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Promoting Play**

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Abstract

The challenges faced by families with young children who are homeless as well as the resources available to them have changed very little in the past 25 years since the passing of the McKinney Vento Act. Homeless children are at great risk for negative outcomes. This study examined the efficacy of the implementation of an evidence-based treatment intervention: *Filial Play Therapy*, to mediate the negative impacts of shelter living. A standardized, evidence-based curriculum, which promotes positive attachment between parent and child, decreases stress for both parent and child, and increases self-esteem in children was implemented with six homeless parents at a homeless shelter. The results of this intervention are reported and suggest recommendations for future research.

Keywords: Filial Play, homeless families, evidence-based intervention

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Parent-child Relationships in a Homeless Shelter: Promoting Play

The challenges faced by families with young children who are homeless as well as the resources available to them have changed very little in the past 25 years since the passing of the McKinney Vento Act (McKinney, 1987). Homeless children are at great risk for negative outcomes. By not having a stable home life, children are at increased risk for violence, poor health, mental illness, diminished ability to learn and other developmental delays (Markos & Lima, 2003). Forty-two percent of homeless children are under age six years and have experienced constant stress, traumatic experiences and acute health problems ("The Characteristics and Needs of Families Experiencing Homelessness," 2011). The experiences of homeless families make it extremely difficult to be an effective parent due to the high stress and/or immediate responsibility to provide for a family's basic needs (Weinreb, Rog, & Henderson, 2010).

Families that are homeless also lack access to parenting education, resulting in limited parent development and opportunities to learn new skills as parents, which further impedes the parent-child nurturing process (Swick, 2008). Considering these factors, as well as the requirements of a healthy parent-child relationship, there is a need for programs that facilitate development of secure attachments and effective communication, and foster effective stress coping for families living in shelter settings. Even though homeless families are primarily focused on meeting their basic survival needs, they could benefit from supportive services that enrich parent-child relationships (Kolos, Green, & Crenshaw, 2009). Shelter programs are in a prime position to help parents understand the importance and benefits of a healthy parent-child relationship in stressful times.

In a recent study exploring the needs of parents with young children living in homeless shelters, both parents and shelter staff noted that there were limited opportunities for children to play in the shelter (Giesler & Wineberg, 2013). Play is severely restricted in the shelter environment. The National Association for the Education of Young Children (NAEYC) affirms that healthy child development requires adults to engage in reciprocal play with children in an effort to model how a child should play (Copley & Bredekanp, 2006). Research found that parents separate themselves from their child during play, which is detrimental to the young child's development

(Wineberg & Chicquette, 2009). Parents who effectively provide emotional support to their children, including during play time, reduce the impact of stress and increase their child's ability to competently cope with stress and trauma (Wills, Blechman, & McNamara, 1996). Wills and colleagues (1996) suggest that supportive parent education can benefit highly stressed families now as well as in the future.

The current research on homeless families has shown that since 2008 the number of homeless families with young children has been on the rise ("The Characteristics and Needs of Families Experiencing Homelessness," 2011; Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013). Secure parent-child relationships are essential for healthy child development (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969, 1982). Additionally, caregivers need to develop effective methods of communicating with their children in order to facilitate children's healthy development and relationship skills (Van Aken, 1994). Development of effective communication skills is often difficult in shelter environments due to myriad distractions and lack of privacy ("The Characteristics and Needs of Families Experiencing Homelessness," 2011; Markos & Lima, 2003). Living in a shelter is very stressful for both children and caregivers ("The Characteristics and Needs of Families Experiencing Homelessness," 2011). Unabated stress can result in mental illness for both adults and children (Rutter, 1996).

Shelter-based programs designed to facilitate secure parent-child relationships, effective communication and stress coping should include strategies that facilitate opportunities for parent-child play. The *Filial Play Therapy* model, which was developed by Bernard and Louise Guerney in the 1960's has been extensively researched in the last fifty years (B. Guerney, Guerney, & Andronico, 1966; Kolos et al., 2009) and offers a standardized curriculum (Bratton, Landreth, Kellam, & Blackard, 2006), evidence-based intervention that promotes positive attachment between parent and child, decreases stress for both parent and child, increases self-esteem in children and has been suggested as an effective intervention in a shelter setting (Kolos et al., 2009). *Filial Play* has been successfully implemented with families of color, highly stressed families, and single-parent families (Kolos et al., 2009). However, this evidence-based intervention was not previously studied in a shelter setting.

Filial Play Therapy teaches parents to be accepting, to reflect feelings and set limits, which improves communication between parent and child (Kolos et al., 2009).

Filial Play Therapy benefits children by improving behavior and self-esteem, decreasing anxiety and empowering children to control and resolve problems (Kolos et al., 2009). *Filial Play Therapy* benefits parents by strengthening disrupted attachments while increasing enjoyable time between parent and child and this relationship can have a positive effect on caregiver's mental health (Kolos et al., 2009). This program teaches parents basic skills for child-centered play, to play in a non-directive manner and to name feelings (Kolos et al., 2009). *Filial Play Therapy* has helped thousands of families and is a unique therapeutic method that involves parents and caregivers directly as agents of therapeutic change (L. Guerney, 2000).

This study examined the efficacy of implementing the *Filial Play Therapy* model in a local, community-based, homeless shelter to facilitate healthy parent-child relationships and reduce parental stress. This study posed two research questions: 1) Will parents with preschool children who are living in a homeless shelter improve their interactions with their child if they participate in the *Filial Play Therapy* project, and 2) Will parents with preschool age children who are living in a homeless shelter reduce their feelings of stress if they participate in the *Filial Play Therapy* project?

Methods

The *Filial Play Therapy* (Bratton et al., 2006) parent education intervention was implemented at a local homeless shelter program. A weekly parent-child play-group was formed during the summer of 2013. Two expert early childhood educators facilitated the implementation of the play-group using the *Child-Parent Relationship Therapy* curriculum (Bratton et al., 2006). Two early childhood education students provided on-site supervised play for the non-focus, children of the parents who participated in the play-group. Seven, two-hour, weekly parent-child play-group sessions were provided at the homeless shelter. Each two-hour session included parent training and skill building, parent-child play, reflection and sharing, review of practice activities, and video observations. Weekly one-hour practice/ homework sessions were held after dinner the following day.

Each family received the *Filial Play Therapy* (Bratton et al., 2006) notebook and a toy box filled with toys recommended by Bratton and colleagues (2006). Each box contained toys that included: "real-life" toys, acting-out, aggressive toys, and toys for

creative/emotional expression. The curriculum manual provided guidelines for each of the seven sessions as well as for the toy box, and focused homework sessions (Bratton et al., 2006). Each play-group session emphasized helping parents to feel welcome, and included a review of the homework assignments. The objectives of the seven sessions were to provide parents with such skills as reflective listening, recognizing and responding to children's feelings, limit setting, building the child's self-esteem and structuring weekly play sessions with the toy boxes. The weekly activities included: informal sharing, role modeling play with the toys, and reflecting on parent-child interaction videos. Each session ended with a motivational children's book, poem or inspirational reading.

Each two-hour play-group session was held in the shelter common area. The one-hour practice/ homework sessions were held the following day after dinner, also in the shelter common area. For 30-minutes the parents practiced with their child what they learned in the training session and played with the toys in the toy box. The two early childhood education students supervised the other children outside in the playground while parents played in the common area with the focus child.

The number of mothers participating in the two-hour play-group sessions and the practice session varied each week from two to seven. There were approximately ten siblings that were supervised by the early childhood students on the playground during the two-hour play-group sessions. Parents who moved out of the shelter were encouraged to return for participation in the project. One parent, who moved to permanent housing, returned to the shelter for the ending celebration on the last day of the project intervention.

Sample

Participant attendance at the intervention varied, but six parents agreed to participate in the research. All participants were people of color ranging in age from 24-29. Most of the participants had completed a high school education (5/6). Each family included two to seven children with two families having four children. Most families were headed by a single parent (4/5). Six preschool age children participated in the project, two females and four males. The children's ages ranged from one year and eleven months to six years and five months.

Attendance at the play-group ranged from two sessions to five sessions. The average number of sessions attended was 3.6 (SD=1.79). One parent who agreed to participate in the research chose not to attend any of the play-group sessions. In an effort to encourage participation in the intervention, research participants were provided a 30-day bus pass after they attended four play-group sessions.

Measurement

Two standardized measures were employed to measure parent-child interactions and parenting stress. It was anticipated that a pre-post assessment design would be used. However, this approach was not possible due to the transitory nature of homeless family behavior. A baseline measure of parenting stress and parent-child interactions was conducted just prior to the implementation of the parent-child play-group intervention. All six parents participated in the assessment.

Parent-child interactions were measured by the *Measurement of Empathy in Adult-Child Interactions Scale* (MEACI) (Bratton, Landreth, & Homeyer, 1993). This measure uses observation of parent-child sensitivity and responsiveness. Twenty-minute video recordings of parent-child play were made and coded using the MEACI assessment criteria for parent communication of acceptance, parent allowance of child self-direction, and parent-child involvement (Bratton et al., 1993). The MEACI has previously been used to measure parent-child interactions in other *Filial Play Therapy* Intervention settings (Bratton et al., 1993). This scale measures the ability of caregivers to demonstrate empathy during adult-child play sessions (Bratton et al., 1993).

The MEACI produces three sub-scores, which are calculated in six three-minute intervals (Bratton et al., 1993). A grand total score is summed at the end of the 20-minute observation. The score for Communication of Acceptance is based on an average score during the observation interval relevant to the highest and lowest observation of parent acceptance of the child's behavior (and one equals a high level of acceptance and five equals a low level of acceptance) (Bratton et al., 1993). Parents who are rated a score of 1, overtly convey acceptance of the child's feelings during the observation interval (Bratton et al., 1993). Parents who are rated a score of five, communicate criticism, preaching or rejection during the observation interval (Bratton et al., 1993). The high and low scores for each interval are averaged and summed for a total score of

Communication of Acceptance (Bratton et al., 1993). The maximum score is 30 and the minimum score is six for this subscale (Bratton et al., 1993).

The score for allowing self-direction is based on the lowest level of response during the interval (Bratton et al., 1993). A score of one indicates a high level of response and that the parent follows the child's lead during the observation interval (Bratton et al., 1993). A score of five indicates a low level of response and that the parent used persuasion, demands, interruption, interference or insistence during the observation interval (Bratton et al., 1993). The score for this subscale is derived by summing the scores for each observation interval for a maximum score of 30 and minimum score of six (Bratton et al., 1993).

The score for parent involvement is based on the most characteristic level of response during the observation interval (Bratton et al., 1993). A score of one indicates that the parent is fully attentive toward the child during the observation interval (Bratton et al., 1993). A score of five indicates that the parent was completely self-involved and not available to the child during the observation interval (Bratton et al., 1993). The subscale score is obtained by summing the observation interval scores for a maximum score of 30 and a minimum score of six (Bratton et al., 1993).

All of the subscale scores are summed to create the grand total score (Bratton et al., 1993). A total score of 90 indicates a very low level of parent empathy toward the child (Bratton et al., 1993). A score of 18 indicates a high level of parent empathy toward the child (Bratton et al., 1993). Two researchers rated each video independently in order to establish inter-rater reliability. Inter-rater reliability was generally high. For the Communication Acceptance sub-scale the Pearson Correlation was .87 ($p=.025$); for the Allowing Self-direction sub-scale the Pearson Correlation was .68 ($p=.138$); for the Involvement sub-scale the Pearson Correlation was .75 ($p=.085$) and for the Total Empathy score the Pearson Correlation was .83 ($p=.042$). Follow-up MEACI assessments were only available for one parent-child dyad. Because inter-rater reliability was high, only the scores of one observer were used in reporting the follow-up results.

Parent stress coping was measured by the *Parenting Stress Index* (PSI-4-SF) (Abidin, 1995). The PSI-4-SF is a 36-item standardized assessment that measures parental distress, parent-child interaction and child difficulties (Abidin, 1995). This

measure has been effectively employed to measure parent-child interactions with children enrolled in Head Start, to explore medication adherence, and to understand child cognitive development (Abidin, 1995). Follow-up PSI-4-SF scores were not available due to the transitory nature of homeless families and the study participants in particular. No participants were available to complete a follow-up assessment.

Parents who participated in the initial assessment were provided a 30-day bus-pass. Parents who completed four parent-child play-group sessions were provided with a second 30-day bus pass. Due to Institutional Review Board policies the researchers were unable to provide a bus-pass to parent participants for compensation for completion of the follow-up assessment. Consequently, the researchers were unable to collect follow-up data even after multiple attempts (via phone and email) were made to contact participants who had completed the intervention.

Results

Table 1: Baseline Results

Variable	N	Mean	Std. Deviation	Percentile for Mean
No of years of school	6	12.17	.753	NA
Defensive Responding Score baseline	6	19.67	4.885	NA
Parental Distress score baseline	6	33.67	7.866	75
Parent-Child dysfunctional Interaction baseline	6	31.83	10.068	81
Difficult Child baseline	6	37.5	9.482	84
Total Stress score baseline	6	103	21.062	79
Parent Intake age	6	30.92	6.612	NA
Child age at intake	6	3.69	2.137	NA
Number of sessions attended	6	3.6	1.789	NA

“Parents who obtain a Total Stress score in the 91st percentile or higher are experiencing clinically significant levels of parenting stress” and should be referred for professional assistance (Abidin, 2012, pg. 60). Parents in these circumstances are at risk for maltreating their children (Abidin, 2012). Two participants scored in this range. The average Total Stress percentile score was 79, which is within the normal range (Abidin, 2012). Total Stress scores above the 85th percentile are considered high (Abidin, 2012)

and one participant scored in the 86th percentile.

“When the Parental Distress sub-scale score is the most elevated of the three sub-scales,” the parent may need assistance with personal adjustment issues (Abidin, 2012, pg. 60). One participant had an elevated Parental Distress sub-scale score. Participants who score below the 75th percentile on the Parental Distress sub-scale are unlikely to experience a loss of parenting control (Abidin, 2012, pg. 60). There were two participants who scored below the 75th percentile on the Parental Distress sub-scale. Scores above the 96th percentile on the Parent-Child Dysfunctional Interaction sub-scale indicate high potential for child neglect or physical abuse (Abidin, 2012). One participant scored in the 99th percentile and one in the 92nd percentile on the Parent-Child Dysfunctional Interaction sub-scale. These scores confirm shelter staff concerns for the children in these families.

If the parent of a child 18-months or younger scores in the 91st percentile on the Difficult Child sub-scale it may mean that the child may have self-regulatory problems (Abidin, 2012, pg. 60). There was one parent-child dyad whose scores met this criteria. It was observed that the parent was uncomfortable playing with the child. High Difficult Child sub-scale scores for parents with children age two and older may indicate that the parent is having “difficulty in managing the child’s behavior in terms of setting limits and gaining the child’s cooperation” (Abidin, 2012, pg. 61).

Such scores were observed in three parent-child dyads. In one case the parent’s percentile score on the Difficult Child subscale (99) indicated that the parent may have significant psychopathology and may require professional assistance (Abidin, 2012, pg. 61). Staff indicated concern that one of the parent participants might be at risk of maltreating a child. These results would support such a concern.

Table 2: MEACI Results at Intake

Scale	Mean* N=6/4	Standard Deviation*	Range*
Communication Acceptance	16.08/14.33	1.8/5.42	10-25
Allowing Self-direction	20/16.08	5.22/4.43	11-27
Involvement	9.25/13.58	2.79/8.13	6-30
Total Score	45.33/44	8.33/17.43	33-79

*Descriptive analysis for both researchers

The MEACI measures empathic behaviors during play sessions (Bratton et al., 1993). A low total score (18) indicates that the parent overtly communicates acceptance of the child's feelings, the parent follows the child's lead and the parent gives the child her full attention during the session (Bratton et al., 1993). Both reviewers scored five of the six participants lower than 54 on the Total Empathy Score, indicating that generally participants demonstrated empathy for their child's feelings and communicated this during the play session (Bratton et al., 1993).

A median total score (54) indicates that the parent-child communication was social or non-existent, the parent took the lead and provided marginal attention to the child during the play session (Bratton et al., 1993). One parent scored a 79 for Total Empathy during the play session, indicating opportunities for growth in the parent-child relationship (Bratton et al., 1993). A high total score (90) indicates that the parent was argumentative, preaching or rejecting of the child's feelings, was persuasive, interrupting or interfering and preoccupied during the play session (Bratton et al., 1993).

The parents primarily engaged in social conversation with their children during the play session and few of them acknowledged their child's feelings. Conversely, the parents rarely engaged in critical or rejecting communication with their children. Generally, the parents were attentive to their child during the play session. It may be that the conditions of being observed during the play session moderated the normal flow of parent-child communication. There was more variability in the degree to which parents allowed the child to lead the play session. The parent often took the lead and in two cases the parent was usually directing or instructing the child during the play session.

The one-tailed Pearson Correlation between Total Stress Score and Total Empathy Score was not statistically significant ($p=.103/p=.147$, $n=6$). The Pearson Correlation was $.603/.516$ (both observers), which would indicate some degree of positive correlation, but the sample size may restrict the statistical significance.

Case Example

Only one participating family engaged in follow-up video assessment of parent-

child play. These results are presented here as the case of Family “A”. Family “A”, a single parent of average age, presented with the following base-line characteristics:

- PSI-4-SF: Parenting Distress score in the 80th percentile (above the mean, some personal adjustment concerns (Abidin, 2012))
- PSI-4-SF: Parent-Child Dysfunctional Interaction score in the 58th percentile (below the mean, in the normal range (Abidin, 2012))
- PSI-4-SF: Difficult Child score in the 72nd percentile (below the mean, normal range (Abidin, 2012))
- PSI-4-SF: Total Parenting Stress score in the 74th percentile (below the mean, normal range (Abidin, 2012))
- MEACI: The Communication of Acceptance score was 16.5/11.5 (at the mean), which indicated the communication was focused on the child’s behavior and/or was generally of a social nature during the play session (Bratton et al., 1993).
- MEACI: The Allowing Self-direction score was 26/17 (above the mean), which indicated that the parent provided considerable direction and instruction to the child during the play session (Bratton et al., 1993).
- MEACI: The Involvement score was 6/10 (at the mean), which indicated that the parent was fully attendant to the child during the play session (Bratton et al., 1993).
- MEACI: Total Empathy score was 48.5/38.5 (above the mean), which indicated that the parent demonstrated some elements of empathy toward her child, but could improve in her ability to allow the child to take the lead during play (Bratton et al., 1993).

Family “A” attended five of the seven parent-child play sessions and participated in two follow-up video recording sessions of play. During both of the follow-up recorded play sessions the parent was fully involved with and attentive to the child. During the second recorded play session the Communication of Acceptance score was 13.1, indicating that the parent was generally accepting of the child’s behavior during the play session (Bratton et al., 1993). The Allowing Self-direction score during the second play session was six, indicating that the parent followed the child’s lead during the entire play session (Bratton et al., 1993). During the final recorded play session the Communication

of Acceptance score was 11.2, indicating that there were more observations of the parent verbally conveying acceptance of the child's feelings than during the second play session (Bratton et al., 1993). The Allowing Self-direction score during the final play session was 9, indicating that half the time the parent followed the child's lead during the play session, and half the time the parent allowed the child the option to lead play (Bratton et al., 1993). During all of the videoed play sessions this participant was fully attentive to her child and received a score of 6 for the Involvement sub-scale. In this case the parent demonstrated many nurturing parenting behaviors prior to the beginning of the intervention and actively employed the skills and knowledge learned during the parent-child play instruction sessions.

Discussion

It appears that the Filial Play Therapy model may effectively improve parent-child interactions for parents with preschool children who are living in a homeless shelter. Family "A" demonstrated many parenting strengths from the outset, and she was committed to improving her interactions with her child by applying the skills learned in the play sessions. During the play sessions that were video recorded the parent verbalized the instructions she had learned in the play-group. She was consciously using this information in her interactions with her child. The facilitators observed that participants had positive things to say about their children. One mother said, "My child is funny." Another mother said, "My child is creative." During the parent-child play-group the participants reported on the approaches that were effective with their children. Many participants commented that it was challenging for them to allow their child to take the lead during the play sessions. Facilitators observed that active participation in discussions increased over time and mothers increased their interest and participation in playing with their child and the toys in the toy box. At the last session, the director of the shelter commented about the wonderful activities that were happening in the outside playground area, an area that had rarely been utilized. These observations are indicators of improved parent-child interaction in the shelter setting.

Specific quantitative follow-up data were not available to answer the question: Will parents with preschool age children who are living in a homeless shelter reduce their feelings of stress if they participate in the Filial Play Therapy project? None of the

research participants made themselves available to complete the follow-up MEACI (Bratton et al., 1993) and PSI-4-SF (Abidin, 2012) assessment. However, observations suggest that intervention participants did reduce their feelings of stress. Initially mothers questioned if any of the suggestions in these sessions would work with their children, who they said were even more stressed since living in the shelter. During the play-group sessions many of the mothers reported that their child's stress level had decreased during the play sessions and their own level of happiness had increased. Anecdotally, it was observed by both the facilitators and the shelter staff that participants seemed to enjoy the parent-child play sessions. Mothers engaged in a steady flow of conversation and laughter while sharing their personal experiences raising their children. Facilitators observed that participants seemed less depressed and tired as they participated in the play-group. These observations serve as indicators of reduced stress.

Living in the shelter presented a number of barriers to participation in the play group. In all of the seven sessions there was a struggle to get the parents to the common area to participate. Staff at the shelter went to each mother's room to remind her of the meeting. Parents reported that they had a sick child to care for, or they had to go to another appointment, as reasons why they were unable to participate. One parent reported that her child had kept her up all night and all she wanted to do was to go back to sleep, but there was no child care to help her in caring for her children. Parents shared their frustration with moving to different rooms and thin walls in the shelter; they could hear all the noises in the building.

Limitations

The sample for this study was self-identified and very small, making it extremely difficult to draw definitive conclusions from the results. The inability to follow-up with the study participants also presented significant barriers to answer the research questions. Several attempts were made to engage all participating families in follow-up video assessments of parent-child play, but only one family agreed to participate in this aspect of the study. Therefore, the results of this study should be considered with caution, but suggest opportunities for further study.

Conclusion

Based on the anecdotal evidence, there is potential that the Filial Play Therapy model (B. Guerney et al., 1966; L. Guerney, 2000) can be effectively implemented in a shelter setting. The structure of the delivery may need to be adjusted to better meet the needs of homeless families with competing interests, but parents, children, and shelter staff seemed to appreciate the opportunity for supportive, structured, strengths-based opportunities for parent-child play. Further research is needed to understand the best approach to delivery and the overall impact of the intervention.

This study also offers insights to social workers practicing in homeless shelters. Practice in a shelter for homeless families requires a broad base of knowledge and skills that are common to generalist practice social workers. Facilitating an evidence-based support group for parents of young children offers a promising social work intervention strategy for very stressed families (Kolos et al., 2009). Implementation of a manualized curriculum suggests an easily accessible and low cost option for supporting homeless families in need.

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