Chapter 5
Cognitive Behavioral Play Therapy

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5.1 Introduction

Cognitive Behavioral Play Therapy (CBPT) integrates cognitive behavioral and play therapies and is based on empirically supported cognitive and behavioral interventions that are incorporated into play. Materials that are appropriate for the child's developmental level are used. By using puppets, stuffed animals, books, and other toys, the therapy is suitable for young children. Modeling allows the therapist to present coping strategies, problem solving, and numerous other interventions to the child via play.

For children to benefit from Cognitive Behavioral Therapy (CBT), it must be adapted for their developmental age. Since pre-operational children are self-centered and concrete by nature, CBT must be modified so that it does not rely on sophisticated language and the use of logic. The theory is the same, namely that our beliefs and thoughts influence our behavior and emotions, the interpretations and perceptions of our environment, and maladaptive beliefs are common in individuals experiencing psychological distress (Beck, 1976). The difference between CBT and CBPT is that interventions are adapted for the developmental level of the child, and largely presented through modeling (Knell, 2009). There is emerging empirical support for the use of CBPT with young (ages 2.5–8 years) children.

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5.2 Foundations

5.2.1 Behavioral Therapy

Behavioral interventions have been shown to be effective with children. These approaches work to modify maladaptive behaviors and identify the factors that reinforce and maintain them. Many behavioral interventions are designed to be implemented by an adult to help a child. However, these interventions can be incorporated into CBPT, so that the child is directly involved with the therapist. The child's direct involvement in change is considered important, particularly in regard to behaviors that are specifically controlled by the child (e.g., eating, elimination). Mastery and control are significant milestones in child development and are considered critical in terms of the child's emerging independence. Whether the therapy is delivered by another adult, or directly implemented with the child in therapy, the therapist tries to identify factors that reinforce and maintain problematic behaviors.

Table 5.1 provides a summary of the behavioral techniques that can be used in CBPT. These include positive reinforcement, shaping, systematic desensitization, stimulus fading, extinction/differential reinforcement of other behavior (DRO), time-out, self-monitoring, exposure with response prevention, activity scheduling, and relaxation training. It is critical that the CB therapist is familiar with these interventions and comfortable using them in play therapy.

5.2.2 Cognitive Therapy

Cognitive therapy was developed as a structured, focused approach to help individuals make changes in their behavior by changing thoughts and perceptions that underly the behaviors. Originally developed as a short-term, present-oriented therapy for depressed adults, the treatment was directed towards changing dysfunctional thinking and behavior (Beck, 1964). Cognitive interventions are effective with children, but often involve more modifications to make them developmentally appropriate. The method of delivering cognitive interventions to children is different than with adults, but the theorical underpinnings are the same (Knell & Dasari, 2011).

The cognitive techniques used through play, provided in Table 5.2, are identifying dysfunctional thoughts, cognitive change strategies/ countering irrational (maladaptive) beliefs, positive self-statements, bibliotherapy, problem solving, and psycho-education.

Table 5.1 Examples of behavioral interventions in CBPT

Positive reinforcement	A puppet who is afraid talk to her teacher gets a sticker for each time she speaks
Shaping	A puppet begins to get closer and closer to talking, and is given a sticker for making utterances, speech sounds, words, and gradually talking. The puppet is getting reinforced for closer and closer approximations (shaping) to talking
Systematic desensitization	A stuffed animal is fearful of the elevator, so systematically goes through the hierarchy (from least to most feared) while simultaneously engaging in relaxing and playful interactions (mutually exclusive with anxiety)
Stimulus fading	A puppet is clingy and upset if father is saying goodnight to her, but able to go to bed easily if mother does the nighttime routine. The mom puppet is gradually faded into the background as dad becomes the parent doing the nighttime routine
Extinction/DRO	A stuffed animal is aggressive with other animals, and does not receive positive reinforcement while aggressive (extinction), but as she exhibits more adaptive behaviors (e.g., playing calmly, sharing) these behaviors are rewarded (DRO)
Time-out	A puppet who is throwing toys at his friends is put in time out away from friends
Self-monitoring	A toy car marks feelings on a scale from frowning to smiling to express his feelings
Exposure/response prevention	A stuffed animal is afraid to use the toilet because she might fall in is gently held on the toilet (exposure) while not being allowed to fall in (response prevention)
Activity scheduling	A puppet who is withdrawing from others is engaged in activities
Relaxation training	A puppet is taught to do deep breathing and practices it with the therapist and other puppets

Table 5.2 Examples of cognitive interventions in CBPT

Identifying dysfunctional thoughts	A puppet draws pictures in a notebook or otherwise records feelings about particular situations
Cognitive change strategies/countering maladaptive beliefs	A puppet says that no one likes her because she was teased. The puppet is taken through the process of examining this, talking about her friends, and how they feel about her, exploring reasons, and trying to make friendships with other puppets
Positive self-statements	A stuffed animal who is afraid to talk in class is helped to make positive statements, “I can talk to my friends”; “It will be nice to talk with them”
Bibliotherapy	A puppet who has divorced parents is read a book about another puppet in that situation
Problem solving	A stuffed animal who is struggling going back and forth between his divorced parents, talks out loud about how he could do this; strategies are discussed and explored
Psychoeducation	A puppet is guided through matching feeling faces with words for those emotions

5.2.3 Integration of Behavior and Cognitive Therapies

It is important to know and understand how behavioral and cognitive interventions can be used and incorporated into CBPT. Once the practitioner is familiar with these interventions, the next step is understanding how they can be incorporated into play. Integrating CB interventions into play communicates concepts without complex verbalizations. Knell and her colleagues have demonstrated such communication through play (Dasari & Knell, 2015; Knell, 1993a, b, 1994, 1997, 1998, 1999, 2000, 2009; Knell & Moore, 1990; Knell & Ruma, 1996, 2003; Knell & Dasari, 2006, 2009).

The clinical efficacy of CBPT (Knell, 1993a) can be expressed by six specific characteristics:

1. Involves the child in therapy through play. So, the child is an active participant, and the problems of resistance and lack of compliance can be more easily addressed. In addition, the therapist can address the child's problems directly, rather than through a parent or significant adult.
2. Focuses on the child's thoughts, feelings, fantasies, and environment. By paying attention to the child's world, the therapist acknowledges that the people, places, and activities the child experiences play a critical role in the development and maintenance of behaviors.
3. Proposes a strategy, or strategies, for the development of adaptive thoughts and behaviors that can help the child deal with situations and feelings. One goal is for the child to replace maladaptive beliefs with more positive adaptive thoughts in order to better cope.
4. It is a structured, directive, and goal-oriented therapy rather than open-ended. Mainly, the therapist works with the child and the family to set goals and helps them work towards achieving these goals.
5. Involves the use of empirically demonstrated techniques. Modeling is one of the most important techniques (Bandura, 1977), and can be easily implemented using puppets and dolls, or other toys. Quite simply, the therapist (via puppets/dolls/toys) models specific behaviors for the child, so that the child observes concrete examples. This, in fact, responds to the need for concrete and non-verbal demonstrations, particularly when addressing children of preschool age.
6. CBPT allows empirical control of treatment, so that both empirically supported treatments can be used, and in situations where possible, the treatment can be empirically studied.

5.2.4 Modeling

Modeling exposes the child to someone or something (e.g., character in a book, stuffed animal, or a toy) that serves as a model and demonstrates adaptive behaviors and coping strategies. According to Bandura (1969, 1976, 1977), modeling is

regulated by interrelated subprocesses such as attention, retention, motoric reproduction, and reinforcement. These processes account for the acquisition and maintenance of observational learning or modeling. Considerable research has demonstrated how people quickly reproduce the actions, attitudes, and emotional responses exhibited by models (Bandura & Walters, 1963; Bandura, 1969; Flanders, 1968). Preschool children are able to induce abstract concepts from cognitive models and to generalize those concepts to unfamiliar tasks (Zimmerman & Lanaro, 1974).

In CBPT, modeling is applied through various tools such as puppets, therapeutic books, storytelling, and movies. For example, a puppet might verbalize problem solving skills, as the therapist speaks at every step: Providing an auditory stimulus and a concrete example for the observing child. At the same time, the therapist can comment out loud and address the issues raised by the puppet. Or, through storytelling, the child has the opportunity to learn models of positive and adaptive behavior through identification with the characters of the story.

A good example of modeling in CBPT is with a 5.5-year-old Terry[1] (first described in Knell & Moore, 1990; Knell, 1993a). Terry refused to use the toilet for bowel movements and was resistant to all parental efforts to finish his "toilet training." After an assessment, a stuffed bear who "pooped his pants" was introduced to Terry. Terry's reactions to the bear in play provided assessment information for the therapist and were used to develop the intervention. The therapist had the bear going through a similar contingency management program as the child (implemented for the child by the parents). In sessions, the bear received stickers, stars, and praise for appropriate toileting and non-soiled pants. The bear expressed maladaptive cognitive beliefs about his toileting which were designed to be like the child's expressed thoughts, and were gradually shaped to be more positive, adaptive self-statements. Thus, the bear's "treatment" was modeled for Terry, who interacted with the bear, and gradually began to exhibit more positive coping skills and toileting behaviors in sync with the bear's behavior and expressed thoughts. Modeling is the main way in which cognitive and behavioral interventions are demonstrated for the child. When one tries to enhance skills, a coping model is often used. Coping models display less than ideal skills and then gradually become proficient. This is contrasted with a mastery model, where the goal behavior is immediately exhibited. For example, a mastery model stops hitting/exhibits calm behavior, whereas a coping model begins to bring hands in to his body, holds them together, and says out loud things that will help with "gentle hands." Modeling is improved by the use of coping models (Bandura & Menlove, 1968; Meichenbaum, 1971). Although there is no clear information regarding when mastery models might be better than coping models, we do know that any type of modeling can be enhanced by positive reinforcement of the model for appropriate/desired behavior and use of models with whom the child identifies (e.g., by age, race, gender, etc.).

[1] This and all subsequent case examples have been scrubbed of any identifiable information.

5.2.5 Structured vs. Unstructured Play

One of the difficult aspects of CBPT for many therapists is how to manage structured vs unstructured play. The goal is to have a balance of both, with structured play possibly leading to more goal-directed activities and unstructured play, where the child brings spontaneous materials to the session. Often the more structured play can be incorporated into the session in a way that is mostly seamless. Examples might be reading a psychoeducational book while characters are enacting being in school, incorporating CB interventions into family play which the child has initiated, but where the therapist has characters introduce such interventions.

CBPT with Terry (encopretic child discussed in the previous section) provides good examples of structured and unstructured play in treatment. Although Terry was engaged and interested in the play, he likely would not have been as involved if therapy had been exclusively structured around the bear's encopresis. The therapist was able to engage Terry by introducing structure into his unstructured play. For example, the therapist introduced the bear as having difficulty "pooping on the potty" (identifying dysfunctional thoughts and behavior), helping the bear work his way, both behaviorally and verbally through using the toilet (exposure/response prevention; countering maladaptive cognitive beliefs), reinforcing the bear for his efforts (positive reinforcement), and ultimately having the bear model appropriate toilet use. These were all structured interventions that were interwoven into Terry's play with the bear and other stuffed animals.

5.2.6 Developmental Issues

CB interventions rely on sophisticated cognitive abilities (e.g., abstract thinking, hypothesis testing), and it is reasonable to question the young child's ability to participate in CBT. However, there is much evidence to suggest that children's ability to understand such interventions can be facilitated by providing them through more developmentally appropriate, accessible means. As such, the therapist can capitalize on the child's abilities, and use play and modeling through play as primary means to communicate some of the more complex CB interventions.

For example, in CBPT with a child who feels no one likes her, a puppet says, "no one likes me" and describes how she is teased. Through play, the puppet "examines" this belief by talking about her friends, and how they feel about her, exploring reasons, and trying to make friendships with other puppets. The therapist can voice some of the alternative explanations for the peers (e.g., Another puppet saying, "My mom was yelling at me, so I was mean to you"; "I teased you because I wish I had that backpack, it's nicer than mine" or other explanations that are derived from the information gathered from the child, parents, and teachers).

5.3 Treatment Description

The CBPT therapist attempts to:

1. Focus on the child's strengths and abilities, rather than weaknesses—play is the child's natural and developmentally appropriate means of communication, so that utilizing play as a communication with the therapist is a logical and natural modality.
2. Focus on experiential interventions that can be incorporated into play, rather than relying on complex verbal skills. When interventions are acted out with toys, the verbal component reinforces the intervention. In these situations, the child does not need to rely on understanding the verbal intervention or be able to express him/herself verbally.
3. Encourage and facilitate language development so that the child learns to describe experiences and emotions. Children are encouraged to learn to associate behaviors with feelings and to express feelings in more adaptive, language-based ways. For example, the child can understand that she is angry and can express that feeling in words (i.e., "I'm angry") rather than behavior (i.e., yelling or hitting). In moving to a more verbal mode of expression, the child can acquire a sense of control and mastery, as well as receive positive feedback from adults around them. For example, if the child is better able to use his words for feelings, and aggressive behavior begins to diminish, he will be showing mastery over those aggressive behaviors and will (hopefully) receive positive feedback for his calmer demeanor (thus reinforcing words rather than aggressive acts). In the previous case example, when Terry would become aggressive with the bear, it was possible to facilitate language development around his feelings, with statements such as, "I think you are angry because the bear…".

CBPT usually takes place in a playroom with traditional toys, art supplies, and books. (See Appendix 10.1 in Knell & Dasari, 2011 for a list of a well-stocked CBPT playroom). There are times when specific anxieties or phobias are best treated outside of a typical playroom, so that they can be approached in vivo. For example, working with a child with an elevator phobia would likely be done both in the playroom and with the therapist in and around a variety of elevators. A fear of being outside, because of bugs, would be better treated in a natural environment, and not in a playroom.

5.3.1 Stages

CBPT is divided into several phases (Knell, 1999), described as the introductory/orientation, assessment, middle, and termination stages.

5.3.2 Introductory/Orientation

The initial interview usually takes place with parents, without the child present, where the therapist gathers a history and background. Additionally, the therapist will help the family know how to prepare the child for the first session. The therapist uses a variety of means, including interviews with parents, bibliotherapy, and structured tasks to explain the therapeutic process to the child. Therapeutic objectives are also identified at this stage (Knell, 2009), and the role of parents and other significant adults are clarified. Parental work is typically an integral part of child assessment and treatment. The therapist can work directly with parents to help them manage child behaviors and establish treatment goals. Knell (1994) points out that although most of the CBPT's work is with the child, the therapist typically continues to schedule regular meetings with parents to support them and work with them towards the achievement of goals.

5.3.3 Assessment

Assessment always takes place at the beginning of treatment, but in many ways is an ongoing process. The therapist aims to define the concerns and develop a treatment plan. The parent interview is used as part of the assessment. In addition to the comprehensive history and background obtained, information is gathered regarding the parental perception of the problem and what has been tried to alleviate the issues. The assessment may also include parent report inventories (e.g., Child Behavior Checklist, Achenbach, 1991), and teacher information obtained via interview and/or teacher report forms (e.g., Teaching Rating Form (TRF)).

When the child is first seen, assessment may include more formal assessment (See Gitlin-Weiner et al., 2000 for such scales), observation of the child's verbalizations and play, and informal measures (e.g., The Puppet Sentence Completion task; Knell, 2018, 1992, 1993a; Knell & Beck, 2000) or therapist-created measures. During this stage, the therapist can collect baseline data (e.g., frequencies of behaviors), if appropriate. During the assessment phase, it is important to gather information regarding maladaptive thoughts that the child may have. These are often obtained via parent report, and through the child's verbalizations during play.

5.3.4 Middle

After a treatment plan is developed, therapy focuses on reinforcement of adaptive behaviors, in efforts to increase the child's self-control and sense of accomplishment, along with teaching the child more appropriate responses to dealing with specific situations. Depending on the presenting problem, the therapist chooses the

most appropriate cognitive and behavioral interventions while engaging the child via play. The interventions must be evaluated carefully, with as much specificity as possible related to the intervention and the child's specific problems/concerns. Caregivers are often involved in the treatment. They may be taught the principles of CBPT, positive reinforcement/ time out, and other approaches to increase the desired behaviors.

The intermediate stage of therapy focuses on interventions to help the child develope adaptive responses to problems, circumstances, and stress factors. Interventions during this phase are often aimed at shifting negative thoughts and beliefs as well as adopting positive self-statements. These traditional cognitive interventions are adapted through tools that do not depend on the use of language, such as expressive arts, bibliotherapy, and semi-structured puppet play (Knell, 1998). Bibliotherapy is particularly useful in CBPT and can involve both published books and books that the child and therapist work on together. The characters in books can function as the model for the child, exhibiting coping skills and demonstrating how to make things better. Additionally, the book may normalize a situation for a child (e.g., "There are so many kids who are dealing with the divorce of a parent, they've written a book about it"). In non-published writings, children might draw pictures of their feelings or tell stories about a child or an animal who shares similar fears. The child observes models of behaviors and coping skills through a character, or interactive dialogue with a puppet (played by the therapist). There are many modes of conveying the CBT aspects of treatment to the child; limited only by the creativity and flexibility of the therapist. The therapist and the child work together to understand the fears and anxieties shared by the puppet and the child to develop affirmations and positive behaviors to help the child.

Towards the end of therapy, the therapist aims to help the child generalize what has been learned in therapy and to bring this "wisdom" back into the natural environment. The child will need to maintain these adaptive behaviors after treatment ends, and therefore promoting generalization should be part of the therapy. Therapy should also be geared to help prevent relapse (Meichenbaum, 1985). This often involves anticipating high risk or difficult situations that might arise and preparing the child and family for dealing with such situations.

5.3.5 Termination

The child and family should be prepared for the end of therapy. As treatment approaches its conclusion, the child may be dealing with feelings associated with losing the therapeutic relationship. The therapist should reinforce the positive changes that the child has made and organize therapy with the conclusion in mind. Generalization and response prevention, which may be introduced in the middle stages of therapy, are a primary focus in the termination phase. Flexibility is usually key. The therapist can gradually decrease therapy appointments with intermittent sessions, rather than having an abrupt end. During these occasional sessions, the

therapist's focus should be on strengthening the learning that has been accomplished. Obviously, any new problems or concerns that arise during this time can be addressed.

5.4 Clinical Applications

By definition, CBPT is playful and there are really no limits to how an individual practitioner can approach each individual child. Play therapists are often, by nature individuals who enjoy getting down on the floor and playing with young children, and as such often capitalize on their own energy, humor, joyfulness, and ability to be "child-like" (in a good way!) Lowenstein (2016) described how creative, play-based activities, when presented within the context of a therapeutic relationship can enhance CBPT's effectiveness. Knell and Dasari (2009) describe a detailed approach for implementing and integrating CBPT into clinical practice.

Therapists may have favorite toys, but it is always important to choose toys that the child enjoys. A favorite toy in the playroom is often a magic wand. Shaking the wand, making a wish, expressing magical thoughts are all things that the therapist can use in positive ways. The child can make a wish at the end of the session which can be an important window into the child's fears and hopes. With parents, the therapist may inquire, "If I had a magic wand that really worked, what would you wish for, for your child?" Again, this may provide important insight into the family's wishes and hopes for their child.

Puppets are another favorite and have been used by play therapists since the early days of play therapy (Woltmann, 1940; Irwin, 1985). Although much of the play therapy literature focuses on puppets, some children do not enjoy them, and it is important to let the child influence the choice of toys. Toy cars and stuffed animals can easily be used as if they were puppets, and therapists need not do much adaptation to make any toy "work" in the CBPT setting.

Children will often identify with certain characters, like superheroes or positive cartoon characters. By integrating these characters and what they stand for into the play, the child can have a clear model of making good choices and doing positive things. The nature of the characters and how they are "super" is critical. Unfortunately, for many young children, characters with over- the -top strength and power, are not helpful models. For example, a child dealing with the struggle between right and wrong can begin to incorporate the powerful, at times aggressive stance of many of the traditional superheroes. This child may try to exert his own strength in negative, aggressive ways. Most play therapists have experienced children bringing strong characters into the playroom, and using them in negative ways (e.g., "I will squash you"; "I am going to kill you").

Sometimes it is important to consider alternatives to these all powerful/all- knowing superheroes. Rescue Heroes is an older (1999–2002) animated series (based on a toy line of the same name, later a movie, currently rebooted on YouTube) in which rescue personnel tried to save lives around the world from human -made and natural

disasters. Calls for help came through a command center where team members (including both male and female rescuers) were dispatched to handle such situations. Personal disagreements were sometimes included, such that the group would demonstrate how to handle conflicts in a positive way. One of the most positive aspects of this series was that the characters were not exhibiting unnatural strength and prowess, but rather using their skills (e.g., as paramedics, firefighters) to "do good." This can be juxtaposed against some of the larger-than-life characters, such as Superman and Batman, the archetypal superheroes. Introducing Rescue Heroes or other positive characters can be critical for some children.

5.5 Case Examples

5.5.1 Clark

Clark was a 6-year-old boy referred because of behavioral issues in his private school classroom. At school, he was often non-compliant and defiant. He had difficulty separating from the parent who brought him to therapy, and often wanted to include his parents in his play. His play frequently portrayed good guys versus bad guys, with lots of violence and killing. His parents noted that they curtailed such play at home. When guided to make better choices, Clark stated that violence was good. This was counter to the messages he was getting at home. His behavior was often silly (in a negative way) and contrary. As therapy progressed, Clark used some of these themes to address issues. For example, he created a circus, in which there were many characters, representing a range of good behaving and problematic characters. As part of the circus, various individuals encouraged others to make positive choices and discourage (e.g., extinguish) negative/aggressive acts. The therapist would encourage various characters when they made positive choices by adding a high five, labeled praise about what they had done, or in some other way behavioral and verbally reinforce adaptive behaviors. Clark leaned towards the powerful characters to determine what direction the play should take, where the therapist encouraged calmer, more appropriate characters. Including the parents in his play, at various times, allowed Clark to involve them in the scenarios he created. A turtle puppet, who could slip into its shell, was used as part of the circus, as the turtle was shy (a term that Clark often used to identify himself) and did not always want to participate in circus activities. The therapist, and later Clark, guided the turtle in slowly feeling more comfortable interacting with the others. Often, the therapist would add positive self-statements for the turtle (e.g., "It feels good to join the others," "It might be scary at first, but I am happy when I join the circus activities"). Later in therapy, when Clark was struggling with "good sportsmanship" in real life, the play often involved games between the therapist and Clark, where he would "teach" good sportsmanship to one of his toys that was observing the game.

This case example shows that CBPT can be quite playful, and that the therapist can use the child's scenarios and issues to encourage characters (models) for the child to exhibit more adaptive and appropriate behaviors. The circus was Clark's idea and came from his spontaneous play. Introducing calmer, more adaptive behaviors to the characters was initiated by the therapist.

5.5.2 Walker

Walker was a 9-year-old boy diagnosed with OCD. His obsessions were extreme and often associated with violence, sexuality, and destruction. The family first consulted a child psychiatrist, and Walker was prescribed medication and CBPT. Walker had a difficult time discussing his obsessions, which he described as "part of his brain being himself, trying to control things, and the other part being controlled by negative forces." In his book, "Talking back to OCD," March (2007) describes how children can take control of their obsessive thoughts and fight back against their compulsive behaviors. His CBT approach to helping children with OCD, described earlier in March and Mulle (1998), puts them in charge of fighting the "bully" in their head. He suggests empowering children in many ways, including giving their OCD a nickname, and countering its maladaptive intrusive thoughts. Because of Walker's interest in war planes, and love of Mexican food, the therapist encouraged him to draw war planes dropping bombs on his obsessions. Walker pretended to be in charge of flying the planes, and ultimately dropping the bombs. He was encouraged to come up with a nickname for the powerful pilot, whom he labeled "General Salsa." General Salsa would drop bombs on the negative, intrusive thoughts. Walker could then write some of the obsessions on a piece of paper, and posing as General Salsa, stomp on the pages, and rip them up. The power and control that these acts provided helped Walker begin to "chase away'" his obsessions. Similarly, General Salsa would crush the compulsive behaviors and help Walker decrease the urges to act out these behaviors.

Walker used the "power" of General Salsa to begin to fight back against negative and intrusive obsessions. By using things that he loved (e.g., War planes, Mexican food), we helped Walker take on the powerful role in talking back to his obsessions.

5.6 Empirical Support for CBPT

A small, but growing body of research considers Cognitive Behavioral Play Intervention (CBPI) with young children. These interventions are not considered to be psychotherapy per se, but they incorporate a standardized three session protocol based on CBPT principles. This work was first introduced in Pearson's (2008) study utilizing CBPT for a non-clinical example of young children. In her study, teachers

reported significantly higher hope and social competence in and fewer anxiety/withdrawal responses in children who received a CBPI intervention.

Fehr reported on the use of CBPI with children with sleep difficulties (Fehr et al., 2016), anxious feelings (Russ & Fehr, 2016) and adjustment in siblings of children with cancer (Fehr et al., 2017). There are also ongoing studies using CBPT with school adjustment and with siblings of children with Autism Spectrum Disorder (ASD) (Personal communication, Fehr, 2020). Although not specifically psychotherapy, these studies are some of the first to empirically support CBP techniques and strategies.

The importance of this preliminary work suggests that CBPI can be used to improve children's adjustment. Given that it is short term (usually three sessions), administered individually or in groups, and targeting both non-clinical and clinical populations, it is an important contribution to the field.

From the perspective of actual psychotherapy, there is strong empirical support for the effectiveness of play therapy with young children (PT-Bratton & Ray, 2000; Bratton et al., 2005; Davenport & Bourgeois, 2008; LeBlanc & Ritchie, 2001). Many of the previous studies did not differentiate among the various theoretical orientations to PT. Given the differences among approaches to PT (e.g., non-directive vs. directive), it is important to utilize as much specificity as possible to understand the findings related to CBPT with young children.

Research has demonstrated that CBT with older children and adolescents is efficacious for a variety of psychological diagnoses (e.g., Compton et al., 2004; Weisz & Kazdin, 2010). Much less research exists when using CBT with young children (under the age of 8) or when integrating CBT with play therapy (e.g., CBPT).

Case reports have described effective adaptations of CBT with younger children (Scheeringa et al., 2007; Miller & Feeny, 2003) although most of these studies do not have a play component. A meta-analysis reviewed studies of CBT with young children (Reynolds et al., 2012). They found that children 4–8 years old, who received CBT displayed better outcomes than no intervention or wait list control children. When compared with 9–18-year-old children, the effectiveness of CBT was not as robust as with the younger population. It seems likely that adding a play component to CBT would increase its effectiveness, but this has not been demonstrated.

Introducing more developmentally appropriate interventions, particular ones that are play based, should increase the effectiveness of CBT protocols as currently used with older children. Trauma Focused Cognitive Behavioral Therapy (TF-CBT), developed by Cohen and colleagues (e.g., Cohen et al., 2000, 2012), is an empirically based intervention used to help children and adolescents recover from trauma. Drewes and Cavett (2012) have developed a CBT intervention that integrated TF-CBT with play for young children.

Knell and colleagues have provided many examples of case reports with CBPT and young children. Presenting problems include: Anxiety (Knell, 1993a, 2000; Dasari & Knell, 2015; Knell & Dasari, 2016,), Behavioral Problems (Knell, 2000), Divorce (Knell, 1993a; Knell, 2003), Fears and phobias (Knell, 1993a; Knell & Dasari, 2006, 2009), Selective Mutism (Knell, 1993a, b; Knell & Dasari, 2011),

Separation Anxiety (Knell, 2000, Knell & Dasari, 2006), Toileting issues and encopresis (Knell & Moore, 1990; Knell, 1993a), and Sexual abuse (Ruma, 1993; Knell & Ruma, 1996, 2003).

One extremely important aspect in understanding any CBPT study involves the use of the term CBPT (which is often applied to studies that do not use a truly CB approach to PT). CBPT is a specific intervention that delivers empirically supported CB techniques using play as the medium. Many researchers are using the term as a catch-all for child therapy that incorporates specific goals and includes play. Given that there is no CBPT manual, there are a wide range of studies that have been labeled CBPT. Many do not truly capture the nature of CBPT and might best be called something else. The term CBPT should be used to describe child psychotherapy, utilizing play, that incorporates cognitive and behavioral interventions. The goals should be psychological in nature (e.g., not purely educational or academic) and should be only used to describe work done by a licensed mental health professional with appropriate training.

Another important consideration is the age range. Even though play is appropriately used with older children, studies of CBPT focusing on children over age 8 years are better categorized as CBT rather than CBPT (Although consideration of intellectual disability should be considered. Thinking of the developmental, rather than chronological age of the child will be critical in cases with older children. For example, a study by Kahveci (2017) used CBPT with a 14-year-old girl with Down syndrome and intellectual disability).

There are some studies that showed improvement after CBPT for children with externalizing behavior problems (Akbari & Rahmati, 2015; Zare & Ahmadi, 2020; Ashori & Bidgoli, 2018) and nighttime fears (Ebrahimi-Dehshiri & Mazaheri, 2011). Several of these studies are published in Arabic, with only an English abstract, making them fairly inaccessible to non-Arabic speaking individuals.

A number of studies described the use of CBPT in group settings with various populations. Included were children with inadequate social skills (Ashori & Yazdanipour, 2018), learning disabilities (Azizi et al., 2018), intellectual disabilities (Bana et al., 2017), self- esteem and social anxiety (Atayi et al., 2018), autism spectrum disorder (Rafati et al., 2016), loneliness and need for self-efficacy (Hadipoor & Akbari, 2017) and externalizing problems in street and working kids (Ghodousi et al., 2017). Although each of these studies documented improvement based on being in a CBPT (vs control) group, it is difficult to truly understand the actual treatments used. Most of these studies do not describe the treatment beyond the broad label of CBPT. Others describe treatment that does not really fall within the rubric of CBPT. For example, Bana et al. (2017) developed play modules, where each session was based on tasks like matching, improving fine motor skills, etc. Although self-esteem improvement was included as a goal of the hands-on skills, the treatment was not geared towards emotional and behavioral improvement, per se. CBPT, by definition, is a psychotherapy approach, not a means of promoting motor skills, cognitive functioning, etc. Furthermore, the children in the Bana et al. study were 8–12 years, which makes them older than the "target" age for CBPT.

Clearly, there is much need for further research in CBPT. Given the current empirical support for use of CBT with older children (ages 9 years and above) and play therapy (ages 3–8 years old) and many successful case studies using CBPT, it seems likely that the play component of CBPT may increase the effectiveness of CBT with younger children.

Future research should be designed to empirically study the use of CBPT with young children with a variety of presenting problems. A clear, concise definition of what constitutes CBPT (ideally a manual, which has yet to be developed) will be critical as a foundation for this research.

5.7 Conclusions

CBPT is a directive therapy focused on improving child behavior and the maladaptive thinking that may exacerbate such behavior. Knell (2009) observes that "cognitive distortions in very young children may be appropriate from the point of view of development, but maladaptive" (p. 119). It is for this reason that the term "maladaptive" seems more appropriate for use with children, as contrasted with the term "irrational" largely used with adults. CBPT focuses on shifting such maladaptive beliefs and cognitive biases and on strengthening adaptive thinking and behavior. The clinical implications of CBPT are based on the correspondence between the level of development of the child and the complexity of the intervention, emphasize the strengths of the child, and reduce the focus on complex linguistic tasks. It is empirical, encourages the development of language regarding feelings, helps the child to develop the correspondence between behaviors and feelings, and encourages the expression of maladaptive behaviors in more adaptive ways.

Finally, cognitive behavioral play therapy interventions are adapted to a child's developmental age. The modality is used as a means of communicating and teaching evidence-based techniques indirectly and as engagingly as possible to young children.

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