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THE THEORY, STRUCTURE, AND TECHNIQUES FOR THE INCLUSION OF CHILDREN IN FAMILY THERAPY: A LITERATURE REVIEW

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Many barriers prevent therapists from including young children in family therapy, despite the theoretical belief that every family member should be present. Although there is a wealth of literature describing how to include children, the information has not been compiled in a way that is easily accessible to therapists. In this article, we report the findings of an exhaustive and systematic literature review of 64 publications, published between 1972 and 1999, related to including children in family therapy. The purpose of this article is to offer therapists a succinct compilation of theoretical, structural, and practical aspects as well as a comprehensive listing of specific techniques for including children in family therapy.

Many of the founders of couple and family therapy, including Ackerman, Satir, Haley, and Whitaker, argued strongly that family therapy should include every family member, particularly children (Gil, 1994; Zilbach, 1986). Whitaker, Satir, and Minuchin included children in family therapy as a matter of course (Gil, 1994; Zilbach, 1986). In 1970, Ackerman wrote an article entitled, "Child participation in family therapy", in which he advocated for the inclusion of children in family therapy, despite the challenges it poses. Montolvo and Haley (1973) discussed ways in which the structural aspects of individual play therapy with a child can affect the family system. A generation later, Keith and Whitaker (1981) stated: "We find again and again that families change less and more slowly when children are not part of the therapy process" (p. 244).

Despite the advocacy to include children, the youngest members of the family are often excluded from the family therapy process. In a survey of 173 couple and family therapists, Korner and Brown (1990) discovered that 40% of the surveyed therapists never include children in therapy, and that 31% of therapists invited children to session, but did so without including them as active participants. Johnson and Thomas (1999) found that 49% of the therapists in their survey believed it appropriate to exclude children if the therapist was uncomfortable with their inclusion. "Thus we are faced with the contradiction that a fundamental principle of family therapy [systems theory] is being widely violated by its own adherents" (Zilbach, Bergel, & Gass, 1972, p. 386). Family therapists do not take as much notice of children in practice as they do in theory (O'Brien & Louden, 1985).

One explanation for family therapists' failure to include children in therapy can be located in the state of the relevant literature. Since the 1950s, the disciplines of family therapy and play therapy have developed simultaneously but separately (for a description of both histories, see Miller, 1994). Although there has been some movement in both fields toward a recognition of the other's validity, there has traditionally been exclusion on both sides (Miller, 1994). Some therapists work only with the parents, whereas others work

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only with the children. Family therapists often accuse child therapists of pathologizing children, whereas child therapists often assert that family therapists ignore or oversimplify children's intrapsychic processes (Wachtel, 1994). Unfortunately, this polarization has left a scattered and limited literature that provides recommendations for integrating family and play therapy (Racusin & Kaslow, 1994; Schatz, 1998).

The successful integration of family therapy and play therapy requires the merging of concepts from both fields. As argued by Villeneuve and LaRoche (1993), "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" (p. 108). Without such integration, therapists may be convinced that including children in family therapy affords theoretical consistency, provides numerous advantages for families, and contributes richly to the therapeutic process, yet they may remain unaware of and unskilled in the most common and effective practices for including children in family therapy. They may be unsure of how to structure the sessions, who to include, what presenting problems are appropriate, what materials are needed, or what techniques to use.

Although the family therapy literature is relatively sparse with respect to the inclusion of children in family therapy (Korner, 1988; O'Brien & Louden, 1985; Wachtel, 1994), there have been a significant number of scholarly articles published on the topic over the last three decades. This literature holds a wealth of theory, suggestions, and techniques that can guide therapists toward successfully incorporating children into family therapy; yet this valuable information has not been comprehensively gathered and synthesized. The purpose of this article is to offer therapists a succinct compilation of theoretical, structural, and practical aspects for including children in family therapy.

A comprehensive literature search was conducted to locate publications that discuss theoretical, structural, or practical techniques for including children in family therapy. A total of 64 publications (40 journal articles and 24 book chapters), published between 1970 and 1999, were reviewed. Eleven of the publications were written in the 1970s, 14 in the 1980s, and 39 in the 1990s. Although it would be unduly difficult to locate every article written on this topic, this sample of publications represents the majority of relevant manuscripts and provides a means of identifying trends in and practices for including children in family therapy.

Rigorous analysis and summarization techniques were used to glean information from these publications. Information was sought to answer the following questions related to the theoretical, structural, and practical aspects of therapy. With regard to theoretical aspects, the following questions were addressed: Why are therapists reluctant to include children in family therapy? What are the benefits of including children in family therapy? Why is play important when including children in family therapy? What theoretical orientations are appropriate for including children in family therapy? Why is it important to address diversity issues in family therapy? In terms of structural aspects, the following questions were addressed: How old should children be to participate in family therapy? What presenting problems can be addressed when including children in family therapy? How is treatment typically structured when children are included? Finally, with regard to practical aspects of therapy, the following questions were addressed: What materials are needed for including children in family therapy? How can therapists create a safe therapeutic context for children? For adults? What are specific therapeutic techniques for the inclusion of children in family therapy?

THEORETICAL ASPECTS OF INCLUDING CHILDREN IN FAMILY THERAPY

Why Are Therapists Reluctant to Include Children in Therapy?

There are numerous reasons why therapists may not involve children in the process of family therapy. First, couple and family therapists receive little or no training to work with children, and they often lack confidence about how to adequately engage children in family therapy (O'Brien & Louden, 1985; Zilbach, 1986). Family therapists who receive direct training involving children are more likely to have high caseloads of children, and therapists who lack training are reluctant to include children as part of the therapy process (Korner & Brown, 1990). Therapists may also exclude children from therapy because they may not be personally comfortable with children (Johnson & Thomas, 1999; Korner, 1988).

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Second, the differing developmental levels in adults and children make it difficult to conduct therapy that is simultaneously appropriate for both age groups (Gil, 1994; Korner, 1988). Children are often seen as too young to benefit from therapy because of linguistic and cognitive immaturity. Therapists are generally trained to conduct talk therapy, and it is difficult to converse with a child for 50–90 min (Carr, 1994; Korner, 1988). Children can often be disruptive or unable to express themselves appropriately, and they may be seen as "annoying" or "distracting" when they frequently interrupt (Schaefer & Carey, 1994). Children also need to touch and explore things to gain mastery and may find it difficult to sit still or stay in one place long enough to participate in talk therapy (Korner, 1988).

Other reasons therapists do not include children in therapy may be because room arrangements are not conducive for the inclusion of children, parents and therapists are often reluctant to expose children to some sensitive family issues (particularly adult issues), and therapists may fear losing professional credibility with parents if they try to include children in therapy and fail (Korner, 1988; Miller, 1994).

The final, and perhaps most fundamental, reason therapists do not include children is because appropriate child therapy techniques are difficult to find (Gil, 1994). As mentioned, although there are some excellent, isolated methods dispersed throughout the literature of psychology, play therapy, social work, and couple and family therapy, there are few resources that comprehensively combine these techniques in an applicable manner (Green, 1994).

What Are the Advantages of Including Children in Therapy?

Despite the difficulties that including children might create in the therapeutic process, there are also many advantages. Working with the entire family helps to redefine the child's problem as the family's problem (Eaker, 1986). The inclusion of all family members allows therapists to observe how each family member contributes to the problems and growth of the family (Gil, 1994; Zilbach, 1986). Children have a right to participate in the process of solving problems that they and their families face, as well as the right to be carefully considered as equal members of their families (Carr, 1994; Korner, 1988).

As individuals, children naturally bring many strengths into the family system, and thereby, into the therapy room. Their spontaneity and candor can bring issues quickly into the open (Gil, 1994; Zilbach, 1986). Unlike adults, children are less inhibited by social and familial constraints and will often tell it like it is (Korner, 1988). "Children tend to break up the compulsive devotion to words, to increase our personal participation . . . [and] force [us] to use more nonverbal communication" (Whitaker, 1982, p. 128). Children often act as the tip of the iceberg by making family problems visible to others by being the symptom bearers who call attention to the family's needs (Eaker, 1986; Zilbach, 1986). Zilversmit (1990) recommended using young children's state of continual transformation as a metaphor for change that provides hope and reflects the possibility of growth in a family.

Why Is Play Important When Including Children in Family Therapy?

Because working with children requires a certain amount of spontaneity and adaptability, the flexible structure of family therapy makes it particularly suitable for children's participation (Villeneuve & LaRoche, 1993). To include children as participants in the therapeutic process, however, therapists must adapt their strategies to the child's level of development (Villeneuve, 1979). Play (the use of toys, art, drama, or games) is a child's medium for communication, and when play is included in family sessions, children are treated as equally important family members with valuable information to offer and assimilate (Gil, 1994).

The use of play in family therapy provides many advantages for children and adults alike. Play provides a medium for both direct and indirect communication and can lead to a decrease in anxiety regarding the therapeutic setting (Eaker, 1986; Miller, 1994; Zilbach, 1986). During play, family members are allowed to relate in a less guarded and more spontaneous way that may cause them to say or do something "accidentally" that had not been thought out in advance (Busby & Lufkin, 1992). Taboo subjects may be symbolically and metaphorically expressed and mastered (Korner, 1988). Play also has an "as if" quality, and is a nonthreatening way for families to disclose secrets or areas of tension (Busby & Lufkin, 1992; Korner, 1988). Play is a door to creativity that allows families to tell new and different stories (Busby &

Lufkin, 1992).

Family therapists can utilize techniques from both family therapy and play therapy as an effective way to include children as part of the therapeutic process. Family therapy and play therapy have many parallels and overlapping goals that make them an excellent fit with one another (Keith & Whitaker, 1981). They are similar in that both modalities respect the client, view the therapist–client relationship as part of the change process, and deem the use of metaphors as important (Anderson & Reynolds, 1996). The integration of play and family therapy helps therapists to use imaginative and multiple perspectives in working with families (Anderson, 1993).

Because it was originally based in psychoanalytic theory (Miller, 1994), couple and family therapists may not feel comfortable with the more interpretive aspects of traditional play therapy, particularly nondirective play therapy. When using play in family therapy, however, it is not necessary for therapists to interpret the symbolic meaning of the play materials (Rober, 1998; Villeneuve & LaRoche, 1993). Instead, family therapists can observe interactions, patterns, and context, just as they do with adult interactions (Carpenter & Treacher, 1982; Larner, 1996; Zilversmit, 1990). The process of play requires sensitivity to space, intensity, and timing. It requires cooperation and, on the adult's part, a reasonable assessment of the child's abilities. Watching a family play can provide numerous cues about the way they function (Carpenter & Treacher, 1982).

What Theoretical Orientations Are Appropriate for Including Children in Family Therapy?

The fact that nearly every theoretical model of couple and family therapy was represented in the publications reviewed demonstrates that any theoretical orientation can be adopted when including children in therapy (Carr, 1994). It is interesting to note that more than one-fourth of the articles did not identify a specific theoretical orientation, which may be due, in part, to the polarization of the fields of family and play therapy. The majority of the articles (29.7%) applied psychoanalytic concepts, but this could be because play therapy has its roots in psychoanalytic theory (Miller, 1994). Structural theory was the most commonly mentioned (25%) of the family therapy theories, but virtually all other theories were mentioned. Solution-focused and narrative therapies were mentioned in 7.8% of the articles, experiential and cognitive-behavioral in 4.7%, Milan in 3.1%, Bowenian and feminist family therapy were cited in 1.6% of the articles, and Mental Research Institute (MRI) was never mentioned.

Family therapists do not need "special" techniques to include children in therapy because any theory within couple and family therapy can easily become "child friendly" with a little adaptation and creativity (Combrinck-Graham, 1991; Villeneuve & LaRoche, 1993). For instance, Larner (1996) proposed a method of narrative child family therapy that does not interpret the play materials chosen by the child, but incorporates the play of the child as part of the child's narrative about the problem. Benson, Schindler Zimmerman, and Martin (1991) provided an excellent example of the use of circular questioning with children. "The creative therapist who wishes to work simultaneously with children and adults can invent fresh ways of talking and playing that will serve almost any therapeutic purpose guided by almost any general theory" (Chasin, 1994, p. 68).

Why Is it Important to Address Diversity Issues in Family Therapy?

When working with families, it is very likely, if not sure, that therapists will encounter those families who are not Caucasian, two-parent, biologically related, middle-class, heterosexual, or without disabilities. More than one-half of the articles in this literature review neglected to mention any issues of diversity or diverse types of families. Of those articles that did touch on diversity, the majority (45.3%) were diverse family forms such as single-parent, divorced, adoptive, or blended families. Multicultural (14.1%), low income (11%), gay or lesbian (3.2%), and special needs/disabled families (4.7%) were virtually ignored. Gender issues were not discussed in any of the articles.

McGoldrick and Giordano (1996) made the following statement regarding working with diverse populations: "Therapists, especially those from dominant groups that tend to take their own values as the norm, must be extremely cautious in judging the meaning of the behavior they observe" (p. 21). Although it is not necessary to "know everything" about a particular subgroup of people, acknowledging one's limited

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knowledge and showing openhearted curiosity will help therapists set up a context of mutual learning with clients (McGoldrick & Giordano, 1996). It is also important for therapists to remember that both children and adults are affected by the stressors that accompany belonging to a marginalized group.

STRUCTURAL ASPECTS OF INCLUDING CHILDREN IN FAMILY THERAPY

What Ages of Children Are Included in Family Therapy?

All ages of children—from infants to adolescents—were deemed appropriate for inclusion in family therapy. The majority of the articles (67.2%) included preschool-aged children, 79.7% included school-aged children, and 70.3% included preadolescent children in therapy; the techniques described below are targeted primarily for these age groups. It is interesting to note that nearly one-third of the articles suggested including infants in session. Although an infant cannot verbally communicate, one can learn from who holds, relates to, cares for, indulges, or ignores the young child (Anderson, 1993). Although many articles (51.6%) mentioned the inclusion of adolescents in therapy, no techniques were targeted specifically toward adolescents. However, therapists can adapt some of the techniques described below for working with adolescents if they are cautious to avoid techniques that teens might feel are too immature for them (e.g., playing with puppets).

What Presenting Problems Can Be Addressed When Including Children in Family Therapy?

A total of 46 presenting problems were cited in these articles, illustrating that the inclusion of children in family therapy is appropriate for a wide range of difficulties families may struggle with (Dare & Lindsey, 1979). The most common presenting problems discussed were attachment/enmeshment problems and parenting difficulties, both of which were listed in 29.7% of the articles. Divorce was the next most common, cited in 28.1% of the articles. Aggression, depression, martial problems, and problems in school were each listed in 23.4% of the articles. Some other presenting problems listed include (in order of frequency): Defiance/disobedience, grief and loss issues, tantrums, stealing, attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), poor social adjustment, anxiety, emotional problems, sleeping problems, and violence.

It is important to note that there are some specific instances when including children in family therapy is not appropriate. In line with some therapists' concerns, some issues (i.e., sexual or financial difficulties) are inappropriate for the child to hear (Korner, 1988). The simultaneous inclusion of children and parents is not recommended for families in which child abuse is occurring, as bringing a victim and perpetrator together in a family session may have costly effects (Eaker, 1986). In addition, family therapy with children also is not recommended as the primary treatment of children with organic disorders or with highly disturbed, psychotic children (Griff, 1983).

How Is Treatment Typically Structured When Children Are Included?

The most common format for treatment (mentioned in 45.3% of the publications) was conducting sessions with the nuclear family unit throughout the course of treatment. A combination of individual, couple/parent, or family sessions was recommended in a quarter of the publications. Approximately 8% of the articles recommended having one session with the parent(s) and then subsequent sessions with the whole family. Approximately 13% of the publications suggested having an initial session with the whole family and then a combination of individual, dyadic, and family sessions, as needed. Only one article excluded children from sessions entirely. A small percentage (8.9%) of publications described therapy in which three generations of family members were present, which may reflect an insensitivity to cultures that may place a high value on extended family.

PRACTICAL TECHNIQUES FOR INCLUDING CHILDREN IN FAMILY THERAPY

What Materials Are Needed for Including Children in Family Therapy?

Many therapists may believe that a large playroom with lots of equipment is necessary for working with

children, but an elaborate playroom setting is not a prerequisite for observing family interactional and behavioral patterns (Guttman, 1975). In this literature review, the most frequently suggested materials were paper, markers, and crayons—materials that many therapists already have in their office. Many techniques, such as circular questioning or role play, do not require toys (Chasin, 1994). Anderson (1993) also suggested that if a therapist does not have toys, they might ask the children to bring their favorite toys with them to the next session. If a therapist is interested in purchasing some toys, the most frequently suggested were dolls, puppets, blocks, clay, and games—all of which can be used with numerous techniques and provide an excellent beginning to a child friendly office. For those interested in setting up a more elaborate playroom, Landereth (1991) provides a comprehensive listing of "essential" toys for a playroom.

How Can Therapists Create a Safe Therapeutic Context for Children?

Rober (1998) suggested that if family therapists do not create a safe therapeutic context for children, they will be confronted with a child, silent or noisy, who does not fully participate in family therapy. This literature review compiled more than 100 suggestions to help children feel more comfortable in therapy, many of which are outlined below.

Before the session, a therapist should have room arrangements that will help children feel more comfortable (Rober, 1998). For instance, have some toys or art materials available and make the room "childproof" by anticipating the child's behaviors (Chasin, 1994; Rober, 1998). When speaking with a child, use elementary, concrete language: Use fewer words, simpler words, and short sentences (Combrinck-Graham, 1991; Villeneuve & LaRoche, 1993). Avoid reliance on verbal interaction and use alternatives to words such as visual aids (O'Brien & Louden, 1985). Treat the child as an equal member of the family by asking for the child's opinion and by valuing the child's comments, thoughts, and feelings (Ackerman, 1970; Keith, 1986; Zilversmit, 1990). Do not speak condescendingly, talk over, talk in third person, or ignore the child (Bloch, 1976).

During the first session, greet children in a low-key manner by asking each their name and age (Ackerman, 1970; Zilversmit, 1990). Establish clear limits, but keep rules to a minimum (Combrinck-Graham, 1991; Rober, 1998; Zilversmit, 1990). Once the rules are explained, it may be helpful to ask the children if they know why they are in therapy and explain it to them in concrete terms (Ackerman, 1970; Carpenter & Treacher, 1982; Carr, 1994; Rober, 1998). The best way to join with a child is to play with a child (Carpenter & Treacher, 1982). Therapists may also utilize the joining techniques they learned with adults and apply them to children. For instance, therapists learn to echo the language their adult clients use by mirroring the tone, intensity, pace, slang, and level of language their clients use. This method is effective with children as well.

During session, allow the child to set the pace and move to the child's level by sitting on the floor (Anderson & Reynolds, 1996; Combrinck-Graham, 1991). Avoid badgering the child with questions, because questioning children too much can have a blocking effect. When asking questions, phrase them using "what" rather than "why" or "how" (Benson et al., 1991; Guttman, 1975). Remember to get to know the child apart from the problem, and to incorporate the child's strengths (Anderson, 1993; Rober, 1998).

How can Therapists Create a Safe Therapeutic Context for Adults?

Although it is important to maintain the child's interest in therapy, therapists should keep the adults engaged as well (Villeneuve, 1979). To reduce anxiety over using childlike activities, present the activities in a confident, eager, and playfulway (Benson et al., 1991). Ask parents if they are willing to participate in play and provide a "warming-up" period to allow for more spontaneity (Blatner, 1994). Acknowledge parental authority and respect their right to discipline children during session (Chasin, 1994; Dare & Lindsey, 1979).

When working with parents, take a collaborative approach and allow parents to participate in the planning of sessions (Carpenter & Treacher, 1982; Griff, 1993; Rober, 1998). View parents as the experts on their family and encourage them to share their parental expertise with teachers and other professionals (Anderson & Reynolds, 1996). Accept the parents' description of their children and their view of the problem (Carpenter & Treacher, 1982; Rober, 1998).

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Parents will feel more comfortable in therapy if therapists avoid blaming them for the child's problems and assume that they have the child's best interest in mind (Rober, 1998). In this literature review, more than one-third of the articles identified one person as the source of dysfunction and of those who did identify patients, nearly two-thirds shifted the identified patient status from the child to the parents. Shifting the blame is not in line with systemic thinking and may contribute to defensiveness on the part of the parents. Parents should be respected, not criticized (Rober, 1998). Remember to give feedback in areas that parents are doing well and to provide a sense of hope for change (Anderson, 1993; Seymore & Erdman, 1996). A therapist is there to help parents fix a temporary problem in the difficult task of raising children (Carpenter & Treacher, 1982). Adopt a developmental view of parents and normalize parenting struggles (Dare & Lindsey, 1979). Satir (1983) also suggested normalizing childhood behavior in the therapy room (i.e., disruptions) so an "acting out" child does not embarrass parents. These suggestions will help adults feel more comfortable, and thereby more engaged, during therapy.

What Are Specific Therapeutic Techniques for the Inclusion of Children in Family Therapy?

The literature describes many techniques for the inclusion of children in family therapy. Of 11 categories of techniques, art techniques were listed in 35.9% of the articles, verbal types of techniques in 29.7%, nondirective techniques in 23.4% of the articles, psychodrama in 18%, and puppets/dolls in 17.2%. Experiential and story-telling techniques were each used in 12.5%, filial in 6.3%, games in 6.3%, and sand-tray and verbal modes were implemented in only 3.1% of the articles. Approximately 20% of the articles did not specify any techniques.

Art techniques. Art techniques were the most commonly mentioned type of technique and consist of a broad spectrum of methods. Therapists may have the family draw a family picture (Anderson, 1993; Rober, 1998), family interactions (Carr, 1994), future dreads and the ideal future (Chasin, 1994), something that happened recently (O'Brien & Louden, 1985), a happy and a sad time (O'Brien & Louden, 1985), school or work (O'Brien & Louden, 1985), a family timeline (Kaslow & Racusin, 1990), presents they would like to give one another (O'Brien & Louden, 1985), genograms (Carr, 1994; Kaslow & Racusin, 1990; see also Nichols & Schwartz, 1998; McGoldrick & Gerson, 1985), three wishes (Gil, 1994), or the animal each person would like to be (Gil, 1994). The family may draw pictures and talk to the pictures rather than to each other (Anderson & Reynolds, 1996). Other techniques include the Kinetic Family Drawing (Gil, 1994), the Hypothetical Future (Benson et al., 1991), cartoons (Benson et al., 1991), the Collaborative Family Drawing (Cordell & Allen, 1997), and the Color-Your-Life technique (Gil, 1994).

As evidenced by the many examples above, therapists can be inventive and have the family draw anything that may be relevant to therapy. It is important to note that any of these techniques can be implemented using different materials, such as markers, paints, crayons, pencils, pens, playdough, or the sand tray. For instance, a therapist may have a family sculpt family figurines using playdough or depict a recent event in the sand (Busby & Lufkin, 1992; O'Brien & Louden, 1985).

Verbal techniques. Most of the verbal techniques compiled in this literature review are methods familiar to family therapists, only applied to families with children. For instance, unbalancing, the empty-chair technique, the miracle question, finding unique outcomes, and "Columbo therapy" (taking a position of not knowing) all can be effective techniques when used with children (Carpenter & Treacher, 1982). Numerous authors used the narrative approach, circular questioning, scaling, degree, percentage, and comparison questions (Anderson, 1993; Benson et al., 1991; Combrinck-Graham, 1991; Larner, 1996). For instance, the therapist can draw a scale of 1–10 on the board and ask children where they are on the scale (Carr, 1994), or can ask degree questions by giving a pictorial representation of faces ranging from frowning to smiling (Dowling, 1993). Degree differences can also be represented using a picture of a thermometer (i.e., "How hot were the fights this week?"; Benson et al., 1991). Other verbal techniques included naming themes (Rober, 1998), creating rituals (i.e., get a drink of ice water to "cool off" before you tantrum; Schatz, 1998), and having the family plan rituals and leisure activities together (Anderson, 1993; Seymore & Erdman, 1996).

When using verbal techniques with children, it may be helpful to use concrete visual aids and metaphor to more clearly demonstrate a concept (Bloch, 1976; O'Brien & Louden, 1985). One example of a metaphor

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is how tantrums are like a rolling snowball that only grows bigger as they last longer (Schatz, 1998). Therapists can use a mobile to describe systems therapy or a balancing scale to demonstrate how families need a balance of positive/negative remarks, between work and play, or seeing good and bad in people (Carr, 1994; O'Brien & Louden, 1985). Family members can "blow stress" into a balloon (Carr, 1994), or the therapist can have each family member bring an object that represents who she or he is (Rober, 1998). It is important to note that it may be helpful for therapists to alternate between using verbal and nonverbal techniques in a way that keeps both the adults and children engaged.

Psychodrama techniques. Psychodrama is play-acting events during therapy and may include elements of enactment, role play, or make believe (see Blatner, 1994). Therapists may have the family enact past and present family events (Busby & Lufkin, 1992; Dare & Lindsey, 1979), a familiar scene of conflict (Benson et al., 1991), several feelings related to an event (Blatner, 1994), the ideal future and what will happen if things continue the same (Chasin, 1994), family myths (Chasin, 1994), or how the family plays together (Busby & Lufkin, 1992). A replay is when the family reenacts an incident and then enacts it again the way they wanted it to go (Blatner, 1994). Some ideas for role play include the role reversal, the double, multiple parts of the self, and talk show (Blatner, 1994). As the family enacts various events or uses role play, the therapist may ask questions, direct interactions, or make comments, acting as a reporter, involved audience provoker, or director (Ariel, Carel, & Tyano, 1985).

Story-telling techniques. Story-telling techniques allow families to personify, reframe, and externalize problems (Anderson, 1993; Carr, 1994). The mutual story-telling technique is when the therapist asks the family to tell a story and the therapist may help family members generate alternate endings (Eaker, 1986). Therapists may also ask the parents to tell a positive story about the child (Rober, 1998), have the family write or tell a family story (Anderson & Reynolds, 1996; Schatz, 1998), or have the family make up a story (Villenueve, 1979).

Puppet and doll techniques. Puppets and dolls may be used to communicate, to ask the family about interactions and to act out behavioral sequences (Anderson, 1993; Carr, 1994; Chasin, 1994). Any of the enactment or story-telling techniques may also be used with puppets or dolls. Some puppet and doll techniques include the family puppet interview (Gil, 1994), now and then (Benson et al., 1991), and the typical day interview (Gil, 1994).

Experiential techniques. Some examples of experiential techniques are the family sculpture (Blatner, 1994) and a can of worms in action (Satir, 1988). Therapists may also use familiar games to look at how families respond to winning, losing, competition, conflict, and power, and to teach communication, conflict resolution, cooperation, and positive interactions (Busby & Lufkin, 1992; Seymore & Erdman, 1996). Some ideas for games are: Hide and go seek, catch, basketball, board games, building a tower from blocks, freeze tag, charades, or keep away (Anderson & Reynolds, 1996; Busby & Lufkin, 1992; Seymore & Erdman, 1996).

Nondirective and filial therapy. Nondirective play in family therapy allows children to play with the toys while the therapist describes what the child is doing, interprets the play to parents, and asks questions regarding the play in the context of family problems (see Hardaway, 1994; Zilbach et al., 1972). Because of the interpretive nature of this type of therapy, many couple and family therapists do not feel comfortable using it, and this article will not address this technique in detail. Filial therapy is a particular method of therapy in which parents are trained to act as their own child's therapist. It requires a specific structure and describing this technique is also beyond the scope of this article (see Guerney & Guerney, 1994).

CONCLUSION

There are many barriers that prevent therapists from including children in family therapy: A therapist's lack of comfort or confidence with children, little training, training in talk rather than play therapy, children are viewed as disruptive and distracting, nonconducive room arrangements, the costliness of supplies, and a perception that techniques are difficult to find. In an attempt to reduce some of the barriers, this literature review has compiled the theory, structure, and techniques in a way that allows therapists to more easily include children in therapy with families.

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Although this article cannot list all of the techniques for including children in family therapy, several authors have written books that compile techniques or work from a specific theoretical orientation. Some excellent resources are *Play in Family Therapy* (Gil, 1994), *Family Play Therapy* (Schaefer & Carey, 1994), *Solution-Focused Therapy with Children* (Selekman, 1997), and *Playful Approaches to Serious Problems: Narrative Therapy with Children and Their Families* (Freeman, Epston, & Lobovits, 1997).

Although therapists may feel uncomfortable or unqualified, they may not realize that they have already received much of the training they need to work with families with young children. They can apply what they have learned about systems theory, joining, systemic thinking, diversity, and their preferred theoretical orientation. With a little creativity and playfulness, therapists can transform the techniques they utilize with adults into effective tools for working with children. Once therapists make the shift to incorporate children into their practice, they may find themselves astonished at the richness, wisdom, and catalytic affect that children can bring to the therapeutic process.

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