Cognitive-behavioral play therapy (CBPT) is an offspring of cognitive therapy (CT) as conceptualized by Aaron Beck (1964, 1976). The cognitive model of emotional disorders involves the interplay among cognition, behavior, and physiology (Beck & Emery, 1985) and contends that behavior is mediated through verbal processes; the way individuals construe the world in large measure determines how they behave and feel and how they understand life situations (Beck, 1967, 1972, 1976). In cognitive theory, emotional experiences are determined by cognitions that have developed in part from earlier life experiences. Over the past 40 years, CT has been applied to an increasingly broad range of populations. Included are psychiatric populations, such as individuals with depression, anxiety, and personality disorders, as well as nonpsychiatric populations such as prison inmates and medical patients (Beck, 1995).

CT as practiced with adults is inappropriate for use with adolescents and children without modification, as a more developmentally appropriate approach is necessary. Over time, adaptations of CT for use with increasingly younger populations have emerged, (e.g., adolescent—Emery, Bedrosian, & Garber, 1983; school-age children—Kendall & Braswell, 1985). However, many believed that CT could not be adapted for preschool and very young school-age children. Clinical lore suggests that therapy with preschoolers must involve some level of play therapy in order to engage the child in what is traditionally a more verbal endeavor. The developmental literature might suggest that preoperational-stage children do not have the cognitive sophistication and flexibility to benefit from CT. CT with adults requires the ability to follow a rational, logical sequence. It assumes that the individual has the capacity to differentiate between rational and irrational/logical and illogical thinking. An adult may need some guidance in identifying and labeling irrational, illogical thoughts. However, once identified, the individual can understand the inconsistencies. Young children, however, may not understand the differences and may not be able to distinguish between irrational, illogical thinking and more rational, logical thought. The application of CT with young children is thus fraught with difficulties, which largely explains why most of the work with youth and CT has focused on adolescents and older school-age children. The preoperational-stage child’s egocentrism, concrete thought processes, and seemingly irrational thinking would seem to preclude the kind of cognitive abilities necessary to participate in CT.
CT, with its emphasis on verbal interventions, and play therapy (PT), with its focus on play, appeared to many as incompatible. Nonetheless, by the mid-1980s, Phillips (1985), himself a developmentalist, not a clinician, hypothesized that incorporating cognitive-behavioral techniques into play interventions offered a promising direction in the field of PT. By the late 1980s, others, such as Berg (1982), had begun to incorporate CT and play interventions, although Berg’s target population was slightly older, school-age children. Knell & Moore (1990), writing about a 5-year-old boy with encopresis, published the first case report of the integration of cognitive interventions and PT with a preschool-age child.

Adapting CT for preschoolers has received increasing attention over the past 10 years. CBPT, as conceptualized by Knell (Knell, 1993a, 1993b, 1994, 1997, 1998, 1999, 2000, 2003; Knell & Beck, 2000; Knell & Dasari, 2006, 2009; Knell & Moore, 1990; Knell & Ruma, 1996, 2003), was developed for use with children between 2½ and 6 years and incorporates cognitive, behavioral, and traditional play therapies. CBPT is based on the cognitive theory of emotional disorders and cognitive principles of therapy and adapts these in a developmentally appropriate way. CBPT is sensitive to the developmental issues of children and emphasizes the empirical validation of effectiveness of interventions.

Cognitive distortions in very young children may be developmentally appropriate yet maladaptive. For example, a child whose parents separate shortly after he misbehaves may believe that he was the cause of the separation. In most cases, children incorporate life experience into their thinking, and with the help of everyday parent–child discourse are able to integrate this learning into a more adaptive thought (“My parents weren’t getting along. Dad didn’t move out because of my behavior. He moved out because he and mom fight too much.”). Given that maladaptive thoughts may be developmentally appropriate, the concept of cognitive distortions is problematic with young children. For this reason, it is more appropriate to label these thoughts as maladaptive rather than distorted.

Sometimes, children do not attach any set of beliefs or meanings to an event. In these instances, maladaptive cognitions may not be present. However, there may be an absence of adaptive beliefs that would facilitate coping, if present. In these instances, the child might need some assistance in creating functional, adaptive self-statements as a coping device, not to replace the maladaptive ones but to boost more adaptive thinking and behavior. For example, a young child may have difficulty coping with the birth of a sibling. Maladaptive beliefs (e.g., “I’m not the baby anymore”; “No one loves me”) may not be present, or they may not be expressed verbally. Helping the child cope with the new sibling by providing adaptive, positive coping statements can facilitate the child’s functioning. Statements such as “We have a new baby, but Mom and Dad still love me” can provide the child with a positive outlook on the experience.

Thus, facilitating adaptive cognitive change is not only possible but quite common with young children. Often, as mentioned, inducing such change takes place in the normal, everyday life of parent–child interactions. When situations are brought to a therapist, evidence supports the use of developmentally appropriate adaptations of CT to facilitate such changes. Bierman (1983) wrote about interviewing
techniques, including the use of concrete examples and less open-ended questions, as a means of facilitating the young child’s understanding of complex problems. Through the use of play, cognitive change can be communicated indirectly (Knell, 1998; Shirk & Russell, 1996). Additionally, the therapist’s ability to be flexible, reduce focus on verbalizations, and increase use of experiential approaches can contribute to the successful adaptation of CT with young children.

**BASIC CONSTRUCTS, GOALS, AND TECHNIQUES**

CBPT is based on behavioral and cognitive theories of emotional development and psychopathology and on the interventions derived from these theories. These theoretical roots are considered with regard to their influence on CBPT.

**Behavior Therapy**

Behavior therapies (BTs) for youth were developed, in part, to help children and parents translate knowledge gained in therapy to the natural environment. Behavioral approaches to child management are often taught directly to parents or significant others. Such approaches have proven extremely effective with problems such as child noncompliance. However, BT can be implemented directly with a child. A direct approach may be necessary for some problems of preschoolers. This may be particularly true if the child’s problem is aversive to the parent (e.g., Knell & Moore, 1990), if the parent–child relationship has inhibited development of the child’s self-mastery (Klonoff, Knell, & Janata, 1984; Klonoff & Moore, 1986), or if issues of control are prominent. Whether the therapy is direct or delivered through a significant other, the therapist tries to identify factors that reinforce and maintain problematic behaviors so that they can be altered. Many interventions are based on classical conditioning (e.g., systematic desensitization) and operant conditioning (e.g., contingency management). Interventions from social learning theory also emphasized observational learning and more cognitive aspects of behavior, which provided much of the impetus for the development of cognitive therapy.

**Cognitive Therapy**

CT was developed as a structured, focused approach to help individuals make changes in their behavior by changing the thinking and perceptions that underlie behavior. Originally developed as a short-term, present-oriented therapy for depressed adults, the treatment was directed toward changing dysfunctional thinking and behavior. Adaptations to younger populations have changed the methods through which CT is delivered but not the theoretical underpinnings of the approach. Finding ways to deliver CT without an emphasis on language that might be too complex for a young child represents one of the challenges faced in the development of CBPT.
Cognitive-Behavioral Play Therapy

Knell (1993a, 1993b, 1994, 1997, 1998) argued that CT could be modified for use with young children if presented in a way that was highly accessible for children. For example, puppets, stuffed animals, books, and other toys could be used to model cognitive strategies. With a coping model approach, the model (e.g., puppet) might verbalize problem-solving skills or solutions to problems that parallel the child’s own difficulties.

Principles of CBPT

Some of the principles of CBT (as adapted from work with adults—Beck & Emery, 1985) apply to young children as well. CBPT is based on the cognitive model of emotional disorder and is brief, time limited, structured, directive, problem oriented, and psychoeducational in nature. A sound therapeutic relationship is a necessary condition for effective CBPT. Though a collaborative relationship is important, and a more Socratic/inductive approach fundamental in CBT, its implementation with young children must be modified for use with children.

Setting

CBPT is usually conducted in a playroom or office equipped with appropriate play materials. Ideally, the room is stocked with toys, art supplies, puppets, dolls, and other materials. Although an array of toys is usually sufficient, there are times when a specific toy may be needed to treat a particular child. At times, play materials that are available can be adapted to meet these specific needs. At other times, a specific toy may need to be brought into the playroom, because the child cannot “pretend” or be flexible in the use of already existing toys. An example of this would be a child who was having a difficult time wearing prescription glasses. She might be able to cut out glasses on paper and use these with a doll. Or the child might have difficulty with this flexible use of the paper-cut glasses and might respond better to actual plastic glasses that fit the doll.

Treatment sometimes takes place outside the playroom/office setting. This is particularly true for children with specific anxieties, such as phobias, which are best treated in vivo. For these children, treatment may take place in a setting that more closely resembles the feared situation. For example, systematic desensitization of elevator-phobic children can take place in and around an elevator (Knell, 1993a, 2000). Similarly, a child with obsessive-compulsive disorder may be treated in a setting that elicits obsessions and compulsions (March & Mulle, 1998).

Similarities/Differences

CBPT is different from more traditional forms of play therapies, although it incorporates several of the assumptions underlying traditional play therapies. CBPT is similar to other types of play therapy in its reliance on a positive therapeutic relationship, use of play as a means of communication between therapist and child, and the message to the child that therapy is a safe place. Despite these similarities, there are assumptions inherent in CBPT that run counter to the premises on which
traditional play therapies are based. Several important areas of difference involve the focus on CBPT on directions and goals, choice of play materials and activities, play as educational, and the importance of making connections between the child’s behavior and thoughts. Whereas the therapist in nondirective play therapy is a more neutral observer, the CBP therapist provides direction, establishes goals, and develops interventions that are suited to facilitate these goals. Similarly, the CBP therapist, along with the child, selects play materials and activities and provides a psycho-educational component to the treatment. Finally, the CBP brings conflicts and problems into verbal expression for the child, using the therapeutic time and relationship to help the child make connections between words and behavior. (See Knell, 1993a, for more details regarding the similarities and differences among various types of play therapies).

**Goals**

Establishing goals is an important part of CBPT. The CBP therapist works with the child and family to set goals and help the child work toward these goals. The therapist assesses movement toward goals on an ongoing basis. Whereas goals and movement toward goals are counter to the basic philosophy of client-entered play therapy (see Axline, 1947), they are an integral part of CBPT. The CBP therapist’s selection of a direction may be based on the child’s lead or on knowledge of the child’s situation as understood from the parent interview or other source. In CBPT, the therapist may introduce themes and provide direction based on knowledge obtained from a parent or teacher and not necessarily from the child him- or herself. For example, the CBP therapist may purposefully and systematically have a puppet behave in a certain way and verbalize issues that the child reportedly exhibits.

**Methods**

Most cognitive behavioral interventions with children include some form of modeling. This is particularly true of CBPT, where modeling is a critical component. Modeling is an efficient and effective way to learn, as well as to acquire, strengthen, or weaken behaviors (Bandura, 1977). Modeling designed to enhance skills often involves a coping model. Coping models display less-than-ideal skills and then gradually become more proficient. The efficacy of modeling is improved by the use of coping models (Bandura & Menlove, 1968; Meichenbaum, 1971).

In CBPT, modeling is used to demonstrate adaptive coping skills to the child. The model may behave in a way that demonstrates use of a positive coping skill. This can involve the model talking out loud as well as acting in a way compatible with adaptive behavior. In CBPT, the model is usually a toy (stuffed animal, puppet, or other toy) that demonstrates the behavior that the therapist wants the child to learn. Modeling can also be presented in other forms, such as through books, movies, or television shows.

Less often used in CBPT, but still an important method of intervention, is role-playing, where the child practices skills with the therapist and receives ongoing feedback. Role-playing is usually more effective with school-age children, although...
Major Theoretical Approaches

it is possible to deliver role-playing through a modeling technique. In this way, models are actually role-playing, and the child is observing and learning from watching the models practice particular skills. For example, a child with separation fears may watch an equally fearful puppet as it “practices” leaving the parent and interacting with others.

Interventions

Empirically supported CBT techniques are incorporated into play and adapted to the child’s developmental level. In general, research suggests that it is the combination of cognitive and behavioral interventions that is effective in helping children cope (Compton et al., 2004; Velting, Setzer, & Albano, 2004). There is a wide array of interventions from both the behavioral and cognitive literature. The more common techniques are described in the following sections and summarized, with examples of how these techniques are integrated into play therapy, in Table 17.1 (Behavioral Interventions) and Table 17.2 (Cognitive Interventions).

Table 17.1 Examples of Behavioral Interventions in CBPT

<table>
<thead>
<tr>
<th>Technique</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive reinforcement</td>
<td>Puppet who is fearful of talking receives stickers for each attempt to talk to another puppet.</td>
</tr>
<tr>
<td>Shaping/Positive reinforcement</td>
<td>Puppet who is fearful of talking begins to make utterances, speech sounds, words, and gradually begins to talk (shaping). The puppet receives encouragement and positive feedback (positive reinforcement) from the therapist as it makes closer and closer approaches to speaking.</td>
</tr>
<tr>
<td>Systematic desensitization</td>
<td>Puppet who is afraid to ride on an elevator systematically goes through a hierarchy (from situations least to most feared) while simultaneously engaging in relaxation (mutually exclusive with anxiety).</td>
</tr>
<tr>
<td>Stimulus fading</td>
<td>Puppet who is clingy and unable to go to bed when its mother says goodnight, is able to appropriately go to sleep when father does the good-night routine. The dad puppet takes care of the goodnights while gradually fading the mom back into the nighttime routine.</td>
</tr>
<tr>
<td>Extinction/DRO</td>
<td>Puppet who is acting aggressively toward other puppets does not receive any positive attention (extinction), while more adaptive behaviors, such as playing nicely, keeping hands to oneself, and using words rather than action (DRO) are rewarded.</td>
</tr>
<tr>
<td>Time-out</td>
<td>Puppet who is throwing toys in the playroom is put in time-out, away from his puppet friends.</td>
</tr>
<tr>
<td>Self-monitoring</td>
<td>Child marks feelings on a scale with frowning and smiley faces.</td>
</tr>
<tr>
<td>Activity scheduling</td>
<td>Events and activities are scheduled for a child who tends to withdraw from others.</td>
</tr>
</tbody>
</table>
Behavioral Interventions. A variety of techniques based on the three models of behavior therapy (classical conditioning, operant conditioning, social learning) can be incorporated into play therapy. Techniques from classical (e.g., systematic desensitization) and operant (e.g., contingency management, shaping, differential reinforcement of other behavior [DRO]) conditioning are typically used to help a child incorporate more adaptive behaviors. Techniques from social learning theory (e.g., modeling) are used extensively in CBPT, utilizing observational learning as a tool for learning new behaviors.

Systematic desensitization (SD) is the process of reducing anxiety by replacing a maladaptive response with an adaptive one (Ollendick & King, 1998; Wolpe, 1958, 1982). This is accomplished by breaking the association between a particular stimulus and the anxiety or fear response that it usually elicits. The stimulus is presented, but the anxiety is prevented from occurring. This is usually done by teaching muscle relaxation to elicit a state of calm that is incompatible with anxiety (Jacobson, 1938). With children, SD may be used in a different way. Older children can be taught a modified relaxation technique (e.g., Cautela & Groden, 1978), whereas relaxation in younger children may be induced through calming play activities or visualization of calming scenes (Knell, 2000). Both imaginal and in vivo desensitization are used with children, though the latter, where anxiety-provoking stimuli are presented in real life, may be superior (Emmelkamp, 1982; King & Ollendick, 1997; Ultee, Griffioen, & Schellekens, 1982).

Contingency management is a general term that refers to techniques that modify a behavior by controlling its consequences. Forms of contingency management are positive reinforcement, shaping, stimulus fading, extinction, and DRO. These interventions can all be used in the CBPT setting and are described briefly here:

- **Positive reinforcement.** In this important component of much of CBPT, a specific target behavior is identified, reinforcers determined, and the reinforcement is made contingent on the occurrence of the targeted behavior. Social
reinforcers (e.g., praise) or material reinforcers (e.g., stickers) can be used. Reinforcement can be direct (e.g., praising a child for specific behaviors) or more subtle (e.g., in a child with separation anxiety, reinforcing a behavior, such as independent play, which ultimately would lead to the desired behavior, separation from parent figure). Reinforcement can be part of the actual CBPT, and the therapist may also instruct parents and significant others in the appropriate use of reinforcers in the natural environment.

- **Shaping.** Shaping is a means of helping a child get closer and closer to a targeted goal. Positive reinforcement is offered for closer and closer approximations or steps toward the desired response. For example, the child who is fearful of sleeping in her own room can be shaped through reinforcement of small steps toward the eventual goal of sleeping in her own room (e.g., sleeping on the floor next to the parents’ bed, sleeping on the floor in the hall near her room, sleeping on the floor in her room, sleeping in her own bed).

- **Stimulus fading.** If a child has some of the skills for a behavior but only exhibits them in certain circumstances or with certain people, stimulus fading may be used. The therapist will help the child transfer these skills to different settings or with different people by gradually fading out the situation or person so that the child is currently able to perform the skill. For example, a child who separates from his father to go to school but is clingy and unable to separate from his mother may initially be dropped off at school by Dad, with Mom gradually faded back into the drop-off routine.

- **Extinction and DRO.** Some children exhibit maladaptive behaviors because they have been or are being reinforced for performing them. In order for the maladaptive behaviors to drop out, the reinforcement must be removed. A common reinforcer is parental attention. Often, it is the contributing or causal factor in the child’s behavior. If reinforcement is withheld (extinction), behaviors will decrease or disappear. However, extinction does not teach new behaviors, so it is often used in conjunction with reinforcement, where a new, more adaptive behavior is reinforced (DRO), while the maladaptive behavior is extinguished.

When a child needs to be removed from reinforcers that are maintaining maladaptive responses, time-out is often used. Technically, time-out means time out from reinforcement, though it has come to mean removing the child from a desirable environment to a less attractive one. Though used more frequently in the natural environment, time-out can be used in play therapy when a child is not following rules (e.g., violates a “no breaking toys” rule) and needs to be removed from the play therapy situation to a neutral place devoid of toys. During the time-out period, the child would not have access to the reinforcing aspects of the therapy (e.g., the therapist’s positive attention, the play therapy materials).

*Self-monitoring* (SM) refers to an individual’s observations and recording of information. This can involve the monitoring of activity or mood and can provide important information. However, SM can be used with young children only if it is offered in a simple form, usually with visual cues (such as smiley faces).
In activity scheduling, specific tasks are planned for, then implemented. Although originally designed for work with depressed adults, activity scheduling can be used with young children, usually with some level of parental involvement. Planned activities may reduce time spent in ruminative or passive activities and can be useful for depressed, anxious, or withdrawn children.

Cognitive Interventions. Behavioral methods in CBPT usually involve an alteration in activity, whereas cognitive methods deal with changes in thinking. Since maladaptive thoughts are hypothesized to lead to maladaptive behavior, changes in thinking should produce changes in behavior. The therapist helps children identify, modify, and/or build cognitions. Through this work, children learn to identify maladaptive thoughts and replace them with more adaptive ones.

Recording dysfunctional thoughts can help adults self-monitor thoughts. Young children can be encouraged to use simple recording devices (e.g., drawing pictures in a notebook or recording in a tape recorder). Often, monitoring is done by the parent rather than the child him-/herself.

With adults, a three-pronged approach is used for cognitive change strategies and countering irrational beliefs (maladaptive beliefs): look at the evidence, explore the alternatives, and examine the consequences (maladaptive beliefs). Many strategies to counter irrational thoughts are used, including examining the evidence to support the belief, considering multiple scenarios (e.g., “What if?”), and examining alternatives (Beck, Rush, Shaw, & Emery, 1979). The hypothesis testing inherent in these approaches makes them difficult to use with children. Especially with young children, the therapist needs to guide the child in generating alternative explanations, testing them, and changing beliefs (Emery, Bedrosian, & Garber, 1983).

Individuals of all ages can use coping (positive) self-statements to facilitate positive coping. Many children have more neutral thoughts—they lack positive self-statements rather than having negative thoughts. For some children who have negative thoughts, replacing these with more neutral statements can be an intermediate step (Kendall & Treadwell, 2007). Individuals of all ages can use positive self-statements to facilitate positive coping. Turning praise from parents and significant adults into self-statements is not automatic. Children often need help in developing positive self-affirming statements (Velting et al., 2004). Young children need to learn how to have clear, self-affirming positive statements that are linguistically and conceptually simple (e.g., “I am strong”; “I can do this”). These statements are in part self-rewarding (“I am doing a good job”) and can involve an element of coping strategies (“I can walk past that bully with a smile on my face”). Further, they can help reduce aversive feelings (“I can sleep in my own room when I’m ready”) and enhance reality testing (“There really are no ghosts in the attic”) (Schroeder & Gordon, 1991).

Though technically not a cognitive intervention, bibliotherapy is used increasingly as an adjunct to therapy. It contains strong cognitive interventions, usually through modeling. In most stories used with young children, a model copes with a similar situation, shows reactions, and problem solves the situation. Children often respond to such stories with increased understanding that others have faced the situations they confront and with ideas about how to approach the problem.
In summary, cognitive interventions are utilized with young children to help them modify their thoughts and learn more adaptive coping skills. For cognitive interventions to be useful for young children, they must be relatively simple, concrete, and not verbally complex. Particularly useful with this age group are coping self-statement and bibliotherapy.

THERAPEUTIC POWERS OF PLAY UNDERLYING THE MODEL

Much has been written about the therapeutic powers of play (e.g., Schaefer & Drewes, 2009), and recently there has been increasing interest in the characteristics of play that make it a change agent (e.g., Russ, 2004). Schaefer (1999) identified 25 factors culled from a review of the literature, which he believed contributed to the role of play in change. Most of these appear to play a role in CBPT. Factors such as self-expression and abreaction are important in the nonstructured, spontaneous components of the therapy. Particularly relevant for the more structured components are those factors that are inherent in the psychoeducational component of CBPT: direct/indirect teaching, stress inoculation, creative problem solving, and behavioral rehearsal.

Role of the Therapist

The role of the CBP therapist is to involve the child in treatment through play. The child’s issues can be dealt with directly rather than through a parent. The therapist’s task is to listen, with both ears and eyes, to hear and see what the child is communicating through his/her play. In addition, the CBPT therapist provides, in a developmentally appropriate way, strategies for developing more adaptive thoughts and behaviors. Such coping skills are modeled through toys and puppets, which necessitates that the therapist be comfortable playing with toys.

Role of the Parents

Inclusion of parents/significant adults in the child’s treatment is an important consideration and should be determined on a case-by-case basis. The initial assessment is usually completed with the parent in order to gain the most complete understanding possible about the child and his/her difficulties. After the parents are interviewed, the child is seen for an evaluation, and upon its completion, the therapist will usually meet with the parents to present evaluation findings and work on a specific treatment plan. The treatment plan may primarily involve CBPT with the child, work with the parents, or a combination of CBPT and parent work. Such decisions are usually made based on an assessment of the nature of the problem and the best method by which to intervene. Considerations include whether the parent will need help in modifying interactions with the child and whether the child will need assistance in implementing a treatment program outside of therapy.

Even when the primary work is with the child through CBPT, it is still important to periodically meet with the parents. During these parent sessions, the therapist will...
obtain information about the child, continue to monitor the parents’ interaction with the child, work on areas of concern, and assist the parent in implementing appropriate child management strategies at home. The therapist may provide support for the parents, which may include information related to specific topics (e.g., developmental issues, appropriate expectations at various ages, diagnostic-specific information).

CASE ILLUSTRATIONS

Case 1: Kelly

Kelly was a 4-year-old girl who had been home with her mother and three siblings when their home burned down. An electric fire in the walls was the cause of the fire, which emitted various noises from the walls before the family realized what was happening. Mom and children were able to leave the house without getting hurt, but the house was burnt to the ground before the fire could be put out. The family watched the house burn, and the fire department’s attempts to save it, from a neighbor’s home. They also spent many hours at the home in the months ahead as it was rebuilt. Kelly refused to speak and would not enter the house as it was being repaired. She also refused to separate from her parents, feared various noises, and wouldn’t sleep by herself at night. During play therapy, her play revolved around characters in a home, firemen, and animals that made strange noises that no one could figure out. When characters tried to find the source of the noises, the animals would hide. Additionally, random frightening things would happen in her play (e.g., bathtubs would fall from the sky). She would replay this repeatedly. During the play, the therapist took on the characters who made the connection between the animal noises and the noise before the fire at her home. At the therapist’s request, mom brought in pictures of the burnt home as well as the rebuilt home, and they were used in the play sessions to help the child talk through what had happened and how it turned out (e.g., “We have sprinklers in all the rooms now”; “Our new house is safer than our old house”). The characters also received stickers for their efforts to sleep in their own beds (as Kelly’s parents were giving her at home), and during the sessions, the therapist, mom, and Kelly would practice the skills of separating from mom and feeling safe by using positive self-statements and other coping techniques.

Case 2: Isabella

Isabella was a 6-year-old girl who had recently moved to a new community with her family. Parents described her as shy and clingy. She had difficulty making friends. Recently, another child had become her friend, but the other girl, Ann, was extremely bossy, often telling Isabella, “If you don’t do this, I won’t be your friend.” CBPT with Isabella began with the therapist organizing a friendship group. The therapist modeled a group of friends who played with each other and talked about being friends and what that entailed. As they interacted, the therapist had one puppet (a bossy donkey) try to dictate what they would all do and who would take
the next turn. The therapist had another puppet tell the donkey that it wasn’t fair to be that bossy. Various puppets modeled assertive behavior, both verbally and nonverbally. Isabella engaged in the play readily. However, in the early stages of therapy, she would never take on a character who “stood up” to the bossy donkey. The therapist modeled assertive behavior via various puppets, with Isabella watching and listening intently. As therapy progressed, Isabella would request that the therapist (via a puppet) “talk back to the bossy donkey.”

**CLINICAL APPLICATIONS**

CBPT has been used successfully with a wide variety of patient populations, including children with diagnoses such as selective mutism (Knell, 1993a, 1993b), encopresis (Knell, 1993a; Knell & Moore, 1990); separation anxiety (Knell, 1998, 1999), and phobias (Knell, 1993a, 2000). Additionally, CBPT has been used with children who have experienced traumatic life events, such as divorce (Knell, 1993a) and sexual abuse (Knell & Ruma, 1996; Ruma, 1993). Populations that might benefit from CBPT include children with control issues, anxious and depressed children, and children who have experienced a traumatic event, such as maltreatment. Additionally, CBPT might be useful for children who need to learn more adaptive coping skills or those whose direct involvement in treatment is important.

Other children may best be treated indirectly through the parents. In such cases, the parent is taught child management skills that will provide parenting that is better suited for that particular child. Children who are more like to benefit from a parent-implemented approach are those whose parents clearly exhibit deficits in parenting or children presenting with noncompliant behavior or habit disorders, such as sleep difficulties. Also, children from families with significant psychopathology might benefit from CBPT in combination with family therapy or individual therapy for either or both of the parents.

**EMPIRICAL SUPPORT**

CBPT is a developmentally based, integrated model of psychotherapy. It incorporates empirically supported techniques, such as modeling. Research suggests that learning through modeling is an effective way to acquire, strengthen, or weaken behaviors and thus is an efficient and effective way to acquire behaviors and skills (Bandura, 1977). Other well-documented interventions, such as systematic desensitization, are utilized in CBPT (Wolpe, 1958, 1982).

CT with adults is a well-established, empirically supported treatment with a range of presenting diagnoses. Controlled studies have demonstrated its efficacy in the treatment of major depression (see Dobson, 1989, for a meta-analysis), generalized anxiety disorder (Barlow, Craske, Cerny, & Klosko, 1989; Beck, Sokol, Clark, Berchick, & Wright, 1992; Clark, Salkovskis, Hackmann, Middleton, & Gelder, 1992), and social phobia (Gelernter et al., 1991; Heimberg et al, 1990), to name a few. CBPT adapts empirically supported techniques for use with young
children using developmentally appropriate play. The efficacy of such adaptations of CBT have yet to be demonstrated. Empirical validation of CBT with adults does not necessarily mean that such treatment is most effective with children. Recently, the question of efficacy of CBPT has been subjected to empirical study.

A 2007 study by Pearson found that teachers reported significantly higher hope, higher social competence, and fewer anxiety–withdrawal symptoms in a CBP intervention group than a matched control group of preschool children without play. The children in the CBP intervention group were seen individually for three sessions incorporating CB interventions, though this was not technically CBPT. However, this study represents the first to empirically support CBPT interventions. More such studies are needed in order to establish the efficacy of CBPT.

**CHALLENGES IN IMPLEMENTING THE MODEL**

There are a number of challenges facing the CBP therapist. Balancing the structured versus unstructured aspects of CBPT is likely the most difficult of these challenges. The process of change takes place in both the structured and unstructured components of the session (Knell, 1993a, 1999), and the balance between the two is considered critical. (See Knell, 2009; Knell & Dasari, 2009, for a discussion of structured versus unstructured play in CBPT.) Given the importance of both, the CBP therapist is faced with the challenge of balancing the session, attempting to obtain the spontaneous material that comes from the unstructured play, as well as the more goal-directed modeling of more adaptive skills that are inherent in the structured play.

**CONCLUSION**

CBPT is appropriate for preschool and early school-age children. It emphasizes the child’s involvement in therapy and addresses issues of control, mastery, and responsibility for changing one’s own behavior. The child is helped to become an active participant in change (Knell, 1993a). The therapist facilitates the child’s involvement in therapy by presenting developmentally appropriate interventions. Many behavioral and cognitive interventions can be incorporated into CBPT.

CBPT provides structured, goal-directed activities while allowing the child to bring spontaneous material to the session. The balance of spontaneously generated and more structured activities is a delicate one, though both are critical to the success of CBPT. Without the spontaneous material, a rich source of clinical information would be lost. Similarly, if the structure and direction of CBPT were not present, it would be impossible to help the child develop more adaptive coping skills.

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