

THE INTEGRATION OF RELATIONAL PLAY THERAPY INTO INFANT MENTAL
HEALTH TREATMENT SERVICES FOR AT-RISK PRESCHOOLERS AND FAMILIES
LIVING IN POVERTY

By

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ABSTRACT

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A mixed-method study was conducted to examine the process of integrating Relational Play Therapy (RPT) into Infant Mental Health (IMH) treatment services for at-risk preschoolers and families living in poverty. Interviews with parents and clinicians highlight the need for tailored treatment interventions and clinical supportive services to promote protective factors and reduce child and parent risk factors associated with living in poverty. Clinicians and parents reported a variety of RPT and IMH interventions and treatment models that were delivered within a consistent treatment process with four distinctive aspects, all of which heightened parental involvement. RPT interventions were used more often than IMH interventions and significant relationships between RPT and IMH models and other treatment interventions indicate a need for specialized techniques within Non-RPT treatment models or a need for clinicians to tailor Non-IMH treatment models to center on attachment reparation. The clinician-parent relationship served as a conduit to deliver treatment interventions and clinical supportive services. Within the context of a supportive clinical relationship, parents reported feeling more confident and empowered to advocate for their child to friends and family, which led to improved familial understanding, improved natural supports and fewer feelings of social isolation. Further development of the integrative model along with clinical, research and implications are examined.

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This dissertation is dedicated to the preschoolers and families living in poverty that demonstrate resiliency each and every day and the clinicians that help them find their voices through unconditional support and advocacy.

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CHAPTER 1: Introduction

Child and Parent Risk Factors

Young children living in poverty are exposed to multiple risk factors that may impede normative behavioral, social, and emotional outcomes (Aber et al., 2000; Morales & Guerra, 2006; Rutter, 1994; Sameroff, Seifer, & McDonough, 2004; Zeanah & Zeanah, 2009). Due to the exposure of risk factors, young children living in poverty are more likely (than children not living in poverty) to experience emotional dysregulation, which can lead to behavioral and relational problems with peers, caregivers, and adults (Zeanah & Zeanah, 2009). Recent studies indicate preschool children living in poverty have a 36% prevalence rate of emotional and behavioral problems (Fung & Fox, 2014), and 9% of preschoolers who exhibit emotional or behavioral problems meet criteria for more than two mental health diagnoses (Buffered et al., 2012). Equally concerning is that young children who exhibit these behavioral or emotional symptoms demonstrate moderate stability of psychological symptoms over time (Buffered et al., 2012; Ford et al., 2007; Lavigne et al., 1998). The long-term consequences of emotional/behavioral problems and/or symptoms may include parent-child relationship difficulties (Lavigne et al., 1998), lower success rates in earning peer and teacher acceptance (Raver et al., 1999), achieving academic success in kindergarten (Emerson, 2004; Isaacs, 2012) and elementary school (Campbell, 1995; Gimpel & Holland, 2003; Lavigne et al., 1998), lower high school graduation rates (Joseph & Schwartz, 2009) and the development of a more intensive mental illness later in adolescence (Nixon, 2002).

Parental risk factors are also important to mitigate as children grow and develop within the context of a healthy (or unhealthy) parent-child relationship. Parents of young children living in poverty are exposed to high levels of emotional and physical stress (Lloyd & Rossman,

2005) and daily financial hardships related to food and clothing needs, poor housing conditions, unsafe neighborhoods, and/or unreliable transportation (Broussard & Joseph, 2009).

Additionally, parents living in poverty are at greater risk of experiencing strained interpersonal relationships with peers and family (Olson & Banyard, 1993), therefore it is not surprising that these parents report more family problems, lower parental satisfaction and wellbeing, less competence and social support (Neece, 2013; Olson & Banyard, 1993; Pisula, 2007; Rodrigue et al., 1990; Sanders & Morgan, 1997). Cumulatively, parents living in poverty are at-risk of developing mental illnesses with particularly high rates of depression and/or substance abuse disorders (Landy, 2000). Consequently, parents with symptoms and/or a mental illness experience higher rates of parental role strain, parental disruption, and child welfare system involvement (Cook et al., 2014).

The exposure and potential consequences of multiple risk factors associated with living in poverty dually influence parents and young children and subsequently, the reciprocal nature of the parent-child relationship. If research indicates a healthy parent-child relationship can serve as a protective factor (Luther, 2006) and enhance child developmental and behavioral outcomes and help parents gain a sense of satisfaction, competence and overall wellbeing (Mortensen & Mastergeore, 2014); treatment services for young children living in poverty need a specific and shared focus on the child, parent, and parent-child relationship.

In exploring current treatment services and evidenced-based practices for the wellbeing of young children, parents, and the parent-child relationship; two approaches, Infant Mental Health (IMH) and Relational Play Therapy (RPT) were found to be the most common. Experts in both modalities agree that addressing early childhood problems is complex, and require a variety of interventions, including multiple treatment approaches when working with high-risk

families (Gil, 2006; Lieberman & Van Horn, 2008). Therefore, the literature reflected infant mental health clinicians integrating play therapy principles into their practice with toddlers, preschoolers (Benham & Slotnick, 2006; Paradis, 2002 as cited in Shirilla & Weatherston, 2002; Tuters & Doulis, 2000) and play therapists integrating infant mental health concepts into their practice and treatment models with at-risk toddlers and preschoolers (Gil, 2006; Jernberg & Booth, 2010).

Similarities and Differences between IMH and RPT

To understand the process of integration between IMH and RPT, individual treatment models within each approach were examined. IMH and RPT both share a focus on the child, parent and parent-child relationship and view the parent-child relationship as the mechanism of change (Landreth, 2002; Zeanah & Zeanah, 2009). IMH provides services to children birth to five years of age, while RPT focuses on children ages two to twelve years. Variability between IMH and RPT centered on the utility of play and play techniques, parental involvement and the clinician-parent relationship. Additionally, the availability of supportive services (i.e. concrete assistance to meet immediate and basic needs, provider collaboration) were embedded within each IMH treatment model, but were only available in one RPT treatment model. These differences are important to consider as they may create barriers in the integrative treatment process.

Play utility and play techniques. In IMH treatment models, play is used within the context of child/parental psychotherapy to explore child/parental thoughts and feelings, internal working models of attachment, and to resolve inner conflicts related to past histories, including trauma (Lieberman & Van Horn, 2005; 2008; Marvin, Cooper, Hoffman & Powell, 2002). Although the utility of play is similar, play techniques within each IMH treatment model slightly

vary and these differences influence the structure of IMH treatment sessions. Watch, Wait, and Wonder (Lojkasek, Muir & Cohen, 2008), an infant or toddler-led psychotherapy uses non-directive play and spontaneous infant/toddler activity during parent-child sessions to improve parental sensitivity, a child's sense of self, and emotional regulation (Lojkasek et al., 2008). Child Parent Psychotherapy (Lieberman & Van Horn, 2005; 2008) uses child-led play and directive play techniques, and reflective developmental guidance within the context of psychotherapy to improve affect regulation and mutuality within the parent-child relationship (which includes reorganizing internal working models of attachment) to help children (and parents) cope with traumatic events and life stressors (Lieberman & Van Horn, 2005; 2008). Circle of Security (Marvin et al., 2002) utilizes parent education on attachment theory, and psychotherapy to assist parents in understanding their child's thoughts, feelings, and behaviors along with their own choices related to attachment-caregiving interactions during clinician-led parent groups.

In RPT, play and specific play techniques (without a dual application of psychotherapy) are used to explore child/parental thoughts and feelings; practice, master and rehearse adaptive coping skills (Landreth, 2002); and/or resolve inner conflicts related to past histories or trauma (Gill, 2006). Similar to IMH, the application of specific play techniques varies within RPT models. Filial Play Therapy (Guerney et al., 1967; Landreth, 2002; VanFleet, 1994) teaches a parent to implement non-directive play techniques during parent-child sessions to enhance parental observation, attunement, and parent-child communication. Parents eventually conduct play sessions without clinical support, and the clinician serves as a consultant (for up to six months). Integrated Play Therapy (Gil, 2006) uses a combination of non-directive and directive play techniques in combination with art or sand tray techniques to help a child process and cope

with trauma, specifically physical, sexual, and/or emotional abuse. Parents are not involved in child trauma sessions, but participate in family play therapy sessions, and/or parenting support groups. In Theraplay (Jernberg & Booth, 2010), directive play techniques are employed during parent-child sessions to foster attachment reparation. Play techniques focus on child acceptance; and parental ability to set limits (which keep the child safe), engage, nurture and support the child in achieving challenging tasks with adult help (Jernberg & Booth, 2010). Thematic Play Therapy (Benedict & Mongoven, 1997) takes a different approach to attachment reparation. Based on themes and metaphors that emerge during individual child play sessions, clinicians use non-directive and directive play techniques to build a secure relationship between the clinician and child in order to repair the child's maladaptive inner working model of attachment. Separate parent sessions include support, education, and psychotherapy to examine their parental internal working models of attachment (Mongoven, 1995).

Clinician-parent relationship. The clinician-parent relationship varies between the two treatment approaches. Based on psychoanalytic principles, the IMH clinician-parent relationship provides a holding (or containing) function for parents to examine unresolved conflicts and reorganize their internal working models, which in turn facilitate growth in the parent-child relationship (Fonagy & Target, 2003). In other words, IMH clinicians parent the parent so they can in turn parent their child. IMH clinicians prioritize a positive clinician-parent relationship, in which parents feel nurtured, safe, and protected. The nurturing of caregivers within a clinician-parent relationship enhances a parent's ability to make behavioral changes, and develop a strong parent-child relationship (Weatherston & Tableman, 2002). IMH clinicians strive to be consistent, respectful, attuned to parental needs, respond with compassion, follow the parent's lead, and set limits and respond with empathy (Weatherston, 2000). Therefore, during sessions,

the role of the clinician is to facilitate the play process and monitor play themes but within the context of building a positive clinician-parent relationship.

The majority of RPT models view the clinician-parent relationship as a collaborative process in which parents gain support through consultation and education on the play process (Landreth, 2001). During consultations, which may occur before or after the play session, parents explore concerns about their child, and reactions to the play process. Clinicians examine parental reactions and session themes (along with possible meanings), provide Developmental Information and Anticipatory Guidance, and introduce specific parenting strategies to address concerns. Within this collaborative process, RPT clinicians embrace an empathic attitude, respect parents as the primary change agents (for the child or family), remain open-minded, maintain a positive outlook, focus on parental strengths, and instill hope (Landreth, 2002). Thus, in the majority of RPT models, the clinician-parent relationship provides support and a space where parents can address their concerns and receive education. However, it is not a conduit in which they can explore past histories or examine the relationship between their internal working models of attachment and current parenting responses as this is the case with IMH. The exception is Thematic Play Therapy (Benedict & Mongoven, 1997), which does examine parental working models of attachment through the use of psychotherapy and education in individual parent sessions. Aside from Thematic Play Therapy, the primary role of the RPT clinician during sessions is to facilitate the play with the use of non-directive and/or directive play techniques while building a positive child and clinician-parent relationship.

Supportive clinical services. Another variation between the two approaches is the inclusion of supportive clinical services. Within each IMH treatment model, supportive clinical services including concrete needs assistance (i.e. to assist families with gaining resources such as

housing, food, clothing, transportation, health insurance or legal services); provider collaboration; advocacy (to ensure stable care for child within the family system and/or to reduce barriers within larger systems such as child welfare or schools); developmental information and anticipatory guidance, and the development of a positive support system (Weatherston & Tableman, 2002; Weatherston, 2000) are provided to at-risk families. In RPT treatment models, only Integrated Play Therapy (Gil, 2006) provides additional case management services to assist families with concrete needs (i.e. housing, food) and education related to the court system and potential trials. It is possible that play therapists employing RPT models with at-risk young children may offer supportive services within the treatment process, but the inclusion of these services are only part of the Integrated Play Therapy treatment model (Gil, 2006). Given the risk factors previously discussed, it seems likely the consistent inclusion of supportive services are needed in order to assist at-risk children and families in reducing the number, and influence of risk factors associated with living in poverty.

Parental involvement. The variability in play utility/techniques and the clinician-parent relationship shape how parents are involved in IMH verses RPT treatment models. In IMH, parents are viewed as an integral part of treatment and actively participate in the treatment process. Initially, parents provide child and family histories, identify child/parent difficulties and determine immediate and long-term treatment goals during a collaborative assessment between the parent and clinician (Lieberman & Van Horn 2005; 2008). During working phases of treatment, parents participate in the child-led play, or observe the play between the child and clinician during home visits. Additionally, parents participate in the psychoanalytic process (during parent-child sessions or after play sessions) by exploring internal working models of attachment and how they relate to current parenting responses, and in receiving clinical

supportive services (i.e. assistance with concrete needs, advocacy, parenting guidance).

Throughout treatment, IMH clinicians provide continual education to parents on the IMH treatment process and its services as a means to engage and sustain parental involvement (Lieberman & Van Horn, 2005; 2008; Weatherston & Tableman, 2002).

In RPT treatment models, parents are viewed as change agents and actively participate in treatment services. Similar to IMH, parents participate in the assessment process by providing child/family histories, identifying child/parent difficulties or engaging in child observation during the assessment phase of treatment. Initially, parents receive education on the play process; in particular why/how play is used as a modality to address child/parent concerns (Landreth, 2002). During the working phases of treatment, parents actively participate in child-led play, and within two treatment models (Filial Play Therapy and Theraplay) apply learned non-directive or directive play therapy techniques (Jernberg & Booth, 2010; Landreth, 2002) during child-parent sessions. Parallel to play sessions (and to sustain parental involvement) parents receive developmental information or assistance with specific parenting strategies (Landreth, 2002). Additionally, parents may participate in psychotherapy, however, only one RPT treatment model, Thematic Play Therapy (Benedict & Mongoven, 1997) is explicit about its use to explore parental internal working models of attachment in individual psychotherapy sessions (Benedict & Mongoven, 1997). Finally, clinical supportive services (i.e. assistance with concrete needs, advocacy) would be part of treatment process only if parents were involved in an Integrated Play Therapy (Gil, 2006) model.

A Common Practice Despite Differences & Limited Studies

Despite the differences within the utility of play and play techniques and treatment components related to parental involvement and the clinician-parent relationship; integration is a

common clinical practice. According to the literature, integration increases the scope of clinical services and fulfills a treatment need within IMH for specialized play techniques, in particular with older toddlers and preschoolers and/or the ability to utilize play-based family sessions (Lieberman & Van Horn, 2008). For RPT, it enhances parental interventions, in particular the ability to address how previous relationships impact current parent responses. Additionally, it ensures supportive services are embedded within each RPT treatment model, which becomes an important aspect when working with families living in poverty. However, to date, there are no known studies examining the integration process and outcomes related to the integration success, or the effects of the integration on child outcomes (see Appendix A for a list of search engines, key words, and specific journals). As a result, little is known about the clinical decision to implement an integrative model including what types of clinical information is considered (i.e. child/parent behaviors and needs, parent-child relationship difficulties, or need for clinical supportive services) who is involved (i.e. young child, parent, clinician, clinical supervisor) and how they are involved in the process. Once a clinician decides to implement an integrative treatment model, it is unclear what tenets of each approach are (or are not) being utilized, how the integration process impacts parental involvement in treatment sessions, the impact on the clinician-parent relationship and/or the utilization of clinical supportive services.

Therefore, research studies regarding the integrative process are needed in order for clinicians and researchers to identify and gain a more explicit understanding of treatment components within the process that do (or do not) align with IMH or RPT treatment approaches and outcomes of the integrative treatment process and the effects of the integrative process on child and parent treatment outcomes. This knowledge can strengthen a clinician's ability to make evidenced-informed clinical decisions (Spring & Hitchcock, 2009; Thyer & Pignotti, 2011)

and can serve as a guide for clinicians focused on promoting the parent-child relationship and reducing risk factors of preschoolers and families living in poverty. Given the limited studies and the state of Michigan recently expanding the definition of IMH to include children ages 4 and 5 years (MAIMH, personal communication, 11-19-14), it is imperative that future studies prioritize integrative treatment models that are inclusive of at-risk preschoolers and families.

Prior to examining an integrative treatment process, it is important to consider the concepts behind integration from each treatment approach and understand the efficacy of individual treatment models. Therefore, the following literature review focuses on conceptual literature related to integration process and efficacy studies for individual IMH and RPT or existing integrative treatment models within IMH and RPT specific to 3 to 5-year-old children living in poverty. This specific age range was chosen because three, four, and five year old children have the developmental capacity to utilize symbolic or metaphoric play, which is a key variable in a child's ability to process and resolve psychosocial difficulties within the context of relational play therapy approaches. IMH clinicians identified the acquisition of this developmental milestone as a primary reason to integrate play therapy into infant mental health (Benham & Slotnick, 2006; Paradis, 2002; Tuters & Doulis, 2000). Since young children ages 0 to 2 do not have the developmental capacity to use symbolic or metaphoric play, they were excluded from this study. The determinant of at-risk was included as a criterion, as RPT clinicians viewed it as a primary reason for integrating infant mental health and play therapy (Benedict & Mongoven, 1997; Gil, 2006).

Definitions of Terms

The following definitions are included to provide clarity. They are derived in accordance with academic literature.

At-Risk: A young child or parent is considered at-risk when they have been exposed to one or more risk factors, which includes poverty.

Risk Factor(s): A risk factor is an attribute or experience that may lead to developmental and/or mental health concerns. Risk factors for young children and parents include insecure or disruptive parent-child attachment relationships, low parental education, parental substance abuse, parental mental illness, poverty, single-parent families, teen mothers, non-employed parents (within the previous year), and residential mobility (changed residences one or more times in a 12 month period) (Robbins, Stagman & Smith, 2012) food shortages and unreliable transportation (Broussard & Joseph, 2009).

Infant Mental Health (IMH): IMH is an inter-disciplinary field rooted in the belief that a healthy parent-child relationship is necessary for the optimal physical, social, emotional, and cognitive development of a young child (Weatherston & Tableman, 2002). The parent-child attachment relationship is a central aspect to IMH services as it shapes the cognitive, emotional, and social context of early childhood experiences. These experiences lead to the development or impairment of cognitive schemas that help a young child organize and interpret information, self-regulatory skills and the organization of behavior from a systems perspective (Weatherston & Tableman, 2002; Whipple, 2015). IMH acknowledges the parent-child relationship is co-constructed and therefore focuses on the reciprocal nature of the secure vs. insecure attachment relationship (Whipple, 2015). Parents are also an integral part of IMH as their ability to seek and maintain a secure relationship relates to their nurturing style and responses, which are derived from their own childhood experiences and current levels of parenting stress (Weatherston & Tableman, 2002).

IMH Services: IMH services are relationship-based with a shared focus on the child,

parent, and the parent-child relationship. IMH services are usually intensive, long-term, home-based, preventive, strength-based, and comprehensive (Whipple, 2015). The young child and parent(s) are seen together and the parent-child relationship is the focus of treatment. However, all members of the family are encouraged to participate in treatment and this may include siblings, grandparents, or be extended to non-family members such as supportive neighbors, or teachers. IMH services include developmental guidance and parenting, parental empathy and support, concrete assistance with basic and immediate needs (which includes connecting families to community resources), advocacy, encouragement to solve problems and plan ahead, support to develop a positive support system and the resolution of unresolved conflicts (rooted in early childhood experiences) to reorganize internal working models of attachment (Fonagy & Target, 2003) and modify current maladaptive behaviors or parenting responses (Weatherston & Tableman, 2002; Weatherston, 2000). Overall treatment goals include healthy development of the young children, reduction of risks and pathology for the child and parent, and stability of the parent-child relationship (Weatherston & Tableman, 2002; Weatherston, 2000).

Concrete Needs Assistance: Clinicians assist families with gaining resources or providing referrals to obtain basic and immediate needs such as housing, food, clothing, transportation, health insurance and legal services.

Advocacy: Clinicians advocate on behalf of the child to ensure stable care within the family system and advocate for families within larger systems such as court, school(s), and/or child welfare.

IMH Clinician-Parent Relationship: Within IMH, the clinician is responsible for the establishment of a positive clinician-parent relationship, in which parents experience a secure attachment relationship. This provides a holding (or containing) function for parents to examine

unresolved conflicts and reorganize their internal working models, which in turn facilitate growth in the parent-child relationship (Fonagy & Target, 2003). Thus, a positive clinician-parent relationship enhances a parent's ability to make behavioral changes, and develop a strong and secure parent-child relationship (Weatherston & Tableman, 2002). To create a positive and secure clinical relationship, IMH clinicians strive to be consistent, respectful, attuned to parental needs, respond with compassion, follow the parent's lead, set limits and respond with empathy (Weatherston, 2001).

Integration of Treatment Models: When one or more treatment models are combined in order to meet the developmental and mental health needs of the young child, parent, and/or family; and within the context of the family's environment and/or cultural needs.

Internal Working Model of Attachment: A person's cognitive framework that compromises mental representations for understanding the world, self and others (Bowlby, 1969). For example, a healthy internal working model comes from secure attachment and looks like this: "I am lovable, others are trustworthy, and the world is open for exploration."

Parent or Caregiver: A parent or caregiver is defined as a person or persons who provide basic care for the young child and serve as the child's primary attachment figure.

Parental Involvement: Occurs when the parent actively participates in discussions with the clinician during home visits and either observes or participates in the play during play sessions.

Positive Parent-Child Relationship: A parent-child relationship is formed during day-to-day reciprocal interactions, and these interactions foster the attachment process. Sensitive, and responsive caregiving support a healthy and secure attachment, which is also known as a positive

parent-child relationship. A positive parent-child relationship provides the foundation for optimal emotional, social, and brain development (Crockenberg & Leerkes, 2000; Zeanah & Zeanah, 2009) including a child's sense of self (Tronick & Beeghly, 2011). In contrast, non-positive or problematic parent-child relationships may increase the likelihood of maladaptive child outcomes (Scheeringa & Zeanah, 2001).

Poverty: When a family's total income falls below the federal poverty level. In 2012, the federal poverty line was \$19, 090 for a family of three (Robbins, Stagman & Smith, 2012). Distinctions within the federal poverty level include low-income (less than 200% of the federal poverty level), poverty (less than 100%), and extreme poverty (less than 50%) (Robbins et al., 2012). For this study, all three distinctions are included in the definition of poverty.

Protective Factor(s): Reduction of the impact of risk factors. For young children, the parent-child relationship is a conduit in which young children experience risk factors (Zeanah, Boris & Scheeringa, 1997), and a positive parent-child relationship can buffer risk factors young children are exposed to (Luther, 2006; Zeanah & Zeanah, 2009). For example, if parents promote self-regulation and minimize problematic behavioral tendencies, children are less likely to develop maladaptive developmental trajectories (Degnan et al., 2008).

Psychotherapy: Is derived from psychoanalytic theory (Freud, 1905) and focuses on the unconscious processes that manifest in a person's current behavior. The relationship to the clinician is the focus of therapy, and a person's adaption to their environment and past relationships are emphasized (Fonagy & Target, 2003). The therapeutic relationship provides a holding (or containing) function (Bowlby, 1969) for clients to examine unresolved conflicts and reorganize their internal working models; which facilitates continued growth and development (Fonagy & Target, 2003).

Relational Play Therapy (RPT): RPT is an overarching term inclusive of play therapy approaches rooted in attachment, relationship, developmental and trauma theories. RPT models are inclusive or solely focus on young children, and parents are actively involved throughout the assessment and treatment process. RPT treatment goals are centered on child symptom reduction and enhancing the parent-child relationship. Based on these criteria, RPT includes the following play therapy models: Filial Play Therapy, Theraplay, Integrated, and Thematic Play Therapy. In all of these approaches, the parent-child relationship is viewed as the mechanism for change, and therefore, aligns with two meta-analyses indicating parental involvement is a strong predictor of play therapy effectiveness (Bratton, Ray, Rhine & Jones, 2005; LeBlanc & Ritchie, 2001).

RPT Models: RPT models are relationship and play-based, and can be applied in a variety of settings including outpatient and/or home-based, schools, and/or hospitals. RPT models do vary in their application of play techniques, and subsequently parental involvement. For example, Theraplay uses directive techniques within parent-child sessions, and Thematic Play Therapy utilizes both non-directive and directive techniques (tailored to needs) for individual child sessions, and psychoanalytic techniques within individual parent sessions. There are differences between intended clinical populations within RPT models. Theraplay, Thematic, and Integrated Play therapy address attachment concerns, but only the latter two focus on resolving interpersonal traumas. Filial Play Therapy is for non-traumatized children, and parents who are stable enough to engage in treatment without their own psychopathology interfering with the process. Other than Thematic Play Therapy (which is solely focused on preschoolers), the majority of RPT models can be utilized with young children up to age 12, and incorporated into treatment with adolescents, and adults. This can be a strength when addressing the needs of older siblings, parents and/or other family members. Overall goals of RPT include

the reduction of risks for the child and parent, reduction of child pathology and stability of the parent-child relationship.

RPT Clinical-Parent Relationship: In RPT, the clinician-parent relationship is viewed as a collaborative process in which parents gain support through consultation and education on the play process (Landreth, 2002). During consultations (which occur before or after the play session), parents explore concerns about their child, and reactions to the play process. Clinicians examine parental reactions and session themes (along with possible meanings), provide developmental information and guidance, and introduce specific parenting strategies to address concerns. Within this collaborative process, RPT clinicians embrace an empathic attitude, respect parents as the primary change agents (for the child or family), remain open-minded, maintain a positive outlook, focus on parental strengths, and instill hope (Landreth, 2002).

Supportive Clinical Services: Supplemental services to parents that include concrete assistance with basic and immediate needs such as housing or food (which includes connecting families to community resources), provider collaboration, advocacy, developmental and anticipatory guidance and the development of a positive support system (Weatherston, 2000; Weatherston & Tableman, 2002).

Metaphoric Play: Play that is inclusive of metaphors in which a child ascribes meaning to one toy “as if” it is another object to suggest a likeness or analogy between them.

Symbolic Play: When a young child uses a toy or toys to represent inner thoughts, feelings and/or life events. Also referred to as fantasy play.

Thematic Play: Play that produces either verbal or themes within the play. Themes are inferences and are not facts.

Treatment Component: Element(s) that are integral to a specific treatment model, and are

needed in order to obtain fidelity of the model.

Treatment Process: Refers the progression of treatment from the assessment to the working phases of treatment, and the end or termination phase. Times within each of these phases depend on the needs of the client/family and specific treatment models.

Very Young Child: A child birth to 3 years of age.

Young Child or Preschooler: A child between the ages of 3 and 5 years.

CHAPTER 2: Literature Review

Prior to examining an integrative treatment process, it is important to understand the concepts behind integration from each treatment approach. Additionally, the efficacy of individual IMH and RPT models and existing integrative models within IMH or RPT specific to 3 to 5 year old children need to be examined. Therefore, the following literature review focuses on conceptual literature and efficacy studies for each IMH and RPT treatment model or integrative IMH or RPT models specific to 3 to 5-year-old children living in poverty.

IMH Treatment Models

Child Parent Psychotherapy (Lieberman & Van Horn 2005; 2008) is a major treatment model within IMH and centers on helping young children and parents cope with traumatic events and life stressors. Thus far, four randomized controlled studies have been conducted on CPP with young children ages 3 to 5 years old. Sample sizes ranged from 75 to 137 indicating positive outcomes on a variety of standardized measures including the Child Behavior Checklist (Achenbach, 1991), Beck Depression Inventory (Beck, 1996), Bayley Scales of Development (Bayley, 1989), Ainsworth Strange Situation (Ainsworth, 1978) and SCL-90 Symptoms Checklist (Derogatis, 1994). Outcomes specific to older toddlers and preschoolers include less child resistance and anger, higher levels of maternal empathy and positive parent-toddler interaction with Latino immigrant mothers (Lieberman, Weston & Pawl, 1991), reduced preschool and parent trauma related symptoms and reduced problematic behaviors (Lieberman, Van Horn, Gosh Ippen, 2005; Ippen et al., 2011) and positive duration of treatment effects for up to six months (Lieberman, Van Horn & Ippen, 2006). The sample for the latter two studies was ethnically diverse and included mothers that identified as Bi-racial (38%), Latino (28%), African American (14%), White (9%), and other (2%). CPP is widely accepted as an evidenced-based

practice within the field of IMH and it has been labeled “well supported and efficacious” by the National Child Traumatic Stress Network Empirical Supporting and Promising Practices (Lieberman et al., 2006).

The Circle of Security (COS) is an IMH treatment model centered on the parent and his/her ability to improve caregiving sensitivity, recognition and understanding of overt and covert child cues and caregiver reflection (Hoffman et al., 2006). Hoffman, Marvin, Cooper & Powell (2006) conducted a pre-intervention and post-intervention study with 65 toddler or preschool dyads from Head Start and Early Head Start in a group treatment setting. The majority of sample identified as Caucasian (86%). Utilizing the Ainsworth Strange Situation (1978), 69% of participants (which included mothers, fathers, foster parents, and one grandmother) changed from a disorganized to an organized attachment classification.

When exploring the efficacy literature, one integrated IMH treatment model was discovered. A randomized controlled trial conducted by Cassidy, Woodhouse, Sherman, Stupica and Lejeuz (2011) integrated a brief version of COS in combination with Video-Based Intervention to Promote Positive Parenting (Velderman et al., 2006) with 174 infants. Four home visits were conducted that focused on enhancing parent observation, recognizing infant signals (to improve sensitivity), attending to attachment and exploratory infant behaviors (i.e. soothing baby cries or slowing down parental response to cries), exploring parental cognitive and affective responses to baby behaviors, and examining the possibility of making changes (Cassidy et al., 2011). The study sample was diverse; mothers identified as African American (43%), White (20%), Bi-racial (18%), Hispanic (14%), and Asian (2%). Although the sample was infants, (which is outside the specific age range for this study) this work became of particular interest due to the integrative components of the treatment model, and the level of detail within

the methods section regarding session content which provided insight into how researchers developed the integrative model, and applied it to parents. Results from the Ainsworth Strange Situation (Ainsworth, 1978) and the Neonatal Behavioral Assessment Scale (Brazelton & Nugent, 1995) demonstrated treatment efficacy for highly irritable infants with dismissive biological mothers and for highly preoccupied mothers with moderately irritable infants (Cassidy et al., 2011). This study also marked the only known IMH publication found that integrated two models (COS and VIPPP) that explored the relationship between the modified model and treatment outcomes.

Finally, Watch, Wait and Wonder (WWW) focuses on parent-infant or parent-toddler dyads to improve a child's sense of self, emotional regulation and the parent-child relationship (Lojkasek, Muir & Cohen, 2008). The developers of Watch, Wait and Wonder (WWW) conducted a non-randomized study with 67 parent-infant dyads that were assigned to either a Watch, Wait and Wonder or an Infant-Parent Psychotherapy treatment group (Cohen, Muir, Lojkasek, Muir, Parker, Barwick & Brown, 1999). The Bayley Scales (Bayley, 1993), Chatoor Play Scale (Chatoor, 1986), and Parenting Stress Index (Abidin, 1986) indicated that for both groups (after five months of outpatient treatment), there was a decrease in infant/toddler problems, parenting stress, maternal intrusiveness, and mother-infant/toddler conflict (Cohen et al., 1999). Additionally, the Watch, Wait and Wonder treatment group indicated greater shifts towards a more organized or secure attachment, and greater improvements in cognitive and emotional regulation along with higher rates of parent satisfaction (Cohen et al., 1999). A six-month follow up study was conducted with 58 (out of the original 67) parent-toddler dyads and found that progress was maintained with the Watch, Wait and Wonder treatment group and that both groups continued to show improvements for two years after treatment (Cohen, Lojkasek,

Muir & Parker, 2002). For both of these studies, it was surprising to learn the race and/or ethnicity of the infants or mothers was not reported. Only maternal age (M=32) years and education (M=6) years post high school were reported.

The Concept of Integration of Play Therapy Within IMH

As noted earlier, only one study was located that examined an integrated treatment model (Cassidy et al., 2011). The study integrated a brief version of COS (4 sessions) in combination with VIPPP, which indicated treatment efficacy for highly irritable infants with dismissive biological mothers and for highly preoccupied mothers with moderately irritable infants (Cassidy et al., 2011). However, as the results indicate, the sample was focused on infants, and was not inclusive of 3 to 5 year olds. Casting a broader net, additional literature was found in conceptual literature, and/or case studies. Overall, the integration of multiple treatment interventions to tailor services to high-risk families was viewed as a necessary and accepted practice (Lieberman & Van Horn, 2005; 2008; Paradis, 2002; Tuters & Doulis, 2000). Specifically, the integration of play therapy and infant mental health was proposed to increase the scope of clinical services and fulfill a treatment need within infant mental health for specialized play techniques, in particular within individual sessions with older toddlers and preschoolers and/or the ability to utilize play-based family sessions (Lieberman & Van Horn, 2008). For play therapists, integration fulfilled a need to focus on parental mental health needs and high-risk families within an ecological (Bronfenbrenner, 1979) and a resiliency-based (Patterson, 2002) framework. Thus, in a sense, it provides play therapists an overarching treatment model focused on early childhood, and the involvement of parents or additional caregivers into treatment.

Within the conceptual writings, it was noted that the use of play was viewed as a natural medium to help facilitate communication and expression in the child-clinician relationship or

within the child-parent-clinician relationship (Paradis, 2002; Tuters & Doulis, 2000). The role of play was based on the development of the young child and their ability to utilize (or not) symbolic or metaphoric play (Benham & Slotnick, 2006; Paradis, 2002; Tuters & Doulis, 2000). Therefore, play with very young children was utilized to increase maternal and paternal sensitivity, while play with older toddlers and preschoolers was used to help the child and parent process their story, and learn additional coping skills. In addition, play therapy was often recommended for individual child sessions (when warranted) and to increase the scope of directive play interventions during parent-child, and/or family sessions (Tuters & Doulis, 2000). However, the details regarding the process of treatment, and the role of the therapist were somewhat vague. It was also unclear if non-directive and/or directive play techniques were being utilized in sessions. Further examination of the CPP manual also discovered the use of play specifically to help young children and parent(s) process and heal from their traumas, which included a discussion on toy selection, and how to include parents in the play process (Lieberman & Van Horn, 2005). However, play was described as “just playing” verses play therapy, and again it was unclear what specific non-directive and/or directive play techniques were being utilized. As integration is an accepted and common practice (Lieberman & Van Horn, 2008; Paradis, 2002; Tuters & Doulis, 2000) with at-risk preschoolers and their families, it is vital that its efficacy is explored.

Future IMH Needs

In order to fulfill current gaps within IMH, future studies need to provide in-depth knowledge about the integrative process and its relationship to specific treatment outcomes. Equally important (for clinicians implementing integrative models), future research needs to include details related to the implementation of the treatment model (i.e. specific constructs from

each model and techniques implemented) to ensure treatment fidelity as demonstrated in Cassidy et al. (2011). In terms of design, the continued use of child, parent and relationship-focused standardized measures is important, however, data also need to be collected from fathers (even if the mother is present) and/or additional caregivers (i.e. grandparents, extended family, supportive friends and/or neighbors) to increase validity and reliability of treatment outcomes with a variety of caregivers. The latter is innovative, and could lead to deeper understanding of the different systems that influence early childhood and parental mental health including how supportive caregivers impact treatment outcomes. Finally, future studies also need to examine treatment outcomes at several different intervals in order to measure long-term outcomes (Lieberman, 2008; Moss, Dubois-Contois, Tarabulsky, St.-Laurent, & Bernier, 2011).

RPT Treatment Models

Filial Play Therapy (Gurney & Gurney, 1967) is centered on improving parental attunement, and communication skills with their child during play sessions. Three controlled trials were conducted on the original six-month format of Filial Play Therapy and results from a parental self-report scale (developed by Gurney, Stover & O'Connell in 1964) indicated significant child (ages 3 to twelve) and parent relational improvements (as cited in Gurney et al., 1967). One of the trials was a group format (1971), and additional clinical observations suggest part of the relational improvement related to the increase of self-reflection during play sessions and less parental directive behavior (Gurney et al., 1967).

Utilizing the tenets and treatment goals of the original model, Landreth developed a 10-week format of Filial Play Therapy (Landreth, 2002). Since this development, several controlled trials have been conducted at the Center for Play Therapy at the University of North Texas. Sample sizes within these trials ranged from 7 to 22 in the treatment groups, and 7 to 21 in the

control groups. The range of children was 3-10 years of age, which is inclusive of 3 to 5 years olds, but not specific to young children. The majority of samples were predominantly White Americans and came from middle class backgrounds. These studies utilized similar measures including the Porter Acceptance Scale (Porter, 1954), Parenting Stress Index (Abidin, 1983), and the Measurement of Empathy in Adult and Child Interaction (Guerney, Stover & DeMerritt, 1968). Results from these controlled trials demonstrate an increase of parental empathy (Bratton & Landreth, 1995; Brown, 2000; Chau & Landreth, 1997; Costas & Landreth, 1999; Glover & Landreth, 2000; Harris & Landreth, 1997; Jang, 2000; Kidron & Landreth, 2010; Smith & Landreth, 2004; Yuen & Landreth, 1997; Yuen, Landreth & Baggerly, 2002) parental acceptance (Alivandi-Vafa et al., 2010; Kale & Landreth, 1999; Landreth & Lobaugh, 1998; Tew et al., 2002; Topham et al., 2011), parental stress (Costas & Landreth, 1999; Glover & Landreth, 2000; Jang, 2000; Kidron & Landreth, 2010; Yuen, Landreth & Baggerly, 2002), reductions in child problematic behaviors (Alivandi-Vafa et al., 2010; Baggerly, 1999; Beckloff, 1997; Topham et al., 2011), reductions in child anxiety (Glazer-Waldman et al., 1992) and depression (Tew et al., 2002), and improved child-parent and family relationships (Boyer, 2011).

Clinical populations within these studies included children with pervasive developmental disorders (Beckloff, 1997), learning disorders (Kale & Landreth, 1999), mental retardation, chronic illness-in the hospital (Tew et al., 2002), chronic illness-out of the hospital (Glazer-Waldman et al., 1992), child sexual abuse (Costas & Landreth, 1999), and domestic violence (Kinsworthy & Garza, 2010; Smith & Landreth, 2004). Filial therapy has also been examined and demonstrated to be effective with incarcerated mothers (Harris & Landreth, 1997), incarcerated fathers (Landreth & Lobaugh, 1998), single parents (Bratton & Landreth, 1995) and

recently in combination with a neuro-sequential model to high-risk preschoolers (Barfield, Dobson, Gaskill & Perry, 2012).

Filial Play Therapy has also demonstrated effectiveness in increasing parental empathy, and reducing parent stress with homogenous samples focused on specific cultures including Native Americans (Glover & Landreth, 2000), Korean Americans (Jang, 2000; Lee & Landreth, 2003), Israeli families (Kidron & Landreth, 2010), Chinese American families (Chau & Landreth, 1997; Yuen & Landreth, 1997; Yuen, Landreth & Baggerly, 2002), and parenting acceptance with Iranian families (Alivandi-Vafa & Ismail, 2010). Additionally, a case study indicated improved parent-child relationships and positive family interactions with a Native American family (Boyer, 2011).

Qualitative studies of the FPT 10-week model have also been conducted and indicate improvements in child problematic behavior, parental understanding, positive perceptions of the parent-child relationship (Bavin-Hoffman, Jennings & Landreth, 1996; Edwards, Ladner, & White, 2007; Foley, Higdon & White, 2006; Kinsworthy & Garza, 2010; Solis Meyers & Varjas, 2004; Wickstrom, 2009), improved partner communication (Bavin-Hoffman et al., 1996), and improved marital relations and family functioning (Wickstrom, 2009). To date, no outcome studies have been completed on the 20-session format (VanFleet, 1994).

Theraplay (Jernberg & Booth, 2010) centers on the parent-child dyad and attachment reparation. There are a total of four controlled studies examining the efficacy of Theraplay (Jernberg & Booth, 2010), however, only one study focuses on young children (Wetting, Coleman & Geider, 2011). The latter study utilized a sample of 167 children ages 2 to 6 that presented with a language disorder and were either shy or withdrawn (Wetting et al., 2011). Results from the Clinical Assessment Scale for Children and Adolescent Psychopathology

(Doepfner, Berner, Flechtner, Lehmkuhl & Steinhausen, 1999 as cited in Wetting et al., 2011) indicated children in the Theraplay treatment group demonstrated improved assertiveness, self-confidence, trust, and expressive and receptive communication along with a decrease in social withdrawal when compared to the control group (Wetting et al., 2011). These results were maintained over a two-year period. Recently, Theraplay has been awarded an evidenced-based status from the California Evidence-Based Clearinghouse (2009) based on the results from the Wetting et al. (2011) study, its publication of a manual which was recently revised (Jernberg & Booth, 2010) and an extensive training certification program.

To date, no known outcome studies have been conducted on Integrated Play Therapy (Gil, 2006) but Gil has outlined a comprehensive treatment approach to children who have experienced varying levels and degrees of physical, sexual, and/or emotional abuse (2006). Interventions include a variety of modalities and are tailored to help the child and/or family process the many aspects of trauma and may include individual play-based therapy inclusive of expressive therapies such as art, play, or sand tray work; group therapy consisting of structured short-term groups for children, family therapy; psychopharmacology (if needed); parent-child therapies including filial play therapy, or parent-interaction therapy; and parent support groups (Gil, 2006). Supportive services are inclusive, but are specific to child maltreatment. These supportive services include advocacy, support and Developmental Guidance to parents, case management as needed, and education focused on navigating court and legal proceedings. Similar to IMH, this model supports tailored treatment services, use of empirically supported theories and neurobiological concepts. These aspects do increase the design validity of this integrated approach, however, studies need to examine its treatment effectiveness with at-risk young children.

Thematic Play Therapy (Benedict & Mongoven, 1997) is the final play therapy approach included within RPT. Thematic Play Therapy seeks to individually repair a child and parent's maladaptive inner working model of attachment. To date, two studies have been conducted using aspects of Thematic Play Therapy. Snow, Hudspeth, Gore and Seale (2007) utilized two case studies to explore connections between play themes and child behavioral outcomes. Utilizing Thematic Play Therapy Thematic Codes (Benedict & Hastings, 2002) and the Childhood Behavioral Checklist (Achenbach, 1991) results indicated a relationship between play themes in play sessions, and the reduction of externalizing behaviors and aggressive behaviors outside of play sessions (Snow et al., 2007). However, generalizability of findings is limited due to the low number of case studies used (Snow et al., 2007).

Holmberg, Benedict and Hynan (1998) reviewed 33 records of children with attachment concerns to explore gender differences within play themes. Utilizing Thematic Play Therapy Codes (Benedict & Hastings, 2002), results indicated both girls and boys held themes related to aggression, failed and positive nurturing, instability, safety, ambivalence, and doing and undoing. Positive nurturing was the most frequent theme for both genders. Girls demonstrated higher rates of positive self-nurturing, fixing, control and constancy (Holmberg et al., 1998). Boys that were exposed to violence had higher levels of aggressive themes, and girls exposed to violence had higher rates of failed nurturing, and broken characters in which figurines were sick, hurt or needed repair (Holmberg et al., 1998). Although these studies further examine the validity and clinical utility of the thematic codes, generalizability is limited due to the small sample size, and the use of the Thematic Play Therapy Code (Benedict & Hastings, 2002), which is a non-standardized measure (Snow et al., 2007).

The Concept of Integration of IMH Within RPT

Many RPT treatment models have been developed from the integration of theories and corresponding clinical interventions specific to young children. Therefore, it is not surprising two RPT models, Integrated Play Therapy and Thematic Play Therapy, utilize similar infant mental health theories (i.e. attachment, developmental, psychoanalytic and trauma) and principles (Benedict & Mongoven, 1997; Gil, 2006). On the other hand, Theraplay is closely related to infant mental health, in particular due to its use of parent-child sessions (Jernberg & Booth, 2010). Filial Play Therapy utilizes similar relational concepts by using the parent-child relationship as the mechanism for change. Similar to IMH, many RPT models recommend the integration of treatment models, and/or additional play techniques to tailor treatment services (Benedict & Mongoven, 1997; Gil, 2006). In addition, supportive clinical services are recommended to meet the needs of high-risk families (Gil, 2006). However, these recommendations stem from either conceptual writings and/or the corresponding treatment manuals and to date, no outcome studies have been conducted focusing on the integration of play therapy into a RPT or non-RPT treatment model.

Future RPT Study Needs

Future studies are needed that focus on the integration of play therapy into an infant mental health approach specific to 3 to 5 year olds who are living in poverty. Moving forward, it is important to keep in mind RPT research critiques while designing future studies. For example, the majority of quantitative RPT studies focus on two-parent families with middle to higher incomes (ranging from \$30,000 to \$60,000). One study attempted to address this limitation, and focused on recruiting single parents, which led to 41% of the sample having an income of below \$20,000 (Topham et al., 2011). Results from this study demonstrated RPT effectiveness as

evidenced by greater reductions in child behavior problems, improved parental acceptance, and parent communication of this acceptance during parent-child play (Topham et al., 2011).

However, the sample size was relatively small (N=27), which limits the generalizability of the study to low-income families. Thus, there continues to be a need to examine RPT efficacy with larger samples of low-income families.

Similar to IMH, data needs to be collected from a variety of caregivers ensuring fathers are also represented in samples. RPT studies used a variety of measures, however, some were not standardized which impacts the validity of the study and leads to a variety of related outcomes. In order to build a more supportive literature base with higher levels of validity and reliability, standardized measures focused on similar relational constructs (i.e. the parent-child relationship) need to be incorporated into new studies along with the continued use of multiple measures.

CHAPTER 3: Methodology

Problem Statement

Although each approach has efficacious treatment models rooted in randomized or non-randomized studies, current evidence does not include specific knowledge about the process of integrating RPT into IMH; outcomes related to integrative process of RPT into IMH for young children living in poverty; or the effects of the integrative process on child and parent outcomes. This is concerning as this integrative model receives support within both fields as an acceptable practice. However, the integrative model is not yet rooted in evidenced-based practices or research specifically with at-risk 3 to 5 year olds and their families living in poverty. Therefore, the following study aims to contribute to this knowledge gap by providing an in-depth examination of the integrative process, and its influence on treatment components.

Research Questions

To gain an understanding of an integrative treatment process, the experiences of those involved in the integrative process need to be examined. Therefore, research questions centered on the experiences of parents with at-risk preschoolers involved in an integrative treatment process, and clinicians providing integrative treatment services with an emphasis on the similar but different treatment components between RPT and IMH treatment models (See Appendix B for a Conceptual Map). Qualitative methods examine the first and last research question, whereas both qualitative and quantitative methods explore the second and third research questions (which will be further discussed in the methods section). To provide a foundation for understanding the different treatment components between IMH and RPT, the first research question explores how clinicians decide to integrate treatment modalities. Research question two focuses on what RPT and Non-RPT models clinicians chose to integrate into an IMH approach.

The third question focuses on parental involvement as this treatment component varies between IMH and RPT treatment models. Finally, the last research question focuses on the variability within the clinical relationship, and how an integrative treatment process influences this specific relationship.

Research Question 1. How do clinicians decide to integrate play therapy within an IMH treatment approach with at-risk 3 to 5 year olds and their families?

Research Question 2. What RPT models vs. Non-RPT are clinicians utilizing within an IMH treatment approach for at-risk 3 to 5 year olds and their families?

Research Question 3. How are parents involved in the treatment process when play therapy is integrated into an IMH approach with at-risk 3 to 5 year olds and their families?

Research Question 4. How does the clinician-parent relationship impact the integrative treatment process?

Research Procedures

This program evaluation started on February 13, 2012 with an agency program that integrates play therapy interventions within the context of infant mental health approach with at-risk preschoolers and their families. A needs assessment was completed in collaboration with the co-primary investigator (Ellen E. Whipple, PhD, ACSW) and the agency program supervisor. A proposal was then submitted and approved by the agency research team on December 5, 2012. Confidentiality statements were signed by this researcher, the co-primary investigator, and an undergraduate research student(s) assisting on the study and sent to the agency research team. An application was also submitted to Michigan State University's Institutional Review Board (IRB). The IRB determined the study "non-regulated research" because the evaluation would not

contribute to generalizable research (i041509/x13-023e) and therefore is not regulated by the IRB under section 45 CFR 46.102(d). No further action was recommended or needed per the IRB. Data collection started with the interviews on April 2, 2013 and ended with the completion of the Service Provider Checklists on March 27, 2013.

Parent and clinician interviews. A program meeting was held to detail the program evaluation to clinicians, and to answer any questions related to the first phase of the study, which focused on the interviews. Following CMH research procedures, clinicians were instructed to ask each parent on their caseload if they wanted to participate in interviews. Specific approaches to educate parents about voluntary participation, and confidentiality were reviewed during the meeting. Parents could contact researchers if needed, and that information was provided to clinicians, which was included in the Informed Consent Form (see Appendix C). If parents were willing to participate, they were given a stamped envelope and the Informed Consent Form detailing their voluntarily participation, interview procedures, and confidentiality. They could sign the Informed Consent Form and return it to their assigned clinician or mail it in at a later time. If parents signed the Informed Consent Form, clinicians turned them into the program supervisor who kept them in a locked drawer in her office. The program supervisor contacted this researcher who picked up the Informed Consent Forms. Per agency research procedures, only the first name and phone numbers of the parents were available to view (the program supervisor had blacked out the last name of the participant). The researcher called parents, and home visits were scheduled to conduct the interviews. If home visits were not preferred or scheduling became problematic for parents, they were offered a phone interview. Interviews with parents were conducted between April 2, 2013 through June 31, 2013.

Clinicians were asked to participate in interviews during the same meeting time that parent interviews were discussed. The researcher provided information on basic procedures, reinforced participation was voluntarily and confidentiality would be maintained. The researcher opened the floor for questions, and also provided contact information if they wanted to ask questions at a later time. Informed Consent Forms were given to the clinicians (See Appendix D) following the question and discussion period. Clinicians could either return the Informed Consent Forms (if they wanted to participate) after the meeting, or mail them to the researcher (the agency provided envelopes and stamps to clinicians). A master list was developed with names of six program clinicians and identification numbers were assigned using a letter (C for clinician) and numbers (1-6). After receiving the Informed Consent Forms, clinicians were contacted via phone to set up interviews. Clinicians were given the choice if they wanted the interview to take place at the program office or an alternative location. All of the clinicians chose to have interviews at the program office. Prior to the interviews, the master list was updated with clinician contact information, date/time of the interview and preferred interview location. Interviews were conducted between March 26, 2013 and April 9, 2013 in a confidential meeting room at the program office.

Prior to conducting interviews, parents and clinicians were asked permission to audiotape the interview, and if they agreed, they signed an additional consent form (See Appendix E). Parents and clinicians were also informed that once the interview was transcribed, and confirmed by three researchers (the researcher and two undergraduate student researchers), the audiotapes would be deleted. Parents and clinicians were offered a \$25.00 Visa, Target, or Meijer gift card for their participation. Gift cards were given at the end of interviews, and if phone interviews were conducted, gift cards were mailed to the participant's home. Once the interviews were

conducted, the researcher updated the master list with the date; length and location of the interview along with indicating the participant signed the Informed Consent Form, the audio consent form, and received a gift card.

Service provider checklist. Clinicians were asked to fill out a Service Provider Checklist after each home visit for two months (See Appendix F). The researcher attended a staff meeting two weeks prior to the implementation of the Service Provider Checklist to provide support and detail the procedures. At the staff meeting, copies of the checklists and a codebook were provided to each clinician and the program supervisor. Although clinicians were aware of the majority of terms on the Service Provider Checklist, the codebook was reviewed and each item on the checklist was defined. Questions pertaining to the definitions were answered during the meeting, and clarification on the overall process of completing a checklist for each home visit and the collection of the checklists was established through clinician questions and open discussions. Checklists were collected for a period of two months between January 27, 2014 through March 27, 2014. The accumulating checklists were kept in a locked office at the agency.

Methods

Research Design

Using a pragmatic perspective, which values both objective and subjective knowledge (Morgan, 2007), a mixed-method program evaluation was chosen to explore the integration of play therapy into infant mental health specific to at-risk preschoolers aged 3 to 5 years of age and their families living in poverty. A mixed-method approach allows an in-depth understanding of the integration process from multiple perspectives, examination of the integrative process in relation to treatment outcomes and the ability to triangulate results (Klassen et al., 2012). Therefore, intentionally using both qualitative and quantitative methods seeks to maximize the

strengths and weaknesses of both approaches (Thyer, 2001). Additionally, the combination of qualitative and quantitative methods also provides a meta-inference or purposeful consideration of the total evidence (Green, 2007), which can identify contradictory and confirmatory evidence leading to a fuller understanding of the integrative treatment process.

The qualitative and quantitative methods in this study utilized a cross-sectional research design and a non-probability purposive sample. To gain in-depth understanding of the process from multiple perspectives, qualitative methods included parent and clinician interviews. In order to triangulate the interview data and increase validity (Creswell, 2013), a Service Provider Checklist was incorporated to further examine the scope and frequency of treatment modalities.

Agency population. A mental health program within a Community Mental Health (CMH) agency in the Midwest was asked to participate in this study because their treatment approach includes the integration of play therapy within an infant mental health context. The program provides home-based mental health services for 3 to 5 year old children who display significant emotional, social, and psychiatric distress, are at risk of preschool expulsion due to behavioral problems, have medical problems, disabilities, or developmental delays which cause distress in the family system (PYC, 2000). To qualify for services, children need to be between the ages of 3 and 5 years of age, low-income, uninsured, or have Medicaid or MI-Child insurance, and meet either the CMH established criteria for a Serious Emotional Disorder (SED) and/or a DSM-IV diagnosis (program is still using the DSM-IV). The majority of families experience high levels of stress related to unresolved traumas, parent-child attachment distributions, problematic and intensive child behaviors, interpersonal violence, financial strains, and systemic barriers (PYC, 2000). The program services an average of 100 families per year (PYC, 2000) and there are a total of six masters-level clinicians with a degree in clinical social

work, and training in infant mental health, play therapy, specialized trauma and attachment interventions with at-risk families. Clinicians do receive reflective supervision weekly or bi-weekly (depending on need). There is also a family service worker (FSW) who provides support to the clinicians as necessary (i.e. attends sessions to complete an activity with the child if clinicians need a one-on-one parent session). The tri-county CMH agency and Medicaid fund the program. Key stakeholders in the program are the 3 to 5 year old children and their families, program clinicians and staff, program supervisor, CMH senior management team, and the CMH board of directors.

IMH treatment interventions utilized by clinicians include parent-child therapy, parental empathy and support, collaboration with other systems providers, concrete needs assistance, anticipatory guidance, parent skill training, crisis resolution and if needed families are referred for a psychiatric evaluation and/or consultations (PYC, 2000). Additionally, play therapy is identified as an intervention for the program, and integrated into the established IMH treatment approach. Treatment services are provided in the home, and occasionally in the community (i.e. at a school or childcare setting).

Sample. Participants in the sample were either parents/caregivers of children enrolled in the program, or clinicians providing direct clinical services to the families enrolled in the program. In order to maximize the number of participants, a non-probability purposive sample was utilized for the parent and clinician interviews, and the collection of the Service Provider Checklists. This method yielded 20 parent interviews, and 4 clinician interviews conducted from April 2, 2013 to June 6, 2013. For two months, program clinicians completed a Service Provider Checklist after each home visit with young children and families. A total of 361 Service Provider Checklists for a total of 81 families were collected from January 27 to March 27, 2014.

Measurement

Qualitative interviews. The interviews with parents and clinicians were semi-structured such that a basic set of questions were asked to each participant; and the responses to the questions were open-ended and utilized standard replies (Grinnell, Gabor & Unrau, 2010). A total of 12 questions for the clinicians (See Appendix G), and a separate set of 12 questions for the parents (See Appendix H) were asked during interviews. However, only clinician questions 2, 3, 4, 5, and 6, along with parent questions 4, 5, and 7 pertain to this study whereas the remaining questions will be explored within program evaluation findings.

To explore the first research question, which centers on exploring how clinicians decide to integrate treatment models, clinicians were asked how they determine treatment modalities (interview question 2). The second research question focuses on what RPT and Non-RPT models clinicians chose to integrate. Therefore, clinicians were asked during interviews what play theories, models and play therapy techniques they applied along with what IMH principles or models they incorporated into sessions (interview questions 3, 4, and 5). Research question three focuses on the variability of parental involvement and to examine this aspect, clinicians were asked how they involved parents (interview question 6) while parents were asked if they were involved in sessions, how they were involved, and what they thought about the process of the sessions. Finally, the last research question focused on the variability within the clinical relationship, and how an integrative treatment process influences this specific relationship. During the interviews, parents were directly asked to describe their relationship with the program clinician (interview question 7).

Establishing trustworthiness is an important aspect of qualitative research. It seeks to ensure data is accurate and dependable (Creswell, 2013). Creswell and Miller (2000) use the

term validation (not verification) to ensure the process is accurate. Eight strategies are recommended which include prolonged engagement and persistent field observation; triangulation of multiple sources, methods, investigators and theories; peer reviews, debriefing, and/or negative case analysis; clarifying researcher bias based on past experiences, prejudices, and orientations that have shaped study design or analyses; member checking; external audits, and providing rich, thick descriptions when describing a case or theme. Creswell and Miller (2000) also recommend a number of reliability activities to enhance dependability that include detailed field notes, recording and transcribing interviews to indicate trivial pauses and overlaps; and inter-coder agreement between multiple coders to analyze transcripts.

For this study, the following procedures were used to strengthen the trustworthiness of the data. In terms of validation techniques (Creswell, 2013), multiple sources (parents and clinicians), multiple methods (interviews and Service Provider Checklists) and multiple investigators (this researcher, and two undergraduate student researchers) were used in order to triangulate the data. The first undergraduate student researcher transcribed the interview data, while a second undergraduate student during the following school year re-checked the transcriptions and participated in the data analysis for the interviews. From this point, participation from an undergraduate student researcher denotes the second student involved in this study. In addition to multiple sources, methods and investigators, debriefing between the researcher and undergraduate student researcher occurred regarding the identification of significant statements and codes, code meanings, and code assignments. Negative case analysis was also completed to search for contrasting data. Additionally, researcher bias was examined through bracketing; and rich, thick descriptions are provided to elicit detailed descriptions that

will enable the reader to determine if information can be transferred to other settings (Creswell, 2013).

In terms of reliability activities (Creswell, 2013), field notes were taken, and interviews were audio recorded. Audiotapes were transcribed by a student researcher, and then re-checked by two additional researchers (the researcher and a different undergraduate student researcher). During a series of meetings between April 1, 2015 and April 10, 2015, consensus was reached on the identification of significant statements, the code label, and its definition. A codebook detailing this information was developed to ensure the researcher and the undergraduate student researcher process the data in a similar manner (Saldaña, 2013). Following the completion of the codebook, significant statements were independently reviewed and coded by the researcher and the undergraduate student researcher, which yielded an 83% inter-coder agreement.

Outside experts Joanne Riebschleger, PhD and Victoria Fitton, PhD reviewed the codebook, and other trustworthiness procedures. The undergraduate student researcher was trained through multiple meetings and readings focused on qualitative methods and analysis. Specific qualitative software was not be used, rather, editing tools within Microsoft Word and Excel were used to compile significant statements, codes, code meanings and assignments.

Service provider checklist. To triangulate the data, and explore patterns of service use (Thyer, 2001), a Service Provider Checklist was developed. The checklist logs the frequency of treatment interventions, and supportive clinical services used during each home visit. The items on the Service Provider Checklist were identified first by researchers via the interview data, and then reviewed by the program supervisor and clinicians. The final version had 53 items that asked clinicians to identify the length and modality of the session; parental participation; specific treatment and parenting interventions; supportive services focused on concrete needs or

advocacy, and/or coordination with medication management services, school or court systems (see Appendix F). In each of the areas, there was an “other” line provided to ensure clinicians were able to document all of their services.

The Service Provider Checklist focuses on research question two and three. Research question two explores what RPT and Non-RPT treatment interventions clinicians are using within an integrative treatment approach for young children and their families. Therefore, the specific RPT (Non-directive, Non-Directive and Directive, and Directive Play Therapies), and IMH (Parent Psychotherapy and Child-Parent Psychotherapy) treatment models were included (items 17-23). In addition, program staff identified using Cognitive Behavioral Therapy (CBT) and Trauma-Focused CBT (TF-CBT), art therapy, safety planning, bibliotherapy, and social skill or sensory integration treatment models (items 24, 25, 26, 27, 28, 29).

Research question three explores how parents are involved in an integrative treatment process. Therefore, the length and modality of the session (items 3-16) were included in the Service Provider Checklist to explore if and how often parents were involved in treatment sessions, and if a relationship exists between length and modality and specific treatment interventions. Supportive clinical services (i.e. developmental or anticipatory guidance, concrete need assistance, advocacy, or collaborations with medical, school, or court systems) were included (items 30-53) to explore the frequency of these services, and if a relationship exists between the occurrence of supportive clinical services and length and modality of parental involvement, and/or specific treatment interventions. Clinicians completed a Service Provider Checklist after each home visit for two months yielding 361 completed checklists on a total of 81 families between January 27, 2014 through March 27, 2014. As the Service Provider Checklist

was developed for the purpose of this study, reliability and validity of the measure is unknown.

Data Analysis

Qualitative analysis. To gain an in-depth understanding of an integrative treatment process, the experiences of parents with at-risk preschoolers involved in an integrative treatment process, and clinicians providing integrative treatment services were examined. An integrated qualitative phenomenological approach (Creswell, 2013) was implemented. This approach integrates a psychological perspective (Moustakas, 1994), which emphasizes participant textual and structural descriptions and a human science orientation (van Manen, 1990) that focuses on interpretations between the meanings and the meanings of the lived experiences (van Manen, 1990). The psychological perspective (Moustakas, 1994) also emphasizes the concept of epoche or bracketing, in which the researcher attempts to set aside (as much as possible) their experiences in order to take a fresh perspective toward the phenomenological under examination (Creswell, 2013). This relates to the philosophical nature of epoche (Husserl, 1859-1938 as cited in Creswell, 2013) which contends research should suspend judgments about what is real until they are founded on a more certain basis; reality is not divided into subjects and objects but instead the nature of both subjects and objects as they appear in conscience; and the reality of an object is only perceived within the meaning of the experience of an individual (pp. 76-83).

The first step in an integrated phenomenological analysis includes bracketing personal experiences related to the phenomena (Marshall & Rossman, 2010). In this study, experiences were documented and explored with a research team member (co-primary investigator or undergraduate research student) related to individual clinicians within the program, the program supervisor, and the program itself. The next step included the identification of significant statements that addressed the phenomena of parents of at-risk preschoolers involved in a CMH

program, and clinicians providing direct services. The researcher and the undergraduate research student independently identified significant statements. Following this, a final list was comprised to ensure significant statements did not overlap.

Next, significant statements were coded using a two-cycle coding process. Saldaña, (2013) recommends an initial cycle of coding, and a second coding cycle that requires more in-depth analytic skills. During the first cycle, a method called themeing the data (Saldaña, 2013) was implemented. Significant statements were used to identify themes throughout the interviews. Themes were labeled using phrases that represent the identity and meaning of the recurrent experiences (DeSantis & Ugarriza, 2000). This method allows participants to construct the meaning of the phenomenon being studied (Kvale & Brinkmann, 2009; Rubin & Rubin, 2012; van Manen, 1990). Once themes were identified independently, the researcher and the undergraduate student researcher came to a consensus regarding the name of the theme, its definition and how the theme was used to code the data. A codebook detailing this information was developed to ensure the researcher and the undergraduate research student process the data in a similar manner (Saldaña, 2013). In the second cycle of coding, efforts centered on deciding what content belonged under each theme. The researcher and the undergraduate student researcher completed the process independently, and met to reach a consensus on theme and content assignments. Once a consensus was reached, data were analyzed to explore processes, explanations, causes, consequences, and/or conclusions (Rubin & Rubin, 2012 as cited in Saldaña, 2013). Following this, negative case analysis was completed to examine contrasts within the data.

Following the coding process, in-depth textural (i.e. what happened) and structural descriptions (i.e. how it was experienced) according to each theme was completed. These

descriptions are a key aspect of phenomenological analysis, as they give richness and voice to the participants (Creswell, 2013). Finally, a composite description blending the textural and structural descriptions was completed. This description, called the essence, is intended to represent the culminating aspects of the phenomenon (Creswell, 2013).

Quantitative analysis. The Statistical Package for Social Sciences (SPSS), Version 22, was employed for the quantitative analysis. Each item on the Service Provider Checklist was coded and entered into SPSS. Descriptive statistics were calculated including the mean, mode, standard deviations, and frequencies of each of the categories on the service provider checklist. Chi-square tests examined if IMH and RPT are independent or if a relationship exists between them. Additionally, relationships between the applications of IMH and/or RPT to treatment modality, session length, and each subgroup of supportive clinical services (i.e. developmental or anticipatory guidance, concrete need assistance, advocacy, or collaborations with medical, school, or court systems) were examined.

CHAPTER 4: Results

Introduction

As previously stated in the literature review, there are limited studies focused on the integration of RPT into IMH for at-risk preschoolers and their families. To gain a better understanding of the integrative treatment process, the experiences of those involved within an integrative process with parents of at-risk preschoolers and clinicians providing directive treatment services were examined. This chapter outlines the results of the qualitative (parent and clinician interviews) and the quantitative (Service Provider Checklist) methods. It begins with demographic information from the parent and clinician interviews followed by a description of the identified themes. The final section examines both quantitative and qualitative results according to each of the four research questions. Qualitative methods examined research question one, which asked how clinicians decide to integrate treatment models. Both qualitative and quantitative methods examined research question two or what RPT and Non-RPT models clinicians utilize in an integrate treatment model; and research question three which examined how parents are involved within an integrative treatment approach. Finally, qualitative methods examined research question four or how an integration treatment process influences the clinician-parent relationship.

Participant Demographics

Parent interviews. To examine parental perceptions, a total of 20 interviews were conducted and audio-recorded with parents. The majority of interviews 17/20 (80%) were conducted in the parent's home by the researcher, and 3 (15%) were audio-recorded and conducted over the phone by a student researcher. The average time of interviews was 45.37 minutes ($SD=27.22$). The average age of the child in the program was 4.77 years ($SD=.92$) and

the majority of families 65% (13/20) had more than two children in the household (including the child in the program). The majority of participants (75%) identified as Caucasian, while 10% identified as African American, 5% identified as Cuban American, 5% identified as Biracial, and 5% identified as Native American (see Table 1). Half of participants were biological parents (10), while 4 (20%) were foster parents, 3 (15%) adoptive parents, and 3 (15%) were grandparents. Two father figures participated in interviews and included 1 biological father, and 1 grandfather.

Table 1
Demographics of Parent Interview Participants

	N	%
Race		
Caucasian	15	75%
African American	2	10%
Cuban American	1	5%
Native American	1	5%
Biracial	1	5%
Gender		
Female	17	85%
Male	3	15%
Parenting Position		
Biological Parent	10	50%
Foster Parent	4	20%
Adoptive Parent	3	15%
Grandparent	3	15%

Note. N=20

Clinician interviews. To explore perspectives of clinicians providing direct services, a total of 4 out of 6 (67%) interviews were conducted and audio recorded by the researcher in an office setting with program clinicians. Two clinicians were unavailable for interviews due to a medical and maternity leave (there are a total of 6 program clinicians). The average length of interviews was 52.34 minutes ($SD=15.01$). All four clinicians identified as Caucasian and female. Each clinician holds a master level degree in either psychology or social work.

Theme Identification

Data from parent and clinician interviews were blended together to identify a total of four main themes and subsequent subthemes (See Table 2). Themes were blended due to the reciprocal experiences of parents and clinicians. The first theme relates to how program clinicians tailored treatment modalities and interventions based on initial and continual assessments utilized to identify child, parent and/or family maladaptive behaviors, salient childhood experiences (child or parent) or problematic parent-child or family attachment or relationship patterns. However, prior to beginning a treatment modality or intervention, clinicians assessed the willingness and readiness of the child/parent to engage in treatment. If a child/parent was not willing or ready to begin the proposed interventions, clinicians adapted treatment modalities and interventions to focus on child/parental areas of concern. Clinicians and parents reported that flexibility in the delivery of treatment interventions was an important aspect to addressing continuous family needs and maintaining a supportive clinical relationship with the child and parent.

The second theme relates to the presence of RPT models (Filial Play Therapy and Theraplay) and techniques (Non-Directive, Directive, and a combination of Non-Directive and Directive) along with IMH theories (Attachment) and models (Child Parent Psychotherapy, Parent Psychotherapy and Circle of Security) clinicians blended and implemented simultaneously. Field observations noted clinicians seemed less comfortable when discussing theories and models, which was supported by clinician reports of uncertainty if their treatment approach or techniques utilized fit into an established treatment model.

The third theme was a consistent treatment model that was identified by clinicians and parents. The treatment process included a check-in period in which the clinician explored with

the parent the previous week, parenting concerns and/or stressors. Next, a play session was conducted between the parent, child and clinician or the child and clinician (parent observed the play). Following the play session, a reflection period occurred between the clinician and parent and play meanings, parenting responses and/or previous childhood experiences were examined. Finally, clinicians assigned a post-session activity to practice feeling identification/expression or coping skills in-between home visits. Parents reported appreciation for this particular treatment process and valued the play and active involvement within it. Parents and clinicians reported involvement in the delivery of clinical supportive services including concrete needs assistance with basic and immediate needs (i.e. referrals or assistance with paperwork to obtain services) anticipatory guidance, developmental information, provider collaboration and advocacy (i.e. to gain additional resources) and assistance in creating a positive support network.

The fourth theme, a supportive clinician-parent clinical relationship was identified by parents. Parents reported clinicians were consistently available and attentive to parental feelings and needs (both during and in-between home visits). Clinicians reported within the context of the supportive relationship, parents were willing to explore child behaviors, and current parenting responses. As a result, parents reported a deeper level of understanding about their child's behaviors/symptoms and their own parenting reactions and responses. With this knowledge, parents felt empowered and more confident in making parent-related decisions, employing new parenting strategies and advocating on behalf of their child with friends and family.

Table 2

Main Themes and Subthemes of Parent and Clinician Interviews

Theme	Subtheme
1. Tailored Treatment Services	Continual Assessment Focused on Child, Parent and Family Readiness and Willingness to Participate Flexibility in Treatment Delivery
2. Blend of Treatment Models/Techniques	RPT Models and Techniques and IMH Theories and Models Uncertainty about 'Goodness of Fit' into Treatment Models
3. Consistent Treatment Model	Check-in, Play Session, Reflection and Post-Session Activity Parent Understood and Valued Treatment Process Delivery of Clinical Supportive Services
4. Supportive Clinician-Parent Relationship	Attunement of Parental Needs and Consistent Availability Deeper Understanding of Behaviors and Parent Responses Parental Empowerment and Confidence

Research Question 1: Qualitative Results**The Clinical Decision to Use an Integrative Treatment Model**

During interviews, clinicians were asked how they chose treatment modalities and/or interventions for at-risk preschoolers and their families. Clinicians reported treatment modalities and interventions were tailored to meet child, parent and family needs. Treatment was tailored based on initial and continual assessments utilized to identify child, parent and/or family maladaptive behaviors or relationship patterns, and the willingness and readiness of the child and parent to engage and participate in treatment interventions. Additionally, flexibility in treatment delivery was reported by clinicians and parents to be an important aspect to tailoring treatment in order to meet ongoing family needs.

Continual assessment. To determine treatment modalities and/or interventions, each clinician 4/4 (100%) discussed the importance of conducting an initial and continuous assessment focused on multiple factors including child, parent and/or family maladaptive

behaviors, salient childhood experiences (child or parent) or problematic parent-child or family attachment patterns. Assessments provided clinicians with knowledge related to child/parent symptoms or pathology and child-parent relationship difficulties, and this knowledge was utilized to determine treatment modalities and interventions. The following are remarks from a clinician discussing how she utilized multiple assessments along with the nature of child symptoms/diagnosis to determine modalities and interventions.

In going in initially, I will look to see what's going on with the family, with the information that they've given to me, and what I've observed. And sometimes over time, different situations come up and evolve. Sometimes, I am thinking it is the child who is identified as the client, but sometimes it turns out the parent is the one who is in greater need of help or direction. Whether it's parenting skills, attachment, fine-tuning what's going on with them emotionally. It's just based on symptoms of the child, experiences, what happened in utero. I might have a different modality and intervention for someone who has FAS than I would someone who does not have FAS.

In addition, clinicians assessed the permanency of the caregiver (i.e. foster care or adoption) to determine treatment duration and subsequently treatment modalities or interventions. For example, a clinician remarks on the importance of considering the experiences of grandparents and permanency of the placement in order to determine if she would use psychotherapy to address potential inner conflicts related to raising their grandchildren.

It's a little different; you take into consideration what's going on for the grandparent. But if it's a temporary one, I am not as willing to do that because I won't be there as long but If I can help an adoptive mom or an adoptive grandma,

deal with another layer there, the remorse and the regret and the things they are feeling about their own child, and now they're raising their grandchild. If we can process some of that stuff and get it on the road to resolution, I'm not saying we always get it resolved, but at least it ends up helping the parenting of this child as opposed to being stuck in this mode of "I didn't do it right the first time, how could I do it right now." Helping them sort through that so that they can be the best parents they can right now to this child.

Willingness and readiness to engage in treatment. Within assessments, all clinicians remarked on the utility of play to examine what the child is willing to do and/or what they can do. This in turn, assisted clinicians in determining specific modalities and interventions they were going to be able to implement within treatment sessions. This was particularly important with foster or adoptive children with or without cognitive delays due to the limited information that was available during the initial assessment period. A clinician remarks on the assessment process and the use of play to determine what modalities and/or interventions a child can or is willing to do within treatment sessions.

So it's interviewing, it's getting a really good history as much as you can. That's always a work in progress with foster children and adopted children. And it's a little frustrating at times. And so you try to get a good history, you find out what brought them to treatment, or what the recommendations were. And you do some interviewing and you start working with that. I've had kids that I have begun to play with to find out what they're able to do or willing to do, or even intelligence-wise, and it's a little trickier, to see what am I going to be able to do.

In addition, clinicians considered the parent's readiness to engage in treatment and/or explore underlying issues when deciding treatment modalities and interventions. A different clinician remarks on the need to address the family's immediate treatment needs, while planting seeds for more long-term interventions.

Its tricky I think. There has to be a readiness on the child's point of view and as well as where the parent or family is. If the family is feeling overwhelmed by behaviors and they really need you to do something a little more immediate, then we might go there first. If the immediate goals, it is kind of goal-driven. I can suggest some things or talk, see if they're interested in this right now. But I can also paint a picture for the future. Plant some seeds saying, okay we can do this now, we can work on some basic behavioral things or self-regulation issues or this or that interventions. But I'm really thinking that if we address the trauma that some of that will go down in time as it's just not going to be a good fix. But if you want me to do this now we can, but I don't think that that's going to fix it. So basically, I don't do anything quickly. I tell people I retired my magic wand about ten, fifteen years ago when I realized it didn't work. I jokingly say there's not a quick fix.

Parents reported clinicians listened and addressed their areas of concern with specific interventions. A parent remarks on how she felt when clinicians listened and addressed her concerns with a behavioral intervention.

All of the things I said to them at the very beginning we focused on, they really listened to my concerns I had, and addressed all of them starting with the one I wanted. It was surprising. My big thing was what do I tell them about what I

really want, you know and they actually listened. We started with bubbles and play dough to help him calm down which helped to stop the fits.

Clinicians reported the readiness and willingness of the child or parent to be an important aspect in building a good working alliance or clinical relationship, however, they also remarked on how this can be a frustrating process because it can limit a clinician's ability to use interventions and at times requires a lot of patience.

There's a lot of things you can't do until you have a good working relationship and you don't know how long that's going to take. Especially with a grandma that has raised nine children and "what are you going to tell me?" and so you just sit there and kind of wait until you can because its that important. I shouldn't say wait, you're not waiting, you're actively building are a relationship until you can get that opportunity to make an intervention go. One that you might have known six months ago, but now they're ready. That's hard because you don't always know that in six months they're going to be ready, you can always hope.

Flexibility in treatment delivery. Flexibility in how clinicians delivered treatment modalities and interventions was reported by clinicians and parents to be an important aspect to tailoring treatment to meet shifting and/or growing child/parent/family needs. A clinician remarks on how she structures a home visit based on child/parent treatment needs and contextual factors within the home.

So say mom's got more than one toddler or more than one child and she is trying to manage. I don't expect her to sit for a whole session and be available for play if the child wants to play sort of thing. But um, I work with families in different ways. Some of them, like, this one case that I have, Mom and I talk ahead of time,

she's got a baby, so she's dealing with a lot of postpartum stuff and she's going back to work. So I deal with her a lot on that level and then the child just really needs me to be there for her and help her through ADHD stuff. She's five and so it's a little bit different, I don't feel like Mom needs to be there but then there are pieces that I do where I include step-Dad or Mom and I make a connection at least, so it may not be the 50-minute hour or anything like that, but everyone is included, so sometimes I do work with kids through their own play and Mom might be tending to the baby or might be having the baby there and not completely focused on what is going on. So it's kind of contextual as far as that goes, what we're dealing with.

A different clinician remarks on the need for flexibility due to the presence of siblings who may (or may not) participate in treatment sessions and how this can relate to treatment retention.

And there's families where the only way I'm going to get this done is to tell one child that I want to work with [child] alone for twenty minutes but then I'll set the timer and the last fifteen you can come in and play too. And that's what I do a lot so that the older child can come play. Because if I don't, most likely the family is not going to have me back because I would cause a disturbance with the older one. They're not going to allow me to come if it's going to do that. So it's not orthodox but that's how we get our work done sometimes. Otherwise I don't know that anything would get as far as seeing truly what the child has going on without doing that. And there are so many areas for corruption as far as home-based and

there is no ‘true formula.’ But you also see a lot that way too and I think that's partially how we get back in because if we're going to cause a big stir they're [parents] not going to want to have us back.

Remaining flexible and tailoring interventions within home visits was also an important aspect to parents. The following is a parent who remarks on the process and a clinician's ability to adjust interventions based on current need(s) while maintaining a focus on long-term goals.

We're going to talk about this [during the session] and something happens and things change and then the next session changes, but then we'll always go back to what we were going to do. So I like the fact that it's not just, you know, oh this is what we're going to do today. It's tailored to us, you know, that what we need.

In summary, tailored treatment services were accomplished by initial and continual assessments that examined the child and parent's willingness and readiness to engage and participate in modalities and interventions; and in maintaining flexibility when employing proposed tailored modalities and interventions to meet the shifting needs of families.

Research Question 2: Quantitative and Qualitative Results

Quantitative Results on Specific RPT and Non-RPT Treatment Models

Service Provider Checklist. To further explore specific RPT and Non-RPT models, Service Provider Checklists were completed after each home visit for two consecutive months by program clinicians, which yielded a total of 349 checklists on 81 families. Checklists documenting a cancellation ($N=18$) or a no-show ($N=4$) by clinicians were dropped leaving a total of 327 checklists for analysis. The average length of home visits was 1.20 hours ($SD=.35$).

Parent-child dyad sessions were conducted 52% of the time whereas family sessions with the parent, child and sibling(s) were held 20% the time. Individual child or parent sessions occurred 18% of the time.

In terms of treatment interventions, results indicate that within a two-month time frame, clinicians were utilizing play therapy interventions (Non-Directive; Directive and Non-Directive; and Directive Play Therapy) a total of 49% of the time, and IMH modalities (Child Parent Psychotherapy and Parent Psychotherapy) 34% of the time (See Table 3). Cumulatively, there is a higher percentage of play therapy, however, when the individual modalities are examined, clinicians report using Child Parent Psychotherapy (CPP) (20%) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) 20% of the time. This finding highlights the need for trauma-based interventions and the possibility clinicians are integrating specific play therapy techniques as needed within the CPP or TF-CBT model. Other treatment approaches were identified, and surprisingly, Bibliotherapy was rated the highest at 24% although this specific intervention also classifies as a form of Directive Play Therapy (DPT) suggesting the frequency of DPT may be higher. Additionally, clinicians are utilizing psychotherapy with parents 12% of the time indicating a need to address parental mental health. Speaking to the intensity of this at-risk population, clinicians are also implementing safety plans 14% of the time due to severe aggressive behaviors and/or self-harm ideations or plans.

Table 3

Service Provider Checklist Frequencies and Percentages of PT, IMH, and Other Treatment Approaches Utilized During Home Visits

PT	Frequency	%
Non-Directive (NDPT)	50	15.3
Non-Directive & Directive PT (NDPT & DPT)	58	17.4
Directive PT (DPT)	52	15.9
Total PT	160	48.9
IMH		
Child Parent Psychotherapy (CPP)	68	20.8
Parent Psychotherapy (PP)	39	11.9
Circle of Security (COS)	3	0.91
Total IMH	110	33.6
Other Treatment Approaches		
Bibliotherapy	79	24.2
CBT/TF-CBT	67	20.4
Sensory Integration	49	15.0
Art Therapy	34	10.3
Safety Planning	47	14.3
IMPACT (Social Skills)	7	2.1
Total Other Treatment Approaches	283	86.3

Note. $N=327$; Treatment approaches self-reported by clinicians; One checklist was completed per home visit; Checklists were collected for 2 consecutive months on a total of 81 families.

Chi-squares. Multiple chi-square tests of independence were performed to examine the relationships between IMH and RPT treatment interventions. Phi values were also calculated to measure effect size or strength of the relationship. Results indicate a significant relationship between CPP and the combination of NDPT and DPT, $\chi^2(1, N=327) = 9.975, p = .003$ (See Table 4). The phi value was .169 ($p = .002$) indicating a small to medium effect (Engel & Schutt, 2009). Thus, clinicians are more likely to use CPP with NDPT and DPT than using CPP without NDPT and DPT techniques. Chi-squares examined the relationship between CPP and the remaining RPT models, DPT or NDPT and were non-significant. Non-significant relationships were found between the other IMH models (PP or COS) and RPT models (NDPT or DPT, NDPT, or DPT);

which may relate to PP and COS primarily being centered on parents verses the parent-child dyad.

Relationships between IMH and RPT with Other Treatment Services were explored with Chi-squares. Results indicate a significant relationship between CPP and TF-CBT, $\chi^2(1, N=327) = 4.443, p=.035$ indicating clinicians are more likely to use CPP and TF-CBT than CPP without TF-CBT. However, the phi value was .113 ($p=.03$) indicating a small effect (Engel & Schutt, 2009).

Results also indicated a significant relationship between Art Therapy and DPT, $\chi^2(1, N=327) = 6.257, p=.012$ and a significant relationship between Bibliotherapy and DPT, $\chi^2(1, N=327) = 5.007, p=.025$. This indicates clinicians were more likely to use Art Therapy and Bibliotherapy with DPT than using Art Therapy and Bibliotherapy without DPT. However, as mentioned earlier, it is possible clinicians view art or Bibliotherapy as DPT techniques. The phi value for Art Therapy and DPT was .134 ($p=.012$) and Phi for Bibliotherapy and DPT was .120 ($p=.025$) indicating small effects (Engel & Schutt, 2009).

Table 4

Significant Chi-Squares and Phi Values of Relationships Between IMH, PT and Other Treatment Models

PT and TF-CBT	CPP		χ^2	ϕ
	Observed	Expected		
NDPT & DPT	20.0	11.3	9.975**	0.169
Non-NDPT & DPT	47.0	38.0		
TF-CBT	2.0	32.0	4.443*	0.113
Non-TF-CBT	6.6	27.4		
Other Treatment Models	DPT		χ^2	ϕ
	Observed	Expected		
Art Therapy	10.0	5.1	6.257**	0.134
Non-Art Therapy	24.0	28.9		
Bibliotherapy	18.0	11.8	5.007*	0.120
Non-Bibliotherapy	61.0	67.2		

Note. $N=327$; * $p < .05$, ** $p < .01$, *** $p < .001$

Qualitative Results Regarding Specific RPT and Non-RPT Treatment Models

During interviews, clinicians were asked what RPT theories, models and techniques and what IMH theories or models they utilized when working with at-risk preschoolers and their families, which provided explanatory knowledge to Service Provider Checklist data. Thus, the second theme relates to the presence of RPT treatment models (Filial Play Therapy and Theraplay) and techniques (Non-Directive, Directive, and a combination of Non-Directive and Directive) along with IMH theories (Attachment) and models (Child Parent Psychotherapy, Parent Psychotherapy and Circle of Security) clinicians blend and implement together. When discussing theories and models, clinicians reported uncertainty on whether or not their approach fit into an established treatment model.

Field Observations. When interviews focused on theories, the researcher observed the clinicians to be less comfortable (i.e. nervous laughter, less eye contact, more silence). No theories were identified while discussing RPT models and techniques, however, attachment

theory was acknowledged as an important piece of IMH treatment models. Clinicians seemed a bit more comfortable discussing treatment models (i.e. less silence, more eye contact) however, all four clinicians reported uncertainty if their techniques “fit into” a treatment model. When discussing techniques clinicians seemed the most relaxed (i.e. talkative, direct eye contact). The following outlines what RPT and IMH treatment models and techniques clinicians utilized within the program.

Play therapy models. Clinicians identified the use of two RPT treatment models, Filial Play Therapy (Guerney & Guerney, 1967) and Theraplay (Jernberg & Booth, 2010). Clinicians reported Filial Play Therapy (with or without modifications) to be a beneficial intervention to children and parents. The following remark is from a clinician regarding how she modifies Filial Play Therapy based on child/parent readiness.

I use filial play therapy where I’m trying to get the parents and children on the same page and sometimes, that’s a rough match. You have to depend on the parent and the child a bit more, but it can be a good model to get them on the same page. Sometimes I don’t do the whole thing, sometimes I just do parts of it that I think they can actually master without resisting. Or if they resist, I might present the whole thing then say let’s just try this and this. You do have to have a good enough relationship to start this. There are a lot of things you can’t do with filial play therapy until you have a relationship at least with the parent.

Theraplay was also identified as a treatment model in which an attachment game was used to engage and strengthen attunement within the parent-child dyad.

We do, actually we do a lot of that in the beginning, especially with attachment stuff. These kids look to be born, I roll them up in a blanket like a burrito and

their heads are sticking out and I'll pick them up of the floor and I'll place them on their parent's lap. And they love that but then I slowly pull the blanket off their feet while their parents hold their upper body. You should see what happens to these kids, they want to do it over and over and over again. I mean, they'll do it 15 times until I can't pick them up anymore because I'm exhausted. And they'll do it over and over and over again. It is the coolest thing.

Another clinician remarks on Theraplay, an attachment-based RPT model and the use of an engagement activity in which a parent and child blow a cotton ball across a pillow to elicit play and eye contact.

We can play games that strengthen the attachment between the parent and child.

When they are both trying to blow the cotton ball across the pillow, they are making eye contact with each other and having fun, which is a mutual goal for both of them.

Play therapy techniques. Clinicians reported a variety of non-directive and/or directive play therapy techniques along with art, Bibliotherapy, and sensory-based play techniques. A clinician remarks on her application of directive techniques based on the young child's experiences and symptoms.

I have different directive techniques, whatever you want to use them, based on the experiences, symptoms of the child that's coming in. I might use more physical activities for a child that may have sensory issues. For a child that presents with trauma and has identified with trauma I would use more traditional play therapy whether it's dolls, a family of pets. Sometimes we can do writing, drawing, I'm trying to think. And also maybe some Biblotherapy, some books. Maybe there's a

concern about attachment, to work on that. Or if there was sexual abuse to work on that piece, if there was domestic violence to work on that piece too. Kind of like a social story about that child's experience.

In addition, sensory-based play therapy techniques were reported by clinicians and parents to help the child learn additional calming techniques. The following is a remark from a clinician using sensory-based techniques followed by a parent's remark on how these techniques helped her child learn how to be calmer.

Clinician: I will do sensory-motor type stuff where you do play dough or there's a thing where you wrap the child. They sit in a blanket and they get that deep pressure around them. So it's like sensory integration techniques that can help them to calm down. I do a lot of that and some of that will work even if you're not totally addressing a deeper issue at that time, just different ways to give them options when they're having a struggle.

Parent: Well, I now realize when you rub certain parts of the body or [use] brushing how it calms him [child]. I used to have to brush him but now he likes to just be tickled. They showed me how to massage him a little bit too to calm him down. The bubbles calm him, he loves running with scarves tied together, that calms him and he has learned some breathing techniques as well.

Clinicians also reported how they adjusted clinical techniques based on treatment phases and/or the need to establish safety. A clinician remarks on the different circumstances in which she applies non-directive and directive play techniques and the importance of ensuring safety during treatment sessions.

I may become more directive depending on where the child is and where they are in the process of therapy, like if they are in trauma resolution I may reinforce safety so the child can feel safe. For example, I had a child recently who just amazed me. Out of nowhere she presented what happened to her and it's just an amazing piece to go with that, and it usually comes from the child feeling safe and the literal holding environment you create with the family so that everybody, Mom, Dad, the child feels safe. And it's just huge, it's amazingly huge is what it is.

Clinicians also discussed selecting toys as a directive technique. A clinician remarks on using specific toys to help the child process feelings related to transitions; and leaving the toys or books in the home in-between home visits.

I use a lot of house play or houses if there's a transition going on, where you kind of have the toys represent their feelings. I use different interventions where we read a book and act out the book. In one case, we act out a book with an owl puppet that is usually a judge. So it's been really interesting because the owl puppets are available to the little guy [child] even when I'm not there [clinician leaves them at the home in-between sessions]. Those issues play themselves out because he's now getting to the point where he's saying, "how could it be different? How could it have gone different?"

Attachment and psychotherapy. Clinicians were asked what IMH theories and models they applied during treatment sessions with at-risk young children and families. When asked this question, all 4/4 (100%) clinicians identified the importance of attachment theory and the use of psychotherapy to help children feel safe and parents to process past experiences and current

parenting responses. For example, a clinician remarks how psychotherapy helps create feelings of safety, improve parental sensitivity and parental self-care.

The attachment piece I find very important, especially with children who have been in out-of-home placements. In working on feeling safe, security, and trust for day-to-day functioning and allowing the parents to be able to look at it from the child's perspective. How the parents' behaviors and feelings can affect the child, that could be an intervention in and of itself so the parent can recognize that they either need to do a poker face and not be so reactive, or maybe be more reactive and more responsive so the child knows that they're available. So that comes in play and I also talk about the parent's families and how important it is for them to take care of themselves and I kind of do this triangle thing, because if you're not here it's hard for you to have anybody else be there where they need to be. You really need to take care of yourself. And that's part of the daily scheduling of the parenting piece, I kind of connect them together.

Clinicians also remarked on the use of psychotherapy to explore parental early childhood experiences and how they relate to current parent responses. For example, a clinician remarks on this process and how play elicits a parent's ability to explore their own childhood experiences.

I like the psychotherapy piece as far as, some parents are more apt to talk about that on their own and some parents you really have to get a drill and dig for it. Like asking what did your parents do, or did you think that was a good idea, or how did you know you wanted to do things the same way or how did you know you wanted to do things different because some parents don't want to talk about it and end up being the dismissive ones that kind of walk the line between

contrasting what they say with what they do. For example, what they say they don't want to happen and then they'll say well that's how it was when I was young and we did okay. They kind of flip flop according to what the question is you're asking because they want it to go away. And so sometimes I have to work that in while we're playing so we're not really focusing necessarily on the play therapy is more sometimes a good time to talk to parents about that. You know, because the dad might say 'oh if my dad saw me playing with that, he'd whip my butt' or something like that. How did you know that you didn't want to be raised like that or how did you know that would be okay if you played with that...that sort of thing.

Another clinician remarks on the need for psychotherapy to help parents process their childhood losses in order to improve attachment relationships and caregiving responses. In these remarks, the clinician discusses the need to have additional support during sessions in to address individual child and parent needs.

I think I do a lot of parent psychotherapy. Because, again, if it's a permanent situation, if we can resolve some of that or explore some of that, so at least they are aware. Some of that is put in a context then I think if they're going to be all the more able to be attached and better caregivers to the little ones. I can't do much with the child if I don't have mom or dad or parents in a better place. So sometimes we use a FSW [family support worker who accompanies the clinician to home visits] like for instance right now, I have an FSW doing a coloring book of good touch-bad touch while I'm over here dealing with mom who has had

multiple losses and in and out of her foster care all through growing up and is terrified of losing little one. So we've got layer upon layer of things.

Uncertainty about the “goodness of fit” into treatment models. When identifying RPT treatment models and the use of attachment theory and psychotherapy, all clinicians seemed uncertain if their treatment approach “fit into an established evidence-based treatment model.” When asked about RPT treatment models, a clinician remarked [while laughing], “um...if I had a manual I could choose which models I use.” After the researcher reassured that there were no right or wrong answers, the clinician remarked on a case where she is working on self-regulation but is unsure if her approach fits into an established treatment model.

I can't help this little guy as much, he has fetal alcohol syndrome. His receptive language is lower than his expressive, which is not typical. So he sounds like he's really doing much, understanding more than he is. And so his frustration tolerance is really low, so if I can get him to cope or communicate, one or the other. Like I said, I know what I'm trying to do, but I'm not sure if it fits in a model.

Another clinician remarks that she is not good talking about theories or models, but is able to identify different types of play therapy techniques.

I know I'm not very good at talking about theories and models. I am really not [the researcher validates clinicians and lets her know there are no right or wrong answers and the clinician continues] well, I use Bibliotherapy, I use quite a bit of different types of non-directive and directive, art, I throw it all together and come up with something [clinician laughs].

Similarly, another clinician remarked on her uncertainty related to the goodness of fit between techniques utilized and existing clinical treatment models.

I use non-directive and directive techniques, I'm just kind of all over the place and I'm not really describing the clinical book treatments or models, but these are the kinds of things I do and they seem to work for our kids.

In summary, clinicians reported using the blend of RPT and IMH treatment models and techniques to tailor treatment services along with uncertainty if their treatment approach fits into an established treatment model. Quantitative results indicate clinicians are utilizing RPT models/techniques a total of 49% and IMH treatment models a total of 34% and chi-square results indicate significant relationships between CPP and NDPT/DPT; CPP and TF-CBT; Art and DPT; and Bibliotherapy and DPT. These findings suggest clinicians are integrating specialized play techniques, in particular within CPP, TF-CBT, Art Therapy and Bibliotherapy.

Research Question 3: Qualitative and Quantitative Results

Quantitative Results Regarding Parental Involvement

Service Provider Checklists. In addition to treatment interventions, parents were involved in clinical supportive services, which included Anticipatory Guidance, Developmental Information, specific parenting curriculums, concrete needs assistance and advocacy. Clinicians reported using anticipatory guidance a total of 65% ($N=214$) of the time and developmental information 55% ($N=179$) of the time (See Table 5). Specific parenting training models Love and Logic (Cline & Fay, 2006) (12%) and Parent Management Training Oregon (Forgatch et al., 2004) 12% of the time. Clinicians reported advocacy focused on school-based interventions a total of 20% of the time including child classroom observation, consultation with teachers and principals and attendance at Individual Education Plan (IEP) meetings. Mental health advocacy occurred 9% of the time and included phone collaboration with the psychiatrist and attendance at medication reviews. Health advocacy, which included collaboration with providers and

transportation to medical appointments, also occurred 9% of the time. Collaboration centered on the court system occurred 2% of the time and included education to families about the court process and attendance at trials. Finally, concrete needs focused on gaining access to housing wait lists and bill re-payment plans (i.e. gas, electric, heat) 4% of the time whereas referrals to gain access to insurance or assistance in filling out needed paperwork occurred 4% of the time. Concrete needs focused on legal aspects of custody or child visitations occurred 2% of the time. Finally, food referrals or assistance with paperwork, transportation referrals or providing bus tickets occurred less than 1% of the time.

Table 5

Clinical Supportive Services and Frequencies of Parenting, Advocacy and Concrete Needs Assistance

Parenting	Frequency	%
Anticipatory Guidance	214	65.4
Focused on client	133	40.6
Focused on family	57	17.4
Other	24	7.3
Developmental Information	179	54.7
Focused on client	106	32.4
Focused on family	53	16.2
Other	20	6.1
Love and Logic	39	11.9
Parent Management Training Oregon	37	11.3
Advocacy		
School (observation, consultation, IEP meetings)	64	19.5
Mental Health (psychiatrist collaboration, med reviews)	29	8.8
Health (collaboration w/providers, transportation to appts.)	28	8.6
Court (education on process, attending trials)	8	2.4
Total Advocacy	129	39.4
Concrete Needs		
Food (referrals, assistance with paperwork)	3	.009
Housing (accessing wait lists, bill re-payment plans)	12	3.6
Transportation (referrals, providing bus tickets)	2	.006
Insurance (referrals, assistance with paperwork)	13	3.9
Legal Services (custody plans, visitations schedules)	8	2.4
Total Concrete Needs	38	11.6

Note. $N=327$; Treatment approaches were self-reported by clinicians; One checklist were completed per home visit; Checklists were collected for 2 consecutive months on a total of 81 families.

Chi-squares. Multiple chi-square tests of independence were performed to examine relationships between IMH and RPT treatment interventions and Clinical Supportive Services (Anticipatory Guidance, Developmental Information and Concrete Needs Assistance). Phi values were also calculated to measure effect size or strength of the relationship. Results indicate a significant relationship between an IMH approach, Child Parent Psychotherapy (CPP)

and Anticipatory Guidance (AG) focused on the child $\chi^2 (1, N=327) = 7.878, p = .005$ and a significant relationship between CPP and AG focused on the family, $\chi^2 (1, N=327) = 8.329, p = .004$ (See Table 5). Thus, clinicians were more likely to use CPP with AG focused on the child or family than CPP without AG. Chi-square values were higher when AG focused on the family versus the child; however, the phi values were similar between a focus on the child ($.150, p = .005$) and family ($.154, p = .004$). Additionally, results indicate a significant relationship between CPP and Developmental Information (DI) focused on child, $\chi^2 (1, N=327) = 9.246, p = .002$ and CPP and DI focused on the family, $\chi^2 (1, N=327) = 10.668, p = .001$. Therefore, clinicians are more likely to use CPP with DI versus CPP without the use of DI. The phi value for CPP and DI focused on child is $.163 (p = .002)$. The phi value for CPP and DI focused on family was $.175 (p = .001)$ indicating small effects (Engel & Schutt, 2009).

Results also indicated significant relationships with another IMH treatment model, Parent Psychotherapy (PP) and AG focused on the child $\chi^2 (1, N=327) = 4.610, p = .032$ and a significant relationship between PP and AG focused on the family, $\chi^2 (1, N=327) = 9.287, p = .002$. Therefore, clinicians are more likely to use PP and AG focused on the child or family than PP without AG. The phi value for PP and AG focused on the child is $.115 (p = .032)$ and $.163 (p = .002)$ for PP and AG focused on the family, which indicates a slighter higher phi value when AG is focused on the family. In addition, results indicate a significant relationship between PP and DI focused on the family, $\chi^2 (1, N=327) = 5.778, p = .01$ and a non-significant relationship between PP and DI focused on child, $\chi^2 (1, N=327) = 3.627, p = .057$. Phi values for PP and DI focused on family is $.129 (p = .016)$ and PP and DI focused on the child is $.102 (p = .057)$ indicating small effects (Engel & Schutt, 2009).

Finally, no significant relationships were discovered between RPT models and AG or DI

meaning the occurrence of RPT was independent of AG or DI. No significant relationships were discovered with IMH or RPT treatment models and other Clinical Supportive Services including Mental Health, Health, Court Advocacy or Concrete Needs Assistance.

Table 6
Significant Chi-Squares and Phi Values of Relationships between CPP, PP and Anticipatory Guidance and Developmental Information

CPP				
Anticipatory Guidance	Observed	Expected	χ^2	ϕ
Child Focus	36	25.9	7.878*	0.150
Non-Child Focus	97	107.1		
Family Focus	19	11.1	8.329***	0.154
Non-Family Focus	38	45.9		
Developmental Information				
Child Focus	21	20.7	9.246***	0.163
Non-Child Focus	19	10.3		
Family Focus	19	10.3	10.668***	0.175
Non-Family Focus	34	42.7		
PP				
Anticipatory Guidance	Observed	Expected	χ^2	ϕ
Child Focus	21	14.9	4.610**	0.115
Non-Child Focus	112	118.1		
Family Focus	13	6.4	9.287***	0.163
Non-Family Focus	44	50.6		
Developmental Information				
Child Focus	17	11.8	3.627*	0.102
Non-Child Focus	89	94.2		
Family Focus	11	5.9	5.778**	
Non-Family Focus	42	47.1		0.129

Note. $N=327$; * $p>.05$, ** $p>.01$, *** $p>.001$

Qualitative Results Regarding Parental Involvement

Check-in, play session, reflection and post session-activity. During interviews, parents provided explanatory data related to the context of parental involvement. Parents were asked how they were involved in treatment sessions and what they thought about their level of involvement. Results indicate most of parents 19/20 (95%) were actively involved within a

consistent treatment process, which included a “check-in” period for the parent, child, and clinician to explore the week’s events and/or concerns, and prepare for the parent-child-clinician play session. For 2/20 (10%) of parents, the preparation for the play session included role-plays in which the parent led a directive play activity. The remaining 16/20 (80%) parents reported verbally reviewing the play agenda (i.e. directive and/or non-directive techniques) or plans for play observation. During the play session, parents were actively involved in the play process or observed the play in close proximity between the child and clinician. Following the play session, clinicians allotted time for parents to reflect on the process of the play session and their own reactions, which may (or may not) be related to their own experiences as a parent. During this time, children were often given a special toy or an art activity to complete. Parents also reported a post session activity (i.e. blowing bubbles for deep breathing, reading a feeling book) clinicians assigned to the parents to complete with their child in-between home visits. The following are remarks from parents about their involvement within this process.

[Clinician] comes in and talks to me before she [child] gets off the bus so that we can have our time to talk and go over different options of discipline. When she [child] comes in, she [clinician] will say, you know I heard you had a good week. And then she'll sit down and talk with her [child] and they'll get out the toys and play and we've been doing the play session where we let her [child] be in charge. It lets her be in charge and she takes control if she wants us involved in the play or we'll draw together and stuff like that and we have this paper where I write down questions. Then she [clinician] turns around and at the end and we'll talk about things what's on the paper and what happened during the play.

Another parent remarks on this process and how her family is involved in treatment

sessions.

We, as far as like all five of us, meet together at first. What happens is she [clinician] would normally come in, touches base, read us a book, and we'd talk about it, which typically deals with feelings. And then the children [identified client and two younger sibs] would play with her [clinician] and us afterwards. Then, he [child] goes to school, which he isn't now because he's off [on school break] but he would get on the bus, and she [clinician] would come back in and stay with us and talk to us in general what's going on with the family or my husband.

A clinician remarks on this process and how she includes an ending ritual (i.e. stickers for the child and a post session activity for the parent).

So I'll ask mom how things have been going, sometimes I'll ask what went well this week, all that kind of stuff. And then mom will tell me, or dad or whoever is there, will tell me what's been going on. And most times they know we'll talk at the end and if it's something the child shouldn't hear and then I'll say, "alright it looks like it's time to ask for thumbs up" because thumbs up means they can get their toys out, but I have to give a thumbs up and they have to give a thumbs up. The parents first, then me. If mom isn't done she'll go, "nope, not ready to give the thumbs up" then when thumbs up is given, the children get the toys out and we all kind of switch gears. So the parent is kind of put in charge and I think they like that piece and they know that they'll be heard that way. And I always check in with the parent at the end too, and I talk about any insights that I've gained from

the play that's gone on, "did you notice this?" or "you seemed to do this more than once, did you see that?" or "I noticed this last time and it happened again, what do you think that's about?" and all that kind of stuff, so then you kind of draw that reflective capacity a little bit as far as thinking and "what do you think you might doing by that?" And then, I do my ritual motion and stickers and all that stuff and then I give parent things to do, like to read *Don't Feed the Monster on Tuesday* (Moser, 1991) because he [child] is, uh, a perfectionist and lots of time he tries to control things. That's part of what we're working on, trusting the adults enough to realize you're safe and all that kind of stuff, so the parents can read the book to him during the week when I am not there and after that. After all that, I am on my way [done with visit].

Limited involvement was reported by 1/20 (5%) of the parents. Participation was reported in the check-in process but not within the child-clinician play session and reflective time with the clinician was not identified nor reported to occur. Additionally, play therapy was not viewed as helpful as one parent remarked, "I think [she] was trying to see with play therapy [explore the child's past history] but it was very unclear and it didn't seem to help." In addition, resistance to parenting suggestions was reported as one parent remarked, "What [she] wants me to do is go around the house all day long and say you were good, let me give you a sticker but then I cannot get *anything* else done!" The latter could be attributed to the level of parent stressors, and/or the stage of the clinician-parent relationship as this same parent reported dissatisfaction with the clinician.

Understood treatment process and valued involvement. Specific to the play process, the following two parents remark on being directly involved in sessions, and as a result, understanding how they are contributing to his [child] treatment progress.

[Parent 1] We all play together, listen to her story together. There's a story. Play a game together. And then at the end we'll let him watch TV and we'll sit down and talk to her [clinician] if we have questions. [Parent 2] And the reason why that is this way is because of the Reactive Attachment. He wants the bond...we want the bond. [Parent 1] With the previous therapist, we just didn't understand (held individual play sessions) but now it's more like we're really helping him because this is what we know and this is what we [Parent 2 points to herself and partner] are doing with her [clinician]. You know what I mean.

Additionally, a foster parent remarks how her direct involvement in the play and reflects about how the play assisted in her in processing her reactions to her foster children's previous childhood experiences.

So they were very helpful in finding the words. I would read the book or she [clinician] would read the book. We had bunnies, little puppets that went with the book to help with figuring out words for us. It meant a lot to me because you know as a Mom myself, I couldn't imagine what she [the biological mother] was experiencing without her kids and I wanted to be able to help. Human to human, I was so emotionally wrapped up in how she [biological mother] felt too. I gotta protect the boys, but I wanted to protect her, and I felt bad and then there's a part of me that was going "how could she do this?" You know what I mean? It was

just nice to have that person to bounce that kinda stuff off after the play especially because that was a very emotional time.

Inclusion of clinical supportive services. Within home visits, parents reported involvement within clinical supportive services, which were delivered in the check-in or reflection parts of the treatment session. Parents and clinicians reported the use of clinical supportive services such as concrete assistance with basic and immediate needs (i.e. referrals or assistance with paperwork), provider collaboration and advocacy within school systems (to gain additional resources for child), developmental and anticipatory guidance and the development of a positive support system. The following is a clinician's remark on concrete assistance and its importance in building relationships and "paving the way" to address other family needs.

I do a lot of concrete assistance to begin with. And it's one of my relationship builders because if they have a basic need like if they are missing some food or clothing, well they can get it, its not totally missing but I come in and say, "oh, its coming in on summer, you know we have this tiny little clothes closet, would you like me to see if there are some clothes? Are you doing good with that?" Then they will say, "oh yes, she wears a 3T." And I that just kind of seems to pave the way of taking care of other child or parent needs.

Parents commonly reported clinical advocacy with teachers and administrators to improve their child's successes in school. In the following, a grandparent remarks on her experiences within the school system and the importance of having advocates to obtain the appropriate level of supportive services.

After I explained to them [school administrators] his medication regime, and some of the emotional in-balance, they took another look, and they decided he

should stay in the program so now he is getting he [child] will get hallway help next year, extra help with math, extra help with reading, speech and language services so I am hoping those services will take him to the top. She [clinician] was there with me the whole time, and she knew what to say, she knew what, I have been out of the loop for awhile, I have not worked since 2008 and I am not as knowledgeable about the right approaches and the clinical terms for this and that. [Clinician] knew it all and she helped convenience them it was a really need for [child]. Not only that but [child]'s teacher said "I am not signing it, I will not sign this IEP, mom to mom, he needs it." She [clinician] is also going to the eye care doctor with me. Just to see what we can get [child] enrolled in. Right now [child] is also enrolled in the respite program, which is great. That is such a nice thing for us; it gives us some nice time away sometime. You need advocates, having them in your corner because not everyone is going to listen to me. Nobody is going to listen to him [points to grandfather] or me [shakes her head side to side three times].

All clinicians 4/4 (100%) reported the use of Development Information and/or Anticipatory Guidance, during the check-in or reflection portion of treatment sessions. A clinician remarks on the process and how it can help the child and parent address transitions to new situations.

Anticipatory guidance, I think, is everything from the justification, to helping with new situations. One kid pops out when we talk about this, I was working with a family who had a new situation, the little guy was saying he was scared about camping this summer. And originally mom was saying, "you're scared?" and I

[clinician] looked at her [mom] like “Do you know what to do?” and she's like, “Oh, some little boys and girls get scared, but then once you're there you will be ok.’ But she wasn’t able to tell him that “When you feel that way, you can come close or ask questions or ask mom to go on a walk with you around the campsite so you don't have to feel afraid” so we worked on that. Just different things like that, with this kid, the dentist was very challenging. School was pretty challenging. There were a lot of things that were pretty challenging. And sometimes anticipatory guidance is half the battle.

A parent remarks on how the involvement in treatment with extended family has improved her ability to use family as natural supports, which is part of the IMH model of supportive clinical services.

She's [clinician] done play therapy and therapy with him, with his dad, with my mom, with my step-dad, with my grandma, so. It's been here, at my Mom's before, at the school. One time we met at McDonald's because something came up last minute for us and we called and she [clinician] said, “Well, I'm over here if you want to meet me at this McDonald's.” Talking to her has been helpful, because especially my step-dad and my grandma, they're very old school. And very, “Well if he's not going to listen just spank him.” So it's been a big, big help, what I've learned and what I've taught my mom how to deal with him, my step-dad has picked up on. It's pretty much changed our whole family. Through what I've learned from [clinician] and passed on to everybody, my sister has kind of picked up with that as well, it's changed my whole family, its changed a whole lot

of what we do. I am more able to call my mom and say, “Look, this is what is going on, what do you think I should do?” rather than calling [clinician] twice a day. She [parent’s mom] is more open and my grandmother and her have read different book that the [clinician] has suggested.

In summary, nearly all of the parents 19/20 (90%) were actively involved in a consistent treatment process, which included a parent check-in, play session, parental reflection and a post-session activity. Additionally, parents received Anticipatory Guidance (65%), Developmental Information (55%), Advocacy (44%) and Concrete Needs Assistance (12%). Chi-squares results indicate significant relationships between CPP and Anticipatory Guidance and Developmental Information focused on the child or family, along with PP and Anticipatory Guidance on the child and family, but only Developmental Information when focused on the family (verses the child).

Research Question 4: Qualitative Results

Qualitative Results Regarding the Clinician-Parent Relationship

During interviews, all clinicians identified a trusting clinician-parent relationship as a key aspect of treatment and nearly all of the parents 19/20 (90%) described the clinician-parent relationship as supportive, consistently available (during and in-between home visits) and attentive to parental thoughts/feelings and needs. Within the context of the supportive relationship, parents reported a deeper understanding of difficult child behaviors and their own parenting responses. As a result, parents felt empowered and more comfortable making parent-related decisions, employing tailored parenting strategies and advocating on behalf of their child to friends/family and reported improved natural supports and fewer feelings of social isolation.

Attunement, support and availability. A parent remarks on a clinician's level of attunement, support and encouragement during treatment sessions.

I like how they come out and they really listen to my concerns. And they don't just write it off, like maybe it's just a change of the season, no they really listen to my concerns and help me and give me ideas of what to do. And I think even though being a young parent, because I'm only 23, they give me the breakdown and tell me what's normal and what's typical. And like, they tell me that certain things are typical at this age too. And it's not just a disorder that's taking over, because that's what I was worried about, the biggest thing. That it would take over everything. I just like how they're so involved with us, they really are. And they listen, they sit down and listen to me, and they listen to my significant other. She has concerns, they just really listen. And then too, sometimes when I was crying, [clinician] would be crying too and would be like, "yeah, I know it's a bit much for you, but we will get through it." She is very encouraging.

A parent remarks on the constant support and availability of the clinician and how the support contributes to feeling less isolated from others.

So she's [clinician] there. She's there for me and she's gone to the pediatrician with me when we're trying to figure out meds. She's been to all the IEP meetings we've had throughout the years, so she's been there a lot. For everything that we're going through. Because I think she knows, you know, we don't have family help around here. So she knows emotionally I need the help, I mean, cause it's hard. So I just like the fact that if she doesn't know then she'll ask a coworker. She'll ask

her supervisor, she'll find the answers for me, I think it's been a really good help for us. It's kind of opened our eyes to different disabilities that are even out there. I think it's been really helpful just to know, you know, that he isn't the only one, so it makes us feel like we aren't alone and there are other kids out there going through this and other families.

Another parent describes how the clinician has built a positive relationship with the child but is equally attuned to her [parent] daily experiences or stressors, which the parent finds surprising.

If you don't trust the person you are counseling with, you are not going to tell them how you really feel so she [child] reaches out to [clinician] and says things to her that she [child] wouldn't of said to me, so I think it's a good relationship and she handles her really well and the [clinician] offers me more support than my family does, and she is always helpful. If I make mention of something, she asks, "How are you?" "You seem sad," and stuff like that and sometimes she offers me solutions sometimes or some resources to help out with things and she does she's really wonderful. I would categorize her as a professional friend. I like that she is certified in child development so if [child] is doing something, I am like is this normal? And she is like, "yeah." And she's so helpful to our family, and I really appreciate everything, because she does things that are not even technically her job really. She comes here for [child], and she doesn't come here to listen to me to gripe out my job because how badly it stresses me out, you know. She's really great.

Deeper understanding of child behaviors and parenting responses. The following are remarks from an adoptive parent and how her insight into child behaviors/ symptoms deepened her understanding, ability cope with frustrations and adapt parent responses.

It's just really helped me learn to look at things differently and approach things. My daughter, instead of immediately interpreting something one way, looking at it and understanding it comes from somewhere else. When she [child] first came [adopted child] I was frustrated, I was a frustrated parent. I didn't understand what was going on and if it wasn't for her [clinician] at the beginning helping us understand what fetal alcohol syndrome was and how to deal with the behaviors and such, I'm not so sure we could have made the other transitions so easy. And so [clinician] has helped me to understand her better and in turn, it's helped me to understand and adapt myself and my reactions. And to be able to cope with frustrations. So she [clinician] has helped us deal with those things and when you have a less frustrated parent, you have a less frustrated child.

Another parent remarks on a similar experience and how support and a deeper understanding contributed to modifying parental reactions.

Talking with her [clinician] has really helped me to understand my [child] and not to take the things personal. Because at first I'd feel like, "you know maybe it is my fault what he does" and she'd [clinician] would say like, "you have to step back and just now that it's not you, this is a disorder." And she used to give me, well she still gives me a lot of praise for how far [child] has come because where we were back in August was a whole different kid from where we are now.

Parental empowerment and confidence. To understand feelings of empowerment, it is important to note that prior to treatment services, parents reported intense stress and frustration related to child difficult behaviors/symptoms. The following is a remark from a parent regarding her frustration about parenting.

His [child] episodes would last an hour to an hour and a half where I had to physically restrain him and it was happening three or four times every single day. And then he wouldn't be safe in the car, like he would unbuckle his seat belt and dash to the front of the car and at one point, he opened the door because I forgot the child locks. And when I looked at him, he was not there, it was not like him, he was not my son and I didn't know how to manage it. I was stressed every day, literally crying everyday.

Parents also reported isolation from friends and family who made quick judgments and blamed the parent for child behaviors/symptoms. A parent remarks,

My father-in-law has a brand of discipline [spanking] he thinks we should use on our child. And if that doesn't work, you just need to do it harder. No, that's not a solution, and it's frustrating because you get advice from a lot of people that don't get the whole thing.

Once involved in treatment services, parents reported feeling empowered by the knowledge they learned about their child's behaviors/symptoms and their own parenting responses. As parents were able to implement new parenting strategies, they felt more confident in making parent-related decisions, using positive coping skills as needed, employing new parenting strategies and advocating on behalf of their child with friends and family. A parent remarks how a supportive clinical relationship has influenced her own anxiety, ability to manage

child behaviors/symptoms and find words to help friends and family understand her [child] better.

I just feel more comfortable in my decision-making after talking to her [clinician] because, you know, it helps to have somebody to talk to about it. And, without it I already have a lot of anxiety, so I feel a lot better if I can talk to her about things and discuss them with her, so that helps a lot. I like the consistency of it, that you know, she's here and she comes once a week and it's, you know, we continue on where we left off. Having her [clinician] to talk to and explain things to me to make me feel, you know, like I understand her [child] better. She [clinician] has explained you know like the right side of the brain and the left side of the brain and how it works, and now I understand more about you know, how kids act. Cause I didn't realize that there was so much in there, some of the ideas that she [clinician] gave me to work with her have specifically helped [child] and given me words to use with my friends and her [child] family so they get her more. I feel I have gotten a valuable education to help her [child].

Another parent remarks on how she has learned triggers to her child behaviors and how she felt more confident managing his behaviors in the community.

It was like we were in prison in our own home and that was what it felt like. And that's what it totally felt like. Because really he [child] determined what we would do as a family and everything. He would determine a lot of things. But now we know to be sensitive to his order, and get out, like maybe if there's a crowd we know how to put [child] in the middle to make a little barrier if he feels

uncomfortable or if he feels like he is starting to get overwhelmed we can tell by his facial expression or his body language that he needs to move to a different area or something else. You know, we are able to pick up on little signs before it gets bigger just like that. So that helps us A LOT, we are better at handling him. We can go out and ride the bus now to go to places.

Another mom talks about feeling accomplished as she now has the words to help her family and friends understand her child more and with new parenting strategies, she can now complete errands in the community.

My family is hard to talk to about her [child] because they say she needs more discipline and I don't think it's about the level of discipline she receives, I think it's something within her and I can say that now to them [friends and family] because disciplining her more is not going to help or build her [child] confidence [building the child's confidence is a treatment goal]. She's making a lot of improvement, like I said, I can go to the grocery store now and that's like an amazing feat, because it was horrible. I was the embarrassed Mom who left her grocery cart full of things because I had a child going bonkers in the store [laughs]. So, now I can finish my shopping and it doesn't take me 2 or 3 tries to go do it. Yeah [mom smiles at baby in her arms], it feels good.

In conclusion, parents and clinicians reported the clinician-parent relationship to be a key aspect in receiving support, treatment interventions and clinical supportive services; and in feeling more confident and empowered to tailor parenting strategies to meet child/family needs to advocate on behalf of their child to friends and family and reported improved natural supports and fewer feelings of social isolation.

Overall Summary

Clinicians used initial and continual assessments to tailor treatment modalities and interventions; however, the willingness and readiness of the child, parent and family was assessed prior to implementing proposed interventions. If a child or parent was not willing to engage or ready to participate, interventions were adapted to meet the family's immediate needs or concerns. Once a client or parent was willing and ready, clinicians remained flexible when employing treatment modalities and interventions to meet the shifting needs of the family.

When examining specific RPT and non-RPT treatment models, clinicians identified the use of Filial Play Therapy and Theraplay along with several non-directive and directive play therapy techniques. In terms of IMH, clinicians identified the use of attachment theory and psychotherapy to help parents explore parenting reactions/responses and unresolved inner conflicts related to their childhood experiences. Analysis of the Service Provider Checklist indicates clinicians utilized RPT models 49% and IMH models 34% of the time during home visits within a two-month time frame. Cumulatively, there is a higher percentage of play therapy, which may suggest clinicians are integrating specific play therapy techniques, as needed within IMH or other treatment models.

Chi-square analyses indicates the relationship between Child-Parent Psychotherapy (CPP) and the combination of Non-Directive Play Therapy (NDPT) and Directive Play Therapy (DPT) was significant indicating clinicians are more likely to use CPP with NDPT and DPT (than using CPP without NDPT and DPT techniques). Additionally, results indicate significant relationships between CPP and TF-CBT; Art Therapy and DPT; and Bibliotherapy and DPT postulating clinicians were more likely to use both models within treatment sessions verses the utilization of a single treatment model.

When exploring parental involvement, 19/20 (95%) of the parents reported active involvement within a consistent treatment process. The process as reported by clinicians and parents included a “check-in” period to explore previous events or concerns, and prepare for the parent-child-clinician play session. This was followed by a play session in which parents actively participated or observed. Following the play session, clinicians allotted time for parents to reflect on the process of the play session and their own reactions, which may (or may not) be related to their own childhood experiences as a parent. Parents also reported a post-session activity where clinicians assigned parents an activity focused on coping skills to complete with their child in-between home visits.

In addition, parents reported involvement in clinical supportive services and more than half of the parents received Anticipatory Guidance (65%) and Developmental Information (55%) and almost half (44%) received advocacy related to school, health, mental health or court systems whereas less than 12% received concrete needs assistance. Chi-squares tests of independence indicated a significant relationship between CPP and Anticipatory Guidance and Developmental Information when focused on either the child or family. Similarly, Chi-squares indicated a significant relationship between Parent Psychotherapy (PP) and Anticipatory Guidance focused on the child and family and PP and Developmental Information only when it is focused on the family. Overall, higher chi-square and phi values indicate a stronger relationship when CPP or PP and AG and DI are centered on the needs of the family. During interviews, the inclusion of clinical supportive services was also reported by clinicians and parents to be an important aspect of building a clinical relationship and gaining access to needed resources for families.

Finally, a trusting clinician-parent relationship was reported throughout clinician and parent interviews. Parents described the clinician-parent relationship as supportive, consistently available and attentive to parental thoughts/feelings and needs. Within the context of the clinical relationship, parents reported gaining a deeper understanding of child behaviors/symptoms, parenting responses and reactions based on their childhood experiences. With this knowledge and support, parents felt more confident in making parent-related decisions; tailoring parenting strategies to meet child needs at home and in the community; and advocating on behalf of the child with friends and family and reported improved natural supports and fewer feelings of social isolation.

CHAPTER 5: Discussion, Limitations and Implications

Introduction

Although IMH and RPT have efficacious treatment models rooted in randomized and non-randomized studies, current evidence does not include specific knowledge about the process and/or related outcomes in regard to the integration of RPT into IMH for preschoolers and their families living in poverty. Therefore, the purpose of this study was to gain an in-depth understanding from the experiences of those involved in an integrative treatment process. Research questions centered on the experiences of parents with at-risk preschoolers and clinicians providing direct treatment services with an emphasis on the similar but different aspects of RPT and IMH treatment approaches. A total of four research questions were developed:

1. How do clinicians decide to integrate play therapy within an IMH treatment approach with at-risk 3 to 5 year olds and their families?
2. What RPT models and Non-RPT Models are clinicians utilizing within an IMH treatment approach for at-risk 3 to 5 year old children?
3. How are parents involved in the treatment process when play therapy is integrated into an IMH treatment approach with at-risk 3 to 5 year old children?
4. How does the clinician-parent relationship impact the integrative treatment process?

An integrated phenomenological approach (Creswell, 2013) was implemented to gain an in-depth understanding of the process from the experiences of parents and clinicians involved in an integrative treatment process. This approach integrates a psychological perspective (Moustakas, 1994), and a human science orientation (van Manen, 1990) that focuses on interpretations between the meanings of the lived experiences (van Manen, 1990). A mixed-

method design was implemented to order in gain an understanding from multiple perspectives, triangulate results (Klassen et al., 2012) and identify contradictory and confirmatory evidence (Green, 2007), all of which can lead to a fuller understanding of an integrative treatment process. Qualitative methods included clinician and parent interviews and applied to research questions 1 through 4; and quantitative methods included a Service Provider Checklist that explored patterns of treatment interventions and clinical supportive services and provided answers to research questions 2 and 3. Qualitative results further illustrated and explained quantitative results. This chapter will begin with an in-depth discussion of findings followed by clinical, research and policy implications followed by a conclusion.

Discussion

The decision to use an integrative model centered on the need to tailor treatment services and supportive services to address child and parent risk factors related to maladaptive emotions/behaviors and to enhance protective factors associated with the parent-child relationship. Tailored treatment services were accomplished by the use of initial and continual assessments; utilizing theories (attachment and psychoanalytic) to determine the relevance and types of data needed during assessments (i.e. child maladaptive behaviors, caregiver permanency and parent-child attachment patterns), assessing the willingness and readiness of the child/parent, and obtaining parental feedback prior to implementing interventions. These attributes represent evidenced-based practices within a collaborative treatment approach (Jordan & Franklin, 2011; Spring & Hitchcock, 2009; Thyer & Pignotti, 2011). Furthermore, clinicians implemented IMH evidenced based models, CPP (Lieberman et al., 2006; Ippen et al., 2011) and COS (Hoffmann et al., 2006); and RPT evidenced based models, Filial Play Therapy (Alivandi-Vafa & Ismail, 2010; Topham et al., 2011) and Theraplay (Wetting et al., 2011). In addition, the use of non-directive

play with children during the assessment period (which was used to assess child willingness) along with a focus on the parent-child dyad were predictors of treatment effectiveness in relationship-based programs focused with high-risk families living in poverty (Mortensen & Mastergeorge, 2014).

Despite the identification of evidenced-based practices, clinicians reported uncertainty about whether their approach “fit into” an evidenced-based model or what was considered evidenced-based practice. This could be related to the hesitancy clinicians demonstrated in identifying theories and specific components of treatment models, hence, they were not comfortable committing to an established evidence-based practice or treatment model. It may also be plausible that the language of evidence-based models/practices are not part of day-to-day clinical conversations and with limited training, this could lead to misconceptions between what constitutes an evidenced-based practice or model (Spring & Hitchcock, 2009).

During interviews, clinicians reported a range of RPT models (Filial Play Therapy and Theraplay) and techniques (Non-Directive, Directive and Non-directive and Directive) along with IMH theories (Attachment and Psychodynamic) and models (CPP and PP). Analysis of the Service Provider Checklist indicated that clinicians utilized RPT models more often (49%) than IMH models (34%) and other treatment models. Other treatment models included utilizing Bibliotherapy (24%), CPP (20%) and TF-CBT 20% of the time. Cumulatively, there is a higher percentage of play therapy, however, the frequencies of individual treatment models highlight the possibility clinicians are integrating specific play therapy techniques in Non-RPT models such as CPP, TF-CBT or Bibliotherapy. For example, clinicians remarked on using directive play techniques within the context of CPP to introduce play that fosters positive attachment behaviors between the parent and child (i.e. cotton ball toss, burrito roll up) or to enhance a

child's ability to self-regulate within treatment sessions. Other treatment models were identified including Parental Psychotherapy (12%) and Safety Planning (14%) due to severe aggressive behaviors and/or self-harm ideations or plans. Collectively, the range of interventions reported highlight the diverse needs within high-risk preschoolers and parents living in poverty (Lieberman & Van Horn, 2008) and the diverse skills of program clinicians. During interviews, clinicians identified the range of interventions to target maladaptive behaviors, child and parent self-regulation, parental sensitivity and/or positive attachment behaviors, which is consistent with the conceptual literature supporting the integration of RPT into IMH (Paradis, 2002; Tuters & Doulis, 2000).

Additional analyses of the Service Provider Checklist indicated significant relationships between CPP and the combination of Non-Directive Play Therapy (NDPT) and Directive Play Therapy (DPT); CPP and TF-CBT; Art Therapy and DPT; and Bibliotherapy and DPT. These findings suggest clinicians are more likely to use the combination of the specified treatment models versus the utilization of one single model. It is plausible clinicians are using two models to increase the scope of interventions (Paradis, 2002; Tuters Doulis, 2000). However, it may also be possible that clinicians are tailoring specific Non-IMH treatment models (TF-CBT) to emphasis parent-child or family attachment reparation or Non-RPT treatment models (Art Therapy and Bibliotherapy) to include play techniques centered on the specific needs of the parent-child dyad or family. This is consistent with literature that suggest integration is needed to meet the needs of the family (Gil, 2006; Lieberman & Van Horn, 2005; 2008) and seems probable in this study, as treatment modalities during home visits focused on the parent-child dyad 52% and encompassed families 20% of the time.

When exploring parental involvement, 19/20 (90%) parents reported active involvement within a consistent treatment process, which was understood by parents. Only one 1/20 (5%) parent reported no involvement with the play or reflection aspects of the treatment process. Each parent was able to identify the different aspects (i.e. check-in, play session, reflection and post-session activity) in the treatment process; and reported value in being involved and working collaboratively with the clinician. The different aspects in the treatment process could serve as a guidebook for clinicians integrating RPT into IMH treatment services as it represented a blend of IMH and RPT treatment principles. For example, the check-in period allowed gave parents the space to voice their concerns and clinicians to provide support and empathy while providing clinical supportive services to meet the needs of the child, parent or family. The latter aligns with IMH treatment principles (Weatherston & Tableman, 2002) whereas the discussion of the subsequent play session and role-plays that occurred follows RPT treatment principles (Gil, 2006; Jernberg & Booth; Landreth, 2002).

In terms of the play session, parents reported that it was held between the child-parent-clinician or the clinician and child with parental observation. Parents did report understanding the utility of play and how it related to client or parent treatment goals, which highlights parental investment within treatment services. However, it was noted clinicians or parents did not report the assessment or use of symbolic or metaphoric play within play sessions. Clinicians may have implied this when they reported the use of RPT treatment models; nonetheless, the capacity to use symbolic or metaphoric play is an important aspect of RPT and was identified as a primary rationale for integration (Benham & Slotnick, 2006). Therefore, further examination of this treatment aspect is needed.

The reflective time clinicians allotted for parents to explore and process the play and its potential meaning(s) also represented a blend of RPT and IMH treatment principles. However, utilizing psychoanalytic theory, clinicians examined parental reactions/responses to the play and how they related to their own childhood experiences. The latter is a cornerstone in IMH treatment approaches and allows parents the opportunity to examine unresolved conflicts and reorganize internal working models, which in turn can facilitate growth and modify in the parent-child relationship (Fonagy & Target, 2003). In other words, it gives parents the therapeutic space to resolve conflicts, which can impact their understanding of the parental role and change how they interact and respond to their child. This inclusion confirms the use of psychoanalytic theory and treatment principles within the integrative treatment process and fulfills a current need within RPT to focus on parental mental health in relation to parenting (Benedict & Mongoven, 1996; Gil, 2006).

The final aspect of the consistent treatment process was a post-session activity, which extended and reinforced parental involvement in-between home visits. Clinicians assigned parents an activity to complete with their child throughout the week that focused on using positive coping skills (i.e. blowing bubbles for deep breathing, reading a feeling book). The idea of post-session activities is embedded with one RPT model, Theraplay (Jernberg & Booth, 2010) and one IMH model, CPP (Lieberman & Van Horn, 2005). However, the goal or focus of the activity for CPP and Theraplay is different and relates to the child/parent practicing positive attachment behaviors focused on attunement, engagement and/or providing structure in the relationship to enhance the reorganization of internal working models of attachment (Jernberg & Booth, 2010; Lieberman & Van Horn, 2005) verses learning/practicing a coping skill. It is plausible clinicians assign similar activities, however, further examination is needed to determine

if post-sessions activities include a focus on attachment reparation and effectiveness within the treatment process.

In this study, parents reported high levels of stress due to child behaviors; therefore it is not surprising the most frequent clinical supportive service was Anticipatory Guidance (65%) and Developmental Information (55%), which focused on either the child or family.

Interestingly, the significant relationships between CPP and Anticipatory Guidance and Developmental Information indicated higher chi-squares and phi values when Anticipatory Guidance and Developmental Information were focused on the family verses the child. These findings may be due to interrelation of the parent-child dyad to other members of the family, which may create a need for Anticipatory Guidance/Developmental Information to address family verses child concerns (Patterson, 2001; Walsh, 2006). Similarly, a significant relationship was indicated between PP and Anticipatory Guidance focused on the client or family and PP and Developmental Information focused on the family. This is also interesting and speaks to the need of Anticipatory Guidance/Developmental Information within a parent-focused treatment intervention. Although Developmental Information and assistance with specific parenting strategies is a part of RPT treatment models, chi-square relationships were non-significant, which may indicate limited knowledge about the use of Parenting Guidance and Developmental Information within RPT treatment models (Gil, 2001; Landreth, 2002). These findings represent a need for parents of preschoolers to obtain Anticipatory Guidance and Developmental Information on child or parent-based treatment models, in order to help reduce the stressors related to child and family behaviors, and/or special needs associated with DMS-IV disorders.

Additionally, clinical supportive services assisted parents in getting concrete needs met 12% of the time whereas advocacy within school systems occurred 20% of the time, which may

represent a specific need for this population. During interviews, clinicians reported consultation with teachers on behavior/symptom management and attendance at IEP meetings. Parents valued clinician attendance at IEP meetings and reported it helped them learn the language of the school systems and gain a deeper understanding of school processes. Per parent report, school advocacy did secure additional services within the school system, which included extra support in completing math and reading assignments, as well as speech and language services. These findings ascertain the presence of a risk factor for children living in poverty (lower school success due to the presence of behaviors/symptoms in school) and a need within this population for clinicians to advocate with parents to help them gain knowledge regarding the language, services and processes of school systems in order to reduce the impact of this specific risk factor (Emerson, 2004; Issacs, 2012). Lastly, clinicians advocated and/or supported mental health services a total of 17% of the time, which indicates a need to help parents further understand and/or navigate psychiatric or health services and provide transportation. The latter is consistent with literature indicating limited or unreliable transportation as a risk factor associated with living in poverty and can influence accessing or obtaining medical services (Broussard & Joseph, 2009).

Within the context of treatment interventions and clinical supportive services, parents identified a supportive clinician relationship, which influenced the treatment process and child and parent risk factors associated with living in poverty. Parents stated they valued the relationship and reported clinicians to be consistent, attuned to parental needs, genuine and supportive. Clinicians continually acknowledged the importance of the clinician-parent relationship throughout interviews and viewed it as a conduit to provide parental support, assess the willingness and readiness for treatment interventions, examine parental childhood

experiences and parenting responses. Clinicians remarked on the use of clinical supportive services; in particular concrete needs assistance and advocacy to build rapport and Anticipatory Guidance and Developmental Information once a trusting relationship was established. To maintain a positive therapeutic relationship, clinicians reported the need to be flexible when employing treatment interventions and modalities. Parents reported this to be a key aspect in meeting immediate and ongoing family needs, which may relate to a parent's ability (if needs were addressed or met) to engage in treatment interventions or clinical supportive services.

This study confirmed the presence of parental risk factors associated with living in poverty including lower parental satisfaction and competence and strained interpersonal relationships (Neece, 2013; Olson & Banyard, 1993; Pisula, 2007; Rodrigue et al., 1990; Sanders & Morgan, 1997). However, within the context of the supportive clinician-parent relationship and tailored treatment services, parents reported feeling more confident about parenting decisions and knowing how to adapt parenting strategies to meet the needs of the child and/or family. Parents also reported feeling empowered to advocate for their child with friends and family, which led to a greater familial understanding about the child's behaviors and/or needs, improved natural supports and fewer feelings of social isolation. These findings highlight the role of a supportive clinician-parent relationship to serve as a conduit to help parents feel more confident and empowered to advocate for their child.

In summary, understanding the experiences of parents and clinicians involved in integrative treatment model allowed an in-depth understanding of how treatment interventions and modalities and clinical supportive services are tailored to meet needs, enhances parental involvement and reduces the influence of risk factors for preschoolers and families living in poverty within the context of a supportive clinician-parent relationship.

Limitations

This study involved a small non-probability sample of parents and clinicians involved in a CMH treatment program in the Midwest. Although the demographic characteristics represent a diverse population of parents for the Midwest, the sample was inclusive of only one father and one grandfather. The population for clinicians was homogeneous in race and gender.

Questions for clinicians and parents were developed for the purpose of a program evaluation impacting their validity. It is possible there may have been selection bias as participation was voluntarily and parents satisfied with treatment services were more likely to participate in interviews than parents who were not satisfied. The majority of clinicians participated in interviews and all clinicians completed Service Provider Checklists. Data collected in interviews were based on self-report and may have been influenced by the positive clinician-parent relationship reported by parents. The Service Provider Checklists were also based on self-report and due to the nature of program evaluations, clinician data may have also been biased and positively skewed. The researcher had a previous working relationship with the program supervisor and one clinician in the program due to similar professional interests (i.e. early childhood and CMH treatment services), thus bracketing was completed to set aside previous experiences as much as possible (Creswell, 2013).

Although a phenomenological approach elicits multiple forms of data and a streamlined data collection process (Creswell, 2013), generalizability of the interviews is limited to the sample population. However, detailed descriptions of clinician and parent remarks were included, which improves the transferability of the data to a similar population (Creswell, 2013). To increase the trustworthiness, data were triangulated using multiple sources (clinicians and parents), multiple methods (interviews and Service Provider Checklist) and multiple

investigators (the researcher and two undergraduate student researchers); debriefings took place between the researcher and undergraduate student research and qualitative experts several times throughout the study; a codebook was developed and significant statements were independently reviewed (inter-rater code was 83%); and negative case analysis was completed.

The Service Provider Checklist was developed for this study, therefore the validity and reliability are unknown which impacts generalizability of findings. To improve validity, clinician and parent interview data informed the items on the Service Provider Checklist, and clinician feedback was obtained prior to finalizing the checklist. In addition, a codebook was developed to ensure clinicians understood the meaning of each item. Despite study limitations, this study does offer an in-depth understanding of an integrative treatment process and the identification of multiple interventions and clinical supportive services utilized with at-risk preschoolers and families living in poverty.

Implications and Recommendations

Clinical Implications

For clinicians, results provide a better understanding of the decision to tailor treatment services and identifies what specific RPT and Non-RPT models are being integrated within an IMH treatment approach for at-risk preschoolers and families living in poverty. Results outline a consistent treatment process and specific methods to enhance parental involvement (i.e. treatment inventions and modalities, parental feedback, clinical supportive services and post-session activities), which can help clinicians make evidenced-informed practice decisions (Spring & Hitchcock, 2009; Thyer & Pignotti, 2011).

Additionally, results highlight the integral aspects of the clinician-parent relationship and its relation to improving parental confidence and empowerment, which led to fewer feelings of social isolation per parental reports. Although the occurrence of risk factors were not measured, results accentuate a need for clinicians to include clinical supportive services within treatment services, especially school advocacy to improve academic success for at-risk preschoolers who display behaviors/symptoms at school (Emerson, 2004; Issacs, 2012). In addition, significant relationships between Child Parent Psychotherapy (CPP) and Parental Psychotherapy (PP) and Anticipatory Guidance and Developmental Information were stronger when focused on the family (verses an individual child), which postulates a family focus may be needed when clinicians are working with at-risk preschoolers and families.

During interviews, clinicians were reserved with the identification of theories and specific treatment models (verses clinical techniques), which may be interrelated to the uncertainty clinicians reported about whether their treatment approach fits into an established evidenced-based model or is considered evidenced-based practice. For clinicians, this may indicate a need for additional trainings and/or trainings focused on clinical techniques to be inclusive of theory and coordinating treatment models. Regulations within early childhood clinical associations or university continuing education programs may need to require presenters to include this information within clinical trainings especially when focused on an integrative treatment approach. Additional trainings on evidence-based practices and models are recommended to assist clinicians in understanding its applications to day-to-day client interactions and treatment services.

Research Implications

This study provides knowledge about the process in which clinicians tailor treatment services, and specific RPT and Non-RPT treatment interventions employed within an IMH treatment approach. However, further treatment model development is needed as it relates to the application of theories, the identification or assessment of symbolic or metaphoric play (as this is an important aspect in RPT models), and the four different aspects of the treatment process, in particular the use of a post-session activity. Further examination of the significant relationships between IMH (CPP) and RPT (NDPT & DPT) treatment models, along with other treatment approaches (TF-CBT, Art Therapy and Bibliotherapy) are needed to identify the specific tenets of each approach clinicians utilize when integrating two treatment models. This will provide a more clear and transparent process, which is needed to enhance reliability of future studies focused on the integrative treatment process for this population (Cassidy et al., 2011).

Future studies also need to examine outcomes related to the IMH/RPT integrative treatment process, in particular the clinician-parent relationship. This relationship was interwoven throughout the assessment and treatment process as reported by parents and clinicians. In fact, clinicians viewed this relationship as a conduit to provide parental support, assess willingness and readiness for treatment interventions, examine parental childhood experiences and parenting responses, and deliver clinical supportive services. To further examine the relationship between the strength of the clinical alliance and therapeutic outcomes, measures such as the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) may elicit insight into the collaborative elements between the working alliance of parents and clinicians and its association with therapeutic outcomes. The inclusion of a measure with good internal consistency (Horvath & Symonds, 1991) and demonstrated convergent and discriminate

validity with similar measures (Horvath & Greenberg, 1989) improves study reliability and validity, and hence its application in the clinical field and in shaping policies to ensure quality treatment services for at-risk 3 to 5 year olds and families living in poverty.

Future studies are also needed to examine child and parent outcomes in relation to an integrative IMH/RPT treatment approach. Parents in this study reported high levels of stress prior to treatment services and the presence of risk factors; hence potential measures could include the Parenting Stress Index (PSI) (Abidin, 1983), which attributes the total amount of stress a parent experiences is due to child characteristics, social support, parental health, role restrictions, parental attachment, and relationships with spouse (Abidin, 1990). Therefore, the PSI provides a baseline or outcome measure for interventions focused on decreasing risk factors associated with parenting stress, family functioning, and/or parenting skills, which could be correlated with WAI results. Ideally, future outcome studies would maintain a diverse sample and strive for larger sample sizes that are inclusive of more fathers or father figures.

Policy Implications

Results from this study will be disseminated to program clinicians and administrators and agency stakeholders including the senior management team and the board of directors. The dissemination will include knowledge regarding the integrative treatment process from multiple perspectives and its impact on parental involvement, the clinician-parent relationship and child and parental risk factors. As part of the discussion, agency policies regarding the use of relationship-based integrative treatment models and clinical supportive services will be examined. The need for agency trainings focused on evidenced-based practices and/or evidenced-based relationship models that are inclusive of theories will also be examined.

As Michigan recently expanded the IMH definition to include 4 and 5 year olds, results from this study could help facilitate discussion regarding competencies for clinical endorsements by infant mental health associations, and/or introduce the idea of competencies for at-risk preschoolers within play therapy associations. Endorsements may increase the number of trainings (as a specific number of training hours are required for endorsements) for clinicians throughout the State of Michigan on integrative treatment approaches with young children, and create an opportunity to advocate for regulations that include theories and evidenced-based practices in the content of trainings.

Recently, the U.S. State Senate passed the Medicare Access and Children's Health Insurance Program on April 14, 2015, which includes a two-year extension for the Maternal, Infant and Early Childhood Home Visiting Program for low-income families (NASW, 2015). It is plausible the results from this study could assist in advocating for legislative policies to ensure continued home-based programs for young children. This extension provides motivation to further examine home-based treatment models inclusive of integrative approaches specific to at-risk preschoolers and families living in poverty.

Conclusion

Findings from this study provide an examination on the process of integrating RPT into IMH treatment services for at-risk preschoolers and families living in poverty. Results highlight the need for initial and continual assessments along with parental feedback and flexibility in treatment delivery to meet the shifting needs of families and tailor treatment specific to the needs of the child, parent and parent-child dyad. A variety of RPT, IMH and other treatment models were reported including parental psychotherapy and safety planning which represent the variety of interventions needed to meet the complex needs of high-risk families (Gil, 2006; Lieberman &

Van Horn, 2005). Results indicated higher frequencies of RPT verses IMH, which may demonstrate a need for additional or specialized techniques within Non-RPT treatment models significant chi-square relationships represent a need for clinicians to tailor Non-IMH treatment models to center on attachment reparation and non-RPT treatment models to include specialized play techniques centered on the specific needs of the parent-child dyad or family.

Nearly all parents were actively involved within a consistent treatment process, which represented a blend of RPT and IMH treatment principles. Parents understood and valued their involvement within the process. Additionally, parents were involved in Clinical Supportive Services, which validates the presence of risk factors associated with living in poverty and represents a need for at-risk families with preschoolers to receive advocacy focused on school, mental health/health, court systems and concrete needs assistance. Additionally, the use of Anticipatory Guidance and Developmental Information demonstrated a greater effect when focused on family needs verses an individual child.

Parents reported a positive and supportive clinician-parent relationship, which was interwoven throughout the assessment and treatment process. Clinicians viewed this relationship as a conduit to provide parental support and treatment services. Within the context of the clinical relationship, parents reported feeling empowered to advocate on behalf of their child to friends and family, which improved familial understanding and fewer feelings of social isolation. This finding highlights the role of the clinician-parent relationship to clinical supportive services and its potential influence on reducing parental stress and risk factors associated with living in poverty.

Finally, clinicians reported uncertainty about theories and if their treatment approach was considered evidenced-based practice or fit into an already established treatment model. This

could be related to the hesitancy in identifying theories and specific components of treatment models, or the possible limited use of evidence-based model/practice language in day-to-day clinical conversations (Spring & Hitchcock, 2009).

Implications of this study include further development of the integrative treatment model, and future studies focused on outcomes related to the integration process and child/parent outcomes in relation to the integrative treatment process. Additional clinical trainings related to early childhood theories, treatment models and evidenced-based practices are needed.

APPENDICES

Appendix A: List of Search Words, Data Bases and Specific Journals

Search Words

Poverty and very young children
Risk factors and preschoolers
Risk factors and parents
Parent risk factors
Protective factors for parents
Prevalence of mental health disorders and young children
Prevalence of mental health disorders and preschoolers
Resiliency theory
Resiliency theory and poverty
Attachment theory
Attachment treatment models for preschoolers
Attachment meta-analyses
Integrated treatment models, young children
Mental health treatment models, young children
Infant Mental Health (IMH)
IMH Treatment Models
Evidence based IMH Treatment Models
IMH meta-analyses
Child Parent Psychotherapy
Circle of Security
Watch, Wait, and Wonder
Parent Child Interaction Therapy
IMH Treatment Approach
IMH Home visiting model
Comprehensive treatment for preschoolers
Home visiting and young children
Parental involvement in home visits
Play and young children
Play and parents
Play and families
Play in IMH
Play Therapy in IMH
Play and mental health treatment
Play Therapy (PT)
PT treatment models
Evidence based PT treatment models
PT effectiveness
PT meta-analyses
PT treatment models with preschoolers
Preschool mental health
Clinical perspectives
Developmental perspectives

Theraplay
Theraplay with preschoolers
Integrated Play Therapy
Filial Play Therapy
Child Parent Relationship Therapy
Thematic Play Therapy
Case studies in IMH
Case studies in PT
Integration of mental health treatment
Integration of IMH and PT
Integration of Non-directive and Directive PT
Integration of IMH treatment models
Integration and early childhood

Data Bases

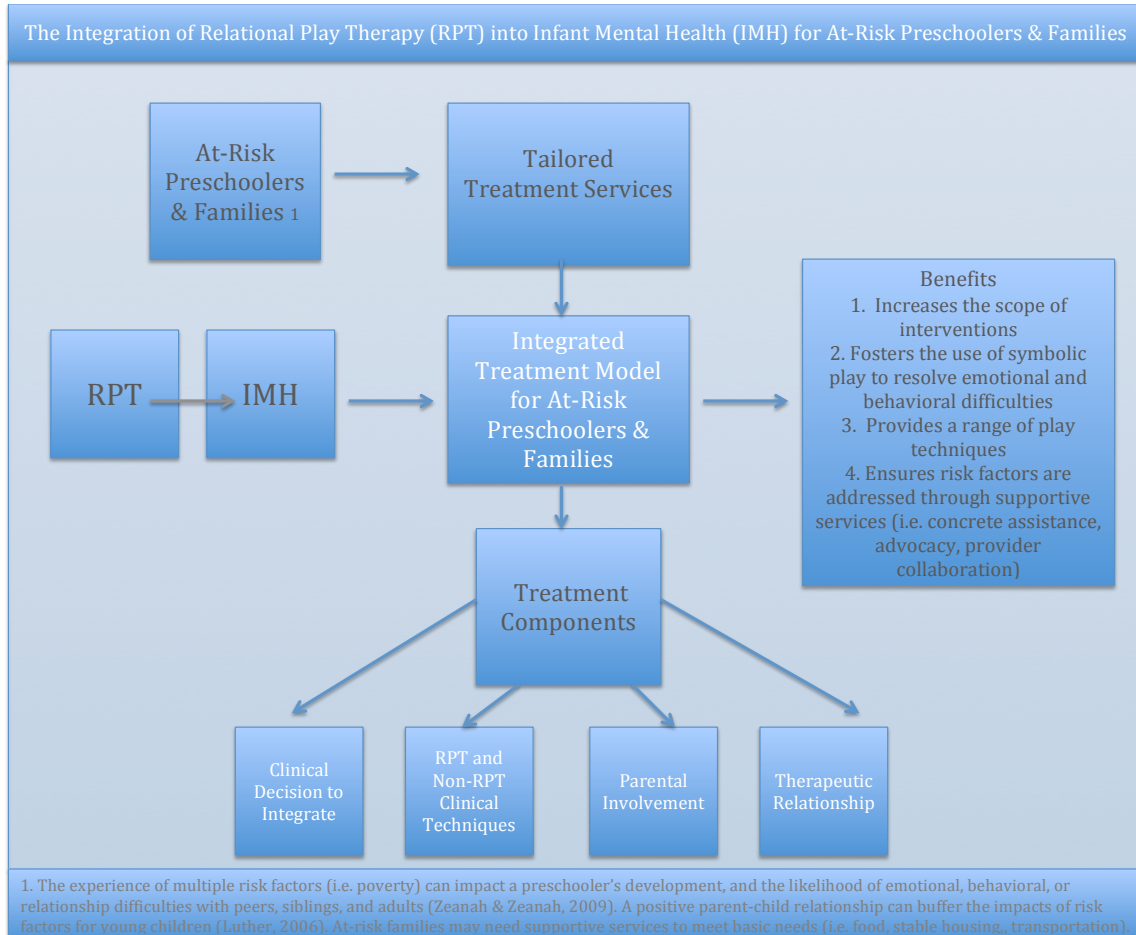
ProQuest Social Sciences
ProQuest Pysc Info., Psyc Articles, Tests & Critiques
ProQuest Dissertations and Theses
ProQuest Health & Medicine: PsycExtra
ERIC
E-Library, Psychology

Specific Journals

Infant Mental Health Journal
International Journal of Play Therapy
Child Development
Clinical Social Work Journal
Research on Social Work Practice

Appendix B: Conceptual Map

Figure 1: Conceptual Map



Appendix C: Consent For Parent Interview

Michigan State University Process and Outcome Evaluation for The CMH/PYC Program

Dear Parents,

This letter invites you to participate in an interview for the PYC program. The interview is part of a research study exploring the program's treatment services and how they impact your child's behaviors. The interview questions relate to what services you think are most helpful, changes you have observed with your child since starting the PYC program, and how you participate in sessions. The interview will take 45 minutes to 1 hour to complete. Snack food will be provided during the interview.

Your participation is completely voluntarily and does not impact treatment services at the PYC program or any CMH services. You may skip any questions, and stop participation any anytime during the interview process. The interviews can take place at your home, or at a PYC meeting room. Researchers will work hard to accommodate your scheduling needs, and be as flexible as possible.

If you chose to participate, please know your answers will be kept confidential and will not be reviewed by PYC staff or administrators. Only Michigan State University researchers collecting the data will review the answers. No identifying information will be associated with your answers.

In order to ensure we have all of your interview responses correct, we would like to tape record your interview. However, this is an option and if you would prefer not to be tape-recorded that is ok. You can participate in the interview without being tape-recorded. If do you consent to your interview being tape recorded, please note the tape will be shredded after it has been reviewed. A separate consent form will be provided to participants on the day of their interview to either agree or not agree to the tape recording.

Your knowledge of the PYC program and participation in this interview is extremely valuable to this research. As a way of expressing our appreciation for participating in the interview process, you will receive a \$25.00 gift card to a grocery store.

If you have any questions, please contact Jennifer Farley at (xxx) xxx-xxxx or Ellen Whipple at (xxx) xxx-xxxx. The Community Mental Health Research Committee has approved this study and the Institutional Review Board (IRB) at Michigan State University has confirmed this study is designed for program evaluation purposes. The IRB identification number is x13-023e. You may also contact the IRB for any questions at (517) 355-2180.

Consent to Participate (agree to participate)

I understand my participation will be to answer questions in an interview process that will take about 45 minutes to 1 hour. Participation is voluntarily, and I can stop at any time. All of my answers will be remain confidential. I do understand my participation and/or answers to the survey will not impact your PYC program or any CMH services.

Parent Signature

Date

Decline to Participate (chose not to participate)

At this time I decline to participate in this research study by participating in an interview. It is ok not to participate and my PYC program or any other CMH treatment services will be not be impacted.

Parent Signature

Date

Thank you your time and consideration to research focused on early childhood programs.

Respectfully,

Jennifer Farley
Secondary Investigator

Appendix D: Consent For Clinician Interview

Michigan State University Process and Outcome Evaluation for The CMH/PYC Program

Dear Parent Young Child Clinicians:

This letter invites you to participate in an interview for the PYC program. The interview(s) are part of a research study exploring the program's treatment process and treatment outcomes. The interview questions relate to treatment modalities utilized, integration of treatment models, working with preschoolers, and parental involvement. The interview will take 45 minutes to 1 hour to complete and snack food will be provided.

Your participation is completely voluntarily and does not impact your employment at the PYC program. During the interview, you may skip any questions and/or stop participation any anytime during the interview process. The interviews will take place at the PYC office and/or a different confidential site if needed. Researchers will accommodate your scheduling needs and be as flexible as possible.

If you chose to participate, please know your answers will be kept confidential and will not be reviewed by PYC staff or administrators. Only Michigan State University researchers collecting the data will review the answers. No identifying information will be associated with your answers.

In order to ensure we have all of your interview responses correct, we would like to tape record your interview. However, this is an option and if you would prefer not to be tape-recorded it is ok. You can participate in the interview without being tape-recorded. If do you consent to your interview being tape recorded, please note the tape will be shredded after it has been reviewed. A separate consent form will be provided to participants on the day of their interview to either agree or not agree to the tape recording.

Your clinical knowledge and participation in this interview is extremely valuable to this research. As a way of expressing our appreciation for participating in the interview process, you will receive a \$25.00 visa gift card.

If you have any questions, please contact Jennifer Farley at (xxx) xxx-xxxx or Ellen Whipple at (xxx) xxx-xxxx. The Community Mental Health Research Committee has approved this study and the Institutional Review Board (IRB) at Michigan State University has confirmed this study is designed for program evaluation purposes. The IRB identification number is x13-023e. You may also contact the IRB for any questions at (517) 355-2180.

Consent to Participate (agree to participate):

I understand my participation will be to answer questions in an interview process that will take about 45 minutes to 1 hour. Participation is voluntarily, and I can stop at any time. My participation and/or answers to the interview will in no way impact your PYC employment. All of my answers will remain confidential.

Clinician Signature

Date

Decline to Participate (chose not to participate):

At this time I decline to participate in this research study by participating in an interview. It is ok not to participate and declining to participate does not impact my PYC employment.

Clinician Signature

Date

Thank you your time and consideration to research focused on early childhood programs.

Respectfully,

Jennifer Farley
Secondary Investigator

Appendix E: Consent For Interview Audio Recording

Michigan State University Process and Outcome Evaluation for The CMH/PYC Program

Authorization for Audio Recording of Research Interviews

I authorize MSU researchers to tape record my interview. I understand these tapes will be used only for research purposes. Only MSU researchers will review these tapes to ensure data collection is accurate. The tapes will be shredded after the data has been verified.

This authorization will expire after the interview has been completed.

I authorize having my interview tape recorded for the purposes stated above.

_____ Yes

_____ No

Any questions I have about this authorization have been explained to my satisfaction included the purpose, risks, and benefits to be reasonable expected. I understand that I may withdraw this authorization at anytime during the interview.

Participants Signature

Date

Witness Signature

Date

Appendix F: Service Provider Checklist

Figure 2: Service Provider Checklist

Please fill out ONE service provider checklist for EACH home visit, Thank you!
[Examined Research Question 2 & 3]

Date of Home Visit: _____		ID#: _____	
Length of Session (pls circle)	Modality (please circle session type & those involved)		
Less than 1/2 hr.	Individual Therapy	Family Therapy	Group
1/2 hour	Client	Client & Parent	Client
45 minutes	Parent	Client & Sibling	Parent
1 hour	Sibling	Client, Parent & Sibling	
1.5 hours			
2 hours or more			
Therapeutic Interventions Utilized (circle those applicable)			
Parent Psychodynamic Therapy Child Parent Psychodynamic Therapy Cognitive Behavioral Therapy (CBT) Trauma Focused CBT Non-Directive Play Therapy Non-Directive Play Therapy and Directive Play Therapy Directive Play Therapy Art therapy Biblotherapy Safety Planning Sensory Integration IMPACT Other: _____			
Parenting Interventions (please circle parenting model and focus of intervention)			
Anticipatory Guidance		Behavioral Parenting Strategies:	PMTO
Developmental Information		Love and Logic	Parenting Through Change
			Other: _____
Focused on: Client, Sibling, Ct. & Sibling, Family			
Additional Clinical Services (please circle type of service)			
Medication Management	School Interventions	Court Interventions	
Gaining appt. for Psychiatrist	Ct. Observation	Coordination w/court staff	
Gaining appt. for Med Review	School consultation	Education to families	
Clinical Coordination w/Psychiatrist	Client IEP Meeting	Recommendation Letters	
Clinical Coordination w/Pediatrician	Other: _____	Testifying	
Other: _____		Other: _____	
Concrete Needs, please list focus: _____			
Advocacy, please list focus: _____			
Please list any other services provided: _____			

Appendix G: Clinician Interview Questions

The following 12 questions were asked to program clinicians. Questions 2, 3, 4, 5 and 6 pertain to the focus of this study. The remaining questions will be explored within program evaluation findings.

1-On your caseload what are the reasons for referral?

2-How do you determine the treatment modality with children and/or families [This question was asked to explore research question one]?

3-What play therapy theories or models do you apply [This question was asked to explore research question two]?

4-What play therapy techniques did you utilize [This question was asked to explore research question two]?

a. What do you generally take to home visits to see children?

b. What do you generally take to home visits to see families?

5-What IMH theories/models do you apply [This question was asked to explore research question two]?

6-If individual work is determined, how do you involve parents in home visits [This question was asked to explore research question three]?

7-How often do you assist parents with anticipatory guidance [This question was asked to explore research question two]?

8-How does external parenting groups or training impact treatment services?

9-What are the most challenging aspects of working with preschoolers?

10-What are the most challenging aspects of working with parents?

11-What would you change about the program and/or its services?

a. Why?

12-What specific trainings and/or credentials have you earned?

a. Which ones do you think have helped you the most?

Appendix H: Parent/Caregiver Interview Questions

The following 12 questions were asked to program parents. Questions 4, 5, 7 pertain to the focus of this study. The remaining questions will be explored within program evaluation findings.

- 1-What were some of the reasons that you decided to participate in the PYC program?
- 2-Do you think the PYC program has helped you? What about your child?
- 3-What do you think has helped you the most? What about your child?
- 4-Are you involved in sessions? How [These questions were asked to explore research question three]?
- 5-If you are involved, what do you think about the process of sessions [This question was asked to explore research question three]?
- 6-How would you describe your child's relationship with your PYC therapist?
- 7-How would you describe your relationship with the PYC therapist [This question was asked to explore research question four]?
- 8-What changes have you seen in your child since he/she began the PYC?
- 9-Do you find treatment helps reduce stressors related to parenting?
- 10-Are you enrolled in any additional parent groups or training? Which ones?
- 11-Do you think treatment impacts your child at school (behaviorally, academically, or socially)?
- 12-What aspects of the program do you like?
 - a. Would you change any aspects of the program?
 - b. Why?

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