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INTERNAL FAMILY SYSTEMS THERAPY FOR CHILDREN IN FAMILY THERAPY

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This article presents a developmentally supported implementation of Internal Family Systems Therapy for school-age children and their families. Relevant developmental characteristics of children are described. Suggestions for working with parents, child-oriented interventions, and a case example are presented.

Internal Family Systems (IFS) therapy was developed as a model combining intrapsychic and systems concepts to assist clients in becoming aware of and embracing their inner lives (Schwartz, 1995). Although Schwartz (1995) mentions the potential benefits of the model for use with children in therapy, neither a rationale nor child-tailored interventions are suggested in his writing. Children have emerging inner lives (Stern, 1985; Watson, 1990), but they have fewer ways than adults to define and explore them (Lane & Schwartz, 1987). In general, interventions for children in family therapy are not prominent. With some exceptions (e.g., Benson, Zimmerman, & Martin, 1991; Combrinck-Graham, 1991; Freeman, Epston, & Lobovits, 1997; Gil, 1994; Hare-Mustin, 1975; Smith & Nylund, 1997; Wachtel, 1994; Wark & Jobalia, 1998; Wark & Scheidegger, 1996; Zilbach, 1986), therapeutic strategies that are oriented toward children have a minor place in the family therapy literature. The purpose of this article is to present developmental underpinnings that support the use of the IFS model with school-age (6–11 years in the applications presented here) children and playful means of implementing the model with this age group. The integration of a family therapy model, developmental principles, and play-oriented techniques is an example of playful family therapy (Wark, 1998), an approach for including children in family therapy sessions.

THE IFS MODEL

The IFS model contends that people have an inner life that can be managed by accessing and acknowledging it (Schwartz, 1995). It is based in part on multiplicity, a theoretical stance that proposes that a person's mind is divided into subpersonalities called parts that interact like a system, forming "networks of relationships" (Schwartz, 1995, p. 35). Each part is unique and complete in itself, yet interconnected to other

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parts like individuals in a family. These parts develop their particular characteristics from life experiences, and thus they are subject to many external influences, including the presence or absence of conflicts with peers, adequate or inadequate parenting, and positive or negative experiences with teachers and other adults in the community. Parts can be positive in nature or can become too extreme (polarized) if they are not given the attention and expression that they require. Extreme parts inhibit an individual's effective functioning. Repression, denial, or nonacceptance of one's parts, or of the aftermath of trauma are avenues to nonexpression of them.

Also identified in the theory is the Self, the core of the personality, which has a different level of consciousness than the parts. According to the theory, each person's Self possesses the qualities of compassion, confidence, and perspective taking, and the Self is the leader of the parts (Schwartz, 1995). It is possible for the Self to be overpowered by extreme parts, which are isolated—sometimes antagonistic—internal family members. Some parts are easily hurt, whereas others are overprotective. Schwartz (1995) identifies three types of parts that have specific functions in the internal family system: Exiles, managers, and firefighters. Exiles carry painful emotions. They are easily hurt and upset and they long to be cared for. Managers try to oversee the exiles and the situations in which exiles might express their pain and distress. If the strategies of the managers fail, the exiles are activated, and firefighters frantically react to control the exiles. Firefighters try to numb the pain of the exiles by any means necessary. Inner resources for growth, creativity, and wisdom are constrained by these polarized parts. When extreme parts are recognized, and their needs are met, the Self becomes strong and in control of a balanced, harmonious internal system. Thus, a basic goal of IFS therapy is the differentiation of the client's parts from the Self (Schwartz, 1995). Therapeutic change occurs through a process of self-awareness, acceptance, and expression of these parts so that the Self can emerge to maintain the leadership role for the parts (Schwartz, 1995). Thus, using the IFS model, the therapist and client work together to recognize and become acquainted with the various parts of the individual and to identify and address the unmet needs of those parts.

A number of theorists have conceived of individuals as being made up of internal parts (see Schwartz, 1995, for an extensive review). Satir, one of the first well-known family therapists to include children in therapy sessions (Zilbach, 1986), proposed that people have many internal parts, each having a number of functions and serving as a source of energy. Satir (1978) referred to an individual's different parts as the person's "many faces" and encouraged the use of imagination to develop personal awareness of the many faces residing within. Satir (1972) also highlighted the importance of expressing all of one's emotions and identified emotional power as essential to the growth of children into emotionally healthy adults.

According to the IFS model, the identification, acknowledgment, and expression of children's parts promotes emotional problem solving and healthy development (Schwartz, 1995). If children are encouraged to learn about and to accept their varied parts and to develop the Self for the leadership role, they may avoid much of the difficulty that adults can have as a result of stifling disliked or threatening parts. A developmentally sensitive application of the model for use with children that is appropriate to their cognitive abilities is needed. The next section considers the developmental readiness of children to conceptualize their behaviors and emotions as expressions of parts of their internal family system.

DEVELOPMENTAL CHARACTERISTICS OF SCHOOL-AGE CHILDREN RELEVANT TO IFS

Several views on child development indicate the appropriateness of IFS as a therapeutic approach for children. The inclusive age range—ages six to eleven—for the interventions presented below corresponds to Piaget's stage of concrete operational thought during which children begin to understand classification systems, can solve cognitive problems, and recognize that more than one perspective on a situation can exist (Salkind, 1985). Thus, children within this age range can separate aspects of their behaviors into categories and are able to understand that a particular aspect of their behavior may be viewed in various ways (Yates, 1991). Well before the age of six, children are capable of creating images in their minds to recall the past or to imagine a possible future (Leslie, 1987; Mandler, 1990), and both primary and secondary emotions are developed (Lewis, 1989). However, without symbolic language ability, which appears around the age of six,

children are not yet cognitively ready to process their internal life. In addition, by the age of six, they also begin to acquire metacognition (Flavell, 1985), the ability to think about their thinking. This growing ability allows them to process information about themselves and contributes to self-knowledge (Rosenberg, 1987). Piaget stressed that development is a spontaneous process, but it is facilitated by adults who elicit a child's perspectives and who stimulate and challenge his/her thinking (Crain, 2000).

At the lower end of this age group, children possess a receptive vocabulary that is more powerful than their expressive vocabulary, meaning that they understand more than they can express (Locke, 1993). Thus, therapeutic tools, such as attractive, fun visual aids, can assist younger children in therapy to find expression for their thoughts and feelings. In addition, children are more likely to express themselves for periods of time during the course of a playful activity. Toward the upper end of this age group, children are able to be more self-reflective regarding their own behavior and its effects on others (Eisenberg, Lennon, & Ross, 1983). Consequently, as children mature cognitively, more internal parts should be available for problem solving as well as a more complicated comprehension of the concept of Self. However, as children experience development uniquely, developmental stage, socioeconomic conditions, gender, and cultural differences, rather than age, should be the primary considerations when assessing developmental accomplishments related to therapy.

In addition to Piaget's conceptualization of cognitive development, Erikson's (1963) theory of psychosocial development is also consistent with the use of IFS with children. Children from ages six to eleven must accomplish a developmental task of wherein they strive to master skills for accomplishments, discover great satisfaction with mastery, and experience feelings of inferiority when skills are not mastered (Salkind, 1985). According to Crain's (2000) commentary on Erikson's views, this stage is a prime time to assist children with feelings of competence by addressing hurts and perceived failures and by acknowledging environmental hindrances to feelings of competence such as racism, sexism, and other forms of oppression. With the therapist's sensitivity and encouragement, children at this stage can be at a ready place developmentally to desire competence in acknowledging and managing their parts.

Another contribution that is relevant to the application of IFS with children is the developmentally based clinical, research, and theoretical work of Harter (1977, 1983*a*, 1983*b*), a researcher and play therapist who has worked with school-age children (6–9 years) on acknowledging and owning contradictory emotions toward the same phenomena. She asserts that interventionists can facilitate the understanding and expression of emotions, specifically more than one emotion at a time (Harter, 1983*b*). Her work suggests that the level of emotional understanding that children can express toward a given situation is diagnostic of problem areas. Cognitively, all young school-age children struggle with emotional concepts; however, those referred for therapy have greater difficulty dealing with contradictory emotions (Harter, 1983*b*). Harter's work supports the identification of emotions to access internal parts as a useful avenue toward resolving therapeutic concerns.

Given the developmental qualities described above, one goal of IFS therapy for children is to create awareness, acceptance, and expression of parts so that the emerging Self can be unobstructed in its development or, if constrained, can be freed for its leadership role. Of equal importance, a second goal of IFS therapy for children is to modify the behaviors of children that may concern adults, teachers, law enforcement, and children. Finally, a third goal of IFS therapy with children is to enhance positive relationship exchanges between parents and children, wherein parents accept and facilitate the expression of their children's parts. In accomplishing this third goal, IFS therapy that fully engages parents in the development of their Selves is optimal.

AN ILLUSTRATION OF CHILDREN'S RECEPTIVITY TO THE IFS MODEL

Children may be more receptive to the IFS approach than many adults because they are less likely to be socialized away from the multiplicity phenomenon (Schwartz, 1995). Certainly, the IFS vocabulary is meaningful and accessible to children as illustrated in the following individual interviews with three children, two of whom were 7 years old, and the other 9 years old, regarding the identification of internal

parts. During their first exposure to IFS concepts, the multiplicity phenomenon was explained to them via photocopies of cartoon characters whose faces demonstrated a wide range of emotions.

Jeffrey, age 7

Therapist: When you look at the character's face, what do you think he's thinking or feeling?
Jeffrey: He's cross-eyed.
Therapist: So, what do you think he's feeling when he's cross-eyed?
Jeffrey: He's feeling silly.
Therapist: So, is there a part of Jeffrey that sometimes feels like being silly?
Jeffrey: Yes.
Therapist: So, what is that part of you like?
[Jeffrey makes silly noises and body movements]
Therapist: [Showing a new cartoon character] Look at the face of this character now. What part of the character is this?
Jeffrey: He's angry [Jeffrey makes growling sounds and punches the air].
Therapist: Do you have an angry part?
Jeffrey: Yes.
Therapist: Talk to me from your angry part.
Jeffrey: I go to my room [Jeffrey says this loudly, punctuating each word].
Therapist: What color would you color this angry part?
Jeffrey: Red.
Therapist: Why red?
Jeffrey: Because red stands for fire.

Bethany, age 7

Therapist: Look at the character's face and tell me what you think it's feeling.
Bethany: Sad.
Therapist: What makes you feel sad?
Bethany: When Alexi [a friend] moves.
Therapist: What is that sad part of Bethany like?
[Bethany curls up in a ball, makes little whimpering noises, sucks thumb].
Therapist: What color would you use to color the sad part?
Bethany: Gray.

Alyssa, age 9

Therapist: What part of the character do you think this is (referring to the cartoon picture)?
Alyssa: The angry part.
Therapist: Do you ever get angry?
Alyssa: Yea, but my heart doesn't, only parts of me do.
Therapist: What color would you choose to make that angry part of you?
Alyssa: Black . . . black and red, because black is darkness and red is fire.
Therapist: Look at this part. Which part of the character do you think this is?
Alyssa: The confusing part.
Therapist: Do you have a confusing part?
Alyssa: Yea, like when I draw a blank on (arithmetic) times tables.
Therapist: What color would you make your confusing part?
Alyssa: White and yellow. White when I draw a blank, because nothing's there, and yellow, like a light bulb, when I think of it again.

The nature of these conversations coincides with other IFS work done with children. A simplified version of IFS was used as one aspect of an intervention to assist children with anger control (Tyrrell & Wark, 1998). These child clients of grade-school age were able to use the basic IFS concepts of parts to identify emotions and to discuss conflicting emotions. They could label their emotional parts by assigning faces, shapes, objects or colors to them, and they were able to use the labels consistently. Research also indicates that children make an association between emotions and colors. In a study of children's understanding of emotions (Scott, 1978), children aged 4–10 years viewed picture cards displaying children who were experiencing physical pain (e.g., accidentally hitting a thumb with a hammer). Particular colors, textures, and shapes were consistently chosen to represent the pain featured in the pictures.

As noted above, children's access to their parts is assisted by using emotional language. Before initiating the exploration of a child's parts, children should have a basic understanding of human emotions including labels for them, the therapist's acceptance of them, and how to communicate them. The child's comprehension of emotions can be assisted by the use of pictures or photos of facial expressions or even cartoon characters designed to help children identify emotions. Poster and book-sized illustrations of emotional expressions are available though therapy resource catalogues. Techniques to assist children in their awareness and means of expressing emotions can be found in other sources (e.g., Gottman, 1997; Gottman, Katz, & Hooven, 1997; James, 1989), and children's books are available to explain emotions to them (e.g., Cain, 1990; Krueger, 1993). Therapists can expect that as children grow older, a wider variety of emotions will be identified because as children develop, their emotions become more differentiated (Harter & Buddin, 1987).

THE PARENTS' ROLE IN IFS-BASED THERAPY WITH CHILDREN

The presence of family members is not necessary to enhance therapeutic efficacy of IFS with adult clients (Schwartz, 1995). However, Schwartz asserts that leaders in families (e.g., parents, grandparents, guardians, or older siblings) must be able to lead internally with their Selves for families to function optimally. Children, who are dependent on adults for a positive growing-up experience, require a context that is amenable to change. In addition, children's means of learning about themselves and of feeling valued primarily occur with close relatives (Cassidy, 1988; Sroufe & Fleeson, 1986) making their involvement in therapy critical. The necessity of the caregivers' roles in their child's therapy is also underscored by the parental contributions required for positive child development. For example, in Erikson's (1963) middle-childhood stage of industry versus inferiority, the parents have a crucial role in promoting ego strength and successful resolution of this developmental stage. Satir (1972) also examined the parental role in positive child development and asserted that parents cannot avoid communicating both positive and negative messages to their child via both their body language and words. Finally, Schwartz (1995) points out that children's parts are most vulnerable to polarization when children are not valued by significant adults. Thus, the contributions of parents as they respond to their child's inner life will be important to the child's self-regard.

The interventions outlined in the next section are preceded by psychoeducation with the caregivers (Schwartz, 1995). Caregivers are introduced to an overview of the IFS for their children, focusing on the parts and self. Knowledge of IFS concepts can move the parents toward a more empathic frame of their child's behavior (Nichols & Schwartz, 1995). If caregivers are reluctant to become personally involved with the interventions, it is helpful to assist them in identifying some nonthreatening, easy-to-relate-to parts of themselves, such as a part that wants the best for their child. The outcome of therapy may not be optimal without the participation and support of caregivers. Therapists may choose to work with caregivers using the full sophistication of the IFS model while simplifying it for their children. For example, with children, the terms manager and exile, are used less often because many children do not have those words in their vocabulary.

THE PROCESS OF IFS THERAPY WITH CHILDREN AND THEIR PARENTS

The process of IFS therapy that includes children is conducted in the following way. From the beginning of therapy to termination, the therapist works through a checklist of steps that interface with the developmental capacity of each child. Repetition of steps could be necessary, and the checklist is not as useful if it is viewed as having a strict temporal sequence. However, therapy is typically initiated by a meeting with parents or other caregivers alone as described above. During the second typical step, the therapist holds one or more sessions focusing each session on the child and leads the child in an awareness of his/her inner life using direct education, playful activities, and/or stories and books. Emotional experiences are an excellent and developmentally appropriate means of accessing children's inner lives, so the therapist assists in the identification of emotions and acknowledges and validates them. The therapist will later use the IFS language in relation to the emotions.

As a third typical step, the therapist interacts with the caregivers in one session regarding some of their own parts, so that the child is not the only one who is revealing his/her inner life, and so the child has examples of what the therapist will ask him/her to do. Therapy for individual caregivers should not supercede therapy for the child. In sessions with the child, the caregivers are engaged in a supportive role, and separate sessions are scheduled for issues that would not directly involve the child. Sensitive therapists will recognize when/if a caregiver is emotionally overcome by the discussion or is moving into a very intimate area of discussion of parts and can schedule a private time with caregivers, if necessary. The discussion regarding parts can be serious, but it should be balanced with some playfulness, so that the child will not become intimidated by the caregivers' discussions.

A fourth typical step involves the engagement of the child by the therapist to define his/her internal parts. The therapist provides activities that can make the parts tangible, examples of which are discussed later. The therapist provides safe, soothing validation for each of the child's internal parts and later elicits the same validation from the parents toward the child. The Self of the child is also provided with concrete representations and the relationships between the parts and the Self is explored and used to resolve the concerns that the family brought to therapy. As therapy unfolds, the third and fourth steps may repeat themselves as new internal parts emerge. Finally, depending on the developmental level of the child, the acceptance of IFS by the parents, and the direction of therapy, the therapist may guide interaction between the child's and parent's internal parts and the development of their Selves. In doing so, the cautious therapist will protect the child's needs in therapy first by conducting individual parent sessions when necessary.

TECHNIQUES

Although he does not elaborate, Schwartz (1995) asserts that any number of techniques can be adapted to access a child client's parts, including those used in play therapy. Traditional play therapy is not used in the following interventions, but a play orientation undergirds them. The use of play is regarded as a highly effective means of conducting therapy involving children and their parents (Chasin & White, 1989). Indeed, encouraging them to be playful in therapy can facilitate problem solving (Gil, 1994; Singer & Singer, 1990). Even very young children are able to understand and enjoy playing games of "let's pretend" (Madanes, 1981; Wachtel, 1994), and make-believe play stimulates experimentation with different ways of behaving and interacting (Ariel, Carel, & Tyano, 1985). Imaginative play exists throughout childhood, but after the age of seven, play becomes more and more oriented to adult-like activities (Singer & Singer, 1990; Pearce, 1992). Suggestions for introducing IFS to children, playful techniques for implementing IFS, and a case example are presented next.

When introducing IFS, children respond well to playful talking about parts and Self. Metaphors and stories for children are a useful beginning for describing parts and their relation to the Self (Mills & Crowley, 1986; Oaklander, 1988). Metaphorically, the color bands of a rainbow become parts, and the sun becomes the Self. Each of the colors is equally important to completing the rainbow. All of the rainbow colors show themselves when the sun is present. Children also relate well to the Walt Disney version of the story of *Snow White and the Seven Dwarfs*. All children feel sleepy, grumpy, happy, or dopey at times. Snow White is a

compassionate Self who treats all of the dwarves as equally important. Although therapists will want to avoid the sexist aspects of the story, the theme of multiplicity is useful, and the story can be retold in nonsexist forms. Older children like to write stories and produce plays about their parts.

Literature or poetry can be used to help children to acknowledge parts that are difficult to reveal to adults or themselves such as those expressing behaviors and emotions that are not considered positive. A classic book, *Where the Wild Things Are* (Sendak, 1963), can suggest that the monstrous creatures, not unlike those with which some children must deal in their internal lives, are like parts with whom children interact. A poem (Viorst, 1981) could express the part of a child that thinks about silent spite for the mean behavior of another child.

The meanest girl I've ever met
Is Mary Ellen Wright
And if a lion came along and
Ate her with one bite
I'd cry and cry and cry and cry.
(But just to be polite.)

Following illustrations of parts and Self, the therapist engages the child in talking about his/her own parts much like the conversation examples earlier in this paper. For example, the therapist may ask the child about parts that are more easily identified or a bit more socially acceptable, such as a disappointed part, a funny part, the part that wants to do well in school, or the part that does not like your sister. In the exploration of parts related to the caregiver's and child's concerns, therapists should be careful to draw out both likable parts and those that are not well liked. Acknowledgment and acceptance of parts leads to less intensity and polarization, which allows the Self to emerge and to lead behaviorally in a more compassionate manner. Thus, the angry or aggressive parts that have been protecting vulnerable parts can be relieved of their domination. Painful, shameful, and uncomfortable parts should be acknowledged so that children can experience their safe expression and resolution in therapy. In doing so, children are not practicing for violent roles in life; they are learning that strong and disturbing feelings can be managed (Monahon, 1993).

Although children have an inner life they may not be curious about it (Harter, 1983*b*), and stimulation of the child's imagination assists recognition of internal parts (Chasin & White, 1989; Irwin & Malloy, 1975; Johnson, 1986; Satir, 1978; Zilbach, 1986). Numerous artistic and playful venues work well to portray the multiplicity phenomena. Some children like to construct enlarged reproductions of pictures or photos of facial expressions or their own depictions of parts into masks. Other children may prefer to focus on the facial expressions on posters or cards. The therapist can continue the process by asking the child what the face is feeling, and by asking if there is a part that ever feels the same way. Dolls, puppets, plastic figures, and stuffed toys are appealing to children who use them to represent parts. Children give voice to them, and their inner lives are sometimes expressed more openly when they communicate their ideas and feelings symbolically (Gil, 1994). Eventually, they develop sympathy for these parts that they can physically touch and behave in accepting ways toward them, for example, by giving them spontaneous hugs.

Some children benefit from the opportunity to use colors with crayons, paints, or markers. The child may choose to color the character as a means of connecting an emotion with the part (Gil, 1994), and therapists can use the connection to elaborate on the characteristics of the parts. If children like drawing, drawings of houses in which rooms are designated for the child's parts work well. Children have created special rooms where parts can go when they are hurt or distressed to ask the Self for comfort and advice. Additions can be made to the house when new parts are discovered, and children can "walk" into the rooms and visit with the parts, introduce them to each other, and eventually have a party, which the Self hosts. Children can be given the opportunity to create personal representations of their parts as the parts become consciously available to them for tackling social and emotional dilemmas. The artwork, posters, dolls, or photographs can be referred to as the child chooses during the course of therapy.

Other child-focused techniques for IFS can be drawn from Harter (1977, 1983*b*). Working from a cognitive-developmental model, Harter (1977, 1983*b*) uses pictures of divided circles to depict different emotions with children who exclude certain emotions from their self-perception. Harter (1983*b*) has also placed a head with multiple faces on clay figures molded by children to suggest multiple emotions and used

balloons over the head of cartoon figures that express the cartoon character's emotions and concerns. She advises that children will show therapists the medium in which they like to work.

CASE EXAMPLE

In the following case, IFS was used to assist a 6-year-old child's adjustment to a new baby in the family. The family consisted of Tyrone (age six), his parents, Mom (age 36) and Dad (age 39), and the new baby, Michelle (age 4 months). Mom called to set an appointment with the therapist because Tyrone was "regressing, being defiant, and acting like a baby." She and her husband believed that Tyrone's development was becoming impaired. Mom also reported that she and Dad had tried talking with Tyrone about what a big boy he was and how he was too old to act like a baby. They had also tried punishing Tyrone with a loss of privileges and using time out when he exhibited anger or immature behavior. None of the parents' attempts had proved successful in stopping these behaviors.

The therapist met briefly with Mom and Dad privately to introduce the idea of an internal system within individuals and to assess their acceptance of the model. Tyrone, but not Michelle, accompanied his parents. The therapist wondered if Tyrone's behavior might be in reaction to the recent birth of his sibling as well as being asked to "be a big boy" faster than he was ready to be one. According to the IFS model, Tyrone's regressed behavior could be an expression of the part of himself that needed parental attention, and the defiant behavior could be expressing an angry part that protected his concern regarding being displaced by a new sibling. This situation seemed to have triggered a need for more physical and emotional nurturing from his parents. The part of Tyrone that was expressing this need could be characterized as his Baby part. The therapist further hypothesized that by permitting and even encouraging Tyrone's Baby part to express his needs and, by encouraging Mom and Dad to meet those needs, the Baby part would come to feel wanted, safe, and less needy. If the Baby part were more satisfied, Tyrone's angry part would feel less need to "protect" the baby by acting out, and Tyrone's Self would regain a leadership role in the internal system.

Next, the therapist used examples of parts with which Mom and Dad were likely to identify to help them gain an understanding of the concepts. For instance, the therapist asked Mom, "I wonder if you find that when you're busy taking care of the baby, but Tyrone is demanding your attention, and there is a part of you that feels sort of torn between your two children, a part of you which feels guilty wondering if you have been short-changing Tyrone because of the needs of the baby?" Mom agreed. Dad believed that he had an Angry part that did not like Tyrone's behavior, but he also thought that he had a part that felt bad for not spending enough time with Tyrone. The therapist was then able to explore with Dad both his Angry part and his Guilty part, which resulted in a calming of the Angry part and a plan to spend more individual time with Tyrone. Finally, the therapist answered the parents' questions and reassured them that what their parts were experiencing was quite common and that they were doing a great job given the demands they faced.

In response to the parents' concerns that Tyrone might not be able to understand the parts conceptualization, the therapist assured them that Tyrone did not need to understand the theory, he needed only to be able to identify and express his parts. The therapist noted that it was her job to help Tyrone initially and that Mom and Dad would eventually take her place. Rather than teach the theory to Tyrone, the therapist would introduce a game of pretending to be a baby while using parts language.

Once the parents indicated that they understood the proposed intervention, the therapist invited Tyrone into the room. The therapist spent a few minutes with Tyrone, chatting about his favorite superheroes, and then she asked Tyrone if he knew why he and his parents had come to the session. Tyrone shook his head, "No." The therapist explained that she was there to help them have a great family. She expressed keen interest in learning more about Tyrone and his family. She asked Tyrone if it were true that he had a baby sister, and he nodded, "Yes." The therapist remarked that babies seemed to have it pretty easy because they were always getting taken care of, cuddled, and held, and fed, and spending lots of time with Mom and Dad. Tyrone nodded agreement. The therapist told Tyrone that there was a part of her that felt like a baby sometimes, a part that liked to be taken care of and liked to feel special. The therapist asked Mom and Dad if they had parts that ever felt that way; Mom and Dad said "Yes." Tyrone's interest in the conversation was piqued. The therapist wondered aloud if Tyrone ever felt like being taken care of in a special way, and

Tyrone almost imperceptibly nodded, "Yes." The therapist then said that she called that feeling a Baby part.

Next, the therapist proposed a game of pretend during which everyone's baby parts could be taken care of and feel special. The therapist asked Dad to start and to have his Baby part make a request for care. Dad's Baby part asked to be hugged by Mom, and she offered a hug. When Tyrone's Baby part's turn arrived, it asked to be held in Mom's lap "Just like Michelle." Mom held Tyrone. Before it was time to end the session, the therapist asked Mom, Dad, and Tyrone if they would be willing to play the baby game with Tyrone whenever he wanted to be with his Baby part. Mom and Dad could take turns letting their baby parts play, but Tyrone's Baby part should get to play everyday if he wished. Privately, the therapist and the parents agreed that Tyrone's Baby part would receive the most attention of anyone in the family.

During the second session, Mom reported that although she and Dad had not made requests of Tyrone, Tyrone's Baby part had made several requests of both parents. A few times, Tyrone had been angry, one time throwing a temper tantrum. Mom and Dad reported that they had told Tyrone that they wanted his Baby part to talk to them and not his Angry part. The therapist reminded the parents that each of Tyrone's part had to be expressed for the Self to emerge in leadership. The therapist suggested that the parents interact with the Angry part when Tyrone wasn't throwing a tantrum.

In the third and last session, Dad relayed that Tyrone had asked whether Michelle had a Baby part. At a 2-month follow-up, the parents reported that Tyrone was still letting them know when his Baby part needed attention. From their perspective, his requests for attention to his Baby part occurred far more than the troublesome behavior.

Play Baby, an intervention designed by Wachtel (1994) was reinterpreted with the IFS model. Play Baby addresses a child's resentment of a caregiver's affection toward a younger sibling or disavowed feelings related to dependency needs. In Wachtel's intervention, caregivers are asked to initiate the expression of pride and enjoyment for their growing child but longing for "their baby." The child's needs are not addressed directly. Instead, the caregivers employ various behaviors that are usually reserved for babies, such as cuddling the child, wrapping the child in a blanket, or feeding the child using a baby bottle.

In addition to the orientation of the IFS model, the approach presented here differs from the Play Baby intervention in that, after practice in therapy, the child initiates the expression of the baby part to receptive caregivers as a step toward the management of parts. In addition, caregivers are assumed to have a role beyond nurturing, and the safe context for Tyrone to express his parts is facilitated by the parents' acknowledging their own parts.

INDICATIONS AND CONTRAINDICATIONS

The IFS model shows great promise for assisting children and their families with children's difficulties. "Knowledge of the internal psychic systems of the family members can be used to understand and respond to the family interactional system" (Dare & Lindsey, 1979, p. 256). The use of the IFS model is indicated as a treatment alternative when children are having trouble directly expressing or identifying their emotions and needs or regressing in some developmental areas in response to stressors or traumas. These interventions are also useful with parents because they normalize the child's behavior. Parents are pleased to understand that when parts are expressed and have their needs met, "troublesome" behavior will be reduced. It is unlikely that the IFS model can be used effectively with children under the age of six because of cognitive limitations, but further clinical exploration is encouraged.

It is recommended that therapists become knowledgeable with and trained in Schwartz's (1995) IFS model before implementing even the simplified version that is presented here. Of course, therapists should not proceed with therapy until joining is accomplished, and trust is established. In addition, they should have a well-honed understanding of child development. Without defining the IFS model developmentally, therapists might expect the Self and parts of a child to look like the Self and parts of an adult. For example, adult clients might portray their managers as superheroes that are trying to perfectly control their distressed exiles. On the other hand, children, who are very attracted to television and film superheroes, might view a personalized superhero as a caring, powerful self.

When using the interventions for extremely sensitive issues, such as abuse, the therapist must proceed

slowly and carefully to prevent the client from becoming overwhelmed with negative emotions (see Schwartz, 1995). One of the greatest areas of concern here are the dissociative disorders such as multiple personality disorder (MPD). With adults, Schwartz (1995) views MPD as a severe fracture and isolation of one's internal parts and does not alter the application of the model with positive outcomes. In contrast, until much implementation of IFS has been documented with MPD children, we rely on the experience of clinicians whose extensive work with dissociatively disordered children recommends against the reinforcement of dissociate mechanism and, thus, the IFS model. "Don't . . . encourage the development of a more complex identity of a fragment [part] that already exists" (James, 1989, p.110).

Internal family systems interventions can be used with a variety of children's presenting concerns. They are beneficial for addressing secrets of sexual abuse by acknowledging the part that "smothers" awareness of abuse and by embracing parts that both hate and love the offender. The model is useful for children who must deal with an adult caregiver's alcoholism by eliciting the part of the child that is confused by the adult's behavior as well as useful as a therapeutic adjunct for the adult abuser. Because of various emotions associated with grief, IFS interventions can be beneficial for children who are coping with death and other loss. Any of the intervention strategies presented can be used during both individual sessions and family sessions.

CONCLUSION

The IFS-based interventions presented here are very adaptable to many presenting concerns with child clients and their families. Generally, these interventions are useful in current problematic situations as well as laying the groundwork for ongoing development and use of IFS language for both child and parents to strengthen their selves and meet the needs of their parts. There are other adult therapies that recognize therapeutic concerns related to one's inner life (for example, see Miller, 1994; Stettbacher, 1993). Such therapies help adult clients to work backward toward the retrieval of child-like aspects that have been neglected or repressed. In contrast, IFS-based interventions for children could increase emotional resiliency and prevent adult pathology (Schwartz, 1995) by uncovering a child's emotional parts and addressing them before these parts become hidden or extreme.

Advancements in the IFS model will include culturally sensitive applications for children and their parents. Further work should also be done to locate developmental shifts in which increasing implementation of the model can be made. In addition, the parents' role should be more closely examined to determine the impact of parental empathy toward their children and their investment on the effectiveness of this therapy. Finally, long-term follow-up studies with child clients could determine whether employing the principles of the IFS model has a preventive capacity.

REFERENCES

Ariel, S., Carel, C., & Tyano, S. (1985). Uses of children's make-believe play in family therapy: Theory and clinical examples. *Journal of Marital and Family Therapy, 11,* 47–60.

Benson, M. J., Schindler-Zimmerman, T. S., & Martin, D. (1991). Accessing children's perceptions of their family: Circular questioning revisited. *Journal of Marital and Family Therapy, 17,* 363–372.

Cain, B. S. (1990). *Double-dip feelings: A book to help children understand emotions.* Pasadena, CA: Magination.

Chasin, R., & White, T. (1989). The child in family therapy: Guidelines for active engagement across the age span. In L. Combrinck-Graham (Ed.), *Children in family contexts: Perspectives on treatment* (pp. 5–25). New York: Brunner/Mazel.

Combrinck-Graham, L. (1991). On technique with children in family therapy: How calculated should it be? *Journal of Marital and Family Therapy, 17,* 373–377.

Crain, W. (2000). *Theories of development: Concepts and applications* (4th ed.). Englewood Cliffs, NJ: Prentice Hall.

Dare, C., & Lindsey, C. (1979). Children in family therapy. *Journal of Family Therapy, 1,* 253–269.

Eisenberg, N., Lennon, R., & Roth, K. (1983). Prosocial development: A longitudinal study. *Developmental Psychology, 19,* 846–855.

Erikson, E. (1963). *Childhood and society* (rev. ed.). New York: Norton.

Flavell, J. H. (1985). *Cognitive development.* Englewood Cliffs, NJ: Prentice-Hall.

Freeman, J., Epston, D. & Lobovits, D. (1997). *Playful approaches to serious problems: Narrative therapy with children and their families.* New York: Norton.
Gil, E. (1994). *Play in family therapy.* New York: Guilford.
Gottman, J. M. (with J. de Claire) (1997). *Raising an emotionally intelligent child.* Cambridge, MA: Harvard University Press.
Gottman, J. M., Katz, L. F., & Hooven, C. (1997). *Meta-emotion: How families communicate emotionally.* Mahwah, NJ: Lawrence Erlbaum.
Hare-Mustin, R. (1975). Treatment of temper tantrums by paradoxical intention. *Family Process, 14,* 481–485.
Harter, S. (1977). A cognitive-developmental approach to children's expression of conflicting feelings and a technique to facilitate such expression in play therapy. *Journal of Consulting and Clinical Psychology, 45,* 417–432.
Harter, S. (1983*a*). Children's understanding of multiple emotions: A cognitive-developmental approach. In W. F. Overton (Ed.), *The relationship between social and cognitive development* (pp.147–194). Hillsdale, NJ: Lawrence Erlbaum.
Harter, S. (1983*b*). Cognitive-developmental considerations in the conduct of play therapy. In C. E. Schaefer & K .J. O'Connor (Eds.), *Handbook of play therapy* (pp.95–127). New York: Wiley.
Harter, S., & Buddin, B. J. (1987). Children's understanding of the simultaneity of two emotions: A five stage developmental acquisition sequence. *Developmental Psychology, 23,* 388–399.
Irwin, E. C., & Malloy, E. S. (1975). Family puppet interview. *Family Process, 14,* 179–191.
James, B. (1989). *Treating traumatized children: New insights and creative interventions.* New York: Guilford.
Johnson, R. A. (1986). *Inner work: Using dreams and active imagination for personal growth.* San Francisco: Harper & Row.
Krueger, D. W. (1993). *What is a feeling?* Seattle, WA: Parenting Press.
Lane, R. D., & Schwartz, G. E. (1987). Levels of emotional awareness: A cognitive-developmental theory and its application to psychopathology. *American Journal of Psychiatry, 144,* 133–143.
Leslie, A. M. (1987). Pretense and representation: The origins of theory of the mind. *Psychological Review, 94,* 412–423.
Lewis, M. (1989). Emotional development in the preschool child. *Pediatric Annals, 18,* 316–327.
Locke, J. L. (1993). *The child's path to spoken language.* Cambridge, MA: Harvard University Press.
Madanes, C. (1981). *Strategic family therapy.* San Francisco: Jossey-Bass.
Mandler, J. (1990). A new perspective on cognitive development in infancy. *American Scientist, 78,* 236–243.
Miller, A. (1994). *The drama of the gifted child.* New York: Basic.
Mills, J. C., & Crowley, R. J. (1986). *Therapeutic metaphors for children and the child within.* New York: Brunner/Mazel.
Monahon, C. (1993). *Children and trauma: A guide for parents and professionals.* San Francisco: Jossey-Bass.
Nichols, M. P., & Schwartz, R. C. (1995). *Family therapy: Concepts and methods* (3rd ed.). Cambridge, MA: Allyn & Bacon.
Oaklander, V. (1988). *Windows to our children.* Highland, NY: Center for Gestalt Development.
Pearce, J. C. (1992). *Evolution's end.* New York: HarperCollins.
Rosenberg, H. S. (1987). *Creative drama and imagination: Transforming ideas into action.* New York: Holt, Rinehart, & Winston, Inc.
Salkind, N. J. (1985). *Theories of human development.* New York: Wiley.
Satir, V. (1972). *Peoplemaking.* Palo Alto, CA: Science & Behavior.
Satir, V. (1978). *Your many faces.* Millbrae, CA: Celestial Arts.
Schwartz, R. C. (1995). *Internal family systems therapy.* New York: Guilford.
Scott, R. (1978). "It hurts red": A preliminary study of children's perception of pain. *Perceptual and Motor Skills, 47,* 787–791.
Sendak, M. (1963). *Where the wild things are.* New York: HarperCollins.
Singer, D. G., & Singer, J. L. (1990). *The house of make-believe.* Cambridge, MA: Harvard University Press.
Smith, C., & Nylund, D. (1997). *Narrative therapies with children and adolescents.* New York: Guilford.
Sroufe, L.A., & Fleeson, J. (1986). Attachment and the construction of relationships. In W. Hartup & Z. Rubin (Eds.), *Relationships and development* (pp.239–252). Hillsdale, NJ: Earlbaum.
Stern, D. N. (1985). *The interpersonal world of the infant.* New York: Basic.
Stettbacher, J. (1993). *Making sense of suffering.* New York: Penguin.
Tyrrell, R., & Wark, L. (1998). The KEY to anger control. In L. L. Hecker, S. Deacon & Associates (Eds.), *The therapist's notebook: Homework, handouts and activities* (pp. 327–330). New York: Haworth.
Viorst, J. (1981). *If I were in charge of the world.* New York: Aladdin.
Wachtel, E. (1994). *Treating troubled children and their families.* New York: Guilford.
Wark, L. (1998, October). *Developmentally appropriate interventions for children in family therapy.* Workshop presented at the annual conference of The American Association for Marriage and Family Therapy, Dallas, TX.
Wark, L., & Jobalia, S. (1998). What would it take to build a bridge? An intervention for stepfamilies. *Journal of Family Psychotherapy, 9,* 69–77.
Wark, L., & Scheidegger, T. (1996). Engaging children in therapeutic enactments in family therapy with the use of a videocamera. *Journal of Family Psychotherapy, 7,* 61–65.

Watson, M. W. (1990). Aspects of self-development as reflected in children's role-playing. In D. Ciccetti & M. Beeghley (Eds.), *The self in transition* (pp. 265–280). Chicago: The University of Chicago Press.

Yates, T. (1991). Theories of cognitive development. In M. Lewis (Ed.), *Child and adolescent psychiatry: A comprehensive textbook* (pp. 246–292). Baltimore, MD: Williams & Wilkins.

Zilbach, J .J. (1986). *Young children in family therapy.* New York: Brunner/Mazel.