A SURVEY OF FAMILY THERAPISTS CONCERNING THE INCLUSION OF YOUNG CHILDREN IN FAMILY THERAPY

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(ABSTRACT)

A survey of 126 randomly selected family therapists investigated attitudes and practices concerning including young children (four years of age and under) in family therapy sessions. The sample was overwhelmingly in favor of including young children, but 70% of the sample included young children less than half of the time they had the opportunity. Moderating variables which were discussed included topics too sensitive to be discussed in front of the children, the lack of clarity in the literature, the need to interact with young children in an affective rather than cognitive way, and the lack of academic and experiential training in the area of child development.

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Introduction

In her classic book Conjoint Family Therapy, Virginia Satir (1964) raised the issue of whether all children, including young children, should be included in family therapy. Little research dealing with this topic has been published in the intervening 20 years, in spite of the numerous commentaries on the subject. Kniskern reviewed the literature through 1979 and reported in 1979 that no study had directly addressed the issue of children in family therapy. A review of the Reader's Guide to Periodical Literature (H. W. Wilson Co., 1980-1984), the Psychological Abstracts (American Psychological Association, 1980-1984), the Inventory of Marriage and Family Literature (Olson, 1980, 1981; Olson & Markoff, 1982-1984), the Sociological Abstracts (Sociological Abstracts, Inc., 1980-1984), and the Sage Family Studies Abstracts (Sage Publications, 1980-1984) reporting on the literature in the subsequent five year period also revealed no such studies. Gurman and Kniskern (1981) took no position on the issue, stating, "insufficient data exist to support any assertions about the necessity of always including two or more generations in the treatment of marital or family dysfunction" (p. 750).

For the most part, comments regarding the inclusion of young children in family therapy have been favorable, but not unanimous. The reasons offered for including young children in family therapy sessions are: (1) to facilitate rapport building and joining the family (Andolfi, 1979); (2) young children serve as an index of family anxiety (Dare & Lindsey, 1979; Dowling & Jones, 1980); (3) their

play and fantasies bring hidden issues to the surface (Dowling & Jones, 1980; Zilbach, Bergel, & Gass, 1972); (4) they can be used as a basis for assessing family strengths (Dare & Lindsey, 1979; Malone, 1979); (5) they are indicators of family process and dynamics (Block, 1976; Malone, 1979; Zilbach, et al., 1972); (6) they are more honest and open than adults in therapy settings (Zilbach et al., 1972); (7) they provide the opportunity to observe intergenerational relationships and parenting skills (Malone, 1979); (8) they provide information which can be used in future interventions (Malone, 1979); and (9) they provide information about how the family deals with family members at different developmental levels when older children are present (Malone, 1979). In general, the above authors believed that only through observing the interactions of the entire family system can family therapy be most effective in the assessment and understanding of the system's functioning.

A number of practical problems arise when young children are included in family therapy sessions. They include: (1) their disruption and distraction may interfere with the therapeutic process (Andolfi, 1979; Digiuseppi & Wilner, 1980; Satir, 1964); (2) the difficulty of simultaneously appropriately interacting with persons of different age groups (Andolfi, 1979); (3) the therapist's fear of losing control of the situation (Andolfi, 1979); (4) the therapist's desire to protect the child from the family or the family from the child (Andolfi, 1979); (5) the context may be too adult (Andolfi, 1979); (6) their lack of verbal skills interferes with the

therapeutic process (Satir, 1964); and (7) their inability to follow the verbal process interferes with the therapeutic process (Palozzoli, Boscolo, Ceechin, & Prata, 1978; Satir, 1964).

As a means of coping with some of these practical problems, limitations to the inclusion of young children in family therapy have been proposed: (1) they should be included only during the evaluation phase (Digiuseppi & Wilner, 1980; Satir, 1964); (2) they should be excluded when a parent or the parental relationship is the identified patient (Kniskern, 1979); (3) they should be excluded when they request exclusion (Kniskern, 1979); (4) they should be excluded in the later stages of therapy (Kniskern, 1979); (5) they should be excluded when adequate progress is being made, but kept in if little or no progress is being made (Kniskern, 1979); (6) they should be excluded when topics which are sensitive to the parents are discussed (Kniskern, 1979); and (7) they should be included when they are the identified patient or the sibling of the identified patient (Flashman, 1982; Kniskern, 1979).

Such practical problems and limitations are countered by practical suggestions that would help the therapist cope with the specific needs of the young child. These include: (1) having available and encouraging young children to use play materials (Andolfi, 1979; Augenbraum & Tasem, 1966; Bloch, 1976; Dare & Lindsey, 1979; Dowling & Jones, 1980; Guttman, 1975; Levant & Haffey, 1981; McDermott & Char, 1974; Zilbach, 1982; Zilbach et al., 1979); (2) avoiding asking young children direct questions about the

therapeutic process (Dowling & Jones, 1980; Flashman, 1982; Zilbach, 1982); (3) avoiding direct interpretation of the significance of young children's verbal and nonverbal behavior to the family as part of the therapeutic process (Guttman, 1975); (4) using young children's verbal and nonverbal behavior only as the basis for future interventions (Flashman, 1982); (5) participating directly in young children's play as part of the therapeutic process (Levant & Haffey, 1981); (6) assuming the responsibility for keeping young children involved in the therapy process, rather than expecting this to be done by the parents (Dare & Lindsey, 1979; Zilbach, 1982); (7) avoiding asking young children "why" questions (Zilbach, 1982); and (8) providing a safe place for children to move around (Bloch, 1976; Zilbach, 1982).

One study concerning licensed behavioral science practitioners' practices concerning involving children in therapy settings was found. McComas, Protinsky and Moran (1985) surveyed 400 randomly selected licensed clinical social workers, licensed professional counselors, and psychologists from the Commonwealth of Virginia, and received 218 responses. Of these, only 76 (34.9%) indicated that they included children of any age in their practice. Nearly 90% of those who included children at all, treated children between the ages of 9 and 17 exclusively with only 12% including children under the age of 12.

The review of the literature leads to the conclusion that to be consistent with the concept of the family as a system, the family

therapist should treat the entire family system. Although some family therapy experts have written about the family as a system and view the family as the unit of treatment, their interventions are more frequently with individuals or couples (see Bowen, 1978; Watzlawick, Weakland, & Fisch, 1974). Such a practice is based on the idea of a ripple effect, the notion that changing any part of a system will influence the rest of the system. Others have enthusiastically recommended the household kin group as the unit of treatment (Haley, 1976; Minuchin, 1974; Palazzoli, et al., 1978). More information about the family processes and dynamics should be obtained by observing the entire system, than by observing a part of the system and hypothesizing the functioning of the absent parts. In addition, interventions aimed at the entire family would be consistent with systems concepts in that the effect on the family system would be directly observable. Whether, in practice, this theoretical model is appropriate is another question, however.

Given the theoretical and practical significance of the issue, the scarcity of research on including young children in family therapy is surprising. A sound place to begin research in the area is to determine the actual practices concerning young children's participation in family therapy, and if the reasons for such practices are consistent with the existing literature.

The present study had two purposes: (1) to determine the extent to which practicing family therapists, who are Clinical Members of the American Association for Marriage and Family Therapy (AAMFT),

include young children (four years of age or younger) in family therapy sessions; and (2) to determine if the reasons for such practices are congruent with the existing literature. In spite of the recommendations that entire family units including preschool children be involved in treatment, it was hypothesized that most family therapists do not consistently involve complete household kin groups, including young children, in family therapy sessions in a systematic way. Their treatment will likely either be parent treatment, parent and identified patient treatment, or the treatment of a single family member. It is hoped that the data obtained from this study will also suggest the direction in which to proceed with family therapy process and outcome research in this area.

Methodology

Questionnaire

Data were collected by the use of mailed survey questionnaires detailing therapists' attitudes and practices regarding inclusion of young children in family therapy (see Appendix B). The questionnaire was composed of 33 items. Each item elicited one or more responses from the subjects in either a multiple choice, checklist, five-point Likert scale, or seven-point Likert scale framework. There were three distinct sections in the questionnaire. The first section collected demographic information regarding the sample. The second section focusing on attitudes, solicited information about the respondents' global attitudes about including children in family therapy, their opinions regarding reasons for including young children in family therapy, their opinions regarding reasons for excluding

young children from family therapy, and their opinions of possible limitations on including young children in family therapy. The final section, focusing on practices, solicited information about the percentage of time the respondents include young children when treating families with young children, and specific practices employed in doing so. The questionnaire was constructed such that all respondents would complete Section I, those respondents who had practiced and/or supervised marriage and family therapy during the three months prior to the initial mailing would complete Section II, and those respondents who had included young children in their practice would complete all of Section III. This kind of construction was necessary because the target population of practicing family therapists was not readily identifiable from the AAMFT directory, the source for the population listing. The directory gives only name, address, phone number, degree, and certain statuses within the organization. No indication of current professional position is given for listed members. Therefore the questionnaire was designed to first identify those in the sample who represented the target population. All respondents were asked to complete Section I so that comparison between practicing and non-practicing family therapists would be possible. The questionnaire was pilot tested on a small group of marriage and family therapists and from this procedure a few items were revised for enhanced clarity.

Sample

The sample was drawn from 400 Clinical Members of AAMFT randomly selected from the 1982 AAMFT directory which includes slightly over

7,000 names. Of the 400 questionnaires which were distributed, 132 were returned. Six of the returned questionnaires were returned with notes that the subject was deceased, terminally ill, or otherwise unavailable. Thus the prospective sample was reduced to 393 subjects. There were 126 usable questionnaires, 32% of the total sample. Of these, 26 (20.6%) indicated they had not practiced within the past three months and of the remaining 100 practicing professionals, 89% of those indicated that they had included young children in therapy sessions at sometime within the past year. Only a maximum of 99 responses were provided to Section II and 85 responses to Section III were available, since a few respondents apparently misinterpreted the directions of the questionnaire.

The sample ranged in age from 31 to 92, with the average age being 48 years. The sample was approximately evenly distributed between males and females. More than three-quarters of the respondents were married. The sample was almost entirely white. More of the respondents held Masters level (60%) than Doctoral level (40%) degrees. Those respondents who had actively practiced or supervised marriage and family therapy during the previous three months spent from 1 to 55 hours weekly doing so. They averaged over 12 hours of practice weekly. For a more complete description of the sample, see Appendix D. The demographic data of the present sample with the exception of a higher percentage of females, appeared to be roughly equivalent to the sample obtained by Fisher and Sprenkle's study of influential theorists (Fisher & Sprenkle, 1978; Sprenkle & Fisher, 1980; Sprenkle, Keeney, & Sutton, 1982) to the

sample obtained by Herakovich (1980), and the description of AAMFT Clinical Members by Discipline from the AAMFT Board Minutes (1982). See Table 1 for comparative data.

Insert Table 1 about here

Procedure

Each subject was mailed the cover letter explaining the nature of the research (see Appendix B), the questionnaire, and a stamped, self-addressed envelope in which to return the completed questionnaire. Each questionnaire was coded for identification for follow-up purposes. Four weeks after the initial mailing, a follow-up mailing was made to those subjects who had not yet returned their questionnaires. The second and third follow-up mailings were each made three weeks after previous mailings. Follow-up mailings utilized a printed postcard (see Appendix C). The follow-up procedures noted above were designed to assure maximum subject participation (Herberlein & Baumgartner, 1981; Yu & Cooper, 1983). Although the follow-up procedures did increase the sample beyond the first mailing by 37.5% , the relatively low response rate remains a major disappointment.

Analysis

Means for the scaled items were compared to neutral points on the scale (a score of 3) by means of *t*-tests. The global attitude scale was collapsed to a three-point scale and analyzed by the use of chi-square. Chi-square analysis was also used to compare demographic data on selected subsamples. In recognition of the problem of

multiple t-tests, significance levels have been set at $p < .005$.

Results

Section I of the questionnaire included sample characteristics and information about the field of education, current employment and professional identity. The sample characteristics have been reported above.

Social work has the most frequently reported field of education (28%), followed by Psychology (26%), Marriage and Family Therapy (14%), Pastoral Counseling (9%), and Guidance and Counseling (6%). Therapist/ Counselor was reported as the primary professional position of about two-thirds of the sample (67%), with no other position reported by more than 10% of the sample. In stark contrast to the respondents' field of education were their current professional positions. Forty-one percent reported that they identified themselves as Marriage and/or Family Therapist. Identities of Psychologist and Social Worker together were reported by only 30% of the sample, indicating that more of the sample than those who earned degrees in Marriage and Family Therapy identified themselves as such, and fewer of those who earned Social Work and Psychology degrees identified themselves by their respective fields (see Table 1). See Appendices D, E, F, and G, for more detailed information.

Some differences between respondents who were practicing marriage and family therapy and those who were found. A higher percentage of doctoral degrees for those not practicing (58%) compared to those practicing (35%) were found, $X^2(1, n = 126) = 4.48$, $p < .05$. See Appendix I for more detailed information.

Section II surveyed therapist attitudes regarding the inclusion of young children in family therapy. Part A concerned whether the inclusion of young children enhances or inhibits the therapeutic process. None of the respondents indicated that including young children always inhibits the therapeutic process. Over one-third of the respondents (34%) indicated that including young children generally inhibits more than enhances the therapeutic process, and only a few of the respondents (4%) indicated that including young children children is irrelevant to the therapeutic process. The majority of the respondents (53%) indicated that including young children generally enhances more than inhibits the therapeutic process with a small number (4%) of the respondents indicating that including young children always enhanced the therapeutic process. Significantly more of the respondents, $X^2(2) = 36.19$, $p < .001$, believed that including young children enhances rather than inhibits the therapeutic process.

Part B was concerned with the respondents' ratings of reasons suggested in the literature for including young children in family therapy sessions. Generally, the respondents agreed with all of the reasons provided by the literature. In these analyses, *t*-tests were computed comparing the respondents' ratings on a five-point scale with the mid-point (i.e., a reply of 3). The strongest agreement, $t(97) = 11.74$, was obtained for the statement, "They provide the opportunity to observe intergenerational relations and parenting skills." Strong agreement was also obtained for the statements,

"They provide information about how the family deals with family members at different developmental levels when older children are present," $t(96) = 10.41$, "They are indicators of family processes and/or dynamics," $t(97) = 9.90$, and "They provide information which can be used in future interventions," $t(97) = 8.93$. Moderate agreement was obtained for the statements, "They can be used as a basis for identifying family strengths, $t(97) = 7.79$, "They are more honest and open than adults in therapy settings," $t(97) = 5.87$, "They bring hidden issues to the surface by their play and fantasies," $t(97) = 5.87$, and "They serve as an index of family anxiety," $t(97) = 5.67$. Relatively weak agreement was obtained for the statement, "They facilitate rapport building with the family," $t(97) = 2.90$. Distributions, means, t-scores, and significance levels are contained in Table 2.

Insert Table 2 about here

In Part C, the respondents' ratings of reasons suggested in the literature for excluding young children from family therapy sessions were examined. The results obtained indicated significant disagreement on some items and non-consensus on others. Strongest disagreement, $t(98) = -5.16$, was obtained for the statement, "Their lack of verbal skills interferes with the therapeutic process." Moderate disagreement, was obtained for the statement, "Parents are generally unwilling to bring their young children with them to family therapy sessions," $t(98) = -4.54$. and for the statement, "Their inability to follow the verbal processes interferes with the therapeutic process," $t(98) = -4.06$. There was no consistent response pattern

to the statement, "Their distraction interferes with the therapeutic process." Distributions, means, *t*-scores, and significance levels are contained in Table 3.

Insert Table 3 about here

Part D addressed some of the possible conditions under which children may be included in family therapy sessions. Significant agreement, $t(97) = 4.39$, was obtained for only one item: "When young children have been included in family therapy sessions, they should be excluded when topics which are sensitive to the parents are discussed." The strongest disagreement was obtained to the statements, "Young children should be included in family therapy sessions only when they are the identified patient," $t(98) = 12.11$, and "When young children are included in family therapy, they should be kept in therapy for the entire treatment course," $t(98) = 11.30$. Moderate disagreement was obtained for the statement, "When young children have been included in family therapy sessions, they should be excluded when adequate progress is being made (but kept in if little or no progress is being made)," $t(98) = -6.99$. Weaker disagreement was obtained for the statements, "When young children have been included in family therapy sessions, they should be excluded in the later stages of therapy," $t(97) = 3.96$, and to the statement, "When young children are included in family therapy sessions, they should be included only during the evaluation phase," $t(98) = 3.33$. No consistent response patterns were obtained to the remaining two

statements: "Young children should be included in family therapy sessions when the identified patient is a parent or the parental relationship," and "When young children have been included in family therapy sessions, they should be excluded when they request exclusion." Distributions, means, *t*-scores, and significance levels are contained in Table 4.

Insert Table 4 about here

Part E was a follow-up to the item in Part D concerning sensitive topics. Of those respondents answering this part, a small number (4%) indicated that no topics are so sensitive that they should not be discussed in the presence of young children. A few commented that it was not the topics themselves, but the affect generated by the topics. The respondents reported that such affect should be dealt with on a case-by-case basis. The overwhelming majority of the respondents indicated that young children should not be included when sex therapy of the parents is discussed (90%). Less than half of the sample reported that other sensitive topics were the criminal history of a parent (41%), incest (or alleged incest) within the family (40%), and spouse abuse (27%). Less than a quarter of the sample reported that the suicide of a family member was a sensitive topic (22%). A complete listing of topics which were reported as too sensitive for young children is contained in Appendix H.

Section III of the questionnaire dealt with the respondents' actual practice. Part A asked: "When treating families which have young children, what percentage of the time did you include these

children at any point in the therapy sessions?" Seventy percent of the sample included children less than half of the time, with half of the sample answering that they included young children less than one-third of the time. The most frequently occurring response was 10%. The higher mean score (41.1%) than median (30%) or modal (10%) score reflects a small number of high percentage scores, skewing the distribution. Several respondents noted specific reasons for not including young children. One respondent who had not included young children in family therapy sessions during the previous year indicated that it was because there was no appropriate treatment environment at her disposal. Of those who indicated that they had previously included young children in the sessions but do not at the present time, two reported that it was because they had none in their client load, and another indicated that it was for "diagnostic purposes" (unelaborated). Table 5 details the distribution of the percentage of time responses.

Insert Table 5 about here

Additional analyses were also performed to investigate possible difference between those practicing therapists who included young children most of the time and those who did not. Thus, the sample was divided into two groups: those who included young children more than 50% of the time (n = 31) and those who included young children 50% of the time or less (n = 66). Only one rather puzzling

difference was found. Males were more prevalent in the former group, $X^2(1, n = 96) = 3.86$, $p < .05$. See Appendix J for additional information.

Part B solicited the respondents' opinions about selected recommendations for therapist behavior when young children are present in family therapy sessions. Significant agreement was obtained for the statements, "I directly interpret the significance of young children's verbal and nonverbal behavior to the family as part of the therapeutic process," $t(84) = 5.46$, and "I ask children direct questions about the therapeutic process," $t(84) = 4.36$. No consistent response patterns were obtained for the statements, "I encourage young children to utilize play materials as part of the therapeutic process," "I use young children's verbal and nonverbal behavior only for the assessment of the family and the child, as the basis of future interventions," "I attempt to keep young children involved in the therapy process," and "I directly participate in young children's play as part of the therapeutic process." Distributions, means, t-value, and significance levels are contained in Table 6.

Insert Table 6 about here

The "Comments" section yielded only 18 responses. As intended, most comments were an elucidation of the respondents' personal practices with young children. The most common response was that of flexibility. They had no firm guidelines about inclusion or exclusion of young children, but they reacted in some unexplained way to the family situation. In general they favored including young children,

but decided in terms of each family's dynamics and issues. Other respondents reported that they typically began with the entire family, then changed focus to marital dyad. One respondent reported that young children are a "pain in the ass" but very helpful, while another considered the distractions to outweigh any potential benefits. One respondent reported the belief that young children are very helpful, but as a supervisor the respondent is sometimes "more worried about the therapist than the child."

Discussion

The hypothesis that the majority of family therapists who participated in the present study would not consistently include young children in family therapy sessions in a systematic way was supported. Half of the sample reported including young children less than 30% of the time. In addition, none of the recommendations found in the literature for facilitating young children's involvement in family therapy were supported. These results, however, are in contrast to the overwhelming support for the reasons for including young children which were suggested by the literature. Such results seem to suggest that even though family therapists are willing to include young children in theory, they do not follow through with their willingness in practice. Perhaps the supervisor who commented, "I worry more about the therapist than the children," is on the right track. Andolfi (1979) suggested that having young children in family therapy sessions was an anxiety provoking situation for therapists when he pointed out the problems posed by the presence of young children.

The problems were: (1) disruption; (2) the difficulty of simultaneously appropriately interacting with persons of different age groups; (3) the therapist's fear of losing control of the situation; (4) the therapist's desire to protect the child from the family or the family from the child; and (5) the context may be too adult. Such problems challenge family therapists' technical abilities and skills, as well as their ability to cope with their own anxieties. Perhaps the present sample of family therapists feel that including young children is a splendid idea - for others - but that personally they are simply not suited to handle any chaos in which they would find themselves. Also, the academic training necessary to become a family therapist very likely makes it easier to keep therapy on a cognitive level, while the presence of young children demands a more affective level of functioning. The training also may have used models in which young children's presence was not encouraged. The pervasiveness of the positive attitude toward including young children is reflected by the finding that while all of the items regarding reasons for including young children were supported by the sample, only one item in the remainder of the questionnaire was supported. Further, four of the items which were rejected by the sample were based on the literature which suggested excluding young children (Digiuseppe & Wilner, 1981; Flashman, 1982; Satir, 1964).

Other attitude items which were rejected by the respondents were items suggesting limiting young children's presence. Thus, no systematic manner for including young children was endorsed by the

sample. It may also be that the sample was not rejecting the specific suggestions out of hand, but rejecting the idea that there should be categorical rules governing young children's presence. They may be asserting the principle that the presence of young children should be a decision based on the presenting problem, the family dynamics and process, and the relative impairment of the family, as suggested by the comments elicited by the questionnaire.

Another reason for the discrepancy between attitudes and practices may be the presence of sensitive topics. Almost all of the respondents believed there were topics to which young children should not be privy. When such topics are introduced, the departure of the young children from the therapy sessions would reduce the amount of time that young children were present.

All of the items detailing specific practices were based on practical recommendations from the literature suggesting including young children in family therapy (Andolfi, 1979; Augenbraum & Tasem, 1966; Bloch, 1976; Dowling & Jones, 1980; Guttman, 1975; Levant & Haffey, 1981; Zilbach, 1982; Zilbach et al., 1972). Four of these items (Section IIIB) found no significant response pattern and the remaining two were in the direction opposite from that suggested by the literature. The reasons for this are unknown. One possibility is that the sample was not knowledgeable in principles of child development. Such is supported by the research of McComas et al. (1985) and Herakovich (1980). McComas and her colleagues found that licensed behavioral science practitioners were generally unable to

answer some basic child development questions. Herakovich asked AAMFT members to comment on three case studies of normal developmental problems. A large majority of the respondents reported that the behavior was pathological (Case I, 88%; Case II, 68%; Case II, 90%). Such responses indicated a lack of knowledge of age appropriate childhood behavior. The practical recommendations found in the literature addressed ways of reaching young children at their own level. Necessarily they were directed at a more affective than cognitive level of treatment. Perhaps the sample did not recognize the need to fully consider the developmental level of the child, or did not have the knowledge to recognize that the developmental level of the young child was well addressed by the recommendations, or elected not to address the affective level required to deal with the young child. In support of such speculation is the lack of a consistent response pattern to the practice item recommended more than any other in the literature, the use of play materials. Andolfi (1979) described play as the principal technique that makes it possible to include children in family therapy without treating them as miniature adults. The sample clearly did not endorse that view.

A final explanation for the discrepancy between the reported attitudes and practices of the sample is the lack of research-based direction. It is presumed that the suggestions reported in the literature are based on clinical experience and the theoretical perspective of the respective author. Such recommendations may lack the clarity and precision that research-based findings have. When clinical practices and processes are researched, they must be

operationalized. Without operationalization, the practices and processes tend to be vague and ambiguous. One respondent commented "several of the questions were too vague, requiring self-definition by the respondent." Since the vast majority of the questions were taken directly from the literature, the vagueness of the items reflected the lack of clarity in the literature. When clinicians are faced with recommendations that are vague and ambiguous, they most likely use their own knowledge base and theoretical framework to understand them. Their understanding will determine, then, their self-definition of terms and concepts.

Another discrepancy in the results was the lack of congruence between the respondents' reported field in which their degree was earned, and their primary professional identity. More than a quarter of the sample each reported they were trained in the fields of Social Work (28%) and Psychology (26%). Slightly more than one-eighth reported they were trained in the field of Marriage and Family Therapy (14%). However, almost half of the sample reported their primary professional identity as Marriage and Family Therapist, Marriage Therapist, or Family Therapist (41%). Slightly more than one-eighth of the sample each reported the identity of Psychologist (16%) and Social Worker (14%). For the present sample of Clinical Members of AAMFT, the identity of Marriage and Family Therapist is more significant than the identity of the field in which they were trained.

The similarity of the demographic data to other studies and AAMFT data files suggest that the sample may be representative, and

the results generalizable. One key difference was the return rate. Fisher and Sprenkle (1978) obtained a 52% return rate, Herakovich (1980) obtained a 40% return rate, and the present study obtained a 32% return rate. Heberlein and Baumgartner (1981), and Yu and Cooper (1983) have suggested that questionnaires concerning topics that respondents believe are more interesting and important obtain higher return rates. Whereas Fisher and Sprenkle's topic (i.e., influential theorists) could be considered relevant to every AAMFT member, the present study addressed a more limited segment of AAMFT membership. The inability to identify that segment prior to sampling may have deleteriously affected the present response rate. A sizeable proportion of AAMFT members are not actively practicing therapy. Others, because of their theoretical orientation, may not have seen the present research question as relevant to the situation. It may also have been that the lack of specific training with young children may have made the potential respondents uncomfortable with the topic, thereby making them less inclined to respond.

Conclusions

The present study emphasizes the importance of McDermott and Char's (1974) concern that "family therapists do not appear to use suitable approaches for younger problem members with their changing, shifting nature" (p. 427). Although the sample overwhelmingly subscribed to

the concept of including young children in family therapy sessions, they failed to support theoretically sound recommendations to facilitate such a practice. By doing so they ignore the child's inner state (Heard, 1978), and fail to fully consider that the child is an individual in his or her own right, in addition to being a part of the family system (Levant & Haffey, 1981). In view of such a finding it is, perhaps, encouraging that practicing family therapists include young children such a low percentage of the time. This may indicate that the negative effects of inappropriate therapeutic techniques used with young children in family therapy are minimal. The situation may be, then, that family therapists are not taking advantage of the hypothesized benefits of young children's presence, rather than placing young children in a therapeutic setting that is counter-productive for them.

Perhaps the crux of the problem lies in the discrepancy between the overwhelming support of the reasons for including young children in family therapy, and the sample's actual practice of excluding young children most of the time. Such enthusiastic support belies a theoretical interest in such a practice. In view of this interest, perhaps there is the need for a clearly developed theoretical model for treating families with young children, which is grounded in one of the dominant schools of family therapy. For example, such a model developed with structural or strategic principles would be very useful.

The implications of the present study seem rather fundamental to the field of family therapy. There is no clear consensus as to what

family members comprise the unit of treatment. Nor are there data providing any useful direction at the present time. We do not even know if the question is important. Indeed only one-third of those asked the question thought it was important enough to answer. It is unknown whether or not there is a significant difference in family therapy effectiveness when some family members are left out of the therapy. Research into the issue of young children's presence in family therapy is highly recommended. Research should be conducted in the following areas: (1) conditions under which young children should be included or excluded; (2) therapist variables when young children are involved in family therapy; (3) therapy outcome variables when young children are included in family therapy; (4) the differences that exist in the process of therapy (if any) when young children are present; (5) how the therapist interacts with the young child; how the young child and family behave in the therapy sessions when young children are present; and (7) how family therapists, who are successful in the conduct of family therapy when young children are present, operate within the therapeutic setting.

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Table 1

Comparative Demographic Data of Present Study to Other Available Data

Characteristics	Present Sample (1985, n=126)	AAMFT (1982, n=7656)	Fisher & Sprenkle (1978, n=310)	Herokovich (1980, n=121)
	Percent of Respondents			
Degree				
Masters	60	61	43	55
Doctoral	40	39	40	45
Theological			5	
Field of Degree				
MFT/Psych/Soc[a]	46	51		
Education	8	12		
Social Work	28	21		
Religion	14	13		
Medicine	3	3		
Professional Identity				
Marriage and Family Therapist	41		44	
Psychologist	16		17	
Social Worker	14		17	
Sex				
Female	48		30	31
Male	54		70	69
Age (in years)	48		47	

[a]AAMFT data was available only for a combined percentage of Marriage and Family Therapy, Psychology and Sociology.

Table 2

Distributions, Means, and t-Values for Items Assessing Reasons for Including Young Children in Family Therapy

Item	Distribution (%)					M	S.D.	t (df = 97)[a]
	SA	A	N	D	SD			
1. They facilitate rapport building with the family.	14.3	30.6	32.7	17.3	5.1	3.32	1.08	2.90*
2. They serve as an index of family anxiety.	23.5	41.8	17.3	11.2	6.1	3.65	1.14	5.67*
3. They bring hidden issues to the surface by their play and fantasies.	18.4	33.7	37.8	7.1	3.1	3.57	.97	5.81**
4. They can be used as a basis for identifying family strengths.	18.4	45.9	25.5	9.1	1.0	3.71	.91	7.79**
5. They are indicators of family processes and/ or dynamics	33.7	43.9	12.2	8.2	2.0	3.99	.99	9.90**
6. They are more honest and open than adults in therapy settings.	21.4	37.8	25.5	12.2	3.1	3.62	1.05	5.87**
7. They provide the opportunity to observe intergenerational relations and parenting skills.	44.9	39.8	8.1	3.1	4.1	4.18	.99	11.74**
8. They provide information which can be used in future interventions.	23.5	40.8	27.6	7.1	1.0	3.79	.92	8.43**
9. They provide information about how the family members at different levels when older children are present.	32.9	43.3	16.5	5.1	2.1	4.00	.95	10.41**

*$p < .005$
**$p < .0001$

[a]Degrees of freedom on item 9 are 96.

Table 3

Distributions, Means, and t-Values for Items Assessing Reasons for Excluding Young Children From Family Therapy

Items	Distribution (%)					M	S.D.	t
	SA	A	N	D	SD			(df = 98)
1. Their distraction interferes with the therapeutic process.	10.1	35.4	28.3	22.2	4.0	3.25	1.04	2.41
2. Their lack of verbal skills interferes with the therapeutic process.	1.0	18.2	26.3	35.4	19.2	2.46	1.03	-5.16*
3. Their inability to follow the verbal process interferes with the therapeutic process.	5.1	16.2	28.3	27.3	23.2	2.52	1.16	-4.06*
4. Parents are generally unwilling to bring their young children with them to family therapy sessions.	3.0	20.2	23.2	27.3	26.3	2.46	1.17	-4.54*

*$p < .0001$

Table 4

Distributions, Means, t-Values for Items Assessing Limitations on Young Children's Presence in Family Therapy

Item	Distribution (%) SA	A	N	D	SD	M	S.D.	t (df = 98)[a]
1. When young children are included in family therapy, they should be kept in therapy for the entire treatment course.	4.0	2.0	14.1	34.3	45.5	1.84	1.01	-11.30*
2. When young children are included in family therapy sessions, they should be included only during the evaluation phase.	4.0	23.2	23.2	28.3	21.2	2.61	1.18	-3.33*
3. Young children should be included in family therapy sessions when the identified patient is a parent or the parental relationship.	9.2	21.4	37.8	16.3	15.3	2.93	1.17	-0.61
4. When young children have been included in family therapy sessions, they should be excluded when they request exclusion.	14.1	16.2	36.4	23.2	10.1	3.01	1.17	0.09
5. When young children have been included in family therapy sessions, they should be excluded in the later stages of therapy.	4.1	14.3	32.7	33.7	15.3	2.58	1.04	-3.96**
6. When young children have been included in family therapy sessions, they should be excluded when adequate progress is being made (but kept in if little or no progress is being made).	2.0	10.1	27.3	35.4	25.3	2.28	1.02	-6.99**
7. When young children have been included in family therapy sessions, they should be excluded when topics which are sensitive to the parents are discussed.	27.6	25.5	27.6	12.2	7.1	3.54	1.21	4.39**
8. Young children should be included in family therapy sessions only when they are the identified patient.	3.0	4.0	12.1	27.3	53.5	1.76	1.02	-12.11**

*$p < .005$
**$p < .0001$

[a]Degrees of freedom on items 3, 5, and 7 are 97.

Table 5

Distribution of "Percentage of Time Including Young Children in Family Therapy Sessions" Scores (n = 89)

Range (%)	Percentage of Sample
0	9.3
1-20	34.0
21-40	14.4
41-60	10.3
61-80	14.4
81-99	12.4
100	5.2

Note: mean = 41.1; median = 30; mode = 10; S.D. = 33.7
n = 97

Table 6

Distributions, Means, and t-Values for Items Assessing Practices When Including Young Children in Family Therapy

Item	Distribution (%)					M	S.D.	t (df = 84)[a]
	SA	A	N	D	SD			
1. I encourage young children to utilize play materials as part of the therapeutic process.	11.9	30.9	36.9	15.5	4.8	3.29	1.03	2.66
2. I ask children direct questions about the therapeutic process.	10.7	45.2	27.4	13.1	3.6	3.46	.97	4.36*
3. I directly interpret the significance of young children's verbal and nonverbal behavior to the family as part of the therapeutic process.	9.4	44.7	34.1	10.6	1.2	3.51	.85	5.46*
4. I use young children's verbal and nonverbal behavior only for the assessment of the family and child, as the basis of future interventions.	9.4	29.4	40.0	17.7	3.5	3.24	.97	2.23
5. I directly participate in young children's play as part of the therapeutic process.	5.9	29.4	35.3	17.7	11.8	3.00	1.09	0.00
6. I attempt to keep young children involved in the therapy process.	11.8	24.7	38.8	22.4	2.4	3.21	1.00	1.95

*$p < .0001$

[a]Degrees of freedom for item 1 are 83.

APPENDIX A

Review of Literature

Literature Review

Introduction

Family therapy is a distinct form of psychotherapy. It is set apart from the individual and group psychotherapies by its focus on the family as the unit of treatment. The emphasis on the family as the focus of treatment is based on the concepts of general systems theory (vonBertalanffy, 1968). A system has been defined as "a set of objects with relationships between the objects and between their attributes" (Hall, 1962, p. 60). When this definition is applied to the family, the objects to which it refers are the individual members of the family. The concept of the family as a system recognizes that family members exert an influence upon and are influenced by other family members. There is some disagreement, however, about the boundaries of the family, that is, who is included in the family. Broderick and Lewis (1979) noted that most family experts include the household kin group as the family system. They further noted, however, that some include the wider friend-kin network, while others limit the family system to triads or dyads within the household kin group. Although some family therapy experts have written about the family as a system and view the family as the unit of treatment, their interventions are more frequently with individuals or couples (see Bowen, 1978; Watzlawick, Weakland, & Fisch, 1974). Such a practice is based on the idea of a ripple effect, the notion that changing any part of a system will influence the rest of the system. Bowen (1978), for example, works primarily with individuals, designing

interventions which are aimed at altering the family structure. The Mental Research Institute (MRI) group (Watzlawick, Wealkand, Fisch, 1974) also intervene primarily with individuals. Their interventions are also designed to impact the family system to initiate a family structure change. Other theorists working from the framework of Milton Erickson (e.g., Haley, 1973) may also intervene primarily at the individual level, but use interventions which are based on and intended to alter the family structure. It should be noted, however, that working primarily with one family member provides no "cross-observer validation" of the client's reports and does not provide a first-hand view of the changes which have been initiated in the family. Others have enthusiastically recommended the household kin group as the unit of treatment (Haley, 1976; Minuchin, 1974; Palazzoli, Boscolo, Ceechin, & Prata, 1978). Thus, there is some disagreement within the profession concerning the need for all family members to participate in family therapy sessions. One of the areas of disagreement concerns the participation of preschool age and younger children.

In her classic book Conjoint Family Therapy, Virginia Satir (1964) listed six questions concerning the issue of young children in family therapy. They were: (1) should the therapist include all the children who are in the family, even the little ones? (2) should the therapist limit treatment to the parent(s) and the child who happens to have the symptom? (3) should the therapist include children from the very beginning of treatment, and if not, when

should they be brought in? (4) how long should children stay in therapy sessions? (5) what guidelines should the therapist follow to keep control of the therapy sessions? and (6) does the presence of children turn family therapy into child therapy? Despite these questions, Kniskern reviewed the literature through 1979 and reported that no study had directly addressed the issue of children in family therapy. A review of the Readers' Guide to Periodical Literature (H. W. Wilson Co., 1980-1984), the Psychological Abstracts (American Psychological Association, 1980-1984), the Inventory of Marriage and Family Literature (Olson, 1980, 1981; Olson & Markoff, 1982-1984), the Sociological Abstracts (Sociological Abstracts, Inc., 1980-1984), and the Sage Family Studies Abstracts (Sage Publications, 1980-1984) reporting on the literature in the subsequent five year period also revealed no such studies. In one related study of licensed behavioral science practitioners in the state of Virginia, McComas, Protinsky, and Moran (1985) surveyed 400 randomly selected Clinical Social Workers, Licensed Professional Counselors, and Psychologists, and received 218 responses. Of these, only 76 (34.9%) indicated they included children of any age in their practice. Nearly 90% of these treated children exclusively between the ages of 9 and 17, with only 12% including children under the age of five. It appears then, that even though Satir raised questions about children's participation in family therapy in 1964, very little research has been published since that time which has directly addressed her questions. There is, however, a great deal of opinion on some of these issues.

Rationale

Early in the family therapy movement, Wynne (1965) and Ackerman (1966) implied that all family members, regardless of age, should be included in family therapy. Both stated that all family members who are involved in the family process should be included in family therapy. In their view, the concept of the family as a system suggests that all family members are involved in the family process. Augenbraum and Tasem (1966) directly suggested that preschool children be included in family therapy. Other family therapy pioneers who stressed the importance of including all family members regardless of age were Boszormenyi-Nagy and Ulrich (1981), Haley (1976), and Minuchin (1974). However, the above authors either offered no clearly elucidated rationale for their recommendations, or did not offer any practical suggestions to facilitate the implementation of such recommendations, or offered neither.

Some authors, however, have provided a rationale for including young children in family therapy sessions. In a later article, Ackerman (1970) recommended that young children be included because they help in the "elucidation...of the family war" (p. 403). By this he meant that young children helped in the identification of family processes and transactions. Bloch (1976) agreed, stating that including all children from the beginning aids in illuminating family processes, dynamics, alliances, and themes. He also reported the opinion that including young children helps the family to maintain the progress it has made by stating that it helps avoid "unravelling the therapeutic knitting" (p. 173) between sessions.

It was Malone's (1979) belief that young children are more likely to reveal the feelings and conflicts upon which family transactions are based. They are also useful, he believed, as a basis for looking for family strengths and information for the future interventions. Finally, he believed that when older children were also in the family, the presence of all the children provided a demonstration of how the family interacted with children at different developmental stages. Such a demonstration would provide information about parenting abilities, and the relative flexibility of the family system.

Zilbach, Bergel, and Gass (1972) also reported the view that the therapist's understanding of the family process is enhanced when including young children. They stated that young children help express family functioning through non-verbal modes of expression, and they provide a view of an important aspect of family life and interaction (parenting and parent-child interactions). They also stated the opinions that young children may serve as a defense against anxiety because families tend to focus on their young children when therapy provokes anxiety, and that young children aid in gaining access to the family's problems. In the view of these authors then, the therapists' understanding of the family is enhanced when including children because (1) children are more direct and honest than adults; (2) children may express through play, issues that the family has difficulty introducing; (3) children seem to make the family dynamics more visible; and (4) children can provide clues to the underlying family issues.

Other authors have also reported that young children's presence in family therapy helps to promote understanding of the family process. Flashman (1982) reported that young children provide "valuable information about the family relationship system" (p. 51). Dare and Lindsey (1979) reported that young children "demonstrate the anomalies, strengths, and conflicts of the current interactional system" (p. 253). They also stated that preschool children and toddlers reflect the high tension present in the therapy session when topics of impact are discussed because of their reactivity to the family system.

While the above authors have stressed the ways in which young children help in the assessment of the family system, others have stressed the dynamic part they play in family therapy. Guttman (1975) stated that children were valuable members of families in treatment because: (1) they may express the family's resistance to change by interfering with attempts to unbalance the family's homeostasis; or (2) they may act as family change agents by behaving in ways that unbalance the family homeostasis. Dowling and Jones (1978) suggested that young children participate in family therapy because they bring repressed issue to the surface. They also echoed the notion that young children serve as an index of the current family affect and functioning because of their openness, and lack of sophisticated, established defenses.

Problems

Undoubtedly there are problems posed by the presence of young children. Satir (1964) cited the issues of young children's short

attention span, their inability to attend to the verbal process, and their potential for distraction as problems. The problems described by Andolfi (1979) were: (1) the disruptions they will inevitably cause, (2) the difficulty of simultaneously appropriately interacting with persons of differing age groups, (3) the therapist's fear of losing control of the situation, (4) the therapist's desire to protect the child from the family or the family from the child, and (5) the context may be too adult. The potential for distraction was also stressed by Digiuseppi and Wilner (1980).

Other authors have cited problems of a different nature. McDermott and Char (1974), for example, wrote about the danger of ignoring the psychiatric needs of children in family therapy sessions, addressing what they believed to be problems of the therapists, not problems that are caused by the young children themselves. They stated, "family therapists do not appear to use suitable approaches for younger problem members with their changing, shifting natures" (p. 427). They were concerned that family therapists will not learn or exercise skills necessary to permit children to be open and honest. Therefore, the individual needs of the child may be lost, they concluded.

The same point of view was stated by Heard (1978) and Levant and Haffey (1981). Heard noted the importance of attending to the young child's inner state while the child is involved in family therapy. Heard added that structural family therapists comment very little on this in the literature as a means of differentiating

themselves from other therapists. Levant and Haffey stressed the importance of viewing the child within the context of the family as both a member of the family and as an individual at a particular stage of development in his or her own life cycle. The family therapist must, they reported, be aware of the family's stage of development as well as the child's stage of development while conducting assessment, planning, and intervention activities.

Limitations

Because of the problems posed by the presence of young children in family therapy, some authors have proposed various methods for limiting the young child's presence. The most frequently reported suggestion is to involve the young child only in the assessment phase of treatment, and exclude them in the intervention phase (Digiuseppi & Wilner, 1980; Satir, 1964). It must be noted, however, that such a practice poses serious practical problems for therapists whose assessment and intervention activities overlap and are intertwined. Examples of such approaches include strategic approaches (Haley, 1976) and structural approaches (Minuchin & Montalvo, 1972) in which interventions are made to both assess the family's response and to initiate change.

Palazolli, Boscolo, Ceechin, and Prata (1978) recommended that children under the age of three years old be excluded from family therapy. They reported that such children could not participate in the therapy process. Another variation on the theme of excluding young children from family therapy was noted by Flashman (1982). She advocated including young children when an older sibling is the

identified patient, and as part of the assessment process in marital therapy, to assess the status of the parenting role.

The most comprehensive listing of limitations has been offered by Kniskern (1979). He recommended beginning family therapy with the entire nuclear family, including both natural parents if they are separated, and all other people who live in the household. He stated the opinion that the presence of young children seems to enhance the family's engagement in therapy, offsetting whatever disruption or distraction they present. He then recommended young children be excluded: (1) if after the evaluation it is determined that the parent(s) or parental relationship is symptomatic; (2) if the parents need to deal with issues which are unacceptable to them in front of the children; (3) if the child requests exclusion, because such a request usually demonstrates an adequate level of differentiation; (4) if adequate progress is being made, but kept in therapy where progress is slow; and (5) in the later stages of therapy. This last recommendation is based on the belief that such a practice would be growth producing, and aid in the differentiation process.

Practical Recommendations

The literature also includes recommendations concerning how to deal with the problems presented when young children are included in family therapy. The most frequent recommendation was the inclusion and use of play materials and play therapy techniques (Andolfi, 1979; Augenbraum & Tasem, 1966; Bloch, 1976; Dare & Lindsey, 1979; Dowling & Jones, 1980; Levant & Haffey, 1981; McDermott & Char, 1974;

Zilbach, 1982; Zilbach et al., 1972). Andolfi reported that the utilization of play facilitates young children's participation by putting them at ease, helping to make the therapeutic context seem familiar to them, allows communication and an avenue for safe expression of feelings, and provides a means by which the children can withdraw if they become too anxious. He reported that play can also serve as a means of gathering information. Having the family play together can provide information about the permeability of systems boundaries, the dyadic ties and alliances, and the rigidity of the system. Thus, according to Andolfi, play is the primary technique by which children can be included in family therapy without treating them as miniature adults.

One article (Zilbach et al., 1972) included a list of recommended play materials. They were the standard play therapy room materials and included: drawing paper, crayons, watercolors, finger paints, blackboard and chalk, plasticine, building blocks, checkers, cards, soldiers, toy pistol, and a furnished doll house with "Flagg Dolls." In a later article, Zilbach (1982) offered a similar list which did not include the "messy" materials, watercolors and fingerpaint, citing the importance of the therapist's placing limits on young children.

Another frequently cited recommendation is the avoidance of asking direct questions to the young children concerning the therapeutic process (Dowling & Jones, 1980; Flashman, 1982; Zilbach, 1982). Zilbach (1982) further specified that since young children cannot think in terms of "why," they should not be asked "why" questions.

Related to such a concept is the recommendation by Guttman (1975) that the therapist not directly interpret young children's verbal and non-verbal input in the session. Instead, he suggested, the information obtained from the input should be used as the basis for future interventions, such as enactments, or directives to be carried out between sessions.

Dare and Lindsey (1979) stated that it is the therapist's, not the parents', responsibility to keep the children involved in the therapy session, although they provided no guidelines for implementing their suggestion. Zilbach and her colleagues (1972) offered some suggestions that may be helpful in this regard. They were: (1) the therapist should show respect for each child as a person and the family hierarchy; (2) no person in the family, especially the child, should be required to answer the questions; and (3) the therapist should make an effort to use simple language. Zilbach (1982) later added that the therapist should set limits during the session and provide a safe environment in which children can move around.

Recommendations have also been made by Bloch (1976) who stated the necessity for the therapist to be equally available to all family members. In addition, family therapists, when young children are present should: (1) each family member "by hand or eye, and by direct speech" (p. 175); (2) use metaphors which the child introduces both in communicating with the family and as part of interventions; (3) childproof the office by placing dangerous or valuable items out of the young child's reach; and (4) include simple, soft, quiet toys, and nonstaining construction and art materials to

facilitate the young child's play.

Only one commentary was found which described a methodology by which to apply child development principles to family therapy when young children were involved. Augenbraum and Tasem (1966) proposed conducting the therapy in a play therapy room. They confined their comments to a description of the uses of family therapy and did not describe any specific techniques to be used with young children. They reported that conducting family therapy in a playroom gives the child the opportunity to move around, and to play.

Summary

The review of the literature describes various recommendations concerning the issue of whether young children should or should not be included in family therapy. The recommendations include various authors' opinions about the conditions under which they should be included and excluded, reasons for such recommendations and suggestions for facilitating the participation of young children in family therapy. In short, the review of the literature demonstrates the conclusion of Gurman and Kniskern (1981) that "insufficient data exist to support any assertions about the necessity of always including two or more generations in the treatment of marital or family dysfunction" (p. 750).

The review also demonstrates the lack of clarity concerning any differences between two-generation family therapy with young children present, two-generation family therapy with the parents and the identified patient, and one-generation family (marital) therapy, in

terms of what actually happens within the sessions, and outcome. Also lacking are clearly elucidated paradigms and procedures for bridging generations which are grounded in the dominant family therapy approaches.

What emerges from the review is the need for a clearly developed theoretical model for treating young children, which is grounded both within a dominant school of family therapy (e.g., structural or strategic) and within child development principles. Although arguments are made for including the young children, there are very few specific guidelines about how this is actually put into practice. For example, does the therapist talk to the adults while the child plays or are all members engaged in a common task? What is the therapist's role in this process? It appears that these issues need clarification in bringing theoretical constructs to an applied practical level.

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APPENDIX B

The Questionnaire

COLLEGE OF HUMAN RESOURCES

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Blacksburg, Virginia 24061 - 8299

DEPARTMENT OF FAMILY AND CHILD DEVELOPMENT (703) 961-4794 or 4795

Dear Colleague,

We are conducting research on the attitudes, practices, and reasons for such practices in regard to the inclusion of young children in family therapy. There seems to be some controversy in the field as to whether or not young children (those ages four and under) should be invloved in family therapy. Your help by completing and returning this questionnaire will be appreciated as a contribution to identifying the current rationale and practices on this topic. Your answers may lead to the extension or revision of family therapy theory in this regard. Each questionnaire is coded for follow-up purposes. Your answers will be kept strictly confidential and analyzed only as group data. Your completing and returning this questionnaire will constitute your consent that the data may be used for the stated purposes. The questionnaire should take less than 15 minutes of your time. A stamped, self addressed envelope is included for your convenience.

Thank you in advance for your cooperation.

Sincerely,

Philip D. Greenwood. MS

James D. Moran, III, PhD

ID ______

Children in Family Therapy Questionnaire

Section I: Background Information

1. Age: ____

2. Sex:
   - __ Female
   - __ Male

3. Current marital status:
   - __ Never married
   - __ Married
   - __ Separated
   - __ Divorced
   - __ Widowed

4. Race:
   - __ Black
   - __ White
   - __ Other

5. Highest degree earned:
   - __ Bachelors (BA/BS)
   - __ Masters (MA/MS)
   - __ Doctorate (PhD/MD/DSW/etc)
   - __ Other (please specify) ______________________________

6. Field of highest degree:
   - __ Anthropology
   - __ Child Development
   - __ Education
   - __ Family Studies
   - __ Guidance and Counseling
   - __ Human Development
   - __ Law
   - __ Marriage and Family Therapy
   - __ Medicine
   - __ Nursing
   - __ Obstetrics and Gynecology
   - __ Pastoral Counseling
   - __ Psychiatry
   - __ Psychology
   - __ Rehabilitation Counseling
   - __ Religion/Theology
   - __ Social Work
   - __ Sociology
   - __ Other (please specify) ______________________________

7. Current professional position (if more than one, please rank from highest percentage of time to lowest percentage of time spent in each position, with "1" as highest):
   __ Administrator
   __ Attorney
   __ Educator
   __ Medical practitioner
   __ Minister
   __ Therapist/counselor
   __ Social worker
   __ Other (please specify) ______________________________

8. Current professional identity (if more than one, please rank in terms of strongest to weakest affiliation, with "1" as strongest):
   __ Family therapist/counselor
   __ Group therapist
   __ Guidance counselor
   __ Marriage and family therapist
   __ Marriage counselor
   __ Mental health counselor
   __ Minister
   __ Nurse
   __ Pastoral counselor
   __ Physician
   __ Professional counselor
   __ Psychiatrist
   __ Psychiatrist, child
   __ Psychologist, clinical
   __ Psychologist, child
   __ Psychologist, school
   __ Sex therapist
   __ Social worker
   __ Social worker, clinical
   __ Sociologist, clinical
   __ University professor
   __ Other (please specify) ______________________________

9. Realizing that most therapists utilize a variety of techniques but organize their data collection within a general theoretical framework, what do you consider to be your theoretical framework (if more than one, please rank from most to least dominant, with "1" as most):
   __ Behaviorism
   __ Client-centered
   __ Cognitive behaviorism
   __ Communications
   __ Family systems
   __ Gestalt
   __ Humanism
   __ Psychodynamic
   __ Reality approach
   __ Rational emotive
   __ Teleological (Adlerian)
   __ Other (please specify) ______________________________

10. During the past three months have you engaged in the practice or supervision of family therapy?
    __ Yes (Please complete and return the remainder of the questionnaire.)
    __ No (Please return the questionnaire with questions 1 - 10 completed.)

11. During the past three months, how many hours each week have you practiced and/or supervised family therapy, on the average? _____

Section II: Attitudes

A. In general, when you are treating families which have young children (under five years of age), the inclusion of young children (circle the number of the phrase which best completes the sentence):

1 always inhibits the therapeutic process
2 generally inhibits more than enhances the therapeutic process
3 is irrelevant to the therapeutic process
4 generally enhances more than inhibits the therapeutic process
5 always enhances the therapeutic process

B. The following reasons have been suggested for including young children in some stage of family therapy. Please indicate your opinion of each statement on a scale of 1 to 5, from strongly disagree to strongly agree, by circling the appropriate response.

		SD				SA
1.	They facilitate rapport building with the family.	1	2	3	4	5
2.	They serve as an index of family anxiety.	1	2	3	4	5
3.	They bring hidden issues to the surface by their play and fantasies.	1	2	3	4	5
4.	They can be used as a basis for identifying family strengths.	1	2	3	4	5
5.	They are indicators of family processes and/or dynamics.	1	2	3	4	5
6.	They are more honest and open than adults in therapy settings.	1	2	3	4	5
7.	They provide the opportunity to observe inter-generational relations and parenting skills.	1	2	3	4	5
8.	They provide information which can be used in future interventions.	1	2	3	4	5
9.	They provide information about how the family deals with family members at different developmental levels when older children are present.	1	2	3	4	5

C. The following reasons have been suggested for excluding young children from family therapy sessions. Please indicate your opinion of each statement on a scale of 1 to 5, strongly disagree to strongly agree, by circling the appropriate response.

		SD				SA
1.	Their distraction interferes with the therapeutic process	1	2	3	4	5
2.	Their lack of verbal skills interferes with the therapeutic process.	1	2	3	4	5
3.	Their inability to follow the verbal process interferes with the therapeutic process.	1	2	3	4	5
4.	Parents are generally unwilling to bring their young children with them to family therapy sessions.	1	2	3	4	5

D. Please indicate your opinion of the following statements on a scale of 1 to 5, from strongly disagree to strongly agree, by circling the appropriate response.

		SD				SA
1.	When young children are included in family therapy, they should be kept in therapy for the entire treatment course.	1	2	3	4	5
2.	When young children are included in family therapy sessions, they should be included only during the evaluation phase.	1	2	3	4	5
3.	Young children should be included in family therapy sessions when the identified patient is a parent or the parental relationship.	1	2	3	4	5
4.	When young children have been included in family therapy sessions, they should be excluded when they request exclusion.	1	2	3	4	5
5.	When young children have been included in family therapy sessions, they should be excluded in the later stages of therapy.	1	2	3	4	5
6.	When young children have been included in family therapy sessions, they should be excluded when adequate progress is being made (but kept in if little or no progress is being made).	1	2	3	4	5
7.	When young children have been included in family therapy sessions, they should be excluded when topics which are sensitive to the parents are discussed.	1	2	3	4	5
8.	Young children should be included in family therapy sessions only when they are the identified patient.	1	2	3	4	5

E. In your opinion, are there any topics that are so sensitive that they should not be discussed in the presence of young children? Yes __ No__

If yes, please indicate each of the following topics that you believe are significantly sensitive to most families so that they should not be discussed in the presence of young children (please check all that apply):

__ Alcohol history of family member
__ Child abuse/neglect
__ Conflicts with relatives
__ Conflicts usually resulting in the loss of control of parent(s)
__ Criminal history of parent(s)
__ Death of family member
__ Drug history of family member
__ Financial issues
__ Incest (or alleged incest) within the family
__ Ostracized family members
__ Parenting conflicts
__ Psychiatric history of family member
__ Sex therapy of parents
__ Sexual topics in general
__ Spouse abuse
__ Suicide of family member
__ Others, please list______________________________

____

____

Section III: Practice

The following items pertain to therapist's practice with young children in family therapy.

A. During the last year, when treating families which have young children, what percentage of the time did you include these children at any point in the therapy sessions? _____%

If you answered "0%":
1. Is it because you do not have an appropriate treatment environment for young children at your disposal? Yes __ No __
2. Did you ever include young children in family therapy sessions? Yes __ No __
   If yes, for what reasons did you stop (please list)?

____

____

____

3. Please skip part B.

B. If you did not answer "0%" to part A, please indicate by circling the appropriate response, to what degree each of the following statements describes your family therapy practices, according to the following scale:

never   always
1   2   3   4   5

		never				always
1.	I encourage young children to utilize play materials as part of the therapeutic process.	1	2	3	4	5
2.	I ask children direct questions about the therapeutic process.	1	2	3	4	5
3.	I directly interpret the significance of young children's verbal and nonverbal behavior to the family as part of the therapeutic process.	1	2	3	4	5
4.	I use young children's verbal and nonverbal behavior only for the assessment of the family and child, as the basis of future interventions.	1	2	3	4	5
5.	I directly participate in young children's play as part of the therapeutic process.	1	2	3	4	5
6.	I attempt to keep young children involved in the therapy process.	1	2	3	4	5

Comments:

APPENDIX C

Supplementary Procedure Information

Follow-Up Postcard

PLEASE FILL OUT AND RETURN THE
QUESTIONNAIRE FROM PHILIP D.
GREENWOOD. THANK YOU.

Human Subjects

The important characteristic of the subjects is that they are members of the AAMFT, the major organization of marriage and family therapists in the United States. No restrictions were be placed on the subjects' age, race, sex, marital status, health, or other demographic data.

Consent was obtained by explaining that the return of the questionnaire constitutes consent that the data can be used for the stated purposes. Such a statement was included in the cover letter to the prospective subjects. The cover letter described the purpose of the survey, the potential usefulness of the information to the field of marriage and family therapy, and the confidential nature of the data (see Appendix B).

It is anticipated that there will be no risk to the prospective subjects. The anticipated benefits will include the knowledge of the practices of marriage and family therapists in relation to the inclusion of young children in family therapy, and the rationale for such practices. The results may have implications for the revision or extension of family therapy theory.

APPENDIX D

Distribution of Sample Characteristics

Distribution of Sample Characteristics

Characteristic	%
Sex	
Female	45.6
Male	54.4
Marital Status	
Never married	7.3
Married	78.2
Separated	4.0
Divorced	7.3
Widowed	3.2
Race	
Black	0.8
White	98.4
Other	0.8
Degree	
Masters	60.0
Doctorate	40.0

APPENDIX E

Percentage Scores For All Reported Fields of Highest Degree

Percentage Scores for All Reported Fields of Highest Degree

	Rank	%
Social Work	1	28.0
Psychology	2	26.4
Marriage and Family Therapy	3	13.6
Pastoral Counseling	4	8.8
Guidance and Counseling	5	5.6
Religion/Theology	6	4.8
Education	7	2.4
Psychiatry	7	2.4
Sociology	9	1.6
Child Development	9	1.6
Anthropology	12	0.8
Family Studies	12	0.8
Human Development	12	0.8
Medicine	12	0.8
Law	16	0.0
Nursing	16	0.0
Obstetrics/Gynecology	16	0.0
Rehabilitation Counseling	16	0.0

Note. n = 125

APPENDIX F

Percentage Scores for all Reported Current Professional Positions

Percentage Scores for All Reported Current

Professional Positions

	Rank	%
Therapist	1	66.7
Administrator	2	8.7
Educator	3	7.9
Other	4	6.3
Minister	5	4.8
Social Worker	6	3.9
Physician	7	1.6
Attorney	8	0.0

Note: Data refer to first choice responses.

APPENDIX G

Percentage Scores for all Reported Current Professional Identities

Percentage Scores for All Reported Current Professional Identities

	Rank	%
Marriage and Family Therapist	1	27.0
Clinical Psychologist	2	12.7
Family Therapist	3	11.9
Clinical Social Worker	4	11.1
Pastoral Counselor	5	7.9
Professor	6	7.1
Other	7	4.0
Minister	8	3.2
Mental Health Counselor	9	3.2
Social Worker	10	2.4
Professional Counselor	11	1.6
Psychiatrist	11	1.6
Child Psychologist	11	1.6
School Psychologist	11	1.6
Marital Therapist	11	1.6
Group Therapist	16	1.6
Guidance Counselor	16	.8
Sex Therapist	18	.0

Note. Data refer to first choice responses; n = 126.

APPENDIX H

Rank and Frequency of Each Reported Sensitive Topic

Rank and Frequency of Each Reported Sensitive Topic

Topic	Rank	Frequency
Sex Therapy	1	86
Criminal History	2	39
Incest	3	38
Spouse Abuse	4	26
Suicide of Family Member	5	21
Parenting Conflict	6	18
Sexual Topics	6	18
Psychiatric History	8	17
Drug History	9	14
Finances	10	13
Loss of Control	10	13
Alcohol History	12	11
Child Abuse and Neglect	12	11
Other	12	11
Death of Family Member	15	4
Ostracised Family Member	15	4
Religious Conflicts	17	3

APPENDIX I

Comparison of Demographic Characteristics for Practicing and Non-Practicing Respondents

Comparison of Demographic Characteristics for Practicing Respondents and Non-Practicing Respondents

Characteristic	Percent of Respondents: Practicing (n = 100)	Percent of Respondents: Non-Practicing (n = 26)
Degree		
Masters	65	42
Doctoral	35	58
Field of Degree		
Marriage and Family Therapy	14	12
Psychology	28	19
Social Work	29	23
Position		
Therapist	71	54
Professional Identity		
Marriage and Family Therapist	49	19
Psychologist	15	19
Social Worker	13	19
Theoretical Framework		
Family Systems	46	23
Sex		
Female	49	31
Male	51	69

APPENDIX J

Comparison of Demographic Characteristics for Practicing Respondents

Who Included Young Children < 50% or > 50% of the Time

Comparison of Demographic Characteristics for Practicing Respondents

Who Included Young Children < 50% or > 50% of the Time

Characteristic	Percent of Respondents	
	< 50% (n = 31)	> 50% (n = 66)
Degree		
Masters	63	71
Doctoral	37	29
Field of Degree		
Marriage and Family Therapy	19	6
Psychology	32	19
Social Work	26	36
Position		
Therapist	71	71
Professional Identity		
Marriage and Family Therapist	53	45
Psychologist	15	13
Social Worker	12	10
Theoretical Framework		
Family Systems	42	59
Sex		
Female	57	35
Male	43	65

APPENDIX K

Percentage Scores for all Reported Theoretical Frameworks

Percentage Scores for All Reported Theoretical Frameworks

	Rank	%
Family Systems	1	41.3
Psychodynamic	2	24.6
Client Centered	3	9.5
Other	4	5.6
Cognitive Behavioral	5	4.8
Reality Approaches	5	4.8
Gestalt	7	2.4
Communications	8	1.6
Humanistic	8	1.6
Rational Emotive	8	1.6
Behavioral	8	1.6
Individual Psychology	11	.8

Note. Data refer to first choice response; n = 126.

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