Filial Therapy technique using parents as therapists is a new concept, the idea of using parents in therapy, as therapists or intermediaries, is not new. Guerney (1964, 1966) has provided an extensive review of the literature in which parents have been used successfully in treating their own children. He has pointed out that psychoanalysts have used parents as cotherapists in unstructured, informal ways, although the analytic emphasis on intellectual interpretation and insight in addition to inducement and understanding of emotional expression prohibits using parents with older children. Not as concerned with insight and interpretation, behavior therapists have readily and frequently made use of parents as therapists or cotherapists.

Moustakas, in 1959, suggested that parents conduct play therapy sessions in their own homes, even with norman children, using Rogerian methods. Likewise, Baruch, on 1949, advised that home play sessions would help foster good parent-child

relationships (Guerney, 1964).

Starkman (1963) reinforced the idea that theories of personality have "contributed little to understnading the therapeutic process and to bringing about therapeutic change (p. 239)." This, coupled with the fact stated earlier that understanding complex personality theory was not needed in order to be a good Filial Therapist, gives more credence to the idea of using parents as therapists. Since Filial Therapy views the child's symptoms as often due to parent-child conflicts, it seems advantageous to bring the parent into the therapeutic process. Furthermore, during the Filial Therapy program the parent's own emotions and attitudes are attended to and discussed as well as the child's, providing a well-rounded therapeutic situation.

Guerney et. al. (1966) have outlined the Filial Therapy method in detail. An abbreviation of his presentation is provided here:

Filial Therapy involves children of ten years of age or younger who have an emotional problem, as opposed to an intellectual or neurological one. The parent is informed of the nature of the problem. Oftentimes emotional problems in children are due to a lack of self-confidence, a feeling of unworthiness, fears and repressions of certain feelings, and inadequate communication with the parents. It is explained to the parent that he can be taught a method of relating to his child which will encourage the child to express his feelings

more freely and at the same time help the parent to understand the child's inner feelings and concerns.

If the parent decides to enter the program, he (or she) is assigned to a group of six or eight other parents who are also beginning Filial Therapy. The group meets with the therapist once a week until the parent is satisfied with the results and decides to terminate the therapy, usually 6 to 18 months later. At the beginning the parent learns the purposes and methods of the role he will soon assume--the role of a client-centered therapist. He learns that since children can see through a mere "technique," honest empathetic feedback is necessary on the part of the parent if the therapy is to be effective.

Usually two or three months after the parent group sessions have begun, the parent is ready to begin therapeutic play sessions with the child. During the several months the mother or father (usually the mother) has observed the therapist demonstrate the technique, she has practiced the method herself, and she has watched the other parents in the group practice.

Once the parent begins, she conducts one or more play sessions a week, at home, for approximately 45 minutes at a time. Each parent buys about $25. worth of standard play therapy equipment generally including a "Joe Palooka" punching bag, a set of hand puppets, clay, crayons, paper, dart guns, "Tinker Toys," a dall house, or other similar toys that lend

themselves to emotional expression. The sessions are conducted, ideally, in a room suitable for play activities in which the parent and child can be alone and uninterrupted for the duration.

Preceding every weekly group meeting is a demonstration play session by one of the parents, so each parent can obtain periodical suggestions and comments on her technique. During the group meetings with the therapist the parents discuss their home sessinns, their children's behavior, and, importantly, their own emotional feelings and reactions. The discussions are facilitated by the common situations in which all the parents are engaged. Comparison, mutual understanding, and commonality of goals aids each parent in working out his own problem in relation to the child.

It is necessary at this point to mention the limitations which are put on the child during the sessions, for as minor as they are in comparison with the child's freedom of behavior, they are of great importance. The child is not permitted to extend the time of the session (though he may leave early); he may not break certain expensive toys; and, he may not physically abuse the parent. The session is terminated if the child breaks one of these rules. These limitations serve to help the parent maintain honest empathy and acceptance by preventing strong frustration or annoyance. They also serve as practice for the parent to be firm, but yet accepting. Thirdly, it is a link with the reality of nontherapy situations

in which restrictions and discipline are, of course, necessary.

Guerney and Andronico (1966) have reported that parents are very willing and capable of undertaking and carrying out the treatment as well as quick to learn the client-centered role. The children were mostly cooperative and eager. They expressed meaningful behavior and emotion earlier in the process than had been expected.

As a point of comparison with the Filial Therapy method, it is interesting to briefly discuss Katz's (1965) ideas in relation to parents and play therapy. Katz maintains, as do many other psychologists, the theory that was stated earlier in this paper--that many, if not most, of personality disorders have their beginnings in childhood, primarily in the area of the child's interpersonal relationships. However, Katz is very strong in his feeling that the parents are almost entirely to blame. He believes that children do not need play therapy, but rather the parents need the help. His parent guidance program is designed to help the parents change their interpersonal relationships with their children. The parents are encouraged to, among other things, accept the child as he is; give individual time to each child; remove excessive pressures and unrealistic demands; and set reasonable limits on the child's behavior. However, in Filial Therapy the parents are not just encouraged to do these things, they do them--regularly, carefully, and with guidance. Both parent and child learn and are helped by Filial Therapy.

Katz also tries to help the parents understand the emotional make-up of their children. In Filial Therapy they do this by working with their children as well as with other parents in the same predicaments. Thus, the Filial Therapy method seems the more complete, more productive method.

One of the circumstances which led to the need for and the subsequent development of Filial Therapy, as was discussed above, was the need to find a means by which the professional therapist could make more effective use of his time and facilities. A logical extension of the idea of bringing the therapy "home to Mother" is bringing it to the other primary environment of the child--the school.

Patterson (1966) has commented on the role of the school in relation to the child's mental health: "... the school no longer is restricted to the teaching of the three R's, but is concerned with the preparation of the young for functioning as responsible citizens in a democracy. For effective, mature, responsible functioning as a citizen, it may be maintained that the individual must be relatively free from the handicap of emotional disturbances, and that the school has some responsibility to this end (pp. 18-19)."

Alexander (1964) mentions, more specifically, the need to help the child in the school situation. He points out that the mildly troubled child is left unhelped because of a lack of facilities or the parents reluctance to enter therapy.

However, by utilizing play therapy or other techniques in the school setting, it is often possible to help the less severely disturbed child without removing him from the academic setting.

Starkman (1966) has offered a suggestion of a way in which the school can help based on the assumption that students tend to go, of their own accord, to certain sympathetic teachers and pour out their problems. Starkman believes that teachers should be trained and supervised in utilizing basic therapeutic techniques so that effective use can be made of these spontaneous contacts between students and teachers. He maintains that not only would the students benefit, but the teachers would feel less anxious and unsure in dealing with these troubled students. He did, however, emphasize that he did not intend to make formal therapists out of the teachers by giving them regular cases to work with, but rather to put the teachers at ease, to provide an earlier recognition of potentially disturbed children, and to offer new insights to the teacher.

The teacher's relationship with the school therapist has been noted as an important aspect of the school's effectiveness in dealing with troubled children. Alexander (1964) points out that the therapist cannot work in isolation from the teacher, since the teacher spends a much longer time with the child and thus can influence the child's behavior more than the therapist can. The therapist must share his exper-

iences with the teacher and thus help the teacher to understand her role better and to relate more therapeutically to her children.

The difficult position of the teacher in relation to therapeutic work in the schools is discussed by Buhler, Smitter and Richardson (1952). The teacher is in an ideal position to observe the children's relationships with other children, the variety or stability of their behavior, their feelings and interests, and their attitudes toward authority. However, the teacher's position as a director and a figure of authority may prevent the rapport which exists in the psychologists relationship with the child. Also, the teacher lacks awareness and experience in individual dealings with students. The psychologist's private sessions can reveal the child's inner emotions and feelings as they could not be in group activities at school. In addition, the school therapist can offer the individual attention that a teacher couldn't.

Andronico and Guerney (1967) have offered two suggestions of ways to take into account the foregoing problems--utilizing the school as a setting for psychotherapy and finding an effective place for the teacher. Both of these suggestions involve the use of Filial Therapy:

1. The school psychologist or other therapist could organize Filial Therapy groups within the school setting. This would serve not only the basic goals of this method, but

would predictably improve relations between parents and school personnel since they would be partners, working together toward the common goal of helping the child to adjust. As the parents become a central part of their children's treatment, they no longer need to view the school authorities as a threat, blaming the parents for their children's problems.

2. The second possible application of Filial Therapy to the school setting is the main concern of this paper, using teachers as therapists in play therapy with their students by teaching them the Filial Therapy principles. This utilization would eliminate the problem of a lack of personal, individual contact between the teacher and the child and would allow the teacher greater influence over the child in a supervised therapeutic situation, in addition to regular classroom contact.

This application of the teacher to Filial Therapy directly follows from the rationals behind the method. "Given the ability to do so, people that are already, by nature of their everyday roles, important in a child's life are in a better position to bring about change than an outsider who is seen only an hour a week, even if that person is a trained therapist (Andronico & Guerney, 1967, p. 5)."

Moak (1958) succinctly states that "next to parents, teachers play the most important role in the life of a young

child (p. 50)." This close, important relationship points up several reasons for using teachers as Filial Therapists:

1. Using teachers as therapeutic agents would not only expand the available services in the school, but once trained, the teachers would be able to see several children during the year and a continuing number of children throughout the years (Andronico & Guerney, 1967).
2. Children could be worked with before they became seriously maladjusted. Even normal children could participate in teacher-student nondirective play therapy as a means of providing preventative mental hygiene.
3. It is believed that the empathetic principles that the teachers would learn during the therapeutic experience would apply to their general classroom behavior, making them more understanding, more aware and more accepting (Andronico & Guerney, 1967).
4. The teacher would probably become more at ease in discussing the problems of the children with their parents and the school psychologists. They would feel more involved with the children's problems and less helpless and stifled (Andronico & Guerney, 1967).
5. Alleviation of a child's problems would also, undoubtedly, bring satisfaction and reinforcement to the teacher, since she would have played an integral part in the process (Guerney, 1968, in press).

In addition to the above, several authors, including

Moustakas (1956), Baxter (1941), and Ojamann (1954) have emphasized the child's need to have a teacher respect him, accept him as unique and worth while, and honestly believe in him. With a teacher's recognition and warmth, the child can learn to accept and understand himself, the key to successful adjustment and growth.

The question arises, of course, as to the ability of a teacher to learn and master the therapeutic technique. There is considerable evidence that teachers can and have played an important role in child psychotherapy, primarily using behavior therapy. Britton (1966) found a teacher "extremely skillful" in carrying out therapy with a nontalking kindergarten child; Harris, Johnson, Kelley, and Wolf used a nursery school teacher successfully in curing the regressed crawling of a child (Ullmann & Krasner, 1966, p. 313); Hart, Allen, Buell, Harris, and Wolf used teachers as therapy agents in two cases (Ullman & Krasner, 1966, p. 320); and Zimmerman and Zimmerman found success with teachers serving as intermediary agents in the therapeutic process (Ullman & Krasner, 1966, p. 320).

In view of the previous successes with teachers in therapy programs and the efficiency of parents engaging in Filial Therapy, it was expected, in the present study, that by learning and using the Filial Therapy method the teacher could effectively function as the major agent in helping the troubled child, and thus, make better use of her already influencial role.

Method

Subject.--Eleven teachers from the Jesse Selover Elementary School in Sayreville, New Jersey were trained in the techniques of Filial Therapy by Dr. Bernard Guerney, Jr., Director of the Rutgers University Psychological Clinic and Mr. Joseph Rimmer, Director of Pupil Personnel in the Sayreville school system.[2] Each teacher selected two "withdrawn" children from her own class to participate in the study. The children were selected on the basis of the teacher's subjective evaluation of the children's failure to communicate with other children, lack of interest in the classroom situation, and unfulfilling approach to school.[3] One child from each class was randomly assigned to the control group and the other to the experimental therapy group. The control group was used to account for any changes in behavior that might have occurred because of factors other than the therapy such as the teachers' general classroom techniques, peer influences, or maturation. Before the end of the study, however, several of the children were eliminated from the program for various reasons including children changing schools, parents not submitting written approval, and children not showing withdrawn behavior in accordance with the set criteria. In the final analysis, children from nine of the eleven teachers were included in the study, with a total of nine children in the experimental group and six in the control group. The children were from

kindergarten, first, second, third and fifth grades; eight were boys and seven were girls.

Four seniors from Douglass and Rutgers Colleges served as coders of the classroom behavior.

Procedure.--

A Coding

A workable coding system was devised to provide an objective method of evaluating behavior and possible changes in behavior. The system coded four types of aggressive or initiating behavior of the part of these withdrawn children:

1. Initiating talk in class.

This category included speaking out of turn to the class ("Let's play initial tag,") speaking out in a classroom discussion, or speaking when called upon by the teacher after having raised one's hand to speak. In all cases the key was initiating talk, not just responding to a question.

2. Raising the hand in an attempt to initiate talk.

This category does not include raising the hand in response to a "How many of you" type question. If the child is subsequently called upon after raising his hand to speak, the response is credited to the category "initiating talk in class "

3. Initiating talk with another student.

This was perhaps the most important measure. Since the aim of the therapy was to "free" the child of his repressions and frustrations and thus help him gain self-respect and

acceptance of himself, the child would hopefully be less reluctant to initiate interactions with other children.

4. Initiating talk privately with the teacher.

This category included walking over to the teacher to speak or calling out directly to her. Since the child was working with the teacher in a relaxed atmosphere, it might have been expected that the child would henceforth be more at ease and verbal with this teacher. However, the ultimate goal of the treatment was for this relaxed feeling to generalize in the child's interactions with others, as well as the teacher. Therefore, this category was included in order to be able to determine exactly where any changes in behavior occurred.

Nonverbal initiations of activity were not included in the coding scheme because of the subjectivity involved in their evaluation.

For four weeks before the actual beginning of the program, the coders observed children in the classrooms involved. They were each assigned an aggressive and a withdrawn child to watch in each class as practice. The verbally aggressive children were observed for three reasons. First of all, while learning the coding method, observing aggressive children was stimulating practice since they required more active concentration on their behavior than did the withdrawn children. Secondly, the behavior of the aggressive children served to highlight the withdrawn behavior of the other children by

providing an extreme comparison. Thirdly, they produced an objective score of aggressive behavior which, when averaged with the scores of the withdrawn children, would provide a rough estimate of the average behavior of the children.

The coders practiced until they reached a very high level of reliability. A rank correlation of .928 was obtained, significant at the .001 level.

The coders were introduced as students who were "learning to be teachers." During this period of practice, the children became accustomed to having visitors in the class. This time also provided the opportunity for this investigator to become aware of some of the behavior difference in the children and the routine of an elementary school class.

The behavior of the control and the experimental child were coded simultaneously in each class for one 65-minute session each week. The coding was done at 15-second intervals, with one initiation in a particular category the limit for that category for that 15-second period. One initiation continuing over several 15-second intervals was scored in each period. This method seemed to be the best in terms of an objective score of behavior, convenience to the coder, and reliability.

As a control for bias, none of the coders aside from this investigator was aware of which of the children in each class was receiving therapy.

An attempt was made to schedule the classroom observations

so as to have the coders in the classes during general participation periods rather than during seat-work time, and to observe activities that were fairly uniform in nature throughout the classes. The classes were observed during the same activity period each week for intra-class consistency.

B. Therapy.

Each teacher met with her child in nondirective play therapy once a week for about 45-minute periods. Each teacher was observed engaging in therapy and was coded on her ability to empathize and respond to the child in an accepting manner. This scoring code was developed at the Rutgers University Psychological Clinic for coding and evalutating the parents in Filial Therapy. This wad done in order to see whether the teacher's ability would have any bearing on the child's improvement. A positive correlation would suggest that the therapy, not merely the extra-attention from the teacher, was producing the behavior change.

The teachers were divided into two small groups which met once each week for group discussion sessions designed after the parent Filial Therapy groups. These sessions served as Supervisory meetings for the teachers. The first 20 minutes of each session was devoted to observations of one of the teachers working with her child. This was followed by a discussion of individual and mutual problems.

Results and Discussion

Base-line data were collected for six weeks before therapy began, and experimental data were obtained during the 17 weeks of the therapy period except for the ninth, tenth and eleventh weeks of the program due to the Christmas vacation. The weekly scores for each child were graphed in order to point up the trends exhibited before and during the therapy period for each child receiving therapy and for his classroom control subject.

Place Figures 1-9 About Here

For reasons stated previously some of the subjects were eliminated and others added; therefore, there are no pre-therapy data for three of the nine experimental subjects (see Figures 5, 6, and 9) and no controls for several of them (see Figures 7, 8, and 9).

Mean verbal-initiation scores for each experimental subject were determined for scores at the beginning of therapy and at the end of the observation period. A *t* test for correlated samples showed a significant difference at the .05 level. It is evident from glancing at the graphs that there was no significant change in the control group.

Figure 10 compares the mean scores for the two groups.

Place Figures 10 About Here

The consistent trends observed in the individual graphs justify the group graph being composed of split numbers of subjects. Of major importance is the apparent equality of the level of verbal initiations of the two groups at the point of the beginning of therapy. A comparison test was run between the two groups using the mean scores from the first two weeks after therapy began and the last two weeks of observation. The difference was significant at the .01 level, and is clear from an examination of Figure 10.

The average score for all 15 withdrawn children at the point of therapy onset was 11; after 14 weeks of therapy, the average score for the experimental group was about 26 (see Figure 10). The average score for nine of the most verbally aggressive children in the classes was 40. This would seem to suggest that the experimental group improved to approximately the estimated average level for the class.

Of the four initiation areas scored, the experimental group improved most in initiating talking with other students as can be seen in Figure 11.

Place Figure 11 About Here

There was a slight increase evident in initiating interactions with the teacher, but this ended by the eleventh week while the other scores continued to rise. Thus, the effect of the therapy did generalize to the children's behavior with others

as was hoped.

Several other variables were investigated. Since all of the teachers were female, it is conceivable that the sex of the child might have been an important factor in the treatment. Four of the therapy subjects were boys (see figures 2, 3, 4, and 7), and five were girls. The girls improved an average of 18 points and the boys an average of 11 points. Though these scores were not significantly different, it is possible that a larger sample might yield significant results.

Another variable considered was the grade of the child. In general, the lower the grade, the greater the average degree of improvement. Here again, larger samples are needed.

The final major relationship analyzed was that between the teacher's ability in therapy and the child's degree of improvement. A rank correlation was run on these data and the resultant correlation of .85 was significant at the .05 level. A larger sample here might also give more strength to these results.

In general, the results were very favorable and invite further study in the use of teachers as Filial Therapists. In every case except one (see Figure 3) the coders were able to guess correctly as to whether or not an individual child was receiving therapy. This suggests that there was probably an obvious behavior change in the children in addition to the revealing objective scores.

On the whole, the teachers themselves were very pleased

with the program, finding the therapy techniques fairly simple and enjoyable. One of the older teachers said that she "felt like a Grandmother" for the first time in her life. They were equally satisfied with the changes evidenced by the children they worked with. Several of the teachers had interesting comments concerning the program:

This program has made me want to try harder with shy pupils. It is so easy to just ignore them, or rather, I should say, to forget them unintentionally."

"I would say I'm more aware of my own attitute toward little things."

"Awareness of this new role with children has made me try it on an individual basis in the classroom."

"I never expected such a change in R. as there has been in such a short time. I am thrilled."

There are several suggestions for future study in this area. The first, as mentioned previously, is to replicate the experiment using a larger number of teachers and students. It might also be worth while to use hostile, overly aggressive, or other types of problem or troubled children in Filial Therapy with their teachers to see whether they would be helped as much as the withdrawn children seemed to have been. One final suggestion is to have the children in the control group play privately once each week with a teacher who has not been trained in Filial Therapy to control for the extra

attention received by the therapy group.

At the present time post therapy data are being collected in order to determine whether the effects of the therapy will last after the therapy has stopped. It is this investigator's opinion that the effects will not deteriorate once the child has been "freed" to enjoy interacting with other people.

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Footnotes

[1] The author is deeply indebted to Dr. Bernard Guerney for his patient guidance and support, and to Joseph Rimmer for his valuable assistance.

[2] The teachers involved in the program were trained in the therapy tedhniques last year and worked with children in the shhool, though not necessarily from their own classes. The children were from grades kindergarten to fifth. The results were very favorable, though subjectively evaluated . The children were reported as being happier, relating better to the other children, initiating activities and often showing improvement in their school work. It was supposed that working with their own children might even be better as far as total understanding and degree of influence were concerned.

[3] Withdrawal is a mechanism of maladjusted behavier which is an unconscious attempt to realize one's self-concept. However, this realization is obtained in an "underground" manner (Axline, 1947). Slavson (1952) attributes withdrawal to an inadequate feeling of security. These withdrawn children, because they are quiet and untroublesome are usually not recommended for therapy but can often benefit from therapy which gives them an opportunity for self-expression and acceptance (Axline, 1947). Wolf (1958) asserts that unless the under-aggressive child gains self

Footnotes, continued

confidence he will be regarded and will regard himself as unworthy. Patterson (1966) feels that relatively nonverbal children would not benefit from purely verbal types of counseling and that there should be facilities for play therapy in the elementary school. There is also a commonly held view that withdrawn children would benefit more from play therapy, specifically client-centered play therapy, than the aggressive child would (Guerney & Andronico, 1966). In addition, Guerney (1966, in press) noted that this type of child presents a challenge to the professional skills of a teacher and consequently the teacher would probably be eager to engage in Filial Therapy with the child. In the present study all of the children were "withdrawn," for the above reasons and also to provide uniformity, even though children with other problem manifestations as hostility and over-aggressiveness have been successfully treated in Filial Therapy.

Figure Captions

Figure 1. A comparison of the number of verbal initiations of one experimental and one control subject as a function of weeks before and during the therapy period.

Figure 2. A comparison of the number of verbal initiations of one experimental and one control subject as a function of weeks before and during the therapy period.

Figure 3. A comparison of the number of verbal initiations of one experimental and one control subject as a function of weeks before and during the therapy period.

Figure 4. A comparison of the number of verbal initiations of one experimental subject before and during therapy and one control subject during the therapy period as a function of weeks.

Figure 5. A comparison of the number of verbal initiations of one experimental and one control subject as a function of weeks during the therapy period.

Figure 6. A comparison of the number of verbal initiations of one experimental and one control subject as a function of weeks during the therapy period.

Figure 7. The number of verbal initiations of one experimental subject as a function of weeks before and during the therapy period.

Figure Captions, continued

Figure 8. The number of verbal initiations of one experimental subject as a function of weeks before and during the therapy period.

Figure 9. The number of verbal initiations of one experimental subject as a function of weeks during the therapy period.

Figure 10. A comparison of the mean number of verbal initiations for six experimental and three control subjects before therapy, and for nine experimental and six control subjects during the therapy period as a function of weeks.

Figure 11. A comparison of the cumulative mean number of four types of verbal initiations for nine withdrawn subjects as a function of weeks in Filial Therapy.