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## **Facilitating Children's In-Session Involvement in Child and Family Therapies: A Dynamic Framework of Clinical Practices**

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### **Abstract**

Children's in-session involvement in child and family therapies correlates with both positive and negative treatment outcomes. Thus, it is important to gain a better understanding of the clinical practices that facilitate children's involvement in therapy sessions so that practitioners can employ them with greater precision. To address this need, we conducted a study to answer the following question: What clinical practices facilitate children's in-session involvement in child and family therapies? The data consisted of 16 extant audiovisual recordings of child and family therapy sessions and 24 stimulated-recall interviews with the participants in the recordings. Following constructivist grounded theory and incorporating storyline as an additional analytical technique, we have constructed a framework consisting of four involvement-enhancing practices: managing time, staying relevant, adjusting intensity, and facilitating inclusion. Furthermore, by detailing some of the complex processes that practitioners navigate when they facilitate children's involvement, our study adds a multi-layered and dynamic dimension to the list of already established involvement facilitators. It may be used to moderate an over-standardized work culture that continues to characterize services that address children's needs. The results may be applied to other institutional encounters, providing resonance beyond the analyzed therapy sessions.

**Keywords:** children's involvement, children's participation, child and family therapy, mental health, social work practice, therapy process research

## **Facilitating Children's In-Session Involvement in Child and Family Therapies:**

### **A Dynamic Framework of Clinical Practices**

Children have the right to be involved in matters that impact their wellbeing (e.g., The United Nations Convention on the Rights of the Child [UNCRC], 1989). This implies that practitioners of child and family therapies should strive to facilitate children's involvement in their sessions. However, facilitating children's in-session involvement is far from a straightforward activity and research on the topic has yielded divergent results. Before turning to how practitioners of child and family therapies facilitate children's involvement in their sessions, we provide an overview of this divergent field of research.

#### **Children's In-Session Involvement in Child and Family Therapies**

What children's in-session involvement in child and family therapies entails, or should entail, is part of an ongoing debate and research results point in different directions. Cederborg (1997) equated children's involvement in family therapies as the amount of time children use verbal and nonverbal activities in sessions. Similarly, Jungbluth and Shirk (2009) classified, in somewhat circular terms, children's involvement in cognitive-behavioral therapy for adolescent depression as active participation in the therapy interaction (cf. O'Malley et al., 1983 on Vanderbilt Psychotherapy Process Scale). Chu and Kendall (2004) distinguished between positive and negative involvement behaviors in manual-based cognitive behavioral therapy for children with anxiety. They suggested that positive involvement behaviors include initiating discussions, demonstrating enthusiasm, self-disclosing, and elaborating or demonstrating understanding. According to the same authors, withdrawing or being passive, as well as inhibiting or avoiding, are negative involvement behaviors. In contrast, Morris et al. (2016) proposed a pan-theoretical conceptualization.

From their perspective, children's involvement is more complex than single acts and consists of behavioral, cognitive, and emotional elements. Similar to Edman et al. (2022), Morris et al. (2016) also argued that children's involvement in child and family therapies is multifaceted and may extend beyond the therapeutic setting.

While emphasizing that involvement is more complex than any single act, Morris et al. (2016), like Chu and Kendall (2004) and Cederborg (1997), approached children's involvement as measurable and concluded that a greater degree of children's involvement was desirable. In contrast, Edman et al., (2022) proposed that children's involvement in child and family therapies is inevitable and identified six non-method-specific dimensions to children's involvement: participatory, directive, positional, emotional, agentic, and narrative. In line with other scholars (e.g., Tambuyzer et al., 2014; Ovenstad et al., 2023), Edman et al. (2022) argued that children's involvement behaviors are not innately positive and that practitioners need to be mindful of the implications that the various dimensions to children's involvement may bring. For instance, at times it may be more beneficial to accept that a child emotionally distances himself from what is being addressed in a session rather than trying to upgrade the child's emotional involvement. Relatedly, in a study on the relationship between children's involvement, alliance, and outcome in trauma-focused cognitive behavioral therapy, Ovenstad et al. (2023) underscored that passivity and avoidance are part of children's natural responses in therapy. Furthermore, a growing number of scholars in allied fields have criticized the research community for its tendency to conceptualize children's involvement through the lens of UNCRC (e.g., Skauge et al., 2021), rather than, for example, the meanings children attribute to the concept (Twum-Danso Imoh & Okyere, 2020).

### **Treatment Outcomes of Children's In-Session Involvement**

Given the lack of agreement regarding what children's in-session involvement entails,

it is no surprise that research on whether increased in-session involvement leads to better outcome has offered conflicting results. Although Hudson et al., (2014) noticed that increases in children's involvement over the course of therapy predicted improvements in teacher reported symptoms, and Chu and Kendall (2004, 2009) linked children's involvement to positive treatment outcomes, Shirk et al. (2013) did not find that children's involvement correlated with positive outcomes. Complicating matters further, Karver et al. (2008) found that the effect size between children's involvement and treatment outcome varied across therapeutic settings and approaches. Furthermore, additional studies have proposed that treatment outcome is not connected to children's involvement in general but to their involvement in particular phases of therapy (e.g., Ovenstad et al., 2023). Adding to the complexity, Ovenstad et al. (2023) discovered that not all positive involvement behaviors (as outlined above, Chu & Kendall, 2004) correlated with lesser symptoms and that children who initiate discussions and demonstrate enthusiasm in their sessions displayed more post-traumatic stress symptoms at posttreatment. Results in allied fields also point in different directions. For instance, while Gallagher et al. (2012) linked children's involvement to messy and compromised practices, Vis et al. (2011) and Van Bijleveld et al. (2015) linked children's involvement to children's resilience, wellbeing, and safety.

### **Facilitators and Barriers**

Research indicating what practitioners can do to facilitate (or hinder) children's in-session involvement in child and family therapies are scattered, though less contradicting. Among the identified facilitators are the following: attending to children's experiences and exploring their motivation (Jungbluth & Shirk, 2009), properly explaining the treatment rationale (Ovenstad et al., 2023), using personal examples (Chu & Kendall, 2009), tailoring treatments (Stige et al., 2021), encouraging children to express themselves freely (Núñez et al., 2021), aligning with children and validating their challenges (O'Reilly & Kiyimba, 2013),

integrating ones' approach with colleagues in child services (Thompson et al., 2020), using feedback systems (Lambert & Ogles, 2014), addressing children at their level, and using play to access their realities (Villeneuve & LaRoche, 1993).

While Ovenstad et al. (2023) recently proposed that children who report a strong alliance are more involved in their therapies, Morris et al. (2016) concluded that an affective bond between children and practitioners is not required for involvement to exist. Furthermore, the extent of organizational support, such as training and supervision, may provide practitioners with the conditions they need to facilitate involvement, or not (Thompson et al., 2020). Similarly, Stige et al., (2021) found that managing the pull between system requirements and clinical judgements is the main gateway to adolescent involvement in psychotherapy initiated by adults. Among the factors identified as constituting major barriers to children's involvement are overly structuring sessions (Jungbluth & Shirk, 2009; Fjermestad et al., 2016), children's subordination in nuclear families (Hutchby & O'Reilly, 2010), and practitioners being too pushy (Fjermestad et al., 2016).

Research in allied fields has concluded that the lack of clarity about what children's involvement entails, protectionist perspectives, and narrow interpretations of policies constitute barriers to children's involvement (e.g., van Bijleveld et al., 2015; Toros, 2021; Wågby Gräfe, 2022). In contrast, maintaining fidelity to children's views (Føleide, 2021), creating and sustaining a positive relationship (e.g., Carter, 2014; Gilljam et al., 2016; Diaz et al., 2019; McCafferty & Garcia, 2023), and giving children the opportunity to influence the framing of problems (Heimer et al., 2018) have been identified as factors that facilitate children's involvement. However, both reviews and original research papers have concluded that it is difficult to achieve children's involvement in services that address their needs (e.g., Tambuyzer et al., 2014; van Bijleveld et al., 2015).

## **The Present Study**

In light of the somewhat conflicting results found in the reviewed research, we wanted to delve deeper into the clinical practices that facilitate children's in-session involvement in child and family therapies. We set out to answer the following question: What clinical practices facilitate children's in-session involvement in child and family therapies? Our study is based on observations of extant audiovisual recordings of practice and stimulated-recall interviews with the participants in these recordings. Thus, we aligned with Midgley (2004), Chu and Kendall (2009), and Ovenstad et al. (2023) recommendations and attended to actual clinical work to amend practitioners' tendency to dismiss psychotherapy research as irrelevant to practice. Further, by using extant audiovisual recordings, we had the opportunity to study involvement as it "interacts with the therapist techniques in an ongoing, cyclical, and facilitative process" (Morris et al., 2016, p. 75). With this approach, this study differs from most research on children's involvement in child and family therapies and in allied fields as they have been based on retrospective or altered sources of practice (van Bijleveld et al., 2015; Toros, 2021; Zhang et al., 2022) and/or attended to the effects of involvement (e.g., Skauge et al., 2021) instead of the interactive processes in the practices themselves (cf. Midgley, 2004).

To stay close to practice we based the interviews with the participants on audiovisual recordings of their therapy sessions. Our rationale for interviewing both children and practitioners was that practitioners and children have been found to have different views on what is helpful in therapies (Chui et al., 2020) and that there appeared to be a lack of research that acknowledged both children's and practitioners' perspectives (Chu & Kendall, 2009; Núñez et al., 2021 is a recent exception). Research that incorporates the perspectives of both children and practitioners and attends to actual practices has also been sought after in allied fields (e.g., Ruch, 2014; Westlake, 2016; Forrester et al., 2020).



Our approach to inquiry followed constructivist grounded theory (CGT) (Charmaz, 2014) and we incorporated storyline as an additional analytical technique (Birks & Mills, 2019). Our research design allowed us to delve more deeply into procedural aspects of facilitating children's involvement.

The Swedish Ethical Review Authority approved the project in August 2019.

## **Method**

### **Research Design Overview**

The data and analytic procedure adhered to CGT (Charmaz, 2014), which included the use of grounded theory storyline (Birks & Mills, 2019). We attended to extant recordings of therapy sessions and stimulated-recall interviews with participants in the recordings. In keeping with CGT, we used *involvement practices* and *facilitating children's involvement* as sensitizing concepts. Sensitizing concepts are open-ended focal points that provide analytical directions and points of departure, as opposed to fixed benchmarks (e.g., Charmaz, 2014). Using these concepts provided focus for our inquiry despite dealing with a large quantity of data. Consistent with CGT, the data collection and analysis, including ongoing memo-writing, occurred simultaneously and iteratively. Memos are the analysts' written ideas about codes and categories (Charmaz, 2014). To strengthen the credibility of the results and discussion, we discussed, revised, and refined the analysis throughout the analytic procedure (see *Analysis: A Twelve-Step Procedure*). The first author also discussed and refined the emerging results in national and international research seminars, and with fellow grounded theorists and practitioners. However, to accommodate readability, we present this iterative procedure in succeeding sections.

### **Reflexivity Statement**

The research team has both clinical experience and personal experiences of child and family therapies. The first author has ten years of experience practicing child and family

therapy at mental health clinics. The first and second author each have personal experiences of child and family therapy sessions as next of kin to children. All authors have researched children's involvement and analyzed therapy sessions prior to this study. Our collective experience indicated that children's involvement tends to equate to children being present during care planning and their voices being heard and considered. After inductively operationalizing how children exercise involvement in child and family therapies (Edman et al., 2022), we recognized that there is more to involvement and that involvement is not innately good or bad.

To identify and manage our perspectives and experiences, we used sensitizing concepts, memo-writing, and a thorough research procedure (cf. Glaser, 1978 and Charmaz, 2014 on *theoretical sensitivity* and *examined stance*). The sensitizing concepts directed the analysis towards what the participants did and what interactive functions their actions had (cf. Bavelas et al., 2017), as opposed to possible clinical interests, previous research results, or experiences of involvement. By writing memos throughout the research procedure, we identified and made use of our prior understanding of the phenomenon without letting it negligently skew our analysis. The thorough research procedure grounded our analyses in data and prevented us from drawing hasty conclusions. We used our collective experiences of both practice and analysis to balance our desire to generate results that resonate with practitioners and abstract theory.

The first author has had formal training in CGT and is part of international grounded theory networks.

### **Study Participants and Data Sources**

The data consisted of 16 extant audiovisual recordings of therapy sessions. Each recording ranged from 30 to 90 minutes. The recordings included cognitive behavioral therapy, eclectic therapy, functional family therapy, narrative therapy, solution focused

therapy, systemic family therapy, and unspecified family therapy. The confidentiality of the mental health clinics and social services departments was transferred to the research project.

We also made use of 24 stimulated-recall interviews (Dempsey, 2010) with 9 children and 11 practitioners from the audiovisual recordings (four practitioners submitted two recordings each and, thus, participated in two interviews each). During the interviews, the first author watched the recording with the children and asked them to indicate when they considered or experienced being and not being involved. The practitioners watched their recordings in separate interviews in which they were asked to indicate when they believed or remembered that the child/children in their session/s were and were not involved.

Involvement was not defined for the participants, but it was suggested that it could mean different things to different people. By including several perspectives (children/practitioners and involvement/not involvement), we built sources of comparisons into the dataset (cf. Charmaz, 2014). When a participant pointed to a scene, the first author paused the recording, noted the timeframe, and asked the participant to elaborate on why they had selected that scene and what took place in it (the interview guide is available as a supplementary material). The participants identified 367 scenes, ranging from a few seconds to a minute. As the coding progressed, the participants were also asked to reflect on scenes that related to or contrasted the analysis so far (cf. Charmaz & Thornberg, 2021). Collecting and analyzing data continued until incoming data kept supporting the codes and categories, and vice versa (O'Reilly & Parker, 2013 and Charmaz, 2014, on *theoretical sufficiency*). The first author took detailed notes of what the children and practitioners said in these interviews.

The first author conducted the stimulated-recall interviews as soon as practicable after each session was recorded (Dempsey, 2010), typically within two weeks of recording, but a couple took close to a year to realize. The interviews were held at the mental health clinics,

social services departments, and at the interviewer's workplace. Three interviews were conducted using video conference technology.

At the time of recording (September 2019–January 2022), the participating children were between 9 and 17 years old. Their mean age was 12 years with a standard deviation of 2.1. The children attended child or family therapy at outpatient mental health clinics and social services departments in Sweden. The children represented various socioeconomic statuses, ethnicities, and gender identities. The participating practitioners had been practicing therapy for 3 to 36 years, with a mean of 14 years. We are unable to provide additional information about the participants due to confidentiality. As previous studies have found that children's involvement is not associated with demographics or diagnostic categories (Chu & Kendall, 2004), withholding such information should not compromise the results' quality or usefulness.

### **Participant Recruitment and Data Collection**

The recruitment procedure focused on obtaining access to extant audiovisual recordings of child and family therapy sessions. The first author announced the study on platforms for clinical social workers and contacted associations for specific therapeutic approaches, individual practitioners, and workplaces where practitioners record their sessions as part of their daily routine. The participating practitioners evaluated which children could be eligible based on their assessment of the children's wellbeing and ability to comprehend the purpose of the study. Additional criteria were that the children did not require interpreters and were at least seven years old. As sessions were routinely recorded, the practitioners informed eligible children (and parents when applicable) about the study after the session had taken place. That is, it can be assumed that the study did not affect the children's engagement in the recorded sessions. The procedure also meant that children whom the practitioners

considered likely to be burdened by the study were not subjected to it (cf. Winter et al., 2017; Westlake, 2016).

Children over the age of 15 provided their own consent. Swedish ethical guidelines protect children under the age of 15 from being burdened with consent decisions and stipulates that their legal guardians approve of their participation and that children do not oppose their legal guardians' approvals. We were available to answer questions throughout the research process and the children and parents were invited to meet with us in conjunction to being informed about the study. The participating children and practitioners were also invited to partake in stimulated-recall interviews (see *Study Participants and Data Sources*).

### **Analysis: A Twelve-Step Procedure**

(1) The first author watched the recording from start to finish, before (2) conducting the stimulated-recall interviews. The analysis progressed with a (3) stricter focus on the scenes and the notes from the stimulated-recall interviews (scene/note units). Guided by the full recordings – which contextualized the 367 units – ongoing memo-writing, and sensitizing concepts, (4) the first author attached process-oriented codes to the units (i.e., initial codes, Table 1). The first author then (5) coded these initial codes in gerund (i.e., first-level focused codes, Table 1) and compared them with each other, the initial codes, the recordings, and memos. These steps were continuously revised and refined in collaboration with the second and third authors. Related codes were then (6) subsumed into fewer, more abstract codes (i.e., second-level focused codes, Table 1).

**Table 1**

*Examples of Initial Codes, Focused Codes, and Category*

<b>Initial Codes</b>	<b>First-Level Focused Codes</b>	<b>Second-Level Focused Codes</b>	<b>Category</b>
the practitioner is	changing one's	feeling heard and	staying relevant

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connecting children's involvement to being able to change one's hypothesis and taking the child's point of view	hypothesis	listened to
the child is speaking his mind when the parent is not present in the session	taking children's point of view	staying close to issues that are important to children
the child is relating their involvement to how the practitioner is self	incorporating children's perspective	contextualizing therapeutic activities
correcting its faulty interpretation of what the child said	listening to children	
the practitioner is utilizing the child's own words and phrases	correcting oneself	
the child is acknowledging that the practitioner is listening and therefore knows what is important to his	accommodating to children's language	
	incorporating children's concerns and interests	
	feeling heard	
	being transparent	
	making it meaningful	

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(7) The second-level focused codes were then revised and compared with each other, the first-level focused codes, the initial codes, and existing memos. (8) The first author also tested how codes worked with incoming recordings, tables, and more recent codes. Guided by the sensitizing concepts and memo writing, (9) the first author collapsed the focused codes into tentative categories, which we thereafter (10) revised, refined, and finalized (i.e.,

category, Table 1). All codes and categories are grounded in each recording and stimulated-recall interview.

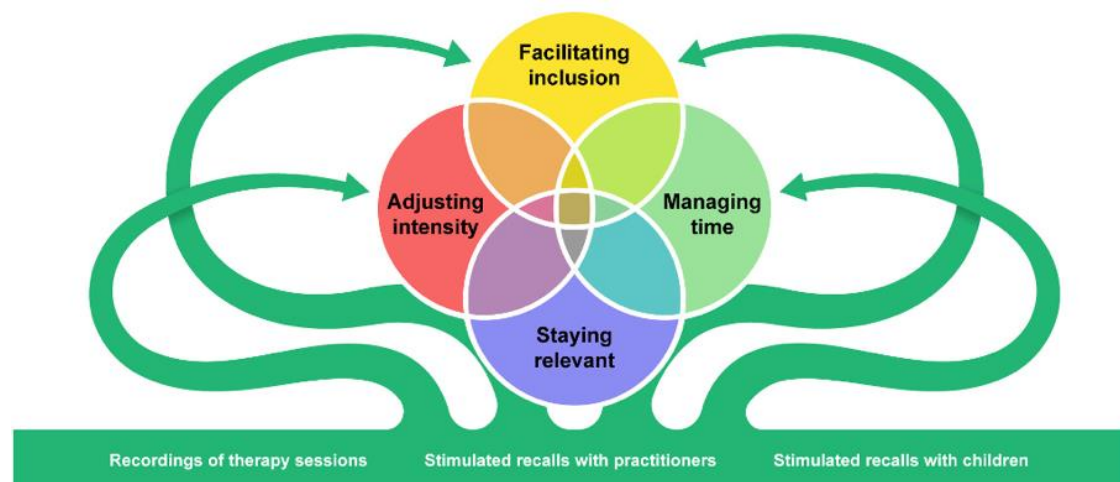
By (11) stepping back from the data and synthesizing the final categories and their relationships on blank pages, the fractured data was woven back together (paraphrasing Glaser, 1978, p. 72) into a storyline (Birks & Mills, 2019). The first author then (12) returned to the data and codes, compared them to the storyline, made minor adjustments, and selected and transcribed units that illustrate the final categories. The first author, who has practiced therapy in English, pseudonymized the units and translated them from Swedish to English. We used “hir” and “ze” pronouns to safeguard the participants' identities.

### **Results**

Following CGT and incorporating storyline as an additional analytical technique, we constructed a framework consisting of four involvement-enhancing practices: managing time, staying relevant, adjusting intensity, and facilitating inclusion (Figure 1). In actuality, the proportions and relationships between the circular fields in the framework may change several times during a single session. For instance, in one sequence a practitioner may focus more on managing time and adjusting intensity than on staying relevant and facilitating inclusion. The same practitioner may do the precise opposite moments later. Thus, the framework depicted in Figure 1 outlines an intricate web of possibilities. Because there is no single process or core practice, the framework adds a multi-layered and dynamic dimension to the list of established involvement facilitators.

**Figure 1**

*A Framework of Involvement-Enhancing Practices in Child and Family Therapy Sessions*



*Note.* A bottom-up conceptualization of clinical practices that facilitate children's in-session involvement in child and family therapies.

Next, we present the framework by combining the storyline we developed in steps 11 and 12 of the analysis with tables that illustrate what the practices look like in actuality (Tables 2–8). The tables contain transcribed scenes that the participants pointed to during their stimulated-recall interviews (left column) and the interviewer's notes of what the participants said about the scenes (right column). We have divided the storyline into four sections. Each section introduces one practice.

### **Managing Time**

*Managing time* consists of temporal aspects of facilitating children's involvement. The practice includes allocating time for children to become involved, regulating the pace of the talk, and managing the timing of therapeutic elements (e.g., questions, formulations) and activities (e.g., affect regulation, psychoeducation).

In the scene in Table 2, the practitioner (Th, short for therapist) timed a hypothetical question (in the form of a "miracle question") with the child's (Ch) current needs and



cognitive abilities. In his stimulated-recall interview, the child reported that the question generated a sense of engagement, which the child associated with his involvement.

**Table 2**

*Key Feature of the Practice Managing Time: Timing Questions with Children's Needs, Abilities, and Preferences*

Scene	Notes
Th: In the middle of, when you're sleeping heavily, a miracle happens	Ch: This question made me reflect. It brought the session forward. I hadn't thought about the question before, so it challenged me and made me engage more in the conversation.
Ch: Mm	
Th: which causes these worries that you have	
Ch: (nods)	
Th: they have resolved.	
Ch: (nods)	
Th: So, you wake up tomorrow morning, and you've no idea because you've slept when this happened.	
Ch: (nods)	
Th: But what's the first thing that'd tell you that something is different, more the way you want it, when you open your eyes tomorrow morning?	
[6.5 second pause]	
Ch: That I'd probably be more eager to go to school.	
Th: (looks at the child and nods)	

In the same interview, the child also expressed appreciation for the general pace of the session. In other words, the table illustrates how hypothetical questions – timed in accordance

with a child's current needs, abilities, and preferred pace of talk – can be used to generate children's involvement. The participating children also identified similar scenes for different reasons: They reported that hypothetical or abstract elements and activities, such as the miracle question, decreased their involvement when they were tired or distracted.

A less successful example of managing time occurred when one of the practitioners, who was about to leave the room, asked a child if they had talked about relevant things. Both the child and the practitioner acknowledged the poor timing of the practitioner's question in their respective stimulated-recall interviews. While the child reported that ze did not have time to answer other than very briefly, the practitioner pointed out that "It would've been better if I'd asked this question sitting down and not while leaving the room." Hence, children's involvement is contingent upon having sufficient time to exercise it. Having time to exercise involvement also concerns more fundamental components, as expressed by one of the children: "I missed the first session because my parent didn't have time to take me to it. This time [points to the recording] my neighbor took me instead." Albeit not always realized, the participating practitioners expressed desires to schedule and structure sessions to meet the children's needs.

An additional aspect of managing time concerns having or taking time to quietly contemplate during sessions. Analyses of scenes in which the children reported being and not being involved, as well as notes from the stimulated-recall interviews, indicated that quiet contemplation arose more effortlessly in sessions with more than two participants. In these larger group constellations, the participants alternated between laid-back positions from which they had time to contemplate and more active roles. When contemplation was not embedded in the two-party constellation, the practitioners created it by providing longer pauses, initiating breaks, using mitigating language, and asking questions timely.

## Staying Relevant

*Staying relevant* consists of sense-making aspects of facilitating children's involvement. The practice includes contextualizing sessions and therapeutic elements and activities, incorporating children's concerns and interests, mitigating one's utterances, offering interpretations that resonate with children, accommodating to children's language, allowing children to set the treatment agenda, and revising one's own agenda and interpretations.

In the scene in Table 3, the practitioner stayed relevant by revising his misinterpretation and accommodating to the child's language and experience. The scene begins with the child explaining that the tone of his parent's voice bothers him.

Although the practitioner expressed that he was unhappy with how he formulated the child's utterance, the child reported that when the practitioner revised his misinterpretation ("it's explicit" and "I don't mean to say that you're overly sensitive") it assisted his sense of involvement. That is, even though the practitioner expressed that he was unhappy with his formulation, the practitioner's ambition and the child's reported need to be heard overlapped.

**Table 3**

*Key Feature of the Practice Staying Relevant: Revising Misinterpretations*

Scene	Notes
Ch: It's the tone [how the parent talks] that bothers me a lot.	Ch: Ze corrects himself, it was nice to hear that ze's listening to me.
Th: Yes ok (nods) you're sensitive to the tone.	
Ch: I'm not sensitive, everyone notices the tone.	Th: I add words that are not right for the child, which isn't how I want to work.
Th: It [the issue] is, that it's [the tone] explicit.	
Ch: Yes	
Th: You notice a difference.	
Ch: Yea, I really notice it.	

Our analysis suggested that accommodating to children's language maintained relevance, but that revising misinterpretations aided children's perceptions of impacting their sessions more forcefully.

In the scene in Table 4, the practitioner stayed relevant by contextualizing the therapeutic process and inviting the child's perspective. The scene was embedded in a sequence in which the participants negotiated the form of their session.

**Table 4**

*Key Features of the Practice Staying Relevant: Contextualizing and Inviting Children's Perspectives*

Scene	Notes
Th: So, I'm thinking, this is the first time we meet to talk alone. Ch: Yeah	Th: I want to understand hir needs. I'm trying to verbalize this.
Th: How would you like to do this, is there something that you think is important? Ch: (looks down) [2 second pause]	

By asking "So I'm thinking, this is the first time we meet to talk alone," the practitioner contextualized the question "How would you like to do this, is there something that you think is important?" The children reported that this type of sense-making and invitation helped along relevance, which, in turn, facilitated their involvement. As a couple of children put it, "I need to know what's going on to be able to be involved" and "When it [the session or a particular element or activity] doesn't make sense, I get anxious and confused. I don't want to talk to hir [the practitioner] if I don't understand what ze's up to."

Furthermore, what increased relevance in one moment could decrease it in another (cf. Table 2 and the accompanying paragraphs). For instance, when practitioners introduced everyday topics at the beginning of a therapeutic process, the children generally reported that they found them relevant (partly because they helped establish a connection with the practitioner) and, thus, facilitated their involvement. When these topics occurred later in a therapeutic process, the children were more likely to write them off as irrelevant as they were ready to talk about more personal or loaded issues. However, as the next practice demonstrates, introducing everyday topics, in contrast to issues that motivated the therapy enrollments, later in a therapeutic session can also reduce the intensity of what could otherwise become overwhelming.

### **Adjusting Intensity**

*Adjusting intensity* addresses the emotional impact that sessions and therapeutic activities may have on children. The practice involves providing emotional relief by making the setting graspable and reducing or moderating therapeutic elements and activities that children experience as too intense. It may also involve amplifying the intensity; if the level of intensity is too low, the child might lose interest and retreat. Hence, adjusting intensity is intertwined with aspects of both managing time and staying relevant. In short, the more relevant children find a topic, the more important it becomes to pay attention to the intensity and the pace of the session.

In their stimulated-recall interviews, the children reported that “easier” questions (e.g., “What have you enrolled in at school?”), as opposed to more abstract topics, nurtured their connection with the practitioners and paved the way for their involvement in more loaded topics (e.g., issues that had motivated their therapy enrollments). Our analysis suggested that by incorporating easier elements in emotionally intense phases (i.e., managing time), also later in the therapeutic process, practitioners can provide a sense of relief that

maintains children's involvement. However, for this to work, children need to understand that this is the desired function (cf. the last paragraph under staying relevant).

In the scene in Table 5 the child and the practitioner spoke about dealing with anxiety. The table foregrounds the relationship between the practices adjusting intensity and staying relevant.

**Table 5**

*Key Feature of the Practice Adjusting Intensity: Balancing Self-Disclosure and Emotional Involvement*

Scene	Notes
Th: What do you do when you're not present, do you zone out or do you withdraw and sort of leave?	Ch: It gets too intense when I talk about how I feel while looking at hir [the therapist]. It's like ze can see inside me. So I become less involved if I don't look away because I can't share as much then, and at the same time I would've been more involved if I'd looked at hir, because we would've had more contact.
Ch: (looks down) but like I can, sort of, I can stay in the room	Th: I want the child to be able to express what ze wants, at the same time I don't want to put too much pressure on hir, so I provide options [refers to "do you zone out or do you withdraw and sort of leave?"]
Th: mm	
Ch: but I'm not really participating in conversations (looks away).	

In hir stimulated-recall interview, the child explained that the topic was so intense that ze had to look down to reduce the intensity to continue speaking. The action of looking down reportedly decreased aspects of hir involvement (hir emotional engagement and connection with the practitioner) while increasing another (self-disclosure). While the table predominantly centers around what the child is doing, it illustrates that children's involvement is linked to adjusting intensity. Our analysis also suggested that both the practitioner's and the child's language soothed and reduced the emotional impact of the topic (the practitioner

provided options and the child's "like" and "sort of" qualified hir utterances). Hence, mitigating language may shape different types of involvement processes (cf. the practices managing time and staying relevant).

During their stimulated-recall interviews, the children also pointed to scenes in which topics that had previously triggered them to retreat (e.g., because they overwhelmed them) had become possible to engage in. This occurred when the level of intensity and the relevance of the topic aligned and were well-timed.

### **Facilitating Inclusion**

*Facilitating inclusion* entails supporting children in becoming involved on their terms. The practice highlights that a useful and well-balanced therapeutic setting is key when encouraging children's involvement. In practice, this entails, but is not limited to, rearranging who is present in sessions, communicating in manners that the children master or prefer, and inviting different forms of involvement. The practice also consists of welcoming children's involvement, even when it is exercised at odd times or in surprising manners.

Aspects of facilitating inclusion were often intertwined with the other three practices. For instance, contextualizing therapeutic activities, qualifying interpretations, and inviting children's points of view (as in Table 4) could generate both relevance and inclusion. Dividing the time to talk among participants (a way of facilitating inclusion in sessions where, for instance, a parent was speaking on behalf of the child) also involved managing time. Dividing time to talk also regulated the intensity of what was spoken about. In the scene in Table 6, the practitioner voiced the participants' roles (teenager/parent) which, reportedly, helped the child become involved on hir terms. Earlier in the session, the child had expressed that hir parent (pt, short for parent/legal guardian) and the rest of hir family place too much responsibility on hir and that ze did not want to be involved in issues that adults are responsible for.

**Table 6***Key Feature of the Practice Facilitating Inclusion: Articulating Positions*

Scene	Notes
Th: On the day of the miracle, it's a miracle that it's as uh good as it can get between a (looks at the child and extends hir hand towards the child, then looks at the parent and gestures towards hir) teenager and a parent, Pt: (smiles) Th: that's the miracle Ch: (nods)	Ch: It's good that ze [the therapist] made it clear that I'm just a teenager and that ze's actually my parent.

While not present in this particular scene, the practitioners also facilitated inclusion by qualifying their interpretations and leaving room for alternative viewpoints and adjustments. Our analysis suggested that practitioners' interpretations were especially useful when they were open to revision and framed as preliminary (which may also manage the pace of the talk and enhance relevance).

In the scene in Table 7, the practitioner had just invited the parent to talk about hir feelings and experiences. The parent's account extended well beyond the selected scene.

**Table 7***Key Feature of the Practice Facilitating Inclusion: Encouraging Listening and Speaking*

Scene	Notes
Pt: Sometimes lately, now, I work in an office that is open until eight, Th: (nods) Pt: so I thought 'ah I get off work half past four so maybe I can stay there [instead of coming home]'.	Ch: It was good that ze [the parent] shared this about thinking about staying at work instead of coming home, so I know. All cards need to be on the table. Th: I let the parent take up space. I don't want to turn a blind eye to the child's context. If the



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Ch: (looks at hir parent)	parent isn't listened to, the parent might disconnect and then I might not be able to continue working with the child.
	In connection to a similar scene, the therapist added:
	Th: It [children's involvement] is about both talking and listening. I want them to speak to each other and hear each other.

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In their separate stimulated-recall interviews, the child expressed that “all cards need to be on the table” and the practitioner reported that listening to and hearing what another person is saying is part of children's involvement – it is difficult for children to be involved in what they are unaware of or do not understand. Feeling a need to know what's going on to be able to be involved concerns both relevance and inclusion.

However, appreciating having all cards on the table (as in Table 7) does not equal being able to speak freely. In the scene in Table 8, the practitioner asked the child what ze would like to be able to do more of. In hir stimulated-recall interview, the child reported that ze did not speak hir mind because ze did not know how hir parent (who was present in the session) would react. On a similar note, the children did not always talk about their involvement as something positive. As one child put it: “I wish that I had held back more”.

### **Table 8**

*Key Feature of the Practice Facilitating Inclusion: Rearranging Who is Present in Sessions*

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Scene	Notes
Th: What would you like to be able to do more of [a potential topic in the therapy], eh, in the next year or so?	Ch: I didn't really dare saying what I was thinking because I didn't know how my parent

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Pt: (looks at hir child)	would react. It's sensitive [the topic] and I get
Th: What sort of things would you like to do more of?	annoyed when ze doesn't understand.
Ch: Ehm (looks away)	Th: I try to involve hir [the child], hear what ze wants and understand what's important to hir.
Th: Is that a difficult question?	
Ch: (nods, looks at the therapist and smiles)	

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Similar to Table 4, where the practitioner mitigated hir utterances, the practitioner in Table 8 was reportedly trying to include the child's perspective (e.g., by asking what the child would like to be able to do more of). However, the child explained ze did not speak hir mind, which the practitioner noticed and compensated for in a later session, where the child was able to speak to the practitioner alone. Using one's professional position to rearrange the therapeutic setting exemplifies facilitating inclusion.

Additional aspects of facilitating inclusion involved creating a space where not only the spoken language was favored and sharing a joint focus on a therapeutic activity. As expressed by one child who stopped the recording at a scene where the practitioner focused more on hir sibling: "But I'm not excluded, I'm also involved. Look [refers to the scene], mom and I are recalling the details of a family event. And all of us are working on the same project."

### **Discussion**

Our results support the proposal made by Morris et al. (2016), that is, children's in-session involvement behaviors "interact with therapist techniques in ongoing, cyclical, and facilitative processes" (p. 75). Indeed, children's involvement is more diverse, inclusive, and relational than dominant discourses imply. Thus, our results may be a step in the direction Twum-Danso Imoh and Okyere (2020) were hoping for when they suggested making children's involvement more holistic, inclusive, and aligned with "the meanings that children

themselves attach to their everyday lives as well as to the key personal and social relationships that they value” (p. 1). For example, our results illustrate that children’s involvement is tied to children’s everyday lives (e.g., managing time), including their interests and values (e.g., staying relevant) relationships (e.g., facilitating inclusion) and their changeable states of being (e.g., adjusting intensity).

Our results indicate that children are involved in their therapies and that children's and practitioners' perspectives coincide (e.g., Tables 3 and 7 where the participants pointed to the same scene for similar reasons). This contrasts previous research that indicate that practitioners and children have different perspectives on both what is helpful in therapies (Chui et al., 2000) and what children’s involvement entails (Van Bijleveld et al., 2015). Thus, despite it being difficult to accomplish (e.g., Tambuyzer et al., 2014; van Bijleveld et al., 2015), our results suggest that children are involved in contemporary child and family therapies, possibly due to the influence prior research. Having said this, and as demonstrated in the results section, facilitating children’s involvement is far from a straightforward activity.

### **Implications for Practice**

In the results section, we delineated an intricate web of involvement-enhancing practices that may provide practitioners, supervisors, and lecturers with ways to further facilitate children’s in-session involvement in child and family therapy sessions. Each involvement-enhancing practice brings about implications for practice. The first practice, managing time, necessitates that practitioners get familiar with each child’s daily hassles and states of being, and adapt sessions accordingly. This presents a particular challenge for family therapy practitioners as more than one child may be present in their sessions.

The centrality of taking time to listen to children, and doing so at times that suits them, is also documented in a study on therapist strategies in adolescent psychotherapy

initiated by others (Stige et al., 2021) and in a study on children's and young people's experiences of the time they spent with their social workers and the skills that their workers employed (Dahlø Husby et al., 2018). Our results suggest that when temporal aspects are not managed in accordance with a child's current needs and abilities, the child may be unable to process or even attend therapy.

The second practice, staying relevant, highlights, similar to the practice managing time, the significance of getting to know children's contexts, including possible experiences of therapy or other institutional encounters. To illustrate, if the child in Table 2 had already heard the miracle question and had not responded well to it, and if the practitioner were to use it again, a contextualization, such as "I understand you've heard this question before, but let's see where it takes us this time," could strengthen the question's relevance. Our results suggest that without relevance, children may neither be interested in getting involved nor motivated to remain involved. This sense-making aspect of staying relevant also pertains to what Ovenstad et al. (2023) underscore, namely the importance of properly explaining the treatment rationale. Since the practice also includes aligning with issues that are relevant to each child, when a practitioner informs a child about their obligations, such as reporting suspected child abuse or neglect, it is imperative that practitioners communicate that the child is still welcome to share such experiences with the practitioner. In accordance with accommodating to children's language (Table 3), a study on young people's recovery from psychological effects of traumatic events associates healing with putting one's experiences into one's own words (Liao Siling et al., 2021). Additionally, restoring breakdown of rapport in the therapeutic alliance, as illustrated in Table 3, is linked to psychotherapy outcome (Eubanks et al., 2018).

Without the third practice, adjusting intensity, children may feel too uncomfortable to talk about what they find relevant and retreat to avoid becoming overwhelmed.

Complicating matters, children may also retreat when the intensity is too low. That is, when encouraging a child's involvement, it is not enough to stay relevant and time sessions and therapeutic elements and activities with the child's current needs and abilities. Moreover, practitioners need to continuously monitor and adjust the emotional impact sessions and therapeutic activities may have on a child. Adjusting intensity by, for instance, letting children set the treatment agendas or accepting that children might need to avoid eye contact is consistent with earlier studies on children's needs and experiences in therapy (e.g., McCrea et al., 2016; Lindqvist et al., 2022). Linguistic devices, such as hedging (mitigating language, e.g., Tables 4 and 5), are also documented as part of goal-related processes in successful therapies (Oddli et al., 2021). In emotionally loaded situations, the soothing function of mitigating language can also protect practitioners and enable them to reconcile complex situations (Ruch et al., 2020). As a result, mitigating language may adjust intensity to meet the needs of both children and practitioners, thereby facilitating the involvement of both. That children in therapy for post-traumatic stress disorder sometimes try to avoid reliving painful experiences (Morris et al., 2016) also underscore the significance of adjusting intensity.

On a similar note, both positive and negative involvement behaviors (Chu & Kendall, 2009) can facilitate involvement processes. For instance, by avoiding eye contact (negative involvement behavior, Chu & Kendall, 2009; Ovenstad et al., 2023), the child in Table 5 was able to self-disclose (positive involvement behavior, Chu & Kendall, 2009; Ovenstad et al., 2023). Adding to the complexity, the children did not report experiences of self-disclosure as exclusively positive. Put differently, children's involvement in child and family therapies is not innately good nor bad (cf. Edman et al., 2022; Ovenstad et al., 2023). It is worth noting that while children have the right to be involved in matters that impact their wellbeing (UNCRC, 1989), they are not obliged to be involved (e.g., Sinclair, 2004).

The fourth practice, facilitating inclusion, highlights that without a useful and well-balanced therapeutic setting, children may feel or become excluded from sessions, thereby making it difficult for them to exercise involvement on their terms or altogether. This means that a practitioner may need to prioritize changing whom is present in a session (cf. Stige et al., 2021) over possible treatment modality traditions and workplace cultures. Tables 7 and 8 both highlight the significance and complexity that this relational aspect may bring: If a parent is not validated and listened to, hir child may miss out on the therapeutic intervention and the chance of exercising involvement. However, a parent's presence can also silence a child and work against hir involvement.

This fourth practice also corroborates earlier studies on what facilitates children's involvement in therapy and what characterizes good practice in allied fields. The significance of being open to different ways of communicating (e.g., Table 4) (Stige et al., 2021), addressing children at their level (e.g., Table 2) (Jungbluth & Shirk, 2009), creating an environment where children can express themselves freely (cf. Table 12) (e.g., Ferguson, 2016; Seim & Slettebø, 2017; Winter et al., 2017; Devaney & McGregor, 2019; Gorin et al., 2021) aligning with children (e.g., Table 4) (O'Reilly & Kiyimba, 2013), and maintaining flexibility when responding to youth's needs (Karver et al., 2018) applies to both staying relevant and facilitating inclusion.

Without a workplace culture that allows practitioners to tailor their sessions to children's individual needs and abilities, the above-outlined practices may become mechanistic and miss their mark. In other words, the type of management and workplace culture (cf. Diaz et al., 2019; Thompson et al., 2020; Stige et al., 2021) may provide practitioners with the skills and conditions necessary both to individualize treatments and to maintain fidelity to their key components – or not. Hence, practitioners' possibilities to

facilitate children's involvement are not necessarily determined by factors they can easily control (cf. Stige et al., 2021).

Because the results are not tethered to a specific therapeutic approach or treatment modality, they may provide resonance outside of the analyzed sessions and insights into procedural aspects of children's involvement in other types of institutional encounters (cf. Midgley, 2004; Morris et al., 2016; Kennan et al., 2018). Our results also illustrate that children's abilities to respond to questions and express concerns are influenced by social and relational processes. These changing aspects of children's involvement may inform and challenge the practice and policies of assessing children's rights to be involved based on their age and maturity – two linear factors that do not sufficiently capture the influence of ever-changing social and relational factors.

Our results extend beyond the explicit topic of children's involvement in child and family therapies. Indeed, children's involvement is not an isolated phenomenon. The components of the delineated practices support part of the existing knowledge on communicating and working with children at large. To conclude, aspects of the outlined practices may have positive side effects (cf. Chu & Kendall, 2004 and 2009; Vis et al., 2011), including healing, reconciling complex situations, and strengthening alliance (Fjermestad et al. 2016).

### **Strengths, Limitations, and Future Research Directions**

By attending to extant audiovisual recordings of practice, preserving their details, and grounding interviews in these recordings, we have strived to achieve ecological validity, namely, results that resonate with both practitioners and children (Cicourel, 1982; cf. Midgley, 2004, on *research-practice gap within child psychotherapy*). By using a rich and theoretically sampled dataset, and a thorough, iterative, and transparent analysis – which steps were continuously discussed and refined among the authors and in additional academic

settings – we have also strived to create a reliable research procedure and credible results. By undertaking a bottom-up analysis of therapeutic processes, attending to naturally occurring audiovisual recordings of practices, and conducting stimulated-recall interviews with both children and practitioners, the article meets calls for research on procedural aspects of children's involvement, research on actual practice, and research that incorporates the perspectives of both children and practitioners.

However, the study has several limitations. Contrary to general guidelines (Dempsey, 2010), two of the stimulated-recall interviews took close to one year to realize. However, when the interviews did not take place in close proximity to the recording, the practitioners appeared more able to focus on the purpose of the interview and less preoccupied with their performance in the sessions and the children's wellbeing. Additional limitations pertain to the dataset and data collection: Because the recordings are of single sessions from longer therapeutic processes, they do not fully capture how children's involvement might change over a longer period. Nevertheless, because we conducted the stimulated-recall interviews after the sessions took place, we were able to attend to some progression (in addition to progressions within the sessions). Since we did not have permission to document detailed demographic information, we were unable to interpret our data and results based on, for instance, ethnicity and gender identities. This limitation may limit the study's transferability. Moreover, involvement processes that may be unique to, for instance, psychodynamic therapy, therapies with even younger children, inpatient clinics, or interpreted sessions are not part of the dataset. While extant, most of the recordings were made after we informed the practitioners about the study (but before the children were informed about it).

Future research may address these limitations by including more detailed demographic information, expanding the inclusion criteria, and only including already recorded sessions. To further secure the practices' usefulness and delve even deeper into what facilitates



children's involvement in child and family therapy sessions, future researchers may replicate the analytic procedure and incorporating more exhaustive forms of membership validation (cf. Stricker & Goldfried, 2019, on *practice-research networks*). Additional studies may also build on our results by exploring how the identified practices and framework might influence treatment outcomes.

### **Conclusion**

The present study delineates a framework of clinical practices that facilitate children's in-session involvement in child and family therapies. The framework may provide practitioners, supervisors, and lecturers with suggestions as to how practitioners may further facilitate children's involvement in child and family therapy sessions. By adding a multi-layered and dynamic dimension to the list of established involvement-facilitators, the framework may also be used to moderate the over-standardized work culture that continues to characterize services that address children's needs (e.g., Munro, 2011; Stige et al., 2021).

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