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Young Children in Family Therapy: A Look at Frequency of Inclusion, Therapist Training, and Therapy Content

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YOUNG CHILDREN IN FAMILY THERAPY: A LOOK AT FREQUENCY OF INCLUSION, THERAPIST TRAINING, AND THERAPY CONTENT.

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CHAPTER I

INTRODUCTION

In the mid-1950's a change began to occur when the family, rather than the individual client, became a potential unit of treatment in psychotherapy. With this change the attention of the therapist focused on the dysfunctional system in which the "identified patient" is seen as but a symptom, and the family, or system, is viewed as the client (Corsini & Wedding, 1989). Consequently, family therapists have a difficult job in that they are expected to understand and incorporate in their treatment all members of the system.

Nathan Ackerman (1970) stated that, ". . . psychotherapists as a group are candid in confessing their preferred patient ages". Many feel uncomfortable working with children and feel that they require too much energy while others relate easily to children and feel uncomfortable working with adults. In individual therapy this may pose no problem yet, in family therapy the problem cannot be avoided (Ackerman, 1970). Thus, the difficulty exists in fully involving all members of the family simultaneously.

The literature regarding young children in family therapy is scarce. In a thorough review of the research, Gurman and Kniskern (1978) found that no study had directly examined the issue of exclusion or inclusion of children in marital or family therapy. However, there is a general impression that children, especially

young children, are either excluded from family therapy or treated in individual therapy (Combrinck-Graham, 1991). Greenwood (1985), in his unpublished dissertation, surveyed family therapists concerning the inclusion of young children ages four years and under in family therapy. He reported that young children were included in sessions less than one third of the time. In spite of this information, many professionals agree that the presence of all family members in therapy sessions is a necessary element to understanding the family. Guttman (1975) stated that, "Family therapy, to be true to its commitment to systems theory, should be as concerned with the younger child as with all other family members, whether he is the presenting problem or not". ". . . a therapist cannot expect to fully understand a family's current situation, its past history as a family, or its future hopes and fears unless he knows all members of the family" (Zilbach, Bergel, & Gass, 1972).

Clinical theory and practice seem to contradict each other when it comes to inclusion of children in family therapy sessions. "... it is largely true in our experience that many therapists do not take as much notice of children in practice as they do in theory" (O'Brien & Loudon, 1985). While the existing literature highlights the benefits, if not necessity, of including children (Combrinck-Graham, 1991; Zilbach, 1989; Zilversmit, 1990), in actual practice, it appears that the majority of clinicians do not include young children in a systematic fashion.

Reasons Cited for Excluding Young Children

It is crucial to understand potential reasons why young children, in practice, are not included in a systematic manner. Simply put, some therapists find that

children bring new obstacles with which to contend, adding to the clinician's stress (Combrinck-Graham, 1986). Young children do not have the attention span of adults. They are curious and thus, may wander, touch, and explore the therapy room. This may create new difficulties, especially for the clinician who is inexperienced with young children.

Dowling and Jones (1978) report that some therapists believe young children are not mature enough verbally and intellectually to participate. Therapists may not be trained in child development. Including young children would require that the therapist be adept in communicating at the various developmental levels of the family. Needless to say, if one is not skilled in working with children at their developmental level, there may be harmful effects.

Carpenter and Treacher (1982) underscore that including young children in family therapy sessions can be overwhelming for the clinician. The therapist may feel embarrassed or silly when the child acts withdrawn or at the other end of the spectrum, disruptive and loud. Another likely possibility is that therapists may feel awkward presenting childlike activities to parents. This may be threatening to therapists' confidence, causing them to feel that their competence is put into question (Benson, Schindler-Zimmerman, & Martin, 1991).

In response to the young child, Kaslow and Racusin (1990) believe that when working with children with severe psychopathology, the multiple levels involved in family therapy work and the increased amount of activity may be too overstimulating for the child. This results in increased chaos. Additionally, children may be used as

the scapegoat (Steinhauer & Rae-Grant, 1983). The behavior of young children often creates distraction which serves to take the focus off the parental relationship.

An impending concern of including young children in family therapy may also exist. Young children may have their rights to tape sessions and release information signed by their parents. As adults, they may regret the decision made for them (Hare-Mustin, 1980).

There is also the risk that a previously asymptomatic family member may become symptomatic during or following participation in therapy (L'Abate, 1982). Korner (1988) suggests that parents may not see a need for all their children to attend. They may fear a form of "emotional contagion" in which the younger child would be exposed to the "negative" behavior of the symptomatic child. In addition, parents may fear that children would be harmed by what they would hear in sessions. Korner poses that this may be a secret fear of therapists as well.

Reasons Cited for Including Young Children

The literature provides many reasons for including young children in family therapy sessions. One argument is simply that as members of the family, children are entitled to family therapy (Korner, 1988). Family therapy is not family therapy unless all members are included, young children being no exception.

Children are also seen as a very rich source of information. They are vital in family sessions because they act as affect barometers. They can sense tension, separation, hostility, and anxiety. They are distinct from adults who are more easily able to diminish the nonverbal. Young children contribute with their behavior by

bringing to the surface the issues repressed or avoided by adults (Dowling & Jones, 1978).

David and Jill Scharff (1987), believe in including children of all ages. They attempt to learn about their contribution to the family by observing their presence. They emphasize that even the very young children, from ages zero to three, can be extremely beneficial to include. The child at this age is cued to the parents' affective tone, even more than to their words.

Ackerman (1970) states, "The disclosures of the children are an important level of checking, a kind of reality testing and consensual validation of the parent's descriptions of their troubles". Similarly, Carl Whitaker (Neill & Kniskern, 1982) saw children as an integral part of change. He believed that children establish themselves as "functional co-therapists" for the parents. He found that parents are often times more able to listen to their children. In addition, children are more able to be frank and honest in the way they relate.

When to Include Young Children

From the existing literature there is fairly strong support for the inclusion of young children in family therapy. Yet, clinicians still lack clarity in regards to when and at what age to include children. Satir (1967) believes that when there is pain in the family, all family members experience the pain in some way. When children are under the age of four, Satir includes them for at least two of the initial sessions. She made exceptions to her cut-off age of four if "the mates cannot bear to look at their own relationship but must have the child there to focus on". However, children four

and older will usually stay in the sessions throughout the course of family therapy. She believes that seeing families together in therapy makes good sense but, most therapists are unsure as to how to conduct therapy with everyone present.

Others practice something quite different from Satir. For example, in an interview conducted by Haley and Hoffman (1967), they noted that Fulweiler works with the parents and the "identified patient" only if a child seems to be the problem. Fulweiler supports his stance with the idea of family homeostasis, i.e., that if one part of the family system is altered, the whole system will be effected (Haley & Hoffman, 1967).

Others agree that at the least during the assessment phase, all members of the family, even infants, should be seen together. It is useful to discover who holds, relates to, cares for, indulges or ignores the young child, as well as the cooperation and/or competition among the parents (Moss-Kagel, Abramovitz, & Sager, 1989).

Appropriate Topics for Young Children

According to the literature, there are differing opinions on what issues are acceptable for discussion when young children are present. Some topics are more closely agreed upon. For example, when initially seeing the family, the therapist may want to spare the children from the tedium of insurance data. However, some issues and topics are not so clear cut.

Kniskern (1979) stated that he does not insist on the inclusion of children if their presence will require a parental disclosure which is unacceptable to the parents such as infidelity or sexual dysfunction. However, he believes that no topic needs to

be kept from children. On the other hand, Chasin (1989) finds that it is a burden for children to learn details of parents' problems. Similarly, Fulweiler (Haley & Hoffman, 1967) believes that children should not be involved when discussing the complexities of parents' problems.

Boatman, Borkan and Schetky (1981) state that, "while some marital issues remain best discussed between husband and wife, there can also be issues between other dyads that need to be explored within the family context". They go on to say that in the treatment of incest, younger siblings almost always know about the sexual abuse. Allowing the siblings inclusion in family meetings is therapeutic and gives them permission to discuss what might otherwise be considered secret. Conte (1986) suggests that interventions based upon "family" ideas about sexual abuse can be harmful to victimized children. He advises future research in this area in which consequences to the child and other family members can be assessed when families are seen together. The literature leads one to believe that some topics are best disclosed while others are not.

A handful of other authors have stated their opinions on the topic of disclosures and inclusion but, they have not tested their theories. Lack of research leaves professionals guided by their personal experience. Even as Kniskern (1979) stated, "Unfortunately, it is difficult to transpose one therapist's guidelines, reflecting as they do specific therapist and treatment variables to practical guidelines for another therapist".

Developmental Distinctions

As early as 1958, Ackerman, in his book, The Psychodynamics of Family Life, wrote about the challenge therapists must face in establishing a relationship with children. He describes the interaction between the therapist and child as they first meet each other. He is careful and cautious, realizing he is a stranger to the child, and yet, being aware of the child's non-verbals. It is clear through his writing that he is cognizant that children must be worked with and engaged in a different manner than adults. They are in a state of rapid growth with nonverbal and verbal communication increasing daily. According to Richard Chasin (1989), Director of the Family Institute of Cambridge, Massachusetts, it is also important from the start of the first session to treat each member equally and to make sure that language and sentence structure used is easily comprehended by children and adults.

O'Brien and Loudon (1985) stress the importance of therapists' familiarity with child development as a vital part of working with young children. Knowledge of developmental stages enables the therapist to communicate on the child's level through each stage of their growth, thus avoiding too intellectual an approach. It is essential that the therapist use language compatible with the child's stage of development with regards to receptive and expressive language (Henggeler & Borduin, 1990).

Lee Combrinck-Graham (1991) presents developmental distinctions in children that are valuable for the family therapist. The four basic developmental stages are: pre-verbal, pre-conventional, conventional, and dissembling. The pre-verbal stage is that of children under age two. Even though this stage is referred to as pre-verbal,

children between the ages of one and two generally understand much more than they can express. Pre-conventional children are verbal children up to the age of elementary school or six years. They are typically frank and outspoken.

When children enter school, they generally enter the conventional stage. They will be honest but, are aware of conventions, therefore more inhibited about divulging personal information. This stage is generally inclusive of the ages six to twelve or thirteen years. The last stage occurs at the time of puberty. Children at this developmental stage learn the skill of dissembling, the capacity to bend the truth or show things as they would have others believe (Combrinck-Graham, 1991). These stages are helpful in giving a general perception of what to expect from children at each of the four stages.

The Use of Play

As previously stated, many object to including young children in family sessions due to the fact that they do not communicate on the same verbal level as adults, limiting children's participation and increasing distraction. However, when young children are included and regarded as beneficial to therapy sessions, therapy tends to maintain a verbal process, making no adjustments for the young children. To engage young children, therapists should be prepared to use play as a medium of communication. Play is often the expressive and primary basic language of children. " . . . play is a child's work" (Zilbach, 1986).

However, Korner (1988) reports that the majority of therapists practicing family therapy, are not confident in their skills and are not trained in modalities

effective with young children (e.g. art and play therapy). If children are entitled to certain unalienable rights from their parents at birth then therapists must give the same consideration to children. He strongly emphasizes that, we must do "... whatever is necessary to understand children's therapeutic needs and to provide for them".

Scharff (1989) emphasizes that therapists need to be able to play with families that have young children. "The contextual holding capacity has to include comfort with play - and the accompanying noise, mess, and regression, all common features of ordinary life." All too often children are given toys to amuse themselves and keep them occupied. They are positioned in some area of the therapy setting while the adults talk in a separate area. Even when playing however, children usually remain attuned to what is going on in the session (Villeneuve & LaRoche, 1993). Using play in this fashion may imply to children that they are to "go away and play".

Toys may also serve the purpose of defending against anxiety that may occur when children are present in the family sessions (Zilbach, Bergel, & Gass, 1972). However, play can be taken a step further, beyond a simple distraction and anxiety defense and be used as a diagnostic tool (Levant and Haffey, 1981). In this way, the therapist is better able to understand the dynamics of the family. Play should not be viewed as a way to occupy the young child; it is fundamental to the work of family therapy with young children.

When using toys, it is important to choose those that the therapist feels comfortable with and can lend themselves to play which is easy to interpret. For

example, hand-puppets, dolls, and crayon drawings are often good choices (Chasin, 1989). Dowling and Jones (1978) suggest that the therapist allow each family to use the same set of toys each week, allowing for greater consistency. They further support this idea by saying that this consistency allows for the family to develop a trust in the therapist, in that the therapist keeps what the family is doing from week to week.

There are forms of play which do not necessarily involve toys. For example, role-playing is a flexible and revealing play technique. Another effective technique for involving children is the story-telling technique. By reading stories, based at least in part on real experiences, the therapist communicates to the child that all sorts of feelings are possible and that the child does not need to be afraid of feelings. Story telling is beneficial not only to the child but, the parents as well. This is the case because similar anxieties are often found in parent and child. Thus, by telling stories in which the disowned feeling is of central importance, the parents are exposing themselves to the feelings that have been uncomfortable expressing. Wachtel (1987) refers to evidence in which exposure to what has been uncomfortable is an effective means of reducing anxiety.

Comments about the children's play and drawings are productive if kept simple, allowing the child to share their story. It is important to remain on a metaphoric level (Zilversmit, 1990). Play is useful in that the therapist can scan the play the same way that he or she does adult conversations and nonverbal behavior, by watching and observing patterns (Zilversmit, 1990). Play also serves the purpose of

reducing anxiety. The young child, by becoming absorbed in an activity, can defend against anxiety through more passive participation (Zilbach, 1986).

The therapist is often more directive when using play materials so as to prevent chaos in the session. However, therapists differ as to who should be in charge of the children during the session. Keith and Whitaker (1977) feel that the therapist should be in charge of the children in the office. However, structural therapists such as Minuchin and Fishman (1981) often see the therapist's role as empowering. Taking this view, they help parents find a way to be in charge. Whichever approach is taken, the best approach is the one in which the therapist is motivated by a desire to help the couple and not undermine them as parents. Nonetheless, it also seems necessary for the therapist to set up basic office rules in order to maintain a safe and secure environment. At a minimum, rules should cover safety, discipline and the use of space and toys (Chasin, 1989).

The Present Study

The purpose of the present study is to address a gap in the literature regarding inclusion of young children in family therapy. Due to this lack of information, there exists a need for clarity as to the factors contributing to successful work with children and resistance to, or obstacles to such inclusive work. Villeneuve and LaRoche (1993) emphasize that, "The time may be ripe to integrate the knowledge from different theoretical views into a model of family therapy in which the child's participation is more systematized and routine".

Much of the literature stresses that therapists must become aware of their own

feelings toward children, especially young children. In an article by O'Brien and Loudon (1985), they traced the attitudes toward children in Britain in the last five hundred years. Children have gradually developed a higher place and status and are now seen as a separate group, not simply miniature adults. The importance of the current study lies in the fact that, if young children are to be viewed by clinicians as a separate group and included in family work, they need treatment specific to their developmental level.

Greenwood (1985) reported that young children, ages four and under, were included in family sessions less than one third of the time. The present study will expand upon findings in the literature and look at the percentage of time children ages six and under are actually included in family sessions. Much of the literature supports reasons for including young children but, this study will assess whether, in practice, therapists agree with this aspect of the literature.

The ages of six years and under has been designated for study utilizing Lee Combrinck-Graham's (1991) developmental distinctions. As was previously discussed, this age grouping encompasses the pre-verbal and pre-conventional stages. The pre-verbal stage consists of children under the age of two. Between the ages of one and two children generally understand much more than they can express. Pre-conventional children are children up to the age of elementary school or six years. They are typically frank and outspoken. This age group was selected because children at the age of six and under are normally unaware of conventions or practices. Since young children do not communicate in the same manner as adults and older

children, it is generally easier to omit them from therapy.

The study will seek to address the therapy content that is appropriate for the child ages six and under when they are present in family sessions. Specifically, clinician's views on topics, feelings, and behaviors discussed in front of children will be assessed. Further, the study will look at the age these topics, feelings, and behaviors become appropriate for the individual to hear. The concern for children exists in that, young children may not be able to tolerate disclosures and the accompanying affect they may produce.

As previously stated, the use of play is critical to effectively including the young child, for it is their means of communicating. This study will assess the training most professionals have had with this treatment modality. Specifically, it will examine the effect of training in art and play therapy on how often practitioners include young children in family sessions.

This information is valuable due to the fact that if young children are to be included, clinicians must be knowledgeable on how to effectively involve them. It seems that the majority of literature says we should include young children but, we must then change our way of interacting with the family. It appears that clinician's must take a more active approach and involve the children through the modalities of play and art therapy.

The study will assess practitioner's agreement regarding reasons, provided in the literature, for including and excluding young children. In addition, it will attempt to assess current practice as to precisely when children should be excluded and

included. For example, it will look at whether clinicians view children's involvement as beneficial for the entire length of treatment or simply the intake phase.

In addition, the study reasons that therapists are not including young children because there has been no clear guiding theoretical framework. Most family therapies are not clear as to how to involve all members of the family system (Combrinck-Graham, 1991). That is, even though the literature suggests that young children should be included, much of this appears to be speculation about technique as opposed to a theoretical understanding about the capabilities and capacities of young children (Combrinck-Graham, 1991).

Chapter II will address the methods used to investigate the previously discussed research questions. Subjects are described as well as the method for obtaining them. Development, administration, and statistical analysis of the mail survey are defined.

Chapter III will be the results section. The findings from the data will be presented, in addition to the statistical analyses performed. Chapter IV will be the discussion section. It will review the study and offer limitations, future suggestions for research, and implications for the clinician.

CHAPTER II

METHOD

This section will describe the methods used in obtaining the data regarding young children in family therapy. In order to ascertain descriptive information regarding this area of research, a survey was designed to answer the previously discussed research questions. The selecting of subjects, devising of a survey, and implementation of the survey will be thoroughly delineated.

Subjects

Subjects were obtained using the National Register of Health Service Providers in Psychology (Council for the National Register of Health Service Providers in Psychology, 1992), the most recent edition. The National Register was chosen for selection of subjects due to its national listing of registrants and the rigid criteria required for acceptance in the National Register. A component of the criteria of admittance requires licensing, certification, or registration by a State/Provincial Board of Examiners of Psychology. It also demands two years of supervised experience with one year at the postdoctoral level. This criteria better ensures that responses to the survey will be guided by a number of years of practical experience.

The National Register of Health Service Providers in Psychology (1992) lists its members alphabetically. Within each individual's entry, the registrant is asked to

list up to three service approaches in order of preference. Registrants are able to select from a list of service approaches which includes: individual therapy, family therapy, couples therapy, group therapy, diagnosis, consultation, and general practice. Subjects were selected randomly. The first name on every other page noting family therapy as one of their service approaches was used for inclusion in the present study. Four hundred members were randomly selected for participation from a pool of over 16,000 professionals listed in the National Register.

The treatment of subjects was in accordance with the Internal Review Board of Loyola University of Chicago.

Materials

After careful review of the literature and formulation of research questions, a mail survey was decided upon to be the appropriate method of data collection. The first draft of a questionnaire was developed (Dillman, 1978; Bourque & Clark, 1992). It was then piloted on a small group of graduate students and professors with an interest and knowledge in family therapy. After revisions the questionnaire was professionally printed and laid out in a booklet format on white survey paper.

The survey consisted of seven pages (see Appendix A). Printing was done on both back and front and there was one insert, totalling six pages. A seventh loose page was added allowing extra space for any written comments regarding the construction of the survey and/or the research topic. Also on the seventh page was a reiteration from the cover page, inviting participants to receive results of the study. The respondent need only check the box on the back of the return envelope and write

their name and address above it. The researcher typed in "Copy of Results Requested" on the return envelope to simplify the process for the respondent.

The questionnaire consisted of four sections: "In your Practice", "Attitudes/Beliefs", "Training", and "Demographics". The title was printed across the top of the first page. It was intended to be general but, informative of what the respondent could expect in the upcoming pages. The questionnaire consisted of twenty-nine open and close-ended items, with some questions composed of sub-items. Approximately seventy-five percent of the questionnaire items requested close-ended responses.

The last section of the survey asked demographic questions. The literature on survey construction recommended that demographics be placed at the end of the survey. Questions to be placed at the beginning should pertain closely to the topic (Dillman, 1978).

The questionnaire was arranged in a vertical flow, to provide a pleasing appearance. This contributed to an image of less clutter and increased simplicity with the aim of increasing response rates. Also to enhance appearance and maintain consistency, all questions were printed in lowercase letters and provided responses were in uppercase letters. Directions were always placed in parentheses in lower case letters. Instructions requested that the respondent circle the number of their response. This not only simplifies matters for the respondent but, aids with data analysis for the researcher. In addition, numbers always corresponded with the same response. For example, throughout the survey, the response "NO" was always a "1" while the

response "YES" was always a "2".

Materials also consisted of a cover letter (see Appendix B), outside envelope, pre-paid return envelope, and a follow-up postcard (see Appendix C), which was pre-printed on 3 1/2" by 5 1/2" postcard stationery. Envelopes and cover letters all used Loyola University of Chicago stationery. Outside envelopes were hand addressed with the first name first, using no initials. This created a personalized appearance with the aim of increasing the chances that it would be opened. Each cover letter was individually printed, containing each individual's name and address. In addition, each cover letter was dated and signed in blue ink to further increase response rates. The cover letter explained the purpose of the study and guaranteed confidentiality. It additionally stated that the researcher would be glad to answer any questions and listed the appropriate phone number. Respondents were thanked for their time.

Funding for the study was furnished through a Grant-in-Aid from Loyola University of Chicago. This provided allocations for stationery, mailing, and copy costs.

Procedure

The first mailing consisted of four hundred questionnaires. Each mailing contained a cover letter, questionnaire, and a pre-paid return envelope, all of which were enclosed in a business size outside envelope.

Each questionnaire was coded with a number so that once it was returned, the respondent would not receive the third mailing. The code was a three digit number beginning at 001 and ending at 400. It was placed in the upper right hand corner of

the first page of the questionnaire using a mechanical black stamp. Surveys were mailed out first class.

Exactly one week later, four hundred hand-addressed postcards were mailed out to all potential respondents as a thank-you for the prompt return of the survey and a reminder to return the survey if they had not already done so. The researcher's name was signed on each in blue ink.

Approximately one month later, the third mailing was sent. Questionnaires were mailed to all those who had not returned their survey to date. This third mailing consisted of a cover letter (see Appendix D), an additional copy of the survey in case the original had been misplaced or discarded, and a pre-paid return envelope. The cover letter explained that the researcher had not yet received the survey and emphasized the importance of each survey to the study. Confidentiality was further reiterated. Once again the researcher's phone number was provided in case of any questions. Respondents were once again thanked for their time and assistance.

Twenty-nine mailings came back undeliverable after the first mailing. Twelve of the twenty-nine addresses were re-located and mailed out with the third and final mailing. This decreased the total possible sample to 383. One hundred and seventy one questionnaires were returned. This yielded a response rate of forty-five percent. The usable surveys however, totalled one hundred and forty. Thirty-one surveys were found not usable. One was returned stating that the intended respondent was deceased. The remainder either stated that they were no longer doing family therapy, never conducted family therapy, or do not work with children in family therapy. This

yielded an effective response rate of forty percent.

As questionnaires were returned, close-ended responses were coded and entered. Open-ended responses were coded once all questionnaires were received so as to set up a comprehensive, reliable, coding system. All direct quotations are from open-ended, anonymous responses obtained from the survey between October and December of 1993. The researcher used the SYSTAT program to analyze the data. Frequency distributions were prepared for each questionnaire item. The distributions list the number of respondents for each response category. For example, frequency distributions were used to observe the amount of time respondents indicated they include young children six years and under in family therapy. For interval scales, means were computed. Chi-square analyses were performed to test for significant relationships between items. For example, the researcher analyzed the relationship between training in art and play therapy with percentage of time young children are included in family therapy. Pearson correlations were computed to measure the relation between "training" items and percentage of time young children are included in family therapy.

CHAPTER III

RESULTS

Results are presented in the order of the four sections of the questionnaire: "In Your Practice ...", "Attitudes/Beliefs", "Training", and "Demographics" (see Appendix A), with the exception that "Demographics" are presented first to establish a foundation for the reader.

The "Demographics" section contained items looking at attributes or personal characteristics of the respondent. Highest degree received, field in which the degree was obtained, and theoretical orientation are examples of items in this section. The next area, "In Your Practice ...", examined what actually takes place in one's clinical practice. Items aimed at getting a report of the respondent's behavior. The "Attitudes/Beliefs" section assessed clinicians feelings and thoughts surrounding various issues, such as comfort in working with young children. "Training" focused on the education clinicians have had in family therapy and more specifically, young children in family therapy.

Demographics

Demographic information revealed the following results. The majority of survey respondents (80.7%, n = 113) held a Ph.D. as their highest degree. The other degrees were Psy.D. (7.9%, n = 11), Ed.D. (6.4%, n = 9), M.A./M.S.

(3.6%, n = 5), J.D. (.7%, n = 1), and one non-response (.7%, n = 1). No respondents indicated their highest degree to be a M.Ed.

The majority of the sample received their highest degree in clinical psychology (71.4%, n = 100). Other areas of study were counseling psychology (16.4%, n = 23), "other" (9.3%, n = 13), education (1.4%, n = 2), family studies (.7%, n = 1), and one non-response (.7%, n = 1). The "other" category was made up of school psychology, developmental psychology, and social psychology. No respondents had indicated receiving their highest degree in marital and family therapy or pastoral counseling.

The most frequently reported theoretical orientations were eclectic (40.7%, n = 57), family systems (22.9%, n = 32), psychodynamic (10.7%, n = 15), "other" (10.0%, n = 14), behavioral (7.1%, n = 10), cognitive (5.7%, n = 8), rational emotive (1.4%, n = 2), and gestalt (.7%, n = 1). There was one missing response (.7%). The "other" category consisted of responses such as interpersonal communications, cognitive-behavioral, Eriksonian, and social learning. No respondents indicated client-centered, existential, humanism, or reality as the theoretical orientation most similar to their approach.

Respondents who had marked family systems as their theoretical orientation were asked to respond to the subsequent question by circling the particular type of family systems approach most similar to their technique. The total number of responses to this item should equal 32, those who had indicated family systems as their theoretical orientation. However, there were a total of 60 responses to this item,

indicating that other orientations had also responded to this item. Perhaps a portion of those who had indicated their theoretical orientation as eclectic, subsuming family systems, had responded to this item.

Regardless, the majority (23.3%, n = 14) selected structural family therapy (e.g., S. Minuchin) as most similar to their approach to family systems. Other frequently reported orientations were communication/strategic (e.g., J. Haley) (18.3%, n = 11), "other" (16.7%, n = 10), experiential/humanistic (e.g., C. Whitaker) (15.0%, n = 9), psychodynamic (e.g., N. Ackerman) (11.7%, n = 7), behavioral (e.g., G. Patterson) (8.3%, n = 5), and Bowenian (e.g., M. Bowen) (6.7%, n = 4). The "other" category consisted of responses such as McMasters' problem solving, M.R.I. Watzlawick, Milan systemic, and a combination of all the choices.

In Your Practice

Actual practice of respondents revealed the following information. The mean number of years spent conducting family therapy was 16.6 years. This ranged from a total of zero years to 45 years in family therapy (SD = 7.87).

Respondents were asked the percentage of time they spend providing family therapy. The item was asked through a forced choice question, with response choices in percent intervals. The most frequently occurring response was between the 1-25% interval (60.0%, n = 84). Other frequently occurring responses were 26-50% (26.4%, n = 37), 51-75% (8.6%, n = 12), and 76-100% (.7%, n = 1). Six respondents (4.2%) indicated spending no time providing family therapy.

In response to the principal question concerning the percentage of time spent including children ages six and under in family therapy, the majority (49.3%, n = 69) selected a low, but, somewhat expected, 1-25%. Other responses included 26-50% (20.0%, n = 28), 76-100% (10.7%, n = 15), 0% (10.0%, n = 14), and 51-75% (9.3%, n = 13). There was one non-response (.7%).

The overwhelming majority (69.3%, n = 97) stated that they do not use a formal process to decide when to include or exclude young children. On the flip side, 28.6% (n = 40) reported that they do use a formal process. The item was left blank by 2.1% (n = 3).

Those who had never worked with a co-therapist in family therapy made up slightly less than half (47.1%, n = 66) of the sample. Thus, those who had worked with a co-therapist in family therapy made up 52.9% (n = 74) of the sample. Of the later group, the majority (63.5%, n = 47) reported never having differing views with a co-therapist regarding including the young child(ren) in family sessions, leaving 36.5% (n = 27) that reported having differing views.

Of those who said they did have differing views with a co-therapist (36.5%), they were asked to specify the percentage of time they differed. The most frequently occurring responses were 1-25% (74.1%, n = 20), 26-50% (22.2%, n = 6), and 51-75% (3.7%, n = 1). No respondents indicated differing between 76-100%.

In a related item, those who had worked with a co-therapist were asked if they had disagreed regarding appropriate topics, feelings, and behaviors for young children. The majority, (62.2%, n = 46) replied that they did not disagree.

However, 29.7% (n = 22) responded that they had and 8.1% (n = 6) left the question unanswered. The six respondents who left the item blank should have answered based on responding to the previous question maintaining that they had worked with a co-therapist.

Of those who did state that they had differing views, the overwhelming majority, (95.5%, n = 21) responded that they differed between 1 and 25% of the time. One subject (4.5%) stated differing between 26 and 50% of the time. No respondents indicated differing between 51-75% and 76-100%.

Over three quarters (76.4%, n = 107) of the respondents indicated having had a parent ask them not to discuss something in front of their children. This left 17.9% (n = 25) stating that they had not. There were 8 subjects (5.7%) who did not respond.

Clinicians were asked on the questionnaire, to specify the topic that parents requested not be discussed in front of their children. A recurrent response to this item was marital problems, including infidelity and divorce. Other topics reported by participants were sexual issues, parentage of the child (e.g., adopted or illegitimate), drug or alcohol use, and behavior problems of the child. Additional less frequent responses were illness and death, incest, money and job loss, criticism of parenting skills, parental abuse as a child, abortion, reading of the child's diary, family secrets, violence, dislike for the child, illegal behavior, family history of mental illness, and the parent's suicide attempt.

Three fifths (60.0%, n = 84) of the sample reported having requested that a

parent refrain from discussing something in front of their children. Three subjects (2.1%) left the question unanswered.

Clinicians were further asked on the questionnaire, to specify the topic that they requested parents not discuss in front of their children. The most frequently occurring response to this item was condemnation of the other parent. Other common responses were issues pertaining to the couple and comments regarding what the child does wrong, including abusive and harmful remarks as well as, extremely high expectations placed on the child. Other topics reported by participants included sexual issues, adult matters (e.g., legal matters and money issues), drug or alcohol abuse, domestic violence and violence in general, specific detail's about a parent's rape, incest, parent's overwhelming depression or homicidal anger, and anything that the child did not seem to understand.

In Your Practice - Open-Ended Responses

Responses to the open-ended items in this section varied extensively, making it difficult to code these responses reliably and sufficiently for data analysis. However, significant and/or widespread responses will be discussed in order of frequency.

Respondents explained how they decide which children (if any) to include in family sessions. The most common factor was the child's relevance to the issues of concern. The decision was made based upon the nature of the presenting problem. For example, often the problem is parental in nature and therefore, the children are excluded. "I do not include them if dealing with parental issues, or issues specifically between parents and an older child." Some explained that children were included if

there were obvious parent-child issues and all members of the family were included when the nature of the problem was family-wide.

The second most common response was that children were always included. "I simply try to have all, even infants, because I want to see how everyone reacts to one another and how the family responds to hierarchical demands." Consistent with the literature, one respondent remarked, "It's not a family session without the family. Without all children present, the family changes in ways that it is not."

Others indicated that children were included if they were "old enough to tolerate the process, understand what is happening, and contribute to the session". Inclusion depends on the child's level of functioning and cognitive development. Further, the child must be emotionally and intellectually capable. Thus, the young children are excluded because they "cannot follow the process or contribute to it, and are often a distraction to other family members".

Some clinicians used this as a general rule, assuming that young children are a distraction. However, others reported that they may include them initially, only later excluding them if they appear too disruptive. Succinctly stated, children are excluded when "parenting obligations may overwhelm therapy opportunities" and "child's pattern of escalating demands may overwhelm therapy".

Numerous clinicians saw a benefit to including all children at least for the initial session. Only after the first session would they determine whom to continue including in family sessions. One reason for involving everyone in the first session is to observe family interactions. The young children are valuable for diagnostic

purposes, to obtain data about the parent-child interactions. Some clinicians reported that after the first session, the young child has a greater chance of inclusion if they are the identified patient or identified as symptomatic.

Others indicated making the decision whether to include the young children based upon talking and consulting with the parents. The decision was a collaborative one. "If parents were willing to have the child involved, then the children were included." This same respondent had no objection to including young children but, stated that some parents do, feeling that therapy might be too upsetting for the young child.

Some respondents provided specific ages they use to decide which children should be included. Examples of such responses are no children under seven, children older than ten, and those over the age of eleven. "If they have normal ability and are over the age of eight then they are included." In addition, one respondent maintained, if the identified patient is fifteen years of age or older, then young children ages six and under are not included. A few individuals related that after the first session no infants and toddlers remain in the sessions.

The next open-ended item asked the respondent to describe how they interact with young children when they are present in family sessions. Common ways of interacting consist of the clinician treating the young child with dignity, respect, and patience. This may be accomplished by using simpler, more understandable words. Others remarked that they try to join with the child by asking for the young child's opinion while talking to them about things they enjoy doing. Interestingly, one

respondent remarked that they connect with the child by making sure to include them in every third or fourth family comment.

Others take a more passive approach and observe how the young child and parents interact. "I usually try to keep the family as a unit. My level of interaction is minimal. Most interaction takes place through other family members. I serve as a facilitator of improved communication."

Modeling and role playing were frequently cited means of interacting. The clinician attempts to model proper interaction for the parent(s) in the way they interact with the young child. The therapist may also interpret the young child's behavior for the parents.

Play was also frequently noted as a way of interacting with the young child. "I usually do therapy in the play room and try to help the family play together." Many stated that they work at the young child's level, down on the floor and interactive. One respondent emphasized, "Expect their participation". The therapist designs tasks to include children in order to keep them actively engaged in the family process.

However, others seemed to use play in a very different capacity. For example, one stated, "... have toys to occupy them." Others mentioned that they ask parents to bring toys to keep the young child entertained and allow the child to play with the box of toys in "one corner of the room". In this fashion, play serves as a distraction, to keep the child occupied and amused.

The next two open-ended questions in the "In Your Practice..." section

produced few generalizable results. Remarks stressed that families vary too greatly to respond with a concise statement. Since there is such discrepancy, the responses will not be mentioned in this results section.

Attitudes/Beliefs

Respondents were asked the minimum age a child must be before they will include them in family therapy. If there was no minimum age, they were specified to leave the item blank. The overwhelming majority, 73.6% (n = 103) left the item blank, indicating no minimum age necessary for inclusion in family therapy. Other frequently occurring responses were age three (7.1%, n = 10), age eight (5.0%, n = 7), age four (4.3%, n = 6), age two (2.1%, n = 3), age five (2.1%, n = 3), age six (1.4%, n = 2), age seven (1.4%, n = 2), age nine (.7%, n = 1), and age ten (.7%, n = 1). The item was unclear for two subjects (1.4%). Additional comments indicated that the response should not be stated in years but, rather developmental level.

Subjects were asked to circle any topics they believed should not be discussed in front of children ages six and under. The most frequently occurring response was sexual topics pertaining to the parents (67.1%, n = 94). Other frequently occurring responses were murder/suicide within the family (37.1%, n = 52), custody issues (33.6%, n = 47), parents' lack of parenting skills (27.9%, n = 39), divorce (22.1%, n = 31), drug or alcohol abuse (22.1%, n = 31), and violence (19.3%, n = 27). The open-ended "Other" category was indicated by 2.1% (n = 3) and included affairs and financial issues.

Participants were also asked to indicate the age at which these topics become appropriate to discuss. This was a complex question as indicated by a large number of respondents. Many found it difficult to state an actual age and instead wrote a statement to explain their answer. Therefore, the actual data, regarding appropriate ages, did not yield much conclusive information. However, after review of the data, respondents' written comments will be detailed.

For the first item, custody issues, the majority (62.1%, n = 87) believed this item to be appropriate for discussion in front of children ages six and under. Seventeen respondents (12.1%), had left the age blank. Again, the respondent might have found it difficult to specify an age and instead inserted a written comment. Ages indicated as appropriate for discussion of custody issues were age twelve (6.4%, n = 9), age ten and age eight (5%, n = 7), age five (2.1%, n = 3), age six (1.4%, n = 2), and age three, seven, nine, eleven, thirteen, fifteen, seventeen, and eighteen (.7%, n = 1).

Regarding the topic of divorce, the majority (73.6%, n = 103) believed that this item was acceptable to be discussed in front of children ages six and under. Of the remainder, those finding the topic inappropriate, twelve respondents (8.6%) left the age blank. Ages indicated as appropriate for discussion of the topic of divorce were age ten (4.3%, n = 6), age six, eight, and twelve (2.1%, n = 3), age three, seven, and thirteen (1.4%, n = 2), and age two, four, five, and nine (.7%, n = 1).

The majority (73.6%, n = 103) believed the topic of drug or alcohol abuse to be acceptable for discussion with children ages six and under. The item was not

answered in the specified manner by 8.6% (n = 12). Ages indicated as appropriate for discussion of the topic of drug or alcohol abuse were age eight (4.3%, n = 6), age six (3.6%, n = 5), age twelve (2.1%, n = 3), age four, seven, nine, and ten (1.4%, n = 2), and age eleven, fifteen, and sixteen (.7%, n = 1).

Regarding the topic of murder/suicide within the family, the majority (58.6%, n = 82), believed this item to be acceptable. The item was left blank or a written comment was included by 14.3% (n = 20). Ages indicated as appropriate for discussion of the topic were age ten (7.1%, n = 10), age six (4.3%, n = 6), age eight and twelve (2.9%, n = 4), age five, seven, nine, and eleven (1.4%, n = 2), and age three, four, thirteen, fifteen, sixteen, and seventeen (.7%, n = 1).

Regarding the topic of parents' lack of parenting skills, the majority (67.9%, n = 95) believed this item to be acceptable. The item was not answered in the specified manner by 13.6% (n = 19). Ages indicated as appropriate for discussion of the topic were age eight (2.9%, n = 4), age twelve and thirteen (2.1%, n = 3), age five, six, fourteen, and eighteen (1.4%, n = 2), and ages three, four, seven, nine, ten, eleven, twenty-three, and twenty-five (.7%, n = 1).

Regarding sexual topics pertaining to the parents, the majority (40.7%, n = 57) left the item blank, however, once again, this could indicate respondents had written a comment in the margin. A 29.3% (n = 41) thought this item was acceptable for young children. Ages indicated as appropriate for discussion of the topic were age twelve (5.7%, n = 8), age eighteen (3.6%, n = 5), age ten and thirteen (2.9%, n = 4), age nine and sixteen (2.1%, n = 3), age six, twenty, twenty-

one, and thirty (1.4%, n = 2), and age seven, eight, eleven, fifteen, seventeen, twenty-five, and thirty-five (.7%, n = 1).

The majority (76.4%, n = 107), found the topic of violence acceptable for young children. The item was left blank or a written comment included by 9.3% (n = 13). Ages indicated as appropriate for discussion of the topic were age twelve (2.9%, n = 4), age six and seven (2.1%, n = 3), age four and ten (1.4%, n = 2), and age three, five, eight, nine, thirteen, and eighteen (.7%, n = 1).

Regarding the open-ended "other" category, there were only two responses indicated; financial topics and affairs. Appropriate ages for discussion were age twelve for financial topics and age ten for the topic of affairs.

Comments regarding this item underscored the difficulty of putting the response into a chronological age. This accounted for the item being unanswered by some respondents. One individual stated that appropriateness for discussion is more a factor of mental age rather than chronological age. "It depends on the maturity of the child with discretion and child's stability and adjustment ...". Several stated that all topics can be discussed under certain conditions. It varies with the situation and the circumstances.

A common response to the appropriate age at which sexual topics pertaining to the parents can be discussed was "never". The majority of respondents did not feel this topic was appropriate for offspring. Other responses to this item were "it varies", "depends on awareness of the child", and "at the parent's discretion".

The following item asked respondents to circle any feelings/behaviors they

believed should not be expressed in front of children ages six and under in family sessions. The most frequently circled feeling/behavior was violence (72.9%, n = 102). Other frequently occurring responses were screaming (51.4%, n = 72), swearing (38.6%, n = 54), desperation (16.4%, n = 23), "other" (12.1%, n = 17), guilt (7.9%, n = 11), fear (6.4%, n = 9), anger (4.3%, n = 6), and crying (2.1%, n = 3). Some replies to the open-ended "other" category included the wish to abandon the family, threats of violence, abusive behavior acted out in the session, sexual acting out, and blaming.

A vast number of respondents stated that they would not allow violence or screaming in any family session. Feelings are okay but, some behaviors are unacceptable or inappropriate. "Children need to see feelings expressed in a proper manner and with resolution". Nonetheless, these feelings/behaviors are highly dependent on the intensity of the feeling and the client's ability to cope with the feeling. "Teaching parents appropriate ways to express themselves in front of children is the art of family therapy."

The next set of items asked respondents to indicate whether they agree or disagree. The majority of respondents (85.0%, n = 119) agreed that they feel comfortable working with young children in family therapy. Agreement was expressed by 89.3% (n = 125) that children are aware of delicate issues within their family even if they are not disclosed. Approximately two-thirds (65.0%, n = 91), disagreed with the statement, "... family therapy is more effective when children six years and under are left out of family therapy sessions". Although, approximately

15.0% (n = 21) remarked in the margin that it depends. The majority of respondents (77.1%, n = 108) agreed that if parents do not feel comfortable sharing information in front of their children, the parent is the final authority. Consistent with other respondents, one stated, "If I feel it is important for a disclosure to be made, I work with parents to help them understand this". A reassuring 90.7% (n = 127) agreed that they feel qualified working with young children in family therapy.

The next three sets of items used a continuum with response choices consisting of "Strongly Disagree" (1), "Somewhat Disagree" (2), "Somewhat Agree" (3), and "Strongly Agree" (4). The first set of items asked for clinician's level of agreement with reasons provided for inclusion of young children. Results are presented in Table 1.

In the second set of continuum items, reasons were given for excluding young children. Respondents were asked their level of agreement with these reasons. Results are presented in Table 2.

In the third and last set, items examined respondent's opinions regarding when children should be included and excluded. The mean for children being kept in therapy for the entire course of therapy was 1.76 (s.d. = .72). Children should be included only during the intake phase had a mean of 1.85 (s.d. = .87). Children should be excluded when topics which are sensitive to the parents are discussed had a mean of 2.93 (s.d. = .84). Children should be included in family therapy when the identified patient is a parent had a mean of 2.49 (s.d. = .82). Children should be excluded from family therapy when they request exclusion had a mean of 2.68 (s.d.

Table 1

Percentages and Frequencies of Reasons for Including Young Children in Family Therapy.

	Clinician's Response					
	Disagree		Agree			
Reasons	Strongly (n)	Somewhat (n)	Somewhat (n)	Strongly (n)	Mean	SD
Keen Observers of Family Life	1% (1)	15% (20)	39% (52)	45% (59)	3.3	.74
More Honest and Open Than Adults	6% (8)	28% (37)	54% (71)	12% (16)	2.7	.75
Not Family Therapy Unless All are Present	32% (42)	30% (39)	26% (35)	12% (16)	2.2	1.0
Enable Rapport Building With the Family	7% (10)	25% (33)	54% (71)	14% (18)	2.8	.79
Family Dynamics Incomplete Without Them	5% (7)	20% (26)	39% (52)	36% (47)	3.1	.87

Note. Response Set: 1 = Strongly Disagree, 2 = Somewhat Disagree, 3 = Somewhat Agree, 4 = Strongly Agree.

Table 2

Percentages and Frequencies of Reasons for Excluding Young Children From Family Therapy.

	Clinician's Response					
	Disagree		Agree			
Reasons	Strongly (n)	Somewhat (n)	Somewhat (n)	Strongly (n)	Mean	SD
May be Hurt by What is Discussed	16% (21)	47% (62)	30% (40)	7% (9)	2.3	.81
Distracting and Disruptive	17% (23)	33% (44)	42% (55)	8% (10)	2.4	.86
They do not Participate on Same Verbal Level	41% (54)	36% (48)	18% (24)	5% (6)	1.9	.87
Therapists may Feel Overwhelmed and Out of Control	41% (54)	30% (40)	19% (25)	10% (13)	2.0	1.0
Potential for the Therapist Undermining Parental Authority	54% (71)	33% (44)	9% (12)	4% (5)	1.6	.80

Note. Response Set: 1 = Strongly Disagree, 2 = Somewhat Disagree, 3 = Somewhat Agree, 4 = Strongly Agree.

= .78). Children should be excluded from family therapy when parents request children's exclusion had a mean of 2.68 (s.d. = .73). Lastly, children should be included in family therapy only when they are the identified patient had a mean of 1.82 (s.d = .87). Results are presented in Table 3.

Attitudes/Beliefs - Open-Ended Responses

Those who felt unqualified working with young children in family therapy were asked to explain to what they attribute this. Only ten subjects indicated feeling unqualified. Reasons cited were lack of experience, empathy, training, and interest. In addition, a few simply did not find it helpful to include young children. One individual replied, "I only see young children in play therapy. This is their medium, not the verbal rough and tumble of family therapy".

Those who felt qualified working with young children were asked to what they attribute this. The most common responses were experience and training. Many had continuing education experiences, involvement in peer study groups, and remained abreast through reading. However, there were a wide range of other important responses. Some mentioned feeling qualified through supervision and feeling reassured that they could seek consultation if need be. In addition, others mentioned having done research in this area and still others stated that they had positive results with the families they worked with.

Other reasons clinicians feel qualified include a basic liking of children, as well as, having kids of one's own. Going through trials and tribulations with families as well as learning by errors was cited by a few. Temperament and attitude,

Table 3

Percentages and Frequencies Regarding When Young Children Should be Included and Excluded From Family Therapy.

	Clinician's Response					
	Disagree		Agree			
Statements	Strongly (n)	Somewhat (n)	Somewhat (n)	Strongly (n)	Mean	SD
Included for Entire Course of Therapy	36% (45)	49% (60)	13% (16)	2% (2)	1.8	.72
Included Only During Intake Phase	39% (48)	41% (50)	14% (18)	6% (7)	1.9	.87
Excluded When Topics Sensitive to Parents are Discussed	6% (8)	21% (26)	49% (60)	24% (29)	2.9	.84
Included When Identified Patient is a Parent	9% (11)	44% (54)	36% (45)	11% (13)	2.5	.82
Excluded When Young Children Request Exclusion	7% (8)	33% (41)	47% (58)	13% (16)	2.7	.78
Excluded When Parents Request Child's Exclusion	5% (6)	36% (44)	49% (60)	10% (13)	2.7	.73
Included Only When Child is Identified Patient	42% (52)	40% (49)	11% (14)	7% (8)	1.8	.87

Note. Response Set: 1 = Strongly Disagree, 2 = Somewhat Disagree, 3 = Somewhat Agree, 4 = Strongly Agree.

especially flexibility of the therapist was mentioned. An understanding of developmental stages seemed fundamental. Play therapy training was also cited as well as experience in testing and assessing children. One also mentioned a love of children's literature and involvement in a children's literature discussion group.

Respondents were asked what therapeutic skills are necessary when working with young children. Many reported that a sense of warmth, caring, and genuineness is essential. The therapist should be able to provide positive reinforcement and support. Patience, a stronger tolerance for frustration, and being able to manage many distractions were also common skills reported when working with young children. In addition, a sense of humor as well as, lack of self-consciousness were noted as helpful.

Another skill was the ability to communicate on the child's level through understanding non-verbal behavior and the use of symbolic play and stories. This includes being able to make interpretations about play therapy through water colors, finger paintings, fairy tales, art, and projective methods. Many felt that a knowledge of diagnostics, child psychotherapy, and developmental psychology, is essential. This may include knowledge in moral, cognitive, and language development. Many also explained that family therapy with young children takes on a more active and concrete process, necessitating that the therapist be increasingly task directed.

Others emphasized that it is primary that the therapist like children and it may be helpful, but, is not essential to have children of one's own. Treating the child with respect and dignity and not infantalizing them is imperative. One individual

stated an important skill is awareness of current fads and people that matter to kids. This enables the therapist to talk "kid talk" and not be too intellectual. At the same time, it also seems important to be able to establish an alliance with both the parents and the children, thus, the skill of diplomacy.

Lastly, it is crucial that the therapist understand when the child is no longer profiting from inclusion in family therapy. This involves providing an atmosphere of safety for the child and protection of their feelings.

Training

The next section of the questionnaire focused on training. It looked at the kind of instruction and education, as well as amount, that each respondent has had. Respondents were asked the number of graduate courses they have had in family therapy. They were asked to circle the appropriate answer from four choices consisting of: 0,1,2-3, and 4+ graduate courses. Actual responses ranged from 1 to 4 with a mean of 2.73 (s.d. = .97).

To investigate the relationship between number of graduate courses in family therapy and time spent including young children in family therapy, Pearson correlations were calculated. Number of graduate courses was significantly correlated with time spent including young children in family therapy, r (133) = .32, $p < .001$.

Respondents were also asked the number of continuing education classes and/or workshop experiences they have had in family therapy with the same four categories used as response choices. The mean was 3.57 (s.d.= .74) with a range of 1 to 4.

The next item asked the number of families seen in supervised clinical experience. This question appears unsuccessful in tapping the intended information since there was such a large range in responses. Responses ranged from 0 to 998. The mean was 50.2 with a standard deviation of 114.59.

Respondents were also asked the percentage of time in training which focused on working with young children in family therapy sessions. Responses ranged from 0 to 90 percent. The mean was 19.31 (SD = 19.80). The median was 10.0.

To investigate the relationship between percentage of time in training focused on working with young children and time spent including young children in family therapy, Pearson correlations were calculated. Percentage of time in training focused on young children in family therapy was significantly correlated with time spent including young children in family therapy, r (120) = .48, $p < .001$.

The respondent was asked if they had training in art and/or play therapy with response choices consisting of art therapy, play therapy, both, or none. Surprisingly, 51.4% (n = 72) of the sample indicated having play therapy training. An additional 21.4% (n = 30) had both art and play therapy training. Other responses were 24.3% (n = 34) having neither art or play therapy training and .7% (n = 1) having solely art therapy training. Three individuals (2.1%) left the question blank.

It was hypothesized that there would be a significant difference between those who had training in art, play, or both art and play therapy and the percentage of time they include young children, six years and under, in family therapy. However, results indicated no significant difference between those having training in these

modalities and the percentage of time young children are included in family therapy ($\underline{X}^2(8) = 12.67, \underline{p} > .05$).

The last item asked if respondent's had received certification in family therapy. The overwhelming majority (82.1%, n = 115) had not received certification in family therapy. This left 15.0% (n = 21) who had received certification and 2.9% (n = 4) who left the item blank. Certification was received from the AAMFT, the Boston Family Institute, and ABPP.

CHAPTER IV

DISCUSSION

The current section will consist of a brief review of the present study and its findings. It will also address the limitations of the study, future suggestions for research, and implications for the clinician.

A Brief Review

The present study was undertaken based on a need for clarity in regards to young children and their involvement in family therapy. The lack of clarity arose with the advent of family therapy in the mid-1950's, when the focus shifted from the individual to the dysfunctional system (Corsini & Wedding, 1989). This shift necessitated that the family therapist be knowledgeable in working with all age groups. However, it appears that some age groups are simply being left out of family therapy or not fully involved when they are included. Children, especially non-verbal children ages six and under, seem to be the easiest group to neglect (Dowling & Jones, 1978).

It appears that the identified patient and those children who can contribute to the process are included in family therapy sessions (Savege-Scharff, 1989). However, there is little research regarding what is occurring with the young child, ages six and under. The present study looked at whether the young child is being systematically

included and what rules are governing their inclusion.

The majority of the literature regarding young children in family therapy emphasizes the benefits of their inclusion (Guttman, 1975; Zilbach, Bergel, & Gass, 1972). This study attempted to assess if clinicians agree with the reasons provided in the literature for including young children.

Another question asked in this study is whether clinicians have the necessary training to work with young children in family therapy. This is important because if the benefits of including young children are acknowledged and young children are to be included, clinicians must then change their way of interacting with the family to effectively and actively involve all family members. They must take a more active approach and be versed in the modality of play therapy (Zilversmit, 1990).

The present study found it important to examine whether there are topics, feelings, and behaviors that are inappropriate for young children. According to a child's developmental level, there may be some degrees of affect which are not beneficial for the young child. This issue is especially important because, "When the children are not addressed at their own level in family therapy, they may get bored or may be overwhelmed by the emotional display of an adult or by the complexity of discussion" (Villeneuve & LaRoche, 1993).

The present study attempted to collect information regarding these research questions through the development of a mail questionnaire. The questionnaire consisted of four sections: "In Your Practice...", "Attitudes/Beliefs", "Training", and "Demographics".

"In Your Practice..." contained items looking at actual practice of the respondent such as percentage of time spent including young children in family therapy. "Attitudes/Beliefs" contained items such as therapist's level of agreement with reasons provided for inclusion of young children in family therapy. Section three, "Training", sought information such as number of graduate courses taken in family therapy and amount of training in art and/or play therapy. Lastly, "Demographics", asked for highest degree received, area of study, and theoretical orientation.

Subjects were obtained using the National Register of Health Service Providers in Psychology (Council for the National Register of Health Service Providers in Psychology, 1992), the most recent edition. Four hundred members were randomly selected for participation from a pool of over 16,000 professionals listed in the National Register.

Seventeen of the mailings were undeliverable, decreasing the total possible sample to 383. One hundred and seventy one questionnaires were returned (a return rate of 45%). Of the total returned, thirty-one surveys were found not usable. Thus, the usable surveys totalled one hundred and forty. This yielded an effective response rate of forty percent.

Findings

The typical respondent had a Ph.D. in Clinical Psychology. Their theoretical approach overall is best described as eclectic, while their approach to family work is primarily structural.

The majority of respondents have spent approximately seventeen years conducting family therapy. They spend between one and twenty-five percent of their time providing family therapy. As predicted from the literature, when providing therapy to families with young children, respondents spend between one and twenty-five percent of the time including young children ages six and under. When beginning with a new family in family therapy, there is no formal process used to decide when to include or exclude young children.

The typical respondent has worked with a co-therapist in family therapy. Respondents reported that they primarily agree with their co-therapists regarding inclusion of young children in family sessions and what topics, feelings, and behaviors are appropriate for the young child.

Most respondents have had a parent ask them not to discuss something in front of their children. Conversely, clinicians have had to request that a parent not discuss something in front of the young children.

The majority of respondents indicated no minimum age a child must be before they will include them in family therapy sessions. Most respondents specified that sexual topics pertaining to the parents should never be discussed in front of children ages six and under. They also specified that screaming and violence should not be expressed in front of young children in family sessions.

Reassuringly, the typical respondent feels comfortable and qualified working with young children in family therapy. They also feel that children are aware of delicate issues within their family even if they are not disclosed. They believe that if

parents do not feel comfortable sharing information in front of their children, the parent is the final authority as to what is disclosed. The majority of respondents did not believe that family therapy is more effective when children ages six years and under are left out of family therapy sessions.

Regarding reasons for including young children in family therapy, the average respondent "strongly agree[d]" with the reason provided that young children are keen observers of family life. They also "somewhat agree[d]" with the reasons that family dynamics will be incomplete without them, that they enable rapport building with the family, and that they are more honest and open than adults in therapy. They "strongly disagree[d]" with the reason given that family therapy is not family therapy unless all members are present.

Regarding reasons for excluding young children from family therapy, they "somewhat agree[d]" with the reason provided that children are distracting and disruptive. They "somewhat disagree[d]" with the statement that children may be hurt by what is discussed. In addition, they "strongly disagree[d]" with the reasons that children do not participate on the same verbal level as adults, therapists may feel overwhelmed and out of control, and the potential for the therapist undermining parental authority.

The typical respondent "somewhat disagree[d]" that young children should be kept in therapy for the entire course of therapy. They "strongly disagree[d]" that young children should be included only during the intake phase. They "somewhat agree[d]" that young children should be excluded when topics which are sensitive to

the parents are discussed and when young children request exclusion. In addition, they "somewhat disagree[d]" that they should be included when the identified patient is a parent. They "somewhat agree[d]" that they should be excluded when parents request children's exclusion. Lastly, they "strongly disagree[d]" that young children should be included only when they are the identified patient.

Regarding training, most respondents have had between two and three graduate courses in family therapy and four plus continuing education classes and/or workshop experiences. The median number of families seen in clinical experience is approximately twenty. Clinicians have had approximately nineteen percent of their time in training focus on working with young children and have had play therapy training. The typical respondent has not received certification in family therapy.

From the data it appears that, in practice, clinicians are spending a very small amount of the time (between 1 and 25%) including young children in family therapy sessions. This is consistent with findings in the literature (Greenwood, 1985). In addition, clinicians utilize no formal process to decide when to include or exclude young children. The decision appears to be made simply on a family to family basis.

However, in theory it does appear that therapists generally support the reasons provided in the literature for inclusion of young children. The only reason disagreed with was that family therapy is not family therapy unless all members of the family are present. From the disparity, it appears that clinicians are not ready to adopt a "pure family therapy" stance, wherein all members of the family are entitled to inclusion.

Consistent with the above support for including young children, the majority of clinicians disagreed with the reasons for excluding young children, with one exception. The typical respondent stated that they "somewhat agree" with the reason that young children are distracting and disruptive. This was also observed in the open-ended responses of the questionnaire. Respondents used as a deciding factor for young children's involvement, the ability for the young child to tolerate, understand, and contribute to the process. As was also noted in the open-ended responses, children who are disruptive may prevent any progress from being made in family sessions.

Further, the majority of clinicians did not agree that young children should be included for the entire course of therapy. However, they also did not agree that they should be included only during the intake phase. Once again, it appears that clinicians see the benefits of including the young child yet, do not want to take the stance that young children should always be included. They do not want to adopt a "pure family therapy" stance.

Overall, the majority disagreed with the statement that family therapy is more effective when young children ages six and under are left out of family therapy. Clearly, the benefit of including young children is acknowledged, however, the amount of involvement is unclear. There emerges a sense of caution to an absolute commitment to involving young children in family therapy. As hypothesized, there appears to be a discrepancy between involvement of young children in theory and in practice.

Although it appears that the majority of clinicians, approximately two-thirds, did not have differing views with their co-therapists regarding inclusion of young children and appropriate topics to be discussed, it is clear from the results that there are inappropriate issues for children. This can be seen from the large majority of clinicians who requested parents not discuss certain topics in front of their children. Parents also felt uncomfortable with their children hearing certain topics and requested that the clinician not discuss them.

From the topics specified as inappropriate, it appears that they all have the common theme of boundary issues. For example, sexual topics and marital issues did not appear appropriate for young children. Some issues are simply not fitting developmentally and serve no benefit for the young child. In fact, they may be harmful.

Reassuringly, the majority of clinicians indicated feeling comfortable and qualified in working with young children. Moreover, it appears that clinicians are becoming increasingly knowledgeable in this area. Surprisingly, the large majority have had play therapy training and some even have had training in art therapy. Yet, still a quarter of the respondents have not had art or play therapy training.

The final page of the questionnaire asked respondents for any additional comments regarding young children in family therapy. Approximately a quarter of the total questionnaires received indicated additional comments.

Some made comments that the research was interesting and questionnaire well-designed. Approvingly, others mentioned they were pleased that such a study was

being undertaken. "It is one of the most neglected issues in family therapy." Another went on to say, "My formal graduate training lacked any family or child orientation. Thus, all of my work with the family/child occurred on my own, both during and after graduate school".

It appears that those who wish to understand and feel comfortable working with young children may have to do much outside work. For example, one stated having been enormously helped by membership in a children's literature study group, wherein current and traditional children's authors are reviewed. "This is very rich literature which I have employed in family and child work for many years, e.g. giving out copies of Paterson's Bridge to Terabithis or Brooks' Moves Make the Man, or little stories by Grimm, Andersen, and MacDonald."

Some used this area of the questionnaire to emphasize the benefits of including young children. "I have found many young children to have old souls, and a wisdom far beyond their years." Thus, it was emphasized that treating young children with respect is essential. It was also stated, as is described in the literature, that young children make wonderful co-therapists in working with their families. Sometimes out of guilt, or simply maturity, parents are more wiling to listen to their children. Further, the children are often more free to say exactly what they think and feel, with little restraint. Thus, children become parents to their parents. As parents become more sufficient in their parent role, the children naturally assume their position in the family (Neill & Kniskern, 1982).

Others stressed the skills necessary when working with young children. They

highlighted that the medium of therapy for young children is play therapy. Thus, if family therapy is to include young children, it should involve all family members utilizing the medium of play to communicate with the children with the therapist interpreting and interacting. Another emphasized that all therapists should be trained as child therapists. "It is only as therapists understand what normal development is and the consequence of stress at each developmental level that they start to see where the poor learning took place with the adult."

As was stated previously, the majority of clinicians do not use a formal process to decide when to include young children in family therapy. Children seem to be included simply on a family to family basis. Consequently, some commented that the questionnaire did not allow for much variance, at times making it difficult to answer the items. Simply, "There is no rule of thumb". It appeared that items depend more on the specifics of each family and not a general rule.

As clarified by one respondent, "I include children when it is appropriate to them and the family; when their presence is of value to the treatment. I do not do so to be a "pure family therapist" to always work with the whole family". Some exclude children when they need to say something to the parent which if the child were present, may compromise the family hierarchy. Others exclude them when issues not relevant to them are discussed.

Other comments included, "If the parent comes wanting to know how to better "parent", or brings a child reflecting gross lack of parenting skills, I usually see the child once, and the parent(s) the balance of the time". In a similar statement, "I

usually see young children at the beginning, to understand the family dynamics, then exclude them later, and concentrate on helping the parent develop more effective parenting skills". In addition, "If the child is 8-10 and above (and especially teens) I will sometimes see both individually and/or as a total family".

Limitations of the Study

Limitations to the present study include a problem innate in all mail surveys, that of response bias. The main factor leading to response bias is low response rates, which make it likely that the resulting sample is biased. Even though bias decreases with larger response rates, it is not completely eliminated unless there is a perfect response rate (Shaughnessy & Zechmeister, 1990).

Due to this possible problem, the present study followed procedures to enhance response rate. These included addressing outside envelopes by hand, including a postage-paid return envelope, and mailing a follow-up postcard and follow-up questionnaire.

A portion of the returned surveys, approximately thirty, were judged unusable due to respondents indicating that they did not conduct family therapy. This was surprising because clinicians were selected for participation due to the fact that in the National Register (1992), subjects had marked family therapy as a service they provided. The researcher assumes that this is the information the respondent entered when first admitted to the National Register. Possibly, since this initial time, services offered have not been updated. This is true also of those that mentioned they no longer do family therapy.

The questionnaire was also designed so that those who do not include young children in family therapy could also respond. However, a few questionnaires were returned unanswered, indicating that they do not involve young children in family therapy. To avoid this problem, the cover letter should emphasize to respondents that even if they do not involve young children in family, they can and should still respond.

In spite of these precautions, there are simply some respondents who did find the topic at hand uninteresting and of little value. Disappointingly, one mentioned indifference towards the topic of young children. As stated in the literature, it is easy to diminish the importance of young children and their potential value to therapy (Combrinck-Graham, 1986).

Regarding particular items of the questionnaire, Section I - "In Your Practice", items Q-11 and Q-12, yielded very little conclusive information. The items sought information regarding ways in which young children and their families interact in family therapy when the young children are included. The researcher found there is no typical response, and thus, the items produced an extremely broad range of information to be of any generalizable use.

In addition, it appears that Section III - "Training", item Q-1 (c) tapped for demanding information. The item asked respondents for the approximate number of families seen in supervised clinical experience. However, responses ranged so greatly, concluding that the item might not have been stated clearly, or simply it is a difficult item for some to recall.

As previously stated, the last page of the questionnaire asked respondents for any additional comments. Those comments regarding young children in family therapy were mentioned in "Findings". However, a few additional comments were indicated regarding the design and implementation of the questionnaire.

Some recommended rank-ordering of the theoretical orientations so as not to lose data. Another recommended wording items differently such as rather than "do you agree with this statement" asking "how often do you believe this is the way it should be done". Again it appears that many see no formulas or rules when it comes to including young children in family therapy.

As Shaughnessy and Zechmeister (1990) applicably expressed:

> No essay can capture all the aspects of a given topic, and no 20-item or even 200-item questionnaire can do so, either. Survey research, like the rest of the scientific enterprise, is built on faith that compiling reliable findings in a series of limited studies will eventually lead to increased understanding of the important broader issues we face.

Future Suggestions

As suggested by one respondent, future research should also take into account the type of clientele, such as income level and ethnicity, with which clinicians work. It was suggested that lower income families often require more flexibility and sensitivity to the pragmatic difficulties in getting all family members together at once than many private practice - type clients.

From the present study, it appears that there is a larger percentage than

expected who have training in art and/or play therapy. However, it would be interesting to investigate actual masters and doctoral level curriculums (course work and practical experiences) to get an idea of what percentage, if any, of the curriculum deals specifically with young children. Respondents to this study commented that they often learned about young children and their involvement in family therapy outside of their graduate education.

It would also be interesting to replicate the current study using a different population of clinicians such as social workers or marriage and family therapists. Perhaps different results would be obtained with a different population, given their distinct training and educational background.

An important next step to this research, which cannot be investigated through a mail survey, would be to investigate how affect and sensitive topics actually effect young children. From the current research, it is clear that there are sensitive topics, feelings, and behaviors which both the therapist and parent feel are inappropriate. The best means of assessing this information would be through process and outcome research in order to see the actual effects, and potential harm on the child and family.

Implications

It is crucial that counseling programs provide a component dealing specifically with young children. Even though some programs offer a child tract, there needs to be required course work or practical experience for all. Although it appears that the decision to include young children depends more on the individual family than the "rule of thumb", there must be some general guidelines for when young children and

the family will benefit from the young child's involvement.

This is significant because it appears that most clinicians had to develop and enhance their skills with regards to young children outside of graduate school. This is often done through continuing education courses, readings, or trial and error. It is important that modalities specific to young children, such as art and play therapy, be offered through graduate training.

It is crucial that the therapist understand when the child is no longer profiting from inclusion in family therapy. The concern of the researcher lies in the fact that if young children are to be included, there need be a benefit to the young child and family for their inclusion. Children need to be actively involved through their mediums, such as art and play therapy. Play cannot simply be used as a distractor to occupy the young child.

The family therapist has a difficult job in that they must be skilled in working with all members of the family and especially know how to handle delicate topics, feelings, and behaviors. Family therapy to be true to its commitment to systems theory, should be as concerned with the younger child as with all other family members, whether they are the presenting problem or not. As a rule, family therapists do not pay enough attention to the child, because to involve them requires meaningfully integrating their communications into the family system. Since children communicate through play, movement, and seemingly irrelevant remarks, therapists must be taught early on to understand and use their contributions (Guttman, 1975). This appears a difficult job, but one which will ultimately benefit the family.

APPENDIX A

YOUNG CHILDREN IN FAMILY THERAPY QUESTIONNAIRE

YOUNG CHILDREN IN FAMILY THERAPY QUESTIONNAIRE

I. IN YOUR PRACTICE ...

Q-1 How many years have you spent conducting family therapy?

_____YEARS

Q-2 What percentage of time do you spend providing family therapy?
(Please circle number of your answer.)

1. 0%
2. 1-25%
3. 26-50%
4. 51-75%
5. 76-100%

Q-3 When providing therapy to families with young children, what percentage of time do you include children ages six and under?

1. 0%
2. 1-25%
3. 26-50%
4. 51-75%
5. 76-100%

Q-4 When beginning with a new family in family therapy, is there a formal process you use to decide when to include or exclude young children?

1. NO
2. YES

Q-5 Please briefly explain how you decide which children (if any) to include in family sessions.

(If you have never worked with a co-therapist in family therapy please skip to Q-8.)

Q-6 Have you ever had differing views with a co-therapist regarding including the young child(ren) in family sessions?

1. NO
2. YES

If you responded "YES" to Q-6, what percentage of time did you differ?

1. 1-25%
2. 26-50%
3. 51-75%
4. 76-100%

Q-7 Have you ever had differing views with a co-therapist as to what topics/feelings/behaviors are appropriate and which are inappropriate when including young children?

1. NO
2. YES

If you responded "YES" to Q-7, what percentage of time did you differ?

1. 1-25%
2. 26-50%
3. 51-75%
4. 76-100%

Q-8 Have you ever had a parent ask you not to discuss something in front of their children?

1. NO
2. YES

Please specify the topic(s). _____

Q-9 Have you ever had to request that a parent not discuss something in front of their children?

1. NO
2. YES

Please specify the topic(s). _____

Q-10 Briefly describe how you as a therapist, typically interact with young children when they are present in the family session.

Q-11 Briefly discuss how young children typically act when included in family sessions.

Q-12 Briefly describe your observations regarding how the family behaves in family sessions when their young children are included.

II. ATTITUDES/BELIEFS

Q-1 Is there a minimum age a child must be before you will include them in family therapy sessions? If so, please specify the age. If not, please leave blank.

_____YEARS

Q-2 Please circle any **topics** which you believe should not be discussed in front of children ages six and under. If you circle any responses, please indicate to the right of the **topic**, at what age they are appropriate to discuss.

1. CUSTODY ISSUES/____YEARS
2. DIVORCE/____YEARS
3. DRUG OR ALCOHOL ABUSE/____YEARS
4. MURDER/SUICIDE WITHIN THE FAMILY/____YEARS
5. PARENTS' LACK OF PARENTING SKILLS/____YEARS
6. SEXUAL TOPICS PERTAINING TO THE PARENTS/____YEARS
7. VIOLENCE/____YEARS
8. OTHER (Please specify.)
   _____/____YEARS
   _____/____YEARS

Q-3 Please circle any (if any) of the following **feelings/behaviors** you believe should not be expressed in front of children ages six and under in family sessions.

1. ANGER
2. CRYING
3. DESPERATION
4. FEAR
5. SWEARING
6. GUILT
7. SCREAMING
8. VIOLENCE
9. OTHER(S) (Please specify)
   _____

Q-4 For the following set of statements, please respond whether you tend to agree or disagree.

A. "I feel comfortable working with young children in family therapy."

1. DISAGREE
2. AGREE

B. "Children are aware of delicate issues within their family even if they are not disclosed."

1. DISAGREE
2. AGREE

C. "I believe that family therapy is more effective when children six years and under are left out of family therapy sessions."

1. DISAGREE
2. AGREE

D. "If parents do not feel comfortable sharing information in front of their children, the parent is the final authority as to what is disclosed."

1. DISAGREE
2. AGREE

E. "I feel qualified working with young children in family therapy."

1. DISAGREE
2. AGREE

Q-5 If you responded "DISAGREE" to the last statement (E), please specify briefly to what you attribute this.

If you responded "AGREE" to the last statement (E), please specify briefly to what you attribute this.

Q-6 Briefly list the therapeutic skills necessary when working with children in family therapy, if these skills differ from working with adults.

Q-7 The following reasons have been suggested for including young children in some stage of family therapy. (Please indicate your opinion of each statement by circling the appropriate response from the following scale.)

1	2	3	4
Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree

Young children should be included because they are keen observers of family life. 1 2 3 4

Young children should be included because they are more honest and open than adults in therapy. 1 2 3 4

Young children should be included because family therapy is not family therapy unless all members are present. 1 2 3 4

Young children should be included because they enable rapport building with the family. 1 2 3 4

Young children should be included because family dynamics will be incomplete without them. 1 2 3 4

Q-8 The following reasons have been suggested for excluding young children from family therapy sessions. (Please indicate your opinion of each statement by circling the appropriate response from the following scale.)

1	2	3	4
Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree

Young children should be excluded because children may be hurt by what is discussed. 1 2 3 4

Young children should be excluded because children are distracting and disruptive 1 2 3 4

Young children should be excluded because children do not participate on the same verbal level as adults. 1 2 3 4

Young children should be excluded because therapists may feel overwhelmed and out of control. 1 2 3 4

Young children should be excluded because of the potential for the therapist undermining parental authority. 1 2 3 4

Q-9 **Please indicate your opinion of the following statements by circling the appropriate response.**

1	2	3	4
Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree

When young children are included in family therapy, they should be kept in therapy for the entire course of therapy.	1 2 3 4
Young children should be included only during the intake phase.	1 2 3 4
When young children are included in family therapy, they should be excluded when topics which are sensitive to the parents are discussed.	1 2 3 4
Young children should be included in family therapy when the identified patient is a parent.	1 2 3 4
Young children should be excluded from family therapy when they request exclusion.	1 2 3 4
Young children should be excluded from family therapy when parents request children's exclusion.	1 2 3 4
Young children should be included in family therapy sessions only when they are the identified patient.	1 2 3 4

III. TRAINING

Q-1 **If you have had an opportunity to have training in family therapy, how much training have you received in family therapy?**
(Circle number of your answer.)

NUMBER OF GRADUATE COURSES

1. 0
2. 1
3. 2-3
4. 4+

NUMBER OF CONTINUING EDUCATION CLASSES/WORKSHOP(S) EXPERIENCES

1. 0
2. 1
3. 2-3
4. 4+

APPROXIMATE NUMBER OF FAMILIES SEEN IN SUPERVISED CLINICAL EXPERIENCE _____

OTHER (Please specify)

_____

Q-2 **Approximately what percentage of this time in training focused on working with young children (ages six and under) in family therapy sessions?**

_____%

Q-3 **Have you had training in art and/or play therapy?**

1. ART THERAPY TRAINING
2. PLAY THERAPY TRAINING
3. BOTH OF THE ABOVE
4. NONE OF THE ABOVE

Q-4 Have you received certification in family therapy?

1. NO
2. YES (Please specify.)

_____

IV. DEMOGRAPHICS

Lastly, we would like to ask a few questions about yourself for statistical purposes.

Q-1 What is the highest degree you have received?
(Circle number of your answer.)

1. ED.D.
2. M.A./M.S.
3. M.ED.
4. PH.D.
5. PSY.D
6. OTHER (Please specify.)

_____

Q-2 In what area of study did you receive this degree?
(Circle number of your answer.)

1. EDUCATION
2. CLINICAL PSYCHOLOGY
3. COUNSELING PSYCHOLOGY
4. FAMILY STUDIES
5. MARITAL AND FAMILY THERAPY
6. PASTORAL COUNSELING
7. OTHER (Please specify.)

_____

Q-3 What is the theoretical orientation most similar to your approach?
(Circle number of your answer.)

1. BEHAVIORAL
2. CLIENT-CENTERED
3. COGNITIVE
4. ECLECTIC
5. EXISTENTIAL
6. FAMILY SYSTEMS
7. GESTALT
8. HUMANISM
9. PSYCHODYNAMIC
10. RATIONAL EMOTIVE
11. REALITY
12. OTHER (Please specify.)

_____

Q-4 If your response to Q-3 was "FAMILY SYSTEMS" please circle the theoretical orientation most similar to your approach to family systems.

1. BEHAVIORAL (e.g., G. PATTERSON)
2. BOWENIAN (e.g., M. BOWEN)
3. COMMUNICATION/STRATEGIC (e.g., J. HALEY)
4. EXPERIENTIAL/HUMANISTIC (e.g., C. WHITAKER)
5. PSYCHODYNAMIC (e.g., N. ACKERMAN)
6. STRUCTURAL (e.g., S. MINUCHIN)
7. OTHER (Please specify.)

_____

Is there anything else you would like to tell us? If so, please use this space for that purpose. Also, any comments you wish to make that you think may help us in future efforts to understand working with children will be appreciated, either here or in a separate letter. Your contribution to this effort is very greatly appreciated. Once again, if you would like a summary of results, please print your name and address on the back of the return envelope (NOT on this questionnaire) and check "copy of results requested". We will see that you get it.

APPENDIX B

COVER LETTER TO FIRST MAILING

October 15, 1993

Dr. Ann Smith
1 Loyola Place
Chicago, IL 60202

Dear Dr. Smith:

I am conducting a nationwide survey among mental health professionals. The purpose of this research is to assess opinions and practices regarding inclusion of young children, ages six and under, in family therapy. Because the literature is scarce in this area, your responses will enable other professionals in the field to be more effective in providing services to children.

You are part of a carefully selected sample. Your answers are very important to the accuracy of our research.

You are assured of complete confidentiality. The questionnaire has an identification number for mailing purposes only. This is so that we may check your name off of the mailing list when your questionnaire is returned. Your name will never be placed on the questionnaire.

It will take approximately 15 minutes to answer the questions on the enclosed questionnaire and to return it in the stamped reply envelope.

If you are interested in receiving a report on the findings of this research, simply write "copy of results requested" on the return envelope, and print your name and address above it. Please do not put this information on the questionnaire itself. I will be glad to send you a report when our study is completed.

I would be happy to answer any questions you might have. The telephone number is (708) 869-6941. Thank you for your time and assistance.

Sincerely yours,

Diane H. Mehbod-Wenzel
Graduate Student

Gloria L. Lewis, Ph.D.
Associate Professor
Department of Counseling & Educational Psychology

APPENDIX C

FOLLOW-UP POSTCARD - SECOND MAILING

Last week I mailed you a questionnaire asking for your participation in an important survey regarding children in family therapy. If you have already returned the questionnaire please consider this card a "Thank You" for your valuable time and assistance.

If you have not had a chance to do so as yet, may I ask you to return the completed questionnaire now? Because it has been sent to only a small, but representative sample, your participation is vital to this success of our study.
Thank you for your time and assistance.

Sincerely,

Diane H. Mehbod-Wenzel

APPENDIX D

COVER LETTER TO THIRD MAILING

November 29, 1993

Dr. Ann Smith
1 Loyola Place
Chicago, IL 60202

Dear Dr. Smith:

Several weeks ago you were sent a questionnaire seeking your views on the practice of including young children in family therapy. Unfortunately, we have not yet received your questionnaire.

The area of involving young children in family therapy is scarce in research. As a result, this study has been undertaken in order to learn more about beliefs and practices of mental health professionals like yourself.

This letter is being sent to you again because of the importance of each questionnaire to this study. Your name has been drawn from a carefully selected sample and you are guaranteed confidentiality. In the event that your questionnaire has been misplaced, a replacement is enclosed.

We would be happy to answer any questions you might have. The telephone number is (708) 869-6941. Your assistance is greatly appreciated and we thank you in advance for your time.

Sincerely yours,

Diane H. Mehbod-Wenzel
Graduate Student

Gloria L. Lewis, Ph.D.
Associate Professor
Department of Counseling & Educational Psychology

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