

Exploring changes in family functioning when a child participates in a School-Based Filial Therapy program

Jane Cooper^{1,2}  | Mong-lin Yu¹ | Linda MacKay³  | Ted Brown¹

¹Department of Occupational Therapy, Faculty of Medicine, Nursing and Health Sciences, School of Primary and Allied Health Care, Monash University, Frankston, Victoria, Australia

²Therapy4Kids, Children's Mental Health (East), Perinatal, Child and Youth Mental Health Service (PCYMHS), Western Sydney Local Health District (WSLHD), NSW Health, Auburn, New South Wales, Australia

³The Family Systems Institute, Sydney, New South Wales, Australia

Correspondence

Jane Cooper, Therapy4Kids, Children's Mental Health (East), Auburn Community Health Centre, Norval Street, Auburn 2144, NSW, Australia.

Email: jane.cooper@monash.edu

Abstract

Child focus is a central construct within Bowen family systems theory (Bowen theory). A clinical implication is that mental health treatment focusing on a child may unwittingly reinforce the operation of child-focused processes, which undermine rather than enhance child well-being. The concept of child focus in Bowen theory presents significant implications for professionals working in school settings and in fields such as children's mental health, which are inherently child-focused. Bowen theory is the guiding theoretical framework for School-Based Filial Therapy (SBFT). SBFT is a play therapy intervention that was initially established in remote and outer-regional New South Wales, Australia in response to the low availability of children's mental health services and the significant barriers associated with caregiver engagement in children's mental health treatment. It involves trained school personnel facilitating therapeutic play sessions with children experiencing emotional-behavioural problems. The intervention occurs on school grounds, during school hours, and children's family members do not participate in the intervention. This mixed-methods study examines the impact of children's participation in SBFT upon family functioning. Interviews with caregivers ($n = 10$) of children who participated in 10 SBFT sessions were analysed using content analysis. Quantitative data were collected using the *Differentiation of Self Inventory – Short Form* and *Visual Analogue Scale – Family Functioning*. A Wilcoxon signed rank test was used to analyse the pre- and post-data. Qualitative outcomes indicated changes in the categories of child functioning, caregiver functioning, and extended family functioning, whilst child-focused processes remained dominant but changed in intensity and valence following SBFT.

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2023 The Authors. *Australian and New Zealand Journal of Family Therapy* published by John Wiley & Sons Australia, Ltd on behalf of Australian Association of Family Therapy (AAFT).

**KEYWORDS**

Bowen family systems theory, family functioning, family therapy, School-Based Filial Therapy, school play therapy

Key points

- The concept of child focus in Bowen's family systems theory presents significant implications for professionals working in fields such as children's mental health. This research explores how a child's participation in an intervention that does not involve the child's family members impacts upon family functioning.
- School-Based Filial Therapy is an intervention which emerged from the field of family therapy and is widely employed as a treatment approach to address children's mental health symptoms. This is the first study that has investigated the impact of a school-based version of the model on family functioning.
- For practitioner-researchers, this paper presents a description of an embedded mixed-methods research approach to exploring family functioning.
- For practitioners and other professionals who are guided by family systems theory as a conceptual paradigm and work within settings that are inherently child-focused, this paper presents some considerations and implications based on outcomes from the research.

INTRODUCTION

The reflexive process of child focus is a mechanism active in all human families, varying only in degrees of intensity (Kerr, 2019). It is a naturally occurring emotional process operating to manage the anxiety present within a nuclear family and is further influenced by the functioning of multiple generations of extended family (Kerr, 2019; Kerr & Bowen, 1988; Klever, 2004). Children raised in families who regulate more of their anxiety via an overactive, pronounced focus on a child are vulnerable to the development of symptoms including emotional-behavioural problems (Klever, 2004). A significant clinical implication embedded in this theoretical perspective is that treatment focused on a child may unwittingly or indirectly act to support and intensify child-focused processes within the family, which may, unintentionally, increase symptom presentation in the child and undermine rather than enhance child well-being (Bowen, 2013; Brown, 2020).

School-Based Filial Therapy (SBFT) is a play therapy intervention for children whose school functioning is being impacted by emotional-behavioural problems (Cooper & Oliaro, 2019; Cooper, Yu, Brown, & MacKay, 2022). One of the major known barriers to children accessing specialist mental health interventions is family complexity and the associated reluctance of caregivers to participate in their children's mental health treatment (Arefadib & Moore, 2017; Brannan et al., 2003). SBFT was initially established in remote and outer regional New South Wales, Australia as a possible solution to the problem of low availability of specialist children's mental health clinicians, and the significant challenges related to low caregiver engagement with school and health services. Apart from children's immediate family members, arguably the next most influential adults in children's lives are the education professionals whom they interact with at school on a regular basis (Giles-Kaye et al., 2022; Guerny & Bach Flumen, 1970). In SBFT, these important adults (or *facilitators*) receive basic play therapy training so that they can facilitate therapeutic play sessions with children presenting with emotional-behavioural challenges during school hours and on school grounds. Although caregivers provide informed consent for their child's participation in the program, SBFT directly addresses the key barrier of low caregiver

engagement by removing the requirement for caregivers' direct active participation in the intervention (Cooper & Oliaro, 2019).

What is not known about SBFT or other filial therapy models which do not involve members of the child's family, is how the child's participation in the intervention impacts upon functioning within the child's family. In the context of SBFT, *family functioning* is defined as the observable actions, effects, or reactions that occur both within and between individuals in a family including those between parents/caregivers, extended family members, and children. The aim of this embedded mixed-methods (QUAL+quan) study is to add to the theoretical conversation about the concept of child focus in Bowen family systems theory (Bowen theory). This is achieved via observations from caregivers who participated in semi-structured interviews following their child's participation in 10 sessions of SBFT with a trained member of school staff. The research question guiding this study was: 'How does a child's participation in 10 sessions of SBFT with a non-caregiver facilitator impact upon family functioning?' Outcomes from this study may provide some considerations and implications for practitioners guided by family systems thinking and working in settings where there is an inherent child focus, such as primary schools and children's mental health services.

Child-focused families and mental health treatment

There is a good deal of literature dedicated to theoretically exploring the concept of child focus (Brown, 2008; Donley, 2003; Kerr, 2019; Kerr & Bowen, 1988). However, there is limited research that considers how a child's engagement in treatment impacts families. Notable studies include Bowen's original research at the National Institute of Mental Health (NIMH) in the 1950s, where he observed that an individual's severe mental illness was a problem that involved the functioning of all family members (Bowen, 2013). Clinical observations highlighted the influence of anxiety on the way that family members became overly concerned about and focused on the symptomatic individual (Bowen, 2013). The focus was sufficiently intense that rigid, reciprocal patterns developed. Over time these patterns reinforced the individual's identity in the nuclear family as 'the black sheep or scapegoat or the holder of the family problem' (Bowen, 2013, p. 29).

Bowen (2013) further observed that most improvements in the functioning of the symptomatic individual occurred when neither the individual nor their mental health symptoms were the focus of therapy. Improvements occurred when therapy involved other members of the individual's family, particularly their parents. Further, when the focus of therapy shifted to exploring family members' reactions to one another when anxiety was present, the individual's functioning also improved. These findings informed Bowen's position that treatment focused on an individual family member would reinforce processes within a family that maintained, rather than alleviated, the individual's symptoms (Bowen, 2013).

Another notable study by Brown (2018, 2020) involved a qualitative exploration of how parents perceived their adolescent's mental health treatment. Brown (2018, 2020) explored the relationship between parental engagement in adolescent mental health treatment and parents' sense of hope and being a resource to their child's recovery. Research outcomes inferred that when parents were invited to consider their own part in interactions with the adolescent, rather than focusing treatment entirely on the adolescent's symptoms, parents experienced a greater sense of hopefulness (Brown, 2018, 2020). Further, when parents were invited to generate their own responses to the family dilemma, rather than being instructed about what to do, their sense of capacity and self-agency to help their child was strengthened (Brown, 2018, 2020).

Whilst research in this area is limited, both the theoretical position and research outcomes invite broader investigation, especially within settings where working with children is a necessity and caregivers are not readily available or in a position to engage in treatment. This may include settings such as children's mental health services, early intervention centres, out-of-home care services, and non-clinical environments such as primary schools.



School-Based Filial Therapy

The original model of filial therapy was influenced in part by the modality of child-centred play therapy (CCPT; Axline, 1947) and in equal measure, knowledge emerging from the field of family therapy during the 1950s and 1960s (Guerney, 1964, 2000). During this period, there was a shift from an individualistic view of pathology to the conceptualisation of an individual's functioning as an interrelated part of a broader family system (Flaskas, 2010). This new way of thinking influenced the move away from individual treatment modalities to working with family relationships (Flaskas, 2010).

The first model of filial therapy involved the clinician working alongside the child's parents to shift the agent of change from the clinician to the parent/s so that the problems for which the family were seeking therapy were addressed directly within the parent-child relationship (Guerney, 1964). Filial therapy has, over the years, informed many variations of the model, including versions of filial therapy, such as SBFT, that engage non-caregivers as the agent of change working with the child. The idea of substituting the child's parent for a teaching professional was first suggested by Andronico and Guerney (1967) based on the significant amount of time children spend in the presence of their teachers. To date however, there has been no formal investigation of the effect on family functioning of filial therapy models that have substituted the parent/caregiver of a child for another significant adult in the child's daily life.

In other models of filial therapy, attachment theory is commonly applied to understand the occurrence of children's mental health symptoms. This is distinct from SBFT where children's symptoms are conceptualised as emerging from and maintained by an intensified version of the child-focused process that operates in all human families (Cooper, Yu, & Brown, 2022). The process begins when caregiver anxiety generates an internal drive to closely monitor the child for signs of a problem. Caregivers begin to focus more of their actions, expectations, and responses to the child based on their fears/concerns about the child rather than the child's actual abilities. The child in turn reacts to caregivers in ways that attract more of their attention and concern (Bowen, 2013; Donley, 2003; Kerr, 2019). Caregivers do not cause the child's behavioural problems, and their sensitivity to the child involves many variables. However, this illustration describes the type of interactions that are replicated between the symptomatic child and education professionals in the school setting.

Where other versions of filial therapy work on strengthening the child's relationship with school staff (Helker & Ray, 2009), SBFT instead works with facilitators to shift their focus from the child to themselves during therapeutic play sessions (Cooper, Yu, Brown, & MacKay, 2022). In addition to learning basic play therapy skills, the focus of facilitator training in SBFT is to invite a conscious effort on behalf of facilitators to monitor, adjust, and regulate their own actions and reactions to the child, thereby toning down the intensity of focus on the child within the facilitator-child relationship. The guiding premise is that an intense focus on a child will unintentionally and indirectly limit the child's exposure to circumstances, experiences, and relationship interactions within play sessions and more broadly within the school setting. The lower levels of exposure thereby limiting rather than promoting the child's development of age-appropriate autonomous functioning. Taking the pressured focus off the child allows them to expand their own repertoire of useful emotional-behavioural skills that can be generalised to other life contexts.

SBFT has been conceptually described in Cooper, Yu and Brown (2022) and has demonstrated a positive impact on increasing children's school attendance and reducing the frequency and intensity of problem behaviour events (Cooper et al., 2020). Research on SBFT has also explored the relationship factors between children and facilitators that influence facilitator adherence to the SBFT skills and method (Cooper, Yu, Brown, & MacKay, 2022). A further question for clinicians led by Bowen or other family systems theories is whether an intervention, such as SBFT, which involves a child's direct participation in therapy can avoid intensifying child focus. Until the present study however, it was not known how children's participation in SBFT impacted upon functioning within their family system – that is, the observable actions, effects, or reactions occurring both within and between individuals in the family. Understanding this aspect of the intervention is imperative if the child's family are considered

to have a significant influence on the child's emotional–behavioural functioning. It is also imperative to explore the notion that interventions focused on a child may intensify child–focused processes given that it presents significant practice implications.

METHOD

Design

An embedded mixed-method design (QUAL + quan; Creswell & Plano Clark, 2011) was used to explore any changes in family functioning that occurred during and following the child's participation in 10 sessions of SBFT.

Participants

Participants were primary caregivers of children who engaged in 10 sessions of SBFT at two public primary schools in regional and outer-regional New South Wales, Australia. Initially 14 caregivers consented to participate but four caregivers did not attend scheduled interviews. Therefore, this resulted in a total of 10 participants. All caregivers were female and ranged in age between 27 and 61 years. Six of the caregivers identified as Aboriginal and Torres Strait Islander and the group consisted of seven biological parents, two kinship caregivers, and one stepparent. For a descriptive summary of research participants, refer to Table 1. Caregiver participants for the study had to meet the following inclusion criteria:

1. Be a primary caregiver of a child currently participating in 10 sessions of SBFT at one of the nominated state schools.
2. Consent to participate in a semi-structured interview of approximately 60 min duration in person or via phone.
3. Agree to complete three self-report questionnaires (*Differentiation of Self Inventory – Short Form* [DSI-SF; Drake et al., 2015]) and a pre- and post-*Visual Analogue Scale – Family Functioning* (VAS-FF) developed for the current study.

Qualitative data collection

Semi-structured interviews were used to collect caregiver narratives. The semi-structured nature of interviews allowed for follow-up questions that invited participants to clarify, elaborate on, or adjust their responses. The question–answer validity approach (Roller & Lavrakas, 2015) was employed by the interviewer as a means of member checking whilst maintaining the research context. This ensured caregivers had the opportunity to hear repeated back to them what they said, and to change their response if they wished to. Interview questions were developed and reviewed by all co-authors until reaching common agreement with contents of the revised interview schedule. An example of one of the interview questions was: ‘What changes if any, did you observe about the way you and other members of your family responded to your child's difficulties following your child's participation in SBFT?’

Qualitative data analysis

Family relationship processes are a complex phenomenon and there has been limited exploration of this subject area within the field of filial therapy. Content analysis lends itself well to discovering with



TABLE 1 Descriptive statistics for caregiver participants.

Caregiver ID	PC1	PC2	PC3	PC4	PC5	PC6	PC7	PC8	PC9	PC10
Gender	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female
Age	29	32	27	28	33	38	34	38	58	61
Aboriginal/Torres Strait Islander: Y/N	Y	N	N	Y	N	N	Y	Y	Y	Y
Caregiver status	Biological parent	Biological parent	Stepparent	Biological parent	Biological parent	Biological parent	Biological parent	Biological parent	Kinship caregiver	Kinship caregiver
DSI-SF (IP) score	4.3	2.67	3.67	4.17	3.67	4.17	3	3.33	3.67	5
DSI-SF (FO) score	5	2.8	4.2	3.6	5	5	3	2.8	1.4	2.2
DSI-SF (EC) score	4.3	5	3.67	3.67	4	4.67	2.33	2.33	1	3
DSI-SF (ER) score	4.5	5	3	2.67	3	3.5	2	2.5	1	3.33
DSI-SF total score	18.1	15.47	14.54	14.11	15.67	17.34	10.33	10.96	7.07	13.53

Abbreviations: DSI-SF (EC), Differentiation of Self Inventory – Short Form (emotional cut-off), higher scores are representative of less emotional cut-off; DSI-SF (ER), Differentiation of Self Inventory – Short Form (emotional reactivity), higher scores are representative of less emotional reactivity; DSI-SF (FO), Differentiation of Self Inventory – Short Form (fusion with others), higher scores are representative of lower tendency for fusion with others; DSI-SF (IP), Differentiation of Self Inventory – Short Form (1 position), higher scores are representative of greater capacity to maintain an I position; PC1-10, primary caregiver code, Y/N, Yes/No.

a good degree of objectivity, new information contained within participant narratives (Kleinheksel et al., 2020) and as such, was selected as the method of analysis. The Erlingsson and Brysiewicz (2017) guide for content analysis was applied and raw participant narratives were condensed into smaller units of meaning, coded, and then categorised. Researcher inferences were drawn from the patterns that emerged from the number of comments and percentage of participants who provided responses within each category and sub-category.

Quantitative instrumentation

Differentiation of Self Inventory – Short Form

The Differentiation of Self Inventory — Short Form (DSI-SF; Drake et al., 2015) provides an indication of a person's level of differentiation of self across four sub-scales (e.g., emotional cut-off, emotional reactivity, fusion with others, and I-position; Drake et al., 2015). Respondents rate each item on a scale between one (not at all characteristic of me) and six (very characteristic of me), with reverse scoring applied to specified items.

Differentiation is a central concept of Bowen theory, referring to the range of human functioning (Drake et al., 2015; Kerr & Bowen, 1988). At one extreme are individuals who are governed mostly by feelings and nervous system responses. At the other extreme end of the range are individuals who possess an astute awareness of reactivity within nervous and feeling systems, have a robust ability to engage cognitive resources and calm arousal, can make thoughtful decisions, and balance intimacy with personal goal-directedness (Kerr, 2019; Kerr & Bowen, 1988). For a summary of participant DSI-SF scores, refer to [Table 1](#).

Visual Analogue Scale – Family Functioning

The Visual Analogue Scale - Family Functioning (VAS-FF) was developed by the first author for this study and included 16 items that fell into four categories: (i) internal experience of caregiver, (ii) caregiver response to child, (iii) caregiver response to child's other parent, and (iv) extended family responses. The 16 items were generated from the theoretical literature and the clinical experiences of the four authors. The VAS-FF was trialled with three participants who provided feedback on the wording of a few of the items. Therefore, the VAS-FF demonstrated evidence of face validity and content validity.

Participants were asked to mark an X on a 10-cm line featuring a continuum with two endpoints. For example, the question 'I respond to my child's other parent by' featured 'supporting them entirely' at one end of the continuum and 'getting into conflict' at the other end. A score out 100 to the closest mm was calculated for each of the 16 items (see [Table 3](#)). Visual analogue scales are an effective method for capturing the subjective experience of research participants. They are also considered more sensitive to participant changes when compared to measures using defined responses or numbers (Briggs & Closs, 1999).

Quantitative data collection

Prior to the child's participation in 10 sessions of SBFT, the program coordinator gave caregivers the DSI-SF and pre-VAS-FF, and the completed forms were returned to the lead researcher. After completion of the 10 sessions of SBFT, the post-VAS-FF was given to caregivers and collected by the lead researcher on the day of scheduled interviews.



Quantitative data analyses

The Statistical Package for the Social Sciences version: 29 (SPSS; IBM Corp., 2022) was used to complete a descriptive analysis of quantitative data from the DSI-SF. SPSS was also used to perform a Wilcoxon signed-rank test of the VAS-FF data to compare ranks at Time 1 and Time 2 on repeated measurements. A p -value lower than or equal to 0.05 is indicative of a statistically significant difference between the two scores (Pallant, 2016).

Rigour and trustworthiness

Several steps to improve the rigour and trustworthiness of the qualitative component of the study were employed to modulate researcher bias, which is acknowledged as an inevitable part of the research process. The lead researcher and first author worked to remain conscious of her positionality, including the influence of her identity, educational background, and life circumstances. Creswell and Plano Clark (2011) support the use of a guiding theory in embedded mixed-methods designs to inform data collection, analysis, and synthesising of outcomes. In this study, Bowen theory guided the formulation of the research question, coding of participant narratives, and interpretation of data in the discussion.

Analyst triangulation, audio-taped interviews, detailed interview notes, and researcher reflections were some of the processes used to enhance rigour and trustworthiness (Creswell & Plano Clark, 2011). Member checking was conducted during caregiver interviews using a question-answer validity approach. No caregivers were willing to participate in further member checking following the completion of interviews. As an alternative, three of the SBFT coordinators engaged in member checking during the final stages of content analysis. Quantitative data were used to further enhance the trustworthiness and rigour of the study, and to supplement, triangulate, and compliment the qualitative data that were collected (Johnson et al., 2020).

Procedure

Following ethics approval from the Monash University Human Research Ethics Committee (14/09/2022; Project No. 26062) and New South Wales Department of Education (07/10/2022; SERAP 2020311) the first author invited three schools to participate in the study. Schools were selected based on their well-established SBFT programs and their prior participation in SBFT research studies. Each school was given a verbal and written explanatory statement about the study, with two of the three schools agreeing to participate in the study. The third school was unable to participate due to staff shortages.

The program coordinator provided explanatory statements to the caregivers of the children selected for participation in SBFT. Children were selected for SBFT through the school learning and support stream, based on concerns about their home situation (e.g., exposure to family violence/conflict, neglect, family separation) or concerns related to the children's emotional-behavioural, academic, and social functioning. Consenting caregivers participated in a semi-structured interview that took on average 60 min to complete.

Most interviews occurred at the school; one interview occurred over the phone due to participant sickness.

All interviews were conducted by the first author, audio-recorded, transcribed verbatim, and analysed using content analysis. This process involved condensing participant narratives into meaning units, then coding and categorising the data. At each stage of the coding process, analyst triangulation was employed. Researcher inferences were drawn from patterns which emerged from frequency counts of comments featuring in all primary category and subcategories. Methods triangulation using quantitative data was employed during the final stage of data analysis.

FINDINGS

Qualitative research results

Qualitative content analysis revealed that changes occurred in three primary areas of family functioning over the course of the child's participation in SBFT. Primary categories included (i) child functioning, (ii) caregiver functioning, and (iii) extended family functioning, with associated subcategories embedded within each. For outcomes from the qualitative content analysis, please refer to [Table 2](#). The following results are summarised according to family functioning pre-SBFT and post-SBFT.

Primary category 1: Pre-SBFT child functioning

Children's functioning represented the second-highest number of participant comments (344 comments or 29%, $n = 10$) related to family functioning prior to the child's participation in SBFT. Coding of children's functioning resulted in the emergence of three subcategories: *child symptoms* (218 comments), *sibling interactions* (70 comments), and *parent interactions* (56 comments). In the subcategory of children's symptoms, children's problem behaviour was the cause of greatest concern for all caregivers (75% of comments), and emotional symptoms (e.g., anxiety, emotional lability) accounted for the second-highest description of child functioning in this sub-category (9.6% of comments, 80% of caregivers).

Fewer comments occurred in the subcategories of children's interactions with siblings and caregivers. Among the 70 comments about sibling interactions prior to SBFT, several caregivers described sibling violence occurring in the family home. Other parents described patterns of siblings avoiding or modulating their interactions with the child to circumvent a possible upset or conflict. For example, caregiver PC2 stated that: 'The other kids know that he's like that so they are like "oh he wants a hug" so he just kind of gets in there...they're kind of used to it.' Only 40% of caregivers commented on the child's interactions with caregivers. Participant comments in this subcategory primarily gave descriptions about the child's reactions to the way a caregiver had responded to the child. For example, 'She goes to Dad if I say no' (PC7) and 'He hit me when I said, do as you're told' (PC9).

Primary category 1: Post-SBFT child functioning

This category received the greatest number of comments related to observations about changes in the family following the intervention period, with the subcategories of *child symptoms* (92 comments), *sibling interactions* (19 comments), and *parent interactions* (12 comments) described respectively by 100%, 50%, and 60% of the participant group.

The subcategory of child symptoms represented 56% of all participant comments related to observed changes in family functioning. Behavioural symptoms (83.7% of comments, 100% of caregivers), and emotional symptoms (13% of comments, 40% of caregivers) remained the most frequently reported aspects of child functioning by caregivers. Fifty percent of the caregiver group described changes in sibling interactions, commonly reporting a reduction in aggression between siblings and in some cases an increase in play interactions. One caregiver made the following observation of how the child's sibling interactions had changed following SBFT:

She's maybe a bit easier on him (her brother) at home when it comes to the fighting,... she's more coming to tell me that he's done something wrong rather than just kicking him.

(PC6)



TABLE 2 Content analysis outcomes from caregiver interviews.

Categories and subcategories	Pre-SBFT (<i>n</i> = 10)		Post-SBFT (<i>n</i> = 10)	
	Total comments, percentage participants (%)	Example quotes	Total comments, percentage participants (%)	Example quotes
Child functioning				
Child symptoms	218 (100)	<p>'She gets pretty aggressive in school' (PC1)</p> <p>'He's not very good playing with other children' (PC2)</p> <p>'Most of the time (his brother) does not want to play with him either because it's hard, he does not like to share' (PC2)</p> <p>'If he hits his brother, sometimes I hear the hits and it's not nice' (PC4)</p>	92 (100)	<p>'She's not so frustrated and cranky' (PC8)</p> <p>'There's been a change in his behaviour. He's settled down a lot' (PC4)</p> <p>'He does try to play with the other kids at home a little bit more' (PC2)</p> <p>'Things have got worse with the kids to be honest. He fights with them so much more' (PC3)</p>
Child interactions with siblings	70 (100)		19 (50)	
Child interactions with caregivers	56 (40)	<p>'She will come out of the school and start yelling at me. I do not even know what I did, she just starts yelling' (PC1)</p> <p>'He just gets more aggressive with me, verbally. He actually hit me once' (PC9)</p>	12 (60)	<p>'He does not listen, like he will stand there and try and row with his stepdad' (PC4)</p> <p>'He is listening to me more now. Whereas he would rather listen to what Dad was saying instead of what I was saying' (PC9)</p>
Caregiver functioning				
Reactive compensatory parenting	24 (70)	<p>'I tried as much as I could with them while he wasn't around to try and do things the way I obviously do them now' (PC2)</p> <p>'I'd be the one that disciplined, and he would sit back. He was more likely to give in' (PC10)</p>	No comments (0)	No comments
Focusing on other caregiver's functioning	92 (100)	<p>'I'm saying one thing and then Dad will say something different' (PC7)</p> <p>'His Dad was very, very hard on him' (PC2)</p>	5 (20)	'He is a lot more helpful and we challenge them together, it's not just me having to put up with the kids problems, he helps a lot more now' (PC6)

TABLE 2 (Continued)

Categories and subcategories	Pre-SBFT (n = 10)		Post-SBFT (n = 10)	
	Total comments, percentage participants (%)	Example quotes	Total comments, percentage participants (%)	Example quotes
Focusing on child's functioning	326 (100)	<p>'There is times when I will get her to breathe, sometimes she will do it and sometimes she will be like "I'm not going to do it, it's not going to help"' (PC1)</p> <p>'When it comes to my kids, I am the background, it does not matter about me, it's all about them' (PC2)</p> <p>'I try and stay calm and not lose my temper' (PC6)</p> <p>'I try and talk calmly' (PC1)</p> <p>'Very hopeful that he will continue to improve' (PC10)</p> <p>'I was hopeful that the program (SBFT) would help' (PC5)</p>	28 (4)	<p>'I used to worry about him a lot, but not now' (PC2)</p> <p>'We are trying to stick with rules and punishments and not just give in' (PC6)</p>
Focusing on self-functioning	19 (60)		No comments (0)	No comments
Sense of hope/confidence	68 (80)		3 (20)	<p>'It does not seem as difficult as it was before' (PC2)</p> <p>'I am confident I'll find a way through this' (PC5)</p>
Expressing helplessness/hopelessness	50 (90)	<p>'I struggled a lot, I did not know how to help him, I was trying everything I could and nothing was working' (PC2)</p> <p>'The problem is too big for me to do something about' (PC9)</p>	No comments (0)	No comments
Avoiding contact	61 (90)	<p>'He walks away, or I walk away, and he comes back and pretends it did not happen' (PC1)</p> <p>'Sometimes I just cannot handle his bullshit and I just walk away' (PC9)</p>	No comments (0)	No comments
Engaging in conflict	69 (80)	<p>'He keeps pushing the situation and we end up having a mad fight in front of them' (PC1)</p> <p>'There was a bit of DV in the past which she may have been witness to' (PC6)</p>	3 (20)	<p>'We fight less and agree more now' (PC4)</p> <p>'There's less fighting now' (PC6)</p>



TABLE 2 (Continued)

Categories and subcategories	Pre-SBFT (<i>n</i> = 10)		Post-SBFT (<i>n</i> = 10)	
	Total comments, percentage participants (%)	Example quotes	Total comments, percentage participants (%)	Example quotes
Extended family functioning				
Engaging in conflict	47 (60)	<p>'She was trying to make it really hard and took out all of these AVOs' (PC5)</p> <p>'I only just had my first child and she was telling people that we hated each other' (PC2)</p> <p>'His parents live in town, I do not have anything to do with them though' (PC2)</p>	2 (20)	<p>'I still have difficulty with his Dad. But it's gone down, about an inch' (PC9)</p> <p>'Things with Mum's partner have gotten worse' (PC8)</p> <p>No comments</p>
Avoiding contact	32 (50)	'His (Dad's) mother soon pulls him into line' (PC7)	No comments (0)	No comments
Taking sides in parent–child relationship	12 (50)	'He (Uncle) told him to step up and start parenting the kids' (PC4)	No comments (0)	No comments
Taking sides in parent–child relationship	15 (60)	'If she does not (Calm down), I normally ring Nan because she listens to Nan' (PC7)	No comments (0)	No comments
Worry about child	10 (60)	'My Dad's brother he lives just across the road, he is really good, he pulls the kids up a lot for me' (PC4)	No comments (0)	No comments
Provides practical support	18 (70)	'They see the problems, they know what's going on' (PC4)	No comments (0)	No comments
		'He (grandparent) will buy it for us and we might send some ideas or we might mention something and he will send it to us out of the blue. He's sent lots of art stuff, the kids are really into art' (PC6)	No comments (0)	No comments
		'We are living with my mum and her partner at the moment' (PC8)		

Abbreviations: PC 1–10, participant ID; SBFT, School-Based Filial Therapy.

TABLE 3 Results from Wilcoxon signed rank test from pre- and post-Visual Analogue Scale – Family Functioning ($n=10$).

Item description	Z value	Asymp. sig (2-tailed)	Effect size	Pre-SBFT percentiles			Post-SBFT percentiles		
				25th	50th	75th	25th	50th	75th
The level of distress I am currently experiencing about my child's difficulties (0 = No distress ↔ 100 = extreme distress)	-1.37	0.17	0.30	47.5	74.5	95.5	51	62.5	88.75
The amount of time I spend thinking and worrying about my child (0 = No time ↔ 100 = constantly)	-0.42	0.68	0.09	57.5	79	90.5	55	79	97.5
The best person to help my child with their difficulties is (0 = Me ↔ 100 = Somebody else)	-0.84	0.40	0.19	46.5	75	97	39.5	52	89.5
I respond to my child's behaviour challenges by (0 = Encouraging my child ↔ 100 = Giving up and walking away)	-0.51	0.61	0.11	39	47.5	65.75	45.25	49	64.5
I respond to my child's behaviour challenges by (0 = Offering support ↔ 100 = Punishment)	-0.30	0.77	0.07	25.75	43.5	50.25	31.5	42.5	48.75
I respond to my child's behaviour challenges by (0 = Going easy on them ↔ 100 = Leave it to other parent to manage)	-1.48	0.14	0.33	35.25	40	50.25	33.5	49.5	53.75
I respond to my child's behaviour challenges by (0 = Encouraging my child ↔ 100 = Calming myself down)	-0.41	0.68	0.09	41.75	45.5	54	26	47	68.25
I respond to my partner's/the child's management of my child's behaviour by (0 = Supporting them entirely ↔ 100 = Getting into conflict)	-0.17	-1.01	0.04	36	52	70	42.75	56.5	80.5
I respond to my partner's/the child's management of my child's behaviour by (0 = Silently disapproving ↔ 100 = Doing things my own way)	-0.52	0.60	0.12	47	68	70	49	72	98
I respond to my partner's/the child's management of my child's behaviour by (0 = I do it, they make it worse ↔ 100 = I leave it to them to sort it out)	-0.07	0.99	0.02	13.25	39.5	48.5	1.75	45.5	52.5
My broader family are aware of the concerns I have about my child (0 = Nobody knows ↔ 100 = I'm constantly sharing my concerns)	-0.51	0.61	0.11	33	52	80	37.25	68.5	100

(Continues)



TABLE 3 (Continued)

Item description	Z value	Asymp. sig (2-tailed)	Effect size	Pre-SBFT percentiles			Post-SBFT percentiles		
				25th	50th	75th	25th	50th	75th
My child's siblings respond to my child's behaviour challenges by (0 = Offering help/support ↔ 100 = Avoiding them)	-1.367	0.172	0.31	44.5	48	58	47.25	50.5	70.5
My broader family responds to my child's behaviour challenges by (0 = Offering support ↔ 100 = Avoiding contact)	-0.701	0.483	0.16	0.75	20.5	54.25	6.5	28	67
I think SBFT will/has (0 = Resolve my child's problems ↔ 100 = Make no difference)	-1.362	0.173	0.31	11.5	25	47	32.25	41.5	70
My child's difficulties are (0 = Extremely problematic ↔ 100 = No problem)	-1.734	0.083	0.39	0	21.5	33.25	13	31.5	45
My Overall, the mood and routines within my family are (0 = Organised around child ↔ 100 = Organised around other things)	-0.663	0.507	0.15	0	49.5	58.75	46	59	88

Note: Cohen (1988) guidelines used to interpret effect size: small effect (0.1), moderate effect (0.3), large effect (0.5).

Abbreviations: Asymp. sig. (2-tailed), associated significance levels with values less than or equal to 0.05 considered statistically significant; SBFT, School-Based Filial Therapy.



Regarding caregiver interactions, again descriptions related to the way in which the child had reacted to a caregiver action, such as setting a limit, saying no, attempting to enforce a consequence or aiding the child. For example, caregiver PC3 described a change in interactions with her child when setting a limit device usage: 'Well now it's heaps better. Like when I take the devices off her, she's not cranky.'

Primary category 2: Pre-SBFT caregiver functioning

Caregiver comments within this category described how caregivers related to one another around the child's problems, where their thinking and energy was directed, and their sense of capacity to manage the child's problems. Coding of caregiver functioning resulted in the emergence of eight sub-categories. The subcategory with the highest number of comments (326, $n = 10$) was *focusing on the child's functioning*, with 226 of those comments related to the caregiver's anxious thoughts about the child's functioning, for example: 'All of my attention was and a lot of it still is focused on him' (PC3).

The remaining comments within this subcategory reflected a caregiver's efforts to address the child's problem in ways that either required the child to change or cooperate, for example: 'I needed to get him counselling' (PC4) and 'I try everything to make him happy and content, so he doesn't disrupt his siblings' (PC3).

The subcategory with the second-highest number of comments related to caregiver functioning was *focusing on other caregiver's functioning* (92 comments). One hundred percent of participants described both their own reactions to what the child's other parent was or was not doing and how they were doing it, and how the other parent reacted to their approach. One caregiver commented about her reaction to the child's stepparent: 'I think, how come you can't get involved? She's not your child but you're still helping raise her' (PC5).

The subcategory that received the fewest comments was *focusing on self-functioning* (19 comments, 60% of participants). In this subcategory, comments related to the caregiver having an inner principle guiding their actions or responses to the child (10 comments), or the caregiver adjusting their own actions or responses to the child (nine comments) in ways that did not require the child or other parent to change or cooperate. Some caregivers described focussing on staying calm with their child, others discussed principles such as being realistic about the pace of change.

Caregivers made more comments in the category of *sense of hope/confidence* (68 comments, 80% of participants) than they did in the subcategory of *expressing helplessness/hopelessness* (50 comments, 90% of participants). Whilst most comments (38) about hope and confidence among caregivers expressed an externally based hope (e.g., hope was invested in expert help or treatment, including SBFT), 30 comments were linked to caregivers having an internally invested sense of hope or confidence to address the family problem. One parent described her plan to begin practicing short dinner outings with the children to build parent confidence for family outings. Comments in the subcategory of helplessness/hopelessness related to having a sense that there were no other options for addressing family dilemmas or challenging circumstances and having a sense that there is no hope that the child's problems would improve.

Subcategories involving descriptions of how caregivers related to one another around the child's problems included *engaging in conflict* (69 comments, 80% of participants), *avoiding contact* (61 comments, 90% of participants), and *reactive compensatory parenting* (24 comments, 70% of participants). Engaging in conflict was commonly reported, with most conflict occurring in reaction to the way the other parent was responding to the child. One kinship caregiver described her highly conflictual relationship with the child's biological father:

My son is very verbal in telling me he is not happy with my approach!

(PC9)

Another commonly occurring reaction among caregivers was avoiding contact with the child's other parent when tension was high. This process involved avoiding difficult conversations with one another, avoiding interactions, and emotionally distancing from the other parent. For example:

I haven't really said hey this is an issue. You know, you can't really force the stepparent to be more hands on.
(PC5)

I'm not a confrontational person, so I avoided him (father).
(PC2)

Within the subcategory of reactive compensatory parenting, caregivers described a process whereby their reactivity to the other parent's approach led them to respond to the child in the opposite way. Some examples from participant comments included:

His Dad was very hard on him but I...give him time and then try and get him to talk to me about what it is.
(PC2)

He reacts to her. I try to understand, so I will actually sit down and talk to her.
(PC5)

Primary category 2: Post-SBFT caregiver functioning

Changes in caregiver functioning were mentioned by the participant group in only four of the subcategories. *Focusing on child's functioning* remained the highest rated subcategory of caregiver functioning, however the number of comments reduced by 91.4% to a total of 28 comments. There was an even distribution of comments related to anxious thoughts about the child and the child featuring as the focus of caregiver change efforts, as compared with pre-SBFT where most comments related to anxious thoughts about the child. *Focusing on other caregiver's functioning* (five comments) and *engaging in conflict* (three comments) featured in comments from 20% of the participant group. This was the same number of participants who expressed comments related to *sense of hope/confidence* (three comments), with two of the three comments describing an internally generated sense of hope and confidence.

Primary category 3: Pre-SBFT extended family functioning

Caregiver comments within this category were characterised by descriptions of how the caregiver and extended family members related to one another around the child's problems, and the reaction from extended family to the conditions within both the parental and the parent–child relationship. Coding of caregiver functioning resulted in the emergence of six sub-categories.

Engaging in conflict and *avoiding contact* featured the highest number of comments, with 47 (mentioned by 60% of participants) and 32 comments (mentioned by 50% of participants) respectively. In most cases, conflict and avoidance occurred between the participant caregiver and the members of the other parent/caregiver's family (including in some cases an ex-partner), rather than between the caregiver and their own family of origin. The following comment from caregiver PC2 regarding conflict and avoidance with members of extended family is representative of comments within these subcategories:

'I don't have anything to do with them. I recently had an AVO put against her because she attacked me, so we don't have contact with them.'

Other subcategories involving comments that described how extended family and caregivers related to one another included *worry about the child* (10 comments, 60% of participants) and *providing practical support* (18 comments, 70% of participants). There was a link between families where worries about the child were expressed more openly between the caregiver and extended family, and the provision of practical support. For example, one parent described having regular contact with her extended family about her concerns, and male family members within the broader family responding by spending more time with her children whilst their father was in prison. For a caregiver who was living in relative poverty with her children, their father communicated their practical needs to the children's paternal grandfather, who would support them by purchasing clothing and school items.

The remaining subcategories within extended family functioning included *taking sides in the parent relationship* (12 comments, 50% of participants) and *taking sides in the parent–child relationship* (15 comments, 60% of participants). Regarding side–taking within the parent relationship, two main patterns emerged. Members of extended family were either invited or became involved to support the most-involved/overwhelmed parent, to recruit more assistance, action, or backing from the less-involved parent. For example:

She (paternal grandmother) just tells him that he needs to back me, he needs to have my back or the kids are going to think that they can just do whatever.

(PC7)

The other pattern that emerged was extended family being invited or getting involved in providing support, protection, and advocacy on the side of the less-involved parent, opposing the parent who was most involved with the children. For example:

Any time that we (parents) had issues, he (father) would run to his parents and his parents would tell him he did absolutely nothing wrong, it was all my fault and he's a good little boy.

(PC2)

Regarding side–taking within the parent–child relationship, caregivers either invited, or extended family members got involved in support of the overwhelmed caregiver, assisting their efforts to get the child to comply, behave differently, or cooperate. For example:

Yeah, they all know. I tell them or they see it. I have my mum's brother, he lives here and if I have problems with (child's name), I usually give him a call and he comes and picks him up and has a talk to him for me.

(PC4)

Extended family members also got involved in support of the children, undermining the efforts of the caregiver out of concern or sensitivity to the child. For example:

She was always undermining me whenever I tried to do anything with my kids at her house, like she would complain that the kids weren't well enough behaved at her house but then undermine any sort of discipline action or parenting ability I had with my children at her house.

(PC2)



Primary category 3: Post-SBFT extended family functioning

Changes in extended family functioning featured in only one of the subcategories, *engaging in conflict* (2 comments, 20% of participants). One participant, a kinship caregiver, explained that at the time of the child completing the SBFT program, she was having less conflict with the child's biological father who was also her son. The other caregiver commented that conflict within the extended family had increased since her child completed SBFT. Caregiver PC8 described the conflict associated with living with her mother and partner in their home: '(Things are) worse because he seems like he's always on my back. He's not on my back, he talks to my mum, for my mum to talk to me.'

Quantitative research results

A summary of quantitative results is featured below. For a comprehensive overview of results from the DSI-SF, refer to [Table 1](#). For results from the Wilcoxon signed rank test of VAS-FF data, refer to [Table 2](#).

Emotional reactivity (ER) scores in the DSI-SF ($M=3.05$, $SD=1.15$) represented the lowest of the four sub-scales, with the emotional cut-off (EC) score ($M=3.4$, $SD=1.23$) representing the second lowest. The I position (IP) score represented the highest ($M=3.77$, $SD=0.68$) of the four sub-scales for participants, with the second highest being the fusion with others (FO) score ($M=3.5$, $SD=1.27$).

Regarding outcomes from the VAS-FF, there were no statistically significant changes between pre- and post-test. Moderate effects occurred across several items, including the level of distress caregivers experienced about their child ($Md=74.5$; $Md=62.5$) and caregiver's response to the child's behaviour challenges, where there was a shift from going easy on the child to leaving the other parent to manage the child ($Md=40$; $Md=49.5$). Other items with a moderate effect included siblings becoming more avoidant of the child ($Md=48$; $Md=50.5$), caregiver perceptions about the effect of SBFT on the child's problems ($Md=25$; $Md=41.5$), and caregivers experiencing their child's difficulties as less of a problem ($Md=21.5$; $Md=31.5$).

DISCUSSION

This study explored how family functioning changed when a child participated in 10 sessions of SBFT. Qualitative content analysis revealed that most changes occurred in the category of child functioning with children's behavioural symptoms being the most reported change overall. The caregiver's focus on the child's functioning also changed, with a reduction in comments related to their anxious focus on the child following the intervention. Other changes were reported in the areas of child–sibling and caregiver–child interactions, a tendency to focus on the other parent, caregiver hope/confidence, and caregiver and extended family conflict. In all other subcategories, there were no comments related to observed changes in functioning following the child's participation in SBFT. Supplementary quantitative data suggested that caregiver's experience of their child's difficulties changed, as did their responses to the child's behaviour challenges. Other changes occurred in the caregiver's response to the child's other parent, and how extended family and siblings responded to the child.

Bowen theory describes several active processes in all human families that function to modulate the anxiety experienced between family members; one such process is child focus (Donley, 2003; Kerr & Bowen, 1988). In a study by Klever (2004) a statistically significant link was found between high rates of dysfunction in the extended family and child symptoms which were indicative of a multigenerational pattern of child focus. A similar pattern emerged among caregivers in the SBFT study who reported a range of highly complex circumstances, indicating associated high levels of acute and chronic anxiety. For example, 30% of caregivers reported a history of violence, neglect, and involvement of child protection services in their own family of origin. Eighty percent of caregivers reported the same conditions



within their nuclear family, which included the child who participated in SBFT. Other stressors for these families included high rates of chronic physical, psychological, social, and developmental illnesses or conditions, and 30% of caregivers reported incarceration of at least one family member in both their family of origin and the nuclear family.

Chronic, anticipatory stress is a type of anxiety that can influence changes in family functioning (Kerr, 2019; Tittleman, 2008). Anticipatory stress does not occur in reaction to an event or experience as is the case with acute anxiety. Instead, it occurs in anticipation of something bad occurring, or under the false belief that something bad is happening (Kerr, 2019). Families experiencing higher levels of anxiety, particularly the chronic, anticipatory kind, will demonstrate less flexibility in the processes they use to manage it (Kerr & Bowen, 1988). The data in this study infer that child focus processes were dominant among participating families as a mechanism for managing their complex circumstances and associated chronic anxiety prior to SBFT. The data also showed the child focus process continued to be dominant following the child's participation in SBFT. This was demonstrated in VAS-FF outcomes, where the median rating for caregiver worries and anxious thinking about the child remained the same before and after the child's participation in SBFT ($Md = 79$).

Caregivers did, however, experience a shift in the intensity with which child-focused processes operated. This shift was accompanied by an increased sense of hope and confidence among caregivers. Another VAS-FF outcome supporting the notion of child focus as a dominant process was caregivers shifting from having the mood and routines within the family organised around the problem child ($Md = 49.5$), toward having family mood and routines organised around other things ($Md = 59$). It is possible that the reported reduction in the intensity of child-focused thinking and anxiety by caregivers occurred in reaction to observed improvements in children's symptoms. Similarly in Brown's (2018) exploration of how an adolescent's mental health treatment was experienced by their parents, it was found that a degree of improvement in the adolescent's mental health symptoms was associated with improvements in parent hopefulness. Regarding the SBFT study, a temporary reduction in caregiver anxiety may have been sufficient to introduce more flexibility into how caregivers organised family routines, rather than being driven to arrange family activities around what would be least disruptive to the child.

It is also likely that additional variables played a role in shifting the intensity of the child-focused process. For example, the extensive period of drought experienced by families in rural Australia has been described as 'a chronic stressor akin to natural disaster experienced over a longer time' (Sartore et al., 2008, p. 2). Regarding the impact of the COVID-19 pandemic in rural Australia, Allan et al. (2022) found that First Nations people experienced significantly higher rates of anxiety related to the pandemic, particularly if they had children living in their household. As caregiver PC4 described: 'COVID was hard. Home schooling didn't work. Trying to keep them inside was hard.' As conditions associated with the COVID-19 pandemic, chronic drought, flooding, and severe rodent plague eased, a reduction in external stressors likely also played a role in changing the intensity of child-focused thinking and anxiety in the family.

A feature of highly stressed families is a greater sensitivity, and increased likelihood of reacting to one another with anticipatory anxiety (e.g., fear about what someone is thinking or feeling; Kerr, 2019; Kerr & Bowen, 1988). The level of sensitivity between family members, or fusion, indicates how much unconscious energy each family member invests in monitoring changes in the physiology (e.g., affect, tone of voice) and behaviour of other members (Kerr & Bowen, 1988). Individuals in highly fused families determine more of their actions and life decisions in favour of what maintains harmony and status quo in the family (Kerr, 2019). These actions effectively relieve short-term discomfort but can inadvertently disrupt the development of autonomous functioning.

The FO subscale of the DSI-SF provides an indication of a person's level of fusion, with scores closer to zero indicating higher levels of fusion. The *mean* FO score for caregivers was 3.5 ($SD = 1.27$), indicating highly fused relationships, also suggesting associated high levels of sensitivity between family members. Fusion offers a possible explanation for the tendency among caregivers to focus on the child's functioning when tension was present within the caregiver relationship. It may also explain the tendency for caregivers to focus on the other parent's functioning when tension was high in the caregiver-child



relationship. This reflex is commonly observable in human families functioning under high levels of chronic anticipatory stress (Kerr, 2019; Kerr & Bowen, 1988).

The reduction in child symptoms that was observed by all caregivers may have been sufficient to relieve some of the tension in the caregiver–child relationship. Improvements were observed in caregiver–child interactions following SBFT and this reduction in tension may be associated with a subsequent reduction in the tendency for caregivers to focus on the other caregiver's functioning. VAS-FF outcomes showed that caregiver relationships remained tense, however changes occurred in the way that tension was managed. For example, caregivers moved from offering support ($Md = 68$) to engaging in conflict ($Md = 72$), and from silently disapproving of the other caregiver's approach ($Md = 39.5$) to doing things their own way ($Md = 45.5$).

There was no change reported in the subcategory of reactive compensatory parenting, which described how a caregiver directed their response to the child based on their reaction to the other caregiver's approach. Given there was no change in this category, it indicates that that a degree of caregiver tension continued to be moderated through a focus on the child. However, some caregivers reported becoming more self-directed in a way that was not driven by a reaction to the other caregiver. Bowen theory suggests that a caregiver becoming more self-directed in their relationship with a child may reduce the intensity of child focus (Bowen, 2013; Kerr, 2019). It is possible that this change reciprocally supported improved symptoms for children in the study.

The ER subscale of the DSI-SF provides an indication of the tendency to become overwhelmed with anxious affect during relationship interactions (Drake et al., 2015). ER represented the lowest of all four subscales for caregivers ($M = 3.05$, $SD = 1.15$), indicating a high tendency for reacting to other family members and a reduced capacity for principled thinking when tension is high. A mechanism that modulates high levels of interpersonal sensitivity, perceived threat, and ER in families is avoidance or cessation of contact (or *cut-off*; Kerr, 2019; Kerr & Bowen, 1988). Ninety percent of caregivers reported cut-off within their family of origin, and 70% reported cut-off within their nuclear family prior to SBFT. The EC subscale of the DSI-SF was the second lowest of the subscales for this caregiver group ($M = 3.4$, $SD = 1.23$), representing a higher tendency to avoid or cease contact when the perception of relationship stress is high. Whilst cut-off is an effective means of alleviating the anxiety that gets stirred up within these more sensitive relationships, it is also a factor that can intensify child–focused processes (Kerr, 2019).

Another indicator of child focus being a dominant mechanism for managing anxiety is the degree to which the symptomatic child is the subject of focus during interactions between nuclear and extended family members (Kerr & Bowen, 1988). The VAS-FF outcomes indicated that caregivers moved toward sharing more of their concerns about the child with extended family members following SBFT ($Md = 68.5$) than prior to SBFT ($Md = 52$). Interestingly, this occurred in the context of extended family members and the child's siblings moving from offering support in response to the child's behaviour challenges ($Md = 20.5$ and $Md = 48$) to avoiding contact ($Md = 28$ and $Md = 50.5$). This reaction is consistent with Kerr and Bowen's (1988) description of family functioning whereby family members become either overly involved or under involved in reaction to the anxiety that is stirred up by the presence of symptoms (Kerr & Bowen, 1988).

An interesting outcome from the study was the change that occurred in caregiver sense of hope and confidence following SBFT. Only three comments were made in this subcategory, so inferences are made with caution, however caregivers primarily described hope and confidence as internally generated. Given the embedded nature of child focus among participants, a possible explanation for improved hope and confidence is the reduction in caregiver anxiety and reactivity that was associated with improvements in children's symptoms (e.g., mood and behavioural problems). It is possible for example, that a less anxious child may have responded more receptively to a caregiver's efforts or instructions. This could then have resulted in a less intense interaction and a subsequent confidenceboost for the caregiver, improving their sense of being a resource to the child. Regarding reactivity, VAS-FF outcomes also suggested there was a shift in caregiver sense of hope and confidence with a move directionally from seeing somebody else as the best person to help the child, to seeing themselves as the best

person to do this ($Md = 75$ to $Md = 52$). Brown (2018) indicated that parent hope and confidence can grow in the context of caregivers experiencing a reduction in children's symptoms; however, a reduction in symptoms did not necessarily account for or result in parents experiencing themselves as more of a resource to their child.

Regarding caregivers of children who participated in SBFT, VAS-FF outcomes saw a move directionally from extreme distress to no distress ($Md = 74.5$ to $Md = 62.5$), and perceiving the child's problems as extremely problematic to no problem ($Md = 21.5$ to $Md = 31.5$). Symptom reduction therefore was likely a contributing factor to caregiver's experience of hope and confidence and could be interpreted as resulting from a lowering of stress related to the child. The temporary reduction in anxiety about the child may have opened more space for caregivers to focus on their own functioning, which infers a contribution to the overall change in valence and intensity of the child-focused process.

Implications for practice

In SBFT, a conceptual tension is held between acknowledging the factual and significant contribution of the family system on a child's functioning, and the realities associated with caregivers who are unable or otherwise unwilling to participate in their child's mental health intervention. It is also acknowledged that the reality position of the primary school system is that education staff must daily navigate the challenge of fostering a child's engagement and participation in learning amid the anxiety provoked by a child's emotion-behaviour problems.

Likewise, children spend a great deal of time with school personnel and how school personnel manage themselves in relation to a child will have an impact on how the child functions within those relationships and environments. Bowen theory suggests that if one person in an anxious system can focus on getting more in control of themselves and less reactive to other people in the system, everyone's functioning will adjust to accommodate the change (Kerr, 2019). However, removing the requirement for caregiver participation in SBFT does not invite caregivers to consider the influence of anxiety on family relationships. Nor does it invite them to adjust how they function in relation to the child or other members of the family system.

This research suggests that changes in the intensity and valence of child-focused processes occurred in the families of children who engaged in SBFT. The research also infers that child-focused processes remained the dominant mechanism for managing chronic and acute anxiety within these families. The reduction in child symptoms and caregiver anxiety about the child, and the increase in caregiver hope and confidence following SBFT, may present ideal conditions to introduce or change the nature of caregiver engagement. It is unlikely that primary schools will have the necessary resources or specialist skills to train caregivers to facilitate filial therapy with their own child, nor is it their remit. However, tailoring coaching and supervision with SBFT facilitators to include the concept of self-management when engaging with children's caregivers may prove additionally useful.

Caregivers of children in SBFT are frequently contacted by school personnel regarding concerns for their child's emotion-behaviour functioning. These interactions are likely reinforcing of caregiver anxieties about the child, which further fuels child-focused processes. These interactions could instead be used to encourage caregiver observations about their functioning in relation to the child and invite broader consideration of contextual factors that may be contributing to child symptoms. For example, inviting caregiver observations about reactions to the child and other caregiver, which may help to tone down child-focused processes in the family. This method of coaching/supervision could support facilitators to engage caregivers as active collaborators, rather than individuals who are passively enduring or causing the challenges in their family. For facilitators, it will require a conscious pursuit to manage the reflex to focus on or direct one's effort to addressing the child's problems or the caregiver's limited agency. As with other aspects of SBFT (see Cooper, Yu, Brown, & MacKay, 2022), this may result in a desire and ability among facilitators to generalise these skills to broader interactions within the school and local community.

Limitations and recommendations for future research

Several limitations are associated with this study, including firstly the small participant sample, small to moderate effect sizes for the VAS-FF data outcomes, and narrow representation of gender, location (rural/urban), and parenting status (e.g., biological, stepparent, kinship caregiver). To draw robust conclusions about the ways in which family functioning changes in relation to a child's participation in a treatment program, it is necessary to have a larger and more representative participant group.

The absence of a comparison group in this study is another limitation and future research may benefit from including caregivers whose children did not participate in the intervention as a control group. Children participated in SBFT for 10 sessions, which is roughly equivalent to one school term. To capture more of the dynamic complexity of family functioning, future research may benefit from a research period of 12 months with 6- and 12-month caregiver interviews.

This study indicated that caregiver self-directedness improved in some families where the child participated in 10 sessions of SBFT. Future research could advance our understanding of the link between improved caregiver self-directedness and a reduction in the intensity of child focus following a child's participation in SBFT. Investigating, for example the emergence of symptoms among other children in the family would indicate either a continued, intense child focus or a genuine reduction in the intensity of child-focused processes in the family.

Bowen theory suggests that a reduction in chronic anxiety in the wider family system would not be sufficient to sustain an ongoing reduction in child focus. A deliberate effort by caregivers to manage their own reactivity and anxiety about the child is also necessary to facilitate better functioning. However, it is also important to acknowledge that many contextual factors would have impacted how families functioned during and following the child's participation in SBFT. Examples of these circumstances experienced by children's families included the presence of COVID-19 infections in the immediate community, recovery from drought, presence of extensive flooding, the presences of a rodent plague, occurrence of bushfires, and the rising cost of living. The reading audience is invited to consider how these additional variables may have contributed to changes in functioning of families who participated in this study.

CONCLUSION

The process of child focus remained the dominant mechanism for managing acute and chronic stressors within families both prior to and following SBFT. However, outcomes did not infer a relationship between a child's involvement in SBFT and an intensification of child-focused processes within the family. The primary aim of SBFT is to reduce the intensity of child-focused processes operating within child-facilitator interactions during therapeutic play sessions that occur within the school setting. This research suggests that in addition to improvements in children's symptoms, caregivers experienced less worry about the child, a greater sense of hope and confidence, and a greater sense that they could be a resource to their child. These changed family conditions present an opportunity to consider how to engage with the child's caregivers in a way that invites their active collaboration, personal reflection, and observations about relationship processes within the family system. Future research about how to engage collaboratively with caregivers in school-based versions of filial therapy would add value to play therapy literature. Further explorations about family functioning when a child is involved in therapy without their family members would add more depth to the body of family therapy research.

ACKNOWLEDGEMENTS

We thank the dedicated and skilful group of SBFT facilitators at each of the research sites. We also acknowledge Eternity Aid's ongoing support of SBFT in remote and outer regional primary schools, where access to specialist mental health services remains a challenge for members of these communities.



Open access publishing facilitated by Monash University, as part of the Wiley - Monash University agreement via the Council of Australian University Librarians.

ORCID

Jane Cooper  <https://orcid.org/0000-0001-6917-2722>

Linda MacKay  <https://orcid.org/0000-0001-9046-8835>

REFERENCES

- Allan, J., Kleinschafer, J., Saksena, T., Rahman, A., Lawrence, J. & Lock, M. (2022) A comparison of rural Australian first nations and non-first nations survey responses to COVID-19 risks and impacts: implications for health communications. *BMC Public Health*, 22, 1276. Available from: <https://doi.org/10.1186/s12889-022-13643-6>
- Andronico, M.P. & Guerney, B., Jr. (1967) The potential application of filial therapy to the school situation. *Journal of School Psychology*, VI(1), 2–7. Available from: [https://doi.org/10.1016/0022-4405\(67\)90057-X](https://doi.org/10.1016/0022-4405(67)90057-X)
- Arefadib, N. & Moore, T.G. (2017) *Reporting the health and development of children in rural and remote Australia*. The Centre for Community Child Health at the Royal Children's Hospital and the Murdoch Children's Research Institute. <https://www.royalfarwest.org.au/wp-content/uploads/2017/12/Murdoch-Report.pdf>
- Axline, V. (1947) *Play therapy: the inner dynamics of childhood*. Houghton Mifflin.
- Bowen, M. (2013) *The origins of family psychotherapy: the NIMH family study project* (J. Butler, Ed.). Jason Aronson.
- Brannan, A.M., Heflinger, C.A. & Foster, E.M. (2003) The role of caregiver strain and other family variables in determining children's use of mental health services. *Journal of Emotional and Behavioral Disorders*, 11(2), 78–92. Available from: <https://doi.org/10.1177/106342660301100202>
- Briggs, M. & Closs, J.S. (1999) A descriptive study of the use of visual analogue scales and verbal rating scales for the assessment of postoperative pain in orthopedic patients. *Journal of Pain and Symptom Management*, 18(6), 438–446. Available from: [https://doi.org/10.1016/s0885-3924\(99\)00092-5](https://doi.org/10.1016/s0885-3924(99)00092-5)
- Brown, J. (2008) We don't need your help, but will you please fix our children. *Australian and New Zealand Journal of Family Therapy*, 29(2), 61–69. Available from: <https://doi.org/10.1375/anft.29.2.61>
- Brown, J. (2018) Parents' experiences of their adolescent's mental health treatment: helplessness or agency-based hope. *Clinical Child Psychology and Psychiatry*, 23(4), 644–662. Available from: <https://doi.org/10.1177/1359104518778330>
- Brown, J. (2020) The reciprocity between parents and their child's mental health treatment systems. *Family Systems: A Journal of Natural Systems Thinking in Psychiatry and the Sciences*, 14(2), 103–125. Available from: <https://doi.org/10.1002/anzf.1409>
- Cohen, J. (1988) *Statistical power analysis for the behavioral sciences*. Routledge.
- Cooper, J., Brown, T. & Yu, M.-L. (2020) A pilot study of School-Based Filial Therapy (SBFT) with a group of Australian children attending rural primary schools: the impact on academic engagement, school attendance and behaviour. *International Journal of Play*, 9(3), 283–301. Available from: <https://doi.org/10.1080/21594937.2020.1806495>
- Cooper, J. & Oliaro, L. (2019) School-Based Filial Therapy in regional and remote New South Wales, Australia. *International Journal of Play Therapy*, 28(1), 34–43. Available from: <https://doi.org/10.1037/pla0000085>
- Cooper, J., Yu, M.-L. & Brown, T. (2022) Occupational therapy theory and School-Based Filial Therapy: intervention rationale and formulation. *Canadian Journal of Occupational Therapy*, 89(1), 62–71. Available from: <https://doi.org/10.1177/00084174211056588>
- Cooper, J., Yu, M.-L., Brown, T. & MacKay, L. (2022) Exploring facilitator adherence in a School-Based Filial Therapy programme. *International Journal of Play*, 11(2), 145–163. Available from: <https://doi.org/10.1080/21594937.2022.2069349>
- Creswell, J.W. & Plano Clark, V.L. (2011) *Designing and conducting mixed methods research*, 2nd edition. Sage Publications.
- Donley, M. (2003) Unraveling the complexity of child-focus. *Family Systems: A Journal of Natural Systems Thinking in Psychiatry and the Sciences*, 6(2), 147–160.
- Drake, J.R., Murdock, N.L., Marszalek, J.M. & Barber, C.E. (2015) Differentiation of Self Inventory – Short Form: development and preliminary validation. *Contemporary Family Therapy*, 37(2), 101–112. Available from: <https://doi.org/10.1007/s10591-015-9329-7>
- Erlingsson, C. & Brysiewicz, P. (2017) A hands-on guide to doing content analysis. *African Journal of Emergency Medicine*, 7, 93–99. Available from: <https://doi.org/10.1016/j.afjem.2017.08.001>
- Flaskas, C. (2010) Frameworks for practice in the systemic field: part 1. Continuities and transitions in family therapy knowledge. *Australian & New Zealand Journal of Family Therapy*, 31(3), 232–247. Available from: <https://doi.org/10.1375/anft.31.3.232>
- Giles-Kaye, A., Quach, J., Oberklaid, F., O'Connor, M., Darling, S., Dawson, G. et al. (2022) Supporting children's mental health in primary schools: a qualitative exploration of educator perspectives. *The Australian Educational Researcher*, 2022, 1–21. Available from: <https://doi.org/10.1007/s13384-022-00558-9>
- Guernsey, B., Jr. (1964) Filial therapy: description and rationale. *Journal of Counseling Psychology*, 28(4), 304–310. Available from: <https://doi.org/10.1037/h0041340>



- Guernsey, B.G., Jr. & Bach Flumen, A. (1970) Teachers as psychotherapeutic agents for withdrawn children. *Journal of School Psychology*, 8(2), 107–113. Available from: [https://doi.org/10.1016/0022-4405\(70\)90029-4](https://doi.org/10.1016/0022-4405(70)90029-4)
- Guernsey, L. (2000) Filial therapy into the 21st century. *International Journal of Play Therapy*, 9(2), 1–17. Available from: <https://doi.org/10.1037/h0089433>
- Helker, W.P. & Ray, D.C. (2009) Impact of child teacher relationship training on teachers' and aides' use of relationship-building skills and the effects on student classroom behavior. *International Journal of Play Therapy*, 18(2), 70–83. Available from: <https://doi.org/10.1037/a0014456>
- IBM Corp. (2022) *IBM SPSS statistics for windows, version 29.0*. IBM Corp.
- Johnson, J.L., Adkins, D. & Chauvin, S. (2020) A review of the quality of indicators of rigor in qualitative research. *American Journal of Pharmaceutical Research*, 84(1), 138–146. Available from: <https://doi.org/10.5688/ajpe7120>
- Kerr, M.E. (2019) *Bowen theory's secrets: revealing the hidden life of families*. Norton.
- Kerr, M.E. & Bowen, M. (1988) *Family evaluation: the role of the family as an emotional unit that governs individual behavior and development*. W. W. Norton & Company.
- Kleinheksel, A.J., Rockish-Winston, N., Tawfik, H. & Wyatt, T.R. (2020) Demystifying content analysis. *American Journal of Pharmaceutical Education*, 84(1), 127–137. Available from: <https://doi.org/10.5688/ajpe7113>
- Klever, P. (2004) The multigenerational transmission of nuclear family processes and symptoms. *The American Journal of Family Therapy*, 32(4), 337–351. Available from: <https://doi.org/10.1080/01926180490454962>
- Pallant, J. (2016) *SPSS survival manual*, 6th edition. Allen & Unwin.
- Roller, M.R. & Lavrakas, P.J. (2015) *Applied qualitative research design: a total quality framework approach*. Guildford Press.
- Sartore, G.-M., Kelly, B., Stain, H., Albrecht, G. & Higginbotham, N. (2008) Control, uncertainty, and expectations for the future: a qualitative study of the impact of drought on a rural Australian community. *Rural and Remote Health*, 8(3), 950.
- Titleman, P. (2008) *The concept of the triangle in Bowen theory: an overview*. Routledge.

How to cite this article: Cooper, J., Yu, M.-I., MacKay, L. & Brown, T. (2023) Exploring changes in family functioning when a child participates in a School-Based Filial Therapy program. *Australian and New Zealand Journal of Family Therapy*, 00, 1–24. Available from: <https://doi.org/10.1002/anzf.1548>