INTEGRATING DEVELOPMENTAL FACTORS INTO THE THEORETICAL AND EMPIRICAL ADVANCEMENT OF FAMILY-SYSTEMIC PSYCHOTHERAPY WITH CHILDREN

by

AMBER BREWER WILLIS

(Under the Direction of Lynda Henley Walters)

ABSTRACT

Children are among the most powerful members of a family system, yet they are commonly excluded from family therapy. The purpose of this dissertation is to explore the potential for including children in family therapy. This dissertation contains a review of literature and three publishable manuscripts on developmental applications in theory-building and empirical evaluation of psychosocial treatments for children. Although individual child therapy approaches are considered, greater emphasis is placed on family-systemic therapies for child-focused problems. The first manuscript provides a review of the empirical status of trauma treatments for children in the birth-to-six age range. Treatments were grouped into 4 categories of empirical support (i.e., I: well-established; II: probably efficacious; III: possibly efficacious; IV: untested), based on a classification scheme informed by recommendations from the Division 12 Task Force on Psychosocial Interventions (Chambless et al., 1996; Chambless & Hollon, 1998). Child Parent Psychotherapy (CPP) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) were the only two models in this review to meet criteria for well-established treatments.
with trauma-exposed young children. In the second manuscript, a theoretical evaluation is presented of an attachment-based family therapy model (i.e., Emotionally Focused Family Therapy: EFFT) recently recommended for use with young children. Suggestions are offered for integrating play therapy activities and developmental considerations within an EFFT framework throughout the course of treatment. The third manuscript comprises a report of an observational study on family play therapy techniques, child participation, and a variety of outcomes in family therapy sessions with children ages 4 to 12. Study findings revealed that increased use of play-based techniques was associated with longer child talk times as well as more positive reports of the child-therapist relationship and participants’ overall emotional experience in session. Conclusions and recommendations for future research are provided at the end of this work.

INDEX WORDS: Family Therapy, Play Therapy, Children, Development, Emotionally Focused Therapy, Trauma, Posttraumatic Stress
INTEGRATING DEVELOPMENTAL FACTORS INTO THE THEORETICAL
AND EMPIRICAL ADVANCEMENT OF FAMILY-SYSTEMIC
PSYCHOTHERAPY WITH CHILDREN

by

AMBER BREWER WILLIS
B.S., Brigham Young University, 2001
M.S., Brigham Young University, 2004

A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial
Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

2012
INTEGRATING DEVELOPMENTAL FACTORS INTO THE THEORETICAL AND EMPIRICAL ADVANCEMENT OF FAMILY-SYSTEMIC PSYCHOTHERAPY WITH CHILDREN

by

AMBER BREWER WILLIS

Major Professor: Lynda Henley Walters
Committee: Maria Bermudez
David Wright

Electronic Version Approved:
Maureen Grasso
Dean of the Graduate School
The University of Georgia
December 2012
DEDICATION

This dissertation is for all the “kiddos” I have worked with and with whom I will have the privilege of working in therapy. May this journey lead us all to a better place.
ACKNOWLEDGMENTS

I would like to express my sincere and deep appreciation for the many individuals who have helped make this work possible. First, I would like to thank Lynda Walters, my major professor, for discerning the potential of my ideas and for assisting me in seeing those ideas to fruition. Lynda, your intelligence, optimism, compassion, and commitment to advancing the child development field have inspired me in both my personal and professional life. I would like to acknowledge the other members of my committee, Maria Bermudez and David Wright, and all the professors at The University of Georgia who helped me navigate the clinical and academic challenges of the doctoral program. I am also grateful for research funding provided by The University of Georgia Dissertation Completion Award and a grant from the Georgia Chapter of the Association for Play Therapy. To my husband, I would like to say thank you for devotedly supporting me throughout this venture (and doing most of the shopping and cooking while I finished my dissertation). To my family and friends, thank you for showing me what it means to know the joy of feeling loved and having a secure base (or safe haven) from which I can spread my wings and explore the world.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
</tr>
<tr>
<td>CHAPTER</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>Literature Review</td>
</tr>
<tr>
<td>References</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>Abstract</td>
</tr>
<tr>
<td>Introduction</td>
</tr>
<tr>
<td>Method</td>
</tr>
<tr>
<td>Results</td>
</tr>
<tr>
<td>Discussion</td>
</tr>
<tr>
<td>References</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>Abstract</td>
</tr>
</tbody>
</table>
The Exclusion of Children from Family Therapy......................75
Rationale for Integrating Play Therapy into Family Therapy........76
Child Development and Application Knowledge is Missing .........77
Using an Attachment Perspective to Reframe and Treat Child Problems .77
Purpose of this Article ..........................................................79
Emotionally Focused Therapy (EFT) for Couples.......................80
Emotionally Focused Family Therapy (EFFT).............................82
Developmental Factors in EFFT with Young Children................84
Integrating Play Therapy Activities into EFFT .........................87
Conclusion .............................................................................106
References .............................................................................107

4 ASSESSING THERAPEUTIC ACTIVITIES, CHILD TALK, AND SESSION OUTCOME IN FAMILY THERAPY WITH CHILDREN ..........116
Abstract .................................................................................117
Introduction ............................................................................118
Methods ..................................................................................121
Results .....................................................................................140
Discussion ..............................................................................147
Conclusion .............................................................................152
References .............................................................................154

5 CONCLUSIONS .....................................................................172
References .............................................................................184
LIST OF TABLES

Table 2.1: Categorical Criteria Used to Evaluate Empirical Support for Treatment Models
........................................................................................................................................... 70

Table 2.2: Type-1 and Type-2 Studies for Treatments Tested with Samples of Trauma-Exposed Young Children (Mean Ages 0 to 6) .......................................................... 71

Table 2.3: Categorization of Empirical Support for Treatments Tested with Samples of Trauma-Exposed Young Children (Mean Ages 0 to 6) ............................................. 72

Table 4.1: Time Spent in Therapy Talk Categories .................................................................. 161

Table 4.2: Family Therapy Techniques .................................................................................... 162

Table 4.3: Range, Means, Standard Deviations of Target Variables ..................................... 163

Table 4.4: Inter-correlations Among Variables in Hierarchical Multiple Regression Analysis ........................................................................................................................................ 164

Table 4.5: Target Child’s Talk Time Across Levels of Binary-Coded Variables In Hierarchical Multiple Regression Analysis ................................................................. 165

Table 4.6: Hierarchical Multiple Regression Summary ............................................................ 166

Table 4.7: Bivariate Inter-correlations Among Variables in Canonical Correlation Analysis .................................................................................................................................... 167

Table 4.8: Canonical Correlation Analysis of Therapy Process (Independent) Variables with Parent/Therapist-Reported Session Outcome (Dependent) Variables... 168
Table 4.9: Redundancy Analysis of Dependent and Independent Variates for Both Canonical Functions.................................................................169

Table 4.10: Sensitivity Analysis of Canonical Correlation Results to Removal of an Independent Variable from the First Canonical Function.........................170

Table 4.11: Bivariate Correlations of Process Variables with Child-Reported Outcome Variables ........................................................................................................171
CHAPTER 1
INTRODUCTION AND LITERATURE REVIEW

Developmental factors are often overlooked in youth psychotherapy literature (Holmbeck, Devine, & Bruno, 2010; Weisz & Hawley, 2002). This dissertation was designed to help fill gaps in clinical literature by demonstrating how development theory and research may be used to advance mental health services for children. To achieve this purpose, the dissertation includes a literature review and three publishable manuscripts addressing several developmental issues within the practice and evaluation of child-focused therapy models. In the review of literature, an argument is made for the need to incorporate developmental considerations more extensively in academic publications pertaining to the psychological treatment of children. A brief summary of the history of play therapy and family play therapy is offered as background for the questions guiding the composition of the manuscripts contained in this dissertation.

Following the literature review, the three manuscripts are presented in chapters 2 through 4. The first manuscript (chapter 2), is a review of the effectiveness of interventions with trauma-exposed children who are aged 6 or younger. Clinical models in the review are sorted into 4 levels of increasing empirical support, ranging from “untested” to “well-established,” using a categorical scheme informed by recommendations from the Division 12 Task Force on Psychosocial Interventions’ reports (Chambless, Sanderson, Shoham, Johnson, Pope, Crits-Chrisoph, et al., 1996). The second manuscript (chapter 3) includes a theoretical evaluation of Emotionally
Focused Family Therapy (EFFT), which is a family therapy approach adapted from the theoretical framework of an adult couples’ therapy model (Emotionally Focused Therapy: EFT). The strengths and weaknesses of using the current EFFT model with children is presented along with recommendations for tailoring the approach to meet the developmental needs of children ages 3 through 6. The third manuscript (chapter 4) contains the report of an observational study exploring the impact of play-based therapy techniques on child participation and other outcomes in family therapy sessions with children. At the end of this work (chapter 5), conclusions and implications for including children in family therapy are discussed. Recommendations for future research on children in family therapy are made.

**Literature Review**

Although the need for accommodating the developmental needs of children in therapy is recognized, a thorough explication of how to do this is missing from most child therapy publications (Holmbeck et al., 2010). Many of the psychotherapeutic methods used with children and adolescents were not originally created with children or youth in mind (Weisz & Hawley, 2002). Instead, therapy approaches for children often involve adaptations of adult therapy models, such as cognitive-behavioral therapy (Barrett, 2000). Furthermore, clinical authors tend to describe treatments in a “one-size-fits-all” manner respective to children’s developmental status by providing insufficient guidelines for catering the approach to children in different developmental groups (Shirk, 1999; Silverman & Ollendick, 1999).

Holmbeck and colleagues (2010) noted that clear consideration of developmental factors is too often absent from the discussion of results in outcome studies on child
therapy interventions. For example, child age (as a proxy for developmental status) is seldom tested as a mediator or moderator of treatment outcome, even when researchers include children from a range of development groups for the same study (e.g., Becker-Weidman, 2006; Berliner & Saunders, 1996; Ellis, Fogler, Hansen, Forbes, Navalta, & Saxe, 2011; Hyde, Bentovim, & Monck, 1995; King, Tonge, Mullen, Myerson, Heyne, & Rollings et al., 2000). Because developmental variables are usually excluded from child and adolescent therapy research, there is little empirical data on the effectiveness of those models when used with children at different developmental stages.

Disregarding developmental issues in children’s mental health therapy may lead to a weakening of treatment effects (Holmbeck et al., 2010) or an exacerbation of the original problem. Whereas a preschooler and an adolescent can exhibit similar psychological symptoms, such as depression, anxiety, or conduct problems, their treatment will likely be dissimilar due to differences in their developmental capabilities. For instance, young children do not have the same cognitive capacity as older children (age 10+) or adolescents to engage in social perspective-taking, hypothetical thought, or meta-cognitive mental processes (Flavell, 2004; Flavell, Green, & Flavell, 1995; Piaget, 1952). Also, younger children have shorter attention spans and are less adept at verbal self-expression (Gil, 1994; Dunn, Bretherton, & Munn, 1987; Malchiodi, 1998; Woodward & Markman, 1998) which presents a problem for the use of predominantly talk-based therapies. Some components of cognitive therapy approaches often used with adolescents and adults (Holmbeck, O’Mahar, Abad, Colder, & Updergrove, 2006) may be too advanced for very young, preschool- and school-aged children (Bierman, Nix, Greenberg, Blair, & Domitrovich, 2008; Grave & Blissett, 2004; Shirk, 2001). On the
other hand, some authors have suggested that cognitive-behavioral approaches can be used effectively with children when certain accommodations are made, such as by blending play therapy techniques or play-based strategies into treatment (Drewes, 2009).

**Play Therapy**

Play therapy techniques have long been recommended as a developmentally-sensitive approach to treating children’s psychological and interpersonal problems, and are widely practiced by child therapists (Bratton, Ray, Rhine, & Jones, 2005; Landreth, 2002; Schaefer, 1993; Sori, 2006; VanFleet, 2005). Play is a developmentally normative process for children, which serves such functions as helping them work off frustration or relieve tension, express their feelings, learn social perspective-taking through make-believe play, and practice their competencies (e.g., focusing attention, recognizing sequences in behaviors, etc.) in a relaxed environment (Santrock, 2007). In play therapy, toys and play materials are used to help children directly or symbolically express their thoughts, feelings, and phenomenological experiences that they would otherwise be unable to articulate due to their developmental limitations (Bratton et al., 2005; Landreth, 2002). Playful therapy techniques can be used to aid children with communication, emotional regulation, relationship enhancement, moral judgment, stress management, self-esteem, self-actualization, and development of life-skills (Schaefer & Drewes, 2011).

The origins of play therapy date back to the early 1900s; it initially arose out of psychoanalytic, Rogerian, and Jungian theories which were designed to be implemented in individual child therapy settings (Axline, 1947; Freud, 1946; Lowenfeld, 1939). Over time, however, the techniques were applied within an assortment of other clinical and theoretical frameworks (Kottman, 1995; Landreth, 2002; Oaklander, 1994; O’Connor,
For example, Bernard and Louise Guerney developed Filial Therapy in the early 1960s (Guerney, 1964; Guerney & Guerney, 1989). Theirs was the first attempt to incorporate traditional play therapy techniques within the context of a systemic parent-child relational model. In the Guerneys’ approach, parents were trained as paraprofessionals to conduct play therapy sessions with their children because there was a shortage of trained therapists who could provide child-related mental health services. Other dyadic therapy models, such as Theraplay (Jernberg & Booth, 2001), Parent-Child Interaction Therapy (PCIT: Eyberg, 1988), and Child Parent Psychotherapy (CPP: Lieberman & VanHorn, 2008) have since been developed to treat children’s psychological problems through improving the security of the parent-child attachment relationship and parents’ child discipline skills during play-based activities with the child.

Reviews of play therapy thus far have been positive and have revealed evidence that play therapy is an effective form of practice (Baggerly, 2009; Bratton et al., 2005; LeBlanc & Ritchie, 2001; Ray & Bratton, 2010). Average effect sizes (Cohen’s d) for play therapy in these reviews ranged from .66 to .80, meaning that children who received play therapy interventions generally performed about three-quarters of a standard deviation better on treatment outcome measures in comparison with children who did not receive play therapy treatment. The strongest effect sizes for play therapy outcome have been demonstrated when parents are included in the child’s treatment (Bratton et al., 2005; LeBlanc & Ritchie, 2001). LeBlanc and Ritchie (2001) found that including parents as therapists (or, paraprofessionals), such as in Filial Therapy or PCIT, significantly differed from other play therapy interventions ($p = .04$), and was associated with an effect size increase of .33 standard deviations above the average effect size of all
the other (individually-oriented) play therapy interventions, combined. Research findings provide strong support that dyadic play-based therapy approaches, like Filial Therapy, can be used to improve outcomes such as children’s problematic internalizing and externalizing behaviors in addition to the parent-child relationship (VanFleet, Ryan, & Smith, 2005).

Whether play therapy or non-play therapy approaches are more effective with youth in mental health treatment remains a subject of controversy (Bratton et al., 2005; Casey & Berman, 1985; Weisz, Weiss, Han, Granger, & Morton, 1995). Overall mean effect sizes from child psychotherapy reviews composed primarily of non-play modalities (e.g., behavioral, cognitive-behavioral therapy) have ranged from .71 to .84 (Casey & Berman, 1985; Kazdin et al., 1990; Weisz et al, 1995; Weisz, Weiss, Alicke, & Klots, 1987), suggesting the general effectiveness of play therapy is similar to non-play methods. However, Weisz et al. (1995) commented that results support the specificity of treatment effects based on particular problems, youth populations, and treatment settings. Congruent with this, LeBlanc and Ritchie (2001) theorized that play therapy is more appropriate for children who cannot participate well in talk-therapy.

Over the past 20 to 30 years, there has been an increase in literature on recommendations for applying play therapy techniques with whole families (Bailey, 2000; Botkin, 2000; Lund, Zimmerman, & Haddock, 2002; Sori, 2006; Wittenborn, Faber, Harvey, & Thomas, 2006; Zilbach, 1986). It has been suggested that play-based strategies can help to engage children and to make family therapy more child-friendly (Gil, 1994). Currently, these suggestions are still in the early stages of development and have not been presented as a comprehensive treatment approach to address family or
individual child problems (Sori & Sprenkle, 2004). Much work remains to be done before integrated family and play therapy approaches can be established as standard treatments.

No empirical studies were found in this review regarding the effectiveness of play therapy techniques with entire families. This is likely the result of a lack of empirical research regarding therapists’ practices with children in family therapy (Ruble, 1999). Only a handful of studies were found on this subject and they were written between 12 and 30 years ago (Cederborg, 1997; Greenwood, 1985; Johnson & Thomas, 1999; Korner & Brown, 1990; Postner et al., 1971; Setchel, 1981; Snow & Paternite, 1986). All but two of these studies (Cederborg, 1997; Postner et al., 1971) were based on survey data rather than observational research. Therefore, our understanding of what therapists do with children in family therapy sessions is very limited, and it is grounded mostly on what therapists say they do rather than observation of what they actually do.

The majority of empirical literature on therapists’ practices with children in family therapy addresses factors influencing therapists’ decisions to include or exclude children from treatment (Greenwood, 1985; Johnson & Thomas, 1999; Korner & Brown, 1990, Setchel, 1981). Only one study was found that included questions about techniques therapists use when they invite children to family sessions (Snow & Paternite, 1986). The most common responses were a combination of activity-oriented interventions, behavioral contracting, and task assignments.

In one of the few observational studies on children in family therapy, researchers conducted a time-/word-space analysis of children’s talk patterns in family sessions (Cederborg, 1997). They found that children were often treated as “nonpersons” in
family sessions and relegated to the side of the room to play as passive participants while the therapist spoke with the parents. In an earlier study, Postner et al. (1971) found that therapists spoke significantly more with parents than children in family therapy. It appears therefore that, when observation is used to analyze family therapists’ practices with children, it portrays a bleak picture where children are sitting on the sidelines, excluded from much of the therapy discourse. However, it is hard to know what contemporary family therapists’ practices are with children because much of the research we have on this topic was conducted 15 or more years ago.

A small number of studies have been conducted on children’s views of their experiences in family therapy (Lobatto, 2002; Stith, Rosen, McCollum, Coleman, & Herman, 1996; Strickland-Clark, Campbell, & Dallos, 2000). From these studies, it is apparent that children prefer and enjoy it when therapists use an activity-oriented approach. In the study by Strickland-Clark et al. (2000), children reported the desire to be included, accepted, and listened to in session. They indicated it was sometimes hard to express themselves verbally when upset in session and this sometimes led them to feel misunderstood and unheard. The need for support in helping children engage in self-expression in a non-shaming environment was emphasized. These findings support the potential value of utilizing play therapy interventions in family therapy sessions because play-based techniques are designed to actively engage children and help them communicate their thoughts and feelings in a developmentally-sensitive manner (Gil, 1994; Lund et al., 2002; Schaefer & Drewes, 2011).
Barriers to the use of play therapy in family-systemic practice

As a group, play therapists tend to be more open than marriage and family therapists (MFTs) to learning about and using play therapy techniques with families (Haslam & Harris, 2011). This may be the result of several factors. MFTs have repeatedly been criticized for excluding children from family therapy sessions (Cox, 1997; Diller, 1991; Sori, 2006; Zilbach, 1989). The family therapy models in which MFTs are typically trained are usually developed for couples, adolescents, or preadolescents; consequently, they are developmentally inappropriate for engaging young children (Gil, 1994). In addition, MFTs often report feeling insufficiently instructed and supervised in developmental applications and clinical techniques for working with children (Raimondi & Walters, 2004; Ruble, 1999; Sori, & Sprenkle, 2004; White & Chasin, 2006). As a result, MFTs are apt to be under-equipped and insecure in their abilities to be productive with children in therapy (Korner & Brown, 1990).

Another barrier inhibiting greater inclusion of children in family therapy is a paradigm split between many individual child/play therapists and family therapists wherein child-focused work is viewed as the realm of child- or play therapists rather than family therapists (Haslam & Harris, 2011). Play therapists tend to view family therapists as under-estimating the intrapsychic conflicts of children whereas family therapists tend to view child therapists as over-pathologizing child clients. Such a belief-system could contribute to feelings among family therapists that young children do not need to be involved in family therapy, whereas play therapists may be more motivated to focus their efforts with the child in individual treatment. Reflecting these attitudes, the majority of MFTs and family therapy program directors in a recent large-scale survey study reported
feeling that training in child/play therapy or family play therapy was not relevant to their practice (Raimondi & Walters, 2004).

A surprise

The most surprising aspect of the general disregard toward children in family therapy is that many of the founding developers of family therapy assumed children would be included. For example, Nathan Ackerman (1970), Carl Whitaker (Keith & Whitaker, 1981), Virginia Satir (1972), and Salvador Minuchin (1974), strongly advocated for active involvement of children in family sessions. Keith and Whitaker (1981, p. 244) wrote, “We find again and again that families change less and more slowly when children are not part of the therapy process.” Including children in family sessions allows the whole family to share in the problem and its solution. Supporting this perspective is the fact that treatments for children’s problems that show some of the strongest effect sizes occur when other family members are included (Bratton et al., 2005; LeBlanc & Ritchie, 2001). It therefore seems strange that family therapists, who have such a potentially useful tool for helping troubled children by harnessing the support of their entire family, would not take more advantage of this opportunity.

Questions

Several questions regarding developmental issues and children’s psychotherapeutic treatment have informed the work of this dissertation. These questions are as follows:

1. Are therapists today working with children in family therapy? If so, what theories and techniques are therapists currently using to address child-related issues in family therapy sessions?
2. Is there any evidence to support that play-based techniques are more effective than solely talk-based therapies with children in family therapy sessions?

3. How can one integrate development theory and play therapy interventions within a model of family therapy to address the inclusion of children in family therapy as well as child-focused problems throughout the course of treatment?

4. In what ways can child therapy outcome research be presented so that empirical results may be interpreted with greater consideration of developmental factors? How do the answers to the above questions inform future directions for research and academic investigation?

The remainder of this dissertation will constitute the author’s efforts to begin answering these questions. Findings from this dissertation are hoped to provide insight regarding active application of developmental principles to theoretical understanding and empirical assessment of child psychotherapy practices.
References


Botkin, D. R. (2000). Family play therapy: A creative approach to including young


Policy. Advance online publication. doi: 10.1037/a0025192.


CHAPTER 2

REVIEW OF EMPIRICAL SUPPORT FOR PSYCHOTHERAPY INTERVENTIONS
WITH YOUNG CHILDREN EXPOSED TO TRAUMA

1 Willis, A. B. To be submitted to the Journal of Clinical Child and Adolescent Psychology.
Abstract

Concern in the field of child psychology and psychiatry is growing regarding the paucity of research, public policies, and development of clinical programs for very young children with posttraumatic stress. Children in the birth-to-five age range are at disproportionately higher risk of trauma-exposure than older children; yet, they are greatly under-represented in trauma literature. This article contains the first systematic review of outcome studies on psychotherapy interventions for infants and preschoolers who have experienced a potentially traumatic event. In this review, only studies of treatments tested with samples of young children, mean aged 0 to 6, are included. Treatment outcome studies are classified according to their level of methodological rigor using a scheme developed by Nathan and Gorman (2007). Clinical models for which there is empirical evidence with traumatized or maltreated young children are separated into four categories (I: well-established; II: probably efficacious; III: possibly efficacious; IV: untested) proposed by Silverman et al. (2008) based on recommendations from the Division 12 Task Force on Psychosocial Interventions (Chambless, Sanderson, Shoham, Johnson, Pope, & Crits-Christoph et al., 1996) and other work by Chambless and colleagues (Chambless & Hollon, 1998). Recommendations for future research are provided.
Introduction

Childhood trauma represents an urgent public health concern and is perhaps one of the most significant challenges faced by social service providers today. Early complex trauma can lead children to develop significant troubles with attachment, interpersonal skills, affect regulation, dissociation, behavioral control, cognitive processing, and self-concept (Cook, Spinazzola, Ford, Lanktree, Baustein, Coitre, et al., 2005). Children with repeated maltreatment or exposure to adverse stressors are also at significantly higher risk of ongoing academic difficulties, alcoholism, drug abuse, depression, suicide, and medical problems such as heart disease, stroke, cancer, and diabetes later in life (Lieberman, Chu, Van Horn, & Harris, 2011; Shonk & Cicchetti, 2001). Moreover, depression experienced by abused children has been found to commence earlier, last longer, and be more difficult to treat with traditional therapeutic methods than depression experienced by a person who was not traumatized in childhood (Zlotnick, Ryan, Miller, & Keitner, 1995).

Although there are many reviews on psychosocial interventions for traumatized youth (Chaffin & Friedrich, 2004; Cohen, Mannarino, Murray & Igleman, 2006; Kowalik, Weller, Venter, & Drachman, 2011; Putnam, 2003; Saunders, Berliner, & Hanson, 2004; Silverman, Ortiz, & Viswesvaran, 2008; Skowron & Reinemann, 2005; Stallard, 2006; Taylor & Chemtob, 2004; Vickerman & Margolin, 2007; Wethington, Hahn, Fuqua-Whitley, Sipe, Crosby, Johnson, et al., 2008), most of the children included for research have either been in elementary school or adolescents. Therefore, ongoing appraisal of interventions for posttraumatic stress is still needed as there are few
treatment effectiveness studies for young children (De Young, Kenardy, & Cobbam, 2011; Lieberman et al., 2011; Scheeringa, Zeanah, Myers, & Putnam, 2005).

On rare occasions when children younger than 6 are included in trauma treatment studies, they are usually grouped with school-aged children and adolescents (e.g., Becker-Weidman, 2006; Berliner & Saunders, 1996; Ellis, Fogler, Hansen, Forbes, Navalta, & Saxe, 2011; Hyde, Bentovim, & Monck, 1995; King, Tonge, Mullen, Myerson, Heyne, & Rollings et al., 2000; Westat, Inc., Chapin Hall Center, & James Bell Associates, 2002). As well, implications regarding the effect of or the effect on development are rarely included in a discussion of results (Holmbeck, Devine, & Bruno, 2010). Thus, there is minimal information regarding whether there are differential treatment effects in trauma-focused interventions with children who are at different points along a developmental trajectory. This draws into question whether: (a) some treatment approaches are appropriate for all the ages for which they have been recommended and (b) what accommodations might make an approach more appropriate and more effective for children whose needs are quite different because of developmental status.

Certain liabilities are associated with ignoring developmental factors in psychotherapy with children. Even though a clinical approach may show efficacy across age-groups, specific techniques will likely need to be applied differently to accommodate children’s developmental capabilities. Limitations in the development of neurological functioning, for example, may reduce a child’s capacity to engage in certain cognitive therapy techniques (e.g., those that require meta-cognitive thinking, social perspective-taking, or introspection; Flavell, Mumme, Green, & Flavell, 1992; Flavell, 2004) used
successfully with adults and adolescents to reduce trauma symptoms (Calhoun & Resick, 2001). Very young children also have short attention spans and limited verbal skills (Santrock, 2007; Woodward & Markman, 1998) which can present an obstacle to traditional talk-based therapies. Due to similar concerns, Holmbeck, and colleagues (2010) warned that inadequate consideration of developmental factors in children’s therapy may result in weaker treatment effects. Because children are likely to try to make sense of treatment experiences that are inappropriate for them, one might wonder whether developmentally inappropriate treatment could exacerbate the problems that are being “treated.”

Relatively little initiative has been displayed in the mental health field toward furthering programs designed to address the psychological repercussions of early child maltreatment and traumatization with young children (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). Toddlers and preschoolers have been excluded from trauma-related public policy initiatives and large-scale, post-disaster programs offered to children in elementary school due to the perception among some policy makers that there are no protocols for very young children (Scheeringa et al., 2011). The gap in our understanding of trauma for young children is alarming as, compared with older children, they are disproportionately exposed to traumatic incidents and are at the highest risk of maltreatment (De Young et al., 2011; Lieberman et al., 2011).

The purpose of this article is to identify developmentally-appropriate treatments for trauma-exposed young children. To accomplish this goal, the article contains a review of outcome studies on psychotherapy interventions for children (ages 0 to 6) who have experienced a potentially traumatic event. This is the first review of trauma
treatments for children that is focused on a specific, age-defined development group rather than on “children” in general. It is hoped this article will advance the awareness of service providers and clinical researchers about developmentally-sensitive interventions for young children suffering from posttraumatic stress. When interventions are developmentally appropriate, it not only increases the likelihood young clients will receive the most effective treatment, it may also reduce long-term health care costs associated with later re-entry into the clinical system.

**Method**

Studies of children’s psychological treatments for posttraumatic stress were accessed through an online search of PILOTS, PsychINFO, MEDLINE, and ERIC databases using the following key words in different combinations: infant, preschooler, child, abuse, maltreatment, trauma, posttraumatic stress, PTSD, intervention, therapy, effectiveness, study, trial, and review. Reference sections from articles identified during the online search were examined in order to track relevant reviews and additional outcome studies that matched inclusion criteria. Developers of the reviewed models were also contacted for recent training materials related to their models, especially any information regarding suggested adaptations for young children. The review was completed in August, 2012.

**Inclusion Criteria**

To be included for review, studies met the following criteria: (a) the majority (or mean age) of the child participants were age 6 or younger; (b) child participants experienced a potentially traumatic event (e.g., exposure to domestic violence, abuse, neglect, war, natural disasters, traumatic bereavement, or removal of primary caregiver);
(c) the treatment was designed to improve the child’s mental health symptoms, behaviors, developmental status, or interpersonal relationships and this was reflected in the use of at least one child-focused outcome measure; and (d) interventions were geared toward treating either the direct effects of trauma, (i.e., PTSD symptoms) or comorbid issues commonly associated with childhood trauma or maltreatment, such as mood or anxiety symptoms, conduct problems, or dysfunctional family dynamics (i.e., negative parenting practices, re-occurrence of abuse, or family conflict) which could theoretically exacerbate or maintain trauma symptoms in the child. Because the focus of this review was on the treatment of children who have actually experienced a potentially traumatic event, studies on abuse-prevention techniques or that involved high-risk families were omitted. Also, because direct therapeutic involvement of the child was considered a priority, studies in which the parents comprised the sole point of intervention were excluded.

**Classification of Empirical Support**

The level of empirical support for clinical models was determined using a categorical scheme proposed by Silverman, Ortiz, and Viswesvaran (2008), which was based on recommendations from the Division 12 Task Force on Psychosocial Interventions (Chambless, Sanderson, Shoham, Johnson, Pope, & Crits-Christoph et al., 1996) and other work by Chambless and colleagues (Chambless & Hollon, 1998). The scheme included four categories: I-well-established; II-probably efficacious; III-possibly efficacious; and IV-experimental\(^2\) (see Table 2.1 for criteria). Silverman et al. (2008) used these categories in a review of trauma interventions for children and

---

\(^2\) Because the word *experimental* is a common label for a very desirable research design for outcome research, the word *untested* will be used to identify category IV studies.
adolescents without regard for developmental status of children. In the present article, I used the scheme to classify only treatments tested with children, ages 0 to 6.

Because young children are the focus of this review, a comprehensive review of youth trauma interventions is beyond the scope of this work. Readers may wish to refer to more general reviews (e.g., Cohen et al., 2006; Silverman et al., 2008; Margolin & Vickerman, 2011; Taylor & Chemtob, 2004; Wethington et al., 2008) for a broader representation of the empirical literature on psychosocial treatments for children and adolescents with posttraumatic stress.

Evaluation of Methodological Rigor

Robustness of method was evaluated using the standards proposed by Silverman et al. (2008) who divided outcome studies into 4 types according to the level of demonstrated methodological rigor (type 1 = most rigorous; type 4 = least rigorous). Nathan and Gorman (2007) had developed a similar strategy for categorizing studies of clinical intervention with children. Combining the suggestions in both articles, I categorized studies into the following groups:

1. Prospective clinical trials or comparison group studies that had random assignment, blind assessments, explicit inclusion and exclusion criteria, state-of-the-art diagnostic methods, adequate sample size for statistical power, and clearly defined statistical methods.

2. Clinical trials where at least one of the type-1 traits was missing (e.g., no randomized assignment, assessments were not blind) or there was an obvious but minor research design flaw.
3. Studies with more substantial methodological limitations, such as open treatment studies aimed at accumulating pilot data or case control studies with retrospective information.

4. Reviews with sophisticated secondary data analysis, reviews without secondary data analysis, and opinion papers, essays, or case studies without retrospective data.

Due to space limitations in this article, only studies in the first two categories will be described in detail as they are the most robust and present the strongest support for empirical validation. Brief references to studies in categories 3 and 4 will be provided so there is documentation of their contribution to the literature. However, it is recognized that findings from such studies are only suggestive but might merit further examination.

**Calculating Effect Sizes**

Cohen’s *d* was used to represent treatment effect sizes in this review. If it was not already provided by study authors, the effect size (*d*) was obtained by calculating the difference between the group means (M₁ – M₂) divided by the pooled standard deviation (Cohen, 1988). When the means or standard deviations were not provided in the study, the effect size was converted from *F*- or *t*-values (Rosenthal & Rosnow, 1991; Rosnow & Rosenthal, 1996).

**Results**

A total of 164 articles on evaluations of psychological trauma interventions for children and adolescents, regardless of age, were identified from the literature search. Of these, 24 met inclusion criteria and were accepted for review. These articles are displayed in Table 2.2. Only 11 of the included articles comprised studies that could be
classified into categories 1 or 2. Characteristics of these more rigorous studies are listed in Table 2.3. The remaining evaluations consisted of five type 3 studies and eight type 4 studies.

Accepted articles included appraisals of the following treatments: Attachment-Focused Home-Visiting Intervention, Child Centered Play Therapy, Childhaven Therapeutic Daycare Program, Child-Parent Psychotherapy, Cognitive Developmental Day Treatment Program, Eye Movement Desensitization and Reprocessing, Parent-Child Interaction Therapy, Resilient Peer Training, Theraplay-Based Preschool Program, and Trauma-Focused Cognitive-Behavioral Therapy. The categorization of empirical support for these treatment models is shown in Table 2.2. Treatment components and research for clinical models in each category (I through IV) of empirical support will hereafter be presented.

**Category I (Well Established) Models for Traumatized Young Children**

**Child-Parent Psychotherapy (CPP)**

*Treatment components.* CPP was developed by Lieberman, Van Horn, and colleagues (Lieberman & Van Horn, 2008) to treat PTSD and other mental health issues in children from infancy up to age 6. The model consists of an integrated, attachment- and psychoanalytic-based approach unifying three age-specific, theoretically congruent treatment modalities: “Infant-Parent Psychotherapy” (Frailberg, 1980; Lieberman, Silverman, & Pawl, 2000), “Toddler-Parent Psychotherapy” (Cicchetti, Toth, Rogosch, 1999; Lieberman, 1992) and “Preschooler-Parent Psychotherapy” (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). In CPP, children’s unstructured play is used during dyadic parent-child sessions to elicit spontaneous interactions between the clients that
serve as “ports of entry” for clinical interventions (Lieberman & Van Horn, 2008, p. 77). The therapist acts as a translator between the parent and child, telling the parent what she believes the child is thinking or feeling and using simple language with the child to reframe many of the parent’s behaviors as having benevolent intentions toward the child. The therapist models appropriate child management skills and works to help parents understand how their early childhood experiences and sense of self may be connected to their attitudes toward the child and their methods of disciplining the child. Some gradual exposure and affect regulation techniques are included to address children’s trauma-related issues.

**Empirical support for treatment of trauma-exposed young children.** CPP was first tested with abused and neglected young children and their mothers in a randomized control study in which Preschooler-Parent Psychotherapy (PPP) was compared with an ecological-behavioral model (Psychoeducational Home Visitation: PHV) and community standard (CS) services; the outcome of interest was children’s maladaptive mental representations of themselves and their caregivers (Toth et al., 2002). One hundred twenty-two mother-child dyads (Child mean age = 48.18 months; SD = 6.88) participated in this study. Eighty-seven of the preschoolers had a maltreatment history and were referred to the study by the Department of Social Services (DSS); 35 of the preschoolers had not been maltreated and were recruited through a list of low-income families receiving temporary financial assistance from the state. Maltreated preschoolers and their mothers were randomly assigned to one of the three treatment conditions: (a) PPP (n = 23), (b) PHV (n = 34), or (c) CS (n = 30) for about 10 to 12 months. The 35 children
who had not experienced abuse or neglect comprised the nonmaltreated comparison (NC) group, and received no intervention or mental health services.

Mother and child dyads in the PPP group attended 60-minute conjoint (parent-child) sessions, weekly, with their therapist. PHV mothers received psychoeducation on cognitive-behavioral techniques (e.g., self-care, child management skills) and factors that promote or reduce risk of abuse. Their children were enrolled in full-day preschool and taught school readiness and adaptive peer relationships. Families in the CS group participated in community services (e.g., individual or family therapy). A narrative story-stem task was administered to assess mental representations of all of the children.

From pre- to post-treatment, children in the PPP group demonstrated a significant decline in maladaptive maternal representations, $t(22) = 4.05, p < .001, d = .92$, whereas the PHV group showed only marginally significant reductions, $t(33) = 1.85, p < .079, d = .40$. No significant changes were found in the maladaptive maternal representations of children in the CS or NC groups. Negative self-representation scores for children in the PPP condition also significantly declined over treatment, $t(22) = 3.86, p < .001, d = .86$, but children in the PHV, CS, and NC groups showed no significant improvements in this area. Children’s positive expectations for the mother-child relationship significantly increased in all groups, PHV: $t(33) = 2.96, p < .01, d = .54$; CS: $t(29) = 3.20, p < .01, d = .78$; NC: $t(34) = 1.96, p = .058, d = .43$; however, the biggest increase was found in the PPP group, $t(22) = 6.46, p < .001, d = 1.56$. PTSD symptoms were not measured in this study so it cannot be ascertained whether the treatments altered children’s trauma status. Nonetheless, children’s negative schemas have been associated with the development of multiple mental health problems (e.g., disorganized attachment, externalizing or
internalizing issues); thus, findings from this study support the possibility that CPP can play an important role in decreasing risk factors associated with abused children’s mental and emotional well-being.

Lieberman, Van Horn, and Ghosh Ippen (2005) conducted a second evaluation of Child-Parent Psychotherapy using a sample of 75 domestic violence-exposed children and their abused mothers. The children were 3 to 5 ($M = 4.06$, $SD = .82$) years in age and many were victims of multiple traumas. Participants were randomly assigned either to CPP treatment or a comparison group (CG) receiving case management plus individual therapy. Families assigned to the CPP group engaged in weekly dyadic (parent-child) conjoint sessions (60 minutes each); mothers had supplemental individual therapy as needed. Mothers in the comparison group were contacted once a month by a clinical case manager and connected to a mental health clinic of their choice for individual therapy. Treatment for both study conditions lasted 50 weeks.

Children in the CPP group showed significantly greater post-treatment reduction in Traumatic Stress Disorder (TSD) symptoms, $F(1, 59) = 10.98$, $p < .001$, $d = 0.63$, and total behavior problems, $F(1, 61) = 5.77$, $p < .05$, $d = 0.24$, than CG children. At intake, there was no difference between the CPP and CG children in meeting criteria for a TSD diagnosis, but after treatment, CPP children were significantly less likely, $\chi^2(n = 61) = 8.43$, $p < .01$, $\phi = 0.37$, than CG children to be diagnosed with TSD. CPP treatment mothers reported significantly, $F(1, 57) = 5.08$, $p < .05$, $d = 0.50$, fewer trauma avoidance symptoms than mothers who received only case management. CPP mothers were also less symptomatic than mothers in the comparison group in global psychiatric distress, $F(1, 57) = 3.48$, $p < .1$, $d = 0.37$, at the end of treatment. At a six-month follow up, the
CPP children demonstrated fewer behavior problems than CG children, $F(1, 48) = 5.39$, $p < .05$, $d = 0.41$, and mothers in the treatment condition showed less distress, $F(1, 47) = 5.12$, $p < .05$, $d = 0.38$, than the mothers in case management (Lieberman, Ghosh Ippen, & Van Horn, 2006).

The data from Lieberman et al.’s (2005) study was later re-analyzed and large effect sizes ($d > 1.0$) were found for CPP treated high-risk preschoolers (i.e., those with 4+ traumas, $n = 20$) on reduction of PTSD, depression, and co-occurring diagnoses (Ghosh Ippen, Harris, Van Horn, & Lieberman, 2010). From pre- to post-treatment, high-risk preschoolers treated with CPP showed significantly lower rates of PTSD, $\chi^2(1) = 12.38, p < .001$, $\phi = .65$, than high-risk children ($n = 15$) in the comparison group, $\chi^2(1) = 10.48, p < .01$, $\phi = .55$. All together, the studies by Ghosh Ippen et al. (2010), Lieberman et al. (2005), Lieberman et al. (2006), and Toth et al. (2002) provide strong evidence for the CPP model in treating maltreated preschoolers who are at high-risk due to multiple traumas.

Some evidence for CPP with maltreated infants and toddlers is also available in a study by Osofsy, Kronenbery, Hammer and colleagues (2007). In this study, 57 parent-child dyads participated in an average of 27 CPP sessions. The children were 1 to 52 months in age ($M = 19.39$ months, $SD = 9.97$ months). Child participants had either been maltreated and were in the child welfare system or were at high-risk for out-of-home placement due to abuse and neglect. Because this was an open-trial pilot test in which no comparison or control group was used, it was classified as a type-3 study. Findings were, however, positive for CPP, revealing significant improvements in parents’ behavioral responsiveness, $t(45) = -4.01, p < .01$, $d = .60$, emotional responsiveness, $t(45) = -3.93, p$
< .01, $d = .56$, intrusiveness, $t(44) = -5.21$, $p < .01$, $d = .67$, and positive discipline, $t(37)$ $= -3.48$, $p < .01$, $d = .70$, toward their child. Treated children showed a significant increase in positive affect, $t(45) = -3.77$, $p < .01$, $d = .48$, and 50% ($n = 22$) of the children demonstrated improvements in one or more areas of development, such as communication, gross or fine motor abilities, problem solving, or personal-social skills. Replications with more robust study designs will be needed to further verify the efficacy of CPP with maltreated children younger than age 2.

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

*Treatment components.* The current TF-CBT model was created over more than 20 years of research and development through the combined efforts of Judith Cohen, Anthony Mannarino, and Esther Deblinger (Cohen, Mannarino, & Deblinger, 2006). Core elements of this approach were originally designed for sexually abused preschoolers (Cohen & Mannarino, 1993; Deblinger & Heflin, 1996), but have been generalized to older and multiply traumatized children (Cohen, Deblinger, Mannarino, & Steer, 2004) as well as to traumatically bereaved children (Cohen, Mannarino, & Deblinger, 2006). TF-CBT is a highly structured and relatively brief model, including such interventions as psychoeducation for PTSD and parenting skills, relaxation, affective modulation, cognitive coping and processing, gradual exposure exercises, trauma narrative, and efforts to enhance the future safety and development of the child. TF-CBT components have been tested in both individual, conjoint, and group therapy formats with traumatized children of various ages and their non-offending parents (Kowalik et al., 2011). Some reviewers claim that TF-CBT is currently the most stringently researched trauma
intervention available for children and adolescents (Kauffman Best Practices Project, 2004; Putnam, 2003; Saunders et al., 2004; Silverman et al., 2008).

**Support for treatment of trauma-exposed young children.** Preliminary support for core components of TF-CBT was obtained in a pilot study involving 19 non-offending mothers and their young sexually abused children (ages 2 to 6, M = 4.2, SD not reported) who were recruited to participate in 11 two-hour sessions of sexual-abuse informed cognitive-behavioral (CBT) group therapy (Stauffer & Deblinger, 1996). Content for the parents’ group was taken from an individual therapy approach developed by Deblinger, McLeer, and Henry (1990). Interactive activities (e.g., singing, reading stories, role playing) were used in the children’s group to provide education on communication, coping strategies, child sexual abuse, and body safety skills. Children were not asked to speak directly about their abusive experiences; however, they were helped to identify people they could talk to about their experiences if they desired. Researchers obtained a “pretreatment baseline” from participants on outcome measures by conducting an assessment at first contact and then again about 12 weeks later, just before treatment began. These pretreatment baseline scores were used in lieu of a control group. Significant improvements were found over the course of therapy on parental distress, $F(3, 51) = 4.53, p < .05, d = .38$, parental avoidance of abuse-related thoughts, $F(3, 54) = 5.33, p < .05, d = .52$, parents’ intrusive thoughts of past abuse, $F(3, 54) = 5.56, p < .05, d = .79$, parent-child interactions, $F(2, 32) = 11.47, p < .01, d = .72$, and the child’s sexualized behaviors, $F(3, 54) = 12.85, p < .01, d = .36$. These gains were maintained for at least 3-months following treatment.
Cohen and Mannarino (1996) compared an individual/conjoint therapy approach founded in TF-CBT principles, called Cognitive Behavioral Therapy for Sexually Abused Preschoolers (CBT-SAP), with Nondirective Supportive Treatment (NST) in a randomized controlled trial with 67 sexually abused preschoolers, ages 2 to 7 ($M = 4.68$, SD not reported), and their non-offending parents. Participants in each condition received 12 treatment sessions (1.5 hours in length) where the therapist spent 50 minutes with the parent and 30 to 40 minutes with the child. The CBT-SAP parents were taught child management skills, affect regulation techniques, and tools for coping with their own abuse-related issues as well as emotionally supporting the abused child. Children in the CBT-SAP condition were educated on safety, assertiveness, appropriate versus inappropriate touching, coping with ambivalent feelings toward the perpetrator, regressive or inappropriate behaviors, and affect regulation. Like Stauffer and Deblinger (1996), researchers in this study did not integrate gradual exposure techniques or a trauma narrative into the children’s treatment. NST therapists used reflective listening, supportive statements, and empathy to support clients and encourage emotional expression.

Prior to treatment, there were no significant differences the treatment and control groups on outcome measures. After treatment, CBT-SAP children were significantly less symptomatic than NST children on internalizing behaviors, $t(65) = -3.16, p < .002, d = .77$, total behavior problems, $t(65) = -2.47, p < .01, d = .60$, and sexualized behaviors, $t(65) = -2.38, p < .05, d = .58$. Results from a one-year follow up study, conducted with 43 of the original child participants, showed treatment gains were either maintained or
enhanced in the CBT-SAP group but were generally non-significant for the NST group (Cohen & Mannarino, 1997).

Deblinger, Stauffer, and Steer (2001) assessed the effectiveness of their CBT group that included a sexual-abuse focus versus Supportive group therapy (ST) with 44 sexually abused young children, ages 2 to 8 (M = 5.45, SD = 1.47), and their non-offending mothers. Random assignment was used to determine which intervention condition participants would attend. Both the CBT and ST groups met for 11 sessions (1 hr. 45 min. per session), but the CBT group met for an additional 15 minutes each week for a conjoint parent-child activity session. In the ST group for parents, the therapist used active listening, unconditional positive regard, and emotion reflection techniques during topics of discussion chosen by the group members. A workbook (Stauffer & Deblinger, 1999) was used in both the CBT and ST groups for children, but the CBT group therapists utilized more interactive activities while therapists in the ST group were more didactic in their approach (i.e., using pictures, stories, and activity page exercises to teach material). Again, children were not invited to discuss their abusive experiences directly in the group. Instead, they were referred to trusted acquaintances or family members if they wished to talk about any traumatic events.

Intervention effect sizes at the end of treatment were moderate to large for the CBT group participants and small for the ST group participants on parents’ intrusive thoughts about their child’s abuse, CBT: $F(2, 41) = 3.23, p < .05, d = .81$; ST: $F(2, 41) = 16.17, p < .001, d = .30$, parents’ emotional reaction to their child’s abuse, CBT: $F(2, 41) = 11.53, p < .001, d = 1.16$; ST: $F(2, 41) = 19.36, p < .001, d = .22$, and children’s awareness of hypothetical situations involving risk of re-abuse, CBT: $F(2, 41) = 4.81, p <$
Small to moderate gains were made in both groups on PTSD symptoms, CBT: $F(2, 41) = 0.43, p > .05, d = .73$; ST: $F(2, 41) = 12.55, p < .001, d = .74$, behavior problems, CBT: $F(2, 41) = 0.37, p > .05, d = .66$; ST: $F(2, 41) = 10.15, p < .001, d = .46$, and inappropriate sexual behaviors, CBT: $F(2, 41) = 0.90, p > .05, d = .74$; ST: $F(2, 41) = 12.70, p < .001, d = .47$, but only the effects sizes for the ST group were significant. The authors suggested that discouraging children from talking openly about their abusive experiences may have reduced the effect of the CBT group (leading to a non-significant $p$-value) and recommended that future evaluations of this model incorporate some discussion of the trauma.

The efficacy of TF-CBT was tested again, and compared with a 12-week waitlist control group, in a randomized control trial with a sample of 64 three- to six- year old children (Mean age = 5.3; SD = 1.1) who had been exposed to heterogeneous types of traumas (Scheeringa et al., 2011). The TF-CBT treatment consisted of a12-session protocol (available online at http://www.infantinstitute.com), adapted from the manual used by Cohen and Mannarino (1996). One of the adaptations to the manual included adding gradual exposure techniques (i.e., trauma narrative, drawing/imagining aspects of the traumatic event) to the children’s treatment. Therapy sessions lasted from 45 to 90 minutes. Usually, the therapist spent half the session individually with the child and the other half with parents; however, parents were present for all of the 1st, 2nd, and 12th sessions and were encouraged to watch their child’s other sessions on video (with the child’s permission).

In this study, effect sizes of PTSD symptom improvement were significantly greater for preschoolers who participated in TF-CBT ($d = 1.48$) than the wait list group ($d$
= .16) over time. No significant pre-/post-treatment differences were found between treatment and control groups for Major Depressive Disorder (MDD), Separation Anxiety Disorder (SAD), Oppositional Defiant Disorder (ODD), and Attention-Deficit/Hyperactivity Disorder (ADHD). However, the effect sizes for these outcomes were mostly large (MDD: \( d = 1.20 \); SAD: \( d = .89 \); ODD: \( d = 1.03 \); ADHD: \( d = .55 \)) for the TF-CBT group, and small to large for the WL group (MDD: \( d = .57 \); SAD: \( d = .86 \); ODD: \( d = .13 \); ADHD: \( d = -.12 \)). At a 6-month follow up, some of the children who received treatment were re-assessed. For these children (\( n = 25 \)), their original post-treatment effect size for PTSD symptoms (which was \( d = 1.01 \) for this specific group of children) increased to 1.88 at the 6-month follow up, suggesting that positive changes on PTSD scores were shown to last and even to improve over time. Follow up analyses also revealed significant (\( p < .0005 \) to \( p < .0001 \)), moderate to large treatment effects for MDD (\( d = 1.01 \)), SAD (\( d = .63 \)), and ODD (\( d = .83 \)), which could indicate there was a gradual, positive effect on these comorbid symptoms over time.

Category II (Probably Efficacious) Models for Trauma-Exposed Young Children

Attachment-Focused Home-Visitation Intervention

Treatment components. Larin and colleagues developed a short-term (8 week) home-visiting program designed to promote children’s attachment security by enhancing parental sensitivity and responsiveness to their child’s emotional and behavioral cues (Larin, St-Georges, Jacques, Otis, and Desauliniers (2006). In this home-based approach (detailed in a manual by Larin et al., 2006, which is currently available only in French) parents are taught to respond sensitively to their child through in-session video-feedback and discussions of attachment and emotion-related themes with the therapist. Sessions
are approximately 90 minutes in length and follow a structured format. First, the therapist meets with the parent-child dyad and discusses the parent’s concerns from the past week. The therapist video-tapes the parent and child as they participate in an interactive activity of the therapist’s choosing for 10 to 15 minutes. Then, the therapist and parent watch the video and discuss the parent’s feelings and/or observations about the film. The therapist inquires about positive interactional sequences between the parent and child, and offers feedback that reinforces the parents’ sensitive responses toward the child. The session ends with the therapist commending the parent on progress made and encouraging the parent to continue using similar activities with the child over the next week.

Support for treatment of trauma-exposed young children. Initial evidence for this home-visiting program was obtained through a randomized controlled trial (Moss, Dubois-Comtois, Tarabulsy, St-Laurent, &Bernier, 2011) in which 67 French-speaking caregivers from Quebec and their maltreated children, ages 1 to 5 ($M = 3.35, SD = 1.38$), were recruited and randomly assigned either to a treatment condition ($n = 35$) or control group ($n = 32$). The intervention, described above, was outlined in a treatment manual (Larin et al., 2006) and administered over 8 weekly home-visits lasting approximately 90 minutes each. From the beginning to end of treatment, parents who had home-visits exhibited significantly higher levels of sensitivity than the control group parents, $F(1, 62) = 4.85, p < .05, d = .47$. A chi-square test showed there was a significant difference between the post-treatment attachment security scores of the children in the two groups, $\chi^2(3, N = 67) = 9.83, p < .05$. Post-hoc analyses revealed that a significantly greater proportion of insecure children who received the intervention were classified, at post-
treatment, as securely attached (42.9%, z = 2.40) in comparison to the control group (15.6%, z = -2.40). A smaller proportion of the treated children who were classified as insecurely attached to their caregiver at the beginning of treatment remained insecure (31.4%, z = -2.50) compared with the control group children (62.5%, z = 2.50).

Another chi-square analysis, $\chi^2(3, N = 67) = 10.91, p < .05$, indicated the two groups also significantly differed on disorganized attachment behaviors demonstrated by the child. Results from post-hoc tests showed that more of the children in the intervention group who were classified as disorganized before treatment became organized (37.1%; z = 2.00) compared to children in the control group (15.6%, z = -2.00). No significant differences were found between treatment and control groups on the children’s externalizing or internalizing behavior problems. Nonetheless, the intervention appears to have interrupted the family patterns that perpetuate young children’s insecure attachment styles and are predictive of the development of problematic internalizing and externalizing behaviors later in middle childhood.

**Category III (Possibly Efficacious) Models for Trauma-Exposed Young Children**

**Child Centered Play Therapy (CCPT).** CCPT is a humanistic play therapy model, developed by Gary Landreth (2002). In this approach, the therapist engages in multiple sessions of nondirective play with the child. Therapy is conducted in a room full of toys and play materials selected to engage the child and facilitate self-expression. The therapist seeks to be genuine, caring, and accepting of the child and sets minimal behavioral limits in order to give the child permission to be fully him- or herself, to gain a sense of self-confidence, and to engage in the process of healing and self-actualization. In a meta-analysis of play therapy, humanistic nondirective models have shown a large
average effect size for children receiving mental health services for a variety of problems (i.e., \( d = .92 \); Bratton, Ray, Rhines, & Jones, 2005); however, only one case study has been published on the use of CCPT with young trauma victims (Dugan, Snow, & Crow, 2010). Thus, in spite of evidence indicating this is a useful therapy model in general for children with psychological problems, the specific effects of the model for young children with trauma are virtually unknown.

**Childhaven Therapeutic Day Care Program.** The Childhaven Program originated at a non-profit day nursery in Seattle designed to provide therapeutic child care to maltreated young children, ages 1 month to 5 years (Durkin, 1986; Gogerty & Durkin, 1981). Child care is offered 5 days a week, and daycare staff work to provide a protective, nurturing environment, and reduce risk factors of re-abuse. Parents are given support through parent education classes, support groups, counseling, and referrals to external professional services. Evidence for the effectiveness of this program comes from a retrospective study by Moore, Armsden, and Gogerty (1998). Maltreated infants and toddlers, 1 to 24 months of age (SD not reported), were randomly assigned either to treatment or community standard (i.e., control group) services and re-assessed 12 years later as adolescents.

Results of the study (Moore et al., 1998) revealed that adolescents who participated as infants in the program were significantly less likely than control group adolescents to engage in serious violent criminal activity, \( F(1, 46) = 4.1, p < .05, d = .51 \), clinical levels of aggression, \( \chi^2(1) = 6.3, p < .05 \), or substance abuse, \( \chi^2(1) = 4.4, p < .05 \). Significantly fewer adolescents who had participated in treatment also demonstrated less clinical level anxiety/depression, \( \chi^2(1) = 5.3, p < .05 \), somatic complaints, \( \chi^2(1) = 6.3, p < \).
adolescents in the control group. Although these results appear to be positive, there is no report of other intervening factors that might have been as, or more responsible, for the findings than the therapy administered 10 to 12 years earlier. Because there are other known, powerful influences on internalizing and social problems of young teens, these results are not very convincing. However, further study on the long-term effects of early treatment would be beneficial.

**Cognitive Developmental Day Treatment Program.** Culp, Heide, and Richardson (1987) evaluated an intensive day treatment program for maltreated preschoolers, which was based on a cognitive developmental model. Children attended the program for six hours a day five days a week. One of the program objectives is to facilitate cognitive development through regular preschool learning activities and educational services. Another treatment objective is to help children overcome social developmental delays related to abuse and neglect by forming strong relationships with their teachers and peers, building self-esteem, and learning to identify and cope with their emotions. To do this, mental health services are provided such as individual child treatment, parent counseling, and planned individual and group activities. In Culp et al.’s (1987) study, 70 maltreated children (Mean age = 36 months; SD not reported) were non-randomly assigned either to the day treatment program \((n = 35)\) or a control group \((n = 35)\). The average length of treatment was 7.6 months (range and SD not reported).

Results revealed the children who attended the program demonstrated significant improvement from intake to discharge in all areas of development: cognitive, \(t(33) = 6.52, p < .001, d = 2.27\); fine motor, \(t(33) = 4.86, p < .001, d = 1.69\); gross/motor, \(t(31) = \).
4.99, \( p < .001, d = 1.79 \); social/emotional, \( t(31) = 5.91, p < .01, d = 2.12 \); and language, \( t(24) = 3.90, p < .01, d = 1.59 \). Mean scores for these variables were not reported; therefore, the effect size \((d)\) was calculated using the \(t\)-values (Rosenthal & Rosnow, 1991). However, because the scores represent dependent groups, the effect size estimates are probably an over-estimate of the actual effect size (Dunlop, Cortina, Vaslow, & Burke, 1996). Post-treatment developmental scores for the treated children were significantly higher than the control group children in the following areas: cognitive, \( t(66) = 4.25, p < .01, d = 1.04 \); fine motor, \( t(66) = 3.70, p < .01, d = .91 \); gross motor, \( t(60) = 3.08, p < .05, d = .80 \); social/emotional, \( t(64) = 4.08, p < .01, d = 1.02 \); and language, \( t(38) = 2.20, p < .05, d = .71 \). While these results seem promising, the researchers did not report whether the two groups varied significantly on these measures prior to treatment so it cannot be said for certain whether the extent of improvement was significantly greater for the treatment group compared to the control group.

**Eye Movement Desensitization and Reprocessing (EMDR).** EMDR (Shapiro, 1995) is designed to reduce clients’ PTSD symptoms and challenge maladaptive beliefs clients often develop after a trauma. In this approach, clients engage in Bilateral Simulation (BLS) and other EMDR techniques while thinking about their traumatic experience. BLS is usually done with eye movements (e.g., visually tracking the therapist’s finger as it goes from side to side), but it can also be accomplished through tactile (e.g., tapping the client’s hands) or auditory (e.g., switching music back and forth between speakers) stimulation. This procedure is theorized to help the client re-process neurological blocks that problematically store the traumatic event in the client’s memory.
Throughout therapy, clients are asked to rate their distress level, track body sensations, create an internal safe/calm place, and replace negative beliefs with positive ones.

Some have questioned whether very young children have the cognitive capacity to complete all the tasks in the adult EMDR protocol and have proposed modifications such as eliminating some of the steps to accommodate the abilities of young children (Greenwald, 1999; Lovett, 1999; Tinker & Wilson, 1999). However, Adler-Tapia and Settle (2008) created a treatment manual (see p. xxii for information on how to download the manual from their website) that includes instructions for using EMDR with children, which implements all the original phases of treatment.

Although extensive research shows EMDR to be an effective treatment for adult PTSD (Spates, Koch, Cusack, Pagoto, & Waller, 2009); EMDR research with children is limited and methodological rigor of the studies has been seriously questioned (Adler-Tapia & Settle, 2008). A meta-analysis of EMDR studies with children of all ages demonstrated an overall effect size (d) of .56 (Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009). EMDR trials with traumatized preschool-age children (that met inclusion criteria) were all case studies (Cocco & Sharpe, 1993; Greenwald, 1994; Tufnell, 2005).

In each of these studies, children were reported to show reductions in PTSD symptoms within only 1 to 4 EMDR sessions. However, outcome measures generally consisted of children’s report of change on a scale of 0 to 10 Subjective Units of Distress (SUDS), and the therapist’s verbal description of improvement from the parents’ report and the therapists’ observation of the child in session without the use of standardized assessment instruments. Obviously, more robust studies will be needed to understand the impact of this approach for young children with trauma. Nonetheless, further research is merited as
there is some indication that PTSD symptoms in very young children might be reduced within just a few sessions.

**Parent Child Interaction Therapy.** The PCIT model (Eyberg, 1988; Hembree-Kigin & McNeil, 1995) is designed to teach parents child management skills, enhance the quality of the parent-child relationship, and reduce children’s behavioral problems. The model is not trauma-focused, but has been recommended for families with physical abuse because it targets problematic parenting practices often associated with risk of re-abuse by the parent (Borrego, Timmer, Urquiza, & Follette, 2004; Timmer, Borrego, & Urquiza, 2002; Urquiza & McNeil, 1996). The initial phase of PCIT consists of didactic instruction to parents on child management and relationship building skills. Afterward, the therapist coaches parents as they implement the skills during periods of child-led play or interactive tasks with the child. Parents are gradually taught how to generalize learned skills to external contexts and other problem times. Empirical evidence for PCIT with trauma-exposed children younger than 6 can be found in one type-3 study (Timmer, Urquiza, Zebell, & McGrath, 2005) and three case studies (Blacker, Dombrowski, Timmer, & Urquiza, 2002; Fricker-Elhai, Ruggerio, & Smith, 2005; Timmer, Urquiza, Herschell, McGrath, Zebell, Porter et al., 2006).

In the Kauffman Best Practices Project (2004), which was conducted under the review of the National Call To Action: A Movement to End Child Abuse and Neglect (NCTA) as well as in collaboration with the National Child Traumatic Stress Network (NCTSN) and the National Center for Child Traumatic Stress at UCLA, a committee of nationally prominent researchers, treatment providers, and abuse survivors was organized to identify best practices for helping children heal from abuse and maltreatment. This
committee recommended PCIT as one of three “best practice” models for treating children, ages 2 to 8, who have externalizing behavior problems and for changing the behavior of physically abusive parents with children ages 4 to 12, irrespective of whether the children were exhibiting behavior problems.

Research cited by the committee (Kaufmann Best Practices Project, 2004) to support this claim to effectiveness consisted of PCIT treatment-outcome studies on non-maltreated children with externalizing problems and their parents (Eyberg & Robinson, 1982; Funderburk, Eyberg, Newcomb, McNeil, Hembree-Kigin, Capage, 1998), and clinical studies with young children at high-risk of maltreatment but who had not been documented to have actually experienced abuse or neglect (Borrego, Urquiza, Rasmussen, & Zebell, 1999). Although the recommendation for PCIT with physically abused children as young as age 4 may be appropriate, it would be useful to have more rigorous trials with preschool-aged children who have a confirmed history of maltreatment to further explore efficacy of this approach with very young, abused children.

**Resilient Peer Treatment (RPT).** RPT is a program typically carried out in Head Start Programs, and was created to help socially-withdrawn and maltreated preschoolers successfully navigate the developmental task of building effective peer relationships (Fantuzzo, Sutton-Smith, Atkins, Meyers, Stevenson, Coolahan, et al., 1996). The program involves pairing socially maladapted preschoolers with socially skilled peers of the same age during periods of free-play in classroom settings. RPT includes three major components: (a) dyadic pairing of a “resilient peer” (or play buddy) with a target child for play sessions, (b) establishing a play corner in the natural
classroom for the children’s regularly scheduled free play, and (c) identifying and training parent volunteers at the preschool to serve as play supporters. Existing evidence for the effectiveness of RPT was demonstrated in a pilot (Fantuzzo, Stovall, Schachtel, Goin, & Hall, 1987) and series of type-2 studies (Fantuzzo, Jurecic, Stovall, Hightower, Goins, & Schachtel, 1988; Fantuzzo, Manz, Atkins, & Meyers, 2005; Fantuzzo, Sutton-Smith, Atkins, et al., 1996).

Results from these studies have been positive in demonstrating significantly greater improvements in treated children compared to control group children on outcomes, such as internalizing ($d = 1.0$) and externalizing ($d = .74$) behavior as well as prosocial skills, including reductions in solitary play ($d = .83$ to 1.5) and increases in interactive play ($d = 1.40$ to 1.50), self-control ($d = .82$), and interpersonal skills ($d = 1.1$). However, reviewers have expressed concern about the treatment specificity of this approach in reducing the effects of child maltreatment because only about half of the children in the samples had histories of abuse or neglect and there was a lack of evidence demonstrating main effects for maltreatment status or Maltreatment X Treatment interaction effects (Silverman et al., 2008). At this point, claims of effectiveness with maltreated children are not convincing.

**Theraplay-Based Preschool Program.** Stubenbort, Cohen, and Trybalski (2010) conducted a retrospective trial on the effectiveness of a therapeutic preschool (TPS) program grounded in Theraplay theory (Jernberg, 1979) on improving the developmental outcome of maltreated young children. Theraplay in its original form is not a trauma-specific treatment nor has it been empirically tested with maltreated children. However, it is an attachment-focused intervention designed to facilitate more secure and healthy relationships between children and their parents, which lays a crucial
foundation for developmental growth. In the study by Stubenbort et al. (2010), TPS staff worked with 53 abused preschoolers (Mean age: 47 months, SD not reported) for an average of 8.5 months (SD not reported) using activities and interactions that were designed to “elicit attachment-related behavioral phenomena” and “mimic the parent-child relationship” (p. 54). Preschool activities were founded in Theraplay’s four categories of intervention: structured interactions (aimed at teaching children appropriate boundaries), challenge behaviors (designed to build children’s self-confidence by encouraging them to perform beyond what they believe are their capabilities), engaging behaviors (encouraged the child’s interaction with staff members), and nurturing activities (used to meet the child’s physical and affective needs).

Treated children made significant gains in personal-social, \( t(44) = -4.85, p < .000, d = 1.46 \), adaptive, \( t(44) = -4.99, p < .000, d = 1.46 \), and developmental total scores, \( t(44) = -6.74, p < .000, d = 2.03 \). The developmental total score represented children’s overall functioning in several domains, including motor, communication, cognitive, personal-social, and adaptive life skills. Mean scores reflecting pre- to post-treatment change on these developmental variables were not provided. Thus, effect sizes were computed using the \( t \)-scores of these dependent (repeated measures design) groups, which may indicate the estimates are inflated. A notable weakness of this study is the lack of comparison group. Consequently, it is unknown whether children who did not receive the treatment would have made the same degree of improvement over time as children in the TPS program.
Category IV (Untested) Models for Trauma-Exposed Young Children

Some clinical models have been recommended for young children with trauma, but have not been tested in studies with samples that met inclusion criteria for this review. These models include such approaches as Attachment Self-Regulation and Competency (ARC: Blaustein & Kinniburgh, 2010), Culturally-Modified Trauma Focused Treatment (CM-TFT: de Arellano & Danielson, 2005), Dyadic Developmental Psychotherapy (DDP: Becker-Weidman, 2010), Integrative Treatment of Complex Trauma (ITCT: Briere & Scott, 2006), Real Life Heroes (RLH: Kagan, 2004; Kagan, 2007a; Kagan, 2007b), Trauma Assessment Pathway (TAP: Chadwick Center for Children and Families, 2009), and Trauma-Focused Play Therapy (TFPT: Gil, 1998, 2006). Brief overviews for many of these treatments can be found in reviews by Saunders et al. (2004) and de Arellano, Ko, Danielson, and Sprague (2008). Most of the models were developed for school-aged children, adolescents, or adults but have been recommended for use with traumatized or maltreated young children. Only the ARC, DDP, RLH and TFPT programs have published guidelines for adapting the techniques to young children.

It should be noted that the untested models described in this section are not intended to be a comprehensive list, but are rather meant to highlight some of the lesser-known treatments that could merit further empirical attention. Identifying these treatments as untested is also important because some of the developers of these approaches charge large sums of money to train other clinicians in their methods. Although this may be helpful in disseminating potentially useful therapeutic material throughout the clinical community, it is vital that model developers go through the proper
research channels to test the validity of their assertions. After all, an intervention that is informed by research but is not tested has no specific claim to effectiveness.

**Discussion**

Compared to the breadth of trauma research for children and adolescents, there are few robust evaluations of psychotherapy interventions for young children with posttraumatic stress. Nonetheless, there are some treatment models that have been evaluated. Two therapy models, including Child Parent Psychotherapy (CPP) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), met the criteria for well-established treatments with trauma-exposed children as young as age 2 and 3, and the Attachment-Focused Home-Visiting Intervention (AF-HVI) demonstrated enough support to be tentatively considered efficacious with 1 to 5 year olds. Treatments found to be possibly efficacious for young children included CCPT, the Childhaven Program, Cognitive Developmental Day Treatment Program, EMDR, and PCIT; also, there are a few untested clinical models that appear to have some promise.

It is important to remember that treatments in Categories II through IV are not necessarily less effective than those in Category I; rather, there is simply not enough empirical evidence to support them as established interventions. Ongoing assessment of clinical models for young children with PTSD is still greatly needed, even for those identified as Category I treatments. Chambless and Hollon (1998, p. 8) commented that the criteria of two or more rigorous studies completed by different research groups demonstrating superiority of a treatment over control conditions should be considered a “minimum threshold rather than an optimal one” when determining which treatments are efficacious. The more study replications conducted in different settings, with children in
specific development groups and/or with comorbid disorders, trauma types, and intensity of symptoms, the more confidence practitioners may have in the results.

The size of treatment effects on child outcomes varied widely across models assessed in this review. CPP demonstrated small to large effect sizes ($d = .24$ to $1.56$) on many child outcomes (e.g., adaptive mental representations, positive affect, development status). The specific effect of CPP on PTSD symptoms ($d = .63$) appeared moderate (Lieberman et al., 2005). However, Ghosh Ippen et al. (2010) found some specificity of effects, with evidence supporting that CPP treatment had a stronger effect on reducing PTSD symptoms for preschoolers with multiple (4+) traumas ($d = 1.79$) than for preschoolers who had been exposed to fewer (<4) traumatic experiences ($d = .66$). Effect sizes for TF-CBT with preschoolers were small to large ($d = .36$ to $1.20$) for child outcomes, such as internalizing and externalizing problems, sexual behaviors, and awareness of factors associated with risk of re-abuse. Moderate to large effect sizes ($d = .73$ to $1.88$) were found for TF-CBT on decreasing trauma symptoms (Deblinger, Stauffer, & Steer, 2001; Scheeringa et al., 2011). Estimates of effect size on child outcomes for Category II through IV models were also in the moderate to large ($d = .50$s to $> 1.5$) range. The therapeutic preschool and daycare programs demonstrated particular promise for helping young children overcome developmental delays associated with maltreatment ($d = .80$ to $> 2.0$).

Findings of effectiveness for TF-CBT with preschoolers complement TF-CBT effectiveness research with school-aged children and adolescents (Kauffman Best Practices Project, 2004; Putnam, 2003; Saunders et al., 2004; Silverman et al., 2008). However, it is notable that one element of TF-CBT (i.e., gradual desensitization
techniques) that has been cited by TF-CBT developers (Cohen, Mannarino, & Deblinger, 2006) as a core component of the model was tested in only one of the studies in this review (Scheeringa et al., 2011). In this study, the TF-CBT approach demonstrated a much larger treatment effect size \((d = 1.48; \text{Scheeringa et al., 2011})\) on children’s PTSD scores than that \((d = .73; p = n.s.; \text{Deblinger et al., 2001})\) obtained in the only other TF-CBT study focusing on preschoolers to include a PTSD measure. Further investigation of this technique will be needed to further ascertain its impact on preschool-aged children with trauma.

Young children were not the only ones to benefit from the therapy services analyzed in this review. Based on findings from the reviewed studies, parents or primary caregivers were considerably involved in all of the Category I (CPP, TF-CBT) and II (AF-HVI), and some of the Category III and IV, treatments. Small to moderate treatment effects were found for such parental outcomes as trauma-related symptoms (TF-CBT: \(d = .52 \text{ to } .81\)), general distress levels (CPP: \(d = .37\); TF-CBT: \(d = .38\)), emotional reaction to the child’s abuse (TF-CBT: \(d = 1.16\)), and positive parenting practices (AF-HVI: \(d = .47\); CPP: \(d = .56 \text{ to } .70\); TF-CBT: \(d = .72\); Deblinger, Stauffer, & Steer, 2001; Lieberman et al., 2005; Moss et al., 2011; Osofsky et al., 2007; Stauffer & Deblinger, 1996).

These are important findings because parental distress and emotional support available to parents have been found to mediate outcome in children’s trauma-focused treatment (Cohen & Mannarino, 1998). Additionally, helping caregivers learn positive parenting skills (e.g., appropriate discipline and emotional sensitivity/responsiveness toward the child) is important because many of the parents of children who have been victimized have their own childhood maltreatment history from which they have learned
overly punitive or inappropriate parenting practices (Borrego et al., 2004; Timmer et al., 2002; Urquiza & McNeil, 1996). Helping caregivers learn healthy parenting skills may therefore lead to ongoing improvements in traumatized children’s mental health following the completion of treatment (Kobak & Mandelbaum, 2003).

Based on this review, the following recommendations are proposed for future trauma intervention research with young children. *First*, treatment-outcomes studies of children with trauma ought to be designed to clarify developmentally-sensitive effectiveness. *Second*, inclusion of a developmentally-appropriate PTSD measure is needed. Only a portion of the studies reviewed for this article assessed for trauma symptoms. Although many studies revealed significant post-treatment improvements in children’s functioning (e.g., internalizing/externalizing problems, developmental status), the absence of a PTSD measure makes it impossible to learn whether treatment gains in these studies extended to children’s trauma symptoms. Posttraumatic stress symptoms vary across young and older children and adolescents (De Young et al., 2011). Thus, trauma-specific measures catered to the child’s developmental level can be expected to result in more accurate treatment effects related to changes in PTSD symptomology.

*Third*, extending follow-up intervals in outcome studies will be necessary to gain greater information about the durability of treatment effects. As can be seen in Table 2.3, the majority of the comparison and controlled trial studies under review had follow-up periods of one year or less. Without data from lengthier follow-up intervals, we will not know the duration of treatment effects. Knowing whether treatment effects tend to decrease or stay the same following treatment will inform clinicians about whether post-
treatment booster sessions or additional mental health support may be required to
maintain long-term therapy gains.

Fourth, integrating components of trauma-focused and non-trauma-focused
modalities (e.g., TF-CBT + PCIT) in the treatment of traumatized children who have
comorbid symptoms (e.g., oppositional-defiance, conduct problems, depression, anxiety)
might foster a more holistic approach for addressing a child’s entire clinical profile
versus targeting only PTSD symptoms.

Lastly, more detailed guidelines are needed for adapting clinical techniques
recommended for young children, which were initially developed for older children,
adolescents, or adults. Drawing explicit links between child development theory and
clinical technique strengthens the rationale for the need and appropriateness of certain
adaptations (Holmbeck et al., 2010). These adaptations can then be standardized and
cross-compared with other child therapy approaches to determine the models (or versions
of models) that are most effective.

In consideration of the issues described here, I concur with Cohen et al. (2006) that it is
time to focus more on adapting and evaluating existing children’s trauma
treatments than on creating new clinical models. Cohen et al. pointed out that
overlapping active ingredients appear across many effective trauma-focused programs for
children. Learning what these ingredients are for children of diverse developmental
levels will help clinicians choose from a limited number of effective models to treat early
childhood trauma.
References


mothers’ responses following episodes of child noncompliance and compliance.


Deblinger, E., Stauffer, L., & Steer, R. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually


stressful events in early childhood: Can treatment help those at highest risk?

*Child Abuse & Neglect, 35,* 504-513.


Practice, and Training, 42, 52-71.


Westat, Inc., Chapin Hall Center, & James Bell Associates (2002). Evaluation of family
preservation and reunification programs: Final report. Washington, DC: DHHS.


Table 2.1 Categorical Criteria Used to Evaluate Empirical Support for Treatment Models

Category I: Well-Established
1.1 There must be at least two group-design experiments, conducted in at least two independent research settings and by independent investigatory teams, demonstrating efficacy by showing the treatment to be:
   a) statistically significantly superior to pill or psychosocial placebo or to another treatment
   OR
   b) equivalent (or not significantly different) to an already established treatment in experiments with statistical power being sufficient to detect moderate differences.
   AND
1.2 Treatment manuals or logical equivalent were used for the treatment.
1.3 Conducted with a population, treated for specified problems, for which inclusion criteria have been delineated in a reliable, valid manner.
1.4 Reliable and valid outcome assessment measures, at minimum taping the problems targeted for change were used.
1.5 Appropriate data analysis.

Category II: Probably Efficacious
2.1 There must be at least two studies showing the intervention to be more effective than no-treatment control (e.g., a waitlist comparison).
   OR
2.2 One or more experiments meeting the Well-Established Treatment Criteria with the one exception of having been conducted in at least two independent research settings and by independent investigatory teams.

Category III: Possibly Efficacious
3.1 At least one study demonstrating efficacy suffices in the absence of conflicting evidence.

Category IV: Experimental
4.1 Treatments not yet tested in trials meeting criteria for methodology.

Note: Categories are based on Silverman and associates’ (2008) adaptation of recommendations from the Division 12 Task Force on Psychosocial Interventions (Chambless et al. 1996; Chambless & Hollon, 1998).
<table>
<thead>
<tr>
<th>Category</th>
<th>Therapy Model</th>
<th>Supporting Studies</th>
<th>Study Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: Well-Established</td>
<td>Child Parent Psychotherapy</td>
<td>Lieberman et al. (2005)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Toth et al. (2002)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Osofsky et al. (2007)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Trauma-Focused Cognitive-Behavioral Therapy</td>
<td>Cohen &amp; Mannarino (1996)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deblinger et al. (2001)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scheeringa et al. (2011)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stauffer &amp; Deblinger (1996)</td>
<td>3</td>
</tr>
<tr>
<td>II: Probably Efficacious</td>
<td>Attachment-Focused Home-Visiting Intervention</td>
<td>Moss et al. (2011)</td>
<td>1</td>
</tr>
<tr>
<td>III: Possibly Efficacious</td>
<td>Child Centered Play Therapy</td>
<td>Dugan et al. (2010)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Kot et al. (1998)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Childhaven Therapeutic Daycare Program</td>
<td>Moore et al. (1998)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Cognitive Developmental Day Treatment Program</td>
<td>Culp et al. (1987)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Eye Movement Desensitization &amp; Reprocessing</td>
<td>Cocco &amp; Sharpe (1993)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greenwald (1994)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tufnell (2005)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Parent-Child Interaction Therapy</td>
<td>Blacker et al. (2002)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fricker-Elhai et al. (2005)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Timmer et al. (2005)</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Timmer et al. (2006)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Resilient Peer Treatment</td>
<td>Fantuzzo et al. (1987)</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fantuzzo et al. (1988)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fantuzzo et al. (1996)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fantuzzo et al. (2005)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Theraplay-Based Preschool Program</td>
<td>Stubenbort et al. (2010)</td>
<td>3</td>
</tr>
<tr>
<td>IV: Untested</td>
<td>Attachment Self-Regulation &amp; Competency</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culturally Modified-Trauma Focused Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integrative Treatment of Complex Trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Real Life Heroes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trauma Assessment Pathway</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trauma-Focused Play Therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Treatment categorizations are based on studies under review in this article. Studies of these interventions in which children had no exposure to trauma or the children’s sample mean age was older than 6 were excluded.*

*Study types are classified using criteria from Silverman et al. (2008) and Nathan & Gorman (2007). Study types for Cohen & Mannarino, 1996; Fantuzzo et al., 1996; Fantuzzo et al., 2005; Lieberman et al., 2005 were also cited in Silverman et al. (2008).*
<table>
<thead>
<tr>
<th>Ref</th>
<th>Tx models assessed</th>
<th>N</th>
<th>Age range (children)</th>
<th>No. of sessions/ Duration</th>
<th>Random assignment</th>
<th>Blind assessment</th>
<th>Tx manual used</th>
<th>Tx fidelity assessed</th>
<th>Outcome measures</th>
<th>Post-tx follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohen &amp; Mannarino, 1996a; 1997 vs. NST</td>
<td>CBT-SAP</td>
<td>67</td>
<td>2-7 y.o. M=4.7(SD=NRA)</td>
<td>12/90 min</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>1, 2, 3, 4</td>
<td>6 &amp; 12 months</td>
</tr>
<tr>
<td>Deblinger et al., 2001</td>
<td>SA-CBT grp vs. ST</td>
<td>44</td>
<td>2-8 y.o. M=5.5(SD=1.5)</td>
<td>11/120 min</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>1, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13</td>
<td>3 months</td>
</tr>
<tr>
<td>Fantuzzo et al., 1987</td>
<td>PT vs. AT vs. CG</td>
<td>39</td>
<td>3-5 y.o. M=4.3(SD=NR)</td>
<td>8/15 min</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>14, 15, 16</td>
<td>6 months</td>
</tr>
<tr>
<td>Fantuzzo et al., 1996</td>
<td>RPT vs. AC</td>
<td>46</td>
<td>3-5 y.o. M=4.7(SD=NR)</td>
<td>15/NR</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>17, 18, 19, 20</td>
<td>2 months</td>
</tr>
<tr>
<td>Fantuzzo et al., 2005</td>
<td>RPT vs. AC</td>
<td>82</td>
<td>3-5 y.o. M=4.4(SD=4.7)</td>
<td>15/NR</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>17, 18, 21</td>
<td>2 weeks</td>
</tr>
<tr>
<td>Kot el al., 1998</td>
<td>CCPT vs. CG</td>
<td>22</td>
<td>4-10 y.o. M=6.9 (SD=NR)</td>
<td>12/45 min</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>1, 2, 23</td>
<td>None</td>
</tr>
<tr>
<td>Lieberman et al., 2005</td>
<td>CPP vs. CM</td>
<td>75</td>
<td>3-5 y.o. M=4.1(SD=NR)</td>
<td>50/60 min</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>1, 6, 24, 25, 26, 27</td>
<td>None</td>
</tr>
<tr>
<td>Culp et al., 1987</td>
<td>CDDT vs. CG</td>
<td>70</td>
<td>M=36 mo (SD=NR)</td>
<td>6 hrs/day</td>
<td>No</td>
<td>NR</td>
<td>No</td>
<td>No</td>
<td>28</td>
<td>None</td>
</tr>
<tr>
<td>Moss et al., 2011</td>
<td>AF-HVP vs. CG</td>
<td>67</td>
<td>1-5 y.o. M=3.35(SD=1.4)</td>
<td>8/90 min</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>1, 29, 30, 31</td>
<td>None</td>
</tr>
<tr>
<td>Scheeringa et al., 2011</td>
<td>TF-CBT vs. WC</td>
<td>64</td>
<td>3-6 y.o. M=5.3(SD=1.1)</td>
<td>12/45-90 min</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>32, 33</td>
<td>6 months</td>
</tr>
<tr>
<td>Toth et al., 2002</td>
<td>PPP vs. PHV vs. CS vs. NC</td>
<td>122</td>
<td>M=48.18 mo (SD=6.9)</td>
<td>50/60 min.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>34, 35</td>
<td>1 &amp; 3 yrs</td>
</tr>
</tbody>
</table>

**Note**: NR=Not Reported; **Tx Models Key**: AC=Attention Control; AT=Adult Treatment; CBT=Cognitive-Behavioral Therapy; CBT-SAP=CBT for Sexually Abused Preschoolers; CCPT=Child Centered Play Therapy; CDDT=Cognitive Development Day Treatment; CG=Control Group; CM=Case Management; CPP=Child Parent Psychotherapy; CS=Community Services; CDDT=Childhaven Therapeutic Daycare Program; NC=Nonmalnourished Control group; NST=Non-directive Supportive Treatment; PHV=Psychoeducational Home Visitation; PPP=Preschool-Parent Psychotherapy; PT=Peer (Initiated) Treatment; RPT=Resilient Peer Treatment; SA-CBT grp=Sex-Abuse informed Cognitive-Behavioral Therapy group; ST= Supportive Treatment; TF-CBT=Trauma Focused Cognitive-Behavioral Therapy; WC=Waitlist Control. **Outcome Measures Key**: (1) Achenbach Child Behavior Checklist; (2) Preschool Symptom Self-Report; (3) Child Sexual Behavior Inventory; (4) Weekly Behavior Record; (5) Miller Behavior Style Scale; (6) Symptom Checklist 90-Revised; (7) Impact of Events Scale; (8) Parent Emotional Reaction Questionnaire; (9) Parent Practices Questionnaire; (10) Social Support Questionnaire; (11) Therapy Satisfaction Questionnaire; (12) PTSD Scale; (13) What If Situations; (14) Positive Social Behavior Observational System; (15) Preschool Behavior Questionnaire; (16) Brigance Diagnostic Inventory of Early Development; (17) Interactive Peer Play Observational Coding System; (18) Social Skills Rating System; (19) Peer Play Interactive Checklist; (20) Family Adaptability and Cohesion Scales; (21) Penn Interactive Peer Play Scale; (22) Joseph Preschool & Primary Self Concept Scale; (23) Children’s Play Session Behavior Rating Scale; (24) Children’s Exposure to Community Violence: Parent Report Version; (25) Semistructured Interview for Diagnostic Classification DC-0-3 for Clinicians; (26) Life Stressor Checklist-Revied; (27) Clinician-Administered PTSD Scale; (28) Early Intervention Developmental Profile; (29) Maternal Behavior Q-Set; (30) Ainsworth Strange Situation Procedure; (31) family background questionnaire; (32) Preschool Age Psychiatric Assessment; (33) Adverse Events Checklist; (34) Narrative Story Stem Task; (35) Wechsler Preschool and Primary Scale of Intelligence-Revised.
CHAPTER 3

EMOTIONALLY FOCUSED FAMILY THERAPY WITH PRESCHOOLERS:

AN INTEGRATION OF DEVELOPMENT THEORY AND PLAY

THERAPY ACTIVITIES ¹

¹ Willis, A. B. To be submitted to Contemporary Family Therapy.
Abstract

As a whole, the field of family therapy needs to increase its service toward young children in family therapy. Family therapists often express feeling inadequately trained to work with children and tend to exclude them from sessions. Additionally, child development principles and applications are often missing from articles purported to offer advice for using traditional family therapy models with children. Attachment theory, which is founded on child development research, has demonstrated promise as a clinical framework for informing relational therapy with adults, adolescents, and young children. This article provides a theoretical evaluation of a forthcoming attachment-based therapy model (Emotionally Focused Family Therapy, EFFT) recently proposed to be used with families with preschool-aged children (ages 3 to 6). Family play therapy strategies and developmental considerations are provided that can be used within an EFFT framework to build secure family attachments.
The Exclusion of Children from Family Therapy

Historically, the field of family therapy has been criticized for insufficiently attending to the needs of young children with mental health problems (Cox, 1997; Diller, 1991; Sori, 2006; Zilbach, 1989). The majority of Marriage and Family Therapists (MFTs) have little training in child therapy or family play therapy approaches, and many family therapists report a reluctance to work directly with children in treatment (Raimondi & Walters, 2004; Ruble, 1999; Sori, & Sprenkle, 2004; White & Chasin, 2006). In a survey of 173 members of the American Association for Marriage and Family Therapy (AAMFT), only 38% of the respondents had any child-specific training (Korner & Brown, 1990). Respondents with little instruction in child therapy approaches reported much lower rates of including children in therapy than those with such training. When included in family sessions, young children have been shown to be treated as passive participants or “nonpersons” (Cederborg, 1997, p. 37).

One is prompted to ask why systemically-trained family therapists would consistently leave out such a vital part of the system during family treatment? Several barriers to engaging children in family therapy have been cited, such as family therapists’ inadequate training or supervision in child therapy techniques or applications of child development, therapists’ personal discomfort with children, verbally biased family therapy models, a desire to protect young children from developmentally inappropriate exposure to adult information, and difficulty structuring sessions around children’s high energy and short attention spans (Gil, 1994; Johnson & Thomas, 1999; Ruble, 1999; White & Chasin, 2006).
Another reason family therapists often fail to involve children in systemic treatment is the mind-set, or “paradigm split,” that child and family therapies “are mutually exclusive modes of practice” (Haslam & Harris, 2011, p. 52). Lund, Zimmerman, and Haddock (2002, p. 445) remarked that family therapy and play therapy disciplines developed “simultaneously but separately,” leading therapists to feel they must choose between a parent-focused or individual child-focused approach rather than integrating the two modalities. Lund et al. (2002) further noted that family therapists tend to view child therapists as “pathologizing children,” whereas child therapists often believe family therapists “ignore or oversimplify children’s intrapsychic processes” (p. 446). These opposing points of view have resulted in limited literature optimizing on the strengths of both child and family therapy practices.

**Rationale for Integrating Play Therapy into Family Therapy**

Multiple scholars have advocated for the merger of family and play therapy techniques to enhance the developmental-sensitivity of family therapy practice with young children (White & Chasin, 2006; Gil, 1994; Keith & Whitaker, 1981; Lund et al., 2002; Sori, 2006; Sori & Sprenkle, 2004; VanFleet, Ryan, & Smith, 2005; Wittenborn, Faber, Harvey, & Thomas, 2006; Zilbach, 1986). Play therapy is a widely practiced counseling approach for treating children’s mental and emotional problems, and many reviews of play therapy have thus far been positive for children of diverse age groups (Baggerly, 2009; Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Ray & Bratton, 2010).

Though play therapy originally arose out of psychoanalytic (Klein, 1955; Freud, 1946), Rogerian (Axline, 1947; Landreth, 2002), and Jungian (Lowenfeld, 1939)
formulations which were focused predominantly on the individual, there are many advantages to using play therapy activities with families. Family play therapy draws on a normative developmental process for children, engages whole families in therapeutic tasks, fosters relational attachments, honors children’s ways of thinking and communicating, and energizes sessions by introducing an element of fun into emotionally-laden topics (Gil, 1994; Sori, 2006). Play therapy techniques have also been claimed to increase the self-expression of young children, and facilitate emotional regulation as children work through their feelings (Schaefer & Drewes, 2011).

**Child Development and Application Knowledge is Missing**

Although efforts to accommodate children in family therapy represent an important step forward in the mental health field, few examples of explicit endeavors to incorporate child development theory and research can be found. This trend is not uncommon in clinical literature on children. References to specific developmental factors are frequently excluded from articles and book chapters purported to expound therapeutic interventions for children and adolescents (Holmbeck, Devine, & Bruno, 2010; Weisz & Hawley, 2002). In response to such trends, Holmbeck et al. (2010) emphasized that children are in a continual process of developmental change and lamented that current child and adolescent treatments are not more developmentally oriented.

**Using an Attachment Perspective to Reframe and Treat Child Problems**

Attachment theory offers a valuable conceptual framework, grounded in child development research, that can guide clinical understanding and treatment of many mental and emotional problems for which children are referred to psychotherapy (Kobak
& Mandelbaum, 2003). According to attachment theory (Ainsworth, Blehar, & Waters, 1978; Bowlby, 1982), the human need for relationships serves an evolutionary, biological function. It is assumed that children’s attachment to their caregivers is motivated out of a need to be protected and to create a secure base from which they can explore their world. The development of a secure child-caregiver attachment is founded on the child’s perception of the primary caregiver as available, dependable, sensitive, and responsive to signals for help (Marty, Readdick, & Walters, 2005). When there is a secure attachment, the child feels confident to learn about the world, knowing the caregiver will be available to assist if necessary. The child can then develop adaptive life skills (e.g., healthy emotional regulation learned from the child’s experience of being soothed by the caregiver), which will help the child successfully navigate future relationships as well as life challenges (Sroufe, 2005).

Kobak and Mandelbaum (2003) claimed that children’s mental health symptoms and distress in parent-child relationships are most likely to occur at times when there is a threat to the attachment security of that relationship, and these perceived threats produce intense feelings of sadness, fear, and/or anger which appear in “distorted or symptomatic forms” (p. 148). Maladaptive parental responses (e.g., dismissing or exaggerating the child’s concerns) can lead to further exacerbation of symptoms. “When the child’s strategies for maintaining the relationship break down, the parent and child often interact in ways that further fuel the child’s anxiety and the parent’s sense of frustration and failure” (Kobak & Mandelbaum, 2003, p. 148).

Empirical support for the use of attachment-based therapies with children and adolescents lends credibility to the value of targeting attachment in the psychological
treatment of them (Cohen, Muir, & Lojkasek, 2003; Diamond, Wintersteen, Brown, Diamond, Gallop, Shelef et al., 2010; Hoffman, Marvin, Cooper, & Powell, 2006; Johnson, Maddeaux, & Blouin, 1998; Lieberman, VanHorn, & Ippen, 2005; VanFleet et al., 2005; Wardrop, & Meyer, 2009). However, there is minimal literature regarding attachment-based family therapy approaches with young children. Currently, there are only two family therapy models with a theoretical core in attachment theory: Emotionally Focused Family Therapy (EFFT: Johnson & Lee, 2005) and Attachment-Based Family Therapy (ABFT: Diamond, & Stern, 2003). Of these two models, only EFFT has been suggested as a potentially effective family therapy approach for young children (Johnson & Lee, 2005; Wittenborn et al., 2006).

**Purpose of this Article**

The premise of this article is that EFFT, when combined with appropriate play therapy techniques, can be used to treat attachment-related problems in families with young children. The author will provide a theoretical review of Emotionally Focused Family Therapy (EFFT), and provide suggestions for how to tailor this approach to families with young children, ages 3 to 6. The conceptual basis of Emotionally Focused Therapy (EFT) will be presented along with illustrations depicting how the model has been applied to couples and families (Johnson, 2004; Jonson, Bradley, Furrow, Lee, Palmer, Tilley, & Wookey, 2005; Johnson & Lee, 2005). This will be followed by an exposition of the strengths and limitations of the current EFFT model (Johnson & Lee, 2005) as well as a list of strategies that may be used from an EFFT perspective with preschool-aged children. Suggestions provided in this article are not intended to be a comprehensive or standardized treatment approach. Rather, the author’s hope is to
inspire ongoing conversation probing the depth and breadth of the possibilities for family therapy.

**Emotionally Focused Therapy (EFT) for Couples**

**Conceptual Basis of EFT**

EFT is a systemic, experiential, and attachment-based clinical model originally designed for adult couples’ therapy (Johnson, 2004). The model includes an emphasis on both intrapsychic and interpersonal processes. Therapists using this model seek to facilitate couples’ secure attachment by helping individuals more fully experience and process their primary emotions, express their attachment needs, and communicate these feelings and needs to their partner, who is primed to remain engaged, open, and receptive. It is theorized that this experience helps to shift partners’ rigid negative interactional stances toward positions of greater accessibility, flexibility, and responsivity. Johnson stated, (2004, p. 10), “When EFT is successfully implemented, each partner becomes a source of security, protection, and contact comfort for the other. Each partner can then assist the other in regulating negative affect and constructing a positive and potent sense of self.”

**Stages of treatment.** EFT for couples consists of three stages: (a) cycle de-escalation, (b) restructuring the interactional cycle, and (c) consolidation/integration (Johnson, 1996). In the cycle de-escalation stage, the therapist works to identify the couple’s problematic interactional cycle, access clients’ unacknowledged feelings underlying the cycle, assess clients’ attachment needs, and reframe couple problems in terms of these needs. During the restructuring stage, the therapist helps clients identify with disowned needs and aspects of self, accept their partners’ new construction of their
experience, express wants and needs to their partner, and become emotionally engaged with their partner. The consolidation and integration stage involves getting the couple to generate new solutions to old problems and strengthen new interactional patterns that foster attachment security.

**Interventions.** EFT techniques are designed to access and process couples’ immediate emotional experiences. The techniques consist of verbal statements and inquiries, such as reflection (“so what you are saying is…”), evocative questions (“what was it like when…”), validation (“it is understandable you would feel that way”), empathic conjecture (tentatively exploring clients’ unexpressed emotions), heightening (intensifying client’s emotional experiences through metaphors, changes in body language/verbal tone, and focusing on emotion), and RISSSC (repetition, images, simple phrases, slowed pace, soft tones, and use of the client’s words).

Once clients individually explore their own emotions and attachment needs, the therapist guides them through a series of enactments in which they express their feelings and needs to their partners. Throughout these enactments, the therapist helps avoidant partners remain more engaged with pursuing partners (i.e., withdrawer engagement) and the pursuing or nagging partners to be less critical of the withdrawers (i.e., blamer softening). The therapist tracks and reflects to the couple any positive changes in the interactional pattern, which can later be consolidated into a new interactive style of attachment behaviors.
Emotionally Focused Family Therapy (EFFT)

Conceptual Basis of EFFT

Johnson et al. (1998) were the first to publish applications of EFT principles within a family therapy context. Later, Johnson and colleagues produced three book chapters describing the theoretical premise and practices of Emotionally Focused Family Therapy (EFFT; Johnson, 2004; Johnson & Lee, 2005; Johnson et al., 2005). Other authors have published on the topic of EFFT and added valuable insights into the development of this model (Efron, 2004; Efron & Bradley, 2007; Dankoski, 2001; Palmer & Efron, 2007; Wittenborn et al, 2006). In these works, it is argued that parents and children frequently engage in demand-withdraw interactions that have similarities to those seen in distressed couples treated with EFT, and that EFT techniques traditionally used with couples could be helpful for building family cohesion and emotional connectedness in EFFT.

The change mechanisms, treatment objectives, and assumptions of the EFFT model have been viewed as comparable to those in EFT (Johnson, 2004; Johnson & Lee, 2005). Family relationships are believed to change as emotional responses that underlie negative family interactional patterns and define family relationships are accessed. The therapist’s goal is to “use emotional experience and expression” as a mechanism to “modify family relationships in the direction of increased accessibility and responsiveness, thus helping the family to create a secure base for children to grow in and leave from” (Johnson, 2004, pp. 244-245). It is assumed that, as the identified patient (IP)/child’s relationship with family members (especially his parents) improves, the child
will be defined more positively by the family and, intrapsychically, by himself, which will lead to a reduction in the child’s symptoms.

**Strengths of the current EFFT model.** A major strength of the EFFT model is that it contains clinical tools designed to improve children’s attachment to their primary caregivers and family. Targeting children’s early attachment relationships holds immense value due to the critical role attachment plays in neurological and socioemotional development across the human lifespan (Allen, Porter, McFarland, McElhaney, & Marsh, 2007; Bohlin, Hagekull, & Rydello, 2000; Sroufe, 2005; Thompson & Meyer, 2007). Attachment is not static; it can be modified for the better or worse by later life experiences, interpersonal relationships, or treatment (Beckwith, Cohen, & Hamilton, 1999; Feeney, Passmore, & Peterson, 2007; Hoffman et al., 2006). Evidence from these studies engenders hope that children’s emotional and mental health could improve when attachment is the focus of treatment.

**Limitations of the current EFFT model.** While EFFT holds much promise for families, some aspects of the model still need refinement. For instance, as it is currently presented by Johnson and her associates (Johnson, 2004; Johnson et al., 2005; Johnson & Lee, 2005), the EFFT model is principally a talk-based approach. This often occurs in “top-down” models (i.e., adapting an adult therapy model to work with children). The vignettes offered in Johnson’s work on EFFT portray therapy almost exclusively with parents and their adolescent children. Young children are therefore at a developmental disadvantage because they cannot participate in talk therapy like school-age children, teens and adults. Without some special accommodation, young children’s perspectives are likely to be left out of the therapy dialogue (Wittenborn et al., 2006).
Developmental Factors in EFFT with Young Children

Attachment Assessment with Young Children

Because attachment is the primary clinical domain of EFFT, therapists who use this model with young children should be well-versed in early attachment development norms. Attachment formation begins in infancy and is largely influenced, at that time, by the caregiver’s attachment-promoting behaviors. The young child’s attachment needs from the caregiver typically include attunement to the child’s emotions, helping the child identify and express these emotions, responding consistently to the child’s emotional dependency needs while enforcing appropriate limits and discipline, gently encouraging growth of the child’s competence and independence, and engaging with the child in regular nurturing routines and rituals (Blaustein & Kinniburgh, 2010; Thompson & Meyer, 2007). Markers of secure attachment are the caregivers’ ability to manage their own affect, clearly communicate their thoughts and feelings to the child, and problem solve with the child in a way that promotes the child’s cooperation (Kobak & Mandelbaum, 2003).

Observation of children during periods of separation and reunion with their caregivers has been recommended as a way to form hypotheses about young children’s attachment status (Wittenborn et al., 2006). This recommendation was based on Ainsworth and associates’ (1978) Strange Situation experiments with 1- to 2-year-olds and might be a valuable suggestion. Formal attachment-measuring procedures using conditions similar to the Strange Situation have been developed for 3 to 6 year olds (Cassidy & Marvin, 1992; Crittenden, 1992), but these methods have demonstrated mixed results in validity tests. Using a sample of 51 mother-preschooler dyads, a group
of researchers cross-compared the Cassidy and Marvin (1992) and Crittenden (1992) methods with an extended version of the Ainsworth Strange Situation method and found the attachment classifications among the 3 measures were highly inconsistent (Crittenden, Clauseen, & Kozlowska, 2007). For now, practitioners should remain cautious about making definitive conclusions regarding preschoolers’ attachment during separations of the child and caregiver. Clearly, more research is needed on assessment of preschool-aged children’s attachment through separating and reuniting them with their caregivers. A few other strategies for clinical assessment of the attachment of young child clients are discussed later.

Culture should also be considered in the assessment of attachment in young children. In one study, cross-cultural comparisons of infant attachment behaviors using Ainsworth’s Strange Situation (van IJzendoorn & Kroonenberg, 1988) demonstrated indications that German and Japanese babies showed different attachment patterns than American infants, suggesting Ainsworth and associates’ (1978) classifications of secure and insecure attachment patterns might be culturally biased. When clinicians work with families of diverse cultures, greater understanding about cultural norms, as well as other theories of relationships, may be needed to appropriately treat family issues.

**Early Emotional Development**

Accessing and processing clients’ emotions are key therapeutic tasks in EFFT so it is vital that EFFT therapists understand developmental factors that affect young children’s ability to recognize and talk about their thoughts and feelings. By age 2 to 3, toddlers have usually learned a few emotional labels, but they vary widely in the frequency of feelings-state talk and causal-understanding of their emotions (Dunn,
Bretherton, & Munn, 1987; Dunn, Brown, & Beardsall, 1991). In contrast, children ages
4 to 5 have gained greater verbal skill and are more able to label a larger variety of
feelings if given some assistance (Dunn et al., 1987, Dunn et al., 1991). Although their
expressive-receptive linguistic abilities may differ, preschoolers have usually developed
some capacity for symbolic thought, sustained attention, sociodramatic play, and the
ability to follow simple instructions (Santrock, 2007; Woodward & Markman, 1998).
With these developmental assets, it is possible to assist them with symbolic
communication of their feelings and needs (Malchiodi, 1998).

Nonetheless, it should be remembered that until they reach adolescence (around
age 12+), children still have limited awareness of their own thoughts and they rarely
connect people’s mental activity to their behavior (Flavell, 2004). As a result, young
children’s meta-cognitive skill (i.e., insight that they have thoughts or consciousness of
what they are thinking) is not particularly good. When asked what they think or feel
about something, they are likely to give a socially appropriate, yet superficial, response
like, “I don’t know,” “Good,” or “It’s okay.” Asking preschoolers questions like “What
do you think about that?” should therefore be avoided until they are a little older (e.g.,
age 6+).

Through practice, perhaps in the course of therapy, children can develop greater
skill at responding to questions about their feelings. With help and experience, children
between 6 and 12 may be able to say that thinking about something makes them feel sad
or anxious or happy, etc., which is a pre-requisite for doing more cognitive-based
therapies (Shirk, 2001). Such experience is gained not just through practice answering
direct questions, but can also be obtained through other methods described here that help
children recognize their feelings. Another developmental consideration is that young children usually learn words from hearing other people’s conversations so their understanding of word-meaning is sometimes superficial or distorted (Woodward & Markman, 1998). Establishing a shared understanding with children on the emotion terms used in therapy may reduce misunderstandings resulting from the child’s newly-emerging vocabulary.

Family rules for emotional display also highly influence the extent to which children are knowledgeable about emotion and which feelings they feel comfortable expressing (Thompson & Meyer, 2007). Based on past experience, many children believe that revealing true feelings puts them at risk. They may misrepresent their feelings as being less distressed or more positive than they actually are in order to protect others from worrying about them or to avoid any anticipated backlash (e.g., criticism or minimization of their feelings). Only when children trust the therapeutic setting can they be expected to reveal feelings with accuracy. In families where the display of particular emotions, such as sadness or anger, have been implicitly prohibited, the therapist may need to model, or assist parents in modeling, appropriate emotional disclosure to encourage the child to share previously censured or disowned feelings (Jarratt, 1994). Separate work with parents may be needed to help them create a safe space for their child’s expression of angry or painful emotions.

**Integrating Play Therapy Activities into EFFT**

The following section includes suggestions from the author for utilizing play therapy techniques within an EFFT framework for families with young children. Recommendations for working with these families will be presented for each stage of the
EFFT model. The delineation of steps in EFFT (identified in subtitles) was taken from Johnson and Lee (2005). As a reminder, the proposed techniques are not meant to constitute a standardized clinical approach but rather are intended to promote further exploration of methods for improving the developmental sensitivity of therapists using EFFT with young children.

**Stage 1: Cycle De-escalation**

**Step 1: Delineate conflict issues and attachment struggles.** Steps 1 and 2 in Emotionally-Focused Therapy are commonly referred to as the assessment phase (Johnson, 2004). An EFFT assessment typically includes inquiry into the evolution of the family’s relationships, family alliances or coalitions, the emotional tone of the household, family members’ efforts to cope with frustration and nurture one another, and the family’s objectives for treatment (Johnson & Lee, 2005). If a young child is the reason parents are seeking treatment, attention should also be given to the child’s mental health symptoms and developmental history (e.g., pregnancy/birth complications, early temperament, delays in developmental milestones, etc.). This can help the therapist determine whether attachment difficulties are perpetuating the child’s symptoms or whether other factors (e.g., learning disabilities, attention-deficit/hyperactivity disorder, autism spectrum disorders) merit a different treatment approach than EFFT.

Information about the attachment history of the child and primary caregivers ought to be explored as well. The therapist might ask about any “unanticipated or unplanned separations [which could] create relationship disruptions that shake the child’s confidence in the caregiver’s availability” (Kobak & Mandelbaum, 2003, p. 147), such as abuse, neglect, death/removal of caregiver, or times the caregiver was emotionally
unavailable (e.g., due to mental health, stressful job, illness). Caregivers could be asked if they have ever had a secure relationship in their lifetime and whether they feel supported socially by family or friends. With two caregivers, the therapist could evaluate whether the caregivers work together cooperatively and share the responsibility of caring for the child. This information can be useful for making preliminary hypotheses about family members’ attachment needs underlying their positions in the negative interactional cycle.

For the first 1 to 2 sessions of EFFT, Johnson and colleagues recommended that therapists meet with the whole family to gather the entire family’s perspective on family dynamics (Johnson & Lee, 2005; Johnson et al., 2005). With older children and adolescents, this is likely an appropriate suggestion because of their ability to participate in a more verbal discussion. However, when a young child is the IP in EFFT, this author concurs with Wittenborn et al. (2006) that the therapist should focus on gaining the report of the primary caregivers first and then seek to understand the young child’s perspective in later sessions. This approach can help in the negotiation of developmental differences between the “adult world” and the “child’s world” (p. 337) by allowing the therapist to conduct a preliminary clinical assessment, which can be expanded upon in subsequent conjoint sessions with the child and/or other family members. As will be demonstrated, younger children often need assistance to express their feelings (which are still new and largely incomprehensible to them) and this may take several sessions.

**Step 2: Identify and clarify negative interactional cycles that maintain insecure attachment.** By the second session, the therapist could meet the entire family and use a combination of unstructured and structured play therapy techniques to gain a
deeper understanding of the family’s problematic interactional cycle and begin validating the children’s experience of the family. Opinions about what defines a problematic interaction may vary according to the subjective interpretation of different family members. Consequently, the desirability of an interactional pattern can only be contemplated in the context of the individual needs of each member. One of the benefits of play-based assessment is that it is harder for parents and children to be guarded, mostly because they do not know what the therapist is looking for. The techniques also serve as good ice-breakers for families because they are fun and can help diffuse anxiety.

Wittenborn et al. (2006) recommended the use of unstructured family play for both assessment and intervention purposes (to strengthen family relationships) in EFFT. Though called by different names (e.g., free-play, non-directive play), this technique is a common observational tool for evaluating parent-child and whole family interactions (Hoffman et al., 2006; Stollack, Barlev, & Kalogiros, 2000; VanFleet et al., 2005; Wittenborn et al., 2006). The technique is begun by showing the family several toys placed in an accessible location in the room, and inviting the family to play together for 15 to 20 minutes as they would at home (Stollack et al., 2000). Usually, no further instructions are given so the therapist can assess the family’s spontaneous response to the task. The therapist sits quietly and observes from the side of the room.

While watching the family play, the therapist could silently note: *Who’s in charge here? How unified do the caregivers seem to be? How easy is it for this family to play together? Are there some pursue-withdraw patterns going on here? Who is “in” and “out” in this family (as indicated by who is playing with whom, body-positioning, and physical proximity)? Who nurtures whom? Are there coalitions or alliances? How well
do caregivers appear to read and respond to the children's signals for help? Are there any unexpected responses to certain interactions? Following play-time, the therapist might ask what it was like for the family to play together like this, whether their behavior was similar or different to their interactions at home, and whether there was anything that happened during their play they did or did not like. Younger children may contribute less descriptive information to these questions than older clients, but the therapist can still absorb information from the observation and interview about family dynamics.

A more structured approach to assessing family attachment processes is the Play Genogram, developed by Eliana Gil (2003). In this technique, the therapist asks family members to select from a collection of objects (e.g., miniatures, animal toys, action figures, puppets, and uniquely shaped buttons) any items that represent their feelings about, or perception of, other members of the family. The therapist uses the metaphor of the selected items to inquire about family interactions and clients’ phenomenological experiences in the family. An EFFT-oriented therapist could use this medium to ask about family attachment promoting behavior or pursue-withdraw cycles.

For example, if a 5-year-old child selected a dinosaur for himself, a fairy for his mother, a dragon for his father, and a porcupine for his big brother, the therapist could ask: (a) Can you show me with the toys which ones are closest to each other (or better friends)? Put the ones who get along best closer together and the ones who don’t get along as well further apart. (b) How well do the dinosaur and porcupine get along? Can you act out what it looks like when they are getting along (or, being nice to each other)? When they are not getting along? What do the dragon and fairy each do when the
dinosaur and porcupine are arguing? (c) Who can the dinosaur go to when he’s feeling sad or worried? How do the dragon and fairy try to make the dinosaur feel better?

Advantages of the Play Genogram are that it draws upon role-play to facilitate direct questioning about family characteristics, and it is a semi-projective technique in which children’s perceptions of their family may be inferred from their toy-selection. Children’s ability to tell stories about the figurines will depend on their verbal skills. Older preschoolers (age 5+) tend to do better at talking about the figures/objects and acting out family interactions.

Assigning the family a mildly challenging task is another procedure for assessing family interactional patterns. The therapist could invite the family to work together to “build a house” out of Lincoln logs, blocks, paper and tape, or fuzzy pipe-cleaners; have the family plan a menu for dinner with their favorite foods (but there can only be 1 meat, 2 vegetables, 1 drink, and 1 dessert); and/or, direct the caregivers to ask the children to clean up the toys (Stollack et al., 2000). Therapists can spend about 10 minutes after these activities discussing interactional patterns that occurred during the activity and reflecting these back to the family.

The therapist might comment on positive or negative interactions that happened or ask about any themes from the project that reflect family processes in the home. For example, the therapist might say, “I noticed, there, during the log-house activity, dad, you were sitting on the couch while mom was working with Janice [the child] on the floor. Can you help me understand what was going on there? What was that like for you, dad? Mom? How did you feel, Janice, when that happened? Does that kind of thing happen
much at home?” The therapist can then use reflection and validation to further clarify the micro-moves in the family’s interactional dance.

**Step 3: Accessing unacknowledged emotions underlying interactional positions.** Step 3 in EFFT is represented by the therapist’s efforts to access and empathically attune to the emotional experiences of family members that drive their behaviors in the interactional cycle. For families with young children, this next set of sessions will likely be focused on accessing children’s emotional experiences and monitoring the parent’s reaction to the children’s communication (Kobak & Mandelbaum, 2003). Separate parenting sessions may be needed to de-escalate parents if they cannot listen respectfully to their children and provide a safe place for the children to explore their feelings. Suggestions designed to help rejecting or non-accepting parents hear the child’s perspective are provided in Step 6. To increase the safety and focus of treatment sessions, the therapist starts with dyadic (e.g. parent-child) sessions and gradually works toward triadic sessions, which include the child and both parents or sibling subsystems (Johnson & Lee, 2005).

Making feelings cards is a useful technique for helping young children co-construct definitions for the emotion terms used in therapy and for creating points of reference, which can be quickly accessed later to identify their feelings within the context of the negative cycle. In the Five Faces Technique (Jarratt, 1994), a therapist asks children to name five feelings kids or grown-ups are likely to have and what people’s faces look like when they have these feelings. Family members demonstrate the facial expression and it is drawn on an index card with the appropriate emotional term. At first, this may seem more like a cognitive exercise (vs. one in which the therapist helps evoke
emotion in the child), but it is nevertheless an important step because it gives young children rudimentary linguistic tools with which to begin to describe their felt experiences (Shirk, 2001).

The therapist can help family members shift from talking about feelings in general to sharing their personal feelings with each other by inviting family members to describe times in their lives they’ve had the emotions on the feelings cards. This provides an excellent opportunity to role-model feelings-talk and validate that everyone has all of these feelings sometimes. Gil (1994) described a technique, entitled *Color Your Life*, in which the therapist creates a color-coded key (e.g. yellow = happy, red = mad, blue = sad, green = scared, purple = lonely, pink = loved) and has the child use crayons or markers to fill in a paper with different colors representing how much of each feeling he has in his life right now. Discussion can ensue about what is “in” those feelings (or, what makes them feel that way), which can help children better identify the source of their distress. Taking this one step further, the therapist could have the child draw a picture of his family and place different colored dot-stickers by each person (using the color-code just described) to show how he feels about the people in his family.

As children become more used to feelings-talk, they can be invited to identify their feelings about various events, issues, or family interactions. To connect a child’s feelings to his behaviors in the cycle, the therapist can ask the child what he does when he has these feelings. The therapist could explore with caregivers what comes up for them emotionally when they see the child act this way, whether caregivers, in the heat of the moment, recognize the emotions motivating the child’s behaviors, and what they do in response. With more verbal children, the therapist could have the family act out a
movie with puppets which portrays times of “upset feelings” in their family (Brewer, 2010a). The therapist can stop the movie (by playfully yelling “Cut!”) at the beginning, middle, and end of the movie, and have them point to feelings cards to show how they feel at different points in the cycle. The therapist could ask “What made you feel that way? Ok, that makes sense you’d feel that. So what happens after that? Can you show me with the puppets?” The therapist can validate feelings and reflect the cycle back to the family.

**Step 4: Redefine the problem.** During EFFT Step 4, the therapist reflects the negative interactional cycle to the family in terms of underlying emotions and attachment needs, and reframes the family as “unwittingly creating, but also being victimized by, the cycle of interaction that characterizes their relationship” (Johnson et al., 2005, p. 103). Due to the developmental limitations of young children in understanding mental processes and the connection between people’s thoughts and behavior (Flavel, 2004; Flavell, Mumme, Green, & Flavell, 1992), the responsibility for understanding the intricacies of the cycle rests primarily on the therapist and caregivers.

The following case example illustrates ideas for reframing the cycle with caregivers. Margie, the divorced mother of a 5 year-old daughter (Clara) has come to therapy for help with Clara’s anger and oppositional behaviors. The mother’s boyfriend (Rob) moved into the home about 3 months ago, and Clara has responded with an increase in argumentative and aggressive behaviors (talking-back, hitting, yelling, name-calling) toward Rob. After meeting with Margie and Clara for several sessions, the therapist schedules a parenting session. The therapist learns that it is hard for Margie to hear her daughter say she doesn’t like Rob because Margie loves Rob and worries that he
will leave her due to Clara’s temper. Margie comments that she feels stuck in the middle ("like a referee"), trying to please Rob while being a good parent to Clara by teaching her to respect adults. Margie states that, when she sees Rob and Clara arguing, she tries to reduce the conflict by yelling at them both to stop. When Clara escalates and starts hitting, Margie feels overwhelmed and wants to leave. She usually says, “I can’t handle this,” drags Clara into her room and locks the door, then goes outside for a cigarette break.

The therapist reflects and validates Margie’s feelings in the cycle, and asks Margie what she has learned from the conjoint sessions with Clara about her daughter’s experience of these arguments. Margie says she felt guilty last session when Clara expressed that she dislikes Rob because he sometimes says “mean things” to Margie, and that she (Clara) feels sad and unloved when Margie yells at her. Margie articulates surprise that Clara also said she worries Rob will take Margie away forever. The therapist comments, “So, could it be that Clara feels threatened by Rob (that he might “take you away forever”) and is trying to protect her relationship with you by directing her anger at him? [Margie nods thoughtfully.] But, when you see Clara’s anger toward him, you think of it as being disrespectful. You feel embarrassed and torn between trying to please him and be a good parent to her. Did I get that right? [Therapist waits for a confirmatory response from Clara.] You become ashamed that you can’t ‘control her’ and you worry you’ll lose him so you yell to try to keep the peace between them. But, when the arguing gets worse, you become overwhelmed, feeling a strong need to withdraw and leave. Is that it?”
At this point, the therapist and Margie could talk about how the repetitiveness of the cycle has convinced Margie that she’s an incompetent parent, helpless, and unlovable to men. The therapist might also explore what Margie guesses the cycle has tried to convince Clara about herself and her place in the family. The therapist could then make the reframe, “This cycle has become so habitual it is almost like an enemy who tries to take over and drive you and your daughter as well as you and Rob apart. Each in your own way, you are all in a fight to protect and preserve your relationships, but these attempts to stay close, without you meaning it to, have actually pushed you away from each other.”

Stage 2: Restructuring Interactions

The restructuring stage of EFFT, which comprises Steps 5 through 7, is designed to help clients more deeply experience their attachment-related emotions (e.g., need for dependency, fears of rejection) so that these disowned or unformulated feelings can be acknowledged, crystalized, and owned. When these emotions are expanded, individuals tend to seek connection and emotional engagement with others. Appropriate expression of the need for closeness and a view of self as vulnerable are believed to naturally evoke a desire to comfort and re-engage from the significant other. Internal conflicts (a.k.a. “blocks”) that inhibit family members from emotionally “letting in” others are explored and reframed in terms of attachment insecurities.

Evocative responding, heightening, and empathic conjecture are the techniques considered to be “particularly crucial” in the restructuring family interactions stage of EFFT (Johnson et al., 2005, p. 172); however, these techniques present some developmental challenges to preschoolers. Children, ages 3 to 6, are usually very limited
in their ability to verbally articulate their intrapsychic experiences in response to abstract (evocative response) questions like, “What is that like for you?” Additionally, the use of empathic conjecture (or, tentatively suggesting feelings the client may have but has not yet expressed) with young children the way it is used with adult couples and adolescents in EFT/EFFT is not appropriate because children younger than age 6 are highly vulnerable to suggestion (Eisen, Goodman, Quin, Davis, & Crayton, 2007; Fritzley & Lee, 2003). Response bias resulting from suggestive questioning can lead to erroneous acceptance or rejection of empathic interpretations that could misrepresent the child’s thoughts or feelings. Nevertheless, as will be shown below, some work can be done to deepen the child’s emotional experience and expression of attachment emotions, which can be used to help the caregiver gain insight into the child’s inner world and strengthen the relationship.

**Step 5: Promoting identification of disowned needs and aspects of self.** Semi-projective art activities may be used in lieu of evocative response questions to access children’s disowned feelings. Children tend to prefer creative art activities to talking about issues because they can “show” instead of “tell” (or verbally describe) their feelings. Furthermore, the time children spend on such art projects can help them and their caregivers (via observation) stay engaged with the children’s emotions, which is a key active ingredient in EFFT. With older preschool-aged children (age 4 or 5+), who are beginning to develop fine-motor skills needed for drawing, projective art techniques, such as Draw-A-Person (Machover, 1949), House-Tree-Person drawing (Buck, 1966), and the Kinetic Family Drawing (Burns & Kaufman, 1972), can reveal information about a child’s views of self and his position in the family.
In addition to these techniques, children may be asked to make a drawing/painting, sandtray world, or sculpture of “what it feels/felt like” during distressing family interactions or when a potential attachment injury occurred (De Domenico, 1995; Malchiodi, 1998; Rhodes, 2008). Images portrayed in the art projects can become quick reference points that capture members’ emotional experiences fueling their behaviors in the cycle. If the therapist directs the child to show or talk about the art project with the caregiver, it can also serve as a type enactment to help the child express his feelings to the caregiver.

Another way to accentuate young children’s feelings is to have them rate the intensity of their emotions and describe where they feel the emotion in their body. For instance, if a recently divorced mother reported that her 4 year-old son (Dexter) becomes sad and withdrawn after visits with his father, the therapist could invite Dexter to point to the feeling cards to show his feelings before, during, and after the visits. Then, the therapist could say, “Okay, Dexter, so you said you feel sad when you come home after visiting your dad? How much sadness do you feel? Can you show me with these stickers? Let’s pretend this paper doll is you... [The therapist shows the child a blank gingerbread-man shaped paper doll.] We’ll say blue stickers are sad feelings. The more stickers you put on this doll, the more sad you feel.”

Traditional non-verbal heightening techniques can then be used to deepen the child’s emotions: “So you feel THAT much sadness?! [The therapist pauses for effect, and continues very slowly and quietly, in RISSSC manner.] That’s a lot of sadness. You know, it’s okay to feel sad sometimes. I think a lot of kids would feel sad if they were in the same situation. Where do you feel the sadness in your body? [The therapist draws
another gingerbread-man shaped figure and has the child mark in the areas he feels his sadness.] I see... So you feel the sadness here, here, and here? [Therapist uses repetition, pointing to the drawing.] Can you tell me about these places? Mm-hmm. Which place hurts the most? Okay. How about we put a band-aid on the places that hurt the most? Sometimes talking about upset feelings helps them to heal. [Therapist hands the child some band-aids.] Can you tell me what it is that makes you the most sad when you leave your dad’s house? [Child answers.] Yes, I can understand that would make you very sad. [Therapist pauses.] Hmm... Do you think you can show your picture to your mom right now? You can say as much or as little as you would like about it to her.” Having the child show the picture to the caregiver can create another enactment and “turn intrapsychic experience into direct interpersonal messages” (Johnson, 2004, p. 83).

**Step 6: Fostering the acceptance of each person’s experience and new interactional responses.** Secure attachment in child-caregiver relationships is predicated on the caregiver’s ability to hear the child’s angry or negative emotions without criticism or threat of abandonment (Diamond & Stern, 2003). Thus, the therapist will need to first work on helping caregivers accept their children’s feelings and needs (rather than vice-versa). One way to accomplish this is by meeting alone with the caregivers periodically to discuss their observations of the child during the conjoint/family sessions and to explore their interpretation of the child’s feeling about key issues, what this might mean about the child’s attachment needs, and how the caregiver is responding to all of this information. This type of questioning has been used in play therapy models, such as Filial Therapy (VanFleet et al., 2005) and Watch, Wait, and Wonder (Cohen et al., 2003), which are designed to enhance parental attunement to young children. These questions
may be thought of as helping caregivers engage in a dialogue of emotional conjecture about the child’s attachment feelings and needs. These are vital conversations to have with caregivers because children do not always know what they need or how to express it if they did.

Sometimes, caregivers come to therapy with the impression that the therapist will “fix” the child’s behaviors and this will make the parents’ problems go away. In such cases, it can be useful to explain to parents that the child’s behavior will likely gradually change as a result of positive changes in the parent’s behavior aimed at strengthening the relationship. Caregiver reluctance to understand or empathize with their child’s feelings constitutes a block (or, obstacle) to the development of a secure bond between the primary caregiver and child. Often, parental anger and frustration directed at the child, or other parental attachment-issues, can interfere with the parent’s ability to feel kindly toward the child. Techniques from Attachment-Based Family Therapy (ABFT) that are designed to prepare parents and their adolescent children for the “Attachment-Repairing Task,” in which adolescents express their grievances to their parents, provides a useful framework for identifying blocks to attachment and softening angry or rejecting parents to listen more empathically to their children.

In the ABFT model (Diamond & Stern, 2003), the therapist first meets individually with the adolescent to identify the adolescent’s grievances underlying attachment insecurities in the parent-child relationship. Then, the therapist meets with the parent separately for an individual session. In this session, the therapist seeks to build an alliance with the parent by learning about and empathizing with the parent’s current stressors (that may compete for the parent’s attention and divert the parent from the being
emotionally accessible to the child) or past attachment failures (e.g., which have resulted in a sense of loss, abandonment, or neglect). The therapist can use these experiences to help the parent be more receptive to the concerns of the adolescent. For example, the therapist might say to the parent, “Sounds like you know how painful it is for a child to have no one to turn to for help. Do you think your daughter might feel this way sometimes?” (Diamond & Stern, 2003, p. 197).

**Step 7: Facilitate the expression of needs and wants to restructure interactions.** Opportunities to help children articulate their wants in relationships often present themselves during play therapy activities described previously, in which there is a re-enactment or discussion of problematic family interactions, or an exploration of the child’s feelings about family problems (in Steps 3, 4, and 5). After acting out the negative cycle during the Play Genogram, for instance, the therapist could ask family members to take turns using the toys to act out how they would like the family to behave during times of potential conflict instead of how they usually behave. Family members could make-up preferred outcomes or they could demonstrate times the family successfully met each other’s needs in the past.

The case of the 4 year-old boy, Dexter, who gets upset after visits with his father (discussed in Step 5) could be used as an example. After Dexter showed his paper dolls depicting his sadness to his mother, the therapist could ask, “Dexter, do you go to anyone when you get sad about this? Who do you go to? What does s/he do to make your feel better? Does that help? Mom, can you tell when he’s sad about this? What do you say/do when you see him so sad? Can the two of you show me what that looks like? Does that help you feel better, Dexter? Is there anything else you wish she would do or
say to make you feel better when you get so sad about your dad? Can you tell her?

[Therapist addresses the mother] Mom, is that something you think you can do? Can you do it now? [Therapist addresses Dexter] How do you feel now, Dexter, as your mother does that? How would that feel if she did that more often when you get sad? [Therapist waits for the child to respond.] Mom, are there any other things you and Dexter could do when he gets down that might help him feel less sad? Can you ask him if that is something he might like to do?”

The therapist can then process the parent’s experience of this exchange (i.e., “What is this like for you to see/hear this from your child?”). Should the parent express empathy and sensitivity regarding the child’s position, this acceptance can be highlighted and expressed in an enactment to the child. If the parent is rejecting, the therapist may process the parent’s non-accepting stance (in separate sessions if needed) and explore blocks (e.g., guilt, anger, fear, shame) to being able to understand the child’s experience (EFFT step 6).

Structuring the conversation in this manner can help the child make requests from his mother in a way that evokes a supportive response. Pictures of these soothing interactions could be drawn on index cards with a needs-request on top (e.g., “I need a hug”, “I would really like to play with you today”, “Can we cuddle?”), and placed in a “good feelings bag” that the child could draw from and show the parent when he was feeling sad and needed comfort.

**Stage 3: Consolidation of Change**

**Step 8. Establish the emergence of new solutions to previously problematic situations.** Once negative feelings have been de-escalated and family members can talk
about their needs “from a position of vulnerability” rather than criticizing or withdrawing, problem solving with the family becomes easier (Johnson & Lee, 2005, p. 122). Some interventions during this part of treatment may have structural or behavioral qualities, including the assignment of homework (e.g., having siblings share activities once a week to enhance their relationship; Johnson, 2004) or recommendations of more traditional child management techniques, such as family rule charts and token-reward systems.

In Family-Structured Play (FSP: Brewer, 2010b), mutual problem-solving techniques and play-time are used to build attachment in families with preschool- or school-aged children. The therapist coaches caregivers to lead family discussions on problematic behaviors that interfere with the family’s ability to have fun together, and then helps the caregivers co-create with the children a personalized contract (or, set of family rules) for handling family conflict. Children are encouraged to contribute their ideas on which consequences to problematic behaviors they prefer; however, the parent gets to decide, ultimately, what rules will be enforced. The family “practices” the new rules during sessions of bonding activities of their choosing. Caregivers are in charge of enforcing the consequences if anyone breaks the rules. Once the family can play well together in session, discussions ensue on how to translate the family rules for home-life.

Revisiting play-themes or symbols revealed in earlier sessions, which depict problematic family interactional patterns can also be used to help the family co-construct new, happier endings that can be applied to real-life situations (Wittenborn et al, 2006). For example, if the family acted out an argument with puppets in an earlier session, the therapist could have the family pick out the same puppets they used previously and
imagine it’s a day or two after their argument. Family members could have the puppets role-play a “pretend” conversation in which the puppets make apologies (if they wish) and then discuss their ideas for making the situation better. Staying within the metaphor of a story that reflects actual family dynamics is generally less threatening to children than talking about interactions directly and can help them stay engaged as new solutions are negotiated.

**Step 9: Consolidate new position.** By now, families are almost prepared to complete therapy. A playful way to help families consolidate positive changes they have made is to invite them to work together in creating a collage of the “new” family they have become. A collage is a creative art technique in which photographs, colored paper, pieces of cloth, and other miscellaneous objects are pasted together onto a dry background. Perkins and Dolbin-MacNab (2008) offered suggestions for using collages with individuals, groups, and families to visually depict their strengths, resources, and skills. The collage could include visual reminders of lessons the family has learned in therapy and pictures symbolizing their new preferred interactional style. Plans for maintaining and further enhancing their progress through future attachment-building activities or routines following the completion of therapy could be symbolically represented as well.

Another technique that can be used to help solidify interactional change is to have family members write thank-you cards to each other (Brewer, 2010c). In these cards, family members express their appreciation for what other members have done for them or the family and identify ways they believe each person in the family has grown or progressed during therapy. Helping family members express praise and appreciation to
each other provides yet another opportunity to build emotional connectedness and
commemorate contributions each family member has made to strengthening the family’s
relationship.

**Conclusion**

Emotionally Focused Family Therapy (EFFT: Johnson & Lee, 2005) is a newly
emerging clinical model, especially when compared to its more seasoned predecessor,
Emotionally Focused Couples Therapy (Johnson, 2004). EFFT holds great promise for
helping families with young children because it addresses attachment processes that
clearly influence children’s mental and emotional health. The purpose of this article was
to show how family play therapy techniques and developmental considerations can be
incorporated into EFFT to engage young children who might not otherwise be able to
participate in therapy. It is hoped that exploring these issues will encourage therapists to
involve young children more actively in family therapy sessions and rise to the challenge
of improving child mental health services in systemic treatment.
References


Wiley & Sons.


CHAPTER 4

ASSESSING THERAPEUTIC ACTIVITIES, CHILD TALK, AND SESSION OUTCOME IN FAMILY THERAPY WITH YOUNG CHILDREN

---

1 Willis, A. B. To be submitted to the *International Journal of Play Therapy*. 
Abstract

This exploratory, observational study was designed to reveal descriptive information regarding counselors’ actual practices with preschool- and school-aged children in family therapy, and to investigate change mechanisms proposed by family play therapy advocates. A purposive sample of 30 families receiving family therapy was recruited and video-taped in family sessions where at least one child between the ages of 4 and 12 was present. Following each session, the therapist and parent(s) completed questionnaires while one of the children (aged 4 to 12) was interviewed. Session recordings were coded, minute-by-minute, for participant talk-time, therapy technique type (e.g., activity-based vs. talk-only techniques), content of therapy talk, and other variables. Hierarchical regression and a series of canonical correlations were used to analyze quantitative data. The time therapists spent in activity-based techniques was found to be associated with the amount of child talk. Also, a latent relation appeared to exist between a set of process-variables (i.e., time in activities, time in verbal-only techniques, participant talk times) and a set of outcome variables (i.e., child-therapist relationship and participants’ emotional experience during the session). Findings supported the theory that play therapy activities promote young children’s participation, enhance the quality of the child-therapist relationship, and build positive emotional experiences in family therapy sessions. A report of the content of therapy talk and specific techniques used in this sample of family therapy sessions is provided in the article.
Introduction

Identification of change mechanisms in psychotherapy has long been regarded as an important contribution to clinical research. Kazdin and Nock (2003) once stated, “Understanding the mechanisms of change can bring order and parsimony to the current status of multiple [mental health] interventions” (p. 1118). Most clinical outcome research is focused on evaluating therapy models as a whole rather than examining the individual parts (or, “active ingredients”) present across psychotherapy approaches that are responsible for creating therapeutic change. Process-outcome correlational studies are a valuable tool for illuminating the specific components of therapy that promote healing and growth (Shirk, Jungbluth, & Karver, 2012). When clinicians learn what makes therapy work, they can maximize the benefit of their services by putting the most effective therapeutic ingredients into practice.

Empirical investigation of change mechanisms in family therapy with young children has been virtually ignored in clinical literature. Studies on counselors’ practices with children younger than age 12 in therapy settings with whole families are scarce (Haslam & Harris, 2011; Ruble, 1999) and are typically based on surveys or interview data (e.g., Johnson & Thomas, 1999; Korner & Brown, 1990; Lobatto, 2002; Snow & Paternite, 1986; Stith, Rosen, McCollum, Coleman, & Herman, 1996). Rarely do such studies include observation of real therapy sessions or processes. The shortage of observational research is unfortunate because it can play an important role in the chain of empirical evidence by informing and adding to future randomized controlled trials (Crosby, Salazar, DiClemente, 2006; Marko, & Weil, 2010).
A likely reason for the dearth of research on young children in family therapy is that they have been largely excluded from family therapy sessions or treated as passive participants (or “nonpersons”) in session proceedings (Botkin, 2000; Cederborg, 1997; Lobatto, 2002; Ruble, 1999). Reasons for the exclusion of children from family therapy include: (a) family therapy approaches tend to be developmentally biased toward adults and inappropriate for engaging young children, (b) therapists have been found to exclude children based on the therapist’s comfort level, and (c) the majority of family therapists are under-trained and under-supervised in the skills needed for working with young children (Gil, 1994; Johnson & Thomas, 1999; Korner & Brown, 1990; Raimondi & Walters, 2004).

Despite the paucity of studies regarding children’s involvement in family therapy, there is a growing body of literature on recommendations for working with children in systemic family practice (Lund, Zimmerman, & Haddock, 2002). Over the last 30 years, multiple child- and family therapy scholars have advocated the use of playful activities to engage children in family sessions (Chasin & White, 1989; Keith & Whitaker, 1981; Lund et al., 2002; Schaefer & O’Connor, 1983; Sori, 2006; Sori & Sprenkle, 2004; Stith et al., 1996; Wittenborn, Faber, Harvey, & Thomas, 2006; Zilbach, 1986). Play therapy techniques have long been used in clinical settings to facilitate children’s self-expression, emotional regulation, emotional processing, and development of life skills (Schaefer, 1993; Schaefer & Drewes, 2011). A play-based approach for child-focused family therapy contexts has also been recommended to build communicative bridges between adults and children, and to strengthen attachment relationships in the family (Gil, 1994; Sori, 2006; Wittenborn et al., 2006).
The proposal to incorporate play therapy techniques into family therapy, however, is not without critics. Although many reviews of play therapy have been positive (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001), some still question the credibility of play therapy as a counseling approach (Frick-Helms & Drewes, 2010). Marriage and family therapists (MFTs), as a group, have reported little interest in child- or play therapy, which may be due to their relative lack of training on the subject and exclusionary practices with children (Raimondi & Walters, 2004). A minority of play therapists have also expressed skepticism about the effectiveness of merging play therapy and family therapy modalities (Haslam & Harris, 2011).

One main reason incredulity still exists about the viability of play therapy with whole families is that this approach is nearly untested. Empirical studies have been conducted on dyadic parent-child play therapy models, such as Child-Parent Psychotherapy (Lieberman, VanHorn, & Ippen, 2005), Filial Therapy (VanFleet, Ryan, & Smith, 2005), Parent-Child Interaction Therapy (McNeil & Hembree-Kigin, 2010), and Theraplay (Wardrop & Meyer, 2009), with positive results. However, there are almost no published studies regarding the effect of family play therapy techniques on family therapy process or outcome, or on how such effects vary with a child’s developmental level. It is not even known how often therapists currently use such techniques.

This study was conducted to learn what actually occurs in family sessions with young children and how different process-related variables may affect participants’ perceptions of the session’s outcome. The results of this study will help practitioners identify active treatment components for young children within the context of systemic therapies for families. In addition to conducting a descriptive report on the clinical
techniques used and topics discussed in this sample of family therapy sessions, the following research questions were addressed:

1. Is the time spent in therapeutic activities during family therapy sessions a significant predictor of child talk time (in minutes) when controlling for time spent in solely talk-based techniques, the child’s age, the child’s distress-level, and other variables believed to potentially influence child talk?

2. Do any latent relations exist between a set of independent, process variables (i.e., participant talk times, time spent in activity-oriented techniques, time spent in solely talk-based, or “verbal-only”, techniques) and a set of dependent outcome variables (i.e., evaluations of the child-therapist relationship, participants’ overall emotional experience during the session)? If a latent relation is found, what is the relative importance of the variables comprising the latent variable?

Methods

Participants

**Therapist participants.** A purposive sample of 16 licensed and graduate-student therapists was recruited from community and university-based clinics in Utah. Recruitment for the study took place from January, 2009 through February, 2012, during which time three recruitment strategies were used. First, letters of invitation were sent to listed members of the Utah Association for Marriage and Family Therapy (UAMFT). Therapists who responded to the invitation letter were emailed an informative flier outlying study procedures. The UAMFT organization was selected to help with recruitment because the study was originally designed to analyze the practices of Marriage and Family Therapists (MFTs). An insufficient number of MFTs responded to
the invitation to produce an adequate sample size so the study was broadened to include all types of mental health therapists or counselors. A second recruitment method included contacting administrators of counseling agencies in the community and encouraging them to forward a copy of the flier to therapists who practiced family therapy in their agency. Interested therapists were asked to contact the investigator.

Third, permission was obtained from the faculty of two accredited university counseling training programs to invite graduate-level student therapists from their programs to participate in the study. Nine of the graduate-students who participated were enrolled in a clinical master’s program and one was a doctoral student. Prior to recruiting the student therapists, the investigator gained approval to conduct the study from the university Institutional Review Boards (IRBs). Student therapists were informed about the study either during practicum groups or via an emailed copy of the informative flier.

**Therapist demographics.** Therapists who participated in the study had backgrounds either in Marriage and Family Therapy \((n = 12)\) or Clinical Social Work \((n = 4)\). Six of the therapists were licensed and 10 were student therapists. Therapist ages ranged from 22 to 59 \((M = 40.44; SD = 20.3)\), and 75\% \((n = 12)\) were female. About 60\% of the therapists were married, 25\% were single, and 6 \% were divorced. The therapists were predominantly Caucasian-American \((n = 14)\). Only two therapists were not Caucasian; one was Latina and the other was Asian. Therapists reported they usually saw 7 to 35 \((M = 14.75, SD = 7.48)\) clients per week. About 1 to 14 \((M = 4.0, SD = 3.25)\) of these therapy hours were said to be typically spent working with children.

The types of clinical models reported by therapists as informing their work with families included such approaches as Play Therapy (56.2\%), Emotionally-Focused
Therapy (50%), Experiential Therapy (43.8%), Cognitive-Behavioral Therapy (37.5%), Solution-Focused/Oriented Therapy (25%), Narrative Therapy (12.5%), Structural Therapy (12.5%), and Post-Modern Therapy (6.3%). The majority of therapists (83%) disclosed they used an integrated approach of 2 or more clinical models in their family therapy practice.

There was a great deal of variability in therapists’ level of experience as counselors. Ten therapists had less than 2 years’ experience, two therapists had 2 to 5 years’ experience, two therapists had 11 to 15 years’ experience, and two therapists reported over 16 years’ experience. In terms of child-specific clinical experience, 25% of the therapists indicated they had worked with fewer than 5 child-related cases in therapy, 25% had worked with 5 to 10 child-therapy cases, and almost 50% had worked with 15 or more therapy cases involving children.

Therapists were invited to disclose what child-focused clinical training they’d received and whether they felt this training was adequate for preparing them to work with children in therapy. All of the therapists indicated they took a child development course, 50% reported they had attended one or more 1- to 3-hour presentations on child-therapy techniques, 25% attended 1 or more all-day workshops on child therapy, 19% completed a child-focused therapy course, and 6% participated in a child-therapy-focused practicum. Only about 30% of the therapists felt their therapy training was “highly adequate.” Approximately 50% of the therapists described their training as “somewhat adequate”, and the remainder (about 12%) responded they felt their child-specific training was “inadequate.”
**Family participants.** Thirty families receiving family therapy services were recruited for this study. Most of the families learned about the study through their therapist, who had been recruited previously through the aforementioned procedures. However, in one of the university-clinics, there was a pre-existing policy to inform new family therapy referrals of research being conducted at the clinic during a pre-intake/screening phone call. If the family was interested, the intake officer would call the study investigator to provide the family’s case number and name of the assigned therapist. The investigator then contacted the therapist and asked him or her to follow up with the family to see if they were still interested in participating. In the happenstance that the therapist had not yet been informed of the study, the investigator emailed a copy of the study flier to the therapist and inquired whether the therapist would be willing to participate. If both the therapist and family were willing to take part in the research, the investigator and therapist scheduled a time for the study appointment.

To participate, families had to meet certain inclusion/exclusion criteria. They had to have a child between age 4 and 12 and to present with problems relating to family conflict. The child (a.k.a., the “target child”) had to demonstrate notable mental health symptoms and be one of the reasons for which the parents were seeking treatment. The target child was selected to be the child who would be interviewed after the session, and whose behaviors during the session would be coded for analysis. If the family had more than one child who fit these criteria, parents were directed to talk with their therapist about which child would participate. Families were required to have at least two family therapy sessions in which at least one of the parents and the target child were present (although other family members could attend) before they could participate in the study.
This requirement was designed to allow time for family members to develop a rapport with their therapist so they would behave more naturally during their study appointment. Families were excluded from the study if they were not citizens of the United States and/or were presenting for issues relating to bereavement, substance abuse, or chronic illness.

**Family demographics.** Twenty-eight mothers and 14 fathers ($N = 42$ parents) participated in the study. Both parents were present for 12 of the sessions. Other sessions were attended by only one parent (mothers-only sessions: $n = 16$; fathers-only sessions: $n = 2$). Mothers’ ages ranged from 29 to 49 ($M = 36.15$, $SD = 5.97$) and fathers’ ages ranged from 32 to 53 ($M = 39$, $SD = 6.41$). With the exception of one parent (who was Asian/Pacific Islander), all the participating parents were Caucasian-American. This sample of parents was generally well educated. None of the parents had less than a GED or High School Diploma. The parents’ highest level of education was reported as follows: GED/HS Diploma (5%), some college (40%), associates/baccalaureate degree (42.5%), and graduate school (12.5%).

The number of children present in the family therapy sessions ranged from 1 to 5 ($M = 2.23$, $SD = 1.2$). Forty percent ($n = 12$) of the sessions included only one child. In 43% ($n = 13$) of the sessions, 2 to 3 children were in attendance. Four to 5 children were present for the remaining 17% ($n = 5$) of sessions. Of the “target” children ($n = 30$) in this sample (i.e., children who were interviewed and whose behaviors were coded during the session), 50% were female and 50% were male. Their ages ranged from 5 to 12 ($M = 8.60$; $SD = 2.09$). Six of the target children were preschoolers (age 6 or younger) and 24 were elementary school-aged (age 7 to 12). Like their parents, most of the target children
were Caucasian-American \((n = 28)\); however, one child was Caucasian-Asian \((n = 1)\) and another child was Caucasian-Mexican \((n = 1)\).

**Procedures**

When a client-family agreed to participate in the study, the family’s therapist contacted the investigator to schedule a study appointment, at which time the investigator came to the therapist’s clinic to video-tape one of the family’s therapy sessions, distribute post-session questionnaires to the parent and therapist, and conduct a post-session interview with the target child. At least one of the child’s parents had to be present for the therapy session, although other family members could attend. Consent forms were reviewed at the beginning of the appointment. The investigator then left the therapy room so the therapist and family could complete their session. Therapists were not asked to perform any special tasks during the session and were instructed to conduct the therapy session in their usual manner.

After the session, the parent(s) and therapist were given a couple of questionnaires to complete in another room while the investigator interviewed the child in the therapy room. The two questionnaires completed by parents were: (a) a post-session questionnaire, designed specifically for the purposes of the study, and (b) a child distress scale (i.e., the Youth-Outcome Questionnaire\(^\text{TM}\), parent-report version) which the parents used to report on the target child. The questionnaires completed by the therapists were: (a) a post-session questionnaire, similar in content to the questionnaire given to parents, and (b) a background and attitude questionnaire. The interview and questionnaires usually took about 45 minutes to complete.
A financial incentive in the form of a $25 gift card to local grocery stores or a restaurant was given to each therapist and family who participated in the study. Additionally, the target child received a small thank-you gift (i.e., toys, action figures, legos) of about $5 to $8 value for participating in the interview.

Measures

**Therapist background questionnaire.** Participating therapists were given a background questionnaire, which was developed by the investigator for this study. The questionnaire contained demographic items and attitude-oriented questions addressing therapists’ feelings about the adequacy of their child-therapy training.

**Youth Outcome Questionnaire™ (Y-OQ™).** The Y-OQ™, developed by Wells, Burlingame, and Lambert (1999), is a parent-report measure of behavioral problems for children ages 4 to 17. It is composed of 64 Likert-scale items (ranging from 0 to 4), comprising 6 subscales: Interpersonal Distress (ID), Somatic symptoms (S), Interpersonal Relations (IR), Social Problems (SP), Behavioral Dysfunction (BD), and Critical Items (CI). The total Y-OQ™ score is a summation of all the items from the six subscales and represents the child’s overall level of distress. Considerable evidence for the reliability (Cronbach’s alpha = .97; test re-test coefficient = .83) and validity of the Y-OQ™ has been found with large normative (N = 2,732) and clinical (N = 1,091) samples (Burlingame, Mosier, Wells, Atkin, Lambert, Whoolery, & Latkowski, 2001; Burlingame, Wells, Cox, Lambert, Whoolery, & Latkowski, & Justice, 2005).

In the current study, a Cronbach’s alpha of .94 was computed for the Y-OQ™ total scores. Paired t-tests of mother and father total Y-OQ™ scores were non-significant (t(9) = .12, n.s., equal variances not assumed); suggesting that mother and
father scores for the same child were not significantly different. Mother and father scores were therefore averaged into a single “parent” score for analysis. The mean total Y-OQ™ score for the entire sample was 60.6 ($SD = 29.0$), which is above the established clinical cut-off total score of 46. This finding indicates that the majority of children in the sample were clinically distressed.

**Parent/therapist questionnaires.** Original questionnaires were designed to assess parent and therapist reports of session outcome-related constructs, including: (a) key events that occurred in the session, (b) the overall helpfulness of the session, (c) the emotional experiences of the parent/therapist and child during key events, and (d) the quality of the child-therapist relationship. The parent and therapist questionnaires were generally equivalent in terms of content and item-wording. Questionnaires were composed of both quantitative and qualitative items. Likert-type scales with 4 to 6 response options were used to gather quantitative data, and qualitative prompts were incorporated to obtain broader information or encourage respondents to expand upon earlier answers to quantitative questions. Demographic items for the child and parent (e.g., age, gender, ethnicity, education, etc.) were also included in the parent post-session questionnaire. A detailed description of questionnaire items used to measure the primary constructs is provided below.

**Key events.** Parents and therapists were asked to identify and describe, in their own words, what they considered to be the two most important events (positive or negative) of the session. They were invited to comment about what made these events important.
**Overall session helpfulness.** Using a Likert-type scale from 1 (very unhelpful/unproductive) to 6 (very helpful/productive), parent/therapist respondents rated the helpfulness of the key events, the conversations that took place over the course of the session, and the session in general. They also reported whether anything happened in the session that made things worse for the family on a scale of 1 (no, not at all) to 4 (yes, a lot worse). The item regarding whether the session made things worse was reverse coded so that it would score in a conceptually congruent manner with other session helpfulness items.

**Emotional experience.** Respondents selected from a list of feelings (i.e., happy, sad, mad, surprised, scared) any emotions they experienced during each of the two key events. The intensity of each felt emotion was rated as 1 (none), 2 (a little), 3 (some), or 4 (a lot). A similar questioning format was used to inquire about what the parents/therapists thought the target child may have felt during the key events and how strongly they believed the child experienced these emotions. “Negative” emotions (i.e., sad, mad, scared) were reverse coded. Separate composite scores, consisting of the summed value for the emotional intensity ratings across Event 1 and Event 2, were calculated for the parent/therapist’s ratings of self and rating of the child.

Parent and therapist respondents then ranked how productive they thought it was to feel each of the emotions they experienced during the two key events. Response options ranged on a Likert scale from 1 (definitely not productive) to 4 (yes, definitely productive). The parents/therapists used the same scale to evaluate the productivity of the emotions they believed the child experienced. Average emotional-productivity ratings across Events 1 and 2 were calculated for the respondents’ self-ratings and their
ratings of the child. These averaged scores were summed into a composite score
(signifying the average level of emotional productivity across all felt emotions) so that
there was one composite score for the parent/therapist and one composite score for the
child.

**Quality of the child-therapist relationship.** To assess the quality of the child and
therapist’s relationship, parents and therapists marked emotions (i.e., happy, mad, sad,
scared, surprised) they believed the child normally feels about: (a) coming to see the
therapist, and (b) talking with the therapist. The parents/therapists indicated how strongly
they believed the child usually feels these emotions (i.e., 1 (none), 2 (a little), 3 (some),
or 4 (a lot)) when seeing and talking with the therapist. Then, they ranked on a similar 4-
point scale how comfortable they believed the therapist was with the child, how
comfortable the child was with the therapist, how well the therapist was able to adapt
therapy discussions and activities to the development level of the child, and how well the
therapist appeared to truly understand the child.

**Construct reliability.** A principle components analysis (PCA) was conducted
with 26 outcome measures from the parent/therapist post-session questionnaires to assess
whether the underlying structure of items appeared to match the theoretical
conceptualization of the constructs. For this analysis, the mother, father, and therapist ($N$
= 70) scores were combined into a single data set, and item values were transformed into
$z$-scores. Typically, a sample size of 5 or more subjects per variable has been
recommended for PCA (Grimm & Yarnold, 2003); therefore, limited confidence may be
placed in the results of this analysis due to the small sample size (3 subjects per variable).
Nevertheless, even under these less-than-ideal conditions, the results of the PCA revealed strong indications of the presence of two separate factors.

The first factor consisted of 18 items, including the child-therapist relationship, session helpfulness, and emotional productivity items. Factor loadings ranged from .265 to .714 ($M = .467$, $SD = .166$). Items associated with a positive child-therapist relationship clearly showed the strongest relative contribution to the factor. The second factor was made up of the 8 emotion-intensity ratings for the parent/therapist and child. Loadings for this factor ranged from .301 to .695 ($M = .560$, $SD = .152$) and the more “negative” emotions (i.e., mad, sad, scared) demonstrated the highest loadings. The first factor accounted for 18.71% of the total variance, and the second factor accounted for 14.25% of the variance. Observation of the scree plot and eigenvalues revealed the remaining variance was not well-captured by any other single factor.

The conclusion was drawn from this analysis that the total variance in the parent/therapist post-session questionnaire scores could best be explained by the quality of the child-therapist relationship (factor 1) and the emotional experience of the parent/therapist and child during the session (factor 2). Based on these findings, it was determined that two therapy outcome composite scores, representing the two factors from the PCA (i.e., the child-therapist relationship, and participants’ overall emotional experience), would be used to evaluate session outcome. These factors were labeled CTR-AR (Child-Therapist Relationship-Adult Report) and OEE-AR (Overall Emotional Experience-Adult Report). Higher CTR-AR total scores represented more positive child-therapist relations. Lower OEE-AR total scores indicated more negative emotional experiences (i.e., more intense feelings of anger, sadness, or fear).
Paired $t$-tests were calculated, comparing the means of the mother and father composite scores on the CTR-AR and OEE-AR outcome variables. These composite scores were computed by summing $z$-scores of items loading onto each factor. The results were non-significant, with $p$-values greater than .05, so the mother and father scores were averaged into a single score on each item used to calculate the composite scores. The averaged-parent item scores and the therapist item scores were thereafter combined into a new data set for analysis. Internal consistency coefficients for the outcome variables (Cronbach’s alpha) were .77 for the CTR-AR total score and .76 for the OEE-AR total score.

**Construct validity.** A preliminary discriminant validity test for the outcome variables was conducted by running a correlational analysis of the CTR-AR, OEE-AR, and Y-OQ™ total scores. This test was used to ascertain whether the outcome variables (CTR-AR and OEE-AR total scores) measured constructs separate from each other and from child distress. The results of the correlational analysis revealed evidence supportive of discriminant validity. The CTR-AR and OEE-AR total scores demonstrated a weak positive correlation ($r = .15$) that was statistically non-significant ($p = .28$). Both the CTR-AR and OEE-AR total scores also showed weak, negative non-significant correlations with the total Y-OQ™ score. Correlations between the CTR-AR and Y-OQ™ total scores, and between the OEE-AR and Y-OQ™ total scores, were respectively -.09 ($p = .51$) and -.02 ($p = .87$).

**Child Interview.** Questions for the child interview were designed to assess constructs similar to those in the parent/therapist questionnaires, namely: (a) identification of two key session events, (b) the emotional experience of the target child
and parent(s) during key events, and (c) the quality of the child-therapist relationship. Interviewed children were not asked to comment on the “overall helpfulness” of the session because the concept was believed to be too developmentally advanced for young children. Evaluating session helpfulness requires the ability to speculate on the long-term implications of a session on family dynamics, which requires a level of meta-cognitive thought and hypothetical thinking that young children typically have not yet acquired (Flavell, Green, & Flavell, 1995; Flavell, 2004; Inhelder & Piaget, 1958).

Evidence-based child interviewing methods, including cognitive interviewing techniques, focused inquiry, and visual aids, were incorporated into the interview to accommodate children’s short attention spans and cognitive developmental limitations. These child interviewing methods have been used in children’s clinical research and in forensic interviews with children to increase their participation and recall of events without sacrificing accuracy (Carnes, Nelson-Gardell, & Wilson, 2000; Faller, 2003; Devoe & Faller, 2002; Myers, Saywitz, & Goodwin, 1996; Parkinson, 2001; Priestley & Pipe, 1997).

**Structure of the interview.** The interview began with a brief rapport-building phase (discussion about child’s age, school, friends, and interests) and reminders to the child about the purpose and voluntary-nature of the interview. Afterward, the child was directed to make a list of everyone present in the family therapy session that day, and use puppets to show where each person sat during the session. The child was asked to describe everything that happened in the session “from the beginning to the middle to the end.” Broad prompts were used (e.g., *Did the therapist talk to you? Did the therapist talk to your parents? Did anyone play with toys or games or do any drawing?*), followed by
more focused inquiries (e.g., What did they/you talk about? What kind of games did you play?), if the child had difficulty recalling session events. The investigator made notes and recited these events back to the child for accuracy.

To help the child identify key events, the investigator asked, “Which of all these things you told me that happened during your meeting today was the most important? Which was second-most important?” The investigator then helped the child create feelings cards depicting happy, sad, mad, angry, and surprised faces. The child was asked to “think back” to the session events s/he identified as “the most important” and point to the emotion cards that best showed how s/he felt at that time. Emotion-labeling questions of this nature were deemed appropriate for the interview because children as young as age 3 and 4 have shown the capacity for labeling simple feelings with assistance (Dunn, Bretherton, & Munn, 1987; Dunn, Brown, & Beardsall, 1991). When the child identified a feeling, follow-up inquiries were made about “how much” (a little, some, or a lot) the child felt the emotion and whether the child “liked” having that feeling.

Similar interview questions were used to learn what the child thought the parent(s) might have felt during the key events and whether the child believed the parent(s) liked having those emotions. The ability to think about thinking (or, meta-cognition) and to recognize what others might be feeling based on facial expression and context cues usually begins to develop around age 5 (Flavell et al., 1995; Flavell, 2004). As a result, the older children’s answers on these items were more likely to be valid than those of preschoolers. However, since most (about 80%) of the children interviewed in this study were older than age 6, it was anticipated that the majority of children’s responses to the social perspective-taking questions were valid.
The remainder of the interview involved a series of questions related to the quality of the child’s relationship with the therapist. The child was asked to point to feelings cards that best portrayed emotions the child generally has about coming to see the therapist. Emotional intensity was measured on a 4-point scale: 1 (none), 2 (a little), 3 (some), or 4 (a lot). Using the same scale, the child disclosed whether s/he thought the therapist “felt good” about having him/her in the session, and how much the child usually understands what the therapist says.

**Construct reliability.** Two quantitative measures, including the Overall Emotional Experience-Child Report (OEE-CR) and the Child-Therapist Relationship-Child Report (CTR-CR) total scores, were calculated from the child interview responses. These measures were intended to be theoretically similar to the OEE-AR and CTR-AR assessed in the parent/therapist questionnaires, but the measures were not entirely equivalent due to differences in item-wording and response option metrics.

To compute the OEE-CR score, the children’s “negative” emotion (i.e., mad, sad, scared) intensity ratings were first recoded so that higher scores represented less negativity. The average emotion-likability score was calculated across each event for the child’s self- and parent-ratings. Tallies of the mean emotion-likability ratings across Event 1 and Event 2 were computed separately for the child’s ratings of self and parent(s). When the child provided ratings for both a mother and a father, these ratings were averaged into a single parent score. The OEE-CR score was calculated by summing the z-scores of emotion intensity ratings and all the mean emotion-likeability scores the child reported for him/herself and the parent(s). Higher OEE-CR scores indicated greater
feelings of happiness and emotion-likability. Cronbach’s alpha for the OEE-CR score was $\alpha = .84$, which indicates this measure had good internal consistency.

The CTR-CR was calculated by summing z-scores of the items assessing the child’s relationship with the therapist. Unfortunately, there was very little variability in this data. Virtually all the children reported only happy feelings and no negative emotions (i.e., mad, sad, scared) about coming to see the therapist. Thus, the negative emotion items were removed from this analysis. Cronbach’s alpha for the remaining 3 items was negative ($\alpha = -.16$), probably a result of the low number of items and lack of variability. It could also indicate the 3 items were not measuring the same construct. Since the reliability of these items was poor, they were analyzed as separate outcome measures, rather than a composite score.

**Construct validity.** A preliminary discriminant validity test was conducted in which the OEE-CR and child-therapist relationship items were correlated with the Y-OQ™ total score to ascertain whether they appeared to measure constructs separate from child distress level. Pearson’s correlations ranged from -.09 to .14, and none of the correlations were statistically significant, which is evidence of discriminant validity. Each of the inter-correlations between the OEE-CR and child-therapist relationship items was also non-significant.

**Video coding.** Video-recordings of family therapy session were coded for the following therapy process variables: *participant talk time*, *props used*, *content of therapy talk*, and the *family therapy technique* used by the therapist. For the talk time variable, a record was made of each person (specifically, the target child, parent(s), and therapist) who talked during each minute of the therapy session. Talk time totals and percentages
were calculated for every participant. For each minute of therapy, a coder used a binary code of 1 (yes) or 0 (no) to indicate whether the therapist utilized any props or visual aids. The type of prop used was qualitatively documented for descriptive purposes.

Topics of conversation were also recorded, and categories were developed based on the collection of topics discussed by therapy participants. The talk-content categories included: updates, review of last session, examples of successful coping, strengths, clinical goals (or treatment direction), activity-specific talk (e.g., preparation, carrying out, or cleaning up an activity), psychoeducation by the therapist, explicit discussion of the problem, processing family members’ feelings, meaning-making of a completed activity or art project, solution-oriented talk, in-vivo discipline of children, and nonclinical conversations (or small talk). The number of times each topic was recorded was tallied across therapy sessions.

Therapy techniques were organized according to a categorical scheme developed by Lund and colleagues (2002), in which family therapy techniques were classified as art, verbal, psychodrama, story-telling, puppet/doll, experiential, non-directive and/or filial therapy techniques. Verbal techniques were coded into two separate categories: verbal-only techniques and verbal techniques with props or visual aids. The time spent in each activity was recorded.

**Coder training.** Session recordings were coded by 3 undergraduate research assistants (RAs). Coders were blind to the purposes of the study and to what the other RAs were coding. Two RAs coded *props* and *therapy techniques*, and one RA coded *participant talk time* and *talk content*. The RAs were given verbal and written instructions, and then allowed to practice coding two videos of family therapy sessions
that were not used in the study. These videos were used previously by the investigator for family therapy training seminars or workshops. Consent had been obtained beforehand by the families in the videos for such purposes. RAs’ questions about differential coding were discussed and documented. Answers to these questions were disseminated to the respective RA (if appropriate) to increase coding consistency.

**Inter-rater reliability.** To assess inter-rater reliability of the video-coding, the investigator randomly selected 1 video from every set of 5 videos in the sample (e.g., 1-5, 6-10, 11-15, etc., resulting in 6 videos), and coded the therapy sessions on all the targeted quantitative variables. Cohen’s kappa was calculated as a measure of inter-rater agreement between the investigator and RAs’ coding of quantitative variables. Kappas for the props variable ranged from .84 to 1.0 ($M = .91; SD = .07$). Technique type kappas ranged from .71 to 1.0 ($M = .88; SD = .10$). The talk time kappas were as follows: child talk time (.64 – 1.0; $M = .88; SD = .18$), mother talk time (.84 – 1.0; $M = .97; SD = .06$), father talk time (1.0 – 1.0; $M = 1.0; SD = 0$), and therapist talk time (-.04 – 1.0; $M = .79; .SD = .42$).

**Validity.** Potential threats to validity were assessed through calculating independent $t$-tests of process variables used in quantitative analyses (i.e., therapist/parent/child talk time, time in activities, time in verbal-only techniques) for different participant groups, such as student vs. licensed therapists, one-parent vs. two-parent families, younger (aged 4 to 7) vs. older (aged 8 to 12) target children, male vs. female target children, clinically vs. non-clinically distressed target children, and families with one vs. two or more children present in the session. Clinical distress was based on the Y-OQ™ total clinical cut-off score of 46. The assumption of equal variances was
used only for the student vs. licensed therapists group and the male vs. female target child group because the sample sizes of these groups were equal. Equal variances were not assumed in any of the other groups.

Statistically significant differences in child talk time were found for student vs. licensed therapists, $t(28) = 2.41, p = .02$; one vs. two-parent families, $t(27.7) = 3.07, p < .01$; and sessions with one-child vs. two or more children, $t(24.4) = 2.83, p < .01$. The time in therapeutic activities differed significantly in sessions with younger vs. older target children, $t(26.6) = 2.64, p = .01$. Time spent in talk-based techniques differed significantly with one vs. two-parent families, $t(17.4) = -2.53, p = .03$, and younger vs. older target children, $t(25.9) = -3.36, p < .01$. No other significant differences in the groups were found.

A one-way analysis of variance (ANOVA) was conducted to further evaluate the relationship between the number of children in the session and child talk time. Child talk time was entered as the dependent variable, and the fixed factor (i.e., the number of children in session) consisted of 3 levels: 1 child, 2 to 3 children, and 4 to 5 children. The ANOVA was significant, $F(2, 27) = 4.97, p = .02$. A Tukey post-hoc test revealed statistically significant differences between the sessions with 1 child (2.08) vs. 4 to 5 children (24.50; $p = .02$), but no statistically significant differences between the sessions with 1 child vs. 2 to 3 children, or between sessions with 2 to 3 children vs. 4 to 5 children. Means (in minutes) for sessions with 1 child, 2 to 3 children, and 4 to 5 children, were 43.08 ($SD = 8.38$), 35.62 ($SD = 8.69$), and 29.80 ($SD = 8.17$), respectively. These findings indicate the target child’s talk time decreased when more children
attended the session, but was not reduced significantly until 4 or more children were present.

**Missing Data**

Three children refused to participate in the child interview and one set of parent and therapist questionnaire responses was lost due to a computer malfunction. The total sample means were used to replace such values. Little’s MCAR test was conducted on the remainder of the continuous quantitative variables to determine whether data were missing systemically or at random. Data found to be missing at random were replaced through multiple imputation methods on SPSS v.20.

**Results**

**Descriptive Report of Family Therapy Sessions**

**Content of therapy talk.** Information regarding the topics of conversation among participants during their family therapy sessions is provided in Table 4.1. Conversational topics discussed at the greatest length across sessions were (in descending order): activity-specific talk (426 minutes), the presenting problem and/or family dynamics (205 minutes), family members’ feelings regarding an event or issue (117 minutes), examples of successful coping (108 minutes), nonclinical (or “small”) talk (85 minutes), meaning-making of completed activities or art projects (74 minutes), and family members’ strengths (72 minutes). The topics addressed in the highest proportion of sessions included discussion of the presenting problem/family dynamics (87%), activity-specific talk (83%), solution-oriented talk (83%), non-clinical talk (80%), successful coping (73%), processing feelings (67%), and strengths (63%).
Family therapy techniques. Table 4.2 contains a summary of time spent in various family therapy techniques. The five techniques that were utilized for the longest periods of time across sessions included: verbal-only techniques (464 minutes), experiential techniques (288 minutes), verbal techniques involving a prop (i.e., “verbal-plus-prop”; 168 minutes), art techniques (152 minutes), and puppet/doll techniques (150 minutes). Family therapy techniques used in the most (or largest percentage of) sessions were: verbal-only (93%), verbal-plus-prop (57%), art (37%), experiential (33%), and puppet/doll (30%) techniques.

Story-telling was never used as a stand-alone technique by this sample of therapists, but sometimes therapists combined story-telling or psychodrama techniques with puppet/doll techniques. For example, therapists would have family members tell a story or re-enact a family interaction with puppets. Story-telling was therefore not listed as an independent category in Table 4.2. Also, the puppet/doll techniques were separated into 3 categories: puppet/psychodrama, puppet/story-telling, and puppet/other. This raises an important point that therapists at times will combine elements of different techniques and therapeutic activities to accomplish clinical goals.

Answers to Research Questions

Question 1. Hierarchical multiple regression analysis was used to determine how well the target child’s talk time (the criterion variable) could be predicted by the time spent in therapeutic activities and two sets of control variables. The first set (or, block) of predictor variables consisted of the total activity time as the primary predictor with the time spent in talk-based (or, verbal-only) techniques, the target child’s age, and target child’s distress level (i.e., Y-OQ™ total score) as control variables. For the second step
of the analysis, a set of categorical, binary-coded control variables, including the number of parents present (1 vs. 2 parents), number of children in the session (1 vs. 2+ children), and the therapist’s licensure status (not licensed vs. licensed), was added to the first block of predictors. This second set of control variables was used to rule out potential validity threats identified in earlier (t-test) analyses. Descriptive information (i.e., range, means, standard deviations) for the predictor variables are displayed in Table 4.3, and intercorrelations among target variables used in the hierarchical multiple regression analysis are shown in Table 4.4.

Both multiple regression equations were significant (First: \(F(4, 25) = 4.01, p = .01, R^2 = .39, \text{adjusted } R^2 = .29\); Second: \(F(3, 23) = 8.22, p < .001, R^2 = .72, \text{adjusted } R^2 = .64\)). As can be seen in Table 4.6, which shows the results of the multiple regression analysis, total activity time (\(\beta = .90, p = .01\)) was the only significant predictor in the first block of variables. With the second block added, total activity time was still significant, and its standardized beta-weight increased to 1.19 (\(p < .001\)). Statistically significant control variables in the second block were time spent in verbal-only techniques (\(\beta = .94, p < .01\)), the number of parents in session (\(\beta = -.31, p < .05\)), and number of children in attendance (\(\beta = -.44, p < .01\)). The partial correlations for total activity time with child talk time were .48 (\(p = .01\)) and .70 (\(p < .001\)) for the first and second multiple regression equations, respectively. These were the highest of all the partial correlations found among the predictors in both multiple regression equations. Such findings offer evidence that, as time spent in therapeutic activities increases, child talk time also increases.

Additional support for the positive relation between child participation and therapist use of play-based techniques can be found through observing the zero-order
correlations between child talk time and total activity time ($r = .44$, $p < .01$), as shown in Table 4.4. In contrast, the zero-order correlation between time in verbal-only techniques and child talk time was negative and non-significant ($r = -.22$, $p = .12$).

It is notable that the target child’s talk time decreased as the number of family members (parents, siblings) who attended the session increased. The changes in mean child talk time for the different levels of family participants in attendance are displayed in Table 4.5. Bivariate correlations between the target child’s talk time and the number of family members (shown in Table 4.4) were congruent with this finding; the correlations were also negative and statistically significant (1 vs. 2 parents: $r = -.50$, $p < .01$, 1 vs. 2+ children: $r = -.52$, $p < .01$).

**Question 2.** To address the second research question, Canonical Correlation Analysis (CCA) was conducted with one set of independent variables designed to represent aspects of therapy process and one set of dependent variables intended to reflect session outcome as reported by the adult participants (parents, therapists). The independent variable set included time in therapeutic activities, time in verbal-only techniques, the target child’s talk time, and the parent or therapist’s talk time. Time was recorded in terms of whether it occurred in each minute of therapy time. The set of dependent variables included the CTR-AR and OEE-AR total scores from the parent and therapist questionnaires. A correlational matrix of all the variables used in the CCA is shown in Table 4.7.

The decision to use CCA rather than structural equation modeling (SEM), or path analysis, was made because of the small sample size. SEM analyses often require sample sizes of over 200, but CCA can be done with sample sizes as low as 30 as long as there
are 10 observations for every assessed variable (Grimm & Yarnold, 2003; Hair, Black, Babin, & Anderson, 2010). Using a dataset containing both parent and therapist scores increased the $N$ to 58 observations, resulting in a ratio of about 10-to-1 observations to variables which met the minimum sample size requirement. CCA was also used because it is particularly useful for analyzing data sets with multiple independent and multiple dependent variables, and assessing dimensionality of the 2 sets of variables. Given these benefits, CCA seemed to be the most appropriate and powerful technique for answering this research question.

The CCA model used in this analysis was restricted to deriving two canonical functions (or, dimensions) because the maximum number of functions that can be extracted from a pair of independent-dependent variates in CCA is equal to the number of variables in the smallest variate (Hair et al., 2010). In the current study, the dependent variate (with two variables) contained the smallest set of variables. Multivariate tests (i.e. Pillai’s criterion, Hotelling’s trace, Wilks lambda, Roy’s gcr) for the entire model, which contained both canonical functions simultaneously, were significant at the .05 level (see Table 4.8). However, as shown in Table 4.8, a dimension reduction test revealed that only the first of the two canonical functions was statistically significant, $F(8) = 2.10, p < .04$. Dimension 1 demonstrated a canonical correlation of .50 between the independent and dependent variable sets while the canonical correlation for dimension 2 was much lower (.13). The squared canonical correlation of the first canonical function indicated that dimension 1 accounted for about 25% of the shared variance between the two canonical variates.
A redundancy analysis (Table 4.9) was calculated for both the independent and dependent variable sets in the first canonical function to learn how much variance in one canonical variate could be explained by the other canonical variate. The purpose of this analysis was to rule out the possibility that shared variance within only one of the variates may have accounted for the majority of the correlation between the two variates (a potential threat to validity). Results of the analysis revealed the redundancy index (.117) for the independent variate explained about 12% of the variance in the dependent variate. Likewise, redundancy results for the dependent variate (.129) offered evidence that the dependent variate accounted for 13% of the variance in the independent variate. Based on these findings, the risk of a validity threat in this area seems very low as both sets of variables appear to contribute almost equally to the total variance shared by the two variates (see Hair et al., 2010 for a discussion of redundancy analysis).

Canonical loadings, which consist of the simple linear correlation between a variable and its respective canonical variate, (a concept analogous to factor loadings in factor analysis) were calculated for each independent and dependent variable in the first canonical function. The loadings are listed under the “Complete Variate” subheading in Table 4.10. After viewing the canonical loadings, one can see the loading (.995) for the CTR-AR total score was a great deal higher than the loading (.246) for the OEE-AR total score. This indicates that the contribution of the parent/therapist-reported child-therapist relationship variable was much stronger to the first canonical function than evaluations regarding the participants’ emotional experiences in the session.

For the independent variate, the highest canonical loadings were found for the time in activities (.825) and child talk time (.842) variables, suggesting that these two
variables have the strongest relative contribution to the shared variance within their own (independent) variable set. On the other hand, the loading for total time in verbal-only techniques was negative and moderate (-.558). This indicates the time spent in solely talk-based therapy techniques demonstrated a negative relationship with the dimension underlying the independent variate. Of the four independent variables, the parent/therapist’s talk time demonstrated the lowest canonical loading (.445).

A sensitivity analysis was conducted by removing independent variables one-at-a-time from the analysis to examine the stability of the canonical loadings. Results from the sensitivity analysis are shown in Table 4.10. This analysis shows that the magnitude and direction of the canonical loadings were very consistent and stable across the cases where the independent variables (X1, X2, X3, and X4) were removed. Notably, the largest reductions in the redundancy indices for the independent variate (dropping to .010 or lower) occurred when either the total activity time or child talk time variables were removed. The other redundancy indices, in which these two independent variables were included in the assessment, ranged from .117 to .139. These findings offer support that, of all the independent variables, the activity time and child talk time variables made the strongest contribution to explaining variance in the dependent variate.

The relations between child-reported session outcome variables (OEE-CR, child-therapist item scores) and therapy process variables (child talk time, therapist talk time, time in activities, and time in verbal-only techniques) were analyzed via bivariate correlational analysis (see Table 4.11). Only the correlation between time in activities and the target child’s happiness about seeing the therapist (r = .39, p = .05) was statistically significant. Three of the remaining correlations were marginally statistically
significant (or approaching significance at the 05 level): child talk time and the OEE-CR
\( (r = .36, p = .06) \), child talk time and child happiness about seeing the therapist \( (r = .35, p = .08) \), and time in verbal-only techniques and child’s happiness about seeing the
therapist \( (r = -.34, p = .09) \). Although the magnitude of these marginally significant
correlations is relatively low, the correlations suggest a positive relation between total
activity time and the intensity of the child’s happiness about visiting the therapist, as well
as the child’s talk time with the child’s happy feelings toward the therapist. Conversely,
as time in verbal-only techniques increases the child’s happiness about the therapist
decreases.

**Discussion**

These results provided preliminary evidence that play-based family therapy
techniques can make a valuable contribution to child-focused family treatment by
eliciting child participation, strengthening the child-therapist relationship, and enhancing
the positivity of the family’s emotional experience in session. Children in this study were
shown to talk more as time spent in therapeutic activities increased, offering an indication
that activity-oriented methods may have evoked greater child involvement. According to
Schaefer (1993), children are internally motivated to engage in play because it is
enjoyable, and when children play, they are focused on the activity itself instead of the
outcome, sometimes even losing their awareness of time or surroundings because the
activity becomes all-engrossing. The increase in children’s talk times could be a
manifestation that positive feelings connected to their play overrode their fears or
anxieties, and helped them stay engaged during therapeutic activities or conversations
which, otherwise, may have been more distressing and led to their withdrawal.
The finding that time spent in therapeutic activities was correlated with aspects of the child-therapist relationship is noteworthy since children’s working alliance has consistently been associated with outcome in youth clinical literature (Hawley & Weisz, 2005; Shirk, Karver, & Brown, 2011). Recently, the emotional bond between child and therapist has been seen by scholars as the core component of the child’s working alliance, and has been theorized to be based more on the child’s perception of the therapist as fun, stimulating, and rewarding rather than as a person who can help them solve their problems (Shirk et al., 2011). Whereas factors found to be important in the development of the adult working alliance (e.g., agreement on tasks and goals) have been postulated to exceed the cognitive capacity of most children (Shirk et al., 2011), family therapists may need to find other ways to establish rapport with child clients. In the current study, therapists who used playful activities more frequently may have strengthened their relationship with the child because they were viewed by the child as more fun and exciting than therapists who employed a predominantly talk-based approach.

Analyses from this study showed child participation and play therapy techniques were correlated with greater parent/therapist reports of emotional positivity during the session. Such findings lend credence to Sori’s (2006) assertion that helping families play together in session “cultivates a new emotional climate which promotes cohesion among family members” (p. 39). The results are also congruent with effectiveness research on dyadic parent-child play therapy models (e.g., Filial Therapy, PCIT, Theraplay) in which techniques for teaching parents to play with their child in nurturing ways have been found to improve relationship quality between the parent and child (McNeil & Hembree-Kigin, 2010; VanFleet et al., 2005; Wardrop & Meyer, 2009). Similarly, it may be that assisting
families, who are used to family conflict, to participate in fun activities with one another could help strengthen the family’s emotional bond by enhancing the mutuality of positive feelings shared among family members.

In contrast to clinical literature which depicts family therapists as dismissive of children in family therapy proceedings (e.g., Cederborg, 1997; Johnson & Thomas, 1999; Korner & Brown, 1990; Snow & Paternite, 1986; Stith et al., 1996), therapists who participated in this study went to great lengths to actively engage children in family sessions. This may indicate that contemporary therapists have been influenced by the influx of clinical literature on child-focused family therapy techniques, and are now working harder to involve children in family sessions compared with 10 to 20 years ago. The fact that most of the therapists used activities to engage children may also suggest that therapists who include children in family therapy are apt to integrate play therapy and family therapy approaches to accommodate children’s needs in these settings.

**Limitations**

Limitations of this study should be considered when interpreting the results. These research findings were based on association and correlational analyses; thus, conclusions regarding causality cannot be made due to the absence of an experimental study design (e.g., random sampling, comparison groups). Non-randomized trials are also susceptible to sample-selection and performance biases (Marko & Weil, 2010). It is plausible that family therapists who valued the inclusion of children in family therapy more than other family therapists, who preferred not to work with children, may have self-selected to participate (a sample bias). Also, participating therapists could have inadvertently escalated their efforts to engage young children if they felt this was
expected in a family therapy study focusing on children (a performance bias). These factors could have resulted in an inflated portrayal of family therapists working directly with young children than is actually practiced in the family therapy field.

Another constraint of the study is that the outcome measures (i.e., parent/therapist questionnaire, child interview) were newly developed instruments with limited psychometric testing. Preliminary evidence of internal consistency (Cronbach’s alphas in the upper .70s or low .80s) and discriminant validity against the Y-OQ™ was demonstrated for the adult-participant (parent/therapist) outcome measures (i.e., OEE-AR, CTR-AR) and target children’s subjective report of their emotional experience (i.e., OEE-CR). In contrast, the reliability of the items used to measure the child’s report of the therapeutic relationship (CTR-CR) was poor. Conceptual replication of this study using more standardized measures of session outcome (e.g., parent-report version or observational assessment of the child-therapist relationship: Shirk et al., 2011) could further validate or disconfirm the findings of the current study.

The small sample size is a limitation common to psychotherapy research (Grimm & Yarnold, 2003). Minimum sample size requirements were met for most of the statistical analyses (e.g., multiple regression, ANOVA, bivariate correlations, CCA), but a larger sample could have resulted in greater statistical power to detect relationships that exist in the true population. Perhaps with more participants, marginally significant correlations (e.g., those found between therapy process and child-reported outcome variables) would have been found to be statistically significant. Replications of the study with a larger sample size would help to clarify the strength of relations among key study variables.
Research Recommendations

Ongoing development and research of play therapy applications in family therapy is sorely needed to advance understanding of the effectiveness of this psychotherapy approach. For family play therapy to be more widely accepted as an efficacious practice, additional effort will be needed to consolidate suggestions for implementing systemic play therapy techniques (e.g., Gil, 1994; Lund et al., 2002) within the theoretical framework of specific family therapy models and to translate these recommendations into treatment manuals or protocols in which the approach is delineated, from start to finish, across the course of treatment. As Sori and Sprenkle (2004, p. 492) stated, “There are a lot of articles on the importance of incorporating child and play therapy ideas into family therapy, but there’s very little on how to do it.” As integrated family/play therapy protocols become more standardized, they can be compared with traditional talk-therapy versions of the model or with empirically-based approaches (e.g., Cognitive-Behavioral Therapy, parent-management training) for treating child-focused problems in randomized controlled trials (Chambless & Ollendick, 2000).

In future studies of this nature, researchers will want to consider both individual child and family-level outcomes. Evaluating child outcome data, including pre- to post-treatment change in children’s diagnostic symptoms (e.g., Oppositional/Defiant Disorder, Conduct Disorder, Posttraumatic Stress Disorder, mood/anxiety disorders), distress level, general measures of functioning or overall quality of life, is standard practice in individual therapy effectiveness research (Chambless & Hollon, 1998) and would facilitate comparisons of family play therapy outcomes to those in individual child- or play therapy practice (e.g., Bratton et al., 2005; LeBlanc & Ritchie, 2001). By including
measures of family relationship outcomes, such as parent-child attachment, family cohesion, family communication patterns, or family therapy alliance, forthcoming studies of family play therapy applications could also be measured against effectiveness research for existing family therapy models. It is only through including both individual and systemic outcome measures that a true conceptualization can be gained of the standing of family play therapy methods relative to other child-focused interventions.

Child developmental factors must also be considered in youth clinical research. Although child age was not associated with statistically significant findings in the current study, further exploration of this variable is merited in relation to children’s response to family play therapy techniques. Lack of statistical significance in analyses from the present study involving child age may have been a result of the underrepresentation of preschoolers in the study sample. It is important in future studies that researchers seek to include adequate representation of children in diverse development levels to learn whether, and how, treatment effects differ across children’s age groups (Holmbeck, Devine, & Bruno, 2010). Findings from such studies may serve as a catalyst to develop treatment accommodations for children of different ages that would otherwise not have been considered.

Conclusion

This exploratory observational study comprises one of the first empirical attempts to assess proposed mechanisms of change in family play therapy. Findings supported the value of an activity-oriented approach with children in family therapy by revealing preliminary evidence that greater use of play-based activities was associated with increased child participation and helpful session outcomes (e.g., stronger child-therapist
relationship, positive emotional experiences among family members) in child-focused family therapy sessions. Future research will be needed to determine whether this is a causal, versus solely correlational, relationship. While play therapy has demonstrated positive outcomes in individual and parent-child conjoint therapy settings (Bratton et al., 2005; LeBlanc & Ritchie, 2001), further testing of family play therapy approaches will be needed to determine whether such treatments rise to the rank of empirically-supported treatments.
References


Johnson, L., & Thomas, V. (1999). Influences on the inclusion of children in family
therapy. *Journal of Marriage and Family Therapy*, 25, 117-123.


<table>
<thead>
<tr>
<th>Therapy Talk Category</th>
<th>Range minutes per session</th>
<th>$M(SD)$ minutes per session</th>
<th>Total minutes spent in category across all sessions</th>
<th># (%) of sessions in which talk category was used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updates</td>
<td>1-10</td>
<td>3.09 (2.7)</td>
<td>34 (3%)</td>
<td>11 (37%)</td>
</tr>
<tr>
<td>Review of last session</td>
<td>1-1</td>
<td>1.00 (0.0)</td>
<td>9 (0.6%)</td>
<td>9 (30%)</td>
</tr>
<tr>
<td>Successful coping</td>
<td>1-15</td>
<td>4.91 (3.9)</td>
<td>108 (8%)</td>
<td>22 (73%)</td>
</tr>
<tr>
<td>Strengths</td>
<td>1-11</td>
<td>3.70 (2.8)</td>
<td>72 (5%)</td>
<td>19 (63%)</td>
</tr>
<tr>
<td>Clinical goals</td>
<td>1-4</td>
<td>2.22 (1.3)</td>
<td>20 (2%)</td>
<td>9 (30%)</td>
</tr>
<tr>
<td>Activity-specific</td>
<td>3-48</td>
<td>17.04 (10.0)</td>
<td>426 (32%)</td>
<td>25 (83%)</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>1-7</td>
<td>2.50 (2.3)</td>
<td>15 (1%)</td>
<td>6 (20%)</td>
</tr>
<tr>
<td>The problem/family dynamics</td>
<td>1-37</td>
<td>7.88 (7.1)</td>
<td>205 (15%)</td>
<td>26 (87%)</td>
</tr>
<tr>
<td>Processing feelings</td>
<td>1-19</td>
<td>5.85 (4.9)</td>
<td>117 (9%)</td>
<td>20 (67%)</td>
</tr>
<tr>
<td>Making meaning of activities</td>
<td>2-20</td>
<td>6.73 (4.7)</td>
<td>74 (6%)</td>
<td>11 (37%)</td>
</tr>
<tr>
<td>Solution-oriented talk</td>
<td>1-22</td>
<td>7.08 (5.1)</td>
<td>177 (13%)</td>
<td>25 (83%)</td>
</tr>
<tr>
<td>In-session child discipline</td>
<td>1-4</td>
<td>2.00 (1.7)</td>
<td>6 (0.4%)</td>
<td>3 (10%)</td>
</tr>
<tr>
<td>Nonclinical</td>
<td>1-9</td>
<td>3.54 (2.3)</td>
<td>85 (6%)</td>
<td>24 (80%)</td>
</tr>
</tbody>
</table>

Note: Percentage values for “Total minutes spent in category across all sessions” were calculated by taking the frequency (i.e., number of minutes in category across all sessions)/total number of minutes across all sessions (i.e., 1,348). Percentage values for the “Number of sessions in which talk category was used” were computed through taking the frequency (i.e., number of sessions)/total number of sessions (i.e., 30).
Table 4.2 Family Therapy Techniques

<table>
<thead>
<tr>
<th>Therapy Technique</th>
<th>Range minutes per session</th>
<th>$M(SD)$ minutes per session</th>
<th>Total minutes spent in technique across all sessions</th>
<th># (%) of sessions in which technique was used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal-only</td>
<td>1-58</td>
<td>16.57 (15.3)</td>
<td>464 (34%)</td>
<td>28 (93%)</td>
</tr>
<tr>
<td>Verbal + prop</td>
<td>1-20</td>
<td>9.88 (5.5)</td>
<td>168 (13%)</td>
<td>17 (57%)</td>
</tr>
<tr>
<td>Art technique</td>
<td>1-38</td>
<td>13.81 (11.7)</td>
<td>152 (11%)</td>
<td>11 (37%)</td>
</tr>
<tr>
<td>Psychodrama technique</td>
<td>2-15</td>
<td>7.00 (5.9)</td>
<td>28 (2%)</td>
<td>4 (13%)</td>
</tr>
<tr>
<td>Puppet/psychodrama technique</td>
<td>6-28</td>
<td>17.60 (10.7)</td>
<td>88 (7%)</td>
<td>5 (17%)</td>
</tr>
<tr>
<td>Puppet/story-telling technique</td>
<td>18-21</td>
<td>19.50 (2.1)</td>
<td>39 (3%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Puppet/other technique</td>
<td>2-21</td>
<td>11.50 (13.4)</td>
<td>23 (2%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Experiential technique</td>
<td>10-49</td>
<td>28.80 (11.3)</td>
<td>288 (21%)</td>
<td>10 (33%)</td>
</tr>
<tr>
<td>Non-directive/Filial technique</td>
<td>9-53</td>
<td>22.00 (20.8)</td>
<td>98 (7%)</td>
<td>4 (13%)</td>
</tr>
</tbody>
</table>

Note: Percentage values for “Total minutes spent in technique across all sessions” were calculated by taking the frequency (i.e., number of minutes spent in technique across all sessions)/total number of minutes across all sessions (i.e., 1,348). Percentage values for the “Number of sessions in which technique was used” were computed through taking the frequency (i.e., number of sessions in which technique was used)/total number of sessions (i.e., 30).
Table 4.3 Range, Means, Standard Deviations of Target Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time in activities</td>
<td>0 – 54</td>
<td>30.6</td>
<td>15.2</td>
</tr>
<tr>
<td>Time in verbal-only techniques</td>
<td>0 – 58</td>
<td>15.3</td>
<td>15.5</td>
</tr>
<tr>
<td>Talk time: Child</td>
<td>21 – 53</td>
<td>37.6</td>
<td>9.6</td>
</tr>
<tr>
<td>Talk time: Parents</td>
<td>12 – 51</td>
<td>37.0</td>
<td>9.5</td>
</tr>
<tr>
<td>Talk time: Therapists</td>
<td>16 – 60</td>
<td>43.4</td>
<td>10.1</td>
</tr>
<tr>
<td>Talk time: Parents + Therapists (combined)</td>
<td>12 – 60</td>
<td>40.2</td>
<td>10.2</td>
</tr>
<tr>
<td>Child age</td>
<td>5 – 12</td>
<td>8.6</td>
<td>2.1</td>
</tr>
<tr>
<td>Y-OQ\textsuperscript{TM} total score</td>
<td>4 – 132</td>
<td>60.6</td>
<td>28.5</td>
</tr>
<tr>
<td>CTR total score</td>
<td>-22.30 – 13.05</td>
<td>00.0</td>
<td>8.3</td>
</tr>
<tr>
<td>OEE-AR total score</td>
<td>-12.09 – 7.08</td>
<td>00.0</td>
<td>4.9</td>
</tr>
<tr>
<td>OEE-CR total score</td>
<td>-19.53 – 6.82</td>
<td>00.0</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Table 4.4 Inter-correlations Among Variables in Hierarchical Multiple Regression Analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child talk time</td>
<td>.44*</td>
<td>-.22</td>
<td>-.16</td>
<td>-.39*</td>
<td>-.50**</td>
<td>-.47**</td>
<td>.41**</td>
</tr>
<tr>
<td>Child age</td>
<td></td>
<td></td>
<td>-.01</td>
<td>.30</td>
<td>.40*</td>
<td>-29</td>
<td></td>
</tr>
<tr>
<td>Y-OQ&lt;sub&gt;TM&lt;/sub&gt; total score</td>
<td></td>
<td></td>
<td></td>
<td>.10</td>
<td>.34</td>
<td>-.29</td>
<td></td>
</tr>
<tr>
<td>Time in activities</td>
<td>--</td>
<td>.87**</td>
<td>-.53**</td>
<td>-.05</td>
<td>-.35</td>
<td>-.15</td>
<td>.02</td>
</tr>
<tr>
<td>Time in verbal-only techniques</td>
<td>--</td>
<td>-.55**</td>
<td>-.06</td>
<td>.43*</td>
<td>.21</td>
<td>.10</td>
<td></td>
</tr>
<tr>
<td>Number of parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.44*</td>
<td>-.34</td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.27</td>
<td></td>
</tr>
<tr>
<td>Therapist licensure status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *p < .05, **p < .01. Binary variables were coded as follows: number of parents (1 parent = 0, 2 parents = 1), number of children (1 child = 0, 2+ children = 1), therapist licensure status (unlicensed = 0, licensed = 1).
Table 4.5 Target Child’s Talk Time Across Levels of Binary-Coded Variables in Hierarchical Multiple Regression Analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>$n$</th>
<th>$M$ (child talk time)</th>
<th>$SD$ (child talk time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of parents present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 parent</td>
<td>17</td>
<td>41.0</td>
<td>2.3</td>
</tr>
<tr>
<td>2 parents</td>
<td>13</td>
<td>32.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Number of children present</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 child</td>
<td>12</td>
<td>40.7</td>
<td>2.9</td>
</tr>
<tr>
<td>2+ children</td>
<td>18</td>
<td>35.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Therapist licensure stats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlicensed</td>
<td>15</td>
<td>35.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Licensed</td>
<td>15</td>
<td>39.9</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Note: Talk time is in minutes.
<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>Δ$R^2$</th>
<th>B</th>
<th>SEB</th>
<th>β</th>
<th>t</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1</td>
<td>.39</td>
<td>.29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time in activities</td>
<td>.57</td>
<td>.21</td>
<td>.90</td>
<td>2.73</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time in verbal-only techniques</td>
<td>.33</td>
<td>.21</td>
<td>.54</td>
<td>1.60</td>
<td>.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child age</td>
<td>.08</td>
<td>.86</td>
<td>.02</td>
<td>1.00</td>
<td>.92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y-OQ&lt;sup&gt;TM&lt;/sup&gt; total score</td>
<td>-.10</td>
<td>.05</td>
<td>-.31</td>
<td>-1.91</td>
<td>.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Model 2</td>
<td>.72</td>
<td>.64</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time in activities</td>
<td>.75</td>
<td>.16</td>
<td>1.19</td>
<td>4.65</td>
<td>.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time in verbal-only techniques</td>
<td>.58</td>
<td>.18</td>
<td>.94</td>
<td>3.26</td>
<td>.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child age</td>
<td>.79</td>
<td>.68</td>
<td>.17</td>
<td>1.15</td>
<td>.26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y-OQ&lt;sup&gt;TM&lt;/sup&gt; total score</td>
<td>-.02</td>
<td>.04</td>
<td>-.07</td>
<td>-.52</td>
<td>.61</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One vs. two parents</td>
<td>-5.88</td>
<td>2.80</td>
<td>-.31</td>
<td>-2.10</td>
<td>.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One vs. two or more children</td>
<td>-5.74</td>
<td>1.89</td>
<td>-.44</td>
<td>-3.03</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Licensed vs. student therapists</td>
<td>1.56</td>
<td>2.77</td>
<td>.08</td>
<td>.56</td>
<td>.58</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4.7 Bivariate Inter-correlations Among Variables Used in Canonical Correlation Analysis

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CTR total score</td>
<td>--</td>
<td>.15</td>
<td>.41*</td>
<td>-.28*</td>
<td>.41*</td>
<td>.21</td>
</tr>
<tr>
<td>2. OEE-AR total score</td>
<td>--</td>
<td>.06</td>
<td>.02</td>
<td>.12</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>3. Time in activities</td>
<td>--</td>
<td>-.87*</td>
<td>.44*</td>
<td>.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Time in verbal-only techniques</td>
<td>--</td>
<td>-.22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Child talk time</td>
<td>--</td>
<td>.47**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Parent/therapist talk time</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *p < .05, **p < .01. CTR = Child-Therapist Relationship, OEE-AR = Overall Emotional Experience-Adult Report
Table 4.8  Canonical Correlation Analysis of Therapy Process (Independent) Variables with Parent/Therapist-Reported Session Outcome (Dependent) Variables

<table>
<thead>
<tr>
<th>Canonical Function</th>
<th>Canonical Correlation</th>
<th>Canonical R²</th>
<th>F Statistic</th>
<th>Probability (Sig)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.50</td>
<td>.25</td>
<td>2.10</td>
<td>.04</td>
</tr>
<tr>
<td>2</td>
<td>.13</td>
<td>.02</td>
<td>.32</td>
<td>.81</td>
</tr>
</tbody>
</table>

Multivariate Tests of Significance

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
<th>Approx. F Statistic</th>
<th>Probability (Sig)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wilk’s lambda</td>
<td>4.00</td>
<td>2.10</td>
<td>.04</td>
</tr>
<tr>
<td>Pillai’s trace</td>
<td>6.00</td>
<td>2.01</td>
<td>.05</td>
</tr>
<tr>
<td>Hotelling’s trace</td>
<td>2.00</td>
<td>2.19</td>
<td>.03</td>
</tr>
<tr>
<td>Roy’s gcr</td>
<td>.245</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4.9 Redundancy Analysis of Dependent and Independent Variates for Both Canonical Functions

<table>
<thead>
<tr>
<th>Canonical Function</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
<th>Canonical R²</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.53</td>
<td>.53</td>
<td>.25</td>
<td>.13</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>.48</td>
<td>1.00</td>
<td>.02</td>
<td>.01</td>
<td>.14</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Canonical Function</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
<th>Canonical R²</th>
<th>Percentage</th>
<th>Cumulative Percentage</th>
<th>Cumulative Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.48</td>
<td>.48</td>
<td>.25</td>
<td>.12</td>
<td>.12</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>.30</td>
<td>.77</td>
<td>.02</td>
<td>.01</td>
<td>.13</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.10  Sensitivity Analysis Of Canonical Correlation Results to Removal of an Independent Variable From the First Canonical Function

<table>
<thead>
<tr>
<th></th>
<th>Complete Variate</th>
<th>Results after Deletion of</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Canonical Correlation (R)</td>
<td>.495</td>
<td>.464</td>
<td>.488</td>
<td>.447</td>
<td>.495</td>
<td></td>
</tr>
<tr>
<td>Canonical Root ($R^2$)</td>
<td>.245</td>
<td>.215</td>
<td>.239</td>
<td>.200</td>
<td>.245</td>
<td></td>
</tr>
</tbody>
</table>

Independent Variate

<table>
<thead>
<tr>
<th>Canonical loadings</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_1$ Time in activities</td>
<td>.825</td>
<td>omitted</td>
<td>.838</td>
<td>.912</td>
<td>.825</td>
<td></td>
</tr>
<tr>
<td>$X_2$ Time in verbal-only techniques</td>
<td>-.558</td>
<td>-.600</td>
<td>omitted</td>
<td>-.614</td>
<td>-.557</td>
<td></td>
</tr>
<tr>
<td>$X_3$ Child talk time</td>
<td>.842</td>
<td>.898</td>
<td>.853</td>
<td>omitted</td>
<td>.843</td>
<td></td>
</tr>
<tr>
<td>$X_4$ Therapist/parent talk time</td>
<td>.445</td>
<td>.470</td>
<td>.447</td>
<td>.497</td>
<td>omitted</td>
<td></td>
</tr>
<tr>
<td>Shared variance</td>
<td>.475</td>
<td>.463</td>
<td>.544</td>
<td>.486</td>
<td>.567</td>
<td></td>
</tr>
<tr>
<td>Redundancy index</td>
<td>.117</td>
<td>.010</td>
<td>.130</td>
<td>.097</td>
<td>.139</td>
<td></td>
</tr>
</tbody>
</table>

Dependent Variate

<table>
<thead>
<tr>
<th>Canonical loadings</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$X_5$ CTR total score</td>
<td>.995</td>
<td>.997</td>
<td>.997</td>
<td>.993</td>
<td>.994</td>
<td></td>
</tr>
<tr>
<td>$X_6$ OEE-AR total score</td>
<td>.246</td>
<td>.222</td>
<td>.226</td>
<td>.262</td>
<td>.251</td>
<td></td>
</tr>
<tr>
<td>Shared variance</td>
<td>.525</td>
<td>.522</td>
<td>.522</td>
<td>.527</td>
<td>.526</td>
<td></td>
</tr>
<tr>
<td>Redundancy index</td>
<td>.129</td>
<td>.112</td>
<td>.125</td>
<td>.105</td>
<td>.129</td>
<td></td>
</tr>
</tbody>
</table>

Note: The “respondent” is the parent or therapist completing the questionnaire. CTR = Child-Therapist Relationship. OEE-AR = Overall Emotional Experience-Adult Report.
Table 4.11 Bivariate Correlations of Process Variables with Child-Reported Outcome Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Child talk time</th>
<th>Therapist talk time</th>
<th>Time in activities</th>
<th>Time in verbal-only techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>OEE-CR</td>
<td>.36 ( .06)</td>
<td>.15 ( .44)</td>
<td>-.09 (.64)</td>
<td>.15 (.45)</td>
</tr>
<tr>
<td>Child’s happiness about seeing the therapist</td>
<td>.35 (.08)</td>
<td>-.04 (.86)</td>
<td>.39* (.05)</td>
<td>-.34 (.09)</td>
</tr>
<tr>
<td>How good child thinks the therapist feels with the child in the room</td>
<td>.09 (.68)</td>
<td>-.22 (.29)</td>
<td>-.11 (.62)</td>
<td>-.08 (.71)</td>
</tr>
<tr>
<td>How much child understands of what therapist says to the family</td>
<td>-.03 (.90)</td>
<td>.25 (.22)</td>
<td>-.12 (.56)</td>
<td>.21 (.29)</td>
</tr>
</tbody>
</table>

Note: *p < .05. Probability values are in parentheses below the Pearson Correlation (r). OEE-CR = Overall Emotional Experience-Child Report.
CHAPTER 5
CONCLUSIONS

As influential members of families (Clark, Kochanska, & Ready, 2000; Halverson & Wampler, 1993; Koenig, Barry, & Kochanska, 2010; Prinzie, Onghena, Hellinckx, Grietens, Ghesquière, & Colpin, 2004), children should be included in family therapy even when they are not identified as part of the presenting problem (Keith & Whitaker, 1981). The challenge with including children is how to do it appropriately (Sori & Sprenkle, 2004). Primarily, the issue that makes it difficult to include children is that they are fundamentally different from adults. Their ability to conceptualize human mental processes, behavior, motives for behavior, affective states, and factors influencing affect is significantly less advanced than that of adults (Dunn, Bretherton, & Munn, 1987; Dunn, Brown, & Beardsall, 1991; Flavell, 2004; Flavell et al., 1995). To make matters worse, we do not always know how adult talk will be assimilated into immature cognitive systems (Woodward & Markman, 1998). Thus, if children are to be included in family therapy, it behooves family therapists to learn about how children function as a result of socio-emotional and cognitive developmental processes. These processes change the very nature of children over time. Therefore, to understand children one must comprehend the effect of development on child functioning from birth to at least age 18 because that effect changes profoundly across the lifespan (Santrock, 2007).

It is clear from this review of literature that most therapists are not thoroughly educated about child development (Johnson & Thomas, 1999; Korner & Brown, 1990;
Ruble, Walters, Yu, & Setchel, 2001). Family therapists need to be experts in child development, and, for that matter, in adult development. The reason the need for child development knowledge is greater than adult development knowledge is that adults are more similar to adults-of-all-ages than they are to children. We cannot “modify” an adult’s thinking to become like that of a child’s, but with sufficient knowledge it is possible to improve the accuracy of adult expectations of children (Hembree-Kigin & McNeil, 1995; Kobak & Mandelbaum, 2003; Marty, Readdick, & Walters, 2005; VanFleet, 2005). With those improved expectations, it is possible to develop effective strategies for working with children in family groups.

**Incorporating development into child and family therapy literature**

Methods for expanding developmental applications in theoretical and empirical literature on children’s mental health treatment are needed (Holmbeck, Devine, & Bruno, 2010). This dissertation is organized with a general review of theoretical and empirical literature on therapy involving children. Chapter 2 contains a review of the empirical status of treatments for young children with an emphasis on child age. Chapter 3 contains suggestions for utilizing play-based strategies and developmental considerations within a known family therapy model. The therapy model chosen for this explication is EFFT, an approach designed to strengthen family attachment relationships with preschoolers. Finally, the manuscript in chapter 4 contains an empirical study of contemporary therapists’ work with children in family therapy and developmentally-appropriate techniques for engaging children in this context. In response to writing these manuscripts, I arrived at several conclusions that may inform further research on
including children in family therapy. These conclusions address issues that were posed as questions at the end of Chapter 1.

1. Are therapists today working with children in family therapy? If so, what theories and techniques are therapists currently using to address child-related issues in family therapy sessions?

2. Is there any evidence to support that play-based techniques are more effective than solely talk-based therapies with children in family therapy sessions?

3. How can one integrate development theory and play therapy interventions within a model of family therapy to address the inclusion of children in family therapy as well as child-focused problems throughout the course of treatment?

4. In what ways can child therapy outcome research be presented so that empirical results may be interpreted with greater consideration of developmental factors? How do the answers to the above questions inform future directions for research and academic investigation?

**Question 1.** Based on my experience recruiting therapists for this study (chapter 4), it appears that little has changed over the last decade in terms of MFTs’ proclivity for excluding children from family therapy. I contacted over 50 family therapy agencies throughout northern Utah, but fewer than 20% \((n = 9)\) of these clinics employed even one MFT who provided therapy for families including children. Most of the individual MFTs who were contacted reported they did not work at all with children younger than age 12. The shortage of MFTs offering clinical services to families with children was so great, I had to open the study to therapists from other professional designations (e.g., clinical psychologists, clinical social workers) to obtain an acceptable sample size. This suggests
that barriers to MFTs’ inclusion of children in family-systemic therapy described by other scholars (Cederborg, 1997; Cox, 1997; Diller, 1991; Korner & Brown, 1990; Ruble, 1999) are as great today as they have ever been.

In terms of the types of clinical interventions used with children in family sessions, almost all the therapists used a combined approach of play therapy and traditional family therapy models (e.g., Emotionally-Focused Therapy, Experiential Therapy, Narrative Therapy). This is interesting in light of existing research portraying the majority of MFTs as being uninterested in play therapy or family play therapy (Raimondi & Walters, 2005; Ruble, 1999). One explanation for this discrepancy is that, whereas the majority of MFTs may not place high value on including younger children in session, and therefore see little need to learn child therapy techniques (Raimondi & Walters, 2005), there are some family-systemic counselors (mostly consisting of clinical social workers and MFTs) who share the belief held by family therapy founders, such as Satir, Ackerman, Whitaker, and Minuchin, that children ought to be a part of family therapy proceedings (Gil, 1994; Sori, 2006). Perhaps these therapists are more prone to look past the traditional paradigm split separating child and family therapy approaches (Haslam & Harris, 2011) by implementing techniques from both traditions.

**Question 2.** Another important discovery from the study reported in chapter 4 was that play therapy techniques, which have heretofore been virtually untested with whole families, demonstrated signs of being more effective than exclusively talk-based approaches for increasing child participation/self-expression and the quality of the child-therapist relationship. Of course, further research will be needed to validate this study. Nonetheless, it lends some support to hypothesized mechanisms of change proposed for
family play therapy approaches (Schaefer & Drewes, 2011), and offers initial evidence that play-based activities are a promising tool for accommodating children’s developmental needs in systemic treatment.

It is noteworthy that play-based strategies were also incorporated into most of the empirically-supported trauma treatments reviewed in chapter 2. For example, interactive activities (e.g., singing, drawing, story-reading, role-playing) were amply implemented within the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) protocols used with sexually abused preschoolers (Cohan & Mannarino, 1996; Scheeringa et al., 2001; Stauffer & Deblinger, 1996). Additionally, periods of unstructured parent-child play were utilized in Child Parent Psychotherapy (CPP) and Attachment-Focused Home-Visitation Intervention (AF-HVI) models. These three therapeutic approaches (i.e., TF-CBT, CPP, AF-HVI) were classified in chapter 2 as either well-established (Category I) or probably efficacious (Category II) models for treating young children with abuse or trauma histories. However, none of these treatments are typically cited as play therapy models. Such findings contribute to the evidence that activity-oriented techniques are a valuable component of developmentally-sensitive therapy with children, even with one of the most difficult-to-treat mental health disorders (i.e., posttraumatic stress).

When one examines the types of treatment studies included in available meta-analyses of youth psychotherapy, tentative interpretations may be made about the meaning of the reported average treatment effect sizes. For example, in some of the child/adolescent therapy meta-analyses (Casey & Berman, 1985; Weisz, Weiss, Alicke, & Klotz, 1987; Weisz, Weiss, Hah, Granger, & Morton, 1995), “behavioral approaches” (e.g., parent training, role-modeling, physical/verbal reinforcement, social skills training,
cognitive behavioral therapy, systematic desensitization), have been found to be overall superior to “non-behavioral approaches” (i.e., client-centered/play therapy, psychodynamic therapy, discussion group) with children and adolescents. Average mean effect sizes across treatments were found to range from .71 to 84. However, in 2 of these 3 meta-analyses (Weisz et al., 1987; Weisz et al., 1995), only 2% \( (n = 7) \) to 7% \( (n = 3) \) of the reviewed studies were play therapy studies; whereas, 74% \( (n = 78) \) to 82% \( (n = 123) \) of the other studies addressed “behavioral” interventions. Thus, play therapy was seriously under-represented in these two meta-analyses. In the third meta-analysis (Casey & Berman, 1985), there was greater representation 27% \( (n = 20) \) of play therapy studies, but many of these studies lacked methodological rigor, suggesting the true effect of play therapy may not have been accurately measured or well-analyzed.

Due to the under-representation of play therapy approaches in meta-analyses of children’s psychological treatments, as well as ongoing advancements in the quality of play therapy research, Bratton et al. (2005) and LeBlanc and Ritchie (2001) conducted recent meta-analyses that focused wholly on play therapy methods. LeBlanc and Ritchie (2001) reviewed 42 studies of play therapy, finding an average play therapy effect size of .66. Bratton et al. (2005) analyzed 93 play therapy studies (almost twice as many as LeBlanc & Ritchie, 2001), and found an overall effect size of .80. Such findings could indicate that the relative effect of play therapy is larger than it originally seemed in earlier meta-analyses (Casey & Berman, 1985, Weisz et al., 1987, Weisz et al., 1995). However, in order to truly compare the effect sizes of play therapy and talk-based methods (e.g., behavioral, cognitive behavioral approaches) with children, new meta-
analyses must be conducted including an updated list of treatment-outcome studies from both (play and talk-based) styles of clinical treatment.

Though few individual studies evaluate the impact of development on treatment outcome, a review of meta-analyses on mental health therapy with youth can also provide support regarding potential explanations about the specificity of treatment effects for play- versus talk- (behavioral, cognitive behavioral) therapy interventions with different age-groups of children. Observing the average age of children in studies included for review in meta-analyses provides some indication about to whom (or which age-group) the overall treatment effect may best apply. For example, in predominantly non-play therapy focused meta-analyses (Kazdin et al., 1990; Weisz et al., 1987; Weisz et al., 1995), the mean ages of child participants ranged from 10.2 to 10.5 years, whereas the mean ages of children in the play therapy-focused meta-analyses by Bratton et al. (2005) and LeBlanc and Ritchie (2001) were 7 and 7.9 years, respectively. The average age in Casey and Berman’s (1985) meta-analysis was 8.9. One could surmise from these findings that the mean effect sizes presented in these meta-analyses generally reflect two separate development groups: early-elementary school (Bratton et al., 2005; LeBlanc & Ritchie, 2001) and late-elementary school/pre-adolescence (Casey & Berman, 1985; Kazdin et al., 1990; Weisz et al., 1987, Weisz et al., 1995); and that earlier findings indicating behavioral (talk-based) methods are superior to non-behavioral interventions (Casey Weisz et al., 1987, Weisz et al., 1995) could apply more to older children and adolescents, than younger (< age 7) children.

Lending support to this theory, other findings suggest there might be a difference in the impact of age on treatment outcome between play therapy and primarily talk-based
methods. Weisz et al. (1995) found that treatment effects across approaches were significantly larger for adolescents (ages 12 and older) than children (ages 11 and younger), suggesting a possible moderating effect of age on outcome. However, the age main effect became marginal when therapy-type and therapist training were controlled, which means the effect sizes were approach-specific. In the meta-analyses with a better representation of play therapy studies (Casey & Berman, 1985; Bratton et al., 2005; LeBlanc & Ritchie, 2001), no relation was found between age and outcome which may indicate that play therapy is appropriate for children of all ages. As mentioned earlier, the majority of treatments reviewed by Weisz et al. (1995) were behavioral or cognitive-behavioral; their findings may indicate that talk-based interventions improve in effectiveness as children age due to advances in their cognitive capabilities (Grave & Blissett, 2005; Shirk, 2001). On the other hand, age may not moderate outcomes in play therapy because the approach requires fewer adult-like cognitive skills. Nevertheless, as these conclusions are still tentative, ongoing research (both in terms of individual studies and future meta-analyses) will be needed to explore how effect sizes differ across treatments for children in diverse age-groups.

**Question 3.** In chapter 3, I sought to present an inter-disciplinary assimilation of three distinct-yet-related fields of study (child development, play therapy, family therapy) to enhance a family therapy approach with young children. Integrating clinical and developmental literature to this degree is rarely seen in family therapy publications. Likely, this is because few family therapists have adequate knowledge of child development (Korner & Brown, 1990; Ruble, Walters, Yu, & Setchel, 2001; Tuma &
Pratt, 1982) which leaves them feeling insecure in their ability to draw explicit links between developmental principles and the micro-moves of therapy.

Bolstering collaboration between scholars in the theoretical and applied sciences of child/human development and child/family therapy may facilitate some of the needed improvements in child therapy literature. In the best of worlds, therapists would have much greater depth and breadth of knowledge of child development, and developmentalists would specialize in the application of development to clinical practice. In reality, rather than having enough familiarity with development literature to function independently, family therapists can regularly use developmentalists as consultants in their work with children in families. However, effective involvement with consultants would likely imply some change in the education of family therapists. For example, courses in which developmentalists and therapists solve hypothetical family therapy problems together would be useful. This would help budding developmentalists and therapists learn to work together productively. Co-supervision by a developmentalist and designated family therapy supervisor would also be desirable for student therapists working with child-related cases.

Certainly, the logistics and potential challenges (e.g., ethical issues, specialized training needed for developmentalist-consultants, reimbursement to developmentalists for time spent, clients’ willingness to be supervised by a non-clinical professional) related to including developmentalists as consultants in therapy practice would need to be addressed. Literature regarding the use of consultants in counseling settings (e.g., Maurizio & Russell, 1994) could be a valuable resource in the design and implementation of such programs. Future research could document efforts to incorporate
developmentalists as consultants in practicum or supervision courses with therapists-in-training and examine the impact of the consultation process on therapists’ attitudes toward children and child-related therapy practices.

**Question 4.** As demonstrated in chapter 2, one way to advance child clinical research is to present reviews (or meta-analyses) that are organized by child age. Though age does not define developmental status, age can still be useful for providing insight about the effectiveness of a treatment with similarly-aged children commonly characterized by certain developmental traits (Shirk, 2001). Holmbeck and colleagues (2010) stated, “If evaluations of age differences in treatment-outcome studies were to become the norm, this would be progress for the field.”

Because age is an imperfect measure of development, instruments assessing developmental status need to be included as mediators, moderators, and outcome measures in treatment-outcome studies. Developmental variables that might be used as treatment outcomes or mediators and moderators could include measures of children’s cognitive skills (e.g., social perspective-taking, meta-cognitive/abstract thinking, decision-making), receptive-expressive linguistic abilities, emotional regulation, or social skills (Holmbeck et al., 2010; Shirk, 2001). Careful selection of developmentally-appropriate instruments (e.g., interviews versus paper-pencil surveys with young children) is important to achieving valid and reliable results in this research (Hibbs, 1993).

Except for screening tests (e.g., Denver Developmental Screening Test: Frankenburg & Dobbs, 1967) which may not be detailed enough (Glascoe, Byrne, Ashford, Johnson, Chang, & Strickland, 1992), there are few clinician-friendly
instruments for measuring developmental status (Holmbeck et al., 2010). Thus, the creation and evaluation of instruments for assessing different aspects of child development status would be useful both in research and clinical settings as diagnostic tools. Investigating different aspects of developmental status in clinical research could reveal “developmental profiles” that tend to respond best to certain therapeutic interventions.

Another fruitful area of research would be to investigate whether merging play therapy activities into established talk-based child or family therapy approaches might improve treatment effects above and beyond that which would be obtained from talk-based therapy without the play-based components. As illustrated earlier, child therapy reviewers have focused for years on evaluating whether play therapy or non-play interventions (i.e., behavioral, cognitive-behavioral therapy) are more effective with child clients (Bratton et al., 2005; Casey & Berman, 1985; Weisz et al., 1995; Weisz & Jensen, 2001). Yet, based on my findings (chapters 2 and 4), it seems that many therapists are combining play-based techniques with other clinical models. Researchers, for example, could compare integrated play therapy and CBT approaches (e.g., Drewes, 2009; Gil, 2006) with standard talk-based CBT protocols to treat children with various mental health disorders. Testing differences in drop-out rates between the integrative/play-based and talk-oriented approaches could also reveal whether the participants’ positive feelings associated with an activity-oriented style of therapy helps to reduce early treatment termination.

In sum, there are many areas in which the field of family therapy could benefit from greater attention to the developmental status of clients. By attending to
developmental variables in child therapy theory and research, practitioners can make more informed choices about appropriate interventions to use with their youngest clients. Disseminating advanced developmental applications in clinical literature for family therapy can lead to greater confidence among therapists for accommodating the development-driven needs of children in therapy. For family therapists, this may eventually result in truly systemic family therapy.
References


personality and children’s proneness to anger as predictors of future parenting.


knowledge of child development in a therapeutic context: A survey of therapists.


psychotherapy with children and adolescents: A meta-analysis for clinicians.

