

Utilizing Filial Therapy With Deployed Military Families

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Current research focuses primarily on the impact of military deployment on soldiers, without taking into account the soldier's family. As a result, many children, partners, and family members struggle with deployment-related changes in the family structure, yet have few resources. Filial therapy offers a unique strategy for assisting the entire family system. This article discusses problems experienced by families and their children 2 to 10 years of age when faced with military deployment, describes filial therapy as a strategy, and offers a case study to aid counselors in the implementation of strategies.

Keywords: deployment, postdeployment, children, filial therapy

From the moment news is given regarding impending deployment, a soldier's entire family is affected. Fear, anger, concern, and worry are but a few of the emotions normally experienced and passed down to children (United States Department of Veterans Affairs, 2015). Specifically, children between the ages of 2 and 5 experience problematic attachment behaviors and increased medical visits, and youth ages 6 to 11 meet criteria for psychosocial, psychological, and anxiety problems in greater numbers than those from homes not experiencing military deployment (Creech, Hadley, & Borsari, 2014). Deployed soldiers also experience reintegration issues and report difficulty reconnecting with children as well as decreased parental alliances after deployment (Allen, Rhoades, Stanley, & Markham, 2010; Willerton, Schwarz, Wadsworth, & Oglesby, 2011). This may explain Gibbs, Martin, Kupper, and Johnson's (2007) study reporting child maltreatment rates as being 42% higher among families experiencing deployment than those in the general population.

The aforementioned effects of deployment on military families and children often vary depending upon whether the soldier is awaiting departure, already stationed at the deployment site, or reuniting after the deployment. Pincus, House, Christenson, and Adler (2007) described five stages families incur before, during, and after deployment. These stages within the "emotional cycle of deployment" include predeployment, deployment, sustainment, redeployment, and postdeployment. A description of each deployment stage, along with inherent family issues precedes a discussion on deployment's specific impact on children. Finally, a background, rationale, filial therapy treatment protocol, and case study are included to guide implementation.

Phases of Deployment and Family Impact

Predeployment begins with notification that deployment is pending and ends upon the soldier's departure. During this predeployment phase, soldiers often work long hours in preparation for upcoming endeavors. These long hours create tension that, when combined with anxiety about future losses, create turmoil for the entire family (Chandra, Burns, Tanielian, Jaycox, & Scott, 2008). The parent and children who are to remain home experience stress, feelings of anger, frustration, and loss of social support. Sheppard, Malatras, and Israel (2010) state that this predeployment phase is especially disruptive on all family members due to enhanced emotions and increased adjustment and

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stressors. Children must find ways to cope with fear, anger, concern, and worry during this stage (Department of Veteran Affairs, 2015).

Once the soldier leaves home, the family enters into the next phase, deployment. The deployment phase consists of the first month in which the service member is away. During this stage, the parent who stays home must adopt all parental responsibilities and attempt to maintain normal family routines. Further, the family grieves the loss with one another and struggles to restructure family roles and responsibilities. During this time, the family experiences feelings of anger, frustration, grief, and loneliness (Pincus et al., 2007; Sheppard, Malatras, & Israel, 2010). Children may also feel guilt and abandonment (Canfield, 2013).

Once the first month of separation has ended, the family enters the sustainment phase. The sustainment phase brings a sense of adjustment to the deployed soldier's absence but is also accompanied by a variety of behavioral, somatic, and attachment problems among children (Chandra et al., 2008). Children between 2 and 5 years old experience problematic attachment behaviors and increased medical visits, whereas youth ages 6 to 11 meet criteria for psychosocial, psychological, and anxiety problems in greater numbers than those from homes not experiencing military deployment (Creech et al., 2014). Fortunately, this phase ends with news the soldier will be returning home.

The redeployment stage starts approximately a month before the soldier's homecoming and is a time of great anticipation. Family members fantasize about the positive changes soon to be occurring. Unfortunately, these fantasies often fall short and create disappointments in the months ahead. Children may be uncertain what to expect from this homecoming (Chawla & Solinas-Saunders, 2011; Pincus et al., 2007).

After several months of separation, deployment ends and the service member returns home. Despite the excitement of reintegration, newly established norms once again create turmoil within the family system. Individual and emotional needs, use of living space, and consideration for each family member's schedules and goals must be given. Further, restructuring and renegotiations in the system's parental responsibilities and authority must occur and requires time, effort, and patience. It comes as no surprise, therefore, that previously deployed

soldiers report difficulty reconnecting with children and tout decreased parental alliances during this postdeployment stage (Allen et al., 2010; Willerton et al., 2011).

Children are especially vulnerable to these transitions and need additional support to offset heightened stress levels, anxiety, awkward child-parent interactions and changes in the family structure (Chawla & Solinas-Saunders, 2011). For this reason, a discussion on deployment's specific impacts on children precedes a rationale for use of filial therapy with this population.

Impact on Children

Over two million children have experienced a parent's deployment and approximately 800,000 have faced multiple parental deployments (Canfield, 2013). This is concerning because risk factors and length of deployments are correlated (Canfield, 2013; Chawla & Solinas-Saunders, 2011). Deployment affects children's psychological, behavioral, and physical health. For example, children of deployed and reintegrating soldiers feel guilt about the parent's departure, worry about both parents, and experience loneliness, abandonment, sadness, and loss of family connection during deployment (Canfield, 2013). This loss of connection results in children with behaviors and emotions such as shyness, anger, anxiety, depression, fear, jealousy, and confusion (Canfield, 2013; Chawla & Solinas-Saunders, 2011; James & Countryman, 2012). As a result, children of deployed soldiers exhibit more behavioral and emotional problems, higher levels of stress and depression, lowered academic achievement, may lack warmth toward the deployed parent, and suffer abuse more frequently than children in the general population (Department of Veterans Affairs, 2015; James & Countryman, 2012). Not surprisingly, children of deployed parents visit physicians more often than children with non-deployed parents and experience anger and emotional outbursts, temper tantrums, poor social skills, and changes in eating and sleeping habits more frequently than other children (Canfield, 2013; Creech et al., 2014).

The literature suggests differences between age groups and genders when examining the effects of military deployment on children. For example, girls are more apt to exhibit problems

during reintegration whereas boys are more affected by the actual deployment (Chandra, Lara-Cinisomo, et al., 2010). Children 3 to 5 years of age demonstrate more behavioral symptoms than younger children (Chartrand, Frank, White, & Shope, 2008). Pincus et al. (2007) contended that infants refused to eat and appeared listless; children between the ages of 1 and 3 cried, threw tantrums, and were irritable or sad; 3–6-year-olds reverted from potty training and became clingy; and those aged 6 to 10 complained and suffered somatically. Because teens responded to deployment differently than younger children, the intervention in this article focuses upon children aged 2 to 10 years (Chandra et al., 2010; Pincus et al., 2007).

Strategies are needed to assist deployed soldiers, partners, and children as they struggle through these transitional phases. Filial therapy promotes cohesion between parents and children (Landreth, 2012; Lin & Bratton, 2015). Further, enjoyable family experiences are touted as helpful catalysts leading to improved family structure and bonding (Pisano, 2010). For this reason, filial therapy is an important strategy toward assisting pre- and postdeployment military families as they separate and eventually come together again as a family. In order that counselors understand the rationale for use of filial therapy with deployed military families, a history and description of the approach must precede a specific rationale for use.

History of Filial Therapy

Play therapy is a research-based intervention used to provide children with strategies to cope with developmental, emotional, and behavioral difficulties encountered in childhood and has been used as a strategy to work with children since the 1920s. Empirical research findings suggest that play therapy is grounded in child-development principles and is an effective intervention for children to communicate feelings and thoughts through play (Bratton, Landreth, & Lin, 2010; Bratton & Ray, 2000; Bratton, Ray, Rhine, & Jones, 2005; Cornett & Bratton, 2014; Lin & Bratton, 2015). Multiple approaches to play therapy exist and are based on studies inferring reduced anxiety and aggressive behaviors in children (Bratton et al., 2005).

Filial therapy is a type of play therapy that involves parents in the treatment and was de-

veloped by Drs. Bernard and Louise Guerney in the late 1950s (Guerney, 1991, 2001). The Filial Therapy Treatment Program was created through research that focused on building positive parent and child relationships as well as preventing negative emotional effects of family problems and interactions (Guerney, 1991). In filial therapy, the counselor provides the parent with skills to work with his or her own child through play sessions in a supportive setting. These sessions intend to foster a trusting parent–child relationship (Guerney, 1991).

Researchers have inferred that filial therapy increases the child's acceptance of a parent and decreases negative behaviors of the child (Bratton & Landreth, 1995). Filial therapy has shown promise with families who have experienced stressful circumstances and separation due to a variety of problems, such as illness, marital problems, financial difficulties, single parent families, parent incarceration, military deployment, and reintegration (Chawla & Solinas-Saunders, 2011; Landreth & Bratton, 2006). Since the creation of filial therapy, a derivation of play therapy, it has been "validated with a wide range of populations who, like military families, face chronically stressful circumstances" (Chawla & Solinas-Saunders, 2011, p. 188).

Rationale for Filial Therapy With Deployed Families

The literature touts the effectiveness of filial therapy for improving child emotional, mental, attachment, and family relationship issues such as those experienced among deployed military families (Bratton et al., 2010; Cornett & Bratton, 2014; Lin & Bratton, 2015; Ray & Bratton, 2010). Because filial therapy improves parental empathy, child self-concept, overall behavioral and emotional problems, and involves parents in the process, it fosters healthy child–parent relationships and provides emotional support within the family system (Bratton & Landreth, 1995; Chau & Landreth, 1997; Cornett & Bratton, 2014; Smith, 2000). Cornett and Bratton (2014) revealed significant improvements in family satisfaction, cohesion, communication, and flexibility as a result of child–parent relationship therapy (CPRT), a filial therapy approach. A meta-analysis conducted by Lin and Bratton (2015) inferred that caregiver involve-

ment in counseling sessions results in better treatment outcomes for children than treatments with no caregiver involvement. Parents also benefit from filial therapy. This may be because “parental symptoms are significantly correlated with child symptoms” (Chawla & Solinas-Saunders, 2011, p. 180). Filial therapy, therefore, may be an optimal treatment approach, given the unique stressors inherent among all family members experiencing a member’s military deployment (Canfield, 2013; Chawla & Solinas-Saunders, 2011; Packman, Paone, LeBeauf, Smaby, & Lepkowski, 2006).

Filial therapy has also shown promise in influencing deployment-related issues such as the parent–child attachment process, negative child behaviors, and lowered emotional health levels among children (Chawla & Solinas-Saunders, 2011; Creech et al., 2014; Topham & VanFleet, 2011). Because filial therapy “integrates ideas with attachment theory,” it has been touted as an effective method for improving parent–child attachment issues through better child–parent relationships (Chawla & Solinas-Saunders, 2011; Topham & VanFleet, 2011, p. 148). Grskovic and Goetze (2008) found that filial therapy decreased negative behaviors among children. This is especially important because behavioral problems are more prevalent among children with deployed parents than those in the general population (Canfield, 2013). In addition to helping develop secure attachment among deployed military families, filial therapy also helps parents learn specific skills associated with such separations.

Parents learn better responses that reframe their children’s behavioral issues. Filial therapy teaches previously deployed and nondeployed custodial parents to use skills such as structuring, empathetic listening, child-centered imaginary play, and limit setting (Chawla & Solinas-Saunders, 2011; Topham & VanFleet, 2011). For example, parents learn structural methods by beginning and ending sessions and navigating session transitions (Topham & VanFleet, 2011). Session structuring may be especially helpful for children who are already experiencing deployment-based family inconsistencies (Chawla & Solinas-Saunders, 2011). Additionally, use of empathetic listening makes the child feel heard and, therefore, respected as a family member and individual (Chawla & Solinas-Saunders, 2011). Child-centered imaginary play

involves child-assigned role plays. By following the child’s lead, the parent demonstrates respect and caring for the child (Topham & VanFleet, 2011). Limit setting helps the custodial parent handle problematic behaviors in a positive way (Chawla & Solinas-Saunders, 2011). This limit setting, along with enhanced parental empathy, may counter increased child-maltreatment rates among families experiencing deployment (Daneker & Hunter-Lee, 2006; Gibbs et al., 2007).

Because filial therapy offers the aforementioned benefits to children and families experiencing military deployment, following is a description of a unique strategy using filial therapy. A case study is included to aid counselors with implementation.

Treatment

Deployment

Upon deployment, the nondeployed parent attends a structured filial therapy-training program consisting of a 1-hr filial therapy demonstration, 4 weeks of skill-development training, and five or six supervised parent–child sessions. Although Bernard and Louise Guerney (1977) intended training to last between 6 and 12 months, a shorter training program followed by six to 12 home sessions has been touted as effective when working with parents under time constraints (VanFleet, 2011, 2013). The first session consists of a play-session demonstration followed by three 1-hr skill-development sessions. Skill-development sessions teach parents to use structuring, empathetic listening, child-centered imaginary play, and limit setting. The next five sessions consist of supervised parent–child play sessions. During these supervised sessions, parents conduct the filial therapy sessions and the therapist observes. At the conclusion of the sessions, the counselor offers feedback to parents. Once parents exhibit sufficient skill levels, parents conduct three to six half-hour biweekly home play sessions and attend weekly progress discussions with the therapist. Counselor feedback emerging from sessions ensures that parents have a clear understanding and the skill needed to effectively work with their children. The goal of these home sessions is to strengthen the bond between the nondeployed parent and child, increase parental em-

pathy, and teach a positive method for setting limits.

Postdeployment

Once the service member returns home, filial training sessions are scheduled between the previously deployed parent and the counselor. The same weekly training sessions are given to the soldier just as they occurred for the nondeployed parent. Following the play-therapy demonstration, the previously deployed service member observes the child in sessions with the counselor and the nondeployed parent. Once the deployed parent has attained necessary skills, this parent conducts supervised sessions with the child. Finally, the deployed parent begins conducting biweekly home filial therapy sessions and meeting with the counselor for feedback, discussion, and support. In addition to training received as part of filial therapy, the deployed parent is educated on the way deployment and other life events have affected the family unit. Over time, the child begins to bond with the previously deployed soldier, with bonds created with the nondeployed parent remaining.

Filial therapy should continue through one-on-one biweekly parental sessions until family members feel connected and the child's problematic behaviors disappear. Adding one-on-one sessions with the deployed soldier allows this parent to assume more responsibility with children and allows caregivers to adjust to changes in the family dynamic. Once stability is present in the home and the child has adjusted to family reintegration, therapy is phased out (VanFleet, 2011, 2013).

Case Study

Trent was a 3-year-old child whose father was to be deployed in the next 3 weeks. His parents entered the counseling office with anxiety about Trent's pending reaction to his father's departure. Trent's mother, Julie, stated that she was "worried that Trent will not understand that she is now in charge." In the past, Trent's father, Brandon, had taken on the primary role of disciplinarian. The counselor suggested that Julie learn filial therapy techniques over the next few weeks and, once comfortable, conduct sessions at home. During the first session following Brandon's deployment, Julie ob-

served the counselor in a 1-hr play session with Trent. After this first session, Julie attended three additional 1-hr sessions without Trent to learn filial therapy skills. Each week, Julie participated in mock filial therapy sessions with the counselor and worked hard to learn structuring, empathetic listening, child-centered imaginary play, and limit setting. Because Julie felt comfortable, she and the counselor decided she should conduct a structured play session in the counselor's office with Trent. Over the next 5 weeks, Julie conducted sessions and the counselor offered feedback, encouragement, and suggestions. Seeing that Julie understood the techniques and was offering a helpful therapeutic intervention, Julie was asked to start conducting 3-min biweekly play-therapy sessions at home. Over the next 3 weeks, Julie conducted and recorded weekly 30-min play sessions at home. Each week, Julie met with the counselor to receive feedback. Throughout the deployment, Julie met weekly with the counselor to discuss Trent's progress. During the follow-up sessions, Julie reported that Trent was doing well. Trent had established a bond with his mother and she had learned positive ways to state limits.

After 7 months, Brandon returned home. At first, Trent did not respond to Brandon and was very guarded in his presence. The counselor explained the normality of this behavior and discussed other issues the family might experience during transition. As suggested by the counselor, Brandon attended a filial therapy-training program just as Julie had done previously. During his first week, he attended the filial therapy demonstration. Through a one way mirror in the counselor's office, Brandon observed the counselor, and later, Julie in session with Trent. Next, he learned filial therapy skills through 3 weeks of training. This training consisted of skill discussions, role play, and mock therapy. Once he became comfortable, Brandon participated in counselor-supervised sessions with Trent. Within a few weeks, Brandon was comfortably conducting biweekly play sessions at home with Trent. The counselor continued to offer weekly feedback and discussions. After 3 months, Julie reported that Trent had readjusted to his father's presence and no longer questioned his parental authority. Brandon also stated that he learned a more positive way in which to handle limits with Trent. Julie re-

sponded by saying the “entire family is now better off because Brandon and I now both participate in discipline. Even better, we know how to handle limits in a more positive way. This helps our whole family feel better.”

Conclusion and Summary

Filial play therapy offers a unique method by which deployed soldiers and families can help children transition during deployment and upon reintegration. Play sessions occurring during deployment between the caregiving parent and the child strengthen bonds and lessen resistance to changes that occur during family transitions. Filial sessions occurring between the previously deployed soldier and child upon reintegration foster the transition of power and restructuring that occurs upon reintegration. Both parents learn structuring, empathy, parameters for participating in child-centered imaginary play, and ways to set positive limits. Filial therapy actively engages parents, builds family cohesion, and teaches better communication patterns. As a result, children and families adapt to role changes and responsibilities more easily when faced with the separation and transitions involved in military deployment.

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