Case Study 1: An Evidence-Based Practice Review Report

How effective is filial therapy in reducing externalised problem behaviours in children aged 2-12 years?

1. Summary

Filial therapy is a psychoeducational intervention that is designed to enhance the parent-child relationship, decrease problematic behaviours in children, and reduce parental stress by including the parent as a therapeutic agent (Landreth, 2012). Parents access group sessions facilitated by a therapist who teaches the adults skills based on play therapy techniques, which parents then implement with their own child under the supervision of the expert facilitator. The intervention aims to empower parents to employ techniques learnt in their daily interactions with their child and has intended implications for children's wellbeing (Guerney, 1964).

The aim of this systematic literature review was to evaluate the evidence base for filial therapy, specifically its effectiveness in reducing children's problem behaviours. A total of six studies were identified for review and evaluation. The review considers the distinct differences between the research samples and the subsequent varying impact of filial therapy on problem behaviours. Overall, the research suggests there is a promising evidence base for filial therapy, but

the review highlights the need to consider results with caution. Recommendations are made in relation to future research.

2. Introduction

A supportive, stable family with clear, consistent parenting is a protective factor for children and young people's (CYP) mental health and supports their ability to build resilience (Public Health England, 2016). Moreover, positive parent-child relationships are associated with increased child wellbeing and improved mental health (Department for Education, 2018). Where problematic behaviours exist early intervention is essential in preventing an escalation of difficulties, which can result in families requiring more intensive support (McNeil, Capage, Bahl & Blanc, 1999). However, currently in the UK there is a shortfall in effective early intervention services for children and families (Ofsted, 2015), as well as an ever-increasing demand on the Child and Adolescent Mental Health Service (CAMHS) to provide the correct support (Association of Child Psychotherapists, 2018). With this in mind, there is a definite need for interventions that are cost-effective and successful in supporting children and their families in a way that yields long-term positive effects.

2.1 Psychological basis for filial therapy

Filial therapy is an integrative psychoeducational intervention developed by Guerney (1964) whereby parents are trained in play therapy techniques, which are then implemented during allocated play sessions with their child (Landreth, 2012). Increased parental involvement can support the strengthening of the parent-child relationship, in turn addressing issues, such as challenging

behaviours, and promoting sustainable changes (VanFleet, 2011a). Change though filial therapy ultimately occurs through establishing empathy between the parent and the child by drawing on social learning theory and family systems theory (VanFleet, 2011b; Ginsberg, 2003). As VanFleet, Sywulak and Sniscak (2010) explain, the parent acts as the psychotherapeutic mediator to their child whilst under the supervision of an experienced therapist. Parents learn skills that can be implemented throughout the intervention process and are subsequently generalised to everyday situations. Guerney (1964) proposed that the child-led techniques adopted within this approach could potentially improve mental health in adulthood by addressing children's emotional problems at an early stage. The phases of filial therapy are summarised as: "assessment, training, supervised play sessions, home play sessions, and generalisation" (Topham & VanFleet, 2011, p. 152).

The original filial therapy model has been adapted by different researchers, one of which is Landreth's (1991) widely used 10-week intervention. Landreth suggests that the parent group, made up of 6-8 participants, should meet weekly for 2 hours with groups being facilitated by a therapist. Sessions consist of the parents learning child-led, non-directive play therapy techniques, which parents then implement weekly during 30-minute 'special playtimes' with their child. Playtimes are video recorded and discussed during the following group sessions. Therapists act as facilitators by offering supervision and guidance, in turn helping parents to develop insight into their child's behavioural responses as well as their own. It is the therapists' role to support the adult in

adapting their parenting behaviour and to incorporate the skills learnt into daily life (VanFleet, 2011a).

Whilst filial therapy aims to address both emotional and externalised behavioural problems, such as aggression, lying and violence towards others, it also serves to positively impact on parental stress and parental acceptance of the child (Smith & Landreth, 2003). However, it is not an approach solely applicable to children displaying challenging behaviour (Landreth, 1991), rather it is a universal intervention that is relevant to a wide age range of children, namely ages 2 to 12 years (Topham & VanFleet, 2011).

One of the key components of filial therapy is the support group format; it is more practical for parents to receive training as a group, which allows for a greater number of parents and children to be targeted at any one time and is therefore cost-effective (Landreth, 1991). Arguably more importantly, it is believed that the encouragement and support experienced within a group is a valuable aspect of the training process (Landreth & Lobaugh, 1998). As noted by VanFleet et al. (2010), parents learning within a group setting benefit through observing the successes and failures of others, and by being in a position to support others in a similar situation. In turn, this leads participants to develop an enhanced belief in their skills, which Reissman termed the 'helper therapy principle' (1965).

2.2 Rationale

As discussed, it is recognised that early intervention is key for children and their families experiencing a range of presenting problems, including children's

externalised problem behaviours (McNeil et al., 1999). Whilst the demands on educational psychology services are increasingly high (DfE, 2014), interventions such as filial therapy may provide a cost-effective approach to supporting more children and families at an earlier stage, as well as those CYP who are experiencing problematic behaviours that are more entrenched. In turn, this has the potential to prevent the escalation of existing problems by teaching parents effective, child-centred techniques that are underpinned by psychological theory. Although delivering filial therapy would require educational psychologists (EPs) to complete additional training, using the intervention can effect change for 6-8 families within a 10-week period, consequently increasing EP capacity and supporting more CYP at one time.

To the author's knowledge, filial therapy is utilised and researched less so in the UK in comparison to the USA, where much of the existing evidence originates from; there is just one filial therapy course in the UK that is clinically accredited (DfE, 2016). It would be beneficial to review the current evidence base and ascertain the robustness of the results. In doing so it can then be considered whether results are generalisable to the UK population and if further research is required. Filial therapy was specifically selected for the current review following a meta-analysis of the effectiveness of play therapies, which concluded that interventions involving parents generated the largest effects (Bratton, Ray, Rhine & Jones, 2005).

2.3 Review question

How effective is filial therapy in reducing externalised problem behaviours in children aged 2-12 years?

3. Critical Review of the Evidence

3.1 Literature search

A literature search was conducted using three databases: ERIC, PsycInfo and Scopus. The searches were completed between 17th and 20th December 2018. Details of the search terms are found in Table 1. Only one term was used under the participant category so as not to exclude relevant studies; filial therapy targets any child aged 2-12 years (Topham & VanFleet, 2011).

Table 1
Search Terms Entered into Databases

Intervention		Participant		Outcome focus		Caregiver
filial therapy OR filial play	AND	child*[1]	AND	behav* problems OR behav* issues OR challenging behav*	AND	parent* OR mother* OR father*

Note. [1]An asterix (*) denotes that variable suffixes can be used. For example, 'child*' would include results of child, child's, children.

The original search identified a total of 141 studies. 102 of these were removed due to not being published in a peer-reviewed journal, and a further 15 studies were removed due to being duplicates, which resulted in 24 studies remaining. These records were then screened by title and abstract using the inclusion

criteria (Table 2); 13 further studies were excluded for not meeting the specified criteria. As such, 11 studies were screened by full text using the same inclusion criteria. Following the final screening, 6 studies were identified for review (Table 3). Figure 1 summarises the search process, while Appendix A provides references for all studies excluded at title and full text screening.

Table 2
Inclusion and Exclusion Criteria

Label	Criteria	Inclusion criteria	Exclusion criteria	Rationale
A	Type of publication	Study is published in an international journal that is peer-reviewed and published in an OECD country	Study is not published in an international peer-reviewed journal published in an OECD country	International peer-reviewed journals that are published in OECD countries will promote credibility in the selected studies and increase generalisability to the UK education system.
B	Participants	Children aged 2-12 years	Children aged below 2 years or above 12 years	The target intervention is aimed at children aged 2-12 years.
C	Intervention facilitators	Primary caregivers of a child aged 2-12 years	Adults who are not the primary care giver of a child aged 2-12 years	The target intervention relies on implementation and facilitation by any adult who is a primary caregiver.

Label	Criteria	Inclusion criteria	Exclusion criteria	Rationale
D	Intervention	Filial therapy	Not filial therapy, i.e. any other play-based therapies	Filial therapy is a specific type of intervention based on play therapy principles. Confining the search ensures that all results are strictly filial therapy based as opposed to another similar intervention.
E	Outcome	Problem behaviours of children that are externalised and therefore observable	Internalised behaviours, for example feelings of anxiety, or outcomes of individuals other than the child	The primary function of filial therapy is to address externalised behaviours of the child. Though there are generally positive outcomes for the parents involved (e.g. parental stress), the focus of this review is on child outcomes alone.
F	Study design	Group experimental design	Non-experimental design or non-group experimental design	Effectiveness of the intervention is determined through group comparisons.
G	Language	English	Non-English	To enable the reviewer to access the content of the article.

Table 3
Final Studies Included in the Review

Draper, K., Siegel, C., White, J., Solis, C. M., & Mishna, F. (2009). Preschoolers, Parents, and Teachers (PPT): A Preventive Intervention with an At Risk Population. *International Journal of Group Psychotherapy*, 59(2), 221–242.

Kale, A., & Landreth, G. L. (1999). Filial Therapy With Parents of Children Experiencing Learning Difficulties. *International Journal of Play Therapy,* (8)2, 35-56.

Landreth, G. L., & Lobaugh, A. F. (1998). Filial Therapy with Incarcerated Fathers: Effects on Parental Acceptance of Child, Parental Stress, and Child Adjustment. *Journal of Counseling and Development*, 76(2), 157–165.

Smith, N., & Landreth, G. (2003). Intensive Filial Therapy with Child Witnesses of Domestic Violence: A Comparison with Individual and Sibling Group Play Therapy. *International Journal of Play Therapy,* 12(1), 67-88.

Tew, K., Landreth, G. L., Joiner, K. D., & Solt, M. D. (2002). Filial Therapy with Parents of Chronically Ill Children. *International Journal of Play Therapy*, 11(1), 79-100.

Yuen, T., Landreth, G., & Baggerly, J. (2002). Filial Therapy with Immigrant Chinese Families. *International Journal of Play Therapy*, *11*(2), 63–90.

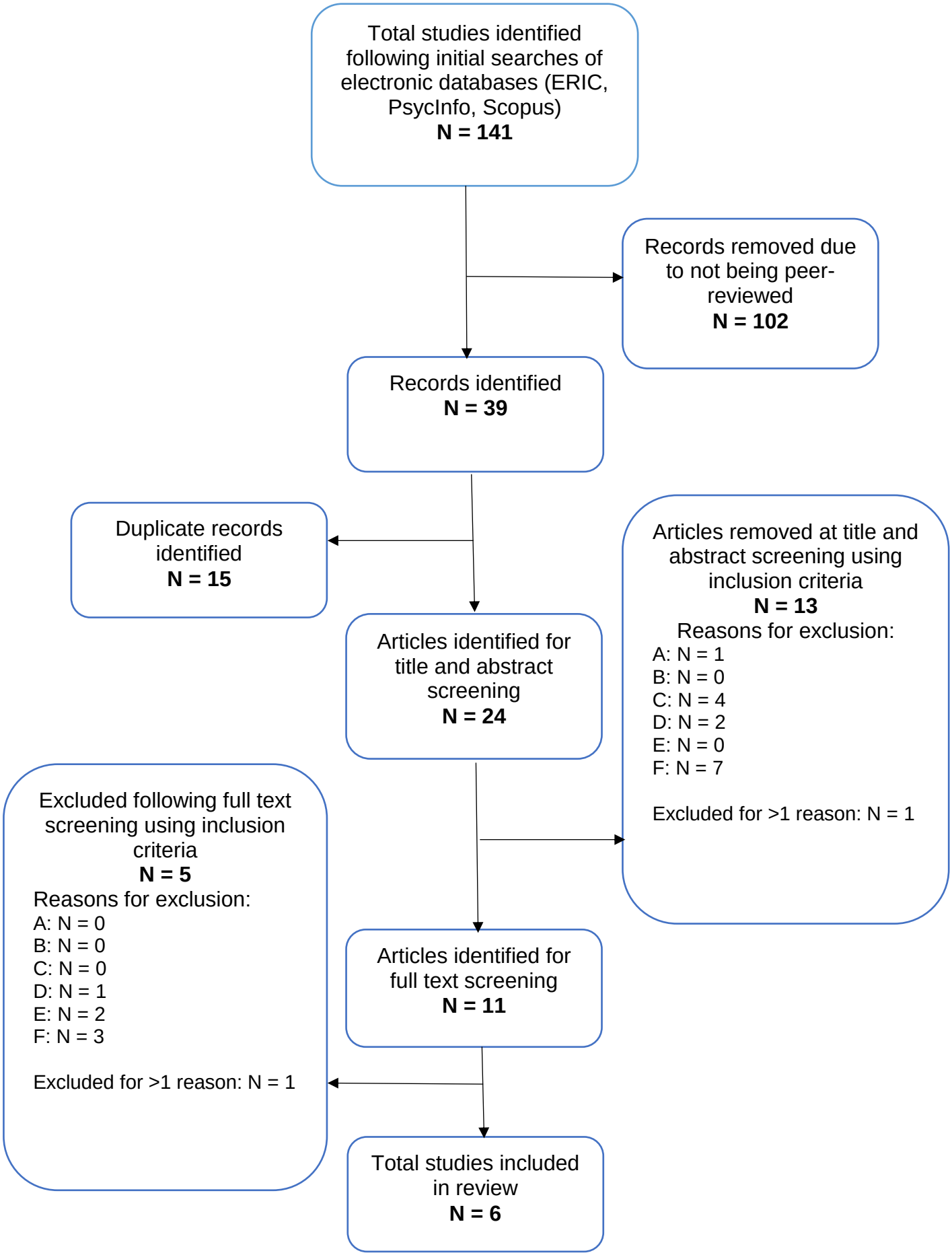
Total studies identified following initial searches of electronic databases (ERIC, PsycInfo, Scopus)
N = 141
Records removed due to not being peer-reviewed
N = 102
Records identified
N = 39
Duplicate records identified
N = 15
Articles removed at title and abstract screening using inclusion criteria
N = 13
Reasons for exclusion:
A: N = 1
B: N = 0
C: N = 4
D: N = 2
E: N = 0
F: N = 7
Excluded for >1 reason: N = 1
Articles identified for title and abstract screening
N = 24
Excluded following full text screening using inclusion criteria
N = 5
Reasons for exclusion:
A: N = 0
B: N = 0
C: N = 0
D: N = 1
E: N = 2
F: N = 3
Excluded for >1 reason: N = 1
Articles identified for full text screening
N = 11
Total studies included in review
N = 6

Figure 1. Flow Diagram of the Search Process

A summary of each study, including participant characteristics, measures and outcomes can be found in Appendix B.

3.3 Weight of evidence

Kratochwill's (2003) protocol was used to code each study for its methodological quality, which is termed Weight of Evidence A (WoE A). This involves screening each record and assigning scores based on the robustness of the methodology. A summary of how the WoE A ratings were allocated can be found in Appendix D. Appropriate adaptions were made to the coding protocol to ensure applicability to the current review (Appendix C). An example of a completed protocol can be found in Appendix E.

Studies were then evaluated in relation to the current review for their methodological relevance (WoE B) and topic relevance (WoE C). Further details of the WoE B and C criteria used can be found in Appendices F and G. Overall weighting (WoE D) was calculated using the average rating for WoE A, B and C for each study, and determines the quality and relevance of each study in relation to the current review focus (Table 4). Studies were allocated a rating in accordance with the following scale: 0 - 0.99 = zero; 1.0 - 1.4 = low; 1.41 - 2.4 = medium; 2.41 - 3.0 = high.

Table 4
Weight of Evidence D: Overall Quality and Relevance

Study	WoE A Methodological quality	WoE B Methodological relevance	WoE C Topic relevance	WoE D Overall quality and relevance
Draper et al., 2009	1.00 (Low)	1 (Low)	1 (Low)	1.00 (Low)
Kale & Landreth, 1999	1.33 (Low)	2 (Medium)	2 (Medium)	1.78 (Medium)
Landreth & Lobaugh, 1998	1.67 (Medium)	1 (Low)	2 (Medium)	1.56 (Medium)
Smith & Landreth, 2003	1.67 (Medium)	1 (Low)	1 (Low)	1.22 (Low)
Tew et al., 2002	1.67 (Medium)	1 (Low)	3 (High)	1.89 (Medium)
Yuen et al., 2002	1.67 (Medium)	2 (Medium)	3 (High)	2.22 (Medium)

3.4 Participants

The total number of participants in the current review is 174, ranging from ages 3-10 years. Whilst filial therapy is appropriate for children aged 2-12 years (Topham & VanFleet, 2011), the Draper et al. (2009) study was the only one

to focus on a specific age range of 4-5 years and the only study whereby problem behaviours actually increased for both the experimental and control groups. Further research into the effectiveness of filial therapy could explore comparisons between different age groups. It may be such that the efficacy of filial therapy for younger children is much lower. Moreover, all studies were completed in the USA or Canada; results should therefore be explored with caution when considering generalisability to the UK.

Disregarding studies where the primary focus of the parent sample was either mothers or fathers, and where the relevant data were reported, there were always more mothers than fathers taking part in the study (Draper et al., 2009; Kale & Landreth, 1999; Tew et al., 2002). Where mothers were the focus of the facilitator role (Smith & Landreth, 2003) a large effect size was found, whereas no effect size was found when fathers were the facilitators (Landreth & Lobaugh, 1998). Whilst on the surface it may be anticipated that these results imply mothers are better able to implement play-based strategies than fathers, thus reducing their child's problematic behaviours, consideration should be given to the disparities in the WoE D ratings of these studies. Smith and Landreth (2003) were allocated a low rating, whilst Landreth and Lobaugh (1998) received a medium rating, meaning that although the former study produced a greater effect size, this should be accepted tentatively due to the lower quality and relevance of the research.

Filial therapy is a universal programme designed to increase the quality of the parent-child relationship and reduce problem behaviours. Only one study out

of the six reviewed, Draper et al. (2009), explicitly sampled children that were already deemed to be at risk of developing problem behaviours. However, the participants in Kale and Landreth's (1999) research were children with learning difficulties who are predisposed to experiencing problem behaviours, which parents can find difficult to manage (Zuckerman & Zuckerman, 1982). Interestingly, these were the two studies out of the six that were reviewed whereby filial therapy did not yield a significant effect on problem behaviours. It could be inferred that whilst filial therapy is an effective intervention for children displaying typical behaviours, families with more complex needs or children already at risk of developing problem behaviours, may require more intensive support, such as a longer intervention period.

3.5 Intervention

All studies used either the Landreth (1991) or Landreth (2002) 10-week adapted filial therapy model, and most studies focused solely on the implementation of filial therapy with parents, though two studies included additional components. Draper et al. (2009) trained teachers in filial therapy as well as parents, and Smith and Landreth (2003) included support group sessions for the children. As a result, both studies received a low WoE C rating, as it could not be concluded that any effects were a consequence of filial therapy. However, it should be noted that the sessions accessed by the children in Smith and Landreth's (2003) research were offered to children in both the experimental and control groups. Such support is likely to be highly valuable to these children who had witnessed domestic violence, though this study did not report data on the efficacy of child-focused support groups.

An essential and unique component of filial therapy is the role of the therapist in facilitating parent training sessions and teaching parents the necessary skills to implement with their child (VanFleet, 2011a). Kale and Landreth (1999) were the only researchers not to utilise the expertise of a therapist who had undergone specific training in filial therapy, hence why criterion 3 of WoE C was not satisfied. Since this was also a study that did not produce a significant effect on problem behaviours, it should be considered whether the absence of an expert facilitator weakened the overall effectiveness of the intervention.

3.6 Designs

It should be noted that the methodological quality of each study, excluding Yuen et al. (2002), is weakened due to the use of nonrandomised designs. Whilst randomised designs are preferable (Barker, Pistrang & Elliott, 2016), authors reported that this was not always possible due to the practical implications of conducting research within naturalistic settings and the additional commitment required from participants to attend training sessions. For example, Kale and Landreth (1999) reported that parents were allocated to experimental groups based on their availability to attend the required training components of the intervention.

3.7 Measures

All measures used in the six studies were outwardly appropriate measures of problematic behaviours: Child Behaviour Checklist (CBCL) (Achenbach, 1991), Filial Problem Checklist (FPC) (Horner, 1974), Behaviour Assessment System

for Children (BASC) (Reynolds & Kamphaus, 1992). However, it is questionable whether some of these measures were suitable for the relevant studies. Three studies used the CBCL (Kale & Landreth, 1999; Smith & Landreth, 2003; Tew et al., 2002), but as Kale and Landreth (1999) comment, this tool is intended to measure behaviour changes over a 6-month period. Seeing as the intervention lasted a maximum of 10-weeks in each study, the CBCL may not have provided reliable results.

Whilst widely utilised, studies that used the FPC stated that no reliability or validity data were available for the measure, and as such were not reported (Landreth & Lobaugh, 1998; Yuen et al., 2002). Both of these studies therefore received a rating of 0 for the 'measurement' criterion within their WoE A coding. It should also be noted that the FPC items specifically ask parents about problematic situations related to parenting, whereas the CBCL and BASC do not. This may have affected the results in that parents completing the CBCL and BASC are likely to have considered their child's behaviour more generally rather than focusing on behaviour as a response to parenting.

All but one study (Kale & Landreth, 1999) used only one measure and one source of data collection, hence the predominantly low WoE B ratings. It would have been advantageous for studies to make use of more than one measure and source of information in order to promote congruence and solidify data collection. Whilst parental views are no doubt vital, parents are also key participants in the intervention and have experienced the learning process themselves, which could impact on their perceptions of their child. In turn, it

can be difficult to differentiate between actual and perceived changes in behaviour.

3.8 Outcomes and effect sizes

All studies reported a significant effect of filial therapy on problem behaviours, with the exception of two (Draper et al., 2009; Kale & Landreth, 1999). None of the six studies reported effect sizes. These were calculated by the current author using Pearson's r, and interpreted with Cohen's (1992) suggested boundaries. A summary of effect sizes is presented in Table 5.

Power calculations were not reported by any of the reviewed studies, nor were they calculated for the purpose of the review as significant results indicate sufficient power within the analysis, whereas non-significant results suggest insufficient power (Field, 2016). It is therefore assumed that all studies, excluding Draper et al. (2009) and Kale and Landreth (1999), had enough power, which is reflected in the coding protocols and WoE A ratings (Appendix D).

Table 5
Effect Sizes

Study	Sample size	Effect size (r)	Effect size interpretation	WoE D
Draper et al., 2009[1]	40	--	--	1.00 (Low)
Kale & Landreth, 1999[1]	22	--	--	1.78 (Medium)
Landreth & Lobaugh, 1998	32	0.035	No effect	1.56 (Medium)
Smith & Landreth, 2003	22	-0.622	Large effect	1.22 (Low)
Tew et al., 2002	23	-0.474	Medium effect	1.89 (Medium)
Yuen et al., 2002	35	-0.315	Medium effect	2.22 (Medium)

Note. [1]Effect size could not be calculated due to insufficient data reported in the study and non-significant results

Smith and Landreth (2003) reported the only large effect size of the six studies; their sample was children who had witnessed domestic violence and their mothers, who were living in women's shelters at the time of the study. Despite a large effect size, the WoE D for this study was low, perhaps due to adaptions made to the intervention that were ultimately necessary for the programme to run. As an example, criterion 1 within WoE C could not be awarded a rating for this study as mothers only accessed 18 hours of facilitated sessions, and the intervention was condensed into an intensive 3-weeks as opposed to the recommended 10-weeks. This was to support the emotional needs of the

mothers; a required adaption to make the intervention sustainable. Nonetheless the effect size was large, which is perhaps attributable to the complex needs of both the mothers and their children, and may be a reflection of how valuable the programme was despite adaptions.

Medium effects were found in two studies (Tew et al., 2002; Yuen et al., 2002), whilst one found no effect (Landreth & Lobaugh, 1998). The latter was a particularly distinctive study in comparison to the others within this review as the parents were incarcerated fathers. This meant that the filial therapy programme needed to be adapted more so in order to accommodate the organisation of the prison, for example the intervention was shortened to 15-hours and play sessions could not be video recorded due to prison rules, thus the feedback received from the facilitator and parent group during training sessions may have been less accurate. Whilst fathers were able to reflect on their behaviours and their child's responses within the group sessions, they were not able to view their interactions, which arguably allows for greater insight. The study therefore did not satisfy the first WoE C criterion. However, though the study was not qualitative, anecdotal reports within the research describe fathers as feeling more competent in their parenting and recognising the value of the intervention, as described as part of the WoE A coding.

Although Smith and Landreth (2003) reported a large effect size, the study holds less weight as the WoE D rating was low, whereas both Tew et al. (2002) and Yuen et al. (2002) reported medium effects and were allocated medium WoE D ratings. Both of these studies also scored highly for their WoE C,

meaning they were highly relevant to the current review. Yuen et al. (2002) is particularly credible due to the use of a randomised design, which is reflected in the associated WoE B rating.

4. Conclusions and Recommendations

The filial therapy evidence base evaluated in this review is somewhat promising, with three out of the six identified studies producing a medium or large effect in the reduction of externalised problem behaviours (Smith & Landreth, 2003; Tew et al., 2002; Yuen et al., 2002). However, the evidence suggests that effectiveness of this intervention is somewhat dependent on the population characteristics. Whilst similar in their implementation of filial therapy, the studies included in the current review are largely different in terms of their sample and caregiver focus, which goes some way in explaining the discrepancies between the findings. CYP with more complex needs or existing behavioural difficulties may benefit from further adapted filial therapy programmes, for example longer intervention cycles, in order to fully address their needs. Future research could examine whether this strategy produces positive effects, as studies that focused on this population within the current review found that filial therapy was not effective whilst using a 10-week model (Draper et al., 2009; Kale & Landreth, 1999). The long-term effects of filial therapy are also unclear as one major limitation of all studies is the lack of follow up assessments. Without this, it cannot be concluded that filial therapy holds the universally lasting benefits that it aims to (Guerney, 1964).

As discussed throughout the critical review, adaptions were made by several researchers in order to best accommodate the needs of the participants and the relevant settings (e.g. Landreth & Lobaugh, 1998; Smith & Landreth, 2003). Whilst this may have altered the results of the research, it is important to note that the models used in all studies (Landreth, 1991; Landreth, 2002) are adaptions in themselves of the original filial therapy model (Guerney, 1964), and were simply the programmes chosen by the researchers. Adaptions are often necessary in order to complete work with participants from lesser-researched backgrounds in alternative contexts. It should also be mentioned that Landreth (1991) developed the widely used 10-week model and is an author on all but one of the six studies (Draper et al., 2009). This incites potential bias in the selected studies. Further research should consider the implementation of differing models to ascertain their effectiveness in comparison to the Landreth programme (1991).

Issues raised regarding methodological quality, such as the use of nonrandomised designs and the use of only one measure of problem behaviours mean that results should be accepted tentatively. Moreover, despite their behaviour being one of the primary outcomes for each study, and the focus of this review, none of the studies collected data on the children's perspectives. It could be argued that externalising behaviours are best identified by the adults observing them, and that having an insight into their own behaviours requires a self-awareness that many children do not possess. On the other hand, obtaining the child's perception, alongside their parents' and teachers', could prove to be valuable data that allows for an enhanced

understanding of the individuals that filial therapy is ultimately designed to support.

Each study was conducted in the USA, meaning generalisability to the UK population is increased due to similarities in education systems. Nonetheless it would be beneficial to complete further research on filial therapy within the UK before encouraging wider use. Despite the concerns raised relating to methodology and the long-term impact, filial therapy has a promising evidence base and the potential to reduce externalised problem behaviours in several children during one cycle of the intervention. There is a potential role for EPs to facilitate programmes and empower parents to utilise psychologically-based strategies as a method in supporting their child's behaviour and wellbeing.

References and Appendices

References

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Topham, G. L., & VanFleet, R. (2011). Filial Therapy: a structured and straightforward approach to including young children in family therapy. *The Austrailian and New Zealand Journal of Family Therapy, 32*(2), 144-158.

VanFleet, R., Sywulak, A. E., & Sniscak, C. C. (2010). *Child-Centred Play Therapy.* Guilford Press: London.

VanFleet, R. (2011a). Filial therapy: strengthening family relationships with the power of play. In C. E. Schaefer, C.E. (Ed.), *Foundations of play therapy.* 2nd ed. (pp. 153-169). New Jersey: Wiley.

VanFleet, R. (2011b). Filial Therapy: what every play therapist should know: part two of a series. Retrieved from http://www.play-therapy.com/images_prof/FT.BAPT.article.pt2.pdf, accessed 19th January 2019.

Yuen, T., Landreth, G., & Baggerly, J. (2002). Filial Therapy with Immigrant Chinese Families. *International Journal of Play Therapy, 11*(2), 63–90.

Zuckerman, L., & Zuckerman, V. (1982). Parenting exceptional children. *Individual Psychology, 38*, 398-403.

Appendix A: Studies Excluded at Title and Full Text Screening

Study	Reason for exclusion

Athanasiou, M., & Gunning, M. (1999). Filial Therapy: Effects on Two Children's Behavior and Mothers' Stress. *Psychological Reports, 84*(2), 587-590.	F
Bennett, M. O., & Bratton S.C. (2011). The effects of child teacher relationship training on the children of focus: A pilot study. *International Journal of Play Therapy,* 20(4), 193-207.	C
Bornsheuer-Boswell, J., Garza, Y., & Watts, R. (2013). Conservative Christian parents' perceptions of child-parent relationship therapy. *International Journal of Play Therapy,* 22. 143.	D
Edwards, N., Sullivan, J., Meany-Walen, K., Kantor, K., & Leblanc, M. (2010). Child Parent Relationship Training: Parents' Perceptions of Process and Outcome. *International Journal of Play Therapy,* 19(3), 159-173.	D, F
Capps, J. E. (2012). Strengthening Foster Parent-Adolescent Relationships through Filial Therapy. *Family Journal: Counseling and Therapy for Couples and Families,* 20(4), 427-432.	F
Cornett, Nick. (2012). A Filial Therapy Model through a Family Therapy Lens: See the Possibilities. *Family Journal: Counseling and Therapy for Couples and Families, 20*(3), 274-282.	E
Goetze, H., & Grskovic, J. A. (2009). The effects of peer-facilitated filial therapy: A play tutor approach. *Person-Centered and Experiential Psychotherapies,* 8(4), 282-298.	C
Guo, Y. (2005). Filial Therapy for Children's Behavioral and Emotional Problems in Mainland China. *Journal of Child and Adolescent Psychiatric Nursing,* 18(4), 171-180.	F
Johnson, L. (1995). Filial Therapy. *Journal of Family Psychotherapy,* 6(3), 55-70.	F

Study	Reason for exclusion
Johnson, L., Bruhn, R., Winek, J., Krepps, J., & Wiley, K. (1999). The use of child-centered play therapy and filial therapy with head start families: a brief report. *Journal of Marital and Family Therapy, 25*(2), 169-176.	F

Jones, L., Rhine, T., Bratton, S., & Glazer, H. R. (2002). High school students as therapeutic agents with young children experiencing school adjustment difficulties: the effectiveness of a filial therapy training model. *International Journal of Play Therapy,* 11(2), 43-62.	C
Kinsworthy, S., & Garza, Y. (2010). Filial Therapy with Victims of Family Violence: A Phenomenological Study. *Journal of Family Violence, 25*(4), 423-429.	D, E
Lee, Y., & Kim, M. (2015). The Effect of Filial Therapy on Physically Disabled Mothers' Empathy Ability and their Non-Diasabled Children's Behavior Problems. Indian Journal of Science and Technology, 8(25).	A
Leung, C. H. (2015). Enhancing Social Competence and the Child–Teacher Relationship using a Child-Centred Play Training Model in Hong Kong Preschools. *International Journal of Early Childhood,* 47(1), 135-152.	C
Rennie, R. L. (2003). Filial Therapy: Firming the Foundation of the Parent-Child Relationship. *Marriage & Family: A Christian Journal,* 6(2), 195-212	F
Ryan, V. (2007). Filial Therapy: Helping Children and New Carers to Form Secure Attachment Relationships. *British Journal of Social Work,* 37(4), 643-657.	F
Topham, G. L., Wampler, K. S., Titus, G., & Rolling, E. (2011). Predicting Parent and Child Outcomes of a Filial Therapy Program. *International Journal of Play Therapy*, 20(2), 79–93. https://doi.org/10.1037/a0023261	F
Winek, J., Lambert-Shute, J., Johnson, L., Shaw, L., Krepps, J., Wiley, K., & Ray, D. C. (2003). Discovering the moments of movement in filial therapy: a single case qualitative study. *International Journal of Play Therapy,* 12(1), 89-104.	F

Key to exclusion criteria:
A: Type of publication
B: Participants
C: Intervention facilitators
D: Intervention

E: Outcome
F: Study design
G: Language

Appendix B: Table to Map the Field

Study	Sample size	Study design	Country	Sample characteristics	Caregiver characteristics	Intervention method	Outcome measure of problem behaviours	Primary findings
Draper et al., 2009	Treatment = 22 Control = 18 Total N = 40	Nonrando-mised group design	USA	4-5 years Equal N of boys and girls Black African American (except 1 not specified)	Mothers = 51, fathers = 5, grandmothers = 4 Median age range= 25 to 29 years	8 x 2-hour parent groups 30-minute play sessions 1 x training day for teachers plus in-class support to teach skills to be used in the classroom	Behaviour Symptoms Index within the Behaviour Assessme-nt System for Children – Teacher Rating Scale (BASC-TRS)	Behaviour of both the treatment and the control group deteriorated

Study	Sample size	Study design	Country	Sample characteristics	Facilitator characteristics	Therapeutic method	Outcome measure of problem behaviours	Primary findings
Kale & Landreth, 1999	Treatment = 11 Control = 11 Total N = 22	Nonrando-mised group design	USA	3-10 years Native American Caucasian, Mixed Race Identified as having learning difficulties	Mothers = 17, fathers = 3, grandmothers = 2 Mean ages = experimental 43 years, control 37 years	10 x 2-hour parent groups 30-minute play sessions	Child Behaviour Checklist - Parent Report Form (CBCL) and CBCL-Teacher Report	No significant difference between post test scores of control/ experimental groups

Study	Sample size	Study design	Country	Sample characteristics	Facilitator characteristics	Therapeutic method	Outcome measure of problem behaviours	Primary findings
Landreth & Lobaugh, 1998	Treatment = 16 Control = 16 Total N = 32	Nonrando-mised group design	USA	4-9 years 19 girls, 13 boys Caucasian, Hispanic, African American Children with incarcerated fathers	Incarcerated fathers (mean age = 30 years)	10 x 1.5-hour parent training sessions 30-minute play sessions	Filial Problem Checklist (FPC)	Significantly lower scores on problem behaviours in experimental group (pre/post test) compared to control group

Study	Sample size	Study design	Country	Sample characteristics	Facilitator characteristics	Therapeutic method	Outcome measure of problem behaviours	Primary findings
Smith & Landreth, 2003	Treatment = 11 Control = 11 Total N = 22	Nonrando-mised group design	USA	4-10 years Equal N of boys and girls Caucasian, Arabic, Hispanic, African American Children who have witnessed domestic violence	Mothers who had been victims of domestic violence and are living in a DV/ homeless shelter	12 x 1.5-hour parent training group sessions over 2-3 weeks (20-45 mins training, 30-40mins play session)	Child Behaviour Checklist - Parent Report Form	Experimental group significantly decreased behaviour problems compared to the control group

Study	Sample size	Study design	Country	Sample characteristics	Facilitator characteristics	Therapeutic method	Outcome measure of problem behaviours	Primary findings
Tew et al., 2002	Treatment = 12 Control = 11 Total N = 23	Nonrando-mised group design	USA	3-10 years Caucasian, Hispanic Chronically ill children	Parents of chronically ill children (mothers = 18, fathers = 5)	10 x 2-hour parent training sessions 30-minute play sessions	Child Behaviour Checklist – Parent Report Form	Problem behaviours in the experimental group significantly decreased
Yuen et al., 2002	Treatment = 18 Control = 17 Total N = 35	RCT	Canada	3-10 years Equal N of boys and girls Chinese immigrants	Chinese immigrant parents (mean age = 40)	10 x 2-hour weekly parent training group sessions Materials translated into Chinese, sessions conducted in Cantonese	Filial Problem Checklist	Significantly lower perceived number of problem behaviours in experimental group than control

Appendix C: Adapted Coding Protocol

Kratochwill's (2003) coding protocol was adapted accordingly to remain relevant to the current review.

Section excluded	Rationale for exclusion
I. B7. Coding; B8. Interactive process	Not relevant as the current review does not consider qualitative methodologies
II. C2. Percentage of primary outcomes that are statistically significant C3. Evidence of appropriate statistical analysis for secondary outcomes C4. Percentage of secondary outcomes that are statistically significant C5. Overall summary of questions investigated	The current review is focused on one primary outcome. Effect sizes are examined elsewhere in the review.
II. D. Educational/ clinical significance	Participants were not selected from a clinical sample and not all interventions were carried out in educational settings. Educational significance is considered elsewhere in the review.
II. E. Identifiable components	The focus of the intervention examined in the current review is comprised of one component.
II. F. Implementation fidelity	The intervention considered in the current review is an established programme, and all studies followed the same intervention model.
II. G. Replication	Not relevant to the current review.
II. H. Site of implementation	Not relevant to the current review.
II. I. Follow Up Assessment	None of the studies within this review completed follow up assessments. This is explored within the discussion of the review.

Section excluded	Rationale for exclusion
III. A1. Participant selection (sampling)	The intervention programme is universal and so does not exclude based on specific criteria unless it is appropriate (i.e. focus of the study is on a particular group).
III. A2. Participant characteristics specified for treatment and control group A3. Details are provided regarding demographic variables	Listed elsewhere in the review (Appendix B).
III. A5. Generalisation of effects	Explored throughout the review.
III. B. Length of intervention	Explored elsewhere in the review (Appendix G).
III. D. Dosage/ response	Not relevant to the current review.
III. E. Programme implementer	Explored elsewhere in the review (Appendix G).
III. F. Characteristics of the intervener	Necessary information not provided in the studies.
III. G. Intervention style or orientation	Not relevant to the current review.
III. H. Cost analysis data	Not relevant to the current review.
III. I. Training and support resources	Not relevant to the current review.
III. J. Feasibility	Not relevant to the current review.

Appendix D: Weight of Evidence A: Methodological Quality (WoE A)

This section considers the quality of methodological factors within each study in relation to the current review. Kratochwill's (2003) coding protocol was completed for each study under review, with the final WoE A rating being determined by the average rating of the three key features provided: measurement, comparison group and appropriate statistical analysis. Table 8 reports the WoE A scores.

Table 8
Weight of Evidence A: Methodological Quality

Study	Measurement	Comparison group	Appropriate statistical analysis	WoE A rating
Draper et al., 2009	1 (Weak)	1 (Weak)	1 (Weak)	1.00 (Low)
Kale & Landreth, 1999	2 (Promising)	1 (Weak)	1 (Weak)	1.33 (Low)
Landreth & Lobaugh, 1998	0 (No Evidence)	2 (Promising)	3 (Strong)	1.67 (Medium)
Smith & Landreth, 2003	0 (No Evidence)	2 (Promising)	3 (Strong)	1.67 (Medium)
Tew et al., 2002	1 (Weak)	1 (Weak)	3 (Strong)	1.67 (Medium)
Yuen et al., 2002	0 (No Evidence)	2 (Promising)	3 (Strong)	1.67 (Medium)

0 - 0.99 = no evidence (equating to zero rating)
1.0 - 1.4 = weak evidence (equating to a low rating)
1.41 - 2.4 = promising evidence (equating to a medium rating)
2.41 - 3.0 = strong evidence (equating to a high rating)

Appendix E: Completed Coding Protocols

Coding Protocol for Group Designs

[Adapted from 'Task Force on Evidence-Based Interventions in School Psychology, American Psychology Association', Kratochwill, T.R. (2003)]

Full Study Reference in proper format:

Draper, K., Siegel, C., White, J., Solis, C. M., & Mishna, F. (2009). Preschoolers, Parents, and Teachers (PPT): A preventive intervention with an at risk population. *International Journal of Group Psychotherapy, 59*(2), 221–242.

Intervention name and description: Filial therapy

Type of Publication:

☐ Book/Monograph
☒ Journal Article
☐ Book Chapter
☐ Other (specify):

i. General Characteristics

A. General Design Characteristics

A1. Random assignment designs (if random design, select one of the following)

☐ Completely randomised design
☐ Randomised block design (between-subject variation)
☐ Randomised block design (within-subject variation)
☐ Randomised hierarchical design

A2. Nonrandomised designs (if nonrandom design, select one of the following)

☐ Nonrandomised design
☒ Nonrandomised block design (between-subject variation)
☐ Nonrandomised block design (within-subject variation)
☐ Nonrandomised hierarchical design
☐ Optional coding of Quasi-experimental designs

A3. Overall confidence of judgements on how participants were assigned (select one of the following)

☐ Very low (little bias)
☐ Low (guess)
☐ Moderate (weak inference)
☐ High (strong inference)
☒ Very high (explicitly stated)
☐ N/A
☐ Unknown/unable to code

B. Participants

B1. Total sample size (start of the study): 60

B2. Intervention group sample size: 22

B3. Control group sample size: 18

C. Type of Programme

☒ Universal prevention programme
☐ Selective prevention programme
☐ Targeted prevention programme
☐ Intervention/treatment
☐ Unknown

D. Stage of Programme

☐ Model/demonstration programme
☐ Early stage programme
☒ Established/institutionalised programmes
☐ Unknown

E. Concurrent of Historical Intervention Exposure

☐ Current exposure
☐ Prior exposure
☒ Unknown

ii. Key Features for Coding Studies and Rating Level of Evidence/Support

(3 = strong evidence 2 = promising evidence 1 = weak evidence 0 = no evidence)

A. Measurement

A1. The study uses outcome measures that produce reliable scores for the majority of the primary outcomes

☒ Yes
☐ No
☐ Unknown/unable to code

A2. The study uses multi-method of data collection (at least two assessment methods)

☐ Yes
☒ No
☐ N/A
☐ Unknown/unable to code

A3. The study uses multiple sources of data collection (at least two sources)

☐ Yes
☒ No
☐ N/A
☐ Unknown/unable to code

A4. The measures used are valid (well-known, standardised or norm-referenced)

☒ Yes validated with the specific target group
☐ In part, validated for the general population
☐ No
☐ Unknown/unable to code

Rating for Measurement: ☐ 3 ☐ 2 ☒ 1 ☐ 0

B. Comparison Group

B1. Type of comparison group (select one of the following)

☐ Typical contact
☐ Typical contact (other) specify:
☐ Attention placebo
☐ Intervention elements placebo
☐ Alternative intervention
☐ Pharmacotherapy
☐ No intervention
☒ Waitlist/delayed intervention
☐ Minimal contact
☐ Unable to identify comparison group

B2. Overall confidence in judgements of type of comparison group (select one of the following)

☐ Very low (little bias)
☐ Low (guess)
☐ Moderate (weak inference)
☐ High (strong inference)
☒ Very high (explicitly stated)
☐ N/A
☐ Unknown/unable to code

B3. Counterbalancing by Change Agents

☐ By change agent
☐ Statistical
☒ Other

B4. Group Equivalence Established

☐ Random assignment
☐ Post hoc matched set
☐ Statistical matching
☐ Post hoc test for group equivalence

B5. Equivalent Mortality

☐ Low attrition (less than 20% for post)
☐ Low attrition (less than 30% for follow up)
☐ Intent to intervene analysis carried out

Rating for Comparison Group: ☐ 3 ☐ 2 ☒ 1 ☐ 0

C. Appropriate Statistical Analysis

Analysis 1: MANOVA (Behaviour Assessment System for Children – Teacher Rating Scale: student behaviour)

☒ Appropriate unit of analysis
☐ Familywise/experimenter wise error rate controlled when applicable
☐ Sufficiently large N

Rating for Statistical Analysis: ☐ 3 ☐ 2 ☒ 1 ☐ 0

iii. Other Descriptive or Supplemental Criteria to Consider

A. External Validity Indicators

A4. Receptivity/ acceptance by target population (treatment group)

Participants from treatment group	Results (what person reported to have gained from participation in programme)	General rating
☐ Child ☒ Parent ☐ Other	Parents reported "feeling validated by the group process" and that they would continue to "use skills taught in the group sessions" (p. 237).	☒ Participants reported benefiting overall from the intervention ☐ Participants reported not benefiting overall from the intervention
☐ Child ☐ Parent ☐ Other		☐ Participants reported benefiting overall from the intervention ☐ Participants reported not benefiting overall from the intervention

C. Intensity/ Dosage of Intervention (select C1 or C2)

C1. ☐ Unknown/ insufficient information provided
C2. ☒ Information provided (if information is provided, specify both of the following):
C2.1 length of intervention session – 2 hours
C2.2 frequency of intervention session – weekly over 8-week period

Summary of Evidence

Indicator	Overall evidence rating (0-3)	Description of Evidence
General Characteristics		
Design		Nonrandomised block design
Type of Programme		Universal preventative programme
Stage of Programme		Established programme
Concurrent/historical Intervention Exposure		Unknown
Key Features		
Measurement	1	Measure scores are reliable and valid. Only one method and source of data collection were used.
Comparison Group	1	33% attrition for post testing. No evidence of group equivalence.
Appropriate Statistical Analysis	2	Appropriate statistical analysis was used (MANOVA)
Other Descriptive Criteria		
External Validity Indicators		Benefits for parents: feeling validated and useful skills learnt
Intensity/ Dosage of Intervention		16 hours of intervention.

Appendix F: Weight of Evidence B: Methodological Relevance (WoE B)

This section examines the methodological relevance of each study in relation to this specific review question.

WoE B Criteria and Rationale

Criterion 1
A control group should be used to ensure that the effectiveness of the intervention can be measured against a group of participants who are not receiving filial therapy.

Criterion 2
Participants should be allocated to groups randomly to reduce the likelihood of differences between the groups before the intervention.

Criterion 3
More than two measures and sources of data collection on child problem behaviours should be used, for example a parent report and a teacher report.

A study that satisfies only one criterion will receive an overall WoE B rating of 1 (low), a study that satisfies two criteria is awarded a rating of 2 (medium), whilst a study that satisfies all three criteria receives a rating of 3 (high). WoE B ratings for each study are summarised in Table 7.

Table 7
Weight of Evidence B: Methodological Relevance

Study	Criterion 1	Criterion 2	Criterion 3	WoE B rating
Draper et al., 2009	✓	×	×	1 (Low)
Kale & Landreth, 1999	✓	×	✓	2 (Medium)
Landreth & Lobaugh, 1998	✓	×	×	1 (Low)
Smith & Landreth, 2003	✓	×	×	1 (Low)
Tew et al., 2002	✓	×	×	1 (Low)
Yuen et al., 2002	✓	✓	×	2 (Medium)

Appendix G: Weight of Evidence C: Topic Relevance (WoE C)

This section considers the relevance of the focus of the studies in relation to the current review.

WoE C Criteria and Rationale

Criterion 1:
Interventions should follow a filial therapy model which enables parents to receive a total of 20 hours of training. This usually takes the form of 2-hour sessions over a 10-week period. The intervention must also involve parents attending training programmes in groups alongside other parents.

This is to ensure that interventions are following the correct model without it being largely adapted. It is widely accepted that a 10-week period (equating to 20 hours) is required in order to allow parents sufficient time and support to learn and implement play therapy techniques. Schedules can be reasonably adapted as needed to suit the needs of the participants, but this should not negatively impact on the number of training hours. It is also essential that parents are trained together so as to benefit from the support of others.

Criterion 2:
Interventions should only involve training parents in filial therapy and should not include additional teaching of alternative strategies and approaches.

If conclusions are to be made regarding the effectiveness of filial therapy, it must be known that it is only the introduction of filial therapy that could have produced any identifiable differences. By including additional training or factors within the intervention, the cause of any changes cannot be reliably attributed to filial therapy alone.

Criterion 3:
Filial therapy training should be delivered by a professional who is an expert in the field or an individual who has received extensive training themselves in the delivery of filial therapy.

In order to promote rigour and ensure instruction is carried out according to the relevant play therapy principles, it is essential that facilitators have undergone the correct training.

A study that satisfies only one criterion will receive an overall WoE C rating of 1 (low), a study that satisfies two criteria is awarded a rating of 2 (medium), whilst a study that satisfies all three criteria receives a rating of 3 (high). A summary of the WoE C ratings is provided in Table 8.

Table 8
Weight of Evidence C: Topic Relevance

Study	Criterion 1	Criterion 2	Criterion 3	WoE C rating
Draper et al., 2009	×	×	✓	1 (Low)
Kale & Landreth, 1999	✓	✓	×	2 (Medium)
Landreth & Lobaugh, 1998	×	✓	✓	2 (Medium)
Smith & Landreth, 2003	×	×	✓	1 (Low)
Tew et al., 2002	✓	✓	✓	3 (High)
Yuen et al., 2002	✓	✓	✓	3 (High)